

UNIVERSITY OF MISSOURI SYSTEM
Dental SPD

Effective January 1, 2020



This Summary Plan Description (SPD) is designed to provide an overview of the Dental Plan. While the University hopes to offer participation in this Plan indefinitely, it has the right to amend or terminate any benefit plan. In addition to this SPD, the University plans to continue to use other methods of communication such as memos, meetings, or newsletter articles to help you stay informed.

This SPD serves as both the Plan document and SPD. This SPD is designed to meet your information needs. It supersedes any previous printed or electronic SPD for this Plan. The terms of this Plan may not be amended by oral statements made by the Plan Sponsor, the Claims Administrator, or any other person. In the event an oral statement conflicts with any term of the Plan, the Plan terms will control.

It's important for you to have a good understanding of all this Plan has to offer. Please review this SPD carefully. If you have questions, contact your [HR Generalist](http://umurl.us/CBR) (umurl.us/CBR) or the [HR Service Center](http://umurl.us/HRSC) (umurl.us/HRSC).

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Introduction

The Dental Plan (Plan) is designed to help you meet the expense of dental care by providing a broad range of benefits for you and your family. The Plan encourages preventive dental care, but also provides meaningful benefits if you incur large dental bills.

The Plan provides payment for covered dental expenses for you and your eligible dependents. Covered dental expenses are the usual charges of a dentist for services and supplies that are necessary for treatment of a dental condition. These charges are covered only to the extent they are reasonable and customary for services and supplies normally used for treatment of that condition.

How the UM Dental Plan works

The dental plan utilizes a passive network. You may receive services from network providers or non-network providers. Member access is not restricted to network providers. Preventive dental care is covered at 100% of reasonable and customary charges, with no deductible. For expenses that are covered as basic or major dental care you will pay a coinsurance amount after you have satisfied your annual deductible. The coinsurance is the same regardless of whether you utilize a network or non-network provider. The dentists that have contracted to be a part of the network have agreed to charge negotiated rates for specific services and member coinsurance rates will remain the same.

Benefit summary

Expenses Covered	Plan Benefit
Type A — Preventive dental care	100% — no deductible
Type B — Basic dental care	80% — after satisfying the deductible
Type C — Major dental care	50% — after satisfying the deductible
Deductible Amounts	
For an individual each calendar year	\$100
For the family each calendar year	\$300
Maximum Benefit	
For preventive, basic, and major dental care combined	\$1,500 per calendar year for each covered individual

Am I eligible for coverage?

Active Employee Eligibility

If you are an active employee or subsidiary employee (CRR 320.050) of the University, you are eligible for coverage, provided you also meet the following conditions:

- You are classified 75% FTE or more
- You have an appointment duration of at least nine months
- You are regularly scheduled to work at least 30 hours a week

For the purpose of this section, any individual who is simultaneously employed by the University and the Harry S. Truman Veterans Administration Hospital pursuant to an agreement between said organizations, and whose joint appointments, combined, otherwise meet the requirements of this section, shall be considered an Employee.

In addition, you are eligible for coverage under this Plan if you are an individual who, while covered as an Employee (as defined in University Collected Rules and Regulations (CRR) 310.020 and CRR 320.050), became totally and permanently disabled in accordance with the University's Long Term Disability Plan and who is entitled to continued service credit (ie. vested) as a disabled Employee under the University's Retirement, Disability and Death Benefit Plan, or, effective January 1, 2020, who has been a benefit eligible employee for the five consecutive years immediately preceding the date on which the Employee became totally and permanently disabled.

Per diem and variable hour employees are excluded as an Employee under this Plan.

Retiree Eligibility

If you are a Retired Employee of the University (Retiree), you are eligible for coverage, provided the following conditions are met:

- you were covered under the Plan immediately prior to your retirement; and
- you re-enroll in the Plan when you retire; and
- if you retired on or before December 31, 2017, you were either:
 - age 55 or older with at least 10 years of service, or
 - age 60 or older with at least 5 years of service; or
- if you retire on or after January 1, 2018, you must have been employed in a UM System benefit eligible-position and accumulated at least five years of service, as measured by the University of Missouri Retirement, Disability and Death Benefit Plan, on December 31, 2017, and on your retirement date you must:
 - be at least 60 years old; and
 - have at least 20 years of service with the UM System.

If you are a Retired Employee, are reemployed by the University after your retirement, and subsequently retire again, special rules apply:

- If, upon your initial retirement from the University, you were eligible to enroll in the Plan, based on your satisfaction of the eligibility requirements above, you will be eligible to reenroll in the Plan upon your retirement following reemployment (even if you did not initially enroll after your initial retirement), provided you still meet all requirements above. For purposes of determining whether you still meet the requirements above upon your retirement following reemployment, your initial date of retirement will determine which eligibility requirements apply. For example, if you initially retired on August 1, 2017, and retired following reemployment on August 1, 2019, you must meet the age and service requirements above for individuals who retired on or before December 31, 2017, not the age and service requirements for individuals who retire on or after January 1, 2018.
- If, upon your initial retirement from the University, you were not eligible to enroll in the Plan, your eligibility to enroll in the Plan upon your retirement following reemployment depends on your reemployment date:
 - If you are reemployed prior to January 1, 2020, and upon your retirement following reemployment you now satisfy the eligibility provisions above, you may enroll in this Plan upon your retirement following reemployment. You must meet the eligibility requirements above applicable to the date of your retirement following reemployment.
 - If you are reemployed on or after January 1, 2020, you may not enroll in this Plan upon your retirement following reemployment, even if you now satisfy the eligibility provisions above.

If you experience a termination from employment, but were not eligible for retirement under the University's Retirement, Disability and Death Benefit Plan, are reemployed by the University, and subsequently separate from employment again, special rules apply:

- If you are reemployed prior to January 1, 2020, and upon your separation following reemployment you satisfy the eligibility provisions above, you may enroll in this Plan upon your separation following reemployment. You must meet the eligibility requirements above applicable to the date of your separation following reemployment.

- If you are reemployed on or after January 1, 2020, you may not enroll in this Plan, upon your separation following reemployment if you did not meet the eligibility requirements above on the date of your initial termination from employment, even if you satisfy the eligibility provisions above at the time of your separation following reemployment.

If you are eligible to reenroll (or enroll for the first time) upon retirement or separation after reemployment, you must enroll in this Plan consistent with the requirements in *When does Coverage Begin, Retirees*.

Please Note: If, after retirement, you drop coverage on any of your dependents, you may not re-enroll them in the Plan.

Are my dependents eligible?

Dependent eligibility

Note: Proof of relationship documentation is required for spouse, sponsored adult dependent and children to be covered. If you fail to provide requested documentation, you may be liable for claims or premiums back to the date you enrolled.

Your eligible dependents include your spouse, your sponsored adult dependent and each of your natural children, stepchildren, foster children, adopted children or children placed in your home for adoption younger than age 26 (note the term “stepchild” does not include the children of your sponsored adult dependent).

If your unmarried child is mentally or physically incapable of self-sustaining employment prior to reaching the maximum age (26 years old) and dependent on you or your spouse for principal financial support, they may be eligible to remain covered by the Plan. See *Coverage for a Disable Dependent Child* for more information.

If you are eligible for coverage based on your employment with the University, you may be covered under your own employment or you may be covered as a dependent. You may not be covered both as a dependent and as an employee.

If you and your spouse or sponsored adult dependent work for or retired from the University and you have children, only one of you may claim the children as covered dependents.

For the purposes of this Plan, your “sponsored adult dependent” means an adult person who meets all of the following criteria:

- has had the same principle residence as you for at least 12 months, and continues to have the same principle residence as you, disregarding temporary absences due to special circumstances including illness, education, business, vacation, or military service;
- is 18 years of age or older;
- is not currently married to another person under either statutory or common law; and
- is not related to you by blood or a degree of closeness that would prohibit marriage in the law of the state in which you reside.

Retirees: If dependents are covered prior to retirement, you may elect to continue dependent coverage. Retirees are not eligible to add Dependents to their dental plan coverage after the date of retirement, unless your Spouse/Sponsored Adult Dependent is also a University of Missouri benefit eligible Employee who separates from the university and/or loses eligibility for retiree dental insurance, you may add your Spouse/Sponsored Adult Dependent as a Dependent to your retiree dental insurance. If your Spouse/Sponsored adult dependent was covering eligible Dependent Child(ren), under their UM eligibility, your Child(ren) are also eligible to be added to your retiree dental insurance. **Contact the HR Service Center to request the appropriate retiree change form, which must be completed and returned** (including proof of relationship) for such Spouse/Sponsored Adult Dependent and eligible Dependent Child(ren) within 31 days after the change in status. Please keep in mind, your newly covered Spouse/Sponsored Adult Dependent and any eligible Child(ren) are eligible only for continued coverage in this plan, if they were enrolled in active dental insurance under your Spouse’s coverage as an eligible Employee.

Coverage for a Disabled Dependent Child

If an unmarried enrolled dependent child with a mental or physical disability reaches an age when coverage would otherwise end (26 years old), the Plan will continue to cover the Child, as long as:

- The child is incapable of self-sustaining employment due to a mental or physical disability prior to reaching the maximum age; and
- The child depends mainly on you, or your spouse, for principal financial support; and
- You provide application for continuation of dependent status for such a child and proof of the child's incapacity and dependency to the University within 31 days of the date coverage would have otherwise ended because the child reached the maximum age, or in the case of a newly benefit-eligible employee, within 31 days of becoming newly eligible; and
- You provide proof, upon the University's request, that the child continues to meet these conditions.

To be eligible for continuation of dependent status once the child has reached the maximum age, the child must be covered as a dependent as defined in this Plan on the day immediately preceding the day the child reaches the maximum age. If you fail to submit proof, coverage shall be discontinued at the end of the month in which the dependent attains maximum age. In the case of a newly benefit-eligible employee, if application for dependent status for such a child and proof of the child's status is not submitted within 31 days of the employee adding the child to their plan, the dependent will not be eligible for coverage.

The University has the right to require proof of the continuation of disability upon attainment of such age as often as deemed necessary; however, you will not be asked to provide proof for more than once a year. Proof includes:

- Social Security Benefit Verification Letter; or
- Federal Tax Return for the most recent calendar year, listing the child as a dependent.

If you do not supply such proof within 31 days of being requested, the Plan will no longer pay benefits for that child. The University reserves the right to request a medical examination at the University's expense.

Coverage will continue, as long as the enrolled dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

Do I have to pay for this coverage?

The University pays approximately one-half of the cost of your dental coverage.

Your contribution will be made on a before-tax basis for yourself, your spouse, and any eligible dependent children, which lowers the current income taxes you pay, unless you choose to contribute on an after-tax basis. For more details about how the before-tax feature works for you, refer to your Flexible Benefits Plan SPD. Your contribution for a sponsored adult dependent will be on an after-tax basis unless the sponsored adult dependent is a qualified tax dependent under IRS rules. The University paid contribution portion of the adult sponsored dependent will be subject to imputed income unless the sponsored adult dependent is a qualified tax dependent under IRS rules.

Please note that when your contributions are on a before-tax basis, certain IRS restrictions prohibit enrollment changes during the year unless the changes are in connection with a family status change.

Retirees: The cost of dental coverage is shared by you and the university. The university contribution amount is determined on the basis of your retirement date.

- If you retired prior to Sept. 1, 1990 under the University of Missouri Retirement, Disability and Death Benefit Plan or Missouri State Employees Retirement System, or if you retire under the Civil Service Retirement System, or the Federal Employees Retirement System, the University pays an amount equal to 50% of the cost of the Dental Plan. You pay the remaining cost. This percentage is applicable to coverage for yourself as well as for any eligible dependents you may have covered. The University Plan will pay 0% of the cost of the Plan for widows/widowers.
- If you retired on or after Sept. 1, 1990 and before Jan. 1, 2018, under the University of Missouri Retirement, Disability and Death Benefit Plan or Missouri State Employees Retirement System, the

University will pay a percentage of the cost of your own coverage. The percentage will be computed individually for each retiree, based on age and length of service at retirement. The University's percentage for retirees will not exceed 50% for dental coverage. 50% of the percentage applicable to you will be paid toward the cost of coverage for your dependents. The University Plan will pay up to 25% of the cost of the Plan for widows/widowers, based on your age and years of service at the time of retirement.

- If your attained age plus years of service is 80 or more as of December 31, 2017 and as of the date of retirement you have attained at least age 60 and at least 20 years of service, you will receive a subsidy equal to retirees who retired on or after 9/1/1990.
- If your attained age plus years of services is less than 80 as of December 31, 2017 and as of the date of retirement you have attained at least age 60 and at least 20 years of service, you will receive a fixed annual subsidy of \$100 per year of service, up to a maximum of \$2,500 annually to purchase UM medical or dental coverage. Your annual subsidy cannot exceed the annual premium(s) for the elected plan(s). For example, if you qualify for a \$2,400 annual subsidy and the premiums are \$1,300, the maximum subsidy allowed for that calendar year will be \$1,300. Under no circumstances will you receive any subsidy amount that exceeds the premiums for the elected plan(s). The University total subsidy is based on years of service at retirement. The University Plan will pay 0% of the cost of the Plan for widows/widowers.

When does my coverage begin?

Coverage begins on the date of hire or the benefit eligibility date provided you submit the form within 31 days of your date of hire or eligibility date.

If you change from part-time to full-time or from temporary to permanent status and become benefit eligible, you must enroll within 31 days of the date of your change in status.

If you are not actively at work on the date your coverage would normally begin, the coverage will not be effective until you return to full-time active employment unless you are not actively at work due to a health factor.

Retirees: If you retire on the first of the month, your retiree coverage eligibility begins on that day. If you retire beyond the first of the month, retiree coverage eligibility will begin on the first of the month following your retirement date provided you submit the plan enrollment form to participate as a retiree within 31 days of retirement. **Please Note:** Once you cancel any part of your dental coverage, you, or your dependents, cannot re-enroll in the Dental plan.

If after retirement you become reemployed by the University or a University Subsidiary Entity and you become eligible for coverage as an employee under University-sponsored active employee insurance plans, your coverage will commence on the later of your date of hire or the first of the month following the date when you first meet the eligibility requirements as an employee, and your retiree coverage under this Plan will "freeze" on the day immediately preceding the date in which coverage as an employee commences. For example, if you are reemployed on October 1 and meet the eligibility requirements as an employee on October 1, your coverage as an employee will commence October 1 and your coverage as a retiree will "freeze" September 30. If you are reemployed on October 1 and do not meet the eligibility requirements as an employee until November 15 (because, for example, you were not initially in benefit eligible employment), your coverage as an employee will begin December 1, and your coverage as a retiree will freeze November 30. Upon your termination from regular employment and loss of University-sponsored active employee insurance coverage (or upon loss of University-sponsored active Employee insurance coverage even while you are still employed, because you no longer meet the definition of Employee), if you are eligible to enroll in this Plan, you must **immediately enroll in (if you have not previously been eligible to do so) or reinstate retiree insurance coverage** or you will forfeit your right to participate in this plan as a retiree at a later date. For more information on eligibility, see *Am I eligible for Coverage, Retiree Eligibility*.

When does coverage begin for my dependents?

Dependent coverage becomes effective on the date your personal coverage becomes effective, if by then you have completed and returned the Plan enrollment form with each dependent's name and Social Security number listed. If, after your coverage becomes effective, you acquire a new dependent — by marriage, for example — you have 31 days to obtain coverage by completing the appropriate enrollment form and returning it to your HR Generalist or HR Service Center.

In the case of an adopted child or a child placed in your home for adoption, you also have 31 days to obtain coverage from the date the child is placed in your custody.

It is your responsibility to notify the University of the addition of a dependent or of any changes in your family status. Contact your HR Generalist or HR Service Center to obtain any necessary forms.

In instances where applications for enrollment are submitted subsequent to 31 days following the initial date of eligibility, two situations may apply.

1. If a specific premium contribution is required for coverage (i.e., coverage for other children did not already exist), coverage will become effective on the date a properly completed enrollment form (including proof of relationship) is submitted to your HR Generalist or HR Service Center *provided* it is done so within 180 days from the date the child was first eligible. If the enrollment form is submitted after 180 days, coverage will not become effective until the following January 1.
2. If a specific premium is not required for coverage (i.e., coverage already exists for other eligible dependent children), coverage will be made effective on the date the child first became eligible for coverage. However, before claims can be paid, a properly completed enrollment form (including proof of relationship) must be submitted to your HR Generalist or HR Service Center.

The University pays a portion of dental premiums for eligible dependent children who are enrolled for coverage under the Plan.

The level of premium subsidy is limited to ten dependent children. Employees will be required to pay the full premium cost for each child that is enrolled beyond the maximum of ten.

Employees who have coverage for over ten children as of December 31, 2001, will continue to receive premium support for all children covered as of that date. Any new children, over the maximum of ten, who are enrolled on or after January 1, 2002, will require payment of the entire premium by the employee.

Retirees: Dependent Coverage becomes effective on the date your retiree coverage becomes effective, assuming you covered the dependent immediately prior to retirement and you have completed and returned the Plan Enrollment Form with each Dependent's name and social security number listed within 31 days of your Retirement. In the event that Your Spouse or Sponsored Adult Dependent is also a University of Missouri benefit eligible Employee who separates from the university and/or loses eligibility for retiree dental insurance, you may add your Spouse or Sponsored Adult Dependent as a Dependent to your retiree dental insurance (and any eligible Dependent Children) if they were enrolled in active dental insurance under your Spouse's coverage as an eligible Employee. Contact the HR Service Center to request the appropriate retiree change form, which must be completed and returned (including proof of relationship) for such Spouse or Sponsored Adult Dependent and eligible Dependent Children within 31 days after the change in status. Coverage will become effective on the first of the month following the date of the event (provided the necessary forms are submitted to the University).

Changing your coverage - qualifying family/employment status changes

You may change your coverage level (including beginning or ending coverage or adding or dropping dependents) during the Plan year only if you have a qualifying family/employment status change.

Qualifying family/employment status changes are limited to:

- marriage, divorce, legal separation, annulment, or termination of a sponsored adult dependent partnership
- death of a spouse or a sponsored adult dependent
- a change in the number of dependent children as a result of birth, death, adoption, or placement of a child for adoption
- the termination or commencement of employment of your spouse or sponsored adult dependent
- a change in your work schedule, or that of your spouse or sponsored adult dependent, that involves an increase or decrease in work hours, a strike, a lockout, or an unpaid leave of absence
- a change in residence or worksite location of you, or your spouse or sponsored adult dependent
- receipt by the University of a valid Notice of Order to Enroll under Missouri law
- a change in entitlement to Medicare or Medicaid for you, your spouse or your sponsored adult dependent, or a dependent child
- a significant change in health coverage provided by your spouse' or sponsored adult dependent's employer that affects you or your spouse or your sponsored adult dependent
- a leave of absence under the Family and Medical Leave Act of 1993 (FMLA)

If any of these qualifying family/employment status changes occur, you may change your level of coverage provided the change is consistent with the status change itself. Contact your HR Generalist or HR Service Center to request the appropriate benefit change form, which must be completed and returned within 31 days of the date of the status change. After that, changes can be made only during the annual enrollment change period, except as required by the Health Insurance Portability and Accountability Act (HIPAA), described later in this section.

Benefit changes, when made within 31 days as described above, will be effective as follows:

- changes due to birth, adoption, placement of a child for adoption, or death will be effective on the date of the event
- changes resulting from all other qualifying family/employment status changes will be effective on the first of the month coincident with or following the date of the event or receipt of the benefit change form, whichever is later

Under the Health Insurance Portability and Accountability Act, you or an eligible dependent may also enroll for coverage if:

1. You or an eligible dependent declined coverage under the University Plan because you had other coverage; *and*
 2. The other coverage ends; *and*
 3. You contact your HR Generalist or HR Service Center and complete an enrollment form and provide written proof that the other coverage ended for the individual involved within 31 days after this event occurs.
- OR
1. you declined coverage under the University Plan because you had other coverage, *and*
 2. your dependents' other coverage ends, *and*
 3. you contact your HR Generalist of HR Service Center and complete an enrollment form and provide written proof that the other coverage ended for the individual involved within 31 days after this event occurs.
- OR
1. due to marriage, establishment through University affirmation of a sponsored adult dependent, birth, adoption, or placement for adoption—for these specific situations eligible dependents include your spouse, your sponsored adult dependent, and newly acquired child/(ren) dependent/(s) (existing child dependents are not eligible for enrollment). You must enroll within 31 days of the event.

This is called a *special enrollment period*. Coverage will be effective on the first of the month following the date of the event, provided your enrollment form is received by your HR Generalist or HR Service Center within 31 days of the date of the event. In situations of birth, adoption, or placement of adoption, coverage will be effective on the date of the event provided the enrollment form is received by your HR Generalist or HR Service Center within 31 days of the date of the event.

Retirees: Retirees are not eligible to add Dependents to their dental plan coverage after the date of retirement even if they experience a qualifying family/employment status change, unless the Retiree's Spouse/Sponsored Adult Dependent is also a University of Missouri benefit eligible employee who was enrolled in active dental insurance under their own eligibility (including dependent children) and separates from the university and/or loses eligibility for retiree dental insurance. Please keep in mind, the newly covered Spouse/Sponsored Adult Dependent and any eligible Child(ren) are eligible only for continued coverage in this plan, if they were enrolled in active dental insurance under your Spouse's coverage as an eligible Employee. You may cancel coverage at any time by completing the retiree benefit change form, however, once you cancel any part of your dental coverage, you, or your dependents, cannot re-enroll in the Dental plan.

When are benefits payable?

Dental benefits are paid when covered expenses are incurred that either exceed or are not subject to the deductible amount.

What is the deductible amount?

The deductible amount is equal to the first \$100 of covered expenses for basic (Type B) and major (Type C) dental care incurred in a calendar year. The deductible does not apply to covered expenses for preventive (Type A) dental care.

The deductible amount applies separately to each covered person. If the expenses applied to the deductible for all of your covered family members combined reach \$300 in one calendar year, no additional deductible will be applied for any of the family members for the remainder of the year.

Covered expenses

Covered expenses include only reasonable and customary charges that you or your covered dependents incur for the following types of services and supplies:

Type A – preventive services

The following preventive dental services are reimbursed at 100% with no deductible:

- Routine oral examinations (includes comprehensive and periodic) and prophylaxis (scaling and cleaning of teeth), not more than twice during any one calendar year.
- Dental x-rays, including full mouth x-rays (not more than once every three years), supplementary bitewing x-rays (not more than twice in one calendar year) and such other dental x-rays as required in connection with the diagnosis of a specific condition requiring treatment
- Topical application of fluoride for covered individuals under age 19, not more than twice during any one calendar year
- Space maintainers to replace prematurely lost teeth for children younger than age 19
- Emergency pain-relief treatment
- Sealants, for children younger than age 16

Type B — basic services

The following basic dental services are reimbursed at 80% after you have satisfied the deductible:

- Extractions
- Oral surgery not covered under the medical plan
- Fillings (amalgam, silicate, acrylic, synthetic porcelain, and composite)
- General anesthetics when medically necessary and administered in connection with oral or dental surgery
- Treatment of periodontal and other diseases of the gums and tissues of the mouth
- Endodontic treatment, including root canal therapy
- Injection of antibiotic drugs
- Repair or re-cementing of crowns, inlays, onlays, bridgework, or dentures

- Adjusting, relining, or rebasing of dentures, if performed at least six months after the denture is installed, but not more than one relining or rebasing in any three-year period

In addition, charges for services and supplies provided by a hospital for inpatient or outpatient services in connection with covered dental services are reimbursed as Type B expenses, when:

- The individual receiving the services and supplies is covered for medical benefits through the University of Missouri Medical Benefits Plan, *and*
- The medical program under which the individual is covered does not cover hospital services or supplies in connection with dental services, *and*
- The services and supplies are medically necessary for the covered dental service

Any benefits payable for such hospital services or supplies will not be subject to the calendar year plan maximum.

Type C — major services

The following major dental services are reimbursed at 50% after you have satisfied the deductible:

- Inlays, onlays, gold fillings or crowns to restore diseased or accidentally broken teeth, but only when the tooth cannot be restored with an amalgam, silicate, acrylic, synthetic porcelain, or composite filling
- Initial installation of fixed bridgework (including inlays and crowns abutments)
- Initial installation of partial or full removable dentures (including adjustments during the six-month period following installation)
- Replacement of an existing partial denture or fixed bridgework by new fixed bridgework or the addition of teeth to existing fixed bridgework
 - *However*, replacements or additions to existing dentures or bridgework will be covered only if one of the following applies:
 - The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed and while the individual was covered
 - The existing denture or bridgework cannot be made serviceable and was installed at least five years prior to its replacement
 - The existing denture is an immediate temporary denture which cannot be made permanent and replacement by a permanent denture takes place within 12 months from the date the immediate temporary denture was installed

What is the Plan maximum?

The most any covered individual can receive in dental benefits in one calendar year is \$1,500.

Advance claim review

If a course of treatment for you and one of your dependents can reasonably be expected to involve covered dental expenses of \$200 or more, a description of the procedures to be performed and an estimate of the dentist's charges should be filed with the Plan's claims administrator before beginning the course of treatment. Contact the Plan's claims administrator for appropriate forms.

The claims administrator will notify you and your dentist of the estimated benefits payable based upon the course of treatment. If a description of the procedures to be performed and an estimate of the dentist's charges are not submitted in advance, benefits will be payable in accordance with the standard features of the Plan and may be less than you expect.

Predetermination of benefits is not mandatory and is not intended to interfere with the dentist/patient relationship. Rather, it is intended to provide useful information to you and your dentist. You are both informed in advance of the treatment, of the estimated benefits payable for the proposed course of treatment, and of the expenses that will remain your full responsibility.

Courses of treatment in progress when coverage begins

Benefits are provided only for covered dental expenses that you or your dependents incur while covered by the Plan. A charge is considered to have been incurred on the date when the services, supplies, or treatments are received.

In addition, no benefits are payable for dentures, bridgework, or crowns that were ordered while the patient was not covered by the Plan. The term "ordered" means the impressions have been taken and in the case of bridgework or crowns, the teeth have been prepared to receive the item.

Reasonable and customary charges

Charges for dental services, treatments, or supplies essential to the care of the individual which are the lesser of:

- actual charges for such services, treatments, or supplies; or
- the amount normally charged for comparable services, treatments, or supplies by most providers in the locality at the time incurred, where the charges were incurred when furnished to a similarly situated individual

What dental services are not covered?

Dental expenses for the following are not covered by the Plan:

- any dental services not specifically listed in this SPD under Type A, Type B or Type C dental services
- oral hygiene and dietary instruction or plaque control problems
- orthodontia, or any treatment, services, or supplies provided for orthodontic purposes
- failure to keep a scheduled visit with the dentist
- completion of a claim form
- charges for any dental services and supplies that are covered expenses in whole or in part by the medical plan
- charges for treatment by someone other than a dentist, except that scaling or cleaning teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of the dentist
- charges for services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures
- charges for replacement of a lost, missing, or stolen prosthetic device
- charges for dentures, crowns, inlays, onlays, bridgework, or other appliance or service to increase vertical dimension
- charges for services and supplies not necessary to improve oral condition or that are not approved by the attending dentist or physician or charges that exceed reasonable and customary limits
- charges that are made only because the insurance exists or charges that you are not legally obliged to pay
- charges for services or supplies required by reason of an act of war or insurrection
- charges for services or supplies which are furnished in a facility operated under the direction of or at the expense of the U.S. Government (or its agency) or by a doctor employed by such a facility and for which no payment would be required if the covered individual did not have this coverage
- services, supplies, or treatments related to an occupational illness or injury or that are covered by any Workers' Compensation laws or Employer's Liability acts or that an employer is required by law to furnish in whole or in part
- charges for services or supplies that are experimental in nature

Example

Here is an example of one employee's dental expenses and how benefits are paid:

Dental service	Dentist fee	Deductible	Plan pays	Employee pays
Type A-Preventive services				
Dental examination, cleaning, and X-rays	\$65	\$0	\$65	\$ 0
Type B-Basic services				
Two fillings (\$90 each)	\$180	Satisfied	\$144	\$36 (20%)
Two extractions (\$180 each)	\$360	Satisfied	\$288	\$72 (20%)
Type C-Major services				
One fixed bridge	\$750	\$100	\$325	\$425 (deductible + 50% of balance)
TOTAL	\$1,355		\$822	\$533

What if my family has other group dental coverage?

Your Dental Plan has a "coordination of benefits" (COB) provision, which means that if you or your dependents are covered under other group insurance programs, (or entitled to payments from a "no fault" auto insurance policy), combined benefits from all plans will pay up to, but not more than, 100% of your covered dental expenses.

Under COB, one plan is considered "primary" and the other "secondary." The Plan that is primary pays first, and usually pays full regular benefits. The primary plan is determined as follows:

- If a plan covers the patient as an employee, then that plan is primary
- If the patient is a dependent child whose parents are not divorced or separated, the Plan of the parent whose birthday is earlier in the calendar year is primary
- If the patient is a dependent child whose parents are divorced or separated, the following rules apply:
 - A plan that covers a child as a dependent of a parent who by court decree must provide health coverage is primary
 - When there is no court decree that requires a parent to provide health coverage to a dependent child, then the Plan of the parent who has custody of the child is primary (the Plan of the custodial parent's spouse is secondary and the Plan of the other natural parent is third)
 - If none of the above rules apply, the Plan that has covered the patient for the longer period of time will usually be primary. After the primary plan pays its benefits, the secondary plan will, in most cases, pay the balance of your eligible dental expenses

To ensure you receive the benefits to which you are entitled under both plans, it is important to submit your claims properly. For example, when you file a claim for your spouse, be sure to file under their plan first. After you have received payment from your spouse's plan, then you can submit for payment to your plan. When you submit a claim to the second plan, be sure to include the explanation of benefits from the primary plan, as well as another copy of the bill. Remember, if you coordinate your benefits correctly, you will receive payment faster and still have the advantage of coordinated coverage under both plans.

When does my coverage end?

Your dental coverage will end on the earlier of the following dates:

- the last day of the month of employment termination
- when you are no longer eligible for coverage
- when you cease making the required dental plan contribution
- when the University terminates the Plan

Your dependent's coverage will terminate on the earliest of the following dates:

- when all dependent coverage under the Plan terminates

- when the individual no longer meets the Plan's definition of a dependent
- when your coverage terminates
- when you cease making the required contribution for dependent coverage

Note: You may not discontinue dependent coverage during the year when the dependent continues to be eligible for coverage unless the change is in connection with a family status change.

Does coverage for my family continue after my death?

If you die while actively employed by the University, your eligible surviving spouse or surviving sponsored adult dependent may continue coverage after your death under the Plan available to retirees, if the following requirements are satisfied:

- Your spouse must have been married to you at the time of your death, and you must have been married to such spouse for at least one year preceding your death; and
- Either:
 - at the time of your death, you must have been vested in the University Retirement, Disability and Death Benefit Plan (having completed at least 5 years of creditable service), or you would have been vested if you were covered by the University of Missouri Retirement, Disability and Death Benefit Plan instead of the Civil Service plan, Federal Employees Retirement plan, or the Missouri State Retirement plan; or
 - effective January 1, 2020, at the time of your death, you must have been a benefit eligible employee for the five consecutive years immediately preceding your death.

Alternatively, your surviving sponsored adult dependent is eligible to continue coverage in this Plan after your death if the above conditions are satisfied, except that in lieu of the marriage requirement above, you must have provided a sponsored adult dependent affidavit to the University at least one year preceding your death.

In addition, the continuation of coverage is available for your children, but only when your surviving spouse or surviving sponsored adults coverage is also continued. The continuation of coverage in this Plan, under this provision, is subject to the payment of monthly contributions by your surviving spouse or surviving sponsored adult dependent. Eligible children are described under *Are my dependent eligible?*

Retirees: If you die after retirement from the University, your eligible surviving spouse or surviving sponsored adult dependent may continue coverage after your death, as described above, including coverage for your eligible children. It is important to note, that the coverage for the surviving spouse or surviving sponsored adult dependent of a retiree is available only to the person to whom the retiree was married or had an affidavit of adult sponsored partnership with the university on the date of the retiree's death and to whom the retiree was married to or had a partnership with at the time of retirement.

No continued coverage in this Plan is available for children unless there is a surviving spouse or surviving sponsored adult dependent who is also covered. Refer to the *Continuation of Dental Plan coverage (COBRA)* section for information on continuation of coverage for dependent children, upon your death, when no surviving spouse or surviving sponsored adult dependent is covered.

The subsidized level of premiums will be somewhat different for surviving spouses and surviving adult sponsored dependents, see *Do I have to pay for this Coverage?, subsection: Retiree*. Eligibility under this Plan will depend on the surviving spouse's or surviving sponsored adult dependent's eligibility

Enrollment for continued coverage must be made within 31 days after your death.

Continued coverage will terminate on the earliest of:

- the date the individual no longer meets this Plan's definition of an eligible dependent
- the date all dependent coverage is discontinued under this Plan with respect to your class of eligible employees
- the end of the period for which any required contributions have been made

Continuation of Dental Plan coverage (COBRA)

Federal law (Consolidated Omnibus Reconciliation Act) requires the Plan to offer covered employees and dependents the opportunity to continue Dental Plan coverage when it ends for certain specified reasons. The following provisions outline the requirements for continued coverage in accordance with the law. These provisions apply only to the extent that the required period of continued coverage has not already been provided under other plan provisions.

Eligibility for continued coverage

An employee and covered dependents may continue dental coverage for up to 18 months if coverage ends because of either a reduction in the number of hours worked or termination of employment for any reason other than gross misconduct.

Dependents may continue their dental coverage under the group plan for up to 36 months if their coverage ends for any of the following reasons:

- divorce or legal separation from the employee
- the death of the employee
- the dependent child reaches the limiting age or otherwise ceases to qualify as a dependent under the Plan

These periods of continued coverage begin on the date of the event that caused loss of coverage (for instance, the date you leave the company or the date a dependent becomes ineligible).

In no event will more than a total of 36 months of continued coverage be provided to any individual, even if more than one of the above events occur.

Continued coverage ends automatically if any of the following occur:

- the cost of continued coverage is not paid on or before the date it is due
- an individual becomes covered under another group dental plan, unless coverage under the other plan is limited due to the individual's pre-existing condition
- an individual becomes entitled to Medicare
- the Plan terminates for all employees
- the applicable maximum coverage period ends

Extension of maximum coverage period

Disabled individuals — An exception applies if an employee or a dependent is determined to be totally disabled during the first 60 days of continued dental coverage due to a reduction in hours worked or termination of employment. The maximum coverage period for the disabled individual will be 29 months, rather than 18 months. In order to be eligible for the extended period, the disabled individual must meet the definition of disability under the Social Security Act and notify the University during the first 18 months of continued coverage and within 60 days after the date of determination of disability has been made by Social Security. The disabled individual is required to notify the University within 30 days after any final determination by the Social Security Administration that the individual is no longer disabled.

Dependents of an employee entitled to Medicare — If an employee becomes entitled to Medicare, the maximum coverage period for dependents will not end until at least 36 months after the date on which the employee became entitled to Medicare.

Divorced or widowed spouse, sponsored adult dependents at least age 55 — Coverage can continue beyond the COBRA period if the continuation coverage under the Plan expires when a divorced or widowed spouse or sponsored adult dependent is at least age 55. Coverage can continue for the spouse, sponsored adult dependent, and eligible dependents until the spouse or sponsored adult dependent reaches age 65.

Application for continued coverage

When the HR Generalist or HR Service Center is notified that one of these events has happened, you will be sent an election form notifying you of the conditions that apply to continued coverage.

However, in the event you become divorced, terminate your sponsored adult dependent partnership or legally separate, or when your dependent child no longer qualifies as a covered dependent under the Plan, you or your covered spouse or sponsored adult dependent or your covered child must notify the HR Generalist or HR Service Center within 60 days. If you fail to do this, your dependent's rights to continued coverage will be forfeited.

Continued coverage is not automatic. You must submit the completed election form within 60 days from the later of the following dates:

- the date you cease to be eligible under the group plan
- the date you receive the election form

Cost of continued coverage

Any person who elects to continue coverage under the Plan must pay on a monthly basis the total cost of that coverage plus any additional amount permitted by law. Your first payment for continued coverage must be made within 45 days of the date you sign the election form. Your payment must be sufficient to pay the applicable costs, retroactive to the day following the event which caused coverage to end.

Benefits under continued coverage

Continued coverage will be exactly the same dental coverage you or your dependent would have been entitled to if your employment or their dependent status had not changed. Any future changes in the benefits or cost of coverage for the Plan also will apply to you.

Extended benefits

Benefits will be payable for covered expenses incurred in connection with dentures, fixed bridgework or crowns, and the fitting thereof which were ordered while the individual was covered under this Plan if the item is finally installed or delivered to such individual within 60 days after termination of coverage.

However, this extension of benefits will not apply if you have received continued dental coverage as a result of total disability, explained in the following section.

Total disability

If you or your dependent is totally disabled on the date that coverage terminates, dental coverage for the disabled individual will be continued until the earliest of the following dates:

- 12 months
- the date the individual becomes covered under another group dental plan

How do I file a claim for dental benefits?

All forms required to file dental claims are available on the Benefits web site or from your HR Generalist or HR Service Center. The completed claim forms should be submitted to the claims administrator at the address shown on the form. The instructions on the form should be followed carefully. This will speed the processing of your claim. Be sure all questions are answered fully.

The claims administrator may require submission of x-rays and other appropriate diagnostic and evaluative materials or records. When these materials are not available, and to the extent that verification of covered dental services cannot reasonably be made based on the information available, benefits for the course of treatment may be for a lesser amount than that which otherwise would have been payable.

All claims should be reported promptly. The deadline for filing a claim for benefits is 12 months after the date the dental expense is incurred.

If, through no fault of your own, you are unable to meet the deadline for filing a claim, your claim will still be accepted if you file as soon as reasonably possible, but not later than one year after the deadline unless you are legally incapacitated. Otherwise, late claims will not be covered.

How will benefits be paid?

Benefits will be paid as soon as the necessary written proof to support the claim is received.

All benefits are payable to you. However, the claims administrator has the right to pay benefits directly to the provider of services unless you have specified otherwise by the time you file the claim.

Also, if you are a minor or otherwise legally unable to give a valid release, or if any benefit is payable to your estate, the claims administrator has the right to pay up to \$1,000 of any benefit directly to any of your relatives whom it may determine to be fairly entitled to the payment.

Claim questions

If any portion of a claim is not paid, or if you do not understand or do not agree with the handling of a claim, there are several things that you can do to appeal the decision. Most of your questions can be answered quickly and efficiently by either calling or writing the claims administrator's office at the address shown on the claim forms.

If any part of your claim is denied, you or your beneficiary will be notified in writing. The notice will include the following information:

- specific reason for denial
- specific references to pertinent plan provisions on which the denial is based
- a description of any additional material or information necessary for you to substantiate your claim and an explanation of why such material is needed

The claims administrator intends to respond to claims promptly. However, if you do not receive a response within 90 days, allowing reasonable time for mailing, assume your claim has been denied and proceed to the claim review stage.

Within 60 days after receiving notice that your claim has been denied, you or your authorized representative may submit a written request for review to the claims administrator.

In your request, state the reasons you believe the claim denial was improper, and submit any additional information, material, or comments you consider appropriate. You may review any pertinent documents related to the claim.

The claims administrator's decision will be in writing and will include specific references to the pertinent plan provision on which it is based.

The Dental Plan is provided directly by the University. The responsibility of the claims administrator referred to in this section is limited to administering benefits according to the rules established by the University.

Confidentiality of Information

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice, which was distributed to you upon enrollment and is available from the benefits manager.

This Plan, and the University, will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates

to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the University.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan maintains a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the notice, please contact your HR Generalist or HR Service Center. If you have questions about the privacy of your health information or wish to file a complaint under HIPAA, please contact the Privacy Officer identified in the privacy notice.