UNIVERSITY OF MISSOURI SYSTEM

Dental SPD

Effective January 1, 2025

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 (umurl.us/CBR) or the HR Service Center (umurl.us/HRSC).

In the event there is a conflict of language between the Summary Plan Description and the insurance documents, the language in the insurance documents will control.

Table of Contents

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. If you receive services from a non-network provider, you will be responsible for the difference between the provider's billed charge and the allowed covered expense making your out-of-pocket expenses more.

Benefit summary

The dental plan offers you the following coverage options:

Expenses Covered	**Base Plan**	**Buy Up Plan**
Type A — Preventive dental services	100% — no deductible	100% — no deductible
Type B — Basic dental services	80% — after satisfying the deductible	80% — after satisfying the deductible
Type C — Major dental services	50% — after satisfying the deductible	50% — after satisfying the deductible
Type D — Orthodontic dental services	No coverage	50% — no deductible
Deductible Amounts		
For an individual each calendar year	$100	$50
For the family each calendar year	$300	$150
Maximum Benefit		
For preventive, basic, and major dental care combined	$1,500 per calendar year for each covered individual	$2,000 per calendar year for each covered individual
Orthodontic lifetime maximum	No Coverage	$1,500 per covered individual
Orthodontic Eligibility		
Eligible Children (up to age max age)	No Coverage	Yes
Eligible Adults	No Coverage	Yes

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.

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

Disabled Employee Eligibility (LTD Recipients)

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. A Disabled Employee is a Long-Term Disability benefit recipient, also known as LTD Recipient.

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 ten (10) years of service, or
    - age 60 or older with at least five (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 twenty (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 <u>were</u> 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 <u>were not</u> 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 (also commonly known as a Domestic Partner) 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).

Children for whom a court has lawfully appointed the Employee (and/or the Employee's legal Spouse) to as a legal guardian (legal guardianship) who is responsible for providing Principal Financial Support provided the:

- Child is unmarried
- Child resides full time with the Employee in a parent-child relationship
- Child is declared a dependent on Employee's federal income tax return, **and**
- Legal guardianship was awarded prior to the Child's 18th birthday and still in effect.
    - Legal guardianship ends on the Child's 18th birthday, unless there is a court order extending the guardianship.

If your unmarried Child is mentally or physically incapable of self-sustaining employment prior to reaching the maximum age 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 Disabled 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 coverage as an Enrollee or you may be covered as an eligible Dependent. You may not be covered both as an Eligible Dependent and as an Enrollee.

If you and your Spouse or Sponsored Adult Dependent are Enrollees and you have Children, only one of you may claim the Children as covered Dependents.

As a Retiree, 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 enrolled Dependent Child with a mental or physical disability reaches the maximum age when coverage would otherwise end, the Plan will continue to cover the Child, as long as:

- The Child is unmarried;
- The Child is incapable of self-sustaining employment due to a mental or physical disability prior to reaching the maximum age; and
- The Child receives Principal Financial Support from you or your Spouse; 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 thirty-one (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 thirty-one (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 thirty-one (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
- Completion of Physician Certification Form

If you do not supply such proof within thirty-one (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?

As an Enrollee, you and the University share in the cost of your dental coverage.

If you are an Employee, the University pays approximately one-half of the cost of the Base Plan. If you choose to enroll in the Buy Up Plan, you must pay 100% of the difference between the Base and Buy Up Plan, plus your cost for the Base Plan. Contributions are deducted from your paycheck. The completed benefits

enrollment (via online or paper) is the authorization to the University to deduct the monthly contributions from your salary. If you are on a leave of absence without salary, you are required to make your contribution by cash payment during your leave.

Contributions are not prorated. If your participation begins on any day other than the first day of the month, your monthly contributions will begin on the first day of the month next following the effective date of your participation (i.e., no contributions will be due for the first partial month of participation). Monthly contributions are paid during the month to which the contributions relate.

Monthly contributions for participation shall cease at the end of the month in which your cease work with the University (which is the day immediately preceding your termination date).

Employee contributions 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 qualifying family/employment status change.

As an LTD Recipient, premium payments are made on an after-tax basis and billed monthly.
As a Retiree, premium payments are made on an after-tax basis and deducted from your pension check or billed monthly.

The University contribution amount is determined on the basis of your retirement date.

- If you retired prior to September 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 Base Dental Plan. You pay the remaining cost. If you choose the Buy Up Dental Plan, you must pay 100% of the difference between the Base and Buy Up, plus your applicable percentage of the cost for the Base Plan. 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 September 1, 1990, and before January 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% of the cost of the Base Dental Plan. 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 twenty (20) years of service, you will receive a subsidy equal to Retirees who retired on or after September 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 twenty (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?

Employees
Coverage begins on the date of hire, or the benefit eligibility date, provided you submit your completed benefits enrollment (via online or paper) within thirty-one (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 submit your completed benefits enrollment (via online or paper) within thirty-one (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.

LTD Recipients
If you become an LTD Recipient mid-year, you will be eligible to continue the coverage you had as employee. Your coverage will begin upon notice of your disability approval or when disability benefits begin, whichever comes later.

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. Whether the retirement date is the first of the month or beyond the first of the month, your Retiree coverage is contingent upon your submission of the New Retiree Benefits Enrollment Form to participate as a Retiree within thirty-one (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 as follows: If your reemployment date is the first of the month, your Employee coverage under this Plan will commence on that date. If your reemployment date is effective any other day of the month, your Employee coverage under this Plan will commence on the first of the month following your rehire date. 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 under this plan), 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?

As an Employee or LTD Recipient, Dependent coverage becomes effective on the date your personal coverage becomes effective, if by then you have completed and submitted the benefits enrollment (via online or paper). If, after your coverage becomes effective, you acquire a new Dependent — by marriage, for

example — you have thirty-one (31) days to obtain coverage by submitting a Life Event through the University's self-service portal (myhr.umsystem.edu), including submitting required proof of relationship documentation within thirty-one (31) after the event occurs.

In the case of an adopted Child or a Child placed in your home for adoption or legal guardianship, you also have thirty-one (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 by completing and submitting a Life Event through the University's self-service portal (myhr.umsystem.edu) within thirty-one (31) days of the event. Otherwise, you will need to wait until the next Annual Enrollment to change your elections.

In instances where applications for enrollment are submitted subsequent to thirty-one (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 benefits enrollment form (including proof of relationship) is submitted to your HR Generalist or HR Service Center *provided* it is done so within one hundred eighty (180) days from the date the Child was first eligible. If the enrollment form is submitted after one hundred eighty (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 benefits enrollment form (including proof of relationship) must be submitted to your HR Generalist or HR Service Center.

The level of premium subsidy is limited to ten (10) Dependent Children. Employees will be required to pay the full premium cost for each Child that is enrolled beyond the maximum of ten (10).

Employees and LTD Recipients who have coverage for over ten (10) 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 (10), who are enrolled on or after January 1, 2002, will require payment of the entire premium by the Employee.

As a Retiree, 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 benefits enrollment form within thirty-one (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 benefits change form, which must be completed and returned (including proof of relationship) for such Spouse or Sponsored Adult Dependent and eligible Dependent Children within thirty-one (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

As and Employee or LTD Recipient, 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
- 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, or legal guardianship
- 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. It is your responsibility to notify the University of any changes in your family/employment status by completing and submitting a Life Event through the University's self-service portal (myhr.umsystem.edu) within thirty-one (31) days of the event. 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 thirty-one (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 following the date of the event, unless the event occurs on the first day of the month, then coverage will become effective on that date.

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 submit a Life Event through the University's self-service portal (myhr.umsystem.edu), including required documentation proving the other coverage ended for the individual involved within thirty-one (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 submit a Life Event through the University's self-service portal (myhr.umsystem.edu), including required documentation proving the other coverage ended for the individual involved within thirty-one (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, or legal guardianship — 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 thirty-one (31) days of the event by submitting a Life Event through the University's self-service portal (myhr.umsystem.edu), including submitting required proof of relationship documentation.

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 benefits enrollment (via online or paper) is completed and submitted within thirty-one (31) days of the date of the event. In situations of birth, adoption or placement of adoption legal guardianship, coverage will be effective on the date of the event provided the benefits enrollment is completed and submitted within thirty-one (31) days of the date of the event.

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.

Annual Enrollment

Each year during Annual Enrollment, Employees and LTD Recipients have the opportunity to review and change your dental election and covered Dependents. After your initial hire or eligibility date, Annual Enrollment is the only period of time when you will be able to change from one Dental Plan to another (Base to Buy Up or Buy Up to Base).

Any changes you make during Annual Enrollment will become effective the following January 1. In the case of Dependents added during Annual Enrollment, documentation must be submitted within thirty-one (31) days of the close of Annual Enrollment or coverage will not be effective on January 1 of the following plan year.

As a Retiree, you are not eligible to add Dependents to your dental plan coverage after the date of retirement. Once you cancel any part of your dental coverage, you, or your Dependents, cannot re-enroll in the Dental Plan. You are allowed to change from one Dental Plan to another during the Annual Enrollment period.

When are benefits payable?

Dental benefits for preventive (Type A), basic (Type B) and major (Type C) are paid when covered expenses are incurred that either exceed or are not subject to the deductible amount, up to the calendar year plan maximum.

Buy Up Plan Only: Orthodontic benefits (Type D) are paid on a quarterly basis, after expenses have incurred, until the covered individual has met their orthodontic lifetime maximum or treatment is completed, whichever comes first. If coverage is terminated before an orthodontic treatment plan is completed, coverage will be provided only to the end of the month in which coverage ends.

What is the deductible amount?

The deductible amount is equal to the first $100 (base plan) or $50 (buy up plan) 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) or orthodontic (Type D) 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 (base plan) or $150 (buy up plan) in one calendar year, no additional deductible will be applied for any of the family members for the remainder of the year.

What is the calendar year plan maximum?

The most any covered individual can receive in dental benefits in one calendar year is $1,500 for the Base Plan and $2,000 for the Buy Up Plan.

What is the orthodontic lifetime maximum?

Buy Up Plan Only: The lifetime maximum is $1,500. This is the maximum benefit any covered individual can receive for orthodontic services during their lifetime on the plan.

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:

- Oral examinations (evaluations), twice in any benefit period
- Problem focused exams, as needed
- Periapical x-rays* as required
- Bitewing x-rays* two sets per benefit period
- Full-mouth x-rays* once in any 36-month period
- Dental prophylaxis (cleaning, scaling, and polishing), twice in any benefit period
- Topical fluoride application for Dependent Children under age 19, twice in any benefit period
- Emergency palliative treatment as needed (minor procedures to temporarily reduce or eliminate pain)
- Space maintainers that replace prematurely lost teeth of eligible Dependent Children under age 19
- Sealants: for Dependent Children under age 16, limited to caries-free teeth
- Cephalometric films

**Multiple individual x-rays provided on the same date of service will be considered a complete mouth series if the total allowed amount equals or exceeds the allowed amount for a complete mouth series.*

Type B — basic services

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

- Restorative services using amalgam, synthetic porcelain, and plastic filling material. Composite filings are a benefit on all teeth
- Diagnostic casts
- Periodontics: treatment for diseases of the gums and bone supporting the teeth. Periodontal surgery is covered only once in a 3-year period for the same site. Coverage for scaling and root planing are limited to once per 24 months
- Periodontal maintenance visits, limited to 4 in any benefit period
- Endodontics: root canal filling and pulpal therapy (therapy for the soft tissue of a tooth)
- Simple extractions
- Surgical extractions
- General anesthesia in conjunction with covered surgical procedures
- Localized delivery of antimicrobials
- Repair or re-cementing of crowns, inlays, onlays, dentures, or bridgework
- Denture adjustments, repairs, rebase and relines to complete and partial dentures. Denture relines and rebases, limited to once in 36 months
- Implants, as well as bone grafts
- Oral surgery, excluding repairs of jaw fractures
- Consultations
- Complete and limited occlusal adjustments
- Brush biopsy

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 (basic) 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:

- Prosthetics: bridges and dentures, once in 5 years
- Crowns, jackets, labial veneers, inlays, and onlays when required for restorative purposes and when teeth cannot be restored with a filling material, as required

Type D — Orthodontic Dental Services (Buy Up Plan Only)
The following orthodontic dental services are reimbursed at 50% after you have satisfied the deductible, up to the lifetime maximum of $1,500. All covered individuals enrolled in the Buy Up Plan are eligible for the following services:

- Treatment for correction of malposed teeth to establish proper occlusion through movement of teeth or their maintenance position.

Example
Here is an example of one Employee's dental expenses and how benefits are paid under the Base Plan vs Buy up Plan:

BASE PLAN

Dental service	Dentist fee	Deductible	Plan pays	Employee pays
Type A-Preventive services				
Dental exam, cleaning, and X-rays	$110	$0	$110	$0
Type B-Basic services				
Two fillings ($90 each)	$180	$100	$64	$116 (deductible + 20% of balance)
Two extractions ($180 each)	$360	Satisfied	$288	$72 (20%)
Root Canal	$880	Satisfied	$704	$176 (20%)
Type C-Major services				
Crown	$800	Satisfied	$334*	$466 (50% +amount over $1,500 annual max*)
TOTAL	**$2,330**		**$1,500**	**$830**

BUY UP PLAN

Dental service	Dentist fee	Deductible	Plan pays	Employee pays
Type A-Preventive services				
Dental exam, cleaning, and X-rays	$110	$0	$110	$0
Type B-Basic services				
Two fillings ($90 each)	$180	$50	$104	$76 (deductible + 20% of balance)
Two extractions ($180 each)	$360	Satisfied	$288	$72 (20%)
Root Canal	$880	Satisfied	$704	$176 (20%)
Type C-Major services				
Crown	$800	Satisfied	$400*	$400 (50%)
TOTAL	**$2,330**		**$1,606**	**$724**

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.

If orthodontic care is already in progress when your coverage begins in the Buy Up Plan, the Plan will pay benefits until the orthodontic lifetime maximum amount has paid out, treatment has concluded or the covered individual is no longer covered by the plan, whichever occurs first.

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, Type C or Type D dental services
- oral hygiene and dietary instruction or plaque control problems
- 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
- charges for repair or replacement of an orthodontic appliance

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 legal 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: Employees and LTD Recipients 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?

Employees

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 five (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 Adult Dependent's 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 Dependents 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 thirty-one (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 eighteen (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 thirty-six (36) months if their coverage ends for any of the following reasons:

- divorce or legal separation from the Enrollee
- the death of the Enrollee
- 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 thirty-six (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 Enrollees
- 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 sixty (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 twenty-nine (29) months, rather than eighteen (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 eighteen (18) months of continued coverage and within sixty (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 thirty (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 thirty-six (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 sixty (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 sixty (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 forty-five (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 sixty (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:

- twelve (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 website 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 twelve (12) months after the date the dental expense is incurred.

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 calling the Claims Administrator's office at the phone number listed on the Plan Contacts webpage: http://umurl.us/benadmin.

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 ninety (90) days, allowing reasonable time for mailing, assume your claim has been denied and proceed to the claim review stage.

Within sixty (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 at:

Delta Dental of Missouri
Customer Service Department
12399 Gravois Rd.
St. Louis, MO 63127-1702

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.

Privacy and Security of Health 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 this section and the Plan's privacy notice.

Definitions

All terms not specifically defined in this Section shall have the meaning ascribed to them in the Privacy Rule and the Security Rule.

a) Breach Notification Rule: the regulations issued under HIPAA set forth in subpart D of 45 CFR Part 164.
b) Business Associate: a person or entity who performs services for the Plan involving the use or disclosure of individually identifiable health information, as defined in 45 CFR Section 160.103.

c) HIPAA: the Health Insurance Portability and Accountability Act of 1996, as amended.
d) Plan Participant: an individual who meets the eligibility requirements specified in the Plan.
e) Plan Sponsor: The Curators of the University of Missouri.
f) Privacy Rule and Security Rule: HIPAA's implementing regulations at 45 CFR Parts 160, 162, and 164.
g) Protected Health Information ("PHI"): individually identifiable health information as defined in 45 CFR Section 160.103.
h) Summary Health Information: information that summarizes the claims history, expenses, or types of claims by individuals for whom the Employer provides Benefits under the Plan, as such information is defined in the Privacy Rule.
i) Workforce Members: For purpose of this attachment, "workforce members" means UM System HR's Employees, volunteers, trainees, students, and other persons whose conduct, in the performance of work for the Plan Sponsor, is under the direct control of Plan Sponsor, whether or not they are paid for that work by the UM System HR.'

Plan Sponsor's Certification of Compliance

Neither the Plan nor any Business Associate servicing the Plan will disclose Plan Participants' PHI to the Plan Sponsor unless the Plan Sponsor certifies that the Plan Documents have been amended to incorporate this Section and agrees to abide by this Section.

Purpose of Disclosure to Plan Sponsor

a) The Plan and any health insurance issuer or Business Associate servicing the Plan will disclose Plan Participants' PHI to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions for the Plan not inconsistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing Regulations (45 CFR Parts 160-164). Any disclosure to and use by the Plan Sponsor of Plan Participants' PHI will be subject to and consistent with the provisions of this Section.
b) Neither the Plan nor any health insurance issuer or Business Associate servicing the Plan will disclose Plan Participants' PHI to the Plan Sponsor unless the disclosures are explained in the Notice of Privacy Practices distributed to the Plan Participants by the Plan.
c) Neither the Plan nor any health insurance issuer or Business Associate servicing the Plan will disclose Plan Participants' PHI to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor.
d) The Plan may disclose Summary Health Information to Plan Sponsor.
e) The Plan may disclose to Plan Sponsor information on whether an individual is participating in the Plan, or is enrolled or has disenrolled from a particular coverage option within the Plan.

Restrictions on Plan Sponsor's Use and Disclosure of PHI

a) The Plan Sponsor will neither use nor further disclose Plan Participants' PHI, except as permitted or required by the Plan Documents, as amended, or required by law.
b) The Plan Sponsor will ensure that any agent, including any subcontractor, to whom it provides Plan Participants' PHI agrees to the restrictions and conditions of the Plan Documents, including this Section, with respect to the Plan Participants' PHI.
c) The Plan Sponsor will not use or disclose PHI that is Genetic Information about an individual for underwriting purposes. The term "underwriting purposes" includes determining eligibility for Benefits, computation of premium or contribution amounts, or the creation, renewal, or replacement of a contract of health insurance.
d) The Plan Sponsor will not use or disclose Plan Participants' PHI for employment-related actions or decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor.
e) The Plan Sponsor will comply with the requirements of the HITECH Act and its implementing regulations to provide notification to affected individuals, HHS, and the media (when required) if the Plan Sponsor or one of its Business Associates discovers a breach of unsecured PHI.

f) The Plan Sponsor will report to the Plan any use or disclosure of Plan Participants' PHI that is inconsistent with the uses and disclosures allowed under this Section promptly upon learning of such inconsistent use or disclosure.
g) The Plan Sponsor will consider requests by a Plan Participant to restrict uses and disclosures of the Participant's PHI to carry out treatment, payment, or health care operations, or restrict uses and disclosures to the Participant's family members, relatives, friends or other persons identified by the Participant who are involved in care or payment of care. Except as otherwise provided, the Plan Sponsor is not required to agree to the Plan Participant's request; however, if the Plan Sponsor does agree to the request, the request will be honored until the Plan Participant revokes it, or until the Plan Sponsor notifies the individual that the Plan Sponsor will no longer honor the request. The Plan Sponsor must comply with the restriction request if: (1) except as otherwise provided by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and is not for the purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the Health Care Provider involved has been paid out-of-pocket in full.
h) The Plan Sponsor will make PHI available to the Plan Participant who is the subject of the information in accordance with 45 CFR Section 164.524.
i) The Plan Sponsor will make Plan Participants' PHI available for amendment, and will on notice amend Plan Participants' PHI, in accordance with 45 CFR Section 164.526.
j) The Plan Sponsor will track disclosures it may make of Plan Participants' PHI so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 CFR Section 164.528 and the HITECH Act and its implementing regulations.
k) The Plan Sponsor will make available its internal practices, books and records, relating to its use and disclosure of Plan Participants' PHI, to the Plan and to the U.S. Department of Health and Human Services to determine compliance with 45 CFR Parts 160-164.
l) The Plan Sponsor will, if feasible, return or destroy all Plan Participant PHI, in whatever form or medium, including any electronic medium under the Plan Sponsor's custody or control, received from the Plan, including all copies of any data or compilations derived from and allowing identification of any Participant who is the subject of the PHI, and retain no copies of such information when the Plan Participants' PHI is no longer needed for the purpose for which the disclosure was made. If it is not feasible to return or destroy all Plan Participant PHI, the Plan Sponsor will limit the use or disclosure of any Plan Participant PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

Adequate Separation Between the Plan Sponsor and the Plan

a) The following classes of Employees or other Workforce Members under the control of the Plan Sponsor may be given access to Plan Participants' PHI received from the Plan or a health insurance issuer or Business Associate servicing the Plan:
    1) any Employee who serves as the Plan Administrator;
    2) any Employee who serves as a Plan fiduciary; and
    3) any Employee who performs functions related to the Plan, including but not limited to human resources, audit, legal, accounting and systems personnel.

    This list includes every class of Employees or other Workforce Members under the control of the Plan Sponsor who may receive Plan Participants' PHI relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business.
b) The classes of Employees or other Workforce Members identified in paragraph 5(a) of this Section will have access to Plan Participants' PHI only to perform the plan administration functions that the Plan Sponsor provides for the Plan.
c) The classes of Employees or other Workforce Members identified in paragraph 5(a) of this Section will be subject to the Plan Sponsor's disciplinary policies and procedures up to and including termination of employment or affiliation with the Plan Sponsor, for any use or disclosure of Plan Participants' PHI in breach or violation of or noncompliance with the provisions of this Section to the Plan Documents. Plan Sponsor will promptly report any such breach, violation or noncompliance to the Plan, as required by

paragraph 4(d) of this Section, and will cooperate with the Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each Employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any Plan Participant, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance.

Disclosures by Others to the Plan Sponsor

The Plan Sponsor shall be entitled to receive PHI from:

a) the Plan;
b) any Business Associate of the Plan;
c) any person or entity that contracts with such Business Associate;
d) any person or entity that contracts with the Plan Sponsor to provide services to or on behalf of the Plan;
e) any health insurer or health insurance issuer or HMO that provides health Benefits coverage or services to or on behalf of the Plan;
f) any health care clearinghouse that provides services to or on behalf of the Plan or with respect to Plan Participants; and
g) any other person or entity that maintains, or has the authority to direct the disclosure of, PHI related to any Plan Participant.

Permitted and Required Uses and Disclosures of PHI

a. Permitted Uses and Disclosures. The Plan Sponsor is and shall be entitled to use and disclose any PHI obtained pursuant to this Section only for the purposes of plan administration functions.
b. Required Uses and Disclosures of PHI. The Plan Sponsor shall be required to use and/or disclose PHI:
    1) to an individual, when requested under, and required by 45 CFR Section 164.524, in order to provide an individual with access to their own PHI;
    2) to an individual, when requested under, and required by 45 CFR Section 164.528, in order to provide an individual with an accounting of disclosures of that individual's PHI; and
    3) when required by the Secretary of the Department of Health and Human Services or those acting under the authority or at the direction of the Secretary to investigate or determine the Plan's compliance with the Privacy Rule, Security Rule, or Breach Notification Rule.

Prohibited Uses and Disclosures of PHI

The Plan Sponsor shall not be entitled to use or disclose PHI for any purpose for which use and disclosure is not expressly allowed under this Plan Document, including but not limited to:

a) using or disclosing PHI other than as permitted or required under this document or applicable law, or in a manner inconsistent with the Privacy Rule or Security Rule; and
b) taking adverse employment action against any Plan Participant who is an Employee of Plan Sponsor, except with respect to any fraud or unlawful act related to the Plan and committed or reasonably suspected to have been committed by such person; and
c) using or disclosing PHI that is genetic information for underwriting purposes.

Minimum Necessary

When using or disclosing PHI or when requesting PHI from another party, the Plan Sponsor must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure, and limit any request for PHI to the minimum necessary to satisfy the purpose of the request.

Security Provisions

a) Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

b) Plan Sponsor will ensure that the adequate separation required by Section 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
c) Plan Sponsor will ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
d) Plan Sponsor will report to the Plan any security incident of which it becomes aware.

Mitigation

a) In the event of noncompliance with any of the provisions set forth in this Section, the HIPAA Privacy Officer or Security Officer, as appropriate, will address any complaint promptly and confidentially. The HIPAA Privacy Officer or Security Officer, as appropriate, first will investigate the complaint and document the investigative efforts and findings.
b) If PHI, including Electronic PHI, has been used or disclosed in violation of the Privacy Policy or inconsistent with this Section, the HIPAA Privacy Officer and/or the Security Officer, as appropriate, shall take immediate steps to mitigate any harm caused by the violation and to minimize the possibility that such a violation will recur.

Breach Notification

Following the discovery of a Breach of unsecured PHI, the Plan shall notify each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed as a result of a Breach, in accordance with 45 CFR § 164.404, and shall notify the Secretary of Health and Human Services in accordance with 45 CFR § 164.408. For a breach of unsecured PHI involving more than 500 residents of a State or jurisdiction, the Plan shall notify the media in accordance with 45 CFR § 164.406.
"Unsecured PHI" means PHI that is not secured through the use of a technology or methodology specified in regulations or other guidance issued by the Secretary of Health and Human Services.

Child or Children means:

- natural Children; or
- stepchildren (note that the child of an Employee's Sponsored Adult Dependent is not a stepchild); or
- foster Children (subject to court order or placement by an authorized agency); or
- legally adopted Children or Children placed in the Employee's home for adoption (subject to court order); or
- each Child, who otherwise meets the definition of "Child" under the Plan, of an Employee for whom the University has received a valid Notice of Order to Enroll and for which the University is obligated to comply under Senate Bill No. 253 which repeals various Sections of RSMO 1986 and RSMO Supp. 1992; or
- each Child who a court has lawfully appointed the Employee (and/or the Employee's legal Spouse) as a legal guardian (legal guardianship) who is responsible for providing Principal Financial Support provided the:
    - Child is unmarried,
    - Child resides full-time with the Employee in parent-child relationship,
    - Child is declared a dependent on the Employee's federal income tax return; and
    - legal guardianship was awarded prior to the Child's 18th birthday and is still in effect.
        - Legal guardianship ends on the Child's 18th birthday, unless there is a court order extending the guardianship.

Claims Administrator means Delta Dental

Disabled Employee means someone who is a Long-Term Disability benefit recipient, also known as LTD Recipient. See *Am I eligible for coverage*.

Dependent means your Spouse/Sponsored Adult Dependent and/or Child(ren).

Domestic Partner see Sponsored Adult Dependent

Employee means 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 as .75 FTE or more.
- You have an appointment duration of at least nine months.
- You are regularly scheduled to work an average of thirty (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.

Enrollee means an Employee, LTD Recipient or Retiree

LTD Recipient, see "Disabled Employee"

Principal Financial Support means during the calendar year, you are continuously providing more than one half of the total support of the Child, including the amount spent to provide food, lodging, clothing, education, medical, dental and vision care, recreation, transportation and similar necessities.

Retiree means you are a Retired Employee of the University (Retiree) and you are eligible for coverage, provided the conditions under *Am I eligible for coverage,* subsection *Retiree,* are met.

Sponsored Adult Dependent, also commonly referred to as a Domestic Partner, means an adult person who meets all of the following criteria:

- has had a single dedicated relationship of at least twelve (12) months with the Employee;
- has had the same principal residence as you for at least twelve (12) months, and continues to have the same principal 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;
- 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; and
- has not been determined by a court or physician to be mentally incompetent.

Spouse means the lawful Spouse of an Employee, LTD Recipient or Retiree.