University of Chicago

Dental Plans

MetLife Dental PPO Plan
MetLife Dental Copay Plan

Summary Plan Descriptions

Table of Contents

Your Dental Benefits

The University of Chicago offers a choice of two dental plans, the MetLife Dental PPO Plan and the MetLife Dental Copay Plan. Under either of the two plans, you are free to visit any licensed dentist you choose. However, you save money if you visit a preferred provider, also called a participating PDP (Preferred Dentist Program) dentist. Although the plans utilize the same provider network, your costs associated with the plans will vary.

- **MetLife Dental PPO Plan** covers two preventive care check-ups each year at 100% of the reasonable and customary charges, with no deductible. For other types of care, you and your family members must meet an annual deductible. Then the plan pays a percentage of your reasonable and customary charges, up to an annual maximum.
- **MetLife Dental Copay Plan** covers two preventive care check-ups each year separated by six months, you pay a copay amount. You and your family members do not have to meet an annual deductible if you use an in-network dentist. Your out-of-pocket expenses for covered preventive, basic and major services are determined by the ZIP code of your PDP dentist's office.

Please review this summary and refer to your dental insurance information provided by the dental plans for important details on plan limits and features.

If you have questions about your benefits, contact the Benefits Office by e-mail at benefits@uchicago.edu.

Participating in a Dental Plan

Eligibility

You are eligible for coverage under a dental plan if you are a:

- Full-time Benefits-eligible employee of the University of Chicago (the "University").
- Part-time Benefits-eligible employee of the University.

The capitalized terms in the Summary Plan Description have special meaning, which impacts your receipt of benefits under the Dental Plan. Please refer to the Glossary for the definitions of those capitalized terms.

You can also cover your eligible dependents, including your:

- Spouse or Domestic Partner.
- Your or your Domestic Partner's unmarried natural child, stepchild, or legally adopted child, until the date of the child's marriage or, if earlier, the last day of the month in which the child attains the age of twenty-three (23) years.
- Unmarried grandchildren or ward under age 23 if you or your Domestic Partner:
    - Is the legal guardian,
    - Claims the child for federal income tax and legal purposes,
    - Lives with the child in a parent/child relationship.
    - Mentally or physically disabled children of any age as long as they were covered under the plan before age 23.

You cannot provide coverage for your parents, grandchildren who do not meet the requirements listed above, or foster children.

Verification of relationship is required for any dependent being added for the first time to your coverage. Documentation may include a marriage certificate or domestic partnership statement to add a new spouse or domestic partner. Documents for a new dependent child may include a birth certificate or adoption papers, or other appropriate legal documents may be provided. Return a copy of the required documents to the Benefits Office within 31 days of your date of hire as a Benefits-Eligible Employee.

If you and your spouse or domestic partner both work for the University, only one of you may cover your children as dependents.

Qualified Medical Child Support Order

A qualified medical child support order (QMCSO) is a legal judgment, decree or order issued under a state domestic relations law by a court or an administrator. A QMCSO recognizes the rights of a child to coverage for health care benefits. Under a child support order, the court can require you to provide coverage to a child under this plan.

You will be notified if any of your children are affected by a QMCSO. You may contact the Benefits Office by e-mail at benefits@uchicago.edu for information regarding the procedures governing QMCSOs.

Enrolling

You may enroll in a dental plan:

- Within 31 days of your date of hire or the date you become a benefits-eligible employee and if you complete and submit an enrollment form within that 31-day period.
- If you do not enroll within 31 days, you must wait until the plan is offered during Open Enrollment, unless you have a Qualifying Change in Status or special enrollment event.

Enrollment materials are available online at http://hr.uchicago.edu or from the Benefits Office.

Coverage Levels

You can choose from three coverage levels:

- **Employee** covers you only.
- **Double** covers you plus one dependent. For example, you could cover yourself and one child or yourself and your spouse or Domestic Partner.
- **Family** covers you, your spouse or Domestic Partner, and your Dependent Children.

Typically, you and your family must enroll in the same plan. For example, if you want to enroll in the MetLife Dental PPO Plan, your children cannot be enrolled in the MetLife Dental Copay Plan. However, if another family member is also a Benefits-eligible employee at the University, that person can elect to enroll in the other plan.

If both you and your spouse or Domestic Partner are University employees, you may each select employee coverage or one of you may choose family coverage. Both of you cannot choose family coverage.

ID Cards

MetLife Dental Plans

You will receive two insurance identification (ID) cards from MetLife. Once you receive your ID card, fill in your name and Social Security number. Be sure to include your name and Social Security number on the ID cards of your family members. Carry your ID card with you at all times.

Cost of Coverage
Your cost for dental coverage is based on the coverage level and plan you choose. The premium may be adjusted each year.

For a current list of premiums, visit our web site at: http://hr.uchicago.edu or contact the Benefits Office.

When Coverage Begins

If you are eligible when you start working for the University, your and, if elected, your Dependents' coverage begins on your first day of work, as long as you return your enrollment form to the Benefits Office within 31 days of your hire date.

If you become a Benefits-Eligible Employee during your employment with the University, your and, if elected, your Dependents' coverage begins on the date you become a Benefits-Eligible Employee, as long as you return your enrollment form to the Benefits Office within 31 days of that date.

If you enroll during the annual Open Enrollment, your and, if elected, your Dependents' coverage begins on the following January 1.

Changing Your Elections

Generally, once you have elected a dental plan and coverage level, you cannot change your elections until Open Enrollment, unless you have a qualifying change in status or special enrollment event as explained below.

Qualifying Change in Status includes:

- Marriage, divorce, legal separation or annulment.
- Registration or termination of a domestic partnership.
- Death of a child, spouse or domestic partner.
- Birth, adoption or placement for adoption of a child.
- Dependent reaching maximum plan age of 23.
- Loss of eligible dependent status.
- A court order which requires that a dependent be covered under your dental coverage.

The above situations require documentation consistent with the qualifying change in status. Dental elections can only be changed mid-year for the above situations. Changing for any other reason may only be made during annual open enrollment.

If you have one of the above qualifying change in status situations, you must complete a change form **within 31 days** of the change. Any change in your elections must be consistent with and on account of the qualifying change in your circumstances.

Verification of relationship is required for any dependent being added for the first time to your coverage. Documentation may include a marriage certificate or domestic partnership statement to add a new spouse or domestic partner. Documents for a new dependent child may include a birth certificate or adoption papers, or other appropriate legal documents may be provided. Return a copy of the required documents to the Benefits Office within 31 days of the qualifying change.

Special Enrollment Event
If you decline enrollment for yourself or your dependents (including your spouse) because of other dental insurance coverage, in the future you may be able to enroll yourself or your dependents in the dental plan provided you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

Verification of relationship is required for any dependent being added for the first time to your coverage. Documentation may include a marriage certificate or domestic partnership statement to add a new spouse or domestic partner. Documents for a new dependent child may include a birth certificate or adoption papers, or other appropriate legal documents may be provided. Return a copy of the required documents to the Benefits Office within 31 days of the special enrollment event.

When Coverage Ends

Your coverage ends on the last day of the month in which:

- You are no longer a Benefits-eligible employee.
- You stop working for the University.
- You die.
- You stop paying direct-billed premiums.
- The plan ends.

Coverage for your spouse or Domestic Partner ends on the last day of the month in which:

- Your coverage ends.
- Your double or family coverage ends.
- You and your spouse are divorced or legally separated, or your domestic partnership ends.
- Your dependent dies.

Coverage for your children ends on the last day of the month in which:

- Your coverage ends.
- Your double or family coverage ends.
- Your covered child reaches age 23.
- Your covered child marries.
- Your dependent dies.

When your coverage ends, you and/or your covered dependents may be eligible to continue coverage for a limited time under COBRA.

Coverage During a Leave

Short-Term Disability
If you are a staff employee and are not actively at work due to an approved short-term disability leave, your dental coverage will remain in place at the same level as before your leave. The costs for the coverage will be deducted from your short-term disability check. Upon return to work from this leave, the cost for your dental coverage will be deducted again from your regular paycheck.

Academic employees are not eligible for short-term disability. Contact your department for more information.

Family Medical Leave
If you are not actively at work due to an approved leave of absence under the Family and Medical Leave Act (FMLA), you may continue your coverage at the same level as before your leave. You will be billed on a monthly basis for this coverage. Upon return to work from this leave, the cost of the dental coverage will be deducted again from your regular paycheck.

The University may recover premiums paid for your and your dependents' coverage if you fail to return to work unless the failure is due to your serious health condition or circumstances beyond your control.

If you are on unpaid FMLA leave, you may also cancel your coverage when your leave starts and reinstate your coverage (at the same coverage level) when your leave ends.

Leave of Absence
If you are not actively at work due to an approved, unpaid leave of absence, you may continue your dental coverage at the same level as before your leave.

If you decide to continue your dental coverage while on an unpaid leave of absence, you will be billed for the cost of coverage on a monthly basis. If you return to work in the same position or another Benefits-eligible position, the cost for your dental coverage will automatically be deducted again from your paycheck.

If you decide not to continue your dental coverage while on leave, your dental coverage will end. When you return to work in the same or another Benefits-eligible position, you will not be eligible to enroll in a dental plan until the next Open Enrollment period after your return from your leave.

If you return to work in a benefits-ineligible position or if you do not return to work at the end of your leave, your dental coverage will end.

Long-Term Disability
For the duration of the long-term disability leave, you can continue your dental coverage. You will be billed for the cost of coverage on a monthly basis. If you fail to pay, you may jeopardize your coverage.

If you return to work in the same or another Benefits-eligible position, your coverage will automatically continue and the cost will be deducted again from your paycheck.

If you return to work in a benefits-ineligible position or if you do not return to work at the end of your leave, your dental coverage will end.

Military Leave of Absence
If you are in the reserves and called up for active duty, you may continue your dental coverage at the same level as before your leave, for up to twenty-four (24) months. You will be billed for insurance coverage on a monthly basis. If you fail to pay, you may jeopardize your coverage. The time period that you are eligible for continuation of coverage under COBRA runs concurrently with this Military leave continued coverage.

If you return to work in the same or another Benefits-eligible position, your coverage will automatically continue and the cost for the dental coverage will be deducted again from your paycheck.

If you return to work in a benefits-ineligible position or if you do not return to work at the end of your leave, your dental coverage will end.

If you are on unpaid Military leave, you may also cancel your coverage when your leave starts and reinstate your coverage (at the same coverage level) when your leave ends.

How The MetLife PPO Dental Plan Works

How It Works

The MetLife Dental PPO Plan is a dental preferred provider organization (PPO). Each time you need care, you can visit any licensed dentist you choose. However, if you visit a preferred provider, you save money since providers in the network charge negotiated rates. After you meet your annual deductible, the plan covers a percentage of the cost of your necessary care, up to the maximum annual benefit.

For a listing of network providers, visit the MetLife website at: www.metlife.com/mybenefits. Provider information can also be obtained on our website at http://hr.uchicago.edu. A provider list may be obtained, without charge, through the website or by contacting MetLife directly.

The table below shows the deductible, coinsurance and maximum annual benefits. For a current list, visit our web site at: http://hr.uchicago.edu or contact the Benefits Office.

MetLife Dental PPO Plan

	In-network	Out-of-network
Choice of Dentist	Network providers only	Any licensed provider
Deductible	$60 per person. Does not apply to preventive care or orthodontia	
Annual Maximum Benefit	Per covered individual: $1,500 Per Family: $3,000	
Preventive Care	Plan pays 100% with no deductible	Plan pays 100% of reasonable and customary charges with no deductible
Basic Care (e.g. fillings)	Plan pays 80% after deductible	Plan pays 80% of reasonable and customary charges after deductible
Major Care (e.g. crowns)	Plan pays 50% after deductible	Plan pays 50% of reasonable and customary charges after deductible
Orthodontia (e.g. braces)	Plan pays 50% with no deductible up to a lifetime maximum of $1,000	Plan pays 50% of reasonable and customary charges with no deductible up to a lifetime maximum of $1,000
Claim forms	None	You file your own claims

Necessary Care
The plan pays a share of your covered expenses for necessary care. **Necessary care** is a specific dental service or treatment that is necessary for the treatment or management of a dental symptom or condition, and is the most efficient care that can be safely provided. The fact that a dentist may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply necessary care. The claims administrator determines whether a service is necessary care.

Deductibles
A **Deductible** is the portion of your dental expenses you pay before the plan begins to pay benefits. Each year, each covered individual must satisfy a deductible before benefits will be paid for basic and major dental services. Preventive care and orthodontia are not subject to the deductible.

If you have expenses during the last three months of a plan year that were or could have been applied to the current year's deductible, these expenses will be applied toward the next year's deductible.

Coinsurance
Coinsurance is the portion of covered dental bills that you pay for necessary care after you meet your deductible. For example, if the plan pays 80%, your coinsurance is 20%.

For Example*

Mark has employee coverage in the MetLife Dental PPO Plan. In March, he gets two fillings. His dentist charges $60. Because Mark has not yet met his $60 deductible, he pays the full bill from his dentist.

In November, Mark needs a crown. His dentist charges him $700. Since Mark has already met his deductible, the plan pays 50%. As shown at right, Mark would pay $350.

First you must meet your deductible:

Charge for fillings	$60
Deductible	- $60
Amount of remaining deductible	$0

Then the plan pays a percentage of your bill:

Charge for crown	$700
Plan covers	x 50%
Plan pays	**$350**

Charge for crown	$700
Mark's coinsurance	x 50%
Mark pays	**$350**

*This example is for illustrative purposes only and may not reflect true claim charges.

Reasonable and Customary Rates
Your coinsurance is subject to **Reasonable and Customary Rates**. That means you are responsible for any amount that the administrator determines exceeds what dentists in your area generally charge for a specific service.

Annual Maximum Benefit

The **Annual Maximum Benefit** is the most each covered person can receive from the plan each year. Once you reach the maximum benefit for the year, no more benefits will be paid.

For Example*		
Mary has employee coverage in the MetLife Dental PPO Plan. Her deductible is $60. Her annual maximum benefit is $1,500. After Mary pays her deductible, the plan pays a percentage of her dental bills. In this case, it pays 50% because bridges and crowns are major care. Once the plan has paid $1,500 in benefits, Mary must pay for any added dental care she receives.	Dentist's charges:	
	Bridge	$2,500
	Crown	+ $900
	Total Charges	$3,400
	First Mary pays a deductible:	
	Total Charges	$3,400
	Deductible	- $60
	Remaining Charges	$3,340
	Then the plan pays a percentage of her charges:	
	Remaining Charges	$3,340
	Plan Covers	50%, up to $1,500
	Plan Pays	**$1,500**
	Mary Owes	**$1,840**

*This example is for illustrative purposes only and may not reflect true claim charges.

Alternate Benefit Program

Dental expense benefits will be based on the materials and method of treatment which cost the least and which in the Plan's view meet generally accepted dental standards.

Pre-determination of Benefits

If your dentist recommends a course of treatment that costs more than $300, your dentist can prepare a special report describing the planned treatment. The report should include copies of necessary X-rays, photographs, models and a cost estimate. The administrator will review the report and notify you and your dentist what benefits will be paid.

What is Covered

For a detailed description of covered procedures and services, please refer to the MetLife materials available from MetLife. A brief set of examples of what may be covered include:

- Oral exams but not more than twice per calendar year.
- X-rays as defined by MetLife materials.
- Amalgam or resin fillings.
- Root canal treatment as defined by MetLife materials.
- Extractions.
- Orthodontia as defined by MetLife materials.

What Is Not Covered

For a detailed description of procedures and services not covered, please refer to the MetLife materials available from MetLife. A brief set of examples of what are not covered include:

- Treatment in progress at the inception of this plan, or dental treatment and expenses incurred prior to the member's eligibility to receive plan benefits under this plan, or after the termination of the member's coverage.
- Services not performed by a dentist except for dental hygienist services which are supervised and billed by a dentist and which are for scaling and polishing of teeth or for fluoride treatments.
- Cosmetic surgery, treatment or supplies, unless required for the treatment or correction of a congenital defect of a newborn dependent child.
- Services which are covered under other non-dental insurance plans, which are covered through workers' compensation or employer liability laws or for which coverage exists through any municipality, county, military or other political entity or which are covered by any medical policy. This plan does not duplicate coverage for dental services.

How the MetLife Dental Copay Plan Works

How It Works

The MetLife Dental Copay Plan is a dental plan in which you make a copay based on a fee schedule, called the Procedure Charge Schedule. The Procedure Charge Schedule is based on the ZIP code where your dentist's office is located. Each time you need care, you can visit any licensed dentist you choose. However, if you visit a preferred provider, you save money since providers in the network charge negotiated rates. If you visit an out-of-network provider you must meet an annual deductible and you pay a higher copay.

For a listing of network providers, visit the MetLife website at: www.metlife.com/mybenefits. Provider information can also be obtained on our website at.http://hr.uchicago.edu. A provider list may be obtained, without charge, through the website or by contacting MetLife directly.

The table below shows the deductible, and approximate Copay percentage that you'll be asked to pay at the time that dental services are rendered. For a current list, contact MetLife directly or visit their website at www.metlife.com/mybenefits or visit our web site at http://hr.uchicago.edu.

MetLife Dental Copay Plan

	In-network	Out-of-network
Choice of Dentist	Network providers only	Any licensed provider
Deductible	None	$75 per covered individual (waived for Orthodontia) $225 per family (waived for orthodontia)
Annual Maximum Benefit	$5,000 per person	$1,000 per person
Preventive Care	You make a copayment (approximately 10% of the cost), then Plan pays the remainder (up to the annual maximum) – up to 2 visits per year separated by 6 months	You pay 30%; Plan pays 70% (up to the annual maximum); you pay any amount over the reasonable and customary charges – up to two visits per year separated by 6 months
Basic Care (e.g. fillings)	You make a copayment (approximately 30% of the cost), then Plan pays the remainder (up to the annual maximum)	You pay 60%; Plan pays 40% (up to the annual maximum); you pay any amount over the reasonable and customary charges
Major Care (e.g. crowns)	You make a copayment (approximately 60% of the cost), then Plan pays the remainder (up to the annual maximum) after deductible	You pay 70%; Plan pays 30% (up to the annual maximum); you pay any amount over the reasonable and customary charges
Orthodontia (e.g. braces)	You pay 60%; Plan pays 40% (up to the lifetime maximum of $1,500)	You pay 60%; Plan pays 40% (up to the lifetime maximum of $500); you pay any amount over the reasonable and customary charges
Claim forms	None	You file your own claims
Negotiated fees	Yes	No

Copay

Copay is the portion of covered dental bills you pay for necessary care after you meet your deductible, if applicable.

Deductible

A Deductible is the portion of your out-of-network dental expenses you pay before the plan begins to pay benefits. The deductible is an annual amount that applies to out-of-network dental services. You do not have to satisfy a deductible for services provided by an in-network provider.

Preferred Dentist Program (PDP)

The program which offers you the opportunity to receive dental care from dentists who are designated by the plan as participating providers. Generally you will incur less out-of-pocket expenses when you use a provider who is in the PDP.

MetLife Preferred Dentist Program (PDP)

Example of savings when you visit a participating PDP dentist:

	Out-of-Network Dentist	Metlife Preferred Dentist Program Provider (PDP)
Dentist's Usual Fee	**$750**	**$750**
Schedule or R&C Fee	**$500**	**$350**
Dental Plan Pays	**$150**	**$350**
Your Cost	**$600**	**$350**
In this example, you save $250 ($600 minus $350) by using a PDP Dentist.		

Alternate Benefit Program

Dental expense benefits will be based on the materials and method of treatment which cost the least and which in the Plan's view meet generally accepted dental standards.

Pre-determination of Benefits

If your dentist recommends a course of treatment that is expected to cost $300 or more, your dentist can prepare a special report describing the planned treatment. If a dental bill is expected to be $300 or more, before the dentist starts the treatment, you can find out what expenses will be paid. Your dentist should send a claim form to the administrator explaining what work will be done and what the cost will be. The administrator will review and notify you and your dentist what benefits will be paid.

What is Covered

For a detailed description of covered procedures and services, please refer to the MetLife materials available from MetLife. A brief set of examples of what may be covered include:

- Oral exams and cleaning of teeth once in a 6 month period
- X-rays as defined by MetLife materials.
- Amalgam or composite fillings
- Root canal treatment as defined by MetLife materials
- Extractions
- Orthodontia as defined by MetLife materials.

What is Not Covered

For a detailed description of procedures and services not covered, please refer to the MetLife materials available from MetLife. A brief set of examples of what are not covered include:

- Services or supplies received before the dental expense benefits start for the covered person.
- Services not performed by a dentist except for those services of a licensed dental hygienist which are supervised and billed by a dentist and which are for scaling and polishing of teeth or for fluoride treatments.
- Cosmetic surgery, treatment or supplies, unless required for the treatment or correction of a congenital defect of a newborn dependent child.
- Services which are covered under other non-dental insurance plans, which are covered through workers' compensation or employer liability laws or for which coverage exists through any municipality, county, military or other political entity or which are covered by any medical policy. This plan does not duplicate coverage for dental services.

Receiving Your Benefits

Filing a Claim

MetLife Dental Plans

You do not have to file a claim if you seek dental care from a network provider. If you use an out-of-network provider, file your claims within 24 months of the date you receive a covered service or supply. Otherwise your claim will not be paid. To file a claim:

1. Obtain a dental claim form from the Benefits Office or from the website at http://hr.uchicago.edu.
2. Complete Part I of the form according to the instructions.
3. After you receive treatment, ask your dentist to complete and sign Part II and Part III.
4. Mail the completed form to MetLife.

Be sure to keep copies of your claim forms and all supporting documentation. After your claim is processed, payment will be sent to your dentist. You will receive a statement, called an Explanation of Benefits, informing you what was paid. If you have already paid the dentist, the administrator will send you the payment. File separate claims for each covered individual.

Coordination of Benefits

Many individuals have dental coverage in addition to their coverage under the University dental plan. For example, you may be covered as a dependent under your spouse's dental plan. This coordination of benefits provision prevents duplication of benefit payments when you or your dependent(s) also have coverage through another group plan. Coordination of benefits procedures also determines which plan pays first.

How Coordination of Benefits Works

The first step in coordinating benefits between two or more group plans is to determine which plan is primary and which plan is secondary. The primary plan pays benefits first. The secondary plan then pays its benefits so that the total benefit paid from both plans is not more than 100% of the allowable expense. No plan pays more than it would pay without coordination of benefits.

Order of Coverage

If you are covered as an employee by one plan and as a dependent by another, the plan that covers you as an employee pays benefits first.

If your child is covered under both your and your spouse's dental plan, the plan of the parent whose birthday comes first during the calendar year is the child's primary dental plan. If two or more dental plans cover a dependent child of divorced or separated parents, benefits for the child are determined as follows:

- First, the dental plan of the parent who has a court decree of financial responsibility will be primary.
- If no such court decree exists, then the dental plan of the parent who has custody of the child will be primary.
- Then, the dental plan of the spouse of the parent who has custody of the child will be primary.
- Finally, the dental plan of the parent who does not have custody of the child will be primary.

Benefit Overpayments

If an overpayment is made by the dental plan, the person or organization that received the benefit must repay the excess amount to the administrator.

Right of Recovery

If you or a covered dependent are injured by another person and receive payment for covered services from this plan and another plan, you must:

- Immediately reimburse the administrator for any duplicate payments you receive, and
- Agree that the administrator will have a lien, to the extent that duplicate benefits are provided. This lien may be filed with the person responsible for the injury, the person's agent or a court having jurisdiction in the matter.

You are responsible for furnishing the information, assistance and/or documents to help the administrator obtain the rights under this provision. If you don't reimburse the claims administrator, the claims administration may reduce your and your dependents future payments under the plan to recover the overpayment.

If Your Claim Is Denied

Benefit Denials

Benefits under the Dental Plan will be paid only if the Plan Administrator or its delegate (in this case MetLife or First Commonwealth) decides, in its discretion, that you or your covered dependents are entitled to them. The Plan Administrator will make a decision about your claim in the time frames outlined below and will notify you of its decision in writing.

Claims for benefits under a group health plan, including a dental plan, fall into four categories: urgent care, a claim requiring advance approval, approval of an ongoing course of treatment, and a claim for the payment of medical services after they have been received ("Post-Service Claim"). The time frame within which you receive notification will depend on what kind of a claim has been made. Please pay attention to the following:

Urgent Care Claims

If a claim is urgent, you will be notified of the Plan Administrator's decision, adverse or not, as soon as possible taking into account the medical circumstances, but not later than 72 hours after the Dental Plan received the claim, unless the claim does not contain sufficient information on which to base a decision.

If the claim is incomplete and additional information is required, you will be notified as soon as possible, but not later than 24 hours after the Dental Plan received the claim, of the information required and give you at least 48 hours to provide it.

You will then be notified of the Plan Administrator's decision as soon as possible, but not later than 48 hours after the earlier of:

- the receipt of any additional information by the Dental Plan; or
- the end of the 48 hours given to you to provide additional information.

A claim is "urgent" in the following cases:

- Where application of the 30-day time period for non-urgent care claims could reasonably be expected to seriously jeopardize your life or health or ability to regain maximum function;
- In the opinion of a physician with knowledge of your medical condition, the application of the 30-day time period for non-urgent care claims would subject you to severe pain that could not be adequately managed without the care that is the subject of the claim; or
- If a physician with knowledge of your medical condition determines that a claim is urgent, such determination shall be determinative.

Claim Requiring Advance Approval or Pre-Authorization
If a claim is for a benefit requiring advance approval by the Plan Administrator (for example, predetermination of a course of dental treatment costing more than $300), you will be notified of the Plan Administrator's decision, adverse or not, within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Dental Plan received the claim. This time period may be extended for an additional 15 days if the claim does not contain sufficient information on which to base a decision, or an extension is required for other reasons beyond the Dental Plan's control.

If an extension is required, you will be notified before the end of the original 15-day period of the circumstances requiring the extension and the date by which a decision is expected. If additional information is required, the Plan Administrator will specifically describe it in the notice and give you a period of at least 45 days to provide it.

Approval of an On-going Course of Treatment
If the Dental Plan has approved an ongoing course of treatment to be provided over a period of time or approved a number of treatments, the following will apply:

- Unless the Dental Plan is amended or terminated, any reduction or termination in the course of treatment will be treated as an adverse determination on a claim (or a claim denial).
- The Plan Administrator will notify you sufficiently in advance to allow you to appeal and obtain a decision on appeal before the reduction or termination.

Post-Service Claim
If your claim is for the payment of medical services after they have been received, the Plan Administrator will decide within a reasonable time, but not longer than 30 days after the Dental Plan received the claim. This time period may be extended for an additional 15 days if the claim does not contain sufficient information on which to base a decision, or an extension is required for other reasons beyond the Dental Plan's control.

If an extension is required, you will be notified before the end of the original 30-day period of the circumstances requiring the extension and the date by which a decision is expected. If additional information is required, the Plan Administrator will specifically describe it in the notice and give you a period of at least 45 days to provide it.

The Plan Administrator may secure independent medical or other advice and require such other evidence, as it deems necessary to decide your claim.

Notification of Denial
If the Plan Administrator issues an Adverse Benefit Determination, you can request to have your claim reviewed and reconsidered. An "Adverse Benefit Determination" includes:

- Coverage denial,
- Denial because the service is experimental, investigational or not medically necessary, or
- Reduction or termination in an ongoing course of treatment (except due to Dental Plan amendment or termination).

The written explanation of the denial will be provided by the Plan Administrator and it will state:

- The specific reasons for the denial,
- A reference to the specific Plan provision on which the denial is based,
- If the Plan Administrator relied on an internal rule, guideline, protocol, or other similar criterion in making its decision, a description of the specific rule, guideline, protocol, scientific or clinical judgment, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request,
- A description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary, and
- Appropriate information as to the steps to be taken if you wish to appeal the Plan Administrator's determination, including your right to submit written comments and have them considered, your right to review (on request and at no charge) relevant documents and other information, and your right to file suit under ERISA with respect to any adverse determination after appeal of your claim.

Appealing Denied Claims
You may appeal an Adverse Benefit Determination. Your appeal must be made in writing within 180 days of the Plan Administrator's initial notice of an Adverse Benefit Determination (or claim denial), or else you will lose the right to appeal your denial. If you do not appeal on time, you will also lose your right to file suit in court, as you will have failed to exhaust your internal administrative appeal rights, which is generally a prerequisite to bringing suit.

Your written appeal should include the following:

- the reasons you feel your claim should not have been denied.
- any additional facts and/or documentation that you feel support your claim.

You can also ask additional questions and make written comments, and you may review (at no charge) documents or other information relevant to your appeal.

All written comments and documents you submit with your appeal, whether or not considered in the initial claim determination, will be reviewed and considered on appeal.

Review of Appeal
An independent fiduciary will review and render a decision on your appeal within the time frames outlined below and will notify you of its decision in writing. The independent fiduciary will not be an individual who participated in or decided your original claim nor be a subordinate to the original decision maker. No deference shall be given to the initial decision. The independent fiduciary may consult with a physician or other licensed health care professional to receive advice or other such evidence as it deems necessary to decide your claim, except that any medical expert consulted in connection with your appeal will be different from any expert consulted in your initial claim. (The identity of a medical expert consulted in connection with your appeal will be provided.)

The time frame review of your appeal, like your initial claim for benefits, depends on whether it is an urgent care claim, a claim requiring advance approval or pre-authorization, approval of an ongoing course of treatment or Post-Service Claim. Please pay attention to the following time frames:

Urgent Care Claims
If your appeal is in connection with an urgent care claim, the Plan Administrator will notify you of its decision on appeal as soon as possible taking into account medical circumstances, but not later than 72 hours after the Dental Plan received the appeal.

Claim Requiring Advance Approval or Pre-Authorization
If your appeal is in connection with a claim for benefits requiring advance approval by the Plan Administrator, you will be notified of its decision on appeal, adverse or not, within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after the Dental Plan received your appeal.

Approval of an On-going Course of Treatment
If your appeal is in connection with a claim for an on-going course of treatment, the Plan Administrator will notify you of its decision on appeal as soon as possible, but not later than the date your treatment ends or is reduced.

Post-Service Claim
If your appeal is in connection with a claim for payment of medical services after they have been received, the Plan Administrator will notify you of its decision on appeal, adverse or not, but not later than 60 days after the Dental Plan received appeal.

Notification of Appeal Denial
If the decision on appeal affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

- the specific reason(s) for the denial,
- the specific Health Plan provisions on which the decision is based,
- a statement of your right to review (on request and at no charge) relevant documents and other information,
- if the Plan Administrator relied on an internal rule, guideline, protocol, or other similar criterion in making its decision, a description of the specific rule, guideline, protocol, scientific or clinical judgment, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request, and
- a statement of your right to bring suit under ERISA § 502(a).

The decision of the plan administrator is final and binding. The insurance company will comply with shorter timeframes if required by the state in which the policy was issued.

Administrative Information

Your ERISA Rights

As a participant in the dental plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to receive information about the plan and its benefits. For example, you can:

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Dental Plan Coverage

You may continue dental coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

You should be provided a certificate of creditable coverage, free of charge, from your group dental plan or dental insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court after you have exhausted the claims procedures as described in this summary. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions
If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Discretionary Authority
As the Claims Administrator, the insurance company has discretionary authority to grant or deny benefits under this contract and plan. Benefits under the contract and plan will be paid only if the insurance company decides in its discretion that you, the applicant, are entitled to them. The decision of the insurance company shall not be overturned unless determined by a court of law to be arbitrary and capricious.

Service of Legal Process
Service of legal process on any benefits matters should be directed to the plan administrator.

Plan Amendment and Termination
The University has reserved the right, in its sole discretion under circumstances that it deems advisable (including, but not limited to, a need to address cost or plan design considerations), to terminate the Plan or to amend or eliminate benefits. In the event of termination or amendment or elimination of benefits, the rights and obligations of participants prior to the date of such event shall remain in effect, and changes shall be prospective, except to the extent that the University's action and applicable law permit otherwise.

Collective Bargaining
Certain provisions of the Group Dental Insurance plan may be subject to collective bargaining agreements between the University of Chicago and certain unions.

If you are a member of a collective bargaining unit affected by these agreements, you can obtain a copy of the unit's agreement by writing to the plan administrator, or you may obtain it at the Office of Employee and Labor Relations.

Privacy Information

During the administration of the dental plan, the plan and claims administrators may come into contact with what is considered "protected health information" under the Health Insurance Portability and Accountability Act (HIPAA). The University has taken specific steps to protect and limit access to this information. For example, the University has:

- Designated a privacy Office.
- Developed privacy policies and procedures
- Implemented safeguards to protect against improper disclosure
- Provided a complaint resolution process
- Developed sanctions for employees and business partners that violate privacy policies
- Established confidentiality agreements with business associates

As part of our compliance efforts, we must provide a privacy notice to employees. If you would like to review the privacy policies and procedures, receive another copy of the privacy notice or just need more information, please contact the Benefits Office.

Continuing Your Coverage Under COBRA

Very Important Notice for you and your spouse (if covered) or your Domestic Partner (if covered)

On April 7, 1986, the Consolidated Omnibus Budget Reconciliation Act ("COBRA") was enacted (Public Law 99-272, Title X) requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end.

You are receiving this notice because you are covered under a group health plan. This notice contains important information about your right to COBRA continuation coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your eligible family members, and what you need to do to protect the right to receive it.

Both you and your spouse or your Domestic Partner, if your spouse or Domestic Partner is currently covered under any of the group health plans sponsored by the University, should take the time to read this section of the summary plan description carefully and keep this summary plan description with your records.

Qualified Beneficiaries

If you are an employee of the University, the spouse or a Dependent of the employee and you are covered under a group health plan sponsored by the University, you have an independent right to elect continuation coverage. An eligible Dependent includes a child who is born or placed for adoption with you or your Domestic Partner during the period of continuation coverage under COBRA.

Qualifying Events
Qualified beneficiaries can elect continuation of coverage for any of the reasons outlined below (called "qualifying events"). Different qualifying events apply to different covered groups as follows:

Qualifying Event	You	Spouse or Domestic Partner	Dependent Children	Notification
Your employment with the University ends (except for gross misconduct, in which case COBRA benefits are not available)	X	X	X	Within 44 days after the date coverage would end because of the event (usually, that date is the end of the month in which the event occurs), the **Benefits Office** will notify you and your covered Dependent(s) of the right to continue coverage under COBRA. You and your covered Dependent(s) will have 60 days after notification to make an election and pay the premium. If you do not elect and pay for continuation coverage on a timely basis, your group health plan coverage will terminate.
You are no longer a Benefits-Eligible Employee	X	X	X	
You become eligible for Medicare		X	X	
You die		X	X	
You divorce, legally separate or terminate your Domestic Partnership		X	X	**You or your Covered Dependents(s)** have 60 days after a divorce, legal separation, termination of a Domestic Partnership or when your child loses Dependent status to notify the Benefits Office of the qualifying event. If you or your covered Dependents provide timely notice of these qualifying events, such notice will preserve the COBRA election rights for all Dependents that lost coverage as a result of the qualifying event. Failure to provide such notice in a timely manner may result in loss of the right to elect COBRA continuation coverage. Upon notice of the qualifying event, within 44 days, the Benefits Office will notify you and your covered Dependents, as applicable, of benefit election rights under COBRA. After receiving a notice of benefit election rights, you or your covered Dependents, as applicable, will then each have 60 days to make an election and pay the premium. If you or your Covered Dependents do not elect and pay for continuation coverage on a timely basis, your group health plan coverage will terminate.
Your child loses Dependent status or disability status			X	

Benefits and Costs
The benefits provided under COBRA will be the same as those provided to active employees. The premiums you pay include the full dental cost, plus a 2% administrative fee. You will be billed by the claims administrator.

When COBRA Coverage Ends
The situations and time limits during which you can continue coverage are shown in the table below.

Who Can Continue Coverage	In What Situations	For How Long
You and your eligible dependents	• A reduction in work hours resulting in a loss of coverage. • Your termination (except for gross misconduct).	18 months
Your eligible dependents	• Your death. • Divorce, legal separation or termination of domestic partner registration. • Eligibility for Medicare.	36 months
Your eligible child(ren)	• Child(ren) reach age 23. • Child(ren) get married.	36 months

If you lost coverage because your employment was terminated or your hours were reduced, you and your dependents' continuation coverage ends after 18 months. If during those 18 months another event takes place that entitles you to continuation coverage, your continuation coverage may be extended up to another 18 months, but in no case can it last more than 36 months.

Continuation coverage will end sooner than the time limits shown if:

- You do not pay your premiums by the required due date.
- You or your dependent(s) become covered under another group plan (except if that plan has a pre-existing condition rule).
- The dependent enrolls in Medicare.
- The University discontinues dental coverage for active employees.
- The Plan ends.

Once you cancel your continuation coverage, you cannot re-enroll in the University dental plans.

Disability Is a Special Case
If you, your spouse or your eligible dependents are disabled (as determined by Social Security) at any time during the first 60 days of continuation coverage, the disabled person may be able to continue coverage for up to a total of 29 months from the date of the qualifying event.

To qualify, you must notify the Benefits Office within 60 days of the date Social Security makes its disability determination, and that determination must be made within the first 18 months of continuation coverage. If the disability ends, you (or your disabled dependent) must notify the Benefits Office within 30 days of the determination. Continued coverage will end on the first day of the month that is 31 or more days after the Social Security determination that the disability has ended.

Trade Act 2002
Certain Individuals who, under limited circumstances, become eligible to take advantage of trade adjustment assistance pursuant to the Trade Act may receive a second 60-day COBRA election period. If you are receiving trade adjustment assistance or if you are eligible for trade adjustment assistance, please contact the Benefits Office for more information.

Additional Continuation Coverage Information
Your COBRA rights are subject to change. Coverage will be provided only as required by law. This notice is only a general summary of the law, federal and state continuation coverage law and the applicable plan provisions will control over this summary in the event of a conflict. If the law changes, your rights will change accordingly.

If You Have Questions
If you have questions about the plan or your COBRA continuation coverage rights, contact the Benefits Office at:

The University of Chicago
Benefits Office
956 East 58th Street
Chicago, IL 60637
773-702-9634

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site.)

To protect your family's rights, you should keep the Benefits Office informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Benefits Office.

Other Plan Information

You will need this information for future reference or if you have any questions about your benefits.

Plan Name	University of Chicago MetLife Dental Plan
Plan Funding and Administration	The plan is funded through premiums paid by employees. The University has a contract for dental insurance with MetLife to provide plan benefits.
Employer, Plan Sponsor and Administrator	The University of Chicago Benefits Office 956 East 58th Street Chicago, IL 60637 773-702-9634
Agents for Service of Legal Process	For the University: The University of Chicago Benefits Office 956 East 58th Street Chicago, IL 60637 773-702-9634 For the insurance company: Metropolitan Life Insurance Company One Madison Avenue New York, NY 10010-3690
Claims Administrator	Metropolitan Life Insurance Company One Madison Avenue New York, NY 10010-3690
Plan Year	January 1 to December 31 for fiscal record purposes
Type of Plan	Welfare (dental insurance)
Employer Identification Number	36-2177139
Plan Number	510

Glossary

Actively at Work	Performing for wages that are regularly paid by the University, the material and substantial duties of your occupation at the usual place of work or at any alternate place of work required by the University.
Annual Maximum Benefit	The most each covered person can receive from the plan each year.
Benefits-eligible Employee	Generally, you are benefits-eligible if you are: **Full-time:** your position is anticipated to exist for one year or longer and you are scheduled to work at least 35 hours per week. **Part-time:** your position is anticipated to exist for one year or longer and you are scheduled to work 20 - 35 hours per week. You are not benefits-eligible if you are scheduled to work fewer than 20 hours per week or if your position is expected to exist less than one year.
Coinsurance	The portion of covered dental bills that you pay for necessary care after you meet your deductible.
Coordination of Benefits	A provision that prevents duplication of benefit payments when you or your dependent(s) also have coverage through another group plan. Coordination of benefits procedures also determines which plan pays first.
Copayment	A flat dollar amount you pay for a specific service.
Deductible	The portion of your dental expenses you pay before the plan begins to pay benefits.
Dependent Children	This includes natural, step- and legally adopted children and children placed in the home for adoption. This also includes grandchildren if you or your domestic partner is the legal guardian, claims the child for income tax and legal purposes, and lives with the child in a parent/child relationship. Coverage continues up to the child's 23rd birthday if he or she is unmarried. If you have a mentally or physically disabled child who was covered under the plan before age 23, you can generally continue coverage for that child indefinitely. You are responsible for notifying the Benefits Office when your dependent child marries or reaches age 23. If you do not, your child may lose his or her coverage, and you may pay for coverage at a higher rate than you should.
Dependents	Includes your spouse, Domestic Partner and Dependent Child(ren). The plan does not cover your parents, grandchildren (unless noted in the Dependent Child(ren) definition) or foster children. If you have questions about your eligible dependents, contact the Benefits Office.
Domestic Partners	Two individuals of the same gender who live together in a long-term relationship of indefinite duration, with an exclusive mutual commitment in which the partners agree to be jointly responsible for each other's common welfare and share financial obligations. The partners may not be related by blood to a degree that would prohibit legal marriage in the state in which they legally reside and may not be married to any other person. Your domestic partner must be registered with the Benefits Office. Certain restrictions may apply if your Domestic Partner is not an Internal Revenue Code Section 152 Dependent.
Emergency Dental Services	Any procedure listed as a covered benefit needed exclusively for the relief of acute pain, acute swelling or trauma.
Necessary Care	A specific dental service or treatment that is necessary for the treatment or management of a dental symptom or condition, and is the most efficient care that can be safely provided.
Qualifying Change in Status	The specific situations when you may change your coverage level outside the Open Enrollment period.
Reasonable and Customary Rates	The amount dentists in your area generally charge for a specific service.

A Final Note

This summary is written in everyday language and provides a general summary of the plan in effect on January 1, 2007 and serves as your summary plan description. We have tried to make it as complete and accurate as possible. If there are any discrepancies between this summary and the formal plan documents, such as the certificate of insurance, those documents will determine how the plan works and the benefits that are paid. The University has the authority to interpret the terms of the plan and to address questions arising under the plan and may delegate some or all of this authority to other entities, such as insurance companies or claims payors. The insurance carrier makes determinations of benefits under its certificate of insurance.

Participating in this plan does not guarantee employment.