Summary Plan Description

University of Virginia Dental Plan

For University of Virginia

Dental Plan Enrollees

Effective January 1, 2016

Contents

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Welcome

This book can help you learn about the University of Virginia Dental Plan (the Plan) offered by the University of Virginia (the University) and its dental benefits. In this book, you'll find information about who is eligible, what is covered and not covered, how to file a claim and what happens when you are no longer eligible for coverage.

This book contains information about the dental plan administered by United Concordia Companies, Inc. (UCCI).

About This Book

This book is the Summary Plan Description (SPD) for the Dental Plan. In it, you'll find:

- Who is eligible for coverage;
- How to enroll and when you are allowed to change the coverage you've chosen;
- What the Plan covers and does not cover;
- Tools and resources to help you take full advantage of your dental plan;
- When coverage starts and ends;
- How to file a claim or appeal a claim decision;
- Administrative information; and

Please read this SPD carefully and refer to it when you need to understand how your dental benefits work. If you have questions or need help, call United Concordia Companies, Inc. at the number shown on your ID card.

Dental Plan at a Glance

This chart summarizes the most common benefits available to you under the Dental Program administered by UCCI.

Basic Dental Summary of Benefits

Program Feature	**In-Network**	**Out-of-Network**
Calendar Year Deductible *(applies to Type B and Type C Services)*	$50 per person	
Calendar Year Maximum *(applies to Type A, Type B and Type C Services)*	$1,000 per person	

Covered Services	**In-Network** (based on allowable charge)	**Out-of-Network*** (based on allowable charge)
Type A: Diagnostic and Preventive		

Includes: Routine Oral Evaluations (2 per calendar year) Limited Oral Evaluation (1 per calendar year) Cleanings (2 per calendar year) Sealants for children under 19 (1 application per tooth every 3 years) Bitewing X-rays (2 per calendar year) Full-mouth or panoramic X-rays (once in 36-month period) Space maintainers for children under 19 (after loss of a primary molar or permanent first molar; one per tooth every 3 years) Fluoride for children under 19 (2 applications per calendar year) Palliative emergency treatment	Plan pays 100%	Plan pays 85%
Covered Services	**In-Network** (based on allowable charge)	**Out-of-Network*** (based on allowable charge)
Type B: Primary		
Includes: Restorative – fillings (one per tooth per 12 months) Oral surgery (including general anesthesia when medically necessary) Periodontal care Endodontic care	You pay 20% after annual deductible; Plan pays 80%	You pay 35% after the deductible; Plan pays 65%
Inlays, onlays, and crowns (repair) Bridges (repair) Full or Partial Dentures (repair after installation)	You pay 20% after annual deductible; Plan pays 80%	You pay 35% after the deductible; Plan pays 65%
Type C: Major Restorative		

Includes: Inlays, onlays, and crowns (installation or replacement) Bridges (installation or replacement) Full or Partial Dentures (installation, repair or replacement) Dental implants	You pay 50% after annual deductible; Plan pays 50%	You pay 65% after the deductible; Plan pays 35%

*Coinsurance amounts are based on the Allowable Charge which is defined as the amount the Claims Administrator will pay for any covered service before any applicable coinsurance. Participants are responsible for amounts above the allowable charge in addition to the appropriate coinsurance if they use nonparticipating providers and this amount may be significant.

*** The most commonly used services are included on this schedule. Contact UCCI at 1.800.332.0366 for coverage details and limitations on other services or view them at UCCI's 'My Dental Benefits' at www.unitedconcordia.com/tuctcc/clients.jsp?id=13.

Enhanced Dental Summary of Benefits

Program Feature	**In-Network**	**Out-of-Network**
Calendar Year Deductible *(applies to Type B and Type C Services)*	$50 per person	
Calendar Year Maximum *(applies to Type A, Type B and Type C Services)*	$2,000 per person	
Orthodontia Lifetime Maximum	$1,000 per person	

Covered Services	**In-Network** (based on allowable charge)	**Out-of-Network*** (based on allowable charge)
Type A: **Diagnostic and Preventive**		

Includes: Routine Oral Evaluations (2 per calendar year) Limited Oral Evaluation (1 per calendar year) Cleanings (2 per calendar year) Sealants for children under 19 (1 application per tooth every 3 years) Bitewing X-rays (2 per calendar year) Full-mouth or panoramic X-rays (once in 36-month period) Space maintainers for children under 19 (after loss of a primary molar or permanent first molar; one per tooth every 3 years) Fluoride for children under 19 (2 applications per calendar year) Palliative emergency treatment	Plan pays 100%	The Plan pays 85%
Type B: Primary		
Includes: Restorative – fillings (one per tooth per 12 months) Oral surgery (including general anesthesia when medically necessary) Periodontal care Endodontic care	You pay 20% after annual deductible; Plan pays 80%	You pay 35% after the deductible; Plan pays 65%
Inlays, onlays, and crowns (repair) Bridges (repair)	You pay 20% after annual deductible; Plan pays 80%	You pay 35% after the deductible; Plan pays 65%
Covered Services	**In-Network** (based on allowable charge)	**Out-of-Network*** (based on allowable charge)
Full or Partial Dentures (repair after installation)		
Type C: Major Restorative		
Includes: Inlays, onlays, and crowns (installation or replacement) Bridges (installation or replacement) Full or Partial Dentures (installation, repair or replacement) Dental implants	You pay 40% after annual deductible; Plan pays 60%	You pay 55% after the deductible; Plan pays 45%
Type D: Orthodontia		

Orthodontic Treatment	You pay 50%. Plan pays 50% up to lifetime maximum.	You pay 50%. Plan pays 50% up to lifetime maximum.

*Coinsurance amounts are based on the Allowable Charge which is defined as the amount the Claims Administrator will pay for any covered service before any applicable coinsurance. Participants are responsible for amounts above the allowable charge in addition to the appropriate coinsurance if they use non-participating providers and this amount may be significant.

*** The most commonly used services are included on this schedule. Contact UCCI at 1.800.332.0366 for coverage details and limitations on other services or view them at UCCI's 'My Dental Benefits' at www.unitedconcordia.com/tuctcc/clients.jsp?id=13.

Smile for Health Benefits**

General Description	Code	Procedure Description	Details	Linked Medical/Dental Condition(s)
Class I 100%	D1110	Routine prophylaxis adult	1 additional cleaning during pregnancy	Preterm Births
	D1208	Topical application of fluoride (prophylaxis not included – adult)	2 per 12 months following perio-surgery or active periodontal therapy	Caries Prevention
	D0415	Collection of microorganisms for culture and sensitivity	1 per lifetime	Diabetes Preterm Births Heart Disease

General Description	Code	Procedure Description	Details	Linked Medical/Dental Condition(s)
	D0425	Caries susceptibility tests	1 per lifetime	Caries Prevention

	D1206	Topical application of fluoride varnish	2 per 12 months following periodontal surgery or active periodontal therapy	Caries Prevention
	D4341	Periodontal scaling and root planning – four or more teeth per quadrant	1 per 24 months per area of mouth	Diabetes Preterm Births Heart Disease
	D4342	Periodontal scaling and root planning – one to three teeth per quadrant	1 per 24 months per area of mouth	Diabetes Preterm Births Heart Disease
	D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	1 per lifetime	Diabetes Preterm Births Heart Disease
	D4910	Periodontal maintenance	2 in 12 months	Diabetes Preterm Births Heart Disease
	D7288	Brush biopsy – transepithelial sample collection	1 per lifetime	Oral Cancer
Class III 50%	D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	6 occurrences per 12 months; regardless of tooth number of area of the mouth	Diabetes Preterm Births Heart Disease

**The coverage level listed in the first column determines the amount UCCI will pay toward the corresponding ADA code/procedure description shown.

Your Rights and Responsibilities

Participant Bill of Rights

1. You have the right to receive information about the University of Virginia Dental Plan, the Plan's services, practitioners and providers, and your rights and responsibilities as a Plan participant.

2. You have the right to every consideration of confidentiality concerning your own claims for dental care.

3. You have the right to expect your provider to inform you about your treatment and to have the information explained or interpreted as necessary.

4. You have the right to make decisions about your plan of care prior to and during the course of treatment.

5. You have the right to benefits for medically necessary services that are covered under the University of Virginia Dental Plan.

6. You have the right to prompt and courteous replies to questions regarding access to care, dental benefits, and dental claims.

7. You have the right to know what your dental care benefits are and have this information provided to you in a language you can understand.

8. You have the right to file an appeal for reconsideration of a decision or complaints about the Plan or the care provided by participating network providers. Furthermore, you have the right to be provided with a defined process for addressing complaints and appeals. Please see the "Claims and Appeals" sections in this Summary Plan Description for this process.

Your Responsibilities as a Plan Participant

1. You are responsible for asking questions when you do not understand information or instructions.

2. You are responsible for knowing whether you are seeking care from a network provider or out-of-network provider. If you have any questions, you should contact the Claims Administrator at the phone number located on your ID card.

3. If you receive services from an out-of-network provider, you will be responsible for paying the amounts above the allowable charge in addition to the appropriate coinsurance.

4. You are responsible for verifying with the Claims Administrator that a provider has obtained any necessary precertification.

5. You are responsible for ensuring your family members are aware of the correct procedures for accessing care before obtaining benefits through the University of Virginia Dental Plan.

6. You are responsible for making all necessary cost-sharing payments to providers as required and outlined in the appropriate Summary of Benefits in this Summary Plan Description.

7. You are responsible for notifying the University Human Resources Service Center of any change in contact information or dependent eligibility.

8. You are responsible for giving your providers the complete information needed to care for you, including accurate information regarding your current dental care coverage, and for following the plan of treatment agreed upon.

9. You are responsible for providing the University Human Resources Service Center with information related to other dental insurance coverage you or your spouse or dependents may have.

10. You are responsible for submitting a completed, signed University of Virginia Dental Plan application to the University Human Resources Service Center or online if you are an active employee within the prescribed timeframe to enroll in the Plan.

11. You are responsible for providing documentation and answering questions that verify eligibility at the request of the Plan Administrator that proves eligibility.

12. You are responsible for informing University Human Resources Service Center when your dependents are no longer eligible for enrollment in the dental plan. You are also responsible for reimbursing the Plan for the cost of any ineligible claims paid by the Plan for eligible or ineligible dependents.

How the Dental Plan Works

The University of Virginia Dental Plan offers the following dental plan options:

- Basic Dental
- Enhanced Dental

This section describes important features of the Plan. Refer to the Summary of Benefits for coverage levels for each option.

You must be covered by the Plan on the date you incur a covered dental expense. The Plan does not pay benefits for expenses incurred before your coverage starts or after it ends. There are no pre-existing condition exclusions.

The Provider Network

If you enrolled in either Basic Dental or Enhanced Dental, you have the freedom to choose any dentist when you need dental care. How that care is covered and how much you pay out of your own pocket depend on whether the expense is covered by the Plan and whether you choose an in-network provider in the UCCI Advantage Plus network or an out-of-network provider. When you use an in-network provider, the plan pays the highest level. That means you pay less out of your own pocket for care. You can find providers in the UCCI Advantage Plus network at www.ucci.com/tuctcc/clients.jsp?id=13. You can also call UCCI Customer Service at 866-215-2354 for help finding an in-network provider in your area.

Allowable Charge

In-network providers have agreed to charge no more than the negotiated or contracted charge for a service or supply covered by the Plan. You are not responsible for amounts that exceed that allowable charge when you obtain care from an in-network provider. If you do not use a provider in the network, you are required to submit claims and are responsible for amounts that exceed the allowable charge in addition to the appropriate coinsurance. This amount may be significant.

Sharing the Cost of Care

You share in the cost of your dental care by paying deductibles and coinsurance.

Deductibles

Annual Deductible

The annual deductible is the part of your covered expenses that each covered person pays each calendar year for Primary (Type B) and Major Restorative (Type C) services before the Plan starts to pay benefits.

Keep in Mind

The annual deductible does not apply to diagnostic and preventive (Type A) care or orthodontic treatment. Amounts above the allowable charge do not count toward your annual deductible.

Coinsurance

Once you meet your deductible, the Plan begins paying benefits for your covered expenses. The Summary of Benefits shows how you and the Plan share the cost. When the Plan's coinsurance is less than 100%, you pay the balance. The part you pay is called your coinsurance.

Refer to the Summary of Benefits for more information about the coinsurance that applies to each type of covered service.

Annual Maximum

The Plan puts a limit on the amount the Plan will pay in benefits for a covered person each calendar year, called the annual maximum. The annual maximum applies to:

- Diagnostic and Preventive (Type A) services;
- Primary (Type B) services; and
- Major Restorative (Type C) services.

Orthodontia expenses are not applied against the annual maximum if you have chosen the option with orthodontia coverage.

Predetermination of Benefits

A predetermination is a review in advance of treatment by the dental administrator to determine eligibility and coverage for planned services in accordance with the Schedule of Benefits and the Plan allowance. Predetermination is not required to receive a benefit for any service under the Plan; however, predetermination is recommended for extensive, more costly treatment. A predetermination gives you and your dentist an estimate of what your coverage is and how much your share of the cost will be for the treatment being considered.

To have services predetermined, you and your dentist should submit a claim form showing the planned procedures but leaving out the dates of services. Be sure to sign the predetermination request. Substantiating materials such as radiographs and periodontal charting may be requested by the dental administrator to estimate benefits. The dental administrator will determine benefits payable, taking into account exclusions and limitations and alternate treatment options based upon accepted standards of dental practice. You and your provider, if participating in the dental administrator network, will receive an explanation of the estimated benefits.

When the services are performed, simply have your dentist call the dental administrator Interactive Voice Response System at the telephone number on the back of your ID card, or fill in the dates of service for the completed procedures on the predetermination notification and resubmit it to the dental administrator for processing. Any predetermination amount estimated is subject to continued eligibility of the patient. The dental administrator may also make adjustments at the time of final payment to correct any mathematical errors, apply coordination of benefits, and comply with the member's Plan in effect and remaining program maximum dollars at date of service.

What the Dental Plan Covers

In this section, you'll find more detailed information about the services and supplies covered by the Plan. It's important to remember that the Plan covers only services and supplies that are necessary to diagnose or treat an illness or injury. If a service or supply is not necessary, it will not be covered, even if it is listed as a covered expense in this book.

The dental options differ as to the benefit levels for each type of covered service, but the options otherwise cover the same services and include the same features.

Type A: Diagnostic and Preventive Services

Taking care of teeth can prevent serious problems later. The Plan covers diagnostic and preventive services including:

- Maximum of two routine oral evaluations per calendar year, including prophylaxis
- Maximum of one limited oral evaluation per calendar year.
- Topical application of fluoride for dependents under age 19, twice per year
- One application of sealants per tooth every three years for dependents under age 19

X-rays, but no more than:

- One full mouth or panoramic series per three-year period (unless approved in advance);
- Bitewing X-rays twice per year.

- Space maintainers for children under age 19 to prevent tooth movement after loss of a primary molar or permanent first molar, one per tooth every three years.
- Oral tissue biopsies
- Pulp vitality tests twice per year
- Emergency palliative treatment for relief of pain

Type B: Primary Services

The Plan covers primary services including:

- Restorative fillings made of amalgam or tooth color synthetics, one per tooth in a 12-month period.
- Endodontics – treatment of dental pulp and pulp chamber, including root canal therapy.
- Oral surgery, including general anesthesia when medically necessary.
- Periodontics services, consisting of:
    - Gingivectomy and gingivoplasty;
    - Osseous surgery, including flap entry and closure; ○ Mucogingivoplastic surgery; and
    - Management of acute periodontal infection and oral lesions
- Oral surgery, including local anesthetics and routine post-operative care. Covered procedures include, but are not limited to:
    ○ Simple extractions; ○ Surgical removal of teeth;
    - Excision, drainage or removal of cysts, tumors and abscesses in the mouth; ○ Apioectomies; ○ Hemisections;
    - Treatment of fractures of the jaw; and
    - Alveoplasties to prepare the gum ridge for dentures

- Repairs of inlays, onlays, crowns, bridges, and dentures:
    - Repair; ○ Recementation; ○ Re-lining; ○ Re-basing; and ○ Adjustment

Type C: Major Restorative Services

The Plan covers Major Restorative services including:

- Inlays, onlays, and crowns: ○ Installation ○ Replacement □ Bridges:
  - ○ Installation
  - ○ Replacement (must be more than five years after installation but not more than once in every five years)
- Dentures:
  - ○ Installation ○ Replacement of full denture Implants.

The Plan's level of coverage is shown in the Summary of Benefits. If these services are not clinically supported, they may be paid at the amount of the lower level alternative determined to be appropriate by the dental administrator.

Type D: Orthodontic Treatment (Enhanced Dental Only)

Orthodontia benefits cover the straightening of teeth with braces or other methods. Coverage for orthodontic treatment includes:

- Comprehensive and limited orthodontic treatment;
- Post-treatment stabilization;
- Fixed and removable appliance therapy;
- Replacement of lost or broken retainer;
- Repair of orthodontic appliance

Benefits are limited to the lifetime maximum for orthodontic treatment shown in the Summary of Benefits.

Alternate Treatment Provision

There are often several ways to treat a dental condition. For example, a filling or a crown can restore a tooth, or a fixed bridge or a partial denture can replace missing teeth. An Alternate Benefit Provision (ABP) will be applied if a dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist. The Plan will pay for the less costly professionally acceptable procedure. The ABP does not commit you to the less costly treatment; however, if you and your dentist choose the more expensive treatment, you are responsible for the additional charges beyond those allowed for the less expensive procedure under the ABP.

Smile for Health® Benefits

The Smile for Health Maternity Dental Benefit provides pregnant women with an additional dental cleaning during pregnancy. This extra cleaning can help prevent periodontal (gum) disease, which has been linked to premature and low-birth weight babies, as well as help control pregnancy gingivitis.

The Smile for Health Enhanced Dental Benefit enhances your current coverage by providing additional diagnostic, preventive and periodontal services and by increasing the amount the Plan will pay toward these services. The services offered help treat

periodontal disease, which has been linked to diabetes, heart disease, stroke and respiratory disease.

For more information about the Smile for Health dental benefits, **go to www.hr.virginia.edu/uploads/documents/media/SmileForHealthRevisedFlyer.pdf**

Keep in Mind

If any of the procedures listed above are payable under the UVA Health Plan, no coverage will be available under the Dental Plan.

What the Dental Plan Does Not Cover

The Plan does not cover all dental expenses; certain expenses are excluded. The list of excluded expenses in this section is representative, not comprehensive. The Advantage Plus network providers (marked in the UCCI provider directory) may apply discounts or agreed upon fees to associated charges. You can review these providers in the UCCI Advantage Plus network at www.ucci.com/tuctcc/clients.jsp?id=13. For further details contact UCCI's Customer Service at 866-215-2354.

General Exclusions

The exclusions that apply to medical and hospital services under this Plan apply to this Section when not inconsistent with the terms of this Section. In addition, the following Special Exclusions apply to dental services. Payment will not be made for the following Dental Services:

- An illness, injury, or condition that is related to your employment or selfemployment.
- Care in charitable institutions that is normally provided at no charge.
- Free or reduced charge services rendered by a dental or medical clinic maintained by the Participant's employer, a mutual Benefit association, labor union, trustee, or like person or group.
- Charges related to genetic malformation.
- Charges rendered to an inpatient in a facility by a Dentist paid by that facility to perform such services.
- Charges for cancelled or missed appointments.
- Charges made only because you have dental coverage.
- Charges you are not legally obligated to pay.
- Claim form completion.
- Instruction in personal dental care, dental hygiene and plaque control.
- Examinations provided for employment, licensing, insurance, school, camp, sports, adoption, or other purposes that are not necessary, and related expenses for reports, including report presentation and preparation.
- Services and supplies that are not necessary for the diagnosis, care, or treatment of the condition – even if they are prescribed, recommended, or approved by a physician or dentist.
- Services that result because you commit, or attempt to commit, a felony.
- Services not listed in the prior section titled "Dental Plan."

Eligibility and Enrollment

This section describes who is eligible for coverage, how to enroll for coverage, and when coverage goes into effect.

Who Is Eligible

Active Employees

You are eligible to enroll in the Plan if you are employed by the University and you are:

A full-time employee;

A part-time employee who is scheduled to work at least 20 hours per week; or

A part-time Medical Center employee who has either signed a Flexible Staffing Agreement or is otherwise an eligible part-time employee as defined by the Medical Center.

A wage employee who has averaged at least 30 hours of service per week during their 12- month measurement period.

- First type of measurement period is the initial measurement period based on your date of hire (one time measurement period).
- Second measurement period is the stability period based on hours worked from October 3rd to October 2nd time frame during this 12 month period (this is measured each year of employment).
- If eligible for the University Health Plan based on above criteria; an administrative period of 90 days provides a window for you to enroll for Plan benefits.

Keep in Mind

Temporary, wage, leased and contract employees are not eligible for the Plan.

Postdoctoral Fellows

You are eligible to enroll in the Plan if you are a postdoctoral fellow with a postdoctoral appointment at the University of Virginia.

Dependents

You may enroll your eligible dependents if you provide documentation confirming their eligibility. Your eligible dependents are:

- Your legally recognized spouse in the Commonwealth of Virginia.
- Your dependent children through the end of the year in which they turn age 26:
  - Your children by birth or adoption; ○ Children placed with you for adoption;
  - Children for whom you are the legal parent through a surrogate contract; ○ Stepchildren; and ○ Foster children
- Unmarried, dependent children for whom you are the legal guardian with permanent custody unless either of the child's biological parents also reside with

you except when the biological parent(s) is (are) a minor who shares custody with you.

- These legal dependents are eligible through the end of the year in which they turn age 26 if custody was awarded prior to the child's 18th birthday, the child lives at home and is declared as a dependent on your income tax return.
- Coverage for a dependent handicapped child may continue beyond the end of the year in which they turn 26 if:
    - The child is permanently and totally handicapped; ○ The handicap began before the child reached age 26; ○ The application forms for handicapped status are requested from University Human Resources Service Center PRIOR to the dependent's 26th birthday and the completed forms (including treating physician's form) are submitted no later than 30 days after your child's 26th birthday;
    - The child is unmarried, does not have a full-time job eligible for benefits, and is declared on your income tax return; and
    - The child has maintained continuous coverage under an employer sponsored plan of the employee or the other natural/adoptive parent

If Your Child Is Adopted

Coverage for your legally adopted child is effective on the date the child is adopted or placed with you for adoption if you request coverage for the child in writing within 60 days of the placement.

If you submit an application more than 60 days after the adoption but within the same plan year, the change will be effective the first of the month following receipt of application.

If Your Child Is Born by Gestational Surrogate

Coverage for your legal child birthed by a surrogate mother is effective on the date the child is born if you request coverage for the child in writing within 60 days of the birth.

If you submit an application more than 60 days after the birth but within the same plan year, the change will be effective the first of the month following receipt of application.

Qualified Medical Child Support Orders

A qualified medical child support order (QMCSO) is a court order that requires a parent to provide dental care benefits to one or more children. Coverage under the Plan can be extended to a child covered by a QMCSO if:

- Your child meets the definition of an eligible dependent under the Plan; and
- The University determines that the order is "qualified."
- Coverage under the QMCSO is not effective until after the date your coverage becomes effective

What If My Spouse and I Both Work for the University of Virginia?

No one may be covered both as an employee and as a dependent, and no dependent may be covered by more than one employee. If you and your spouse are both eligible employees, you have these options:

- One of you may enroll as an employee and cover the other as a dependent.
- You may each enroll as an employee. Only one of you may enroll your children as a dependent.

Audit Dependent Eligibility

The Plan will require all newly enrolled or eligible dependents being in enrolled in the Health Plan to provide documentation as requested above. The Plan has the obligation and the right to audit dependent eligibility from time to time to ensure the Dental Plan is administered according the Summary Plan Description.

Retirees

You are eligible to enroll in the Plan as a retiree if you retire from the University, you worked at the University of Virginia Academic Division or Medical Center for at least five (5) consecutive years directly prior to your retirement, and you were eligible for enrollment in the Plan as an active employee on your last day as an active University employee (not including COBRA coverage), you are enrolled in the UVA Health Plan as a retiree, and you are:

- A retiring University employee eligible for a monthly annuity payment from Virginia Retirement System (VRS) or a periodic benefit payment from the Medical Center Retirement Plan (MCRP) or Optional Retirement Plan (ORP) programs; and you begin to receive your payments immediately upon retirement; and your last employer before retirement was the University of Virginia.
- You are also eligible to enroll in the Plan as a retiree if you are approved for long-term disability through the VSDP or other Employer-Sponsored disability plans and have applied for Social security disability.
- You may join the Retiree group even if you weren't enrolled in the Plan as an active Employee as long as you were eligible for enrollment in the Plan as an active employee on your last day as an active University employee. You will only be eligible for single coverage.
- Your eligible dependents that are enrolled under your plan on your last day as an active University employee may enroll under your Retiree coverage if they are enrolled in the UVA Health Plan under your Retiree coverage.

Keep in Mind

If you do not enroll within 31 days of first becoming eligible as a retiree, you will not have another chance to enroll in the Plan.

Survivors of Active Employees

Your surviving spouse and/or dependents are eligible to enroll in the Plan as a survivor if you die while you are an active employee at the University and they were enrolled under your plan on your last day as an active University employee. Their enrollment under your plan will terminate on the last day of the month following the month in which you died.

How to Enroll

Participation in the Plan is usually not automatic; you must enroll in order to have the coverage of your choice. You and your dependents can enroll:

- Within 60 days of the date you become eligible for coverage;

- During the annual open enrollment period; or
- Within 60 days of a qualified life event

- All requests for enrollment of spouses or children must include documentation confirming dependent eligibility
- Retiree enrollments must be submitted within 31 days of your retirement date.
- All survivor enrollments must be submitted within 31 days of the termination of their coverage on your plan

New Employees

As a new employee, you must enroll within 60 days of your hire date. If you do not enroll within this 60-day period, you will not able to enroll until the next annual open enrollment period unless you have a qualified life event.

Annual Open Enrollment

During the annual open enrollment period, you have a chance to review your coverage needs for the upcoming year and change your coverage choices, if necessary. The choices you make during open enrollment will be in effect for the following calendar year.

Qualified Life Event Changes

During the calendar year, you may add or drop dependents only when you have a qualified life event. You must submit an application in writing to University Human Resources Service Center or online if you are an active employee for any change prior to or within 60 days of the qualified life event. The change will be effective the first of the month following receipt of the application or online request.

If you are dropping dependents because they are no longer eligible to be enrolled on your Plan, their coverage will end as of the date described in the section “When Coverage Ends.” To avoid being responsible for any claims the Plan may pay for your ineligible former dependents, you must notify the University Human Resources Service Center in writing or online of the dependent’s ineligibility at least three weeks prior to the end of the dependent’s coverage (date described in the section “When Coverage Ends.”) and provide documentation. If you have not done so, you will be responsible for reimbursing the Plan for any payments made by the Plan for claims submitted for your ineligible dependents after the date their coverage ends, whether you have notified the University Human Resources Service Center of your dependent’s ineligibility within 60 days of the qualified life event or not. Participants with ineligible dependents enrolled on their policy or those who owe reimbursement for the cost of any ineligible claims paid by the Plan for you or your dependents may receive disciplinary action up to and including employment termination.

Keep in Mind

- The change in coverage you request must be consistent with, and due to, the qualified life event.
- Documentation must be submitted to confirm qualifying events. Documentation must also be submitted to confirm dependent eligibility.

- All changes to enrollment as a retiree or survivor due to qualified life events must be submitted within 31 days instead of the instead of the 60 days applicable for active employees and COBRA enrollees. This includes all changes in the chart below.
- Online requests by active employees must be made through Benefits@ for academic employees and PeopleSoft for Medical Center employees.

The following are examples of qualified life events and the mid-year enrollment changes they allow:

Qualified Life Event	Enrollment Changes Allowed
You get married	Enroll your spouse and spouse's dependent children; or Drop coverage for yourself
You have a child, by birth or adoption, or add a stepchild or foster child to your family	Enroll the child and other eligible dependents
You get divorced, your marriage is annulled, or a covered dependent dies	Drop coverage for your ex-spouse or deceased dependent
Your covered child reaches the maximum age for coverage	Drop coverage for your child
As the result of a change in your spouse's or dependent's employment, dental care coverage is available under your spouse's or dependent's plan	Drop coverage for you and any dependents who enroll in your spouse's or dependent's plan
As the result of a change in your spouse's or dependent's employment, dental care coverage under your spouse's or dependent's plan is lost or the cost of coverage will increase significantly	Add coverage for you and/or any eligible dependents who lost the other coverage
You move into or out of the PPO Program service area	None
You become eligible for Medicare or Medicaid	Drop coverage for yourself

Special Enrollment Rights

There are certain Qualified Life Events that provide you with Special Enrollment Rights:

- For birth, adoption, or placement for adoption, you can enroll yourself, the new child, as well as any other eligible dependents not already on your policy. If you make application to add the child within 60 days of the event, the coverage is retroactive to the date of birth or adoption and the premium change, if appropriate, is effective the first of the month in which the event occurs. The addition of other dependents to your policy will be retroactive to the first of the month after the event date.
- For marriage, you can enroll yourself, your new spouse, and any other eligible dependents not already on your policy. The coverage is effective the first of the month following the receipt of the enrollment application at the University Human Resources or online request.
- An additional Special Enrollment Right is granted by a federal law known as HIPAA when eligibility is lost for other coverage or when COBRA coverage is exhausted or terminated. Based on these events, you may enroll yourself, your spouse, and/or your

dependents that have lost other coverage within 60 days of the event. The coverage is effective the first of the month following receipt of the enrollment application at the University Human Resources or online request.

- Loss of S-CHIP/Medicaid eligibility or provision of premium assistance by SCHIP/Medicaid is an additional Special Enrollment Right. You may enroll yourself, your spouse, and/or your dependents who have lost eligibility for the government provided coverage or who have become eligible for state assistance which provides help paying for Plan coverage. The coverage is effective the first of the month following receipt of the enrollment application at the University Human Resources Service Center or online request.

Finalization of Enrollment Elections

During any enrollment period, New Employee Enrollment, Annual Open Enrollment, Qualified Life Event Changes or Special Enrollment periods, there is a specific period of time to make election/changes under Section 125 of the IRS code based on the event and time period listed above. No enrollments/changes can be allowed until the next Annual Open Enrollment or a Qualified Life Event has occurred.

New Employees

- Making an election will provide you an opportunity to print a confirmation of your elections to validate all elections. If elections are not correct, immediately notify the HR Service Team of the error and they can correct any inaccurate elections. Once the deductions begin in your paycheck all elections are confirmed until Annual Open Enrollment or a Qualified Event has occurred.
- If no attempt has been made to elect benefits any default benefits will be elected and be applied for payroll deductions. Once the deductions begin in your paycheck all elections are confirmed until Annual Open Enrollment or a Qualified Event has occurred.

Annual Open Enrollment

- Any elections/changes made will provide you an opportunity to print a confirmation of your elections to validate all elections. If elections are not correct, immediately notify the HR Service Team of the error and they can correct any inaccurate elections. Once the Annual Open Enrollment/Confirmation period closes all elections are confirmed until the next Annual Open Enrollment or a Qualified Event has occurred.
- If no attempt has been made to elect/change benefits any default benefits will be elected/carried over and applied for payroll deductions. Once the enrollments have been sent to the providers all elections are confirmed until Annual Open Enrollment or a Qualified Event has occurred.

Qualified Life Events and Special Enrollments

- Making an election/change will provide you an opportunity to print a confirmation of your elections to validate all elections. If elections are not correct, immediately notify the HR Service Team of the error and they can correct any inaccurate elections. Once the deductions begin in your paycheck all elections are confirmed until Annual Open Enrollment or a Qualified Event has occurred.
- If no attempt has been made to elect/change benefits any default benefits will be elected/carried over and be applied for payroll deductions. Once the deductions begin in your paycheck all elections are confirmed until Annual Open Enrollment or a Qualified Event has occurred.

When Coverage Begins

When Plan coverage begins depends on when you and your dependents enroll:

- For people who enroll when they first become eligible, coverage begins on the first of the month following your date of hire. If you are hired on the first of the month, coverage begins immediately.
- For people enrolling during an open enrollment period, coverage begins on the following January 1.
- For people enrolling because of a qualified life event, coverage begins on the first of the month following receipt of the enrollment and documentation at University Human Resources Service Center except births and adoptions. These changes are effective the date of the event if the enrollment is received within 60 days of the event and the premium change, if appropriate, is effective the first of the month in which the event occurs. If you submit the enrollment more than 60 days after the date of the birth or adoption but within the same plan year, coverage begins on the first of the month following receipt of the enrollment.

What If I Leave the University, Then Come Back?

Do you have to meet another waiting period if you come back to work for the University? When will your coverage begin? It all depends on when you are re-hired.

- If you're re-hired in a benefit eligible position within 26 weeks and were enrolled in benefits upon separation, you have no waiting period and no break in coverage.
- If you're re-hired in a benefit eligible position greater 26 weeks after your termination date, you must complete another waiting period before your new coverage begins, the same as a new employee.

How You Pay for Coverage

While you are an active employee, you share the cost of coverage under the Plan through payroll contributions. Your contribution is deducted from your pay on a before tax basis.

Before-Tax Contributions and Social Security

Before-tax contributions come from your pay before federal income taxes, FICA (Social Security and Medicare) taxes, and most state and local income taxes are figured. Because your taxes are calculated on a lower amount of taxable income, you pay less tax. This has the effect of reducing the cost of your coverage.

When you reduce the amount of your pay that is subject to Social Security taxes, you may also reduce your Social Security benefit. Any benefit reduction, however, should be only slight, and it will likely be more than offset by your reduced taxes.

Important!

Consult your tax adviser if you have questions about your benefit contributions and taxes.

Postdoctoral Fellow Premiums

When you are a postdoctoral fellow, you are responsible for the monthly premium payments that are not covered by your grant or department. You can elect to receive coupons for monthly premium payments or arrange monthly electronic payments from your bank.

Self-payments are due on the first day of the month for which coverage is sought (the coverage period). If payment in full is not received within 30 days of the due date, the coverage will be cancelled with no option to reinstate coverage. If your premium is received after the due date but before the end of the 30-day grace period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the premium is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. Reimbursements for covered expenses incurred will only be made when all required self-payments have been received.

The premium rates charged for the postdoctoral fellow group and the benefits provided under the Plan are subject to change annually. Premium rates and benefits will generally not change more than once per year.

Requests for termination of your or your dependent's coverage will be granted prospectively. Retroactive termination requests and associated premium refunds will not be honored.

Retiree and Survivor Premiums

When you are a retiree or survivor, you are responsible for the monthly premium payments. You can elect to have the premium debited directly from your VRS annuity, receive coupons for monthly premium payments, or arrange monthly electronic payments from your bank.

Self-payments are due on the first day of the month for which coverage is sought (the coverage period). If payment in full is not received within 30 days of the due date, the coverage will be cancelled with no option to reinstate coverage. If your premium is received after the due date but before the end of the 30-day grace period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the premium is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. Reimbursements for covered expenses incurred will only be made when all required self-payments have been received.

The premium rates charged for the retiree and survivor group and the benefits provided under the Plan are subject to change annually. Premium rates and benefits will generally not change more than once per year.

Requests for termination of your or your dependent's retiree or survivor coverage will be granted prospectively. Retroactive termination requests and associated premium refunds will not be honored.

When Coverage Ends

Plan coverage for an employee ends the last day of the month in which any of the following occurs:

The employee no longer meets the Plan's eligibility requirements;

- The Plan is terminated;
- The employee dies;
- Employment ends;
- The employee fails to pay any required contribution for coverage or reimbursement for payment of ineligible claims; or The employee covers an ineligible dependent.

Coverage for dependents ends on:

- The last day of the month in which:
  - The employee's coverage ends; ○ The dependent is no longer eligible for dependent coverage; ○ The employee does not pay the required contribution for dependent coverage;
  - The dependent dies;
  - All dependent coverage under the Plan ends; or ○ The dependent becomes covered as an employee.
- The last day of the year in which:
  - The dependent child reaches age 26.
- The last day of the month after the month in which:
  - The employee dies.
- Coverage for a retiree or survivor ends on the earliest of the following dates:
  - The last day of the month in which a retiree or survivor waives coverage;
  - The last day of the month preceding the first day of the month in which the retiree or survivor becomes eligible for Medicare;
  - The last day of the month preceding the first day of the month for which the retiree or survivor fails to make a premium payment or repayment for ineligible claims, in full, when due;
- The last day of the month in which long-term disability payments end;
- The last day of the month in which a retiree or survivor no longer meets the Plan's eligibility requirements;
- The last day of the month in which a survivor remarries;
- The date the Plan is terminated or coverage for all retirees/survivors under the Plan is terminated; or
- The date of the retiree's or survivor's death.
- In the event of a divorce, coverage for a spouse ends on the last day of the month of the divorce.

Leaves of Absence

The Plan includes rules about how a leave of absence affects your coverage. The rules vary based on the reason for the leave.

Family, Medical, and Military Leave Act

Through the Family and Medical Leave Act (FMLA), you may request up to 12 work weeks of leave during any 12-month period for the birth or adoption of a child, or for a serious health condition affecting you or a family member and up to 26 weeks for qualified military leave. During FMLA leave, your Plan coverage continues so long as you continue making your contributions.

USERRA Military Leave

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) allows qualified employees to continue their enrollment in the Plan for up to 24 months when they are called to active duty for more than 31 days.

You may continue Plan coverage during your military leave until the earlier of:

- 24 months (terms are similar to COBRA); or
- The date you fail to return to work as outlined by USERRA.

If you do not continue coverage for you or your family members during your leave and you return to work:

- You and your family members will again be covered on the first of the month following the date you return to work from your military leave, if you apply at that time (this requires you to return to work as outlined by USERRA);
- Any eligibility waiting period not completed earlier will not be credited during your leave.

You will be given credit for the time you were covered under the Plan before your military leave, as well as credit for any/all of the 24-month continuation period, when elected.

You are responsible for paying the employee cost for coverage during a military leave. If you fail to make timely payments, as outlined in your billing statement, your coverage will be terminated. You must pay the billed amount in full; you cannot defer payments until you return to work.

Continuing Coverage

When Plan coverage would normally end, you or your covered dependents may be able to continue coverage in certain circumstances. This section describes how you or your covered dependents may be able to temporarily continue coverage:

- For a handicapped child;
- Through the Consolidated Budget Reconciliation Act of 1985 (COBRA)

Continued Coverage for a Handicapped Child

If your child is handicapped, the child's dental care coverage may be continued past the Plan's age limit for dependents.

Your child is considered handicapped if:

- He or she is unable to earn a living because of a mental or physical handicap that starts before he or she reaches the age limit for dependents; and
- He or she depends mainly on you for support and maintenance.

You must contact the University Human Resources Service Center prior to your handicapped dependent's 26th birthday and request the application forms for handicapped status. You and the child's treating physician must complete the forms giving proof of your child's handicap. You must submit the forms no later than 30 days after your child's 26th birthday. The child must also be unmarried, live with you 100% of the time in a regular child-parent relationship, be claimed as a dependent on your income tax return, and not have a full-time job. The child's coverage will end on the first to occur of the following:

- Your child is no longer handicapped;
- You fail to provide proof that the handicap continues; You fail to have any required exam performed; or
- Your child's coverage ends for a reason other than reaching the age limit.

The University Human Resources Service Center has the right to require proof that the handicap continues.

Continuing Plan Coverage under COBRA

If your employment ends for any reason other than for gross misconduct, or if you or your covered dependent is no longer eligible for coverage under the Plan, you and/or your covered dependent may temporarily continue coverage through the federal law known as COBRA. Notify the University Human Resources Service Center immediately if you or your covered dependents experience a "COBRA Event" as defined in the following chart. You have 60 days from the date of the event to contact the University Human Resources Service Center to enroll for COBRA. The University Human Resources Service Center will inform their COBRA Administrator of your or your dependents' eligibility upon receiving notification from you. If you do not report the COBRA Event during this timeframe, you will lose your eligibility to continue under COBRA.

If you wish to choose this continued coverage, you must do so in writing to the COBRA Administrator within 60 days of the later of the date of the COBRA notification letter from the COBRA Administrator or the date of the COBRA event that ends your regular active employee coverage under the Plan. You pay the full cost of COBRA coverage, plus a 2% administration fee on an after-tax basis. The full cost of coverage is different from the contribution you pay while you are working for the University.

The chart below lists the reasons that coverage could end for you or your covered dependent. For each of those reasons, COBRA specifies the length of time that you may continue your Plan coverage.

	Maximum COBRA Continuation Period		
Reason Coverage Ended ("COBRA Event")	**You**	**Your Spouse**	**Your Child**
You lose coverage because of reduced work hours	18 months	18 months	18 months
Your employment terminates for any reason, other than for gross misconduct	18 months	18 months	18 months
You or your covered dependent becomes eligible for Social Security disability benefits when you lose coverage under the Plan	29 months	29 months	29 months
You divorce	N/A	36 months	36 months
You become entitled to Medicare	N/A	36 months	36 months
Your child is no longer eligible (e.g., reaches age 26)	N/A	N/A	36 months

Being eligible for Medicare at the time of your COBRA event does not prevent you from electing COBRA coverage for yourself.

Electing and Paying for COBRA Coverage

You pay the full cost of your Plan coverage when you elect COBRA coverage, plus a 2% administration fee. When you are eligible for COBRA coverage, you will be notified of its monthly cost. If you become eligible for Social Security disability benefits, the cost of COBRA coverage starting with the 19th month will be 150% of the Plan's cost, plus a 2% administration fee.

When you are notified by the Plan's COBRA Administrator that you are eligible for COBRA coverage, you will have 60 days to elect that coverage. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your coverage began (the date of your COBRA event). During the 60-day election period, the Plan will, upon request, notify dental care providers of your right to elect COBRA coverage, retroactive to the date of your COBRA event. Actual coverage will not begin until your first payment is received.

On an ongoing basis, premium payments are due on the first day of the month for the upcoming coverage period. You will not receive reminders for unpaid premiums. If payment due is not received within 30 days of the due date, coverage will end. If your premium is received after the due date but before the end of the 30-day grace period, your coverage under the Plan will be suspended as of the first day of the coverage period. When payment is received, coverage will be retroactively reinstated back to the first day of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied. If so, you may have to resubmit your claim once coverage is reinstated.

Notification Requirements

COBRA Event	Notification Procedures	Who Must Take Action and When
If you terminate employment	The COBRA Administrator will send a COBRA notification letter to your last known address notifying you and your dependents of your right to continued coverage	You must send a written request for COBRA to the COBRA Administrator within 60 days of the later of the date of the letter of Notification or the date of your employment termination, or the date that Plan coverage would otherwise be lost, if later
If you reduce work hours	The COBRA Administrator will send a COBRA notification letter to your last known address notifying you and your dependents of your right to continued coverage	You must send a written request for COBRA to the COBRA Administrator within 60 days of the later of the date of the letter of Notification or the date of your employment termination, or the date that Plan coverage would otherwise be lost, if later
Other COBRA events	The covered employee or qualified beneficiary must notify the University Human Resources Service Center of certain COBRA events. Those events are: Employee's divorce or child's loss of dependent status under the Plan's terms	You must notify the University Human Resources Service Center within 60 days of the date of the COBRA event. Failure to notify within this timeframe results in the loss of the opportunity to elect COBRA.
Specific Notice	The COBRA Administrator will send a COBRA notification letter to the last known address of your ex-spouse in the case of divorce or your address for a child's loss of eligibility	The ex-spouse or ineligible dependent must elect COBRA within 60 days of the COBRA event (such as the date of divorce or the date of loss of dependent eligibility) or the date of the letter of Notification, or the date that Plan coverage would be otherwise lost, if later. Failure to notify within this timeframe results in the loss of the opportunity to elect COBRA.
If you seek an extension of COBRA coverage due to disability	You must notify the COBRA Administrator	Within 60 days of any final determination by the Social Security Administration that the individual is no longer disabled and within 18 months of the COBRA event. Failure to notify within this timeframe results in the loss of the opportunity to seek an extension.

Will my COBRA Coverage be the same as active employee coverage?

Yes. And any changes made to the Plan for active employees will also apply to you under COBRA.

While you are covered by the Plan under COBRA:

- You have the same rights as any other eligible employee – including the right to change your coverage election during the annual open enrollment.
- If you have another COBRA event or a qualified life event, as described in the section titled Qualified Life Event Changes, you may change your coverage election.
- If your dependent has another COBRA event while under the COBRA coverage period of 18 months, your dependent may qualify for an additional period of COBRA coverage, with the total COBRA coverage period limited to 36 months; you or your dependent must notify the COBRA administrator of the second COBRA event.

Notification of Your COBRA Rights

The Plan's COBRA administrator will notify you by mail of your right to elect COBRA coverage when your COBRA event is a reduction in hours or termination of employment. The notice will give you instructions on how to continue your plan coverage.

If your covered dependents lose coverage because of a divorce or loss of dependent status, you or your covered dependents must notify the University within 60 days of the COBRA event, so that COBRA coverage may be offered and election rights can be mailed.

To extend your COBRA coverage beyond 18 months because of eligibility for disability benefits from Social Security, notice of the Social Security Administration's determination must be provided within 60 days after you receive it, and before the end of your initial 18-month continuation period.

The COBRA Administrator is:

Chard Snyder
3510 Irwin Simpson Road
Mason, OH 45050 800-982-7715

Address Changes

In order to protect your family's rights, you should keep the COBRA Administrator informed of any changes in address for all family members.

When COBRA Ends

COBRA coverage will end before the maximum continuation period shown in the above chart if:

- You or your covered dependent becomes eligible for Medicare after electing COBRA.
- You or your covered dependent becomes covered under another group plan that does not restrict coverage for a pre-existing condition. If your new plan does have a restriction for pre-existing conditions:
- Your COBRA continuation under this Plan can continue until the earlier of the following: pre-existing condition restriction ends under the other plan or you reach the end of the maximum continuation period for this Plan.

- You fail to make a premium payment in full when due. The Plan terminates.

Requests for termination of your COBRA coverage prior to the date you or your dependent has been covered for the maximum continuation period will be granted prospectively. Retroactive termination requests and associated premium refunds will not be honored.

Coordination with Other Plans

Effect of Another Plan on This Plan's Benefits

If you have coverage under other group or individual plans or receive payments for an illness or injury caused by another person, the benefits you receive from this Plan may be adjusted. This may reduce the benefits you receive from this Plan. The adjustment is known as coordination of benefits (COB).

Benefits available through other group or individual plans, contract or other arrangement, including automobile insurance coverage, where a dental Benefit is to be provided, arranged, or paid for, on an insured or uninsured basis, are coordinated with this Plan. "Other plans" include any other plan of dental coverage provided by:

- Group insurance or any other arrangement of group coverage for individuals, regardless of whether that plan is insured. This includes prepayment groups.
- Motor vehicle personal injury protection benefit (PIP) or optional motor vehicle insurance, to the extent of applicable law. Whenever legally possible, this Plan will be secondary.

To find out if benefits under this Plan will be reduced, dental administrator must first use the rules listed below, in the order shown, to determine which plan is primary (pays its benefits first). The first rule that applies in the chart below will determine which plan pays first:

If . . .	**Then . . .**
1. One plan has a COB provision and the other plan does not	The plan without a COB provision determines its benefits and pays first.
2. One plan covers you as a dependent and the other covers you as an employee or retiree	The plan that covers you as an employee or retiree determines its benefits and pays first.
3. A child's parents are married or living together (whether or not married)	The plan of the parent whose birthday occurs earlier in the calendar year determines its benefits and pays first. If both parents have the same birthday, the plan that has covered the parent the longest determines its benefits and pays first. But if the other plan does not have this "parent birthday" rule, the other plan's COB rule applies.
4. A child's parents are separated or divorced with joint custody, and a court decree does not assign responsibility for the child's dental expenses to either parent, or states that both parents are responsible for the child's dental coverage	The "birthday rule" described above applies.

If . . .	Then . . .
5. A child's parents are separated or divorced, and a court decree assigns responsibility for the child's dental expenses to one parent	The plan covering the child as the assigned parent's dependent determines its benefits and pays first.
6. A child's parents are separated, divorced or not living together (whether or not they have ever been married) and there is no court decree assigning responsibilities for the child's dental expenses to either parent	Benefits are determined and paid in this order: 1. The plan of the custodial parent pays, then 2. The plan of the spouse of the custodial parent pays, then 3. The plan of the non-custodial parent pays, then 4. The plan of the spouse of the non-custodial parent pays.
7. You have coverage as an active employee (that is, not as a retiree or laid off employee) and coverage as a retired or laid off employee. Or you have coverage as the dependent of an active employee and coverage as the dependent of a retired or laid off employee	The plan that covers you as an active employee or as the dependent of an active employee determines its benefits and pays first. This rule is ignored if the other plan does not contain the same rule. Note: this rule does not apply if rule 2 (above) has already determined the order of payment.
8. You are covered under a federal or state right of continuation law (such as COBRA)	The plan other than the one that covers you under a right of continuation law will determine its benefits and pay first. This rule is ignored if the other plan does not contain the same rule. Note: this rule does not apply if rule 2 (above) has already determined the order of payment.
9. The above rules do not establish an order of payment	The plan that has covered you for the longest time will determine its benefits and pay first.

When the other plan pays first, the benefits paid under this Plan are reduced as shown here:

- The amount this Plan would pay if it were the only coverage in place, *minus* Benefits paid by the other plan(s)
- This prevents the sum of your benefits from being more than you would receive from just this Plan
- If your other plan(s) pays benefits in the form of services rather than cash payments, the Plan uses the cash value of those services in the calculation.

Dental Claims and Appeals

Filing Claims

Upon completion of treatment, a claim form needs to be filed with UCCI. If you visit a UCCI participating dentist, the dental office will submit claim forms for you and your dependents. UCCI will pay covered benefits directly to the participating dentist. Both you and the dentist will be notified if your claim is denied or reduced.

If you use an out-of-network provider, you must file a claim to be reimbursed for covered expenses. You can obtain a claim form from UCCI by calling the number on the back of your ID card, or by going online at www.ucci.com. The form has instructions on how, when, and where to file a claims.

File your claims promptly – the filing deadline is 365 days after the date you incur a covered expense. Claims filed more than one year after the deadline will be accepted only if you had been legally incapacitated.

You may file claims and appeals yourself or through an "authorized representative" who is someone you authorize in writing to act on your behalf. In a case involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative. The Plan will also recognize a court order giving a person authority to submit claims on your behalf.

Appeal of an Adverse Benefit Determination

An adverse benefit determination is a denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any denial based on your eligibility to participate in your employer's dental plan. If you are not completely satisfied with UCCI's initial customer service response and determination, you must submit this concern in writing to begin the appeal process. An appeal is a written request for review of an adjudicated claim or related item. To obtain review of an adverse benefit determination, you must follow the appeal procedures below.

Appeal Procedure

Under the appeal procedure, you are entitled to a two-step appeal process. The plan must provide you with a written determination within 30 calendar days of receipt of your written requests for appeal at each level.

To initiate Level 1 appeal, you or your authorized representative must send UCCI a written statement explaining why you disagree with the determination. Mail this to UCCI Appeals, P.O. Box 69420, Harrisburg, PA 17110. Include in your request all documentation records or comments you believe support your position. You must file your appeal within 180 days of the date you were notified of the adverse benefit decision, whichever is later. This can be initiated by contacting UCCI Customer Service at 866-215-2354. UCCI will respond to your appeal request in writing within 30 days unless they have notified you in writing that additional information is needed to complete the appeal.

If you agree with the response, it becomes the final determination and the appeal ends. If you disagree with the response to your Level 1 appeal, you may then proceed to Level 2. You must request the Level 2 appeal in writing no later than 60 calendar days after you receive the Level 1 determination. The Level 2 appeal is administered by UCCI. This can be initiated by contacting UCCI Customer Service at 866-215-2354. Provide all documentation, records and comments that support the position. UCCI will provide you a written determination within 30 days of receipt of your request for Level 2 appeal unless they notify you in writing that additional information is needed for them to complete the appeal.

If your claim is still denied after Level 2 appeal because it was determined that the service is not appropriate or is experimental or investigative in nature, you may submit a written request for an external review. Contact UCCI Appeals, P.O. Box 69420, Harrisburg, PA, 117110, within four months of the Level 2 appeal decision to initiate the external review. UCCI will submit your appeals file to the External Review Organization (ERO). The ERO will review all the information and documents it receives and will provide a written notice of the decision within 45 days after the ERO receives the request for the External Review.

Administrative Information

This section includes information about the administration of the Plan described in this Summary Plan Description. While you may not need this information for your day-to-day participation, it is information you may find important from time to time.

Plan Information

Plan Name: The University of Virginia Health Plan

Employer Identification Number (EIN): 54-6001796

Plan Number: 501

Plan Sponsor:
The University of Virginia
914 Emmet Street
P.O. Box 400127
Charlottesville, VA 22904-4127
434-982-0123

Type of Plan: Self-funded welfare plan

Plan Year: January 1 – December 31

Dental Claims Administrator:
United Concordia Companies, Inc. (UCCI)
P.O. Box 69421
Harrisburg, PA 17106-9421
866-215-2354

Plan Documents

This is the official Plan document that governs the plan are known as the Summary Plan Description.
You (or your personal representative) may get a copy of these documents by downloading them from the University Human Resource website: http://www.hr.virginia.edu/ or by written request to the Plan Administrator, for a nominal charge.

Future of the Plan

Although the University expects to continue the Plan described in this book indefinitely, it necessarily reserves the right to discontinue the Plan or to implement any changes to it at any time, and for any reason, at the sole determination of the University.

The University may amend, modify, revoke or terminate the Plan at any time, as it may determine in its sole discretion.

The University's decision to terminate or end the Plan may be due to changes in federal or state laws governing employee benefits or the requirements of the Internal Revenue Service. A Plan change may transfer Plan assets and debts to another plan or split the Plan into two or more parts. If the University does change or terminate the Plan, it may decide to set up a different plan providing similar or different benefits.

If the Plan is terminated, both active and retired employees will not have the right to any other benefits from the terminated Plan, other than for those claims incurred prior to the date of termination or as provided by the individual contracts. In addition, if the Plan is amended, all covered persons – active, retired or beneficiaries – may be subject to altered coverage and benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the plans and decisions by the University. After all benefits have been paid and other requirements of the law have been met, remaining Plan assets will be turned over to the University.

Privacy of Your Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

University of Virginia's Plan's Commitment to Privacy

The University of Virginia Health Plan and the University of Virginia Dental Plan (collectively referred to as the "Plan") are committed to protecting the privacy of your protected health information. Protected health information, which is referred to as "health information" in this Notice, is information that identifies you and relates to your physical or mental health, or to the provision or payment of health services for you. The Plan creates, receives, and maintains your health information when it provides

health, dental, prescription drug, and medical flexible spending account benefits to you and your eligible dependents. The Plan also pledges to provide you with certain rights related to your health information.

By this Notice of Privacy Practices ("Notice"), the Plan informs you that it has the following legal obligations under the federal health privacy provisions contained in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the related regulations ("federal health privacy law"):

- to maintain the privacy of your health information;
- to provide you with this Notice of its legal duties and privacy practices with respect to your health information; and
- to abide by the terms of this Notice currently in effect.
- to provide you with notice of breaches of your health information as required by federal health privacy or other laws.

This Notice also informs you how the Plan uses and discloses your health information and explains the rights that you have with regard to your health information maintained by the Plan. For purposes of this Notice, "you" or "yours" refers to insured participants and eligible dependents.

This Notice was initially effective as of April 14, 2003. This notice was revised effective January 1, 2013, September 1 2013, January 1, 2014, January 2016 and January 2017.

Information Subject to this Notice

The Plan creates, receives, and maintains certain health information about you to help provide health benefits to you, as well as to fulfill legal and regulatory requirements. The Plan obtains this health information, which identifies you, from applications and other forms that you complete, through conversations you may have with the Plan's administrative staff and health care professionals, and from reports and data provided to the Plan by health care service providers, insurance companies, and other third parties. The health information the Plan has about you includes, among other things, your name, address, phone number, birthdate, social security number, and medical and health claims information. This is the information that is subject to the privacy practices described in this Notice.

This Notice does not apply to health information created, received, or maintained by the University of Virginia on behalf of the non-health employee benefits that it sponsors, such as disability benefits and life insurance benefits. This Notice also does not apply to health information that the University of Virginia requests, receives, and maintains about you for employment purposes, such as employment testing, or determining your eligibility for medical leave benefits or disability accommodations.

Summary of the Plan’s Privacy Practices

The Plan's Uses and Disclosures of Your Health Information: Generally, you must provide a written authorization to the Plan for it to use or disclose your health information. However, the Plan may use and disclose your health information without your authorization for the administration of the Plan and for processing claims. The Plan also may use and disclose your health information without your authorization for other purposes as permitted by the federal health privacy law, such as health and safety, law enforcement or emergency purposes. The details of the Plan's uses and disclosures of your health information are described below.

Your Rights Related to Your Health Information: The federal health privacy law provides you with certain rights related to your health information. Specifically, you have the right to:

- Inspect and/or copy your health information;

- Request that your health information be amended;
- Request an accounting of certain disclosures of your health information;
- Request certain restrictions related to the use and disclosure of your health information;
- Request to receive your health information through confidential communications;
- File a complaint with the Plan or the Secretary of the Department of Health and
- Human Services if you believe that your privacy rights have been violated; and Receive a paper copy of this Notice.

These rights and how you may exercise them are detailed below.

Changes in the Plan's Privacy Practices: The Plan reserves its right to change its privacy practices and revise this Notice as described below.

Contact Information: If you have any questions or concerns about the Plan's privacy practices or about this Notice, if you wish to obtain additional information about the Plan's privacy practices, or if you wish to submit a complaint, please contact:

Privacy Officer
914 Emmet Street
P.O. Box 400127
Charlottesville, VA 22904-4127
(434) 924-3552

Detailed Notice of the Plan's Privacy Policies – the Plan's Uses and Disclosures

Except as described in this section, as provided for by the federal health privacy law, or as you have otherwise authorized, the Plan only uses and discloses your health information for the administration of the Plan and the processing of health claims. The uses and disclosures that do not require your written authorization are described below.

Uses and Disclosures for Treatment, Payment, and Health Care Operations

- For Treatment. The Plan may disclose your health information to a health care provider, such as a hospital or physician, to assist the provider in treating you.
- For Payment. The Plan may use and disclose your health information without your authorization so that your claims for health care services can be paid according to the Plan's terms. For example, the Plan may use and disclose your health information to determine whether certain health care services that you seek are covered by the Plan or to process your health care claims. The Plan also may disclose your health information to coordinate payment of your health care with others who may be responsible for certain costs.
- For Health Care Operations. The Plan may use and disclose your health information without your authorization so that it can operate efficiently and in the best interests of its participants. For example, the Plan may disclose your health information for underwriting purposes, for business planning purposes, or to attorneys who are providing legal services to the Plan. The Health Plan may not use or disclose PHI that is genetic information for any underwriting purposes per GINA rules. (Genetic Information Nondiscrimination Act)

Uses and Disclosures to Business Associates

The Plan may disclose certain of your health information without your authorization to its "business associates," which are third parties that assist the Plan in its operations. For example, the Plan may share your claims information with a business associate that provides claims processing services to the Plan, and the Plan may disclose your health information to its business associates for actuarial projection and audit purposes, and legal services. The Plan enters contracts with its business associates requiring that the privacy your health information be protected.

Uses and Disclosures to the Plan Sponsor

The Plan may disclose your health information, without your authorization, to the Plan Sponsor, which is the University of Virginia, for plan administration purposes, such as performing quality assurance functions, and for monitoring and auditing functions. The Plan Sponsor will certify to the Plan that it will protect the privacy of your health information and that it has amended the plan documents to reflect its obligation to protect the privacy of your health information.

Other Uses and Disclosures That May Be Made Without Your Authorization

The federal health privacy law provides for specific uses or disclosures of your health information that the Plan may make without your authorization, some of which are described below.

- *Required By Law.* The Plan may use and disclose health information about you as required by the law. For example, the Plan may disclose your health information for the following purposes: for judicial and administrative proceedings pursuant to legal process and authority; to report information related to victims of abuse, neglect, or domestic violence; or to assist law enforcement officials in their law enforcement duties.
- *Health and Safety.* Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law. Your health information also may be disclosed for public health activities, such as preventing or controlling disease, injury, or disability.
- *Government Functions.* Your health information may be disclosed to the government for specialized government functions, such as intelligence, national security activities, and protection of public officials. Your health information also may be disclosed to health oversight agencies that monitor the health care system for audits, investigations licensure, and other oversight activities.
- *Active Members of the Military and Veterans.* Your health information may be used or disclosed in order to comply with laws and regulations related to military service or veterans' affairs.
- *Workers' Compensation.* Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation benefits.
- *Emergency Situations.* Your health information may be used or disclosed to a family member or close personal friend involved in your care in the event of an emergency, or to a disaster relief entity in the event of a disaster.
- *Involved Family and Friends.* We may disclose information about you to a relative, a friend, or other person involved in your health care or payment for your health care, such as the subscriber of your health benefits plan, provided the information is directly relevant to that person’s involvement with your health care or payment for that care. For example, if a family member or a caregiver calls us with prior knowledge of a claim, we may confirm whether or not the claim has been received and paid. You have the right to stop or limit this kind of disclosure by calling the toll-free Member Services number on your ID card. To authorize disclosures to a relative or other person, call the toll-free Member Services number on your ID card for release of

information from the Third Party Administrator, and the Privacy Officer at (434) 924-3552 for release of information from the UVA Health Plan. If you are deceased, the Plan may disclose your health information to such individuals involved in your care or payment for your health care prior to your death the health information that is relevant the individual's involvement, unless you have previously instructed the Plan otherwise.

- *Personal Representatives.* Your health information may be disclosed to people that you have authorized to act on your behalf, or people who have a relationship with you that gives them the right to act on your behalf. Examples of personal representatives are parents for minors and those who have Power of Attorney for adults.
- *Treatment and Health-Related Benefits Information.* The Plan and its business associates may contact you to provide information about treatment alternatives or other health-related benefits and services that may interest you, including, for example, alternative treatment, services, and medication.
- *Research.* Under certain circumstances, the Plan may use or disclose your health information for research purposes as long as the procedures required by law to protect the privacy of the research data are followed.
- *Organ and Tissue Donation.* If you are an organ donor, the Plan may use or disclose your health information to an organ donor or procurement organization to facilitate an organ or tissue donation transplantation.
- *Deceased Individuals.* The health information of a deceased individual may be disclosed to coroners, medical examiners, and funeral directors so that those professionals can perform their duties.

Uses and Disclosures for Fundraising and Marketing Purposes. The Plan does not use your health information for fundraising or marketing purposes and does not sell your protected health information.

Any Other Uses and Disclosures Require Your Express Written Authorization

Uses and disclosures of your health information other than those described above or otherwise allowed by the federal health privacy law will be made only with your express written authorization. Your written authorization is also required for most uses or disclosures of psychotherapy notes. (where appropriate) You may revoke your authorization in writing. If you do so, the Plan will not use or disclose your health information authorized by the revoked authorization, except to the extent that the Plan already has relied on your authorization.

Once your health information has been disclosed pursuant to your authorization, the federal health privacy law protections may no longer apply to the disclosed health information, and that information may be re-disclosed by the recipient without your or the Plan's knowledge or authorization.

Your Health Information Rights

You have the following rights regarding your health information that the Plan creates, receives and maintains. If you are required to submit a written request related to these rights, as described below, you should address such requests to:

Privacy Officer
914 Emmet Street
P.O. Box 400127
Charlottesville, VA 22904-4127
(434) 924-3552

Right to Inspect and Copy Health Information

You have the right to inspect and obtain a copy of your health information that is maintained by the Plan. This includes, among other things, health information about your plan eligibility, plan coverage, claim records, and billing records.

To inspect and copy health information maintained by the Plan, submit a written request to the UVa Privacy Officer. The Plan may charge a fee for the cost of copying and/or mailing the health information that you have requested. In limited instances, the Plan may deny your request to inspect and copy your health information. If that occurs, the Plan will inform you in writing. In addition, in certain circumstances, if you are denied access to your health information, you may request a review of the denial.

If your request for access is granted, then the Plan will provide you with access to your health information in the form and format you requested, if it is readily producible in such form or format; if it is not readily producible, then access will be provided in a mutually agreed upon form and format.

Right to Request That Your Health Information Be Amended

You have the right to request that the Plan amend your health information if you believe the information is incorrect or incomplete.

To request an amendment, submit a written request to the Privacy Officer. This request must provide the reason(s) that support your request. The Plan may deny your request if you have asked to amend information that:

- Was not created by or for the Plan, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of your health information maintained by or for the Plan;
- Is not part of the health information that you would be permitted to inspect and copy; or
- Is accurate and complete.

The Plan will notify you in writing as to whether it accepts or denies your request for an amendment to your health information. If the Plan denies your request, it will explain how you can continue to pursue the denied amendment.

Right to an Accounting of Disclosures

You have the right to receive a written accounting of disclosures, which is a list of certain disclosures of your health information by the Plan to others. Generally, the following disclosures are not part of an accounting: disclosures that occur before April 14, 2003; disclosures for treatment, payment, or health care operations; disclosures made to or authorized by you; and certain other disclosures. The accounting covers up to six years prior to the date of your request (but not disclosures made before April 14, 2003).

To request an accounting of disclosures, submit a written request to the Privacy Officer. If you want an accounting that covers a time period of less than six years, please state that in your written request for an accounting. The first accounting that you request within a twelve month period will be free. For additional accountings in a twelve month period, the Plan may charge you for the cost of providing the accounting.

But, the Plan will notify you of the cost involved before processing the accounting so that you can decide whether to withdraw or modify your request before any costs are incurred.

Right to Request Restrictions

You have the right to request restrictions on your health care information that the Plan uses or discloses about you to carry out treatment, payment, or health care operations. You also have the right to request restrictions on your health information that the Plan discloses to someone who is involved in your care or the payment for your care, such as a family member or friend. The Plan is not required to agree to your

request for such restrictions, and the Plan may terminate its agreement to the restrictions you requested. To request restrictions, submit a written request to the Privacy Officer that explains what information you wish to limit, and how and/or to whom you would like the limits to apply. The Plan will notify you in writing as to whether it agrees to your request for restrictions. To restrict access to your online health information by the subscriber of your health policy, contact the Plan Administrator.

Right to Request Confidential Communications, or Communications by Alternative Means or at an Alternative Location

You have the right to request that the Plan communicate your health information to you in confidence by alternative means or in an alternative location. For example, you can ask that the Plan only contact you at work or by mail, or that the Plan provide you with access to your health information at a specific, reasonable location.

To request confidential communications by alternative means or at an alternative location, submit a written request to the Privacy Officer. Your written request should state the reason(s) for your request, and the alternative means by or location at which you would like to receive your health information. If appropriate, your request should state that the disclosure of all or part of your health information by non-confidential communications could endanger you. The Plan will accommodate reasonable requests and notify you appropriately.

Right to File a Complaint

You have the right to complain to the Plan and/or to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. To file a complaint with the Plan, submit a written complaint to the Privacy Officer named above.

You will not be retaliated or discriminated against and no services, payment, benefits, or privileges will be withheld from you because you file a complaint with the Plan or with the Secretary of the Department of Health and Human Services.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this Notice. To make such a request, submit a written request to the Privacy Officer named above.

Changes in the Plan's Privacy Policies

The Plan reserves the right to change its privacy practices and make the new practices effective for all protected health information that it maintains, including your protected health information that it created or received prior to the effective date of the change and protected health information it may receive in the future. If the Plan materially changes any of its privacy practices that are covered by this Notice, it will revise its Notice and provide you with the revised Notice with the next annual mailing. In addition, copies of the revised Notice will be made available to you upon your written request, and any revised notice will be available at the Plan's website, www.hr.virginia.edu.

PROTECTED HEALTH INFORMATION

This section describes the administrative procedures used to implement the commitment of University of Virginia Health Plan and the University of Virginia Dental Plan (collectively referred to in this section as the "Plan") to privacy of protected health information.

Use and Disclosure of Protected Health Information. The Plan shall use Protected Health Information to the extent of and in accordance with the uses and disclosures permitted by HIPAA, as set forth in the Privacy Regulations. Specifically, the Plan shall use and disclose Protected Health Information for purposes related to health care treatment, Payment for health care, and Health Care Operations.

"Health Care Operations," as defined by 45 CFR § 164.501, as amended, generally include, but are not limited to, the following activities taken by or on behalf of the Plan:

Quality assessment;

Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, or contacting health care providers and patients with information about treatment alternatives and related functions;

Rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;

Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);

Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;

Business management and general administrative activities of the Plan, including, but not limited to: management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements; customer service, including the provision of data analyses for policyholders, plan sponsors or other customers; resolution of internal grievances; due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity; and any other activity considered to be a "health care operation" activity pursuant to 45 CFR § 164.501.

"Payment" activities, as defined by 45 CFR § 164.501, as amended, generally include, but are not limited to, activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an Individual to whom health care is provided. These activities include, but are not limited to, the following:

Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, Plan maximums and copayments as determined for an Individual's claim);

Coordination of benefits;

Adjudication of health benefit claims (including appeals and other payment disputes);

Subrogation of health benefit claims;

Establishing Eligible Employee contributions;

Risk adjusting amounts due based on an Eligible Employee's health status and demographic characteristics;

Billing, collection activities and related health care data processing;

Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to an Eligible Employee's inquiries about payments;

Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

Medical necessity reviews or reviews of appropriateness of care or justification of charges;

Utilization review, including precertification, preauthorization, concurrent review and retrospective review;

Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following Protected Health Information may be disclosed for Payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan);

Reimbursement to the Plan; and

Any other activity considered to be a "payment" activity pursuant to 45 CFR § 164.501.

<u>Disclosures by Plan to the Employer</u>. The Plan may:

Disclose Summary Health Information to the Employer, if the Employer requests the Summary Health Information for the purpose of: obtaining premium bids from health plans for providing health insurance coverage under the Plan; or modifying, amending, or terminating the Plan. For purposes of this Section, "Summary Health Information" is as defined by 45 CFR § 164.504(a), as amended, which generally is information that may be individually identifiable health information, and:

That summarizes the claims history, claims expenses, or type of claims experienced by Individuals for whom the Employer has provided health benefits under a group health plan; and

From which the information described at § 164.514(b)(2)(i) of the Privacy Regulations has been deleted, except that the geographic information described in § 164.514(b)(2)(i)(B) of the Privacy Regulations need only be aggregated to the level of a five digit zip code.

Disclose to the Employer information on whether an Individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

Disclose Protected Health Information to the Employer to carry out Plan administration functions that the Employer performs, consistent with the provisions of Sections 1.5 to 1.7 of this Article.

With an authorization from the Covered Person, disclose Protected Health Information to the Employer for purposes related to the administration of other employee benefit plans and fringe benefits sponsored by the Employer.

Not permit a health insurance issuer or HMO with respect to the Plan to disclose Protected Health Information to the Employer except as permitted by this Section.

Not disclose (and may not permit a health insurance issuer or HMO to disclose) Protected Health Information to the Employer as otherwise permitted by this Section unless a statement is included in the Plan's notice of privacy practices that the Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose Protected Health Information to the Employer.

Not disclose Protected Health Information to the Employer for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer.

Uses and Disclosures by Employer. The Employer may only use and disclose Protected Health Information as permitted and required by the Plan, as set forth within this Article. Such permitted and required uses and disclosures may not be inconsistent with the provisions of HIPAA. The Employer may use and disclose Protected Health Information without an authorization from a Covered Person for Plan administrative functions including Payment activities and Health Care Operations. In addition, the Employer may also use and disclose Protected Health Information to accomplish the purpose for which any disclosure is properly made pursuant to Section 1.4.

Certification. The Plan may disclose Protected Health Information to the Employer only upon receipt of a certification from the Employer that the Plan documents have been amended to incorporate the provisions provided for in this Section and that the Employer so agrees to the provisions set forth therein.

Conditions Agreed to by the Employer. The Employer agrees to:

Not use or further disclose Protected Health Information other than as permitted or required by the Plan document or as required by law;

Ensure that any agents, including a subcontractor, to whom the Employer provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such Protected Health Information, and that such agents or subcontractors agree to implement reasonable and appropriate security measures to protect any Electronic Protected Health Information belonging to the Plan that is provided by the Employer;

Not use or disclose Protected Health Information for employment-related actions and decisions unless authorized by an Individual;

Not use or disclose Protected Health Information in connection with any other benefit or employee benefit plan of the Employer unless authorized by an Individual;

Report to the Plan any Protected Health Information use or disclosure that is inconsistent with the uses or disclosures provided for by this Article, or any Security Incident of which it becomes aware;

Make Protected Health Information available to an Individual in accordance with HIPAA's access requirements pursuant to 45 CFR § 164.524;

Make Protected Health Information available for amendment and incorporate any amendments to Protected Health Information in accordance with 45 CFR § 164.526;

Make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;

Make internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of the Department of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA;

If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such Protected Health Information when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible);

Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Plan; and

Ensure that the separation and requirements of Sections 7.09, 7.10, and 7.11 of the Plan are supported by reasonable and appropriate security measures.

<u>Adequate Separation Between the Plan and the Employer</u>. In accordance with HIPAA, only the following employees or classes of employees may be given access to Protected Health Information: UHR Service Team, Financial Analyst, Benefit Program Manager, Wellness Manager, Total Rewards Compliance Manager, Director of Total Rewards, Ombudsman.

Limitations of Access and Disclosure. The persons described in Section 1.8 of this Article may only have access to and use and disclose Protected Health Information for Plan administration functions that the Employer performs for the Plan.

Noncompliance. If the persons or classes of persons described in Section 1.8 of this Article do not comply with this Plan document, the Plan and the Employer shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

Definitions. When the initial letter of a word or phrase is capitalized in this Article, the meaning of such word or phrase shall be as follows:

"Electronic Protected Health Information" or "EPHI" means "electronic protected health information" as defined at 45 CFR § 160.103; which, generally, means Protected Health Information that is transmitted by, or maintained in, electronic media. For these purposes, "electronic media" means: (i) electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or (ii) transmission media used to exchange information already in electronic storage media (e.g., the internet, extranet, leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media).

"Privacy Regulations" mean the regulations under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164, as amended).

"Protected Health Information" means "protected health information," as defined at 45 CFR § 160.103, which generally means information (including demographic information) that (i) identifies an Individual (or with respect to which there is a reasonable basis to believe the information can be used to identify an Individual), (ii) is created or received by a health care provider, a health plan, or a health care clearinghouse, and (iii) relates to the past, present, or future physical or mental health or condition of an Individual; the provision of health care to an Individual; or the past, present, or future Payment for the provision of health care to an Individual. For purposes of this Plan, Protected Health Information shall only include information related to a Benefit Feature: (1) that provides medical care benefits (including medical, dental, vision, long term care, or other coverage affecting any structure of the body) that is subject to the Privacy Regulations; and (2) that is either uninsured or insured and provides Protected Health Information to the Company or the Employer.

"Security Incident" means "security incident" as defined at 45 CFR § 164.304; which, generally, means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

"Security Regulations" mean the regulations under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Parts 160 and 164, as amended.)

PLAN SPONSOR CERTIFICATION FOR THE

UNIVERSITY OF VIRGINIA HEALTH PLAN AND UNIVERSITY OF VIRGINIA DENTAL PLAN

The Rector and Visitors of the University of Virginia ("Plan Sponsor") sponsors the University of Virginia Health Plan and the University of Virginia Dental Plan (collectively referred to in this certification as the "Plan") for eligible employees and their dependents ("Covered Persons"). As required by the Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164) ("Privacy Regulations") of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Plan Sponsor certifies that the Plan has been amended to incorporate the following provisions and Plan Sponsor agrees:

(1) not to use or further disclose protected health information other than as permitted or required by the Plan or as required by law;

(2) to ensure that any agents, including subcontractors, to which Plan Sponsor provides protected health information received from the Plan agree to the same restrictions and conditions that apply to Plan Sponsor,

(3) not to use or disclose protected health information for employment-related actions and decisions;

(4) not to use or disclose protected health information in connection with any other benefit or employee benefit plan of Plan Sponsor,

(5) to report to the Plan any protected health information use or disclosure inconsistent with the Privacy Regulations' requirements of which Plan Sponsor becomes aware;

(6) to make protected health information available to the Plan or a Covered Person pursuant to the Privacy Regulations' access requirements at 45 CPR § 164.524;

(7) to make protected health information available to the Plan for amendment, and incorporate any protected health information amendments in accordance with the Privacy Regulations at 45 CPR § 164.526;

(8) to make available to the Plan the information required to provide an accounting of disclosures in accordance with the Privacy Regulations at 45 CFR § 164.528;

(9) to make available to the United States Secretary of the Department of Health and Human Services Plan Sponsor's internal practices, books and records relating to the use and disclosure of protected health information received from the Plan to determine the Plan's compliance with the Privacy Regulations;

(10) if feasible, to return or destroy all protected health information received from the Plan that Plan Sponsor still maintains in any form, and to destroy protected health information when it is no longer needed for the disclosure purpose. If return or destruction is not feasible, Plan Sponsor agrees to limit further uses and disclosures to those purposes that make the return or destruction infeasible;

(11) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic

Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Plan; and

(12) to ensure that an adequate separation between the Plan and Plan Sponsor is established pursuant to 45 CFR § 164.504(f)(.i)(iii}.

For purposes of this Certification, the term-"protected health information" shall have the same meaning as set forth in 45 CFR § 160.103, limited to information created or received by the Plan. Any reference herein to the Privacy regulations or to the Code of Federal Regulations means the section as in effect or amended, and for which compliance is required.

as amen

7/8/16

Plan Sponsor Representative's Signature Date

Interim VP, Human Resources

Title