UNIVERSITY of VIRGINIA

University of Virginia Dental Plan
Summary Plan Description

For University of Virginia Dental Plan Enrollees
Effective January 1, 2026

1/1/26

Your UVA Dental Plan Benefits

The University of Virginia Dental Plan (the UVA Dental Plan or the Plan) offers two dental options, Basic Dental and Enhanced Dental, to provide comprehensive dental care to you and your eligible dependents. You choose the coverage that best meets the needs of you and your family. The Plan is administered by United Concordia Companies, Inc. (UCCI).

This book helps you learn about the UVA Dental Plan offered by the University of Virginia (the University). You will find important Plan information, including who is eligible, what is covered and not covered, and how to file a claim so that you and your covered dependents can get the most from your benefit coverage.

Please read this book carefully and refer to it when you need to understand how your dental benefits work. If you have questions or need help, call UCCI at the number shown on your ID card or refer to "Contacts" in this book, on page 3.

Dental Coverage at a Glance

The UVA Dental Plan provides comprehensive coverage and access to an extensive network of providers. Here's an overview of how the Plan works:

Feature	Overview
Your options	You have two options for coverage under the UVA Dental Plan: ▪ Basic Dental; and ▪ Enhanced Dental.
The UVA Dental Plan network	Both options use United Concordia's Elite Prime network as in-network providers, giving you access to a network of general and specialty dentists. Visit https://www.unitedconcordia.com/dental-insurance/member/clients-corner/university-of-virginia/ or call UCCI Customer Service at 866-215-2354 to find in-network providers in your area. Each time you receive care, you can choose to receive it from an in-network or out-of-network provider. The Plan pays benefits for in-network and out-of-network covered services.
How the two options are the same	Both options share many features: ▪ They have the same overall design and provide coverage for a wide range of dental services; ▪ They are administered by United Concordia and use United Concordia's Elite Prime network as in-network providers; ▪ They provide coverage for you and your eligible dependents; ▪ They have the same calendar-year deductible; and ▪ They offer the same coverage for in-network and out-of-network diagnostic and preventive coverage (such as routine cleanings and x-rays) and for primary services (such as fillings and periodontic care). In addition, you are eligible for UCCI's Smile for Health benefits no matter which option you choose.

Feature	Overview
How the two options are different	The differences between the two options include: ▪ Orthodontic benefits are only available with Enhanced Dental; ▪ You receive a higher level of coverage for major restorative services (such as crowns and bridges) with Enhanced Dental; and ▪ The annual maximum benefit for dental services is higher under Enhanced Dental.
What's covered	The Plan offers 100% coverage for in-network eligible preventive and diagnostic care and you do not need to meet your annual deductible first. In addition, the Plan provides coverage for eligible in-network and out-of-network care for: ▪ Primary services such as fillings, periodontics, and oral surgery; ▪ Major restorative services such as crowns, bridges, and dentures; and ▪ Under Enhanced Dental, Orthodontic services are covered up to the lifetime maximum benefit.
Your cost for coverage	In general, the more you pay for coverage through payroll contributions or monthly premiums, the less you will pay for the cost of the dental care services you receive. You share in the cost of coverage through payroll contributions or monthly premiums, and for the cost of care you receive through deductibles and coinsurance. Your Plan benefits, under both options, are subject to an annual maximum benefit.
About Smile for Health	With Smile for Health maternity and enhanced benefits, pregnant individuals and those with certain chronic health conditions receive additional dental care services and an increase in the amount the Plan will pay toward these services. See "Smile for Health® Benefits" on page 33 for more information.

Contacts

When you have questions or need more information, refer to this table for available resources. You will also find important, personalized information and resources on Workday.

Resource	Situation	How to Contact
UVA HR	Contact UVA HR when you: ▪ Have a qualified life event; or ▪ Need to report a change in your name, address, or telephone number.	Call: 434-243-3344 Email: askHR@virginia.edu
United Concordia member services	Contact member services when you have questions about: ▪ The Plan's benefits; ▪ Smile for Health benefits; or ▪ Claims.	Call: 866-215-2354
United Concordia website	Use the secure member website when you need: ▪ Eligibility or claim status information; ▪ A replacement ID card; ▪ Copies of claim forms; or ▪ Access to tools that help you manage your healthcare.	Log on to your account at: https://www.unitedconcordia.com/dental-insurance/member/clients-corner/university-of-virginia/
United Concordia network portal	Use this website to find providers within United Concordia's Elite Prime network	Visit: https://www.unitedconcordia.com/dental-insurance/member/clients-corner/university-of-virginia/.
Smile for Health schedule of benefits	Use this summary to find information about coverage and benefits.	Visit: https://www.unitedconcordia.com/docs/SFH_Flyer.pdf

Contents

YOUR UVA DENTAL PLAN BENEFITS **1**

DENTAL COVERAGE AT A GLANCE **1**

CONTACTS **3**

ABOUT THIS SUMMARY **7**

YOUR RIGHTS AND RESPONSIBILITIES **8**

PARTICIPANT BILL OF RIGHTS 8
YOUR RESPONSIBILITIES AS A PLAN PARTICIPANT 8

ELIGIBILITY AND ENROLLMENT **9**

WHO IS ELIGIBLE 9
Active Employees *9*
Postdoctoral Fellows *9*
Dependents *10*
Adopted Children *11*
Children Born by Gestational Surrogate *11*
Qualified Medical Child Support Orders *11*
HOW TO ENROLL 11
New Employees *12*
Open Enrollment *12*
QUALIFIED LIFE EVENT CHANGES 12
Special Enrollment Rights *13*
Qualified Life Event Required Documentation *14*
Required Documentation Confirming Relationship of Spouse or Dependent *16*
FINALIZATION OF ENROLLMENT ELECTIONS 18
New Employees *18*
Open Enrollment *18*
Qualified Life Events and Special Enrollments *19*
WHEN COVERAGE BEGINS 19
WHAT IF I LEAVE THE UNIVERSITY, THEN COME BACK? 19
HOW YOU PAY FOR COVERAGE 19
Before-Tax Contributions and Social Security *19*
Postdoctoral Fellow Premiums *20*

WHEN COVERAGE ENDS **20**

LEAVES OF ABSENCE 21
Family, Medical and Military Leave Act *21*
USERRA Military Leave *21*
Paid Leave and Unpaid Leave *22*
CONTINUED COVERAGE FOR A DISABLED CHILD 22
CONTINUING PLAN COVERAGE UNDER COBRA 22
Electing and Paying for COBRA Coverage *23*
Notification Requirements *24*
Notification of Your COBRA Rights *26*
Address Changes *26*
When COBRA Ends *26*

COORDINATION WITH OTHER PLANS 27

If You Have Other Coverage 27

YOUR UVA DENTAL COVERAGE OPTIONS 29

Basic Dental Schedule of Benefits 29
Enhanced Dental Schedule of Benefits 31
Smile for Health® Benefits 33

HOW DENTAL COVERAGE WORKS 34

The Provider Network 34
Allowable Charge 34
Sharing the Cost of Care 34
Annual Deductible 34
Coinsurance 35
Annual Maximum 35
Predetermination of Benefits 35

WHAT IS COVERED 36

Diagnostic and Preventive Services 36
How the Plan Pays Benefits 36
Covered Services 36
Primary Services 37
How the Plan Pays Benefits 37
Covered Services 37
Major Restorative Services 38
How the Plan Pays Benefits 38
Covered Services 38
Orthodontic Treatment (Enhanced Dental Only) 39
How the Plan Pays Benefits 39
Covered Services 39
Alternate Treatment Provision 39
Smile for Health® Benefits 39

WHAT IS NOT COVERED 40

General Exclusions 40
Special Exclusions 41

UCCI DENTAL CLAIMS & APPEALS 41

Filing Claims 41
Appeal of an Adverse Benefit Determination 42
Appeal Procedure 42

ADMINISTRATIVE INFORMATION 43

Plan Information 43
Plan Documents 43
Interpretation of Eligibility Roles 43
Claim Decisions 44
Future of the Plan 44

PRIVACY OF YOUR HEALTH INFORMATION 45

UNIVERSITY OF VIRGINIA'S PLAN'S COMMITMENT TO PRIVACY 45
INFORMATION SUBJECT TO THIS NOTICE 45
SUMMARY OF THE PLAN'S PRIVACY PRACTICES 46
YOUR RIGHTS RELATED TO YOUR HEALTH INFORMATION 46
Uses and Disclosures for Treatment, Payment, and Health Care Operations 47
Uses and Disclosures to Business Associates and to the Plan Sponsor 47
Other Permitted Uses and Disclosures 47
Your Health Information Rights 48
Changes in the Plan's Privacy Policies 48
Contact Information 48
PROTECTED HEALTH INFORMATION 48

About this Summary

This book, including the UVA Dental Plan's Schedules of Benefits, constitutes the UVA Dental Plan's Summary Plan Description (SPD) and Plan Document.

In this book, you will find the information you need to understand your UVA Dental Plan benefits, including:

- What rights and responsibilities you have under the Plan;
- Who is eligible for coverage;
- How to enroll and when you are allowed to change the coverage you have chosen;
- When coverage starts and ends;
- What the Plan covers and does not cover; and
- How to file a claim or appeal a claim decision.

In addition, be sure to refer to "Administrative Information" on page 43 for key information about the administration of the Plan and "University of Virginia's Plan's Commitment to Privacy" on page 45 for the University's privacy policy.

Please read this SPD carefully and refer to it when you need to understand how your dental benefits work. The SPD is the binding document for Plan Administration in any appeal process. If you have questions or need help, call UCCI at the number shown on your ID card or see "Contacts" on page 3.

This book outlines provisions of the University of Virginia Dental Plan (UVA Dental Plan) as of January 1, 2026. The University of Virginia reserves the right to change, amend, suspend, or terminate any or all of the benefits under the UVA Dental Plan, in whole or in part, at any time and for any reason at its sole discretion.

The University of Virginia adopts this Plan Document as a description of the UVA Dental Plan. This Plan Document replaces any prior statement of dental coverages of the Plan, effective January 1, 2026. If any provisions of this Plan are contrary to any law to which it is subject, such provision is hereby amended to conform to such law.

Note that by adopting and maintaining the UVA Dental Plan, the University of Virginia has not entered into an employment contract with any employee or UVA Dental Plan participant. Nothing in the legal UVA Dental Plan documents or this book gives any employee or UVA Dental Plan participant the right to employment by the University of Virginia or to interfere with the University of Virginia's right to discharge any employee at any time.

Certain company, product, and service names mentioned herein may be trademarks of their respective companies.

Your Rights and Responsibilities

Participant Bill of Rights

- You have the right to receive information about the UVA Dental Plan, the Plan's services, practitioners and providers, and your rights and responsibilities as a Plan participant.
- You have the right to every consideration of confidentiality concerning your own claims for dental care.
- You have the right to expect your provider to inform you about your treatment and to have the information explained or interpreted as necessary.
- You have the right to make decisions about your plan of care prior to and during the course of treatment.
- You have the right to benefits for medically necessary services that are covered under the UVA Dental Plan.
- You have the right to prompt and courteous replies to questions regarding access to care, dental benefits, and dental claims.
- 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.
- 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 "UCCI Dental Claims & Appeals" on page 41 in this Summary Plan Description for that process.

Your Responsibilities as a Plan Participant

- You are responsible for asking questions when you do not understand information or instructions.
- 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.
- If you receive services from an out-of-network provider, you will be responsible for ensuring that the Claims Administrator has authorized the services, if required, and to know if they are approved out-of-network or in-network so that you receive benefits at the maximum benefit level.
- You are responsible for verifying with the Claims Administrator that a provider has obtained any necessary precertification.
- You are responsible for ensuring your family members are aware of the correct procedures for accessing care before obtaining benefits through the UVA Dental Plan.
- You are responsible for making all necessary cost-sharing payments to providers as required and outlined in the appropriate Schedule of Benefits in this Summary Plan Description (see "Your UVA Dental Coverage Options" on page 29).
- You are responsible for notifying UVA HR of any change in contact information or dependent eligibility by completing the changes through the online benefit portal.

- 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 agreed upon plan of treatment.
- You are responsible for providing UVA HR with information related to other dental insurance coverage you or your covered spouse or dependents may have.
- You are responsible for completing your on-line enrollment within 30 days of eligibility or 60 days of mid-year qualifying events to enroll or make changes in the Plan. If the enrollment period is missed for newly eligible benefits, your benefit status for those benefits will default to "waived."
- You are responsible for providing documentation and answering questions that verify eligibility at the request of the Plan Administrator.
- You are responsible for informing UVA HR 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.

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 is scheduled to work at least 20 hours per week.

Keep In Mind
Temporary, wage, leased, and contract employees are not eligible for the Plan.
Eligible employees on leave should see "Leaves of Absence" on page 21 for coverage details.

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 month in which they turn age 26, including:
  - 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 month 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 disabled child may continue beyond the end of the month in which they turn age 26 if:

- The child is permanently and totally disabled;
- The disability began before the child reached age 26;
- The application forms for disability status are requested from UVA HR, completed, returned, and approved PRIOR to the dependent's 26th birthday;
- The child is unmarried, lives with you full-time in a regular parent-child relationship, 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 since the disability began.

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 under the UVA Dental Plan 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.

Adopted Children

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 miss this 60-day deadline, you must wait until the next open enrollment to submit the request and documentation. The change will be effective the first of the following year.

Children Born by Gestational Surrogate

Coverage for your legal child birthed by a surrogate 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 miss this 60-day deadline, you must wait until the next open enrollment to submit the request and documentation. The change will be effective the first of the following year.

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.

Enrolled ineligible participants and/or their ineligible enrolled dependents will be retroactively terminated to their enrollment date. The participant will owe reimbursement for the cost of any ineligible claims paid by the Plan for you and/or your dependents and may receive disciplinary action up to and including employment termination.

Dependent Eligibility Audit
All newly enrolled and newly eligible dependents requesting enrollment in the UVA Dental Plan must provide documentation to confirm their relationship to the employee. The required documentation is detailed on the UVA HR website at https://hr.virginia.edu/. The Plan has the obligation and the right to audit dependent eligibility from time to time to ensure that the Plan is administered according to the Summary Plan Description.

How to Enroll

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

- Within 30 days of the date you become eligible for coverage;
- During the open enrollment period; or
- Within 60 days of a qualified life event.

Important Enrollment Reminders
All requests for enrollment of spouses or children must include documentation confirming dependent eligibility.

New Employees

As a new employee, you must enroll within 30 days of your hire date. If you do not enroll or waive coverage within this 30-day period, you will not be able to enroll until the next open enrollment period unless you have a qualified life event.

Open Enrollment

During the 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 UVA HR or through Workday 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 Workday request and required documentation (see "Qualified Life Event Required Documentation" on page 14) but no earlier than the event date. If you miss this 60-day deadline, you must wait until the next open enrollment to submit the request and documentation. The change will be effective the first of the following year.

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 "When Coverage Ends" on page 20. You will be responsible for reimbursing the Plan for any payments made by the Plan for claims submitted for your ineligible dependents with dates of service later than their coverage end dates. These reimbursements may be deducted from your paycheck.

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.

Any retroactive premiums refunded to employees for ineligible dependents must have been paid within the same calendar year as the notification of ineligibility to UVA HR. Retroactive premiums paid in prior calendar years will be forfeited.

When You Have a Qualified Life Event
▪ 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 (see "Qualified Life Event Required Documentation" on page 14). Documentation must also be submitted to confirm dependent eligibility.
▪ Online requests by active employees must be made through Workday for academic and medical center employees.
▪ A qualified life event does not allow you to change from one Plan option to any other Plan option.

The following are examples of qualified life events and the enrollment changes they allow. For more information, see "Qualified Life Event Required Documentation" on page 14 or visit https://hr.virginia.edu/.

Qualified Life Event	Enrollment Changes Allowed
You get married	▪ Enroll your spouse and other eligible dependents; 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 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 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 Plan 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, and any other eligible dependents not already on your policy. If you make an application to add the child within 60 days of the event, the coverage for the child 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 effective 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 if you make application within 60 days of the event. The coverage is effective the first of the month following the receipt of the enrollment request and documentation at UVA HR or through Workday but no earlier than the event date.

- An additional Special Enrollment Right is granted by a federal law known as HIPAA when non-COBRA coverage is terminated because of loss of eligibility for group health coverage or when COBRA coverage is exhausted. 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 request and documentation at UVA HR or through Workday but no earlier than the event date.
- Loss of S-CHIP/Medicaid eligibility or provision of premium assistance by S-CHIP/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 within 60 days of the event date. The coverage is effective the first of the month following receipt of the enrollment request and documentation at UVA HR or through Workday, but no earlier than the event date. Contact UVA HR through Workday with your documentation for assistance with this special enrollment.

Qualified Life Event Required Documentation

You will need to submit documentation to UVA HR with your application to verify your qualified life event. Here is a summary of the documentation you should provide for each qualified life event.

Qualified Life Event	Required Documentation
If you get married	A copy of a state-issued marriage certificate received after the date of the ceremony with recorded file date.
If you get divorced or your marriage is annulled	A copy of portions of the court documents (e.g., divorce decree or annulment) with the: ▪ Names of both parties; ▪ Date of divorce; and ▪ Judge's stamp or signature.
The birth of a child	A copy of the birth certificate or birth letter showing the employee as parent.
The adoption or placement of adoption of a child	A copy of court-approved adoption order, placement order or modified birth certificate showing the employee's name as parent.
Your employment status changes at UVA and affects your enrollment in the UVA Dental Plan	No documentation is required when a UVA employee has the following employment status changes: ▪ Increase in hours from part-time to full-time; ▪ Reduction of hours; or ▪ Commencement or return from an unpaid leave of absence.
Your spouse or child's employment is terminated and coverage is lost	A document from the employer on the employer's letterhead, indicating the employment termination date and the date dental coverage ended.

Qualified Life Event	Required Documentation
Your spouse or child has an employment change that affects benefits enrollment due to eligibility	A document from the employer on the employer's letterhead, indicating the date your spouse or child became eligible or ineligible for dental coverage and the date coverage began or ended.
Your spouse or child commenced or returned from an unpaid leave of absence and coverage is lost or gained	A document from the employer on the employer's letterhead, indicating the date your spouse or child began or ended an unpaid leave of absence and the date dental coverage began or ended.
You are no longer required to provide dependent coverage	Submit a Department of Social Services Order to confirm that you are no longer responsible for providing dental plan coverage for your child(ren).
There is a change in legal custody	Provide a copy of a court document showing the: ▪ Name of employee or spouse as responsible party; ▪ Date of the change of eligibility; ▪ Name(s) of minor child(ren); and ▪ Judge's stamp or signature.
You (or your dependent) is no longer entitled to government-sponsored coverage	Provide government documents showing the entitlement to or loss of eligibility for government-sponsored programs such as Medicaid, S-CHIP, or TRICARE.
There is a coverage or cost change of more than 20% with your spouse or child's other coverage.	Provide documents from the employer showing: ▪ The effective date of the changes; and ▪ The changes in cost and/or coverage (including information about the before coverage/cost and after coverage/cost in order to confirm the type and percentage change).
Your spouse or child dies	Provide a copy of the death certificate or obituary.

Required Documentation Confirming Relationship of Spouse or Dependent

If you are adding a spouse or dependent to your coverage, you must also provide documentation to confirm their relationship to you. Here are details regarding required relationship documentation.

Dependents	Eligibility Definition	Documentation Required
Spouse	The marriage must be recognized as legal in the Commonwealth of Virginia. NOTE: Ex-spouses will not be eligible, even with a court order.	▪ Copy of state-issued marriage certificate received after the date of the ceremony with recorded file date, **and** ▪ Copy of the first page of the employee's most recent federal tax return that shows the dependent listed as "Spouse." "Mark out" all financial information and the first five digits of all Social Security numbers.
Natural (Biological) Child	A child may be covered to the end of the month in which they turn age 26.	▪ Copy of birth certificate or proof of birth showing employee as parent.
Adopted Child	A child may be covered to the end of the month in which they turn age 26.	▪ Copy of birth certificate or court approved adoption order showing employee's name. If this is a legal pre-adoptive agreement, it must be reviewed and approved by the UVA HR.
Stepchild (Biological Child of Spouse)	A stepchild may be covered to the end of the month in which they turn age 26.	▪ Copy of birth certificate (or adoption agreement) showing the employee's spouse as parent, **and** ▪ Copy of state-issued marriage certificate received after the date of the ceremony with recorded file date showing the employee and dependent parent's name, and one form of proof of joint ownership, **and** ▪ Copy of the first page of the employee's most recent federal tax return that shows the dependent's parent listed as "Spouse." "Mark out" all financial information and the first five digits of all Social Security numbers.

Dependents	Eligibility Definition	Documentation Required
Foster Child	A foster child may be covered to the end of the month in which they turn age 26.	▪ Copy of birth certificate, **and** ▪ Copy of the Final Court Order granting permanent custody with name of employee as responsible party, name of minor children, and presiding judge's signature, support order number, and seal.
Other Child for Whom You Have Permanent Legal Guardianship or Custody	A child for which a court has ordered the employee (and/or the employee's legal spouse) to assume permanent custody may be covered to the end of the month in which they turn age 26 if: ▪ They are unmarried, ▪ Reside full-time with the employee in a regular parent-child relationship, ▪ Is declared as a dependent on the employee's federal income tax return, and ▪ Custody was awarded prior to the child's 18th birthday.	▪ Copy of birth certificate, **and** ▪ Copy of the Final Court Order granting permanent custody with name of employee or spouse as responsible party, name of minor children, and presiding judge's signature, support order number, and seal.
Other Child — Exception	If the employee (or the employee's spouse) shares permanent custody of an "other child" with their minor child who is the parent of the "other child — exception", then that "other child" may also be covered if the other child, the minor child (who is the parent) and the employee's spouse (if applicable): ▪ All live in the same household as the employee, ▪ Both children are unmarried, ▪ Both children are declared as dependents on the employee's federal tax return, and ▪ A court has ordered the employee or the employee's spouse to assume joint permanent custody.	▪ Copy of the other child's birth certificate showing the name of the minor child as the parent of the other child, **and** ▪ Copy of the birth certificate (or adoptive agreement) for the minor child showing the name of the employee, **and** ▪ Copy of the Final Court Order granting custody with names of employee or spouse and their minor child as the responsible parties, name of "other child", and presiding judge's signature, support order number, and seal.

Dependents	Eligibility Definition	Documentation Required
Disabled Adult Child	The employee's adult children who are disabled due to a physical or mental health condition may be covered beyond the end of the month in which they turn age 26 if: ▪ They are permanently and totally disabled, ▪ They are unmarried, ▪ They reside full-time with the employee (or the other natural/adoptive parent), ▪ They are declared as a dependent on the employee's federal income tax return, ▪ They are deemed disabled prior to the end of the month in which they reach age 26, and ▪ They have maintained continuous coverage under an employer-sponsored plan of the employee (or the other natural/adoptive parent).	▪ Copy of birth certificate or legal adoptive agreement showing employee's name, **and** ▪ Other medical certification and eligibility documentation as needed. ▪ In the case of a new employee, copy of the HIPAA Certificate showing prior employer-sponsored coverage.

Finalization of Enrollment Elections

During any enrollment period including new employee enrollment, 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 other enrollments or changes can be allowed until the next open enrollment or Qualified Life Event occurs.

New Employees

When making an election in Workday, you are provided an opportunity to print a confirmation of your election choices. If the confirmation does not reflect your chosen elections, immediately notify UVA HR of the error so they can correct the inaccurate election before deductions begin in your paycheck. All elections are final until the next open enrollment or Qualified Life Event occurs.

If no attempt has been made to elect dental benefits within 30 days of your hire date, you will be defaulted to "waived" for your dental coverage.

Open Enrollment

If you make any elections or changes during open enrollment, you are provided an opportunity to print a confirmation of your election choices. If the confirmation does not reflect your chosen elections, immediately notify UVA HR of the error so they can correct the inaccurate election. Once the open enrollment period closes, all elections are final until the next open enrollment or Qualified Event occurs.

Qualified Life Events and Special Enrollments

When making an election or change, you are provided an opportunity to print a confirmation of your election choices. If the confirmation does not reflect your chosen elections, immediately notify UVA HR of the error so they can correct the inaccurate election before deductions begin in your paycheck. All elections are final until the next open enrollment or Qualified Event occurs.

When Coverage Begins

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

- If you enroll as a new hire when you first become eligible, coverage begins on your choice of the date of hire or the first of the month following your date of hire. If you are hired on the first of the month, coverage begins immediately.
- If you enroll when you first become eligible due to a UVA "change job" or "transfer" event, coverage begins on the first of the month following the event date. If the event date is on the first of the month, coverage begins immediately.
- If you enroll during the open enrollment period, coverage begins on the following January 1.
- If you enroll because of a qualified life event, coverage begins on the first of the month following receipt of the enrollment request and documentation at UVA HR if the enrollment is received within 60 days of the event, but no earlier than the event date 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 miss the 60-day deadline, you must wait until the next open enrollment to submit the request and documentation.

What If I Leave the University, Then Come Back?

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

- If you are re-hired in a benefit eligible position within 31 days of leaving the University and were enrolled in benefits upon separation, you have no break in coverage. You must enroll in the same benefits you had prior to your separation.
- If you are re-hired in a benefit eligible position greater than 31 days after your termination date, you are treated as a new employee. 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.

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.

For More Information
Consult your tax advisor 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.

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;
- The dependent becomes covered as an employee; or
- The dependent child reaches age 26.

- The last day of the second month after the month in which the employee dies.

In the event of a divorce, coverage for a spouse ends on the last day of the month of the divorce.

You will be responsible for reimbursing the Plan for any payments made by the Plan for claims submitted for you or your dependents with dates of service later than your coverage end date.

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.

Paid Leave and Unpaid Leave

The University and Medical Center policies describe several types of leave for several types of employee populations. Eligibility for dental coverage, length of time dental coverage is offered, and employee/employer premium costs vary depending on the leave type. For details on leave types, leave policies and dental coverage while on leave, visit https://hr.virginia.edu/, Time Off. You are responsible for paying your dental premiums during your leave. If you fail to make timely payments as outlined in your billing statements, your coverage will be terminated. You must pay the billed amount in full; you cannot defer payments until you return to work.

If your coverage is retroactively terminated or waived, you will be responsible for reimbursing the Plan for any payments made by the Plan for claims submitted for you or your dependents with dates of service later than your retroactive coverage end date.

Continued Coverage for a Disabled Child

When Plan coverage would normally end, your covered disabled dependent(s) may be able to continue coverage. This section describes how your disabled dependent may be able to continue coverage past the Plan's age limit for dependents.

Your child is considered disabled if:

- They are unable to earn a living because of a mental or physical disability that starts before they reach the age limit for dependents; and
- They depend mainly on you for support and maintenance.

You must contact the UVA HR prior to your disabled dependent's 26th birthday and request the application forms for disability status. You and the child's treating physician must complete the forms giving proof of your child's disability, submit the forms, and be approved prior to 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 of the following to occur:

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

Disability status must be renewed annually. UVA HR will require proof that the disability continues in order to recertify your child's disability.

Continuing Plan Coverage under COBRA

When Plan coverage would normally end, you or your covered dependents may be able to temporarily continue coverage in certain circumstances. This section describes how you or your covered dependents may be able to continue coverage through the Consolidated Budget Reconciliation Act of 1985 (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 UVA HR 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 UVA HR to enroll for COBRA. UVA HR 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.

Reason Coverage Ended ("COBRA Event")	Maximum COBRA Continuation Period		
	You	*Your Spouse*	*Your Child*
You lose coverage because of reduced work hours	18 months	18 months	18 months
Your employment terminated 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 lost 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 UVA HR 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 UVA HR 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.

COBRA Event	Notification Procedures	Who Must Take Action and When
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	You must notify within 60 days of any final determination by the Social Security Administration that the individual is 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.
If you are no longer disabled	You must notify the COBRA Administrator	You must notify within 30 days of notification by the Social Security Administration that the individual is no longer disabled.

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

Yes. 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 open enrollment period.
- If you have another COBRA event or a qualified life event, as described in "Qualified Life Event Changes" on page 12, 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
P.O. Box 249
Fort Washington, PA 19034-9998
888-878-6175

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; or
- 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

If You Have Other Coverage

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).

Dental benefits available through other group or individual plans, contracts, or other arrangements 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, the 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 in rule 3 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: ▪ The plan of the custodial parent pays, then ▪ The plan of the spouse of the custodial parent pays, then ▪ The plan of the non-custodial parent pays, then ▪ 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.

Your UVA Dental Coverage Options

The UVA Dental Plan offers the following dental plan options:

- Basic Dental; and
- Enhanced Dental.

In addition, Smile for Health benefits are available for pregnant individuals and those with certain chronic health conditions. This section describes important features of the Plan.

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

Basic Dental Schedule of Benefits

Basic Dental Program Feature	
Annual deductible (Applies to primary services and major restorative services)	$50 per person
Annual maximum (calendar year) (Applies to diagnostic and preventive care, primary services, and major restorative services)	$1,000 per person

Basic Dental Services Provided***	In-Network (based on allowable charge)	Out-of-Network* (based on allowable charge)
Diagnostic and Preventive Care*		
Includes: ▪ Routine oral evaluations (2 per calendar year) ▪ Limited oral evaluation (1 per calendar year) ▪ Fluoride treatment (for dependents under age 19, 2 per calendar year) ▪ Dental X-rays (full-mouth or panoramic X-rays once every 3 years, unless approved in advance by TPA) ▪ Bitewing radiographs (2 per calendar year) ▪ Space maintenance for children under age 19 (after loss of a primary molar or permanent first molar; one per tooth, every 3 years) ▪ Biopsies of oral tissues ▪ Sealants (one application for children under age 19, one tooth every 3 years) ▪ Pulp vitality tests (2 per calendar year) ▪ Palliative emergency treatment See “What Is Covered” on page 36 for information about more covered services	Plan pays 100%	You pay 15%; Plan pays 85%

Basic Dental Services Provided***	In-Network (based on allowable charge)	Out-of-Network* (based on allowable charge)
*Primary Services***		
Includes: ▪ Fillings (limited to 1 per tooth in a 12-month period) ▪ Endodontics ▪ Oral surgery ▪ Periodontal care ▪ General anesthesia when medically necessary and administered in connection with oral surgery ▪ Repairs of crowns, inlays, onlays, bridges, and dentures See "What Is Covered" on page 36 for information about more covered services	You pay 20% after annual deductible; Plan pays 80%	You pay 35% after the deductible; Plan pays 65%
*Major Restorative Services***		
Includes: ▪ Crowns, inlays, and onlays: installation or replacement ▪ Bridges: installation or replacement (must be more than five years after installation but not more than once in five years) ▪ Dentures (full or partial): installation or replacement ▪ Dental implants: replacement of implant-related crown/prosthetic (limited to one tooth in a five-year period) See "What Is Covered" on page 36 for information about more covered services	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 if they use non-participating providers in addition to the appropriate coinsurance and this amount may be significant.

** Smile for Health benefits are available for those with a diagnosis of pregnancy, heart disease, stroke, diabetes, and respiratory disease.

***The most commonly used services are included on this schedule. Contact UCCI at 866-215-2354 for coverage details and limitations on other services or view them at UCCI's 'My Dental Benefits' at www.unitedconcordia.com/dental-insurance/member/clients-corner/university-of-virginia/.

Enhanced Dental Schedule of Benefits

Enhanced Dental Program Feature	
Annual Deductible (Applies to primary services and major restorative services)	$50 per person
Annual Maximum (Applies to diagnostic and preventive care, primary services, and major restorative services)	$2,000 per person
Orthodontia Lifetime Maximum	$1,500 per person

Enhanced Dental Services Provided***	In-Network (based on allowable charge)	Out-of-Network* (based on allowable charge)
Diagnostic and Preventive Care*		
Includes: ▪ Routine oral evaluations (2 per calendar year) ▪ Limited oral evaluation (1 per calendar year) ▪ Fluoride treatment (for dependents under age 19, 2 per calendar year) ▪ Dental X-rays (full-mouth or panoramic X-rays once every 3 years, unless approved in advance by TPA) ▪ Bitewing radiographs (2 per calendar year) ▪ Space maintenance for children under age 19 (after loss of a primary molar or permanent first molar; one per tooth, every 3 years) ▪ Biopsies of oral tissues ▪ Sealants (one application for children under age 19, one tooth every 3 years) ▪ Pulp vitality tests (2 per calendar year) ▪ Palliative emergency treatment See "What Is Covered" on page 36 for information about more covered services	Plan pays 100%	You pay 15%; Plan pays 85%

Enhanced Dental Services Provided***	In-Network (based on allowable charge)	Out-of-Network* (based on allowable charge)
Primary Services*		
Includes: ▪ Fillings (1 per tooth in a 12-month period) ▪ Endodontics ▪ Oral surgery ▪ Periodontal care ▪ General anesthesia when medically necessary and administered in connection with oral surgery ▪ Repairs of crowns, inlays, onlays, bridges, and dentures See "What Is Covered" on page 36 for information about more covered services	You pay 20% after annual deductible; Plan pays 80%	You pay 35% after the deductible; Plan pays 65%
Major Restorative Services*		
Includes: ▪ Crowns, inlays, and onlays: installation or replacement ▪ Bridges: installation or replacement (must be more than five years after installation but not more than once in five years) ▪ Dentures (full or partial): installation or replacement ▪ Dental implants: replacement of implant-related crown/prosthetic (limited to one tooth in a five-year period) See "What Is Covered" on page 36 for information about more covered services	You pay 40% after annual deductible; Plan pays 60%	You pay 55% after the deductible; Plan pays 45%
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 if they use non-participating providers in addition to the appropriate coinsurance and this amount may be significant.

** Smile for Health benefits are available for those with a diagnosis of pregnancy, heart disease, stroke, diabetes, and respiratory disease.

***The most commonly used services are included on this schedule. Contact UCCI at 866-215-2354 for coverage details and limitations on other services or view them at UCCI's 'My Dental Benefits' at www.unitedconcordia.com/dental-insurance/member/clients-corner/university-of-virginia/.

Smile for Health® Benefits

General Description*	ADA Code	Procedure Description	Details	Linked Medical/Dental Condition(s)
Diagnostic and Preventive Care	D1110	Routine prophylaxis adult	1 Additional cleaning during pregnancy	Preterm births
Primary Services	D0415	Collection of microorganisms for culture and sensitivity	1 per lifetime	▪ Diabetes ▪ Preterm births ▪ Heart disease
	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 — 4 or more teeth per quadrant	1 per 24 months per area of mouth	▪ Diabetes ▪ Preterm births ▪ Heart disease
	D4342	Periodontal scaling and root planning — 1 to 3 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

General Description*	ADA Code	Procedure Description	Details	Linked Medical/Dental Condition(s)
Major Restorative Services	D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	6 occurrences per 12 months; regardless of tooth number or area of the mouth	▪ Diabetes ▪ Preterm births ▪ Heart disease

* The coverage level listed in the first column determines the amount United Concordia will pay toward the corresponding ADA code/procedure description shown. Please refer to your Schedule of Benefits for the amounts paid by the Plan.

How Dental Coverage Works

This section describes important features of the Plan.

The Provider Network

If you are 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 depends on whether the expense is covered by the Plan and whether you choose an in-network provider in United Concordia's Elite Prime 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 United Concordia's Elite Prime network at https://www.unitedconcordia.com/dental-insurance/member/clients-corner/university-of-virginia/. 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. If your dental care during a calendar year exceeds the Plan's annual maximum for covered services other than orthodontia, if applicable, you are responsible for paying the cost above the annual maximum.

Annual Deductible

The annual deductible is the part of your covered expenses that each covered person pays each calendar year for primary services and major restorative services before the Plan starts to pay benefits. The annual deductible does not apply to diagnostic and preventive 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 Schedule 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.

See "Your UVA Dental Coverage Options" on page 29 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 services;
- Primary services; and
- Major restorative 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, 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, calculate the remaining program maximum dollars at the date of service, and comply with the member's Plan in effect.

What Is Covered

In this section, you will 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 cover the same services and include the same features as described below.

Diagnostic and Preventive Services

Taking care of teeth can prevent serious problems later. With Basic Dental and Enhanced Dental, you are covered at 100% for in-network care for eligible diagnostic and preventive services. You do not need to meet your deductible before the Plan pays benefits.

How the Plan Pays Benefits

	Basic Dental		Enhanced Dental	
	In-Network	*Out-of- Network*	*In-Network*	*Out-of- Network*
Diagnostic and Preventive Services*	Plan pays 100%	You pay 15%; Plan pays 85%	Plan pays 100%	You pay 15%; Plan pays 85%

* You do not need to meet your deductible before the Plan pays benefits. Coinsurance is based on the allowable charge. Participants are responsible for amounts above the allowable charge if they use non-participating providers in addition to the appropriate coinsurance.

Covered Services

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); and
  - 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; and
- Emergency palliative treatment for relief of pain.

Primary Services

Coverage for primary services, which includes fillings, endodontics, and oral surgery, is the same under both Plan options.

How the Plan Pays Benefits

	Basic Dental		Enhanced Dental	
	In-Network	*Out-of- Network*	*In-Network*	*Out-of- Network*
Primary Services*	You pay 20% after meeting your annual deductible: then the Plan pays 80%	You pay 35% after meeting your annual deductible: then the Plan pays 65%	You pay 20% after meeting your annual deductible: then the Plan pays 80%	You pay 35% after meeting your annual deductible: then the Plan pays 65%

* Coinsurance is based on the allowable charge. Participants are responsible for amounts above the allowable charge if they use non-participating providers in addition to the appropriate coinsurance.

Covered 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; and

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

Major Restorative Services

Coverage for major restorative services, which includes crowns, bridges, and dentures, is the same under both Plan options.

How the Plan Pays Benefits

	Basic Dental		Enhanced Dental	
	In-Network	*Out-of- Network*	*In-Network*	*Out-of- Network*
Type C: Major Restorative Services*	You pay 50% after meeting your annual deductible: then the Plan pays 50%	You pay 65% after meeting your annual deductible: then the Plan pays 35%	You pay 40% after meeting your annual deductible: then the Plan pays 60%	You pay 55% after meeting your annual deductible: then the Plan pays 45%

* Coinsurance is based on the allowable charge. Participants are responsible for amounts above the allowable charge if they use non-participating providers in addition to the appropriate coinsurance.

Covered Services

The Plan covers Major Restorative services including:

- Inlays, onlays, and crowns:
  - Installation; and
  - Replacement;
- Bridges:
  - Installation; and
  - Replacement (must be more than five years after installation but not more than once in every five years);
- Dentures:
  - Installation; and
  - Replacement of full denture; and
- Implants. (replacement of implant related crown/prosthetic — one tooth per five years)

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.

Orthodontic Treatment (Enhanced Dental Only)

Orthodontia benefits cover the straightening of teeth with braces or other methods. Coverage for orthodontic treatment is available through Enhanced Dental only and benefits are limited to the lifetime maximum benefit.

How the Plan Pays Benefits

	Enhanced Dental
Orthodontics	You pay 50%; the Plan pays 50%
Lifetime maximum benefit	$1,000 per person

If orthodontia treatment began prior to enrollment, coverage is prorated based on the remaining treatment. The provider should submit a new claim using the member's effective coverage date and include the comprehensive orthodontia treatment plan so the amount of remaining orthodontia work and the prorated maximum can be calculated.

Covered Services

Coverage for orthodontic treatment includes:

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

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 individuals with an additional dental cleaning and periodontal services during pregnancy. Extra oral care during pregnancy helps 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 https://www.unitedconcordia.com/docs/SFH_Flyer.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 UVA Dental Plan.

What Is Not Covered

The Dental Plan does not cover all dental expenses; certain expenses are excluded. The list of excluded expenses in this section is representative, not comprehensive. Just because a type of dental treatment or an expense is not listed here does not mean that the treatment or expense will be covered.

This section and "What Is Covered" on page 36 should be read together to learn more about what is covered and not covered under the plan for certain conditions, procedures, services and supplies.

General Exclusions

The Plan does ***not*** cover charges:

- For cancelled or missed appointments;
- For care, treatment, services, or supplies:
  - Given by an unlicensed provider; or
  - Outside the scope of the provider's license;
- For care, treatment, services, or supplies not prescribed, recommended, or approved by a physician or dentist;
- For claim form completion;
- For drugs, devices, treatments, or procedures that are experimental or investigational, except as described in "What Is Covered" on page 36;
- For services and supplies UCCI determines are not necessary for the diagnosis, care, or treatment of the disease or injury or condition involved — even if they are prescribed, recommended, or approved by a physician or dentist;
- For services given by volunteers or persons who do not normally charge for their services;
- For services and supplies provided as part of treatment or care that is not covered by the Plan;
- For services and supplies provided in school, college, or camp infirmaries;
- For services billed by a resident physician or intern;
- For services, supplies, medical care, or treatment given by members of your immediate family (your spouse, domestic partner, child, stepchild, brother, sister, in-law, parent, or grandparent) or your household;
- Incurred before the date coverage starts or after the date coverage ends;
- In excess of the recognized charge for a service or supply given by an out-of-network provider;

- In excess of the negotiated charge for a given service or supply given by an in-network provider;
- In excess of any annual or lifetime maximums specifically outlined;
- Made only because you have dental coverage or that you are not legally obligated to pay, such as:
  - Care in charitable institutions that normally provide services free of charge; or
  - Care in a hospital or other facility that is owned or operated by any government that normally provides services free of charge;
- Related to employment or self-employment. This includes injuries that arise out of (or in the course of) any work for pay or profit unless there is no other source of coverage or reimbursement available to you;
- Resulting from a felony that you commit or attempt to commit; and
- To have preferred access to a dentist's services, such as boutique or concierge dental practices.

Special Exclusions

In addition, the following exclusions apply to dental services. Payment will not be made for the following dental services:

- 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;
- 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; and
- Services not listed in "What Is Covered" on page 36.

UCCI Dental Claims & Appeals

Upon completion of treatment, a claim form needs to be filed with UCCI. In general, your dentist will file a claim for your in-network care. However, you are responsible for making sure the claim is filed or, if needed, filing a claim for your out-of-network care.

This section describes the steps for claiming benefits under the Plan.

Filing Claims

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 visiting

https://www.unitedconcordia.com/dental-insurance/member/clients-corner/university-of-virginia/. The form has instructions on how, when, and where to file a claim.

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 healthcare 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. 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 Dental Plan

Employer Identification Number (EIN)

54-6001796

Plan Sponsor

The University of Virginia
2420 Old Ivy Road
P.O. Box 400127
Charlottesville, VA 22904-4127
434-243-3344

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 and is also known as the Summary Plan Description for the Plan (this book). Copies of this document are available for your inspection during regular business hours in the office of the Plan Sponsor. You (or your personal representative) may get a copy of these documents by downloading them from the University Human Resource website: https://hr.virginia.edu/ or by written request to the Plan Sponsor, for a nominal charge.

Interpretation of Eligibility Roles

The Plan Sponsor shall have the exclusive right to interpret the meaning of any description of eligibility, enrollment, and payment rules.

Claim Decisions

Claim decisions are made by the Dental Claims Administrator in accordance with the provisions of the Plan. The Dental Claims Administrator has complete authority to review denied claims for benefits under the Plan. This includes, but is not limited to, determining whether treatment is, or is not, medically necessary. The Dental Claims Administrator has discretionary authority to:

- Determine whether, and to what extent, you and your covered dependents are entitled to benefits; and
- Interpret the provisions of the Plan when a question arises.

The Dental Claims Administrator has the right to adopt reasonable policies, procedures, rules, and interpretations of the Plan to promote orderly and efficient administration. The Dental Claims Administrator may not act arbitrarily or capriciously, which would be an abuse of its discretionary authority.

United Concordia Companies, Inc. (UCCI) is the Dental Claims Administrator for the Plan and has discretionary authority to review all denied claims for benefits under the Plan.

The University is responsible for making reports and disclosures, including the creation, distribution, and final content of:

- Summary Plan Descriptions;
- Summary of Material Modifications; and
- Schedule of Benefits.

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, neither active and retired employees will 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 dependents — 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 of privacy practices 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 (PHI). PHI is information that identifies you and relates to your physical or mental health, or the provision or payment of health services for you.

The Plan creates, receives, and maintains your PHI in connection with providing health, dental, prescription drug, and medical flexible spending account benefits to you and your eligible dependents. This Notice of Privacy Practices ("Notice") explains the Plan's privacy practices, your legal rights regarding your PHI, and the Plan's legal obligations under the federal health privacy provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations (collectively, "federal health privacy law").

Under federal health privacy law, the Plan is required to:

- maintain the privacy of your health information;
- provide you with this Notice describing its legal duties and privacy practices regarding your health information;
- comply with the terms of this Notice as currently in effect; and
- notify you of any breaches of your health information as required by federal health privacy or other applicable laws.

This Notice also describes how the Plan may use and disclose your PHI and explains your rights with respect to the PHI maintained by the Plan. For purposes of this Notice, the terms "you" and "your" refer to insured participants and eligible dependents.

This Notice was initially effective as of April 14, 2003, and has been revised effective January 1 of each year through January 1, 2025. This Notice is now updated to include changes required by federal law effective February 16, 2026.

Information Subject to This Notice

This Notice applies to health information that identifies you and that the Plan obtains in connection with administering your health and dental benefits. This includes information obtained from applications, forms you complete, communications with the Plan, and data provided by health care providers, insurers, and third parties.

This Notice **does not** apply to health information created or maintained by the University of Virginia for non-health employee benefits (e.g., disability or life insurance) or for employment purposes, such as job screening/testing or determining eligibility for leave or disability accommodations.

Summary of the Plan's Privacy Practices

The Plan's Use and Disclosure of Your Health Information

Subject to the restrictions described below, the Plan may use and disclose your health information without your written authorization for plan administration, claims processing, and other purposes permitted by law.

Special Protections for Substance Use The Plan is required by law to protect the confidentiality of substance use disorder (SUD) treatment records it receives from programs subject to 42 C.F.R. Part 2 ("Part 2 records"). These records are subject to stricter confidentiality protections than those that apply under HIPAA.

Disorder (SUD) Records (42 C.F.R. Part 2)

Consent Requirement

Unlike standard health information, Part 2 records may not be used or disclosed for treatment, payment, or health care operations without your written consent, except in limited circumstances permitted by law (such as medical emergencies, certain audits, or pursuant to a subpoena or court order).

Use in Legal or Administrative Proceedings

Part 2 records may not be used or disclosed in any civil, criminal, administrative, or legislative proceeding against you unless:

- You provide written consent; or
- A court order authorizes the disclosure after notice and an opportunity to be heard and meets applicable regulatory requirements.

Prohibition on Onward Disclosure

The Plan prohibits onward disclosure of Part 2–protected records unless expressly authorized by you or permitted by law.

Redisclosure Notice

Information disclosed by the Plan may be redisclosed by the recipient and may no longer be protected by HIPAA. However, if the information is protected by 42 C.F.R. Part 2, the recipient is prohibited from redisclosing it without your consent or unless otherwise authorized by law.

Fundraising Communications

If the Plan uses or discloses Protected Health Information, including Part 2 records, for fundraising purposes, you will be provided with a clear and conspicuous opportunity to opt out of receiving future fundraising communications.

Your Rights Related to Your Health Information

You have the right to:

- Inspect and copy your PHI;
- Request amendment if you believe your PHI is incorrect or incomplete;
- Request an accounting of certain disclosures of your PHI;

- Request restrictions on uses and disclosures of your PHI;
- Request confidential communications of your PHI;
- File a complaint with the Plan or the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated;
- Receive a paper copy of this Notice.

These rights are described in detail below.

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

Treatment: The Plan may disclose PHI to assist a health care provider in treating you.
Payment: The Plan may use and disclose PHI to determine coverage and to process claims.
Health Care Operations: The Plan may use and disclose PHI for business planning, auditing, and organizational functions.

Note on Genetic Information: The Plan will not use or disclose genetic information for underwriting purposes, in accordance with the Genetic Information Nondiscrimination Act (GINA). Under GINA, genetic test results and family medical history cannot be used to determine eligibility, set premiums, or make any underwriting decisions related to your health coverage.

Uses and Disclosures to Business Associates and to the Plan Sponsor

The Plan may disclose PHI to third parties that assist with Plan functions under contract. The Plan may also disclose PHI to the Plan Sponsor (the University of Virginia) for plan administration, as permitted by law and after certifications of privacy protections are in place.

Other Permitted Uses and Disclosures

The Plan may disclose PHI when required by law or for public health, law enforcement, military and veterans' activities, workers' compensation, emergencies, involuntary disclosures to involved family or friends, personal representatives, research, organ donation, and disclosures of deceased individuals' PHI, subject to applicable law.

Fundraising and Marketing: The Plan does not use PHI for fundraising or marketing and does not sell PHI.

Any Other Uses and Disclosures Require Your Express Written Authorization

Any uses or disclosures of your health information not described above, or not otherwise permitted by federal health privacy law, will be made only with your express written authorization. In addition, most uses and disclosures of psychotherapy notes (where applicable) require your written authorization.

You may revoke your authorization at any time by submitting a written request. If you revoke your authorization, the Plan will no longer use or disclose your health information based on that authorization, except to the extent that the Plan has already relied on it.

Once your health information is disclosed pursuant to your authorization, the protections of federal health privacy law may no longer apply. As a result, the information may be re-disclosed by the recipient without your or the Plan's knowledge or further authorization.

Your Health Information Rights

Right to Inspect, Copy, and Amend PHI

You have the right to inspect and obtain copies of PHI maintained by the Plan and to request amendments. Copying cost and mailing fees may apply.

Right to Accounting of Disclosures

You may request a written accounting of certain Plan disclosures of your PHI for a period up to six years prior to the date of your request.

Right to Request Restrictions and Confidential Communications

You may request limits on certain uses and disclosures of PHI and request alternative means or locations for disclosures.

Right to File a Complaint

To file a complaint with the Plan, or to the Secretary of HHS, contact the Privacy Officer.

Right to a Paper Copy of This Notice

You may request a paper copy of this Notice at any time.

Changes in the Plan's Privacy Policies

The Plan reserves the right to change its privacy practices and revise this Notice. Any material changes to the Notice will be prominently posted on our website (www.hr.virginia.edu) within 60 days of the revision**,** and at the next annual mailing. Copies of the revised Notice will be available upon written request.

Contact Information

If you have any questions regarding this Notice or wish to exercise your privacy rights, contact:

UVA Health Plan Privacy Officer
2420 Old Ivy Road
P.O. Box 400127
Charlottesville, VA 22903
(434) 924-4346

Protected Health Information

This section describes the administrative procedures used to implement the commitment of the 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.

Section 1.1 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 healthcare treatment, Payment for healthcare, and Health Care Operations.

a. "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:

   1. Quality assessment;
   2. Population-based activities relating to improving health or reducing healthcare costs, protocol development, case management and care coordination, disease management, or contacting healthcare providers and patients with information about treatment alternatives and related functions;
   3. Rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;
   4. 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 healthcare claims (including stop-loss insurance and excess of loss insurance);
   5. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
   6. 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;
   7. 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 "healthcare operation" activity pursuant to 45 CFR § 164.501.

b. "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 healthcare is provided. These activities include, but are not limited to, the following:

   1. 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);
   2. Coordination of benefits;
   3. Adjudication of health benefit claims (including appeals and other payment disputes);
   4. Subrogation of health benefit claims;
   5. Establishing Eligible Employee contributions;

6. Risk adjusting amounts due based on an Eligible Employee's health status and demographic characteristics;
7. Billing, collection activities and related healthcare data processing;
8. Claims management and related healthcare data processing including auditing payments, investigating and resolving payment disputes, and responding to an Eligible Employee's inquiries about payments;
9. Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
10. Medical necessity reviews or reviews of appropriateness of care or justification of charges;
11. Utilization review, including precertification, preauthorization, concurrent review, and retrospective review;
12. 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);
13. Reimbursement to the Plan; and
14. Any other activity considered to be a "payment" activity pursuant to 45 CFR§ 164.501.

Section 1.2 Disclosures by Plan to the Employer

The Plan may:

a. 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:
   1. 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
   2. 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.

b. 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.

c. 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.

d. 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.

e. 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.

f. 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.

g. 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.

Section 1.3 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.

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.

Section 1.5 Conditions Agreed to by the Employer

The Employer agrees to:

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

b. 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.

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

d. 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.

e. 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.

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

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

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

i. 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.

j. 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).

k. 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.

l. 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.

Section 1.6 Adequate Separation Between the Plan and the Employer

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.

Section 1.7 Limitations of Access and Disclosure

The persons described in Section 1.6 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.

Section 1.8 Noncompliance

If the persons or classes of persons described in Section 1.6 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.

Section 1.9 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:

a. "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).

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

c. "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 healthcare provider, a health plan, or a healthcare clearinghouse, and (iii) relates to the past, present, or future physical or mental health or condition of an Individual; the provision of healthcare to an Individual; or the past, present, or future Payment for the provision of healthcare 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.

d. "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.

e. "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).