
**PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR**

**THE UNIVERSITY OF ARKANSAS
DENTAL BENEFIT PLAN**

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INTRODUCTION

The purpose of this document is to provide the Employee and their Covered Dependents, if any, with summary information on benefits available under the UNIVERSITY OF ARKANSAS DENTAL BENEFIT Plan (The "Plan") as well as information on a Covered Person's rights and obligations under the Plan. As a valued Employee of UNIVERSITY OF ARKANSAS SYSTEM, we are pleased to sponsor this Plan to provide benefits that can help meet the Covered Person's dental care needs. Please read this document carefully and contact the Human Resources or Personnel office if there are any questions.

No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain other expenses. This document provides information on the benefits and limitations of the Plan and will serve as the Summary Plan Description and Plan document. Therefore, it will be referred to as both the Summary Plan Description ("SPD") and Plan Document.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, exclusions, limitations, definitions, eligibility and the like.

To the extent that an item or service is a covered benefit under the Plan, the terms of the Plan shall be applied in a manner that does not discriminate against a health care Provider who is acting within the scope of the Provider's license or other required credentials under applicable State law. This provision does not preclude the Plan from setting limits on benefits, including cost sharing provisions, frequency limits, or restrictions on the methods or settings in which treatments are provided and does not require the Plan to accept all types of Providers as a Contracting Dentist.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. The University is transitioning into a uniform on-line employee benefits enrollment system. In this document there are references to completing enrollment applications, enrollment forms, dependent change forms and similar paper processes which may be administered differently at each campus during this transition period. Please contact the campus Human Resources Office for current procedures specific to this request. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

Dental care has become an increasingly common and expensive medical cost in recent years. Yet, dental health can be maintained easily through regular, routine care. Therefore, in addition to reimbursement for much of the cost of major procedures, the Plan encourages preventive and restorative dental care in order to avoid future, more costly major dental expenses.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Defined Terms. Defines those Plan terms that have a specific meaning.

Claim Provisions. Explains the rules for filing claims.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

Continuation Coverage Rights Under COBRA. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees. All Active Employees, who qualify under one of the classes below, and Retired Employees.

- (1) **Eligible Employee:** An Employee is Eligible if he or she is full time Employee of the University or of a designated affiliated entity operating exclusively for the benefit of the University. A full time Employee is any Employee who is employed half-time or greater and is on at least a nine month appointment period. However, for purposes of this Plan "Eligible Employees" shall also include Residents, Interns and house staff members at the University of Arkansas for Medical Sciences.

Coverage becomes effective on the first day of the month following the date of employment as an Eligible Employee, subject to completion of enrollment requirements. If the hire date is the first day of the month and election is made prior to or on the hire date, coverage is effective on the hire date.

- (2) **Retired Employee:** An eligible Retiree is:
- (a) an Employee who retires while covered under the Plan and on the date of retirement has age and continuous years of service with the UA equal to at least a total of 70 and immediately prior to retirement has completed 10 or more consecutive years of continuous coverage under the Plan; or,
 - (b) an eligible employee who retires while covered under the Plan and on the date of retirement is age 65 or older and immediately prior to retirement completed five or more consecutive years of service with the UA and has five or more consecutive years of continuous coverage under the Plan; or,
 - (c) has retired under an early retirement agreement approved by the Board of Trustees of the University of Arkansas.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

- (1) A covered Employee's Spouse.

The term "Spouse" shall mean the person with whom the covered Employee has established a valid marriage under applicable State law but does not include common law marriages. The term "Spouse" shall include an individual of the same sex as the Covered Employee, if they were legally married under the laws of a State or other foreign or domestic jurisdiction. The Plan Administrator may require documentation proving a legal marital relationship.

- (2) A covered Employee's Child(ren).

An Employee's "child" includes a natural child, adopted child, or a child placed with the Employee for adoption, stepchild, foster child, and children for whom the Employee is a Legal Guardian.

To be eligible for Dependent coverage under the Plan, a natural child, adopted child, or child placed with the Employee for adoption, or stepchild must be under the limiting age of 26. A foster child or a child for whom the Employee is a Legal Guardian must be under the limiting age of 18 to be eligible for Dependent coverage under the Plan. Coverage will end on the last day of the child's birthday month.

The phrase "placed for adoption" refers to a child whom a person intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

The Plan Administrator may require documentation proving eligibility for Dependent coverage, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

- (3) A covered Dependent Child who reaches the limiting age and is Totally Disabled, unmarried incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance, and unmarried. The Plan Administrator may require, at reasonable intervals, continuing proof of the Total Disability and dependency.

The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's or Retiree's home, but who are not eligible as defined; the divorced former Spouse of the Employee or Retiree; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee or Retiree.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for all amounts applied to maximums.

If both parents are Employees, their eligible Dependent will be covered as the Dependent of one or the other, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a Child qualifies or continues to qualify as a Dependent as defined by this Plan.

FUNDING

Cost of the Plan. The University of Arkansas System shares the cost of Employee and Dependent coverage under this Plan with the covered Employee. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be completed in a manner set forth by the Plan Administrator.

The level of any Employee contributions are authorized by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by completing the electronic enrollment process. In this document there are references to completing enrollment applications, enrollment forms, dependent change forms and similar paper processes which may be administered differently at each campus during this transition period. Please contact the campus Human Resources Office for current procedures specific to this request. The covered Employee is required to enroll each Dependent for coverage also.

TIMELY OR LATE ENROLLMENT

- (1) **Timely Enrollment** - The enrollment will be "timely" if the completed electronic form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage.

If two Employees who are covered under the Plan are the parents of children who are covered under the Plan, and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

- (2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis."

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or herself, or his or her dependents (including his or her spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 31 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption, or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 31 days of the birth, marriage, adoption, or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator, University of Arkansas System, 2404 North University Avenue, Little Rock, Arkansas, 72207.

SPECIAL ENROLLMENT PERIODS

The events described below may create a right to enroll in the Plan under a Special Enrollment Period.

- (1) **Losing other coverage may create a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if the individual loses eligibility for other coverage and the loss of eligibility for coverage meets all of the following conditions:
 - (a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
 - (b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
 - (c) Either (i) the other coverage was COBRA coverage and the COBRA coverage was exhausted, or (ii) the other coverage was not COBRA coverage, and the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were

terminated. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment electronic form is received.

- (d) The Employee or Dependent requests enrollment in this Plan no later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment electronic form is received.

(2) For purposes of these rules, a loss of eligibility occurs if one of the following occurs:

- (a) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (for example: part-time employees).
- (b) The Employee or Dependent has a loss of eligibility as a result of divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment, or contributions towards the coverage were terminated.
- (d) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement in the individual or group market, that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions, or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(3) Acquiring a newly eligible Dependent may create a Special Enrollment right. If:

- (a) The Employee is a participant under this Plan (or is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and
- (b) A person becomes a Dependent of the Employee through marriage, birth, adoption, or placement for adoption, then the Dependent may be enrolled under this Plan. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

The Special Enrollment Period for newly eligible Dependents is a period of 31 days that begins after the date of the marriage, birth, adoption, or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 31-day period.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

- (a) In the case of marriage, the first day of the month following marriage;
- (b) In the case of a Dependent's birth, as of the date of birth; or
- (c) In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(4) **Eligibility changes in Medicaid or State Child Health Insurance Programs may create a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if:

- (a) The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan (CHIP) under Title XXI of such Act, and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage, and the Employee or Dependent requests enrollment in this Plan within 60 days after such Medicaid or CHIP coverage is terminated.
- (b) The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee or Dependent requests enrollment in this Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

If a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

Coverage will become effective as of the first day of the first calendar month following the date the completed enrollment form is received unless an earlier date is established by the Employer or by regulation.

EFFECTIVE DATE

Active Employee Requirement. An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

The Employer or Plan has the right to rescind any coverage of the Employee and/or Retiree and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Retirees and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Retiree's and/or Dependent's paid contributions.

When Employee Coverage Terminates. Employee coverage will terminate at midnight on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

- (1) The date the Plan ceases; or
- (2) The date the Plan ceases for the Class of Employees to which a Covered Person belongs; or
- (3) The date active employment ceases, except as provided by the Plan; or

- (4) The date ending the period for which the last contribution is made, if a Covered Person is required to pay all or part of the cost of the Plan; or
- (5) In the event that a Covered Person terminates employment before the end of the payroll cycle, coverage will end on the date employment is terminated; or,
- (6) The date a Covered Person ceases to be eligible for coverage under the Plan.
- (7) If an Employee commits fraud, makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage.

Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff. A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff. This continuance will end as follows:

For disability leave only: An Employee can remain on the Plan as an Employee on unpaid leave of absence until employment terminates. The Employee is responsible for paying their contribution to the cost of Plan coverage while on disability leave. If the coverage of an Employee on disability leave terminates due to non-payment of the required contribution, and the Employee is reinstated or rehired at a later date, they will not be subject to a Waiting Period.

For leave of absence or layoff only: An Employee can remain on the Plan until the end of the maximum time period defined in Board policy provided Employee premium payments are made in the required amounts within the required timeframes.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person. Any continuance will run concurrently with leave taken under the Family and Medical Leave Act.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements to the extent permitted by the terms of the Plan and applicable law.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

- (1) The maximum period of coverage of a person and the person's covered Dependents under such an election shall be the lesser of:
 - (a) The 24 month period beginning on the date on which the person's absence begins; or
 - (b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.
- (2) A person who elects to continue dental coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for 31 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
- (3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator University of Arkansas System, 2404 North University Avenue, Little Rock, Arkansas, 72207, 1-501-686-2500. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent, not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

- (1) The date the Plan or Dependent coverage under the Plan ceases.
- (2) The date the Plan ceases for the Class of Employees to which a Covered Person belongs; or
- (3) The date that the Employee's coverage under the Plan ceases, except as provided by the Plan; or
- (4) The date a covered Spouse loses coverage due to loss of eligibility status.
- (5) The date a covered Child ceases to meet the applicable eligibility requirements.
- (6) The date ending the period for which the last contribution is made, if a Covered Person is required to pay all or part of the cost of the Plan; or
- (7) If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage.

OPEN ENROLLMENT

During the annual open enrollment period, eligible Employees and their Eligible Dependents who are late Enrollees will be able to enroll in the Plan.

An Open Enrollment will only be extended to Active Employees. A Retired Employees is not eligible to enroll in the Plan as a Late Enrollee or add dependents outside of a Special Enrollment event or a change in family status.

Benefit choices made by Active Employees during the open enrollment period will become effective January 1 and remain in effect until the next January 1, unless there is a Special Enrollment event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverages.

SCHEDULE OF BENEFITS

DENTAL BENEFITS

Dental Benefits are available to Employees and their Covered Dependents who elect Dental Benefits coverage.

All benefits described in this Schedule are subject to the Claims Administrator’s permissible Charges, and the benefit limits and exclusions described more fully herein including, but not limited to the determination that: care and treatment is Dentally Necessary; that services, supplies and care are not Experimental and/or Investigational. Some of the terms used in this document begin with a capital letter, even though the term normally would not be capitalized. These terms have special meaning under the Plan. Most terms will be listed in the Defined Terms section but some terms are defined within the provision where the term is used. Becoming familiar with the Defined Terms section will help to better understand the provisions of this Plan. Individuals covered under this Plan will be receiving an identification card to present to the Provider whenever services are received. On the back of this card are phone numbers to call in case of questions or problems.

A list of Contracting Dentists are available on the web at www.uasdental.blueadvantagearkansas.com.

Calendar Year Deductible

The deductible is an amount of dental charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year, a Covered Person must meet the deductible.

Per person.....	\$50
Per Family Unit.....	\$100

Deductible accumulation.

In-Network and Out-of-Network charges contribute to the Calendar Year Deductible.

The deductible applies to these Classes of Service:

- Class B Services - Basic
- Class C Services - Major

Rollover Benefit

- Carryover Benefit: \$375
- Claims Threshold: Less than \$750
- Carryover Benefit Maximum: \$1,500

Dental Percentage Payable

Class A Services – Preventive

In-Network reimbursement rate	100%, deductible waived
Out-of-Network reimbursement rate	90%, deductible waived

Class B Services – Basic Restorative

In-Network reimbursement rate	80%, after deductible
Out-of-Network reimbursement rate	72%, after deductible

Class C Services – Major Restorative

In-Network reimbursement rate	50%, after deductible
Out-of-Network reimbursement rate	45%, after deductible

Class D Services - Orthodontia

In-Network reimbursement rate50%, deductible waived
Out-of-Network reimbursement rate40%, deductible waived

Calendar Year Aggregate Maximum

For Class A, B, and C Services:

Per person, per Calendar Year.....\$1,750

Lifetime Orthodontic Maximum

For Class D-Orthodontia:

Lifetime maximum, per person\$2,000

- Coverage limited to dependent children up to age 18.

COVERED SERVICES

Coverage Class A – Diagnostic and Preventative Services

- (1) Routine periodic examinations not more than twice in any benefit period, inclusive of an initial oral examination.
- (2) Bitewing and periapical X-rays as required.
- (3) Full-mouth X-rays once in any three year period.
- (4) Prophylaxis (cleaning). ***Please see information on Dental Xtra.**
- (5) Topical application of fluoride once per benefit period for dependent children to age 19.
- (6) Sealants once per tooth on permanent maxillary and mandibular first and second molars with no caries (decay) on the occlusal surface, for dependent children to age 19.

Coverage Class B – Basic Restorative Services

- (1) Minor emergency treatment for the relief of pain as needed by the participant.
- (2) Amalgam (silver) and composite/resin (white) fillings.
- (3) Endodontics, including pulpal therapy and root canal filling.
- (4) Simple and surgical extractions.
- (5) Oral surgery, including pre- and post-operative care and surgical extractions, except TMJ surgery.
- (6) Space maintainers for prematurely lost teeth of eligible dependent children 16 years of age and under.
- (7) Stainless steel crowns used as a restoration to natural teeth for dependent children to age 16 when the teeth cannot be restored with a filling material.
- (8) Surgical periodontics.
- (9) Non-surgical periodontics.

- (10) Periodontal maintenance; two per benefit period following active periodontal treatment. ***Please see information on Dental Xtra.**
- (11) Antibiotic injections when given by the Dentist.

Coverage Class C – Major Restorative Services

- (1) Crowns, inlays, onlays, and veneers for the treatment of visible decay and fractures of tooth structure when teeth are so badly damaged, they cannot be restored with amalgam or composite restorations.
- (2) Prosthodontics, including procedures for construction of fixed bridges, partial or complete dentures, and repair of fixed bridges.
- (3) Complete or partial denture relines, including chair side or laboratory procedures, to improve the fit of the appliance to the tissue.
- (4) Complete or partial denture rebase, including laboratory replacement of the acrylic base of the appliance.
- (5) Addition of teeth to an existing fixed bridge, partial or full denture.
- (6) Periodontal splinting for the stabilization of mobile teeth.
- (7) Repairs and recementing of crowns, inlays, bridgework or dentures.
- (8) Endosteal Implants

Coverage Class D – Orthodontia Services

Orthodontic Services and Payment Procedure. The normal payment procedure for orthodontic claims is a 25% down payment of the allowable or lifetime maximum (whichever is less) and the remainder is paid out (prorated) over the number of months in the Treatment Plan. Once the Treatment Plan is submitted and the treatment begins, the monthly payment will automatically be reimbursed. All covered services are subject to the orthodontic Lifetime maximum as listed in the Schedule of Benefits. Coverage is limited to Covered Persons to age 18.

DENTAL XTRA

Dental Xtra is a program that provides additional dental benefits for Covered Persons with one or more of the following conditions: diabetes, chronic obstructive pulmonary disease, end stage renal disease, metabolic syndrome, coronary artery disease, stroke, pregnancy, oral cancer, and Sjogren's Syndrome. For Covered Persons with oral cancer, these benefits are available when there has been a previous diagnosis of oral cancer. For pregnancy, enrollment in the Dental Xtra program terminates on the reported expected delivery date, which is provided at time of enrollment. Periodontal maintenance and scaling is available (as needed) for plans that offer periodontal benefits, see the Schedule of Benefits. Covered services are not subject to the deductible. Benefits paid do not count towards the Calendar Year Aggregate Maximum and continue to be covered services under Dental Xtra once the Calendar Year Aggregate Maximum has been reached. Coinsurance does not apply to covered services, when billed by a PPO Dentist or Contracting Dentist. Covered services billed by a Non-Contracting Dentist, are subject to coinsurance as listed in the Schedule of Benefits. To receive benefits under Dental Xtra, a Covered Person must qualify and enroll into the program. More information about enrollment and the benefits for Dental Xtra, is available on the web at www.uasdental.blueadvantagearkansas.com.

Dental Xtra	Prophylaxis (Cleanings) or Periodontal Maintenance Visit Every 3 Months	Periodontal Scaling* Every 24 Months	Pre-diagnostic Oral Cancer Screening Every 6 Months	Fluoride Treatment Every 3 Months
Diabetes	X	X		
Chronic Obstructive pulmonary disease	X	X		
End-stage renal disease	X	X		
Metabolic syndrome	X	X		
Coronary Artery Disease	X	X		
Stroke	X	X		
Pregnancy	X	X		
Oral Cancer**	X		X	X
Sjogren's Syndrome**	X		X	X
*Periodontal maintenance and scaling are available (as needed) with plans that offer periodontal benefits. See the Schedule of Benefits.				
**This benefit is available for members who have previously been diagnosed with oral cancer or for members who have been diagnosed with Sjogren's Syndrome.				

LIMITATIONS AND EXCLUSIONS

Diagnostic and Preventive Benefits	
Diagnostic	Routine periodic and specialty examinations not more than twice in any benefit period. This is inclusive of an initial oral examination.
	Bitewing and periapical X-rays as required.
	Full-mouth X-rays once in any three year period.
Preventive	Prophylaxis (cleaning) not more than twice in any benefit period.
	Topical application of fluoride once per benefit period.
	Sealants once per tooth.

LIMITATIONS AND EXCLUSIONS ON DIAGNOSTIC AND PREVENTIVE BENEFITS

- (1) The Plan will pay for two oral examinations and cleanings in benefit period.
- (2) The Plan will pay for full mouth x-rays once within three years. A combination of periapical and bitewing x-rays (ten or more films) or a panoramic film and additional x-rays make up a full mouth series.
- (3) A sealant is a benefit only on the unrestored, decay-free chewing surface (occlusal surface) of the maxillary (upper) and mandibular (lower) first and second molars. Sealants are a benefit for dependent children to age 19. Sealants are payable once per tooth.
- (4) Preventative control programs (oral hygiene instructions, carries susceptibility tests, dietary control, tobacco counseling, etc.) are not a benefit.
- (5) The Plan will pay for one topical application of fluoride in a benefit period for dependent children to age 19. Fluoride rinses or self-applied fluorides are not a benefit.
- (6) The Plan will not pay for adult cleanings for Covered Persons to age 14.
- (7) Pulp vitality tests are payable per visit, not per tooth, and only for the diagnosis of emergency conditions.
- (8) See the General Limitations and Exclusions Section for more restrictions which apply to Diagnostic and Preventive Benefits.

Basic Restorative Benefits	
Palliative Emergency treatment	Minor emergency treatment for the relief of pain as needed by the Covered Person.
Fillings	Amalgam (silver) and composite/resin (white) fillings.
Endodontics	Includes pulpal therapy and root canal filling.
Non-Surgical Periodontics	Includes treatment for the disease of the gums and bone supporting the teeth.
Extractions	Simple and surgical extractions.
Oral Surgery	Oral surgery, including pre- and post-operative care, except TMJ surgery.
Space Maintainers	For prematurely lost teeth of eligible DEPENDENT children to age 16.
Stainless Steel Crowns	Used as a restoration to natural teeth for DEPENDENT children to age 16 when the teeth cannot be restored with a filling material.
Surgical Periodontics	Includes surgical procedures for the disease of the gums and bone supporting the teeth.

LIMITATIONS AND EXCLUSIONS ON BASIC RESTORATIVE BENEFITS

- (1) Palliative treatment is payable on a per visit basis, once on the same date.
- (2) Fillings are allowed once per surface per tooth in a 12 month period. This is allowed irrespective of the number of combinations of procedures requested or performed.
- (3) Payment for root canal treatment includes charges for temporary restorations. Root canal treatment is limited to once in a lifetime, per tooth, by the same Dentist or dental office. Retreatment of root canal by the same Dentist or dental office will be considered after 24 months have lapsed since initial treatment. Root canals on deciduous teeth are not a benefit unless there is no permanent successor. Pulpal therapy is limited to primary teeth and therapeutic pulpotomy is limited to primary teeth once in a lifetime.
- (4) Non-surgical periodontics will not be provided more often than once in a 24 month period per quadrant.
- (5) Periodontal maintenance is a benefit after three months following active periodontal treatment.
- (6) Extractions, surgical extractions, root removal, alveoplasty, surgical exposure of impacted or unerupted tooth, tooth reimplantation and/or stabilization, transseptal fiberotomy, and oroantral fistula closure are limited to once per lifetime.
- (7) Charges for general anesthesia/intravenous sedation are not covered except when administered in conjunction with covered oral surgery, excluding single tooth extractions (ADA procedure code 7140) and for children to age three.
- (8) Analgesia, anxiolysis, therapeutic drug injection, other drugs and/or medicines, and desensitizing medicines are not covered.

- (9) Composite resin crowns are not a benefit on primary teeth. A stainless steel crown allowance will be made, with any fee difference the responsibility of the patient.
- (10) A space maintainer is a benefit when used to replace prematurely lost or extracted teeth for children to age 16, limited to once in a 60 consecutive month period. Recementation of a space maintainer is limited to once in five years (sixty consecutive months). Recementation of a space maintainer within six months of the seating date is part of the original procedure. A space maintainer is not considered an orthodontic appliance.
- (11) The Plan will not pay for the replacement of a stainless steel crown within a 60 month period of the initial placement.
- (12) See the General Limitations and Exclusions Section for more restrictions which apply to Basic Restorative Benefits.
- (13) Payment for periodontal surgery shall include charges for three months' post-operative care and any surgical re-entry for a three consecutive year period. Root planing, curettage, and osseous surgery are not a benefit for participant(s) to age 14.

Major Restorative Benefits	
Crowns, Inlays, Onlays, and Veneers	Crowns, inlays, onlays, and veneers are Benefits for the treatment of visible decay and fractures of tooth structure when teeth are so badly damaged, they cannot be restored with amalgam or composite restorations.
Prosthodontics	Procedures for construction of fixed bridges, partial or complete dentures, and repair of fixed bridges.
Complete or Partial Denture Reline	Chair side or laboratory procedure to improve the fit of the appliance to the tissue (gums).
Complete or Partial Denture Rebase	Laboratory replacement of the acrylic base of the appliance.
Endosteal Implants	Endosteal implants are covered once in a lifetime per tooth.

LIMITATIONS AND EXCLUSIONS ON MAJOR RESTORATIVE BENEFITS

- (1) The Plan will not pay to replace any crowns, inlays, onlays, or veneers received in the previous five years (60 consecutive months). Payment for crowns, inlays, onlays, and veneers shall include charges for preparations of tooth, gingival, and impression.
- (2) The Plan will not pay for a crown, inlay, onlay, or veneer on a tooth that can be restored with an amalgam or composite restoration.
- (3) Porcelain/ceramic or cast crowns for children to age 12 are not covered.
- (4) Crown repair is limited to once in a two consecutive year period on the same tooth. Crown and fixed partial denture recement is limited to once in 12 consecutive months per tooth. Repairs for bridges and full and partial dentures are limited to once in a five consecutive year period.
- (5) Procedures for purely cosmetic reasons are not covered.

- (6) The Plan will not pay to replace any fixed bridges or partial or complete dentures that the participant received in the previous five years, except where the loss of additional teeth requires the construction of a new appliance.
- (7) The Plan will not pay to replace a bridge or denture unless it cannot be made satisfactory.
- (8) Recementation of a bridge within six months of the seating date is part of the original procedure.
- (9) Payment for a partial or complete denture shall include charges for any necessary adjustment within a six month period.
- (10) Payment for a reline or rebase of a partial or complete denture is limited to once in a three year period. Adjustments made within the first six months after delivery are not covered. Adjustments after the post six month delivery period are limited to not more than twice in any 12 consecutive month period.
- (11) A posterior fixed partial denture and a removable partial denture in the same dental arch is not covered. The benefit is limited to the allowance for the partial, removable denture.
- (12) Adjustments to complete or partial dentures are limited to two adjustments per denture per 12 months after six months have elapsed since initial placement.
- (13) The Plan limits payment for standard dentures to the maximum allowable fee for a standard partial or complete denture. A standard denture means a removable appliance to replace missing natural, permanent teeth. A standard denture is made by conventional means from acceptable materials. If a denture is constructed by specialized techniques and the fee is higher than the fee allowable for a standard denture, the patient is responsible for the difference.
- (14) The Plan does not pay for fixed bridges or full or partial dentures for children to age 16.
- (15) A fixed bridge where a partial denture is constructed in the same arch is not a covered benefit.
- (16) Fixed partial denture retainers are a benefit once in any five consecutive month period.
- (17) Temporary and provisional crowns and partial dentures are not a benefit.
- (18) Procedures for purely cosmetic reasons are not covered.
- (19) Tissue conditioning is limited to two in a three consecutive year period. Tissue conditioning is not a benefit if performed on the same day a denture is delivered or a reline/rebase is provided.
- (20) Endosteal implants are covered once in a lifetime per tooth.
- (21) The implant abutment to support a crown is covered once in any five consecutive year period.
- (22) An implant or abutment supported crown is covered once in any five consecutive year period.
- (23) An implant or abutment supported retainer is covered once in any five consecutive year period.
- (24) Implant maintenance procedure is covered once in any 12 consecutive months.
- (25) Repair of an implant supported prosthesis or implant abutment is covered once in any five consecutive year period.
- (26) Re-cementation of implant/abutment supported crown or fixed partial denture is covered once in any 12 consecutive month period after six months have elapsed since initial placement.

- (27) See the General Limitations and Exclusions Section for more restrictions which apply to Major Restorative Benefits.

EXCLUSIONS FOR ALL BENEFITS

The Claims Administrator will only pay the Benefits stated for each type of dental service set out in the Schedule of Benefits. **Not all dental services are Benefits under this Plan.** Benefits will only be provided for Covered Persons who are enrolled on the date of treatment. Benefits will be determined based on the date services were rendered. Services must be provided by a Dentist or properly licensed employee of the Dentist. Services must be necessary and customary. Services must be provided following generally accepted dental practice standards as determined by the dental profession to be a paid benefit. The Claims Administrator will pay allowable Benefits based upon the percentages and subject to the Annual Maximum Benefit as stated on the Schedule of Benefits. Such percentages will be applied to the lesser of the Maximum Plan Allowance or the fees the Dentist charges for the service. **The maximum payment for Non-Participating Dentists will be 10% less than to a Participating Dentist.** Payments for covered services performed by Non-Participating Dentists will be sent to the patient(s). Non-Participating Dentists may balance-bill patients for the difference of their charges and the Claims Administrator's payment; Participating Dentists shall not balance-bill patients for charges exceeding the MPA for covered Benefits under this Plan.

OPTIONAL SERVICES

- (1) Services that are more expensive than the treatment usually provided under accepted dental practice standards are called optional services. Optional services also include the use of specialized techniques instead of standard procedures. Benefits for optional services will be based on and paid the same as the usual service. The Covered Person will be responsible for the remainder of the Dentist's fee.
- (2) Payment made by the Claims Administrator for any surgical service will include charges for routine, post-operative evaluations or visits.
- (3) If a Covered Person transfers from one Dentist to another during the course of treatment, Benefits will be limited to the amount that would have been paid if one Dentist rendered the service.

EXCLUSIONS

The following dental services are not eligible under this Plan:

- (1) Benefits or services for injuries or conditions covered under Worker's Compensation or Employer's Liability laws. Benefits or services available from any federal or state government agency; municipality, county, other political subdivision; or community agency; or from any foundation or similar entity.
- (2) Charges for services or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared.
- (3) Charges for services or supplies for which no charge is made that the patient is legally obligated to pay. Charges for which no charge would be made in the absence of dental coverage.
- (4) Charges for treatment by someone other than a Dentist, except that a licensed hygienist may perform services in accordance with applicable law. Services must be under the supervision and guidance of the Dentist in accordance with generally accepted dental standards.
- (5) Charges for the completion of forms and/or submission of supportive documentation required by the Claims Administrator for a benefit determination. A charge for these services is not to be made to a patient by a Participating Dentist.
- (6) Benefits to correct congenital or developmental malformations.
- (7) Services for the purpose of improving appearance when form and function are satisfactory, and there is insufficient pathological condition evident to warrant the treatment (cosmetic Dentistry).

- (8) Benefits for services or appliances started prior to the date the Covered Person became eligible under this Plan, including, but not limited to, restorations, prosthodontics, and orthodontics.
- (9) Services with respect to diagnosis and treatment of disturbances of the temporomandibular joint (TMJ).
- (10) Services for increasing the vertical dimension or for restoring tooth structure lost by attrition, for rebuilding or maintaining occlusal services, or for stabilizing the teeth.
- (11) Experimental and/or investigational services, supplies, care, and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered. The Claims Administrator must make an independent evaluation of the experimental or non-experimental standings of specific technologies. The Claims Administrator's decision will be final and binding on the Plan. Drugs are considered experimental if they are not commercially available for purchase and/or are not approved by the Food and Drug Administration for general use.
- (12) Charges for replacement of lost, missing, or stolen appliances/devices.
- (13) Charges for services when a Claim is received for payment more than 12 months after services are rendered.
- (14) Charges for complete occlusal adjustments, occlusal guards, occlusion analysis, enamel microabrasion, odontoplasty, bleaching, and athletic mouthguards.
- (15) Specialized techniques that entail procedure and process over and above that which is normally adequate. Any additional fee is the patient's responsibility.
- (16) Behavior management.
- (17) Removable appliances for control of harmful habits, including but not limited to tongue thrust appliances.
- (18) Analgesia, anxiolysis, therapeutic drug injection, other drugs and/or medicines, and desensitizing medicines are not covered. Charges for general anesthesia/intravenous sedation are not covered except when administered in conjunction with covered oral surgery excluding single tooth extractions (ADA procedure code 7140) and for children three and under.
- (19) Procedures that do not comply with the Claims Administrator's Claims procedures.
- (20) Charges for precision attachments, provisional splinting, desensitizing medicines, home care medicines, premedications, stress breakers, coping, office visits during or after regularly scheduled hours, case presentations, and hospital-related services.
- (21) All other benefits and services not specifically covered in the Plan and/or Schedule of Benefits.
- (22) Care provided by an individual who normally resides in your household or is a member of your immediate family, which is defined as including parents, siblings, spouses, children, grandparents, aunts, uncles, nieces and nephews.

CONDITIONS UNDER WHICH BENEFITS WILL BE PROVIDED

Choice of Dentist. Neither the Plan Administrator nor the Claims Administrator furnishes covered services directly. The Claims Administrator pays for licensed Dentists to provide these services. A Covered Person may choose any Dentist. Covered Persons should determine the qualifications of the Dentist they select.

PPO Dentists and Contracting Dentists. PPO Dentists and Contracting Dentists have agreed to accept the Charge as payment in full for covered services except for the deductible and In-Network coinsurance, if applicable. PPO Dentists and Contracting Dentists will not bill a Covered Person beyond the Charge for covered services, unless the Calendar Year Aggregate Maximum has been met. Covered services performed by a PPO Dentist or Contracting Dentist are subject to the In-Network coinsurance percentage of the Charge for the covered service stated in the Schedule of Benefits. The Covered Person is responsible for the payment of the applicable deductible, In-Network coinsurance, and any charges in excess of the Calendar Year Aggregate Maximum or the Lifetime orthodontic maximum, if applicable, stated in the Schedule of Benefits.

Non-Contracting Dentists. Covered services performed by a Non-Contracting Dentist are subject to the Out-of-Network coinsurance percentage of the Allowable Charge for the covered service stated in the Schedule of Benefits. When covered services are performed by a Non-Contracting Dentist, the Plan will pay contract benefits directly to the Employee. Any difference between the Non-Contracting Dentist's billed charge and the contract benefits paid by the Plan shall be the responsibility of the Covered Person.

Clinical Examination. Before approving a Claim, the Claims Administrator may obtain from any Dentist or hospital such information and records they may require to administer the Claim. The Plan Administrator may require that a Covered Person be examined by a dental consultant, retained by the Plan Administrator, in or near his/her place of residence.

Pre-Determination. A Dentist may file a Claim form showing the services he or she recommends. The Claims Administrator will then pre-determine the benefits payable under this Plan. Payment will only be made for pre-determined services if the Covered Person receives treatment for which benefits are payable, remains eligible, and has not exceeded his or her Annual Maximum Benefits. A Claim form requesting a Pre-Determination may be submitted electronically.

Proof of Loss. Claims must be furnished to Claims Administrator within 180 days after completion of treatment for which benefits are payable. Any Claim filed after this period will be denied.

Treatment of Benefits on Lack of Eligibility. The Claims Administrator will not pay benefits for any services received by a patient who is not eligible under this Plan at the time of treatment.

To Whom Benefits Are Paid. Benefits provided under this Plan will be paid as follows:

- (a) For services provided by a Participating Dentist, payment will be made to the Participating Dentist.
- (b) For services provided by a Non-Participating Dentist, payment will be made to the Employee. The Employee is responsible for all payment(s) to a Non-Participating Dentist

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Eligible Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time or part-time basis.

Allowable Charge when used in connection with covered services or supplies delivered in Arkansas, will be the amount deemed by the Claims Administrator, in its sole discretion, to be reasonable. The customary allowance is the basic Allowable Charge. However, the Allowable Charge may vary, given the facts of the case and the opinion of the Claims Administrator.

Allowable Charges for services or supplies received out of Arkansas may be determined by the local Blue Cross and Blue Shield Plan. Please note that all benefits under this Plan are subject to and shall be paid only by reference to the Allowable Charge as determined at the discretion of the Plan. This means that regardless of how much a health care Provider may bill for a given service, the benefits under this Plan will be limited by the established Allowable Charge. If services are rendered by a Participating Dentist, that Dentist is obligated to accept the established rate as payment in full, and should only bill the member for the Deductible, Coinsurance and any non-covered services; however, if services are rendered by a Non-Participating Dentist, the member will be responsible for all amounts billed in excess of the Allowable Charge.

Calendar Year means January 1st through December 31st of the same year.

Charge when used in connection with dental services or supplies covered in this dental Plan, will be the amount deemed by the Plan to be reasonable. An amount equaling the lesser of the charge billed by the Dentist is the basic charge. However, the Charge may vary, given the facts of the case and the opinion of the Dental Advisor.

Claim means a request for benefits under the Plan made in accordance with the Plan's procedures for filing benefit claims. A Claim includes a request for payment for a service, supply, prescription drug, equipment, or treatment covered by the Plan. A Claim must be made in accordance with the claims procedures under the Plan as set forth in the How to Submit a Claim section of this document. A Claim does not include any benefits inquiries where such inquiries do not follow the requirements established in the claims procedures.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person is an Employee, Retiree or Dependent who is covered under this Plan.

Dental Advisor is a Dentist, group of Dentists, or another qualified person or persons utilized by the Plan to review claims for treatment.

Dental Xtra is a program that provides additional dental benefits for Covered Persons with certain conditions such as diabetes, coronary artery disease, oral cancer, and pregnancy.

Dentist is a person who is properly trained and licensed to practice Dentistry and who is practicing within the scope of such license.

An **Eligible Employee** is a Full-Time Employee of the University or of a designated affiliated entity operating exclusively for the benefit of the University. A full-time employee is any Employee who is employed half-time or greater and is on at least a nine month appointment period. However, for purposes of this Plan, "Eligible Employees" shall also include Residents, Interns and house staff members at the University of Arkansas for Medical Sciences.

Employee means a person who is classified by his Employer as an Eligible Employee.

Employer is University of Arkansas System and designated affiliated entities of the UA.

Experimental and/or Investigational means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the dental community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

- (1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- (2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
- (3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- (4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Family Unit is the covered Employee or Retiree and the family members who are covered as Dependents under the Plan.

Hospital means an acute general care Hospital, a psychiatric Hospital and a rehabilitation Hospital licensed as such by the appropriate state agency. It does not include any of the following, unless required by applicable law: Hospitals owned or operated by state or federal agencies, convalescent homes or Hospitals, homes for the aged, sanitariums, long term care facilities, infirmaries, or any institution operated mainly for treatment of long-term chronic diseases.

Injury means an accidental physical Injury to the body caused by unexpected external means.

In-Network Dentist, Contacting Dentist or Participating Dentist means a Dentist who has entered into a network participation contract with the Claims Administrator.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Medically or Dentally Necessary care and treatment is recommended or approved by a Dentist; is consistent with the patient's condition or accepted standards of good dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or Provider of dental services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Out-of-Network Dentist, Non-Contracting Dentist or Non-Participating Dentist means a Dentist who does not have a network participation contract with the Claims Administrator. Out-of-Network Dentist, Non-Contracting Dentist or Non-Participating Dentist are free to bill the Covered Person charges for Covered Services which are in excess of the Plan's payment.

Physician means a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) duly licensed and qualified to practice medicine and perform surgery at the time and place a claimed intervention is rendered. Physician also means a Doctor of Podiatry (D.P.M.), a Chiropractor (D.C.), a Psychologist (Ph.D.), an Oral Surgeon (D.D.S.) or an Optometrist (O.D.) duly licensed and qualified to perform the claimed health intervention at the time and place such intervention is rendered.

Plan means the University of Arkansas Dental Benefit Plan, which is a benefits plan for certain Employees of University of Arkansas System and is described in this document.

Plan Administrator. The President of the UNIVERSITY OF ARKANSAS SYSTEM is named the Plan Administrator for this Plan. The Plan Administrator has designated staff of the UNIVERSITY OF ARKANSAS SYSTEM to act on the President's behalf in plan administration and has retained the services of independent Third Party Administrators to process claims and handle other duties for this self-funded Plan.

Plan Allowance means the maximum amount the Plan will cover or pay for any health care services, drugs, medical devices, equipment, supplies or benefits covered by the Plan. This overall limit on the amount of Plan benefits available under the Plan may also be referred to as the "Allowable Charge" or "Allowance" under the Plan.

Plan Participant is any Employee, Retiree or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on January 1 and ending on the following December 31.

Provider means a Hospital or a Physician. Provider also means a certified registered nurse anesthetist; certified nurse practitioner; clinical nurse specialist; certified nurse midwife; a licensed audiologist; a chiropractor; a dentist; a licensed certified social worker; a licensed durable medical equipment Provider; an optometrist; a pharmacist; a physical therapist; a podiatrist; a psychologist; a respiratory therapist; a speech pathologist and any other type of health care Provider which the Plan Administrator, in its sole discretion, approves for reimbursement for services rendered.

Retired Employees - An eligible Retiree is:

- (1) an Employee who retires while covered under the Plan and on the date of retirement has age and continuous years of service with the UA equal to at least a total of 70 and immediately prior to retirement has completed 10 or more consecutive years of continuous coverage under the Plan; or,
- (2) an eligible employee who retires while covered under the Plan and on the date of retirement is age 65 or older and immediately prior to retirement completed five or more consecutive years of service with the UA and has five or more consecutive years of continuous coverage under the Plan; or,
- (3) has retired under an early retirement agreement approved by the Board of Trustees of the University of Arkansas System.

Total Disability (Totally Disabled) means: In the case of a Dependent, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Treatment Plan means a written report of a series of procedures recommended for the treatment of a specific dental disease, defect or Injury, prepared by a Dentist as a result of an examination of the Covered Person.

University of Arkansas System or UA means the University of Arkansas System and designated affiliated entities of the UA.

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator, in its discretion, interprets the Plan to provide such benefits to the Covered Person.

Claims must be filed by Covered Person or Covered Person's authorized representative within 180 days after completion of treatment for which benefits are payable. Any claim filed after this period will be denied. The Claims Administrator has complete discretion to interpret the terms of the benefits under the Plan and such interpretation shall be final and conclusive.

FILING A CLAIM

Usually, a claim form will be filed by the Dentist. If a Covered Person is responsible for filing a claim, a dental claim form can be found online at the following web address: www.uasdental.blueadvantagearkansas.com.

The completed claim form should be sent to the following address:

Dental Claims Administrator
P.O. Box 69436
Harrisburg, PA 17106-9436

Participating Dentists. Participating Dentists will complete and submit claim forms for Covered Persons at no charge. Participating Dentists may ask Covered Persons to fill out the patient section of the claim form, which includes the Covered Employee's name, social security number, and address; the Covered Person's name, date of birth, and relationship to Covered Employee; full time student information, if dependent; and coordination of benefits information, if applicable.

Non-Participating Dentists. If the Covered Person visits a Non-Participating Dentist, Covered Person may be required to complete the claim form or pay a service charge. The patient section should be completed, which includes the Covered Employee's name, social security number, and address; the Covered Person's name, date of birth, and relationship to Covered Employee; full time student information, if dependent; and coordination of benefits information, if applicable.

Covered Person will also be responsible for ensuring the Non-Participating Dentist completes the Dentist and the diagnostic (treatment) sections of the claim form. The Dentist section includes the Dentist's name, address, social security number or tax identification number, license number, and phone number. The Dentist must also indicate whether x-rays are attached and answer questions regarding treatment that is the result of an accident. The Dentist must also indicate if dentures, bridges, and crowns are replacements, and if so, the date of prior placement and reason for replacement must be noted.

The diagnostic section (treatment) includes services performed (name description and ADA procedure code), including date of service, fee for service, and if applicable, tooth number or letter and tooth surface. For any unusual services, the remarks section of the claim form must give a brief description. The claim form needs to be signed by the Dentist who performed the services and by the Covered Person.

Processing the claim. The claim will be processed according to the Plan benefits upon receipt. Notification of the benefit determination will be sent to the Covered Person in the form of an explanation of benefits, which details by service rendered what the Plan allowed and the Covered Person's obligation, if any.

Initial claim determination. If the Claims Administrator denies all or a portion of the claim, the Covered Person will receive an explanation of benefits indicating the reason for the denial. The denial explanation will be printed at the bottom of the page.

The Covered Person will be notified within 30 days of the receipt of the claim by Claims Administrator of the benefit determination.

In the case of an urgent care claim, the Covered Person will be notified within 72 hours from the time the claim is received by the Claims Administrator of the benefit determination.

Appeal of Denied Claim. If the Claims Administrator has denied a claim, claimant may appeal the denial. Both the claimant and Claims Administrator must take the following steps to complete an appeal (decision review):

- (1) Procedures the claimant must follow:
 - (a) Write to the Claims Administrator at the following address: P.O. Box 1460, Little Rock, Arkansas 72203-1460 within 180 days of the date on the notice of Covered Person's claim denial.
 - (b) State why the claim should not have been denied.
 - (c) Include the denial notice and any other documents, data information, or comments that claimant believes may have an influence on the appeal of the claim.
 - (d) If requested, claimant will receive, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the denied claim.
 - (e) For an expedited review of an urgent care claim, the request may be submitted orally (by telephone) or in writing (by facsimile or another similarly expeditious method).
- (2) Procedures Claims Administrator must follow for a full and fair appeal:
 - (a) Identify the medical or vocational experts whose advice was obtained and utilized on behalf of Claims Administrator in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.
 - (b) Not consider the initial denial in the review.
 - (c) Conduct a review that includes one or more of the members of the Claims Administrator's appeals committee (to be determined at the sole discretion of Claims Administrator), but in no event will the individual who made the initial claim denial, nor the subordinate of that individual be part of the review.
 - (d) Consult a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted initially, nor who is the subordinate of such individual if your denial is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate.
- (3) Procedures Claims Administrator must follow to notify claimant of its decision (if adverse):
Provide claimant with a notice that includes the following information:
 - (a) The specific reason(s) for the adverse determination.
 - (i) Reference to the specific plan provision(s) on which the adverse determination is based.
 - (ii) A statement that claimant is entitled to receive, free of charge, access to and copies of all information relevant to the claim.

- (iii) A statement describing any voluntary appeal procedures, if any, and a statement of claimant's right to bring an action under section 502 (a) of the employee retirement income security act.
 - (iv) The internal rule that was relied upon in making the adverse determination.
 - (v) If adverse determination is based on a medical necessity or experimental treatment, either an explanation of the scientific or clinical judgment for the determination, or a statement that such explanation will be provided free of charge upon request.
 - (vi) The following statement: "you and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency."
- (b) Provide claimant with the aforementioned notice within 72 hours if the claim is an urgent care claim.
 - (c) Provide claimant with the aforementioned notice within 60 days if the claim is a post-service claim.

Legal actions. Any action must be brought within three years from the time proof of loss is required by this Plan. Notwithstanding the foregoing, an action may only be brought after a Covered Person has exercised all the review and appeal rights and completed all administrative remedies under this Plan.

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan, or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance up to each one's plan formula minus whatever the primary plan paid. This is called non-duplication of benefits. The total reimbursement will never be more than the amount that would have been paid if the secondary plan had been the primary plan—50% or 80% or 100%—whatever it may be. The balance due, if any, is the responsibility of the Covered Person.

Benefit plan. This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

- (1) Group or group-type plans, including franchise or blanket benefit plans.
- (2) Blue Cross and Blue Shield group plans.
- (3) Group practice and other group prepayment plans.
- (4) Federal government plans or programs. This includes, but is not limited to, Tricare.
- (5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
- (6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

- (1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
- (2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:
 - (a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").
 - (b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
 - (c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

- (d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:
 - (i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year.
 - (ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.
- (e) When a child's parents are divorced or legally separated, these rules will apply:
 - (i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
 - (ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.
 - (iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.
 - (iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.
 - (v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.
- (f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. This includes situations in which a person who is covered as a dependent child under one benefit plan is also covered as a dependent spouse under another benefit plan. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.
- (3) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.
- (4) The Plan will pay primary to Tricare and a State child health plan to the extent required by federal law.

Claims determination period. Benefits will be coordinated on a Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

THIRD PARTY RECOVERY PROVISION

Reimbursement

This section applies when a Covered Person, or the legal representative, estate or heirs of the Covered Person (sometimes collectively referred to as the "Covered Person") recovers damages, by settlement, verdict or otherwise, for an injury, sickness or other condition. If the Covered Person has made, or in the future may make, such a recovery, including a recovery from any insurance carrier, the Plan will not cover either the reasonable value of the services to treat such an injury or illness or the treatment of such an injury or illness. These benefits are specifically excluded.

However, if the Plan does advance moneys or provide care for such an injury, sickness or other condition, the Covered Person shall promptly convey moneys or other property from any settlement, arbitration award, verdict or any insurance proceeds or monetary recovery from any party received by the Covered Person (or by the legal representative, estate or heirs of the Covered Person), to the Plan for the reasonable value of the medical benefits advanced or provided by the Plan to the Covered Person, regardless of whether or not [1] the Covered Person has been fully compensated, or "made-whole" for his/her loss; [2] liability for payment is admitted by the Covered Person or any other party; or [3] the recovery by the Covered Person is itemized or called anything other than a recovery for medical expenses incurred.

If a recovery is made, the Plan shall have first priority in payment over the Covered Person, or any other party, to receive reimbursement of the benefits advanced on the Covered Person's behalf. This reimbursement shall be from any recovery made by the Covered Person, and includes, but is not limited to, uninsured and underinsured motorist coverage, any No-Fault Auto Insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation settlement, compromises or awards, other group insurance (including student plans), and direct recoveries from liable parties.

In order to secure the rights of the Plan under this section, and because of the Plan's advancement of benefits, the Covered Person hereby [1] acknowledges that the Plan shall have first priority against proceeds of any such settlement, arbitration award, verdict, or any other amounts received by the Covered Person; and [2] assigns the Plan any benefits the Covered Person may have under any automobile policy or other coverage, to the extent of the Plan's claim for reimbursement. The Covered Person shall sign and deliver, at the request of the Plan or its agents, any documents needed to protect such priority or reimbursement right, or to effect such assignment of benefits. By accepting any benefits advanced by the Plan under this section, the Covered Person acknowledges that any proceeds of settlement or judgment, including a Covered Person's claim to such proceeds held by another person, held by the Covered Person or by another, are being held for the benefit of the Plan under these provisions.

The Covered Person shall cooperate with the Plan and its agents, and shall sign and deliver such documents as the Plan or its agents reasonably request to protect the Plan's right of reimbursement, provide any relevant information, and take such actions as the Plan or its agents reasonably request to assist the Plan making a full recovery of the reasonable value of the benefits provided. The Covered Person shall not take any action that prejudices the Plan's rights of reimbursement and consents to the right of the Plan, by and through its agent, to impress an equitable lien or constructive trust on the proceeds of any settlement to enforce the Plan's rights under this section, and/or to set off from any future benefits otherwise payable under the Plan the value of benefits advanced under this section to the extent not recovered by the Plan.

The Plan shall be responsible only for those legal fees and expenses to which it agrees in writing. No Covered Person hereunder shall incur any expenses on behalf of the Plan in pursuit of the Plan's rights hereunder. Specifically, no court costs or attorney's fees may be deducted from the Plan's recovery without the express written consent of the Plan. Any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right.

The Plan shall recover the full amount of benefits advanced and paid hereunder, without regard to any claim or fault on the part of any beneficiary of Covered Person, whether under comparative negligence or otherwise.

Subrogation

This section applies when another party is, or may be considered, liable for a Covered Person's injury, sickness or other condition (including insurance carriers who are so financially liable) and the Plan has advanced benefits.

In consideration for the advancement of benefits, the Plan is subrogated to all of the rights of the Covered Person against any party liable for the Covered Person's injury or illness, or is or may be liable for the payment for the medical treatment of such injury or occupational illness (including any insurance carrier), to the extent of the value of the medical benefits advanced to the Covered Person under the Plan. The Plan may assert this right independently of the Covered Person. This right includes, but is not limited to, the Covered Person's rights under uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, or other insurance, as well as the Covered Person's rights under the Plan to bring an action to clarify his or her rights under the Plan. The Plan is not obligated in any way to pursue this right independently or on behalf of the Covered Person, but may choose to pursue its rights to reimbursement under the Plan, at its sole discretion.

The Covered Person is obligated to cooperate with the Plan and its agents in order to protect the Plan's subrogation rights. Cooperation means providing the Plan or its agents with any relevant information requested by them, signing and delivering such documents as the Plan or its agents reasonably request to secure the Plan's subrogation claim, and obtaining the consent of the Plan or its agents before releasing any party from liability for payment of medical expenses.

If the Covered Person enters into litigation or settlement negotiations regarding the obligations of other parties, the Covered Person must not prejudice, in any way, the subrogation rights of the Plan under this section. In the event that the Covered Person fails to cooperate with this provision, including executing any documents required herein, the Plan may, in addition to remedies provided elsewhere in the Plan and/or under the law, set off from any future benefits otherwise payable under the Plan the value of benefits advanced under this section to the extent not recovered by the Plan.

The costs of legal representation of the Plan in matters related to subrogation shall be borne solely by the Plan. The costs of legal representation of the Covered Person shall be borne solely by the Covered Person.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under the University of Arkansas Dental Benefit Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

COBRA continuation coverage under the Plan is administered by the COBRA Administrator. The COBRA Administrator is UA System, 2404 North University Avenue, Little Rock, Arkansas 72207, 1-501-686-2500. Complete instructions on COBRA, as well as election forms and other information, will be provided by the COBRA Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

There may be other options available when group health coverage is lost. For example, an individual may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, he or she may qualify for lower costs on their monthly premiums and lower out-of-pocket costs. Additionally, an individual may qualify for a 31-day special enrollment period for another group health plan for which he or she is eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

- (1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (3) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., common-law employees (full or part-time), self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

- (1) The death of a covered Employee.
- (2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
- (3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.
- (4) A covered Employee's enrollment in any part of the Medicare program.
- (5) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).
- (6) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993, as amended ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee

portion of premiums for coverage under the Plan during the FMLA leave. For non-FMLA leaves of absence, the COBRA Qualifying Event date will be the day after the leave ends, if the Employee does not return to work in an Eligible Class.

What factors should be considered when determining to elect COBRA continuation coverage? When considering options for health coverage, Qualified Beneficiaries should consider:

- **Premiums:** This plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive. Qualified Beneficiaries have special enrollment rights under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a spouse's employer) within 31 days after Plan coverage ends due to one of the Qualifying Events listed above.
- **Provider Networks:** If a Qualified Beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care Provider. An individual may want to check to see if their current health care Providers participate in a network in considering options for health coverage.
- **Drug Formularies:** For Qualified Beneficiaries taking medication, a change in health coverage may affect costs for medication - and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.
- **Severance payments:** If COBRA rights arise because the Employee has lost his job and there is a severance package available from the employer, the former employer may have offered to pay some or all of the Employee's COBRA payments for a period of time. This can affect the timing of coverage available in the Marketplace. In this scenario, the Employee may want to contact the Department of Labor at 1-866-444-3272 to discuss options.
- **Medicare Eligibility:** Individuals should be aware of how COBRA coverage coordinates with Medicare eligibility. If an individual is eligible for Medicare at the time of the Qualifying Event, or if he or she will become eligible soon after the Qualifying Event, he or she has eight months to enroll in Medicare after employment-related health coverage ends. Electing COBRA coverage does not extend this eight-month period. For more information, see www.medicare.gov/sign-up-change-plans.
- **Service Areas:** If benefits under the Plan are limited to specific service or coverage areas, benefits may not be available to a Qualified Beneficiary who moves out of the area.
- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, the Plan requires participants to pay copayments, deductibles, coinsurance, or other amounts as benefits are used. Qualified beneficiaries should check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Qualified Beneficiaries through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, as extended by the Trade Preferences Extension Act of 2015, and the Employee and his or her covered Dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information about the special second election period. If continuation coverage is elected under this extension, it will not become effective prior to the beginning of this special second election period.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 31 days following the date coverage ends when the Qualifying Event is:

- (1) The end of employment or reduction of hours of employment,
- (2) Death of the Employee,
- (3) Commencement of a proceeding in bankruptcy with respect to the employer, or
- (4) Entitlement of the employee to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), the Covered Person or someone acting on their behalf must notify the Plan Sponsor at the Employee's home campus HR office within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any Spouse or Dependent child who loses coverage will not be offered the option to elect continuation coverage.

NOTICE PROCEDURES:

Any notice must be *in writing*. Oral notice, including notice by telephone, is not acceptable. The notice must be mailed, faxed or hand-delivered to the address shown above.

If mailed, the notice must be postmarked no later than the last day of the required notice period. Any notice provided must state:

- the **name of the plan or plans** under which coverage has been lost or is being lost,
- the **name and address of the Employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, the notice must include a **copy of the divorce decree or the legal separation agreement**.

There are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their Spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If an individual does not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the COBRA Administrator.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- (1) The last day of the applicable maximum coverage period.
- (2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- (3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.
- (4) The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).

- (5) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
- (a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary, whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension, is no longer disabled, whichever is earlier; or
 - (b) The end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

- (1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
- (2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries ends on the later of:
 - (a) 36 months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; or
 - (b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.
- (3) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Spouse, surviving Spouse or Dependent child of the retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the retiree.
- (4) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.
- (5) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying

Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the **Plan Sponsor at 2404 North University Avenue, Little Rock, Arkansas, 72207, 1-501-686-2500** in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to **Plan Sponsor at 2404 North University Avenue, Little Rock, Arkansas, 72207, 1-501-686-2500** in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which Timely Payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, Covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

For More Information

If an individual has questions about COBRA continuation coverage, they should contact the Plan Sponsor.

Keep The Plan Administrator Informed Of Address Changes

In order for an individual to protect his or her family's rights, they should keep the Plan Administrator informed of any changes in the addresses of family members. The individual should also keep a copy, for his or her records, of any notices sent to the Plan Administrator.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. The University of Arkansas Dental Benefit Plan is the benefit plan of University of Arkansas System, the Plan Administrator, also called the Plan Sponsor. An individual or committee may be appointed by University of Arkansas System to be the Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator or a committee member resigns, dies or is otherwise removed from the position, the University of Arkansas System shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Discretionary Authority. The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion, shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan documents, including this SPD, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties, except that the Plan Administrator has delegated certain responsibilities to the Third Party Administrators for this Plan. Any interpretation, determination or other action of the Plan Administrator or the Third Party Administrators shall be subject to review only if a court of proper jurisdiction determines its action is arbitrary or capricious or otherwise a clear abuse of discretion. Any review of a final decision or action of the Plan Administrator or the Third Party Administrators shall be based only on such evidence presented to or considered by the Plan Administrator or the Third Party Administrators at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator or the Third Party Administrators make, in its sole discretion, and further, means that the Covered Person consents to the limited standard and scope of review afforded under law. Nothing herein shall waive the sovereign immunity of the State of Arkansas or of the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR.

- (1) To administer the Plan in accordance with its terms.
- (2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
- (3) To decide disputes which may arise relative to a Plan Participant's rights.
- (4) To prescribe procedures for filing a claim for benefits and to review claim denials.
- (5) To keep and maintain the Plan documents and all other records pertaining to the Plan.
- (6) To appoint a Claims Administrator to pay claims.
- (7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

- (1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including genetic information and information about treatment or payment for treatment.
- (2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care Providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. However, Protected Health Information that consists of genetic information will not be used or disclosed for underwriting purposes.
- (3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.
 - (a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.
 - (b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.
 - (c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:
 - (i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
 - (ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

- (iii) Mitigating any harm caused by the breach, to the extent practicable; and
 - (iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
- (4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:
- (a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;
 - (b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;
 - (c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
 - (d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;
 - (e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;
 - (f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
 - (g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;
 - (h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
 - (i) 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 information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and
 - (j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of University of Arkansas System's workforce are designated as authorized to receive Protected Health Information from the University of Arkansas Dental Benefit Plan ("the Plan") in order to perform their duties with respect to the Plan: Human Resources Office staff.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

- (1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic

Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

- (2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.
- (3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION: The Plan is self-funded by participating campuses of the UNIVERSITY OF ARKANSAS SYSTEM through monies set aside for the purpose of paying the Covered Person's dental care; however, Employees help cover some of the costs of covered benefits through contributions, deductibles, out-of-pocket amounts, and Plan Participation amounts as described in the Schedule of Benefits. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

The administration of the Plan is under the supervision of the Plan Administrator. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. Blue Advantage Administrators of Arkansas provides administrative services such as claim payments for dental claims.

FUNDING OF THE PLAN: Employer and Employee Contributions. Benefits are provided by a benefit plan maintained on a self-insured basis by his or her employer.

BENEFIT PLAN YEAR: Benefits begin on January 1 and end on the following December 31. For new Employees and Dependents, a Benefit Plan Year begins on the individual's Effective Date and runs through December 31 of the same Benefit Plan Year.

PLAN'S FISCAL YEAR: January 1 through December 31

COMPLIANCE: It is intended that this Plan meet all applicable laws. In the event of any conflict between this Plan and the applicable law, the provisions of the applicable law shall be deemed controlling, and any conflicting part of this Plan shall be deemed superseded to the extent of the conflict.

PLAN NAME: University of Arkansas Dental Benefit Plan

TAX ID NUMBER: 71-6003252

PLAN EFFECTIVE DATE: January 1, 2002, and is amended and restated effective January 1, 2023.

EMPLOYER INFORMATION

University of Arkansas System
Attn: Associate Vice President for Employee Benefits and Risk Management
2404 North University Avenue
Little Rock, Arkansas 72207
1-501-686-2500

PLAN ADMINISTRATOR

Board of Trustees of the University of Arkansas
Attn: President
2404 North University Avenue
Little Rock, Arkansas 72207
1-501-686-2500

NAMED FIDUCIARY

Board of Trustees of the University of Arkansas

AGENT FOR SERVICE OF LEGAL PROCESS

Board of Trustees of the University of Arkansas
Attn: President's Office
2404 North University Avenue
Little Rock, Arkansas 72207

CLAIMS ADMINISTRATOR

BlueAdvantage Administrators of Arkansas
P.O. Box 1460
Little Rock, Arkansas 72203-1460
1-888-223-4999

For Claims Filing:
P.O. Box 69436
Harrisburg, PA 17106-9436
1-888-223-4999

BlueAdvantage Administrators of Arkansas is an independent licensee of the Blue Cross and Blue Shield Association. BlueAdvantage Administrators does not underwrite or assume any financial risk with respect to the claims liability of the Plan.