University of Virginia Dental Plan

For University of Virginia Dental Plan Enrollees

Effective January 1, 2014
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Welcome

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

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

About This Book

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

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

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

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

**Basic Dental Summary of Benefits**

<table>
<thead>
<tr>
<th>Program Feature</th>
<th>In-Network</th>
<th>Out-of-Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calendar Year Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(applies to Type B and Type C Services)</td>
<td>$50 per person</td>
<td></td>
</tr>
<tr>
<td><strong>Calendar Year Maximum</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(applies to Type A, Type B and Type C Services)</td>
<td>$1,000 per person</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>In-Network</th>
<th>Out-of-Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type A: Diagnostic and Preventive</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral exams (2 per calendar year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleanings (2 per calendar year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sealants for children under 19 (1 application per tooth every 3 years)</td>
<td>Plan pays 100%</td>
<td>Plan pays 85%</td>
</tr>
<tr>
<td>Bitewing X-rays (2 per calendar year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-mouth or panoramic X-rays (once in 36-month period)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Space maintainers for children under 19 (after loss of a primary molar or permanent first molar; one per tooth every 3 years)</td>
<td>Plan pays 100%</td>
<td>Plan pays 85%</td>
</tr>
<tr>
<td>Fluoride for children under 19 (2 applications per calendar year)</td>
<td>Plan pays 100%</td>
<td>Plan pays 85%</td>
</tr>
<tr>
<td>Palliative emergency treatment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **Type B: Primary**                                   |                             |                          |
| Includes:                                             |                             |                          |
| Restorative – fillings (one per tooth per 12 months)  | You pay 20% after annual deductible; Plan pays 80% | You pay 35% after the deductible; Plan pays 65% |
| Oral surgery (including general anesthesia when medically necessary) | You pay 20% after annual deductible; Plan pays 80% | You pay 35% after the deductible; Plan pays 65% |
| Periodontal care                                      |                             |                          |
| Endodontic care                                       |                             |                          |

Inlays, onlays, and crowns (repair) You pay 20% after annual You pay 35% after the
<table>
<thead>
<tr>
<th>Covered Services</th>
<th>In-Network (based on allowable charge)</th>
<th>Out-of-Network* (based on allowable charge)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bridges (repair)</td>
<td>deductible; Plan pays 80%</td>
<td>deductible; Plan pays 65%</td>
</tr>
<tr>
<td>Full or Partial Dentures (repair after installation)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Type C: Major Restorative</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inlays, onlays, and crowns</td>
<td>You pay 50% after annual deductible; Plan pays 50%</td>
<td>You pay 65% after the deductible; Plan pays 35%</td>
</tr>
<tr>
<td>(installation or replacement)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bridges (installation or replacement)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full or Partial Dentures (installation, repair or replacement)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental implants</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Program Feature</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calendar Year Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(applies to Type B and Type C Services)</td>
<td>$50 per person</td>
<td></td>
</tr>
<tr>
<td><strong>Calendar Year Maximum</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(applies to Type A, Type B and Type C Services)</td>
<td>$2,000 per person</td>
<td></td>
</tr>
<tr>
<td><strong>Orthodontia Lifetime Maximum</strong></td>
<td></td>
<td>$1,000 per person</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>In-Network</th>
<th>Out-of-Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type A: Diagnostic and Preventive</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral exams (2 per calendar year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleanings (2 per calendar year)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>(1 application per tooth every 3 years)</td>
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<td></td>
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<tr>
<td>Bitewing X-rays (2 per calendar year)</td>
<td></td>
<td>Plan pays 100%</td>
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<tr>
<td>Full-mouth or panoramic X-rays</td>
<td></td>
<td>The Plan pays 85%</td>
</tr>
<tr>
<td>(once in 36-month period)</td>
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<td></td>
</tr>
<tr>
<td>Space maintainers for children under 19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(after loss of a primary molar or permanent first molar; one per tooth every 3 years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluoride for children under 19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2 applications per calendar year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palliative emergency treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Type B: Primary</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restorative – fillings (one per tooth per 12 months)</td>
<td>You pay 20% after annual deductible; Plan pays 80%</td>
<td>You pay 35% after the deductible; Plan pays 65%</td>
</tr>
<tr>
<td>Oral surgery (including general anesthesia when medically necessary)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periodontal care</td>
<td></td>
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</tr>
<tr>
<td>Endodontic care</td>
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<td><strong>Type A: Diagnostic and Preventive</strong></td>
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<td>Full-mouth or panoramic X-rays</td>
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<td>(after loss of a primary molar or permanent first molar; one per tooth every 3 years)</td>
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<td></td>
</tr>
<tr>
<td>Fluoride for children under 19</td>
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<td></td>
</tr>
<tr>
<td>(2 applications per calendar year)</td>
<td></td>
<td></td>
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<tr>
<td>Palliative emergency treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Type B: Primary</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restorative – fillings (one per tooth per 12 months)</td>
<td>You pay 20% after annual deductible; Plan pays 80%</td>
<td>You pay 35% after the deductible; Plan pays 65%</td>
</tr>
<tr>
<td>Oral surgery (including general anesthesia when medically necessary)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periodontal care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endodontic care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Inlays, onlays, and crowns (repair)
Bridges (repair)
Full or Partial Dentures (repair after installation)

<table>
<thead>
<tr>
<th></th>
<th>You pay 20% after annual deductible; Plan pays 80%</th>
<th>You pay 35% after the deductible; Plan pays 65%</th>
</tr>
</thead>
</table>

**Type C: Major Restorative**

Includes:
- Inlays, onlays, and crowns (installation or replacement)
- Bridges (installation or replacement)
- Full or Partial Dentures (installation, repair or replacement)
- Dental implants

<table>
<thead>
<tr>
<th></th>
<th>You pay 40% after annual deductible; Plan pays 60%</th>
<th>You pay 55% after the deductible; Plan pays 45%</th>
</tr>
</thead>
</table>

**Type D: Orthodontia**

Orthodontic Treatment

<table>
<thead>
<tr>
<th></th>
<th>You pay 50%. Plan pays 50% up to lifetime maximum.</th>
<th>You pay 50%. Plan pays 50% up to lifetime maximum.</th>
</tr>
</thead>
</table>

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

---

**Smile for Health Benefits**

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

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5
<table>
<thead>
<tr>
<th>ADA Code</th>
<th>Description</th>
<th>Frequency</th>
<th>Medical/Dental Condition(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0425</td>
<td>Caries susceptibility tests</td>
<td>1 per lifetime</td>
<td>Caries Prevention</td>
</tr>
<tr>
<td>D1206</td>
<td>Topical application of fluoride varnish</td>
<td>2 per 12 months following periodontal surgery or active periodontal therapy</td>
<td>Caries Prevention</td>
</tr>
<tr>
<td>D4341</td>
<td>Periodontal scaling and root planning – four or more teeth per quadrant</td>
<td>1 per 24 months per area of mouth</td>
<td>Diabetes Preterm Births Heart Disease</td>
</tr>
<tr>
<td>D4342</td>
<td>Periodontal scaling and root planning – one to three teeth per quadrant</td>
<td>1 per 24 months per area of mouth</td>
<td>Diabetes Preterm Births Heart Disease</td>
</tr>
<tr>
<td>D4355</td>
<td>Full mouth debridement to enable comprehensive evaluation and diagnosis</td>
<td>1 per lifetime</td>
<td>Diabetes Preterm Births Heart Disease</td>
</tr>
<tr>
<td>D4910</td>
<td>Periodontal maintenance</td>
<td>2 in 12 months</td>
<td>Diabetes Preterm Births Heart Disease</td>
</tr>
<tr>
<td>D7288</td>
<td>Brush biopsy – transepithelial sample collection</td>
<td>1 per lifetime</td>
<td>Oral Cancer</td>
</tr>
<tr>
<td>Class III 50%</td>
<td>Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report</td>
<td>6 occurrences per 12 months; regardless of tooth number of area of the mouth</td>
<td>Diabetes Preterm Births Heart Disease</td>
</tr>
</tbody>
</table>

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

Participant Bill of Rights

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Basic Dental
- Enhanced Dental

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

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

The Provider Network

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

Allowable Charge

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

Sharing the Cost of Care

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

Deductibles

Annual Deductible

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

Keep in Mind

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

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

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

**Annual Maximum**

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

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

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

**Predetermination of Benefits**

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

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

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

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

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

Type A: Diagnostic and Preventive Services

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

- Maximum of two routine oral exams per calendar year, including prophylaxis.
- Topical application of fluoride for dependents under age 19, twice per year.
- One application of sealants per tooth every three years for dependents under age 19.
- X-rays, but no more than:
  - One full mouth or panoramic series per three-year period (unless approved in advance);
  - Bitewing X-rays twice per year.
- Space maintainers for children under age 19 to prevent tooth movement after loss of a primary molar or permanent first molar, one per tooth every three years.
- Oral tissue biopsies.
- Pulp vitality tests twice per year.
- Emergency palliative treatment for relief of pain.

Type B: Primary Services

The Plan covers primary services including:

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

**Type C: Major Restorative Services**

The Plan covers Major Restorative services including:

Inlays, onlays, and crowns:
  Installation
  Replacement

Bridges:
  Installation
  Replacement (must be more than five years after installation but not more than once in every five years)

Dentures:
  Installation
  Replacement of full denture

Implants.

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

**Type D: Orthodontic Treatment** *(Enhanced Dental Only)*

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

  Comprehensive and limited orthodontic treatment;
  Post-treatment stabilization;
  Fixed and removable appliance therapy;
  Replacement of lost or broken retainer;
  Repair of orthodontic appliance.
Benefits are limited to the lifetime maximum for orthodontic treatment shown in the Summary of Benefits.

**Alternate Treatment Provision**

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

**Smile for Health® Benefits**

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

The Smile for Health Enhanced Dental Benefit enhances your current coverage by providing additional diagnostic, preventive and periodontal services and by increasing the amount the Plan will pay toward these services. The services offered help treat periodontal disease, which has been linked to diabetes, heart disease, stroke and respiratory disease.

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

**Keep in Mind**

If any of the procedures listed above are payable under the UVa Health Plan, no coverage will be available under the Dental Plan.
What the Dental Plan Does Not Cover

The Plan does not cover all dental expenses; certain expenses are excluded. The list of excluded expenses in this section is representative, not comprehensive.

General Exclusions

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

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

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

Who Is Eligible

Active Employees

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

A full-time employee;

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

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

Keep in Mind

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

Postdoctoral Fellows

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

Dependents

You may enroll your eligible dependents. Your eligible dependents are:

Your spouse recognized as legally married in Virginia.

Your dependent children through the end of the year in which they turn age 26:

Your children by birth or adoption;

Children placed with you for adoption;

Children for whom you are the legal parent through a surrogate contract;

Stepchildren; and

Foster children.

Your unmarried, dependent children through the end of the year in which they turn age 26 if custody was awarded prior to the child’s 18th birthday, the child lives at home and is declared as a dependent on your income tax return;

Children for whom you are the legal guardian with permanent custody unless either of the child’s biological parents also reside with you except when the biological parent(s) is (are) a minor who shares custody with you.

Your unmarried, dependent child of any age who lives at home, is declared as a dependent on your income tax return and is permanently and totally handicapped, provided that the handicap began before the child reached the Plan’s age limit for coverage and the child has maintained continuous coverage under an employer-sponsored plan of the employee or the other natural/adoptive parent.
What If My Spouse and I Both Work for the University of Virginia?

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

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

If Your Child Is Adopted

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

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

If Your Child Is Born by Gestational Surrogate

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

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

Qualified Medical Child Support Orders

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

   Your child meets the definition of an eligible dependent under the Plan; and
   The University determines that the order is “qualified.”

Coverage under the QMCSO is not effective until after the date your coverage becomes effective.

Retirees

You are eligible to enroll in the Plan as a retiree if you retire from the University and you were eligible for enrollment in the Plan as an active employee on your last day as an active University employee (not including COBRA coverage) and you are:

   A retiring University employee eligible for a monthly annuity payment from Virginia Retirement System (VRS) or a periodic benefit payment from the Medical Center Retirement Plan (MCRP) or Optional Retirement Plan (ORP) programs; and you begin to receive your payments immediately upon retirement; and your last employer before retirement was the University of Virginia; OR
   Approved for long-term disability through the VSDP or other Employer-Sponsored disability plans.

You may join the Retiree group even if you weren’t enrolled in the Plan as an active Employee as long as you were eligible for enrollment in the Plan as an active employee on your last day as an active University employee. You will only be eligible for single coverage.
Your eligible dependents that are enrolled under your plan on your last day as an active University employee may enroll under your Retiree coverage.

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

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

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

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

**Keep in Mind**
All retiree enrollments must be submitted within 31 days of your retirement date.
All survivor enrollments must be submitted within 31 days of the termination of their coverage on your plan.

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

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

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

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

Keep in Mind

The change in coverage you request must be consistent with, and due to, the qualified life event.

All changes to enrollment as a retiree or survivor due to qualified life events must be submitted within 31 days instead of the 60 days applicable for active employees and COBRA enrollees. This includes all changes in the chart below.

Online requests by active employees must be made through Benefits@ for academic employees and PeopleSoft for Medical Center employees.

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

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

**Special Enrollment Rights**

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

For birth, adoption, or placement for adoption, you can enroll yourself, the new child, as well as any other eligible dependents not already on your policy. If you make application to add the child within 60 days of the event, the coverage is retroactive to the date of birth or adoption and the premium change, if appropriate, is effective the first of the month in which the event occurs. The addition of other dependents to your policy will be retroactive to the first of the month after the event date.

For marriage, you can enroll yourself, your new spouse, and any other eligible dependents not already on your policy. The coverage is effective the first of the month following the receipt of the enrollment application at the University Human Resources or online request.

An additional Special Enrollment Right is granted by a federal law known as HIPAA when eligibility is lost for other coverage or when COBRA coverage is exhausted or terminated. Based on these events, you may enroll yourself, your spouse, and/or your dependents that have lost other coverage within 60 days of the event. The coverage is effective the first of the month following receipt of the enrollment application at the University Human Resources or online request.

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

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

For people who enroll when they first become eligible, coverage begins on the first of the month following your date of hire. If you are hired on the first of the month, coverage begins immediately.

For people enrolling during an open enrollment period, coverage begins on the following January 1.

For people enrolling because of a qualified life event, coverage begins on the first of the month following receipt of the enrollment at University Human Resources Benefits Division except births and adoptions. These changes are effective the date of the event if the enrollment is received within 60 days of the event and the premium change, if appropriate, is effective the first of the month in which the event occurs. If you submit the enrollment more than 60 days after the date of the birth or adoption but within the same plan year, coverage begins on the first of the month following receipt of the enrollment.

What If I Leave the University, Then Come Back?

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

If you're re-hired within 31 days, you have no waiting period and no break in coverage. If you're re-hired more than 31 days after your termination date, you must complete another waiting period before your new coverage begins, the same as a new employee.

How You Pay for Coverage

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

Before-Tax Contributions and Social Security

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

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

Important!

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

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

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

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

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

Retiree and Survivor Premiums

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

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

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

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

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

- The employee no longer meets the Plan’s eligibility requirements;
- The Plan is terminated;
- The employee dies;
- Employment ends;
- The employee fails to pay any required contribution for coverage or reimbursement for payment of ineligible claims; or
- The employee covers an ineligible dependent.

Coverage for dependents ends on:

- The last day of the month in which:
  - The employee’s coverage ends;
  - The dependent is no longer eligible for dependent coverage;
  - The employee does not pay the required contribution for dependent coverage;
  - The dependent dies;
  - All dependent coverage under the Plan ends; or
  - The dependent becomes covered as an employee.
- The last day of the year in which:
  - The dependent child reaches age 26.
- The last day of the month after the month in which:
  - The employee dies.

Coverage for a retiree or survivor ends on the earliest of the following dates:

- The last day of the month in which a retiree or survivor waives coverage;
- The last day of the month preceding the first day of the month in which the retiree or survivor becomes eligible for Medicare;
- The last day of the month preceding the first day of the month for which the retiree or survivor fails to make a premium payment or repayment for ineligible claims, in full, when due;
- The last day of the month in which long-term disability payments end;
- The last day of the month in which a retiree or survivor no longer meets the Plan’s eligibility requirements;
- The date the Plan is terminated or coverage for all retirees/survivors under the Plan is terminated; or
- The date of the retiree’s or survivor’s death.
In the event of a divorce, coverage for a spouse ends on the last day of the month of the divorce.

**Leaves of Absence**

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

**Family, Medical, and Military Leave Act**

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

**USERRA Military Leave**

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

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

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

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

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

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

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

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

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

Continued Coverage for a Handicapped Child

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

Your child is considered handicapped if:

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

You must contact the University Human Resources Benefits Division prior to your handicapped dependent’s 26th birthday and request the application forms for handicapped status. You and the child’s treating physician must complete the forms giving proof of your child’s handicap. You must submit the forms no later than 30 days after your child reaches the dependent age limit. The child’s coverage will end on the first to occur of the following:

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

The University Human Resources Benefits Division has the right to require proof that the handicap continues.

Continuing Plan Coverage under COBRA

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

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

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

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

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

**Electing and Paying for COBRA Coverage**

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

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

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

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

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

While you are covered by the Plan under COBRA:

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

Notification of Your COBRA Rights

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

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

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

The COBRA Administrator is:

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

Address Changes

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

When COBRA Ends

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

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

You fail to make a premium payment in full when due.

The Plan terminates.

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

Effect of Another Plan on This Plan’s Benefits

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

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

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

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

<table>
<thead>
<tr>
<th>If . . .</th>
<th>Then . . .</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. One plan has a COB provision and the other plan does not</td>
<td>The plan without a COB provision determines its benefits and pays first.</td>
</tr>
<tr>
<td>2. One plan covers you as a dependent and the other covers you as an employee or retiree</td>
<td>The plan that covers you as an employee or retiree determines its benefits and pays first.</td>
</tr>
<tr>
<td>3. A child’s parents are married or living together (whether or not married)</td>
<td>The plan of the parent whose birthday occurs earlier in the calendar year determines its benefits and pays first. If both parents have the same birthday, the plan that has covered the parent the longest determines its benefits and pays first. But if the other plan does not have this “parent birthday” rule, the other plan’s COB rule applies.</td>
</tr>
<tr>
<td>4. A child’s parents are separated or divorced with joint custody, and a court decree does not assign responsibility for the child’s dental expenses to either parent, or states that both parents are responsible for the child’s dental coverage</td>
<td>The “birthday rule” described above applies.</td>
</tr>
<tr>
<td>5. A child’s parents are separated or divorced, and a court decree assigns responsibility for the child’s dental expenses to one parent</td>
<td>The plan covering the child as the assigned parent’s dependent determines its benefits and pays first.</td>
</tr>
<tr>
<td>6. A child’s parents are separated, divorced or not living together (whether or not they have ever been married) and there is no court decree assigning responsibilities for the child’s</td>
<td>Benefits are determined and paid in this order: 1. The plan of the custodial parent pays, then 2. The plan of the spouse of the custodial parent pays, then</td>
</tr>
</tbody>
</table>

29 Coordination with Other Plans
<table>
<thead>
<tr>
<th>If . . .</th>
<th>Then . . .</th>
</tr>
</thead>
<tbody>
<tr>
<td>dental expenses to either parent</td>
<td>3. The plan of the non-custodial parent pays, then 4. The plan of the spouse of the non-custodial parent pays.</td>
</tr>
<tr>
<td>7. You have coverage as an active employee (that is, not as a retiree or laid off employee) and coverage as a retired or laid off employee. Or you have coverage as the dependent of an active employee and coverage as the dependent of a retired or laid off employee</td>
<td>The plan that covers you as an active employee or as the dependent of an active employee determines its benefits and pays first. This rule is ignored if the other plan does not contain the same rule. Note: this rule does not apply if rule 2 (above) has already determined the order of payment.</td>
</tr>
<tr>
<td>8. You are covered under a federal or state right of continuation law (such as COBRA)</td>
<td>The plan other than the one that covers you under a right of continuation law will determine its benefits and pay first. This rule is ignored if the other plan does not contain the same rule. Note: this rule does not apply if rule 2 (above) has already determined the order of payment.</td>
</tr>
<tr>
<td>9. The above rules do not establish an order of payment</td>
<td>The plan that has covered you for the longest time will determine its benefits and pay first.</td>
</tr>
</tbody>
</table>

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

\[
\text{The amount this Plan would pay if it were the only coverage in place, minus Benefits paid by the other plan(s).}
\]

This prevents the sum of your benefits from being more than you would receive from just this Plan.

If your other plan(s) pays benefits in the form of services rather than cash payments, the Plan uses the cash value of those services in the calculation.
Dental Claims and Appeals

Filing Claims

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

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

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

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

Appeal of an Adverse Benefit Determination

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

Appeal Procedure

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

To initiate Level 1 appeal, you or your authorized representative must send UCCI a written statement explaining why you disagree with the determination. Mail this to UCCI Appeals, P.O. Box 69420, Harrisburg, PA 17110. Include in your request all documentation records or comments you believe support your position. You must file your appeal within 180 days of the date you were notified of the adverse benefit decision, whichever is later. This can be initiated by contacting UCCI Customer Service at 866-215-2354. UCCI will respond to your appeal request in writing within 30 days unless they have notified you in writing that additional information is needed to complete the appeal.
If you agree with the response, it becomes the final determination and the appeal ends. If you disagree with the response to your Level 1 appeal, you may then proceed to Level 2. You must request the Level 2 appeal in writing no later than 60 calendar days after you receive the Level 1 determination. The Level 2 appeal is administered by UCCI. This can be initiated by contacting UCCI Customer Service at 866-215-2354. Provide all documentation, records and comments that support the position. UCCI will provide you a written determination within 30 days of receipt of your request for Level 2 appeal unless they notify you in writing that additional information is needed for them to complete the appeal.

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

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

Plan Information

- **Plan Name:** The University of Virginia Health Plan
- **Employer Identification Number (EIN):** 54-6001796
- **Plan Number:** 501
- **Plan Sponsor:** The University of Virginia
  914 Emmet Street
  P.O. Box 400127
  Charlottesville, VA 22904-4127
  434-924-4392
- **Type of Plan:** Self-funded welfare plan
- **Plan Year:** January 1 – December 31
- **Dental Claims Administrator:** United Concordia Companies, Inc. (UCCI)
  P.O. Box 69421
  Harrisburg, PA 17106-9421
  866-215-2354

Plan Documents

The official Plan documents and insurance contracts that govern the plans are summarized in the Summary Plan Description for the Plan (this book). Copies of those documents are available for your inspection during regular business hours in the office of the Plan Administrator. You (or your personal representative) may get a copy of these documents by written request to the Plan Administrator, for a nominal charge.

Future of the Plan

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

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

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

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

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

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

University of Virginia’s Plan’s Commitment to Privacy

The University of Virginia Health Plan and the University of Virginia Dental Plan (collectively referred to as the "Plan") are committed to protecting the privacy of your protected health information. Protected health information, which is referred to as "health information" in this Notice, is information that identifies you and relates to your physical or mental health, or to the provision or payment of health services for you. The Plan creates, receives, and maintains your health information when it provides health, dental, prescription drug, and medical flexible spending account benefits to you and your eligible dependents. The Plan also pledges to provide you with certain rights related to your health information.

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

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

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

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

Information Subject to this Notice

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

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

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

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

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

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

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

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

UVa Health Plan Ombudsman
914 Emmet Street
P.O. Box 400127
Charlottesville, VA 22904-4127
(434) 924-4346

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

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

- For Treatment. The Plan may disclose your health information to a health care provider, such as a hospital or physician, to assist the provider in treating you. The Plan does not anticipate making disclosures "for treatment" purposes. However, if necessary, the Plan may make such disclosures without your authorization.

- For Payment. The Plan may use and disclose your health information without your authorization so that your claims for health care services can be paid according to the Plan's terms. For example, the Plan may use and disclose your health information to determine whether certain health care services that you seek are covered by the Plan or to process your health care claims. The Plan also may disclose your health information to coordinate payment of your health care with others who may be responsible for certain costs.

- For Health Care Operations. The Plan may use and disclose your health information without your authorization so that it can operate efficiently and in the best interests of its participants. For example, the Plan may disclose your health information for underwriting purposes, for business planning purposes, or to attorneys who are providing legal services to the Plan. The Health Plan may not use or disclose PHI that is genetic information for any underwriting purposes per GINA rules. (Genetic Information Nondiscrimination Act)

Uses and Disclosures to Business Associates

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

Uses and Disclosures to the Plan Sponsor

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

Other Uses and Disclosures That May Be Made Without Your Authorization

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

- **Required By Law.** The Plan may use and disclose health information about you as required by the law. For example, the Plan may disclose your health information for the following purposes: for judicial and administrative proceedings pursuant to legal process and authority; to report information related to victims of abuse, neglect, or domestic violence; or to assist law enforcement officials in their law enforcement duties.

- **Health and Safety.** Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law. Your health information also may be disclosed for public health activities, such as preventing or controlling disease, injury, or disability.
• **Government Functions.** Your health information may be disclosed to the government for specialized government functions, such as intelligence, national security activities, and protection of public officials. Your health information also may be disclosed to health oversight agencies that monitor the health care system for audits, investigations licensure, and other oversight activities.

• **Active Members of the Military and Veterans.** Your health information may be used or disclosed in order to comply with laws and regulations related to military service or veterans' affairs.

• **Workers' Compensation.** Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation benefits.

• **Emergency Situations.** Your health information may be used or disclosed to a family member or close personal friend involved in your care in the event of an emergency, or to a disaster relief entity in the event of a disaster.

• **Involved Family and Friends.** We may disclose information about you to a relative, a friend, or other person involved in your health care or payment for your health care, such as the subscriber of your health benefits plan, provided the information is directly relevant to that person's involvement with your health care or payment for that care. For example, if a family member or a caregiver calls us with prior knowledge of a claim, we may confirm whether or not the claim has been received and paid. You have the right to stop or limit this kind of disclosure by calling the toll-free Member Services number on your ID card. We reserve the right to require your written authorization or verbal authorization by telephone before disclosing information about you to a relative, a friend, or other person involved in your health care or payment for your health care. To authorize disclosures to a relative or other person, call the toll-free Member Services number on your ID card for release of information from the Third Party Administrator, and the UVa Health Plan Ombudsman at (434) 924-4346 for release of information from the UVA Health Plan. If you are deceased, the Plan may disclose your health information to such individuals involved in your care or payment for your health care prior to your death the health information that is relevant the individual's involvement, unless you have previously instructed the Plan otherwise.

• **Personal Representatives.** Your health information may be disclosed to people that you have authorized to act on your behalf, or people who have a relationship with you that gives them the right to act on your behalf. Examples of personal representatives are parents for minors and those who have Power of Attorney for adults.

• **Treatment and Health-Related Benefits Information.** The Plan and its business associates may contact you to provide information about treatment alternatives or other health-related benefits and services that may interest you, including, for example, alternative treatment, services, and medication.

• **Research.** Under certain circumstances, the Plan may use or disclose your health information for research purposes as long as the procedures required by law to protect the privacy of the research data are followed.

• **Organ and Tissue Donation.** If you are an organ donor, the Plan may use or disclose your health information to an organ donor or procurement organization to facilitate an organ or tissue donation transplantation.

• **Deceased Individuals.** The health information of a deceased individual may be disclosed to coroners, medical examiners, and funeral directors so that those professionals can perform their duties.
Uses and Disclosures for Fundraising and Marketing Purposes. The Plan does not use your health information for fundraising or marketing purposes and does not sell your protected health information.

Any Other Uses and Disclosures Require Your Express Written Authorization

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

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

Your Health Information Rights

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

UVa Health Plan Ombudsman
914 Emmet Street
P.O. Box 400127
Charlottesville, VA 22904-4127
(434) 924-4346

Right to Inspect and Copy Health Information

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

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

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

Right to Request That Your Health Information Be Amended

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

To request an amendment, submit a written request to the UVa Health Plan Ombudsman. This request must provide the reason(s) that support your request. The Plan may deny your request if you have asked to amend information that:
- Was not created by or for the Plan, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of your health information maintained by or for the Plan;
- Is not part of the health information that you would be permitted to inspect and copy; or
- Is accurate and complete.

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

**Right to an Accounting of Disclosures**

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

To request an accounting of disclosures, submit a written request to the UVa Health Plan Ombudsman. If you want an accounting that covers a time period of less than six years, please state that in your written request for an accounting. The first accounting that you request within a twelve month period will be free. For additional accountings in a twelve month period, the Plan may charge you for the cost of providing the accounting. But, the Plan will notify you of the cost involved before processing the accounting so that you can decide whether to withdraw or modify your request before any costs are incurred.

**Right to Request Restrictions**

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

To request restrictions, submit a written request to the UVa Health Plan Ombudsman that explains what information you wish to limit, and how and/or to whom you would like the limits to apply. The Plan will notify you in writing as to whether it agrees to your request for restrictions. To restrict access to your online health information by the subscriber of your health policy, contact Aetna Customer Service at 1-800-887-9072.

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

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

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

**Right to File a Complaint**

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

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

**Right to a Paper Copy of This Notice**

You have the right to a paper copy of this Notice. To make such a request, submit a written request to the UVa Health Plan Ombudsman named above.

**Changes in the Plan’s Privacy Policies**

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