

University of Arkansas

Dental Benefit Plan Document/ Summary Plan Description

Administered by
Delta Dental Plan of Arkansas, Inc.

By: _____
(Authorized Signature)

Title: _____

Date: _____

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INTRODUCTION

University of Arkansas System (EMPLOYER) established a self-funded dental PLAN University of Arkansas System Dental Benefits Plan, as amended (PLAN), effective January 1, 2002 and amended effective January 1, 2012, for the benefit of its ELIGIBLE EMPLOYEES.

This document is the primary source of information about your benefit program under the PLAN; it serves as the PLAN DOCUMENT and the SUMMARY PLAN DESCRIPTION. It includes information you need to know about eligibility for BENEFITS, BENEFITS available, and how to file a CLAIM for BENEFITS. This document is intended to explain the various provisions of the PLAN, but is, of necessity simplified.

ARTICLE 1. DEFINITIONS

As used in this PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION:

The definitions of certain capitalized words used in this PLAN are set forth in this Article 1. Unless defined within the text of this PLAN or the context clearly denotes otherwise, these capitalized words will have the meaning set forth below.

“ANNUAL MAXIMUM BENEFIT” is the sum that will be paid for BENEFITS for any PLAN YEAR.

“BENEFITS” means the amounts paid by the EMPLOYER under the PLAN for limited scope dental services under the PLAN as set out in this document, subject to the conditions, limitations, and restrictions set forth therein.

“BENEFIT PERIOD” is the PLAN YEAR during which BENEFITS are paid. This represents the accumulation period applicable to DEDUCTIBLES, benefit maximums, and applicable time limits.

“CALENDAR YEAR” means the twelve (12) months beginning on January 1 and ending on December 31 of each year.

“CLAIM” means a request for BENEFITS under the PLAN made in accordance with the PLAN’s procedures for filing benefit CLAIMS. A CLAIM includes a request for payment for a service, supply, prescription drug, equipment, or TREATMENT covered by the PLAN. A CLAIM must be made in accordance with the CLAIMS PROCEDURES under the PLAN as set forth in CLAIMS procedure section of this PLAN. A CLAIM does not include any BENEFITS inquiries where such inquiries do not follow the requirements established in the CLAIMS procedures.

“CLAIMS ADMINISTRATOR” is Delta Dental Plan of Arkansas, Inc. (DDPAR) with regards to an initial CLAIM and with regards to the appeals of a CLAIM.

“CLAIM FORM” is the standard dental form used to file a CLAIM or request a PRE-DETERMINATION of BENEFITS issued by CLAIMS ADMINISTRATOR.

“COBRA” means Title X of Consolidated Omnibus Budget Reconciliation Act (Public Law 99-272).

“COBRA-PARTICIPANT” is a COVERED PARTICIPANT who ceases to be eligible as an EMPLOYEE or DEPENDENT but chooses to continue coverage as allowed for the time periods provided under COBRA.

“CODE” means the Internal Revenue Code of 1986, as amended.

“COVERED EMPLOYEE” is an ELIGIBLE EMPLOYEE who is enrolled in this PLAN.

“COVERED DEPENDENT” is an ELIGIBLE DEPENDENT who is enrolled in this PLAN.

“COVERED PARTICIPANT” is an ELIGIBLE EMPLOYEE, ELIGIBLE DEPENDENT, or ELIGIBLE RETIREE who is enrolled in this PLAN.

“DDPAR” is Delta Dental Plan of Arkansas, Inc.

“DEDUCTIBLE” is the amount the COVERED PARTICIPANT must pay for services in any BENEFIT PERIOD before certain BENEFITS will be paid by the PLAN, subject to limitations shown on the SCHEDULE OF BENEFITS.

“DELTA DENTAL PREFERRED OPTION POINT-OF-SERVICE” is a preferred provider organization that can reduce the out-of-pocket expenses for the SUBSCRIBER and ELIGIBLE DEPENDENTS if they receive care from one of DDPAR’s PPO DENTISTS. This program has back-up coverage through DELTA DENTAL PREMIER when treatment is received from a NON-PPO DENTIST.

“DELTA DENTAL PREMIER” is DDPAR’s standard fee-for-service dental benefits program that covers the SUBSCRIBER and/or ELIGIBLE DEPENDENTS when treatment is received by a NON-PPO DENTIST.

“DENTIST” is a person licensed to practice dentistry when and where services are performed.

- **“DELTA DENTAL PPO PARTICIPATING DENTIST”** is a dentist who has signed an agreement with DDPAR to be a preferred provider. The PPO dentist accepts DDPAR’s payment and patient’s payment, if any, as payment in full.
- **“DELTA DENTAL PREMIER PARTICIPATING DENTIST”** is a dentist who has signed an agreement with DDPAR to participate in DeltaPremier. The PARTICIPATING DENTIST accepts DDPAR’s payment and the patient’s payment, if any, as payment in full.
- **“NON-PARTICIPATING DENTIST”** is a DENTIST who has not signed an agreement with DDPAR to be a preferred provider. It is the SUBSCRIBER’s responsibility to make full payment to the NON-PPO DENTIST, unless the NON-PPO DENTIST is participating with the DeltaPremier program.

“DEPENDENT” is as defined in Article 2 of this PLAN.

“DISCLOSURE” means the release, transfer, provision of, access to, or divulging in any other manner of information outside the entity holding the information.

“EFFECTIVE DATE” of the PLAN is January 1, 2002, and the PLAN was amended and restated effective January 1, 2012.

“ELIGIBLE DEPENDENT” is a DEPENDENT who meets the eligibility requirements to enroll under the PLAN.

“ELIGIBLE EMPLOYEE” means you are an eligible employee if you are a full time employee of the University, unless you are an employee of a community college not participating in the Plan. A full time employee is any employee who is employed half-time or greater and is on at least a nine month appointment period. However, for purposes of this Plan “Eligible Employees” shall also include Residents, Interns and house staff members at the University of Arkansas for Medical Sciences.

“ELIGIBLE RETIREE” means an Eligible Employee who retires while covered under the Plan and on the date of retirement has age and continuous years of service with the UA equal to at least a total of seventy (70) and immediately prior to retirement has completed ten (10) or more consecutive years of continuous coverage under the Plan or who has retired under an early retirement agreement approved by the University of Arkansas System.

“EMPLOYEE” is the common law EMPLOYEE of the EMPLOYER.

“EMPLOYER” is University of Arkansas System and any of its campuses, units or divisions which adopt the PLAN.

“ENROLLMENT FORM” is the form submitted to apply for coverage for an ELIGIBLE EMPLOYEE and ELIGIBLE DEPENDENTS, if applicable, under the PLAN.

“ENROLLMENT QUALIFYING EVENT” means the occurrence of a specified event, as described in Article 2 that would allow an ELIGIBLE EMPLOYEE and ELIGIBLE DEPENDENT to enroll under the PLAN after the initial eligibility period without LATE ENTRY restrictions, as applicable.

“GROUP HEALTH PLAN” is the group dental BENEFITS program to which the PLAN applies.

“HEALTH CARE OPERATIONS” means any of the following activities of the COVERED PARTICIPANT to the extent that the activities are related to covered functions, and any of the following activities of an ORGANIZED HEALTH CARE ARRANGEMENT in which the covered entity participates:

- a) Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities, population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care PROVIDERS and patients about TREATMENT alternatives, and related functions that do not include TREATMENT.
- b) Reviewing the competence or qualifications of health care professionals; evaluating practitioner and PROVIDER performance; health plan performance; conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care PROVIDERS; training of non-health care professionals; accreditation, certification, licensing, or credentialing activities;
- c) Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
- d) Business planning and development, such as conducting and cost management and planning related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and
- e) Business management and general administrative activities of the entity, including, but not limited to:
 - 1) Management activities relating to the implementation of and compliance with the requirements of this sub-chapter.
 - 2) Customer service, including the provision of data analyses for policy holder, PLAN sponsor, or customer.
 - 3) Resolution of internal grievances.
 - 4) Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor of interest is a covered entity or, following the completion of sale or transfer, will become a covered entity, and
 - 5) Consistent with the applicable requirements of HIPAA and related regulations, creating de-identified health information, fundraising for the benefit of the covered entity, and marketing for which an individual authorization is not required as described in the Health Insurance Portability and Accountability Act of 1996, as amended (“HIPAA”) and related regulations.

“HIPAA FAMILY STATUS CHANGE” means a change in your coverage level due to marriage, birth or adoption of a child, death or divorce, or court orders mandating dental coverage for minor children.

NOTE: An ELIGIBLE EMPLOYEE has 31 days from any of the above-mentioned changes to add UA Dental Benefit Coverage for the employee and any ELIGIBLE DEPENDENT.

“HIPAA SPECIAL ENROLLMENT” is a 31-day dental plan enrollment period immediately following an EMPLOYEE or ELIGIBLE DEPENDENT’s loss of COBRA coverage, loss of eligibility for other dental coverage (including dental coverage attributable to the spouse’s employment), or loss of the employer contribution for the other coverage. However, the EMPLOYEE must have previously declined the UA Dental Benefit Coverage due to having other dental coverage. **NOTE: Loss of coverage does not include loss due to failure to pay premiums on a timely basis.** HIPAA Special Enrollment periods apply only to active employees or COBRA continues.

“INDIVIDUAL” means a person who is the subject of PROTECTED HEALTH INFORMATION.

“INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION” is information that is a subset of health information, including demographic information collected from an INDIVIDUAL, and:

- a) is created or received by a health care PROVIDER, health plan, or healthcare clearinghouse, and
- b) relates to the past, present, or future physical or mental health or condition of an INDIVIDUAL, or the past, present, or future payment for the provision of health care to an INDIVIDUAL, and
- c) that identifies an INDIVIDUAL, or
- d) with respect to which there is a reasonable basis to believe the information can be used to identify the INDIVIDUAL.

“MAXIMUM PLAN ALLOWANCE or MPA” is the maximum payment allowed under the PLAN for the applicable covered service(s) provided by the DENTIST(s). The CLAIMS ADMINISTRATOR shall have the discretionary authority to determine the MPA.

“NON-PARTICIPATING DENTIST” is any DENTIST other than a PARTICIPATING DENTIST.

“ORGANIZED HEALTH CARE ARRANGEMENT”

- a) A clinically integrated care setting in which INDIVIDUALs typically receive health care from more than one health care PROVIDER,
- b) An organized system of health care in which more than one covered entity participates, and in which the participating, covered entities:
 - 1) hold themselves out to the public as participating in a joint arrangement, and
 - 2) participate in joint activities that include at least one of the following:
 - i) utilization review, in which health care decisions by participating entities are reviewed by other participating covered entities or by a third party on their behalf, or
 - ii) quality assessment and improvement activities, in which TREATMENT provided by participating covered entities or by a third party on their behalf, or
 - iii) Payment activities, if the financial risk for delivering health care is shared, in part or in whole, by participating covered entities through the joint arrangement and if PROTECTED HEALTH INFORMATION created or received by a covered entity is reviewed by other participating covered entities or by a third party on their behalf for the purpose of administering the sharing of financial risk.
- c) A GROUP HEALTH PLAN or HMO with respect to such GROUP HEALTH PLAN, but only with respect to PROTECTED HEALTH INFORMATION created or received by such HEALTH PLAN or HMOs that relates to INDIVIDUALs who are or have been COVERED PARTICIPANTs or beneficiaries in such GROUP HEALTH PLAN.
- d) A GROUP HEALTH PLAN and one or more other GROUP HEALTH PLANs each of which are maintained by the same PLAN sponsor.

“PARTICIPATING DENTIST” or **“NETWORK PROVIDER”** is a licensed DENTIST who has contracted with and agreed to abide by the rules and regulations of DDPAR or any other organization that is a member of Delta Dental Plans Association, DeltaUSA, or its affiliates. A list of current Participating DENTISTs or NETWORK PROVIDERs is available from DDPAR, or you may access the website at www.deltadental.com.

“PLAN ADMINISTRATOR” is Delta Dental Plan of Arkansas, Inc (DDPAR).

“PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION (PLAN)” is this University of Arkansas System Dental Benefits Plan (PLAN).

“PLAN TERM” is the time commencing on the EFFECTIVE DATE plus any renewals or extensions while the PLAN is in effect.

“PLAN YEAR” is the twelve (12) months starting on January 1 and ending on December 31 of each year while the PLAN is in effect.

“PRE-DETERMINATION” is an opinion from the CLAIMS ADMINISTRATOR as to payments that would be made by the CLAIMS ADMINISTRATOR as reasonably necessary for anticipated TREATMENT of a COVERED PARTICIPANT. The opinion is based upon information forwarded to the CLAIMS ADMINISTRATOR. It does not guarantee such payment in that actual payment would also depend on applicable coverage being in effect at the time any such services were rendered. The payment may also be subject to DEDUCTIBLE, co-insurance, and maximum BENEFITS allowed. Similar terms also used for PRE-DETERMINATION are pre-authorization, prior-authorization, pre-TREATMENT review, and/or, pre-certification. A COVERED PARTICIPANT, however, is not required to seek a PRE-DETERMINATION for any TREATMENT under the PLAN.

“PRE-EXISTING CONDITION” means the state or condition of the mouth that exists prior to the patient’s EFFECTIVE DATE of coverage under the PLAN.

“PROTECTED HEALTH INFORMATION” (PHI) shall have the same meaning as defined in the Health Insurance Portability and Accountability Act of 1996, as amended (“HIPAA”) and related regulations. PHI means INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION:

- a) that is:
 - 1) transmitted by electronic media,
 - 2) maintained in any medium described in the definition of electronic media pursuant to HIPAA and/or related regulations, or
 - 3) transmitted or maintained in any other form or medium.
- b) PROTECTED HEALTH INFORMATION excludes INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION in education records covered by the Family Educational Right and Privacy Act.

“PROVIDER” means a legally licensed DENTIST or any other legally licensed dental practitioner rendering services. Services must be covered under the PLAN and be within the scope of the INDIVIDUAL’s license.

“QUALIFIED FAMILY STATUS CHANGE” means a change in your coverage level due to marriage, birth or adoption of a child, death, divorce, disability, court orders mandating medical coverage for minor children, or loss of health coverage as defined in HIPAA SPECIAL ENROLLMENT, see number 11, below. **NOTE:** An ELIGIBLE EMPLOYEE has 31 days from any of the above-mentioned changes to add UA Medical Benefit Coverage for the employee and any ELIGIBLE DEPENDENT.

“QUALIFIED MEDICAL CHILD SUPPORT ORDER OR QMCSO” is an order within the meaning of ERISA Section 609(a) that requires coverage under the PLAN for an EMPLOYEE’s DEPENDENT child. The PLAN ADMINISTRATOR has established procedures for the qualification of QMCSOs.

“REQUIRED BY LAW” means a mandate contained in law that compels a covered entity to make a use or DISCLOSURE of PROTECTED HEALTH INFORMATION and that is enforceable in a court of law. REQUIRED BY LAW includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general; or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care PROVIDERS participating in the program;

and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public BENEFITS.

“**SCHEDULE OF BENEFITS**” provides a list of the BENEFITS that will be provided to a COVERED PARTICIPANT. Such SCHEDULE OF BENEFITS shall be the one in effect and for which EMPLOYEE contributions are made, if any, at the time dental care is provided.

“**TOTALLY DISABLED**” means, in the case of a DEPENDENT child, the complete inability, as a result of illness or injury, to perform the normal activities of a person of like age and sex in good health.

“**TREATMENT**” means the provision, coordination, or management of health care and related services by one or more health care PROVIDERS. This includes the coordination or management of health care by a health care PROVIDER with a third party, consultation between health care PROVIDERS relating to a patient, or the referral of a patient for health care from one health care PROVIDER to another.

“**TREATMENT PLAN**” is a written report showing the recommended TREATMENT of any dental disease, defect, or injury for a COVERED PARTICIPANT prepared by a DENTIST as a result of any examination made by such DENTIST while coverage under this PLAN is in effect for the COVERED PARTICIPANT.

“**URGENT CARE**” involves medical care or TREATMENT that is necessary and reasonable and if not provided:

- a) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or
- b) In the opinion of a physician with knowledge of the claimant’s medical condition would subject the claimant to severe pain that cannot be adequately managed without the care or TREATMENT that is the subject of the CLAIM.

“**USE**” means, with respect to INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION, the sharing, employment, APPLICATION, utilization, examination, or analysis of information within an entity that maintains such information.

“**USERRA**” means the Uniform Services Employment and Reemployment Rights Act of 1994, as amended.

ARTICLE 2: ELIGIBILITY AND ENROLLMENT

2.01 ELIGIBLE EMPLOYEES. Only ELIGIBLE EMPLOYEES will be eligible to participate in this Plan.

2.02.1 ELIGIBLE DEPENDENTS. ELIGIBLE DEPENDENTS means only the following persons not otherwise eligible for coverage under the Plan as a Participant.

- a) The lawful spouse of the COVERED EMPLOYEE.
- b) Each child of the COVERED EMPLOYEE from birth until the date on which they attain the age of twenty six (26) years and.

“**CHILD**” includes (in addition to a legitimate natural child of the COVERED EMPLOYEE) the following:

- a) an adopted child for whom a petition for adoption has been filed or the final court order has been issued;
- b) a step-child as long as a natural parent remains married to the COVERED EMPLOYEE.
- c) a foster child for whom the COVERED EMPLOYEE is legally responsible.
- d) a person for whom a COVERED EMPLOYEE is the Legal Guardian.

No person not described above including a grandchild shall be considered a CHILD.

2.03 ELIGIBILITY EXTENSION FOR DEPENDENT CHILDREN. If a DEPENDENT child, upon reaching age twenty six (26) is TOTALLY DISABLED and resides with the COVERED EMPLOYEE, such DEPENDENT child will continue to be an ELIGIBLE DEPENDENT under the PLAN until such time as the DEPENDENT child is no longer TOTALLY DISABLED or coverage under the PLAN terminates for any reason.

The EMPLOYEE will be required to provide the PLAN with written evidence of a DEPENDENT child's disability status.

2.04 PROBATIONARY PERIOD. ELIGIBLE EMPLOYEE's and ELIGIBLE DEPENDENTs' participation in the PLAN begins on first day of full time employment. There is no probationary period.

2.05 INITIAL PLAN ENROLLMENT. ELIGIBLE EMPLOYEEs and ELIGIBLE DEPENDENTs who elect to participate in the PLAN must enroll for coverage under the PLAN by completing, signing, and returning the necessary ENROLLMENT FORM to PLAN ADMINISTRATOR's Human Resources Office within thirty-one (31) days of the eligibility date. Failure to enroll within this time limit will be deemed waiver of participation.

2.06 ENROLLMENT QUALIFYING EVENT. ELIGIBLE EMPLOYEEs and their ELIGIBLE DEPENDENTs who do not enroll within thirty-one (31) days from the eligibility date, can enroll pursuant to an ENROLLMENT QUALIFYING EVENT, as described below, if such ELIGIBLE EMPLOYEEs and ELIGIBLE DEPENDENTs enroll within thirty-one (31) days from the ENROLLMENT QUALIFYING EVENT.

a) **ENROLLMENT DUE TO LOSS OF OTHER COVERAGE**

An ELIGIBLE EMPLOYEE or ELIGIBLE DEPENDENT may enroll under the PLAN due to the loss of other coverage if the following conditions are met:

- 1) The ELIGIBLE EMPLOYEE or ELIGIBLE DEPENDENT was covered under another dental health plan or had dental insurance coverage at the time of initial eligibility and enrollment under this PLAN;
- 2) The ELIGIBLE EMPLOYEE completed a written waiver of coverage at the time of initial eligibility under this PLAN stating that other dental health coverage was the reason for declining enrollment in this PLAN;
- 3) The other coverage of the ELIGIBLE EMPLOYEE or ELIGIBLE DEPENDENT who has lost the coverage was under COBRA and COBRA coverage was exhausted or was not under COBRA, and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or EMPLOYER contributions toward the coverage were terminated;
- 4) The ELIGIBLE EMPLOYEE requests enrollment in this PLAN not later than thirty-one (31) days after the exhaustion of COBRA coverage or the termination of coverage or EMPLOYER contributions as described in 3) above; and

5) The other coverage was not lost as a result of the INDIVIDUAL's failure to pay premiums or for cause (such as making a fraudulent CLAIM).

b) **ENROLLMENT DUE TO NEW DEPENDENT STATUS**

An ELIGIBLE EMPLOYEE or an ELIGIBLE DEPENDENT may enroll in the PLAN as a result of new DEPENDENT status through marriage, birth, or adoption if the following conditions are met:

- 1) An INDIVIDUAL becomes an ELIGIBLE DEPENDENT of the ELIGIBLE EMPLOYEE through marriage, birth, adoption, or placement for adoption; and
- 2) The ELIGIBLE EMPLOYEE or ELIGIBLE DEPENDENT requests enrollment in this PLAN not later than thirty-one (31) days after the marriage, birth, adoption, or placement for adoption.

An ENROLLMENT FORM must be completed to add any ELIGIBLE DEPENDENTs even if the COVERED EMPLOYEE already has selected DEPENDENT COVERAGE (family coverage) under the PLAN. If no ENROLLMENT FORM is received by the PLAN ADMINISTRATOR within the thirty-one (31) days from satisfaction of the enrollment provisions set forth above, no coverage will be provided under the PLAN on behalf of the ELIGIBLE EMPLOYEE or ELIGIBLE DEPENDENT as applicable.

2.07 OPEN ENROLLMENT. Though the University of Arkansas System reserves the right to offer an open enrollment period, there is no automatic open enrollment for this plan. In the event of an Open Enrollment Plan participants will receive detailed information regarding the open enrollment period..

2.08 EFFECTIVE DATE OF PARTICIPATION FOR ELIGIBLE EMPLOYEES. Subject to the EFFECTIVE DATE, an ELIGIBLE EMPLOYEE shall become a Participant in this PLAN at 12:01 a.m. on the earliest of the following dates:

- a) January 1, 2012, with respect to an ELIGIBLE EMPLOYEE who, on December 31, 2011 was covered under the UA PLAN which has been amended January 1, 2012; or
- b) The first day of the month coincident with or next following the date the ELIGIBLE EMPLOYEE enrolls and authorizes any required contributions for coverage, provided he does so within thirty-one (31) days after the Eligibility Date; or
- c) All EMPLOYEEs please visit your Human Resources Office to complete the forms adding or dropping coverage. YOU MUST NOTIFY YOUR HUMAN RESOURCES OFFICE OF ANY ADDITION/CHANGE WITHIN 31 DAYS of your Loss of Coverage or Qualified Event (QE) as defined by HIPAA. *Your EFFECTIVE DATE will be no later than the date of the Qualified Event or written election or the date of the pay period following the QE or written election.* **NOTE: The EMPLOYEE must enroll and authorize any required contributions for EMPLOYEE coverage, provided such EMPLOYEE does so within thirty-one (31) days after his Eligibility Date;** or
- d) Benefits-eligible part-time EMPLOYEEs changing to a benefits-eligible full-time position will be effective on the first day of the month coincident with or next following the date the ELIGIBLE EMPLOYEE enrolls and authorizes any required contributions for coverage, provided the EMPLOYEE enrolls within thirty-one (31) days of this non-HIPAA enrollment event; or
- e)
- e) During any Open Enrollment that may be designated by the University of Arkansas, on the first day of the month as designated by the University of Arkansas following the date the ELIGIBLE EMPLOYEE enrolls and authorizes any required contribution for coverage.

An ELIGIBLE EMPLOYEE who does not enroll on his or her eligibility date will not be able to enroll in the PLAN unless he or she subsequently has a QUALIFIED FAMILY STATUS CHANGE, a non-HIPAA

enrollment event as defined in letter “d” above or the University conducts an open enrollment.

Each EMPLOYEE's Eligibility Date for DEPENDENT Coverage shall be the first date on which the EMPLOYEE is eligible for coverage under this PLAN and has one or more ELIGIBLE DEPENDENTS, as defined in this Article One.

- 2.09 EFFECTIVE DATE OF COVERAGE FOR ELIGIBLE DEPENDENTS.** Subject to the EFFECTIVE DATE, Coverage for ELIGIBLE DEPENDENTS shall become effective on the applicable date determined below, but in no event prior to the date the EMPLOYEE becomes a Participant in this PLAN:
- a) The EMPLOYEE's Eligibility Date for DEPENDENT Coverage, provided the EMPLOYEE enrolls and authorizes any required contributions for DEPENDENT Coverage on or before the date;
 - b) The date the EMPLOYEE has a QUALIFIED FAMILY STATUS CHANGE which is on account of and consistent with the reason for the change, as defined by I.R.C. Section 125, and enrolls and authorizes any required contributions for DEPENDENT Coverage, provided such employee does so within thirty-one (31) days after his Eligibility Date for DEPENDENT Coverage;
 - c) All EMPLOYEES please visit your Human Resources Office to complete the forms adding or dropping DEPENDENT coverage. YOU MUST NOTIFY YOUR HUMAN RESOURCES OFFICE OF ANY CHANGE WITHIN 31 DAYS of the Qualified Event (QE) as defined by HIPAA. *Your EFFECTIVE DATE will be no later than the date of the Qualified Event or written election or the date of the pay period following the QE or written election.* Notwithstanding the foregoing, if the QE results from the birth or adoption of a child, and the child is under the age of three (3), ELIGIBLE DEPENDENT may be enrolled, as applicable, any time until the first of the calendar month following the child's third birthday but the EMPLOYEE must complete new forms in the Human Resources Office. .
- 2.10 REHIRED EMPLOYEE.** A terminated COVERED EMPLOYEE who is rehired by the EMPLOYER within thirty (30) days from his or her termination date shall become immediately eligible for coverage under the PLAN, so long as the former COVERED EMPLOYEE is an ELIGIBLE EMPLOYEE upon his or her reemployment. A terminated COVERED PARTICIPANT re-employed thirty (30) days after his or her termination date will be treated as a new EMPLOYEE and will be required to satisfy all eligibility and enrollment requirements of the PLAN prior to becoming covered under the PLAN. Notwithstanding the foregoing, a former COVERED EMPLOYEE who returns to work for the EMPLOYER directly from COBRA continuation coverage elected under this PLAN will become immediately eligible for coverage.
- 2.11 IDENTIFICATION CARD.** Possession of an identification card does not guarantee a COVERED PARTICIPANT is eligible for BENEFITS. Eligibility is based on information reported to the CLAIMS ADMINISTRATOR by PLAN ADMINISTRATOR. Eligibility may be confirmed by calling the CLAIMS ADMINISTRATOR Customer Service Representatives, but the card **is not a guarantee of payment.**
- 2.12 EMPLOYEES ON MILITARY LEAVE.** Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to COVERED EMPLOYEES and COVERED DEPENDENTS covered under the Plan immediately before leaving for military service.
- 1. The maximum period of coverage of a person under such an election shall be the lesser of:
 - a. The 24 month period beginning on the date on which the person's absence begins; or

- b. The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

This right to continue coverage is not in addition to any COBRA rights.

- 2. An exclusion or waiting period may not be imposed in connection with the reinstatement at coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion period may be imposed for coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

2.13 CONTINUATION DURING FAMILY AND MEDICAL LEAVE. This PLAN shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA) as promulgated in regulations issued by the Department of Labor, as applicable. During any leave taken under FMLA, the EMPLOYER will maintain coverage under this PLAN on the same conditions as coverage would have been provided if the COVERED EMPLOYEE had been continuously employed during the entire leave period. If PLAN coverage terminates during the FMLA leave, coverage will be reinstated for the COVERED EMPLOYEE and his or her COVERED DEPENDENTS if the COVERED EMPLOYEE returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this PLAN when the FMLA leave started and will be reinstated to the same extent that it was in force when that coverage terminates. For example, PRE-EXISTING CONDITION limitations and other waiting periods will not be imposed unless they were in effect for the COVERED EMPLOYEE and/or his or her COVERED DEPENDENTS when PLAN coverage terminates. Notwithstanding the foregoing, a COVERED PARTICIPANT on FMLA leave shall have no greater rights to BENEFITS for the remainder of the PLAN YEAR in which FMLA leave commences as other PLAN COVERED PARTICIPANTS who continuously worked during the PLAN YEAR.

2.14 COBRA. Federal law requires certain EMPLOYERS sponsoring GROUP HEALTH PLANS to offer EMPLOYEES and their DEPENDENTS the opportunity to elect a temporary extension of health coverage (called “continuation coverage” or “COBRA coverage”) in certain instances where coverage under the GROUP HEALTH PLAN would otherwise end. COVERED PARTICIPANTS do not have to show they are insurable to elect continuation coverage. However, you will have to pay all premiums for your continuation coverage.

This summary is intended only to summarize, as best possible, rights and obligations under the law, if applicable to this PLAN. The PLAN offers no greater COBRA rights than what the COBRA statute requires, and this summary should be construed accordingly.

Both COVERED EMPLOYEE and his or her spouse should read this summary carefully and keep it with their records.

COBRA QUALIFYING EVENTS:

If you are a COVERED EMPLOYEE under the PLAN, you have the right to elect continuation coverage if you lose coverage under the PLAN because of any one of the following two (2) “COBRA qualifying events”:

- a) Termination (for reasons other than your gross misconduct) of employment.
- b) Reduction in the hours of your employment.

If you are the spouse of a COVERED EMPLOYEE, you have the right to elect continuation coverage if you lose coverage under the PLAN because of any of the following four “COBRA qualifying events”:

- a) The death of your spouse.
- b) A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment with the EMPLOYER.
- c) Divorce or legal separation from your spouse. (Also, if a COVERED EMPLOYEE drops his or her spouse from coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, the later divorce will be considered a COBRA qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the PLAN ADMINISTRATOR within sixty [60] days of divorce and can establish the coverage was dropped earlier in anticipation of divorce, COBRA coverage may be available for the period after the divorce or legal separation.)
- d) Your spouse becomes entitled to Medicare BENEFITS.

In the case of a DEPENDENT child of a COVERED EMPLOYEE, he or she has the right to elect continuation coverage if group health coverage under the PLAN is lost because of any of the following five "COBRA qualifying events":

- a) The death of the COVERED DEPENDENT'S parent.
- b) The termination of the COVERED DEPENDENT'S parent's employment (for reasons other than gross misconduct) or reduction in the COVERED DEPENDENT'S parent's hours of employment with the EMPLOYER.
- c) Parents' divorce or legal separation.
- d) The DEPENDENT'S parent becomes entitled to Medicare BENEFITS.
- e) The DEPENDENT ceases to be a DEPENDENT child under the PLAN.

NOTICES AND ELECTION:

The PLAN provides that your spouse's coverage terminates (thus, is lost) as of the last day of the month in which a divorce or legal separation occurs. A DEPENDENT child's coverage terminates the last day of the month in which he or she ceases to be an ELIGIBLE DEPENDENT under the PLAN (for example, after attainment of a certain age). Under the COBRA statute, you (the EMPLOYEE) or a DEPENDENT have the responsibility to notify the PLAN ADMINISTRATOR upon a divorce, legal separation, or a child losing DEPENDENT status. You or your DEPENDENT must provide this notice no later than sixty (60) days after the last day of the month of the divorce, legal separation, or a child losing DEPENDENT status. If you or your DEPENDENT fail to provide this notice to the PLAN ADMINISTRATOR during this sixty (60) day notice period, any DEPENDENT who loses coverage will *not* be offered the option to elect continuation coverage. Further, if you or your DEPENDENT fail to notify the PLAN ADMINISTRATOR, and any CLAIMS are paid mistakenly for expenses incurred after the last day of the month of the divorce, legal separation, or a child losing DEPENDENT status, you and your DEPENDENT will be required to reimburse the PLAN for any CLAIMS so paid.

If the PLAN ADMINISTRATOR is provided timely notice of a divorce, legal separation, or a child's losing DEPENDENT status that has caused a loss of coverage, the PLAN ADMINISTRATOR will notify the affected family member of the right to elect continuation coverage.

You (the COVERED EMPLOYEE) and/or your COVERED DEPENDENTs will be notified of the right to elect continuation coverage automatically (i.e., without any action required by you or your DEPENDENTs) upon the following events that result in a loss in coverage: the COVERED EMPLOYEE's termination of employment (other than for gross misconduct), reduction in hours, or death, or the COVERED EMPLOYEE becoming entitled to Medicare.

You (the COVERED EMPLOYEE) or your COVERED DEPENDENTs must elect continuation coverage within sixty (60) days after PLAN coverage ends, or, if later, sixty (60) days after the

PLAN ADMINISTRATOR sends you or your DEPENDENTs notice of the right to elect continuation coverage. If you or your qualifying DEPENDENTs do not elect continuation coverage within this sixty (60) day election period, you will lose your right to elect continuation coverage. Your (or your qualifying DEPENDENT's) election is effective on the day the election is sent to the PLAN ADMINISTRATOR. Please Note: No CLAIMs will be paid until the COBRA payment is received.

A COVERED EMPLOYEE or the spouse of the COVERED EMPLOYEE may elect continuation coverage for all qualifying DEPENDENTs. The COVERED EMPLOYEE, and his or her spouse and DEPENDENT children each have an independent right to elect continuation coverage. Thus a spouse or DEPENDENT child may elect continuation coverage even if the COVERED EMPLOYEE does not (or is not deemed to) elect it.

You or your qualifying DEPENDENTs can elect continuation coverage even if covered under another EMPLOYER-sponsored GROUP HEALTH PLAN or is entitled to Medicare.

TYPE OF COVERAGE AND PREMIUM PAYMENTS:

Ordinarily, you or your qualifying DEPENDENTs will be offered COBRA coverage that is the same coverage you, he, or she had on the day before the COBRA qualifying event. Therefore, a person (EMPLOYEE, spouse or DEPENDENT child) who is not covered under the PLAN on the day before the COBRA qualifying event is generally not entitled to COBRA coverage except, for example, where there is no coverage because it was eliminated in anticipation of a qualifying event, such as divorce.

If the coverage for similarly situated EMPLOYEEs or their DEPENDENTs is modified, COBRA coverage will be modified the same way.

Premium payments for the "initial premium months" must be paid for you (the EMPLOYEE) and any qualifying DEPENDENTs by the 45th day after electing continuation coverage. The initial premium months are the months that end on or before the 45th day after the date of the COBRA election. Once continuation coverage is elected, the right to continue coverage is subject to timely payment of the required COBRA premiums. Coverage will not be effective for any initial premium month until that month's premium is paid within the forty-five (45) day period after the election of continuation coverage is made. All other premiums are due on the first of the month for which the premium is paid, subject to a thirty (30) day grace period. A premium payment is made on the date it is post-marked or actually received; whichever is earlier. If you don't make the full payment by the due date or within the thirty (30) day grace period, COBRA coverage will be canceled retroactively to the first day of the month.

MAXIMUM COVERAGE PERIODS:

36-Months. If you (spouse or DEPENDENT child) lose dental coverage because of the COVERED EMPLOYEE's death, divorce, legal separation, or the COVERED EMPLOYEE's becoming entitled to Medicare, or because you lose your status as a DEPENDENT under the PLAN, the maximum coverage period (for spouse and DEPENDENT child) is thirty-six (36) months from the date of the COBRA qualifying event.

18-Months. If you (EMPLOYEE, spouse, or DEPENDENT child) lose dental coverage because of the EMPLOYEE's termination of employment (other than for gross misconduct) or reduction in hours, the maximum continuation coverage period (for the EMPLOYEE, spouse, and DEPENDENT child) is eighteen (18) months from the date of termination or reduction in hours. There are three (3) exceptions:

- a) If an EMPLOYEE or DEPENDENT is disabled at any time during the first sixty (60) days of continuation coverage (running from the date of termination of employment or reduction in hours), the continuation coverage period for all qualified beneficiaries under the qualifying event is twenty-nine (29) months from the date of termination or reduction in hours. The Social Security Administration must formally determine under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act that the disability exists and when it began. For the twenty-nine (29) month continuation coverage period to apply, notice of the determination of disability under the Social Security Act must be provided to the EMPLOYER or the PLAN ADMINISTRATOR, both within the eighteen (18) month coverage period and within sixty (60) days after the date of the determination.
- b) If a second COBRA qualifying event that gives rise to a thirty-six (36) month maximum coverage period (for example, the EMPLOYEE dies or becomes divorced) occurs within an eighteen (18) month or twenty-nine (29) month coverage period, the maximum coverage period becomes thirty-six (36) months from the date of the initial termination or reduction in hours.
- c) If the COBRA qualifying event occurs within eighteen (18) months after the EMPLOYEE becomes entitled to Medicare, the maximum coverage period (for the spouse and DEPENDENT child) ends thirty-six (36) months from the date the EMPLOYEE became entitled to Medicare.

CHILDREN BORN TO, OR PLACED FOR ADOPTION WITH THE COVERED EMPLOYEE AFTER THE COBRA QUALIFYING EVENT:

If, during the period of continuation coverage, a child is born to, adopted by, or placed for adoption with the COVERED EMPLOYEE, and the COVERED EMPLOYEE has elected continuation coverage for himself or herself, the child is considered a qualified beneficiary. The COVERED EMPLOYEE or other guardian has the right to elect continuation coverage for the child, provided the child satisfies the otherwise applicable PLAN eligibility requirements set forth in the Eligibility Section of this PLAN. The COVERED EMPLOYEE or a family member must notify the PLAN ADMINISTRATOR within thirty-one (31) days of the birth, adoption, or placement to enroll the child on COBRA, and COBRA coverage will last as long as it lasts for other DEPENDENTS of the COVERED EMPLOYEE. You must notify the PLAN ADMINISTRATOR to enroll the child on COBRA even if you have elected Family Coverage under COBRA. If the COVERED EMPLOYEE or family member fails to so notify the PLAN ADMINISTRATOR in a timely fashion, the COVERED EMPLOYEE will *not* be offered the option to elect COBRA coverage for the child.

OPEN ENROLLMENT RIGHTS:

Qualified beneficiaries who have elected COBRA will be given the same opportunity available to similarly-situated active EMPLOYEES to change their coverage options or to add or eliminate coverage for DEPENDENTS at open enrollment, if applicable.

TERMINATION OF COBRA BEFORE THE END OF MAXIMUM COVERAGE PERIOD:

Continuation coverage of the EMPLOYEE, spouse, and/or DEPENDENT child will automatically terminate (before the end of the maximum coverage period) when any one of the following six (6) events occurs:

- a) The EMPLOYER no longer provides group health coverage to any of its EMPLOYEES.
- b) The premium for the qualified beneficiary's COBRA coverage is not timely paid.

- c) After electing COBRA, you (EMPLOYEE, spouse, or DEPENDENT child) become covered under another group dental plan (as an EMPLOYEE or otherwise) that has no exclusion or limitation with respect to any PRE-EXISTING CONDITION that you have. If the “other plan” has applicable exclusions or limitations, your COBRA coverage will terminate after the exclusion or limitation no longer applies (for example, after a twelve (12) month PRE-EXISTING CONDITION waiting period expires). This rule applies only to the qualified beneficiary who becomes covered by another group dental plan.
- d) After electing COBRA, you (EMPLOYEE, spouse, or DEPENDENT child) become entitled to Medicare BENEFITS. This will apply only to the person who becomes entitled to Medicare.
- e) If you (EMPLOYEE, spouse, or DEPENDENT child) became entitled to a twenty-nine (29) month maximum coverage period due to disability of a qualified beneficiary, but then there is a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled (however, continuation coverage will not end until the month that begins more than thirty (30) days after the determination).
- f) Occurrence of any event (e.g., submission of fraudulent benefit CLAIMS) that permits termination of coverage for cause with respect to COVERED EMPLOYEES or their spouses or DEPENDENT children who have coverage under the PLAN for a reason other than the COBRA coverage requirements of Federal law.

OTHER INFORMATION:

If you (the EMPLOYEE) or a qualifying DEPENDENT have any questions about this summary or COBRA, please contact the PLAN ADMINISTRATOR.

If your marital status changes or a DEPENDENT ceases to be a DEPENDENT eligible for coverage under the PLAN TERMS, or if you or your DEPENDENT are no longer determined to be disabled, or you or your spouse’s address change, you must immediately notify the PLAN ADMINISTRATOR in writing (this notification is necessary to protect your COBRA rights).

ARTICLE 3. TERMINATION

3.01 TERMINATIONS

COVERED EMPLOYEES:

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

- a) Upon termination of this PLAN.
- b) At the end of the period for which the required premiums or any other payments required under the PLAN have been paid, if the premiums or any other required payments for the next period are not paid when due.
- c) On the last day of the calendar month in which the COVERED EMPLOYEE's employment terminates.
- d) On the last day of the calendar month in which the COVERED EMPLOYEE shifts to a non-eligible classification under the PLAN.
- e) The day the COVERED EMPLOYEE retires.
- f) The day the COVERED EMPLOYEE begins FMLA unless the appropriate premium payments are made.
- g) The day the COVERED EMPLOYEE enters active duty service in the armed forces of any country.
- h) The day the COVERED EMPLOYEE fails to return to work from an EMPLOYER-approved leave of absence.

COVERED DEPENDENTS:

Coverage will end for COVERED DEPENDENTS at the earliest time stated below, subject to the COVERED DEPENDENT's right to elect continuation of coverage through COBRA, continuation during FMLA, or USERRA, as applicable:

- a) Upon termination of the COVERED EMPLOYEE's coverage for any reason.
- b) Upon the termination of this PLAN or DEPENDENT coverage under this PLAN.
- c) When such INDIVIDUAL ceases to be an ELIGIBLE DEPENDENT.
- d) At the end of the period for which the required premiums or any other payments required under the PLAN have been paid if the premiums or any other required payments for the next period are not paid when due.
- e) The day the COVERED DEPENDENT enters active duty service in the armed forces of any country.

There will be no coverage upon any termination as specified above unless continuation coverage is available, pursuant to COBRA, continuation during FMLA, or USERRA, if applicable.

ARTICLE 4: COVERED DENTAL BENEFITS

Schedule of Benefits for University of Arkansas

- a) **Effective Date:** 12:01 a.m. Central Standard Time, January 1, 2012
- b) **Group Number:** 9304 -All Locations
- c) **Deductible:** \$50 for benefits received in Coverage B and Coverage C with a maximum of \$100 per family per calendar year. There is no deductible on Coverage A.
- d) **Annual Maximum Payment:** \$1,500 Per Person Per Calendar Year.
- e) **Dependents:** Covered up to age 26.

If you pay your premiums on an after-tax basis, children may be added to the dental policy at any time through age 3 years and 1 month. If you pay your premium on a pre-tax basis, contact the Human Resources Office for restrictions that would apply. See page 11 for details. .

f) Covered Services:

Coverages and Maximum Plan Allowances

Coverage A – Diagnostic and Preventative Services	In-Network 100%
<ul style="list-style-type: none">• Routine periodic examinations not more than twice in any benefit period, inclusive of an initial oral examination.• Bitewing and periapical X-rays as required.• Full-mouth X-rays once in any three (3) year period.• Prophylaxis (cleaning). *Please see information on Evidence Based Dentistry.• Topical application of fluoride once per benefit period for dependent children to age nineteen (19).• Sealants once per tooth on permanent maxillary and mandibular first and second molars with no caries (decay) on the occlusal surface, for dependent children to age nineteen (19).	
Coverage B – Basic Restorative Services	In-Network 80%
<ul style="list-style-type: none">• Minor emergency treatment for the relief of pain as needed by the participant.• Amalgam (silver) and composite/resin (white) fillings• Endodontics, including pulpal therapy and root canal filling.• Simple and surgical extractions.• Oral surgery, including pre- and post-operative care and surgical extractions, except TMJ surgery.• Space maintainers for prematurely lost teeth of eligible dependent children sixteen (16) years of age and under.• Stainless steel crowns used as a restoration to natural teeth for dependent children to age sixteen (16) when the teeth cannot be restored with a filling material.	

- Surgical periodontics.
- Non-surgical periodontics.
- Periodontal maintenance; two (2) per benefit period following active periodontal treatment.
*Please see information on Evidence Based Dentistry.
- Antibiotic injections when given by the dentist.

Coverage C – Major Restorative Services

**In-Network
50%**

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

Carryover Benefit Rider

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

*** Evidence Based Dentistry covers additional routine cleanings or periodontal maintenance procedures up to four per benefit period for covered members with diabetes, heart disease, who are pregnant or have a history of periodontal disease. The additional benefits may not be combined by those with more than one of the above conditions.**

The benefit allowance for services of an out-of-network dentist will be reduced by 10% for eligible services as determined by DDPAR after applying the applicable deductibles, co-payments and maximums. This means your out-of-pocket expense may be greater if you choose an out-of-network dentist.

DIAGNOSTIC AND PREVENTIVE BENEFITS
AND THEIR
LIMITATIONS AND EXCLUSIONS

4A.1.00 DIAGNOSTIC AND PREVENTIVE BENEFITS

- | | | |
|----|------------|---|
| a) | Diagnostic | Routine periodic and specialty examinations not more than twice in any BENEFIT PERIOD. This is inclusive of an initial oral examination.
Bitewing and periapical X-rays as required.
Full-mouth X-rays once in any three (3) year period. |
| b) | Preventive | Prophylaxis (cleaning) not more than twice in any BENEFIT PERIOD.
Topical application of fluoride once per BENEFIT PERIOD.
Sealants once per tooth. |

4A.2.00 LIMITATIONS AND EXCLUSIONS ON DIAGNOSTIC AND PREVENTIVE BENEFITS

- a) The PLAN will pay for two (2) oral examinations and cleanings in BENEFIT PERIOD.
- b) The PLAN will pay for full mouth x-rays once within three (3) years. A combination of periapical and bitewing x-rays (ten [10] or more films) or a panoramic film and additional x-rays make up a full mouth series.
- c) A sealant is a BENEFIT only on the unrestored, decay free chewing surface (occlusal surface) of the maxillary (upper) and mandibular (lower) first and second molars. Sealants are a benefit for DEPENDENT children to age nineteen (19). Sealants are payable once per tooth.
- d) Preventative control programs (oral hygiene instructions, carries susceptibility tests, dietary control, tobacco counseling, etc.) are not a benefit.
- e) The PLAN will pay for one (1) topical application of fluoride in a BENEFIT PERIOD for DEPENDENT children to age nineteen (19). Fluoride rinses or self-applied fluorides are not a benefit.

- f) The PLAN will not pay for adult cleanings for COVERED PARTICIPANT(s) to age fourteen (14).
- g) Pulp vitality tests are payable per visit, not per tooth, and only for the diagnosis of emergency conditions.
- h) General Limitations and Exclusions found in Article 6 of this PLAN also apply to Diagnostic and Preventive BENEFITS.

BASIC RESTORATIVE BENEFITS
AND THEIR
LIMITATIONS AND EXCLUSIONS

4B.1.00 BASIC RESTORATIVE BENEFITS

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

4B.2.00 LIMITATIONS AND EXCLUSIONS ON BASIC RESTORATIVE BENEFITS

- a) Palliative TREATMENT is payable on a per visit basis, once on the same date.
- b) Fillings are allowed once per surface per tooth in a twelve (12) month period. This is allowed irrespective of the number of combinations of procedures requested or performed.
- c) Payment for root canal TREATMENT includes charges for temporary restorations. Root canal TREATMENT is limited to once in a lifetime, per tooth, by the same DENTIST or dental office. Retreatment of root canal by the same DENTIST or dental office will be considered after twenty-four (24) months have lapsed since initial TREATMENT. Root canals on deciduous teeth are not a benefit, unless there is no permanent successor. Pulpal therapy is limited to primary teeth and therapeutic pulpotomy is limited to primary teeth once in a lifetime.
- d) Non-surgical periodontics will not be provided more often than once in a twenty-four (24) month period per quadrant.
- e) Periodontal maintenance is a benefit after three (3) months following active periodontal TREATMENT.

- f) Extractions, surgical extractions, root removal, alveoplasty, surgical exposure of impacted or unerupted tooth, tooth reimplantation and/or stabilization, transseptal fiberotomy, and oroantral fistula closure are limited to once per lifetime.
- g) Charges for general anesthesia/intravenous sedation are not covered except when administered in conjunction with covered oral surgery, excluding single tooth extractions (ADA procedure code 7140) and for children to age three (3).
- h) Analgesia, anxiolysis, therapeutic drug injection, other drugs and/or medicines, and desensitizing medicines are not covered.
- i) Composite resin crowns are not a benefit on primary teeth. A stainless steel crown allowance will be made with any fee difference the responsibility of the patient.
- j) A space maintainer is a benefit when used to replace prematurely lost or extracted teeth for children to age sixteen (16), limited to once in a sixty (60) consecutive month period. Recementation of a space maintainer is limited to once in five (5) years (sixty [60] consecutive months). Recementation of a space maintainer within six (6) months of the seating date is part of the original procedure. A space maintainer is not considered an orthodontic appliance.
- k) The PLAN will not pay for the replacement of a stainless steel crown within a sixty (60) month period of the initial placement.
- l) General Limitations and Exclusions found in Article 6 of this PLAN also apply to Basic Restorative BENEFITS.
- m) Payment for periodontal surgery shall include charges for three (3) months' post-operative care and any surgical re-entry for a three (3) consecutive year period. Root planing, curettage, and osseous surgery are not a benefit for participant(s) to age fourteen (14).

MAJOR RESTORATIVE BENEFITS
AND THEIR
LIMITATIONS AND EXCLUSIONS

4C.1.00 MAJOR RESTORATIVE BENEFITS

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

4C.2.00 LIMITATIONS AND EXCLUSIONS ON MAJOR RESTORATIVE BENEFITS

- a) The PLAN will not pay to replace any crowns, inlays, onlays, or veneers received in the previous five (5) years (sixty [60] consecutive months). Payment for crowns, inlays, onlays, and veneers shall include charges for preparations of tooth, gingival, and impression.
- b) The PLAN will not pay for a crown, inlay, onlay, or veneer on a tooth that can be restored with an amalgam or composite restoration.
- c) Porcelain/ceramic or cast crowns for children to age twelve (12) are not BENEFITS.
- d) Crown repair is limited to once in a two (2) consecutive year period on the same tooth. Crown and fixed partial denture recement is limited to once in twelve (12) consecutive months per tooth. Repairs for bridges and full and partial dentures are limited to once in a five (5) consecutive year period
- e) Procedures for purely cosmetic reasons are not BENEFITS.
- f) The PLAN will not pay to replace any fixed bridges or partial or complete dentures that the participant received in the previous five (5) years, except where the loss of additional teeth requires the construction of a new appliance. The PLAN will not pay to replace a bridge or denture unless it cannot be made satisfactory.
- g) Recementation of a bridge within six (6) months of the seating date is part of the original procedure.
- h) Payment for a partial or complete denture shall include charges for any necessary adjustment within a six (6) month period. Payment for a reline or rebase of a partial or complete denture is limited to once in a three (3) year period. Adjustments made within the first six (6) months after delivery are not covered. Adjustments after the post six (6)

month delivery period are limited to not more than twice in any twelve (12) consecutive month period.

- i) A posterior, fixed partial denture and a removable partial denture in the same dental arch is not covered. The benefit is limited to the allowance for the partial, removable denture.
- j) Adjustments to complete or partial dentures are limited to two (2) adjustments per denture per twelve (12) months after six (6) months have elapsed since initial placement.
- k) The PLAN limits payment for standard dentures to the maximum allowable fee for a standard partial or complete denture. A standard denture means a removable appliance to replace missing natural, permanent teeth. A standard denture is made by conventional means from acceptable materials. If a denture is constructed by specialized techniques and the fee is higher than the fee allowable for a standard denture, the patient is responsible for the difference.
- l) The PLAN does not pay for fixed bridges or full or partial dentures for children to age sixteen (16).
- m) A fixed bridge where a partial denture is constructed in the same arch is not a covered benefit.
- n) Fixed partial denture retainers are a benefit once in any five (5) consecutive month period.
- o) Temporary and provisional crowns and partial dentures are not a benefit.
- p) Procedures for purely cosmetic reasons are not BENEFITS.
- q) Tissue conditioning is limited to two (2) in a three (3) consecutive year period. Tissue conditioning is not a benefit if performed on the same day a denture is delivered or a reline/rebase is provided.
- r) Endosteal implants are covered once in a lifetime per tooth.
- s) The implant abutment to support a crown is covered once in any five (5) consecutive year period.
- t) An implant or abutment supported crown is covered once in any five (5) consecutive year period.
- u) An implant or abutment supported retainer is covered once in any five (5) consecutive year period.
- v) Implant maintenance procedure is covered once in any twelve (12) consecutive months.
- w) Repair of an implant supported prosthesis or implant abutment is covered once in any five (5) consecutive year period.
- x) Re-cementation of implant/abutment supported crown or fixed partial denture is covered once in any twelve (12) consecutive month period after six (6) months have elapsed since initial placement.
- y) General Limitations and Exclusions found in Article 6 of this PLAN also apply to Major Restorative BENEFITS.

ARTICLE 5. DEDUCTIBLE, ANNUAL MAXIMUM, AND COORDINATION OF BENEFITS

5.01 The CLAIMS ADMINISTRATOR will not pay BENEFITS until the annual DEDUCTIBLE amount has been satisfied, unless the covered procedure is not subject to the DEDUCTIBLE. The DEDUCTIBLE will apply as indicated on the SCHEDULE OF BENEFITS.

5.02 The DEDUCTIBLE applies to the benefit categories as shown on the SCHEDULE OF BENEFITS. Only fees a COVERED PARTICIPANT pays for services covered under the benefit schedules included in this PLAN will count toward satisfying the DEDUCTIBLE.

5.03 Unless otherwise indicated on the SCHEDULE OF BENEFITS, the DEDUCTIBLE and maximum apply to each BENEFIT PERIOD.

5.04 COORDINATION OF BENEFITS

If a COVERED PARTICIPANT is entitled to coverage under more than one benefit plan or benefit program, the BENEFITS of this PLAN will be subject to the following conditions:

- a) If the other program is not primarily a dental program, this PLAN is primary.
- b) If the other program is for dental coverage, the following rules apply:
 - 1) The program covering the patient as an EMPLOYEE is primary over a program covering the patient as a DEPENDENT.
 - 2) Where the patient is a DEPENDENT child, primary dental coverage will be determined as follows:
 - i) The coverage of the parent whose date of birth occurs earlier in the CALENDAR YEAR will be primary.
 - ii) Except for a DEPENDENT child of legally separated or divorced parents, the coverage of the parent with legal custody, or the coverage of the custodial parent's spouse (i.e., stepparent) will be primary, unless there is a court decree stating that one parent has financial responsibility for a child's health care expenses. If so, any DEPENDENT coverage of that parent will be primary to any other DEPENDENT coverage.
 - 3) When primary coverage cannot be determined according to a) and b), the program that has covered the patient for the longer period will be primary.
 - 4) Coordination of BENEFITS within this PLAN will not be allowed.

If a COVERED PARTICIPANT is covered under more than one group PLAN, including this PLAN, BENEFITS will be coordinated with the BENEFITS from the "other plan". The intent is to provide combined BENEFITS for the MAXIMUM PLAN ALLOWANCE (MPA), as defined in Article 1, which do not exceed BENEFITS which would be eligible as if PLAN ADMINISTRATOR were primary.

ARTICLE 6. EXCLUSIONS FOR ALL BENEFITS

6.01 The CLAIMS ADMINISTRATOR will only pay the BENEFITS stated for each type of dental service set out in the SCHEDULE OF BENEFITS. **Not all dental services are BENEFITS under this PLAN.** BENEFITS will only be provided for COVERED PARTICIPANTs who are enrolled on the date of TREATMENT. BENEFITS will be determined based on the date services were rendered. Services must be provided by a DENTIST or properly licensed employee of the DENTIST. Services must be necessary and customary. Services must be provided following generally accepted dental practice standards as determined by the dental profession to be a paid benefit. The CLAIMS ADMINISTRATOR will pay allowable BENEFITS based upon the percentages and subject to the ANNUAL MAXIMUM BENEFIT as stated on the SCHEDULE OF BENEFITS. Such percentages will be applied to the lesser of the MAXIMUM PLAN ALLOWANCE (MPA) or the fees the DENTIST charges for the service. **The maximum payment for NON-PARTICIPATING DENTISTs will be ten percent (10%) less than to a PARTICIPATING DENTIST.** Payments for covered services performed by NON-PARTICIPATING DENTISTs will be sent to the patient(s). NON-PARTICIPATING DENTISTs may balance-bill patients for the difference of their charges and the CLAIMS ADMINISTRATOR's payment; PARTICIPATING DENTISTs shall not balance-bill patients for charges exceeding the MPA for covered BENEFITS under this PLAN.

6.02 **OPTIONAL SERVICES**

- a) Services that are more expensive than the TREATMENT usually provided under accepted dental practice standards are called optional services. Optional services also include the use of specialized techniques instead of standard procedures. BENEFITS for optional services will be based on and paid the same as the usual service. The COVERED PARTICIPANT will be responsible for the remainder of the DENTIST's fee.
- b) Payment made by the CLAIMS ADMINISTRATOR for any surgical service will include charges for routine, post-operative evaluations or visits.
- c) If a COVERED PARTICIPANT transfers from one DENTIST to another during the course of TREATMENT, BENEFITS will be limited to the amount that would have been paid if one DENTIST rendered the service.

6.03 **EXCLUSIONS**

The following dental services are not eligible under this PLAN:

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

- h) BENEFITS for services or appliances started prior to the date the COVERED PARTICIPANT became eligible under this PLAN, including, but not limited to, restorations, prosthodontics, and orthodontics.
- i) Services with respect to diagnosis and TREATMENT of disturbances of the temporomandibular joint (TMJ).
- j) Services for increasing the vertical dimension or for restoring tooth structure lost by attrition, for rebuilding or maintaining occlusal services, or for stabilizing the teeth.
- k) Experimental and/or investigational services, supplies, care, and TREATMENT which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered. The CLAIMS ADMINISTRATOR must make an independent evaluation of the experimental or non-experimental standings of specific technologies. The CLAIMS ADMINISTRATOR's decision will be final and binding on the PLAN. Drugs are considered experimental if they are not commercially available for purchase and/or are not approved by the Food and Drug Administration for general use.
- l) Charges for replacement of lost, missing, or stolen appliances/devices.
- m) Charges for services when a CLAIM is received for payment more than twelve (12) months after services are rendered.
- n) Charges for complete occlusal adjustments, occlusal guards, occlusion analysis, enamel microabrasion, odontoplasty, bleaching, and athletic mouthguards.
- o) Specialized techniques that entail procedure and process over and above that which is normally adequate. Any additional fee is the patient's responsibility.
- p) Behavior management.
- q) Those services and BENEFITS excluded by the rules and regulations of DDPAR, including DDPAR's processing policies.
- r) Removable appliances for control of harmful habits, including but not limited to tongue thrust appliances.
- s) Analgesia, anxiolysis, therapeutic drug injection, other drugs and/or medicines, and desensitizing medicines are not covered. Charges for general anesthesia/intravenous sedation are not covered except when administered in conjunction with covered oral surgery excluding single tooth extractions (ADA procedure code 7140) and for children three (3) and under.
- t) Procedures that do not comply with the CLAIMS ADMINISTRATOR's CLAIMS procedures.
- u) Charges for precision attachments, provisional splinting, desensitizing medicines, home care medicines, premedications, stress breakers, coping, office visits during or after regularly scheduled hours, case presentations, and hospital-related services.
- v) All other BENEFITS and services not specifically covered in the PLAN and/or SCHEDULE OF BENEFITS.
- w) Care provided by an individual who normally resides in your household or is a member of your immediate family, which is defined as including parents, siblings, spouses, children, grandparents, aunts, uncles, nieces and nephews.

ARTICLE 7. CONDITIONS UNDER WHICH BENEFITS WILL BE PROVIDED

7.01 CHOICE OF DENTIST. Neither the PLAN ADMINISTRATOR nor the CLAIMS ADMINISTRATOR furnishes covered services directly. The CLAIMS ADMINISTRATOR pays for licensed DENTISTS to provide these services. A COVERED PARTICIPANT may choose any DENTIST. COVERED PARTICIPANTS should determine the qualifications of the DENTIST they select. Participation in the DDPAR network is open to all DENTISTS who meet DDPAR's standards and who are licensed in Arkansas unless they have previously had their participation in DDPAR terminated. DDPAR only controls credentialing in Arkansas. However, there is currently in effect a policy by Delta Dental Plans Association (National), which is applicable to DeltaUSA groups, that requires all Delta Plans to have credentialing. Other state's credentialing policies are available upon request. Whether a DENTIST is a PARTICIPATING or NON-PARTICIPATING DENTIST should not be viewed as a statement about that DENTIST's abilities.

PLAN ADMINISTRATOR shares the public and professional concern about the possible spread of HIV and other infectious diseases in the dental office. However, neither PLAN ADMINISTRATOR nor the CLAIMS ADMINISTRATOR can ensure the DENTIST's use of precautions against the spread of such diseases. Neither PLAN ADMINISTRATOR nor the CLAIMS ADMINISTRATOR can compel the DENTIST to be tested for HIV or to disclose test results to DDPAR or to the COVERED PARTICIPANT. If there are questions about a DENTIST's health status or use of recommended clinical precautions, COVERED PARTICIPANT should discuss them with the DENTIST.

7.02 CLINICAL EXAMINATION. Before approving a CLAIM, the CLAIMS ADMINISTRATOR may obtain from any DENTIST or hospital such information and records they may require to administer the CLAIM. PLAN ADMINISTRATOR may require that a COVERED PARTICIPANT be examined by a dental consultant, retained by PLAN ADMINISTRATOR, in or near his/her place of residence.

7.03 PRE-DETERMINATION. A DENTIST may file a CLAIM FORM showing the services he or she recommends. The CLAIMS ADMINISTRATOR will then pre-determine the BENEFITS payable under this PLAN. Payment will only be made for pre-determined services if the COVERED PARTICIPANT receives TREATMENT for which BENEFITS are payable, remains eligible, and has not exceeded his or her ANNUAL MAXIMUM BENEFITS. A CLAIM FORM requesting a PRE-DETERMINATION may be submitted electronically.

7.04 PROOF OF LOSS. CLAIMS must be furnished to CLAIMS ADMINISTRATOR within twelve (12) months after completion of TREATMENT for which BENEFITS are payable. Any CLAIM filed after this period will be denied.

7.05 TREATMENT OF BENEFITS ON LACK OF ELIGIBILITY. The CLAIMS ADMINISTRATOR will not pay BENEFITS for any services received by a patient who is not eligible under this PLAN at the time of TREATMENT.

7.06 TO WHOM BENEFITS ARE PAID. BENEFITS provided under this PLAN will be paid as follows:

- a) For services provided by a PARTICIPATING DENTIST, payment will be made to the PARTICIPATING DENTIST.
- b) For services provided by a NON-PARTICIPATING DENTIST, payment will be made to the EMPLOYEE. The EMPLOYEE is responsible for all payment(s) to a NON-PARTICIPATING DENTIST.

ARTICLE 8. CLAIMS PROCEDURES

- 8.01 CLAIMS.** CLAIMS must be filed by COVERED PARTICIPANT or COVERED PARTICIPANT's authorized representative with DDPAR within twelve (12) months after completion of TREATMENT for which BENEFITS are payable. Any CLAIM filed after this period will be denied. The CLAIMS ADMINISTRATOR has complete discretion to interpret the terms of the BENEFITS under the PLAN and such interpretation shall be final and conclusive.
- 8.02 FILING CLAIMS/PARTICIPATING DENTISTS.** PARTICIPATING DENTISTS will complete and submit CLAIM FORMS for COVERED PARTICIPANTS at no charge. PARTICIPATING DENTISTS may ask COVERED PARTICIPANTS to fill out the patient section of the CLAIM FORM, which includes the COVERED EMPLOYEE's name, social security number (SSN), and address; the COVERED PARTICIPANT's name, date of birth, and relationship to COVERED EMPLOYEE; FULL TIME STUDENT information, if DEPENDENT; and coordination of BENEFITS information, if applicable.
- 8.03 FILING CLAIMS/NON-PARTICIPATING DENTISTS.** If the COVERED PARTICIPANT visits a NON-PARTICIPATING DENTIST, COVERED PARTICIPANT may be required to complete the CLAIM FORM or pay a service charge. The patient section should be completed, which includes the COVERED EMPLOYEE's name, SSN, and address; the COVERED PARTICIPANT's name, date of birth, and relationship to COVERED EMPLOYEE; FULL TIME STUDENT information, if DEPENDENT; and coordination of BENEFITS information, if applicable.

COVERED PARTICIPANT will also be responsible for ensuring the NON-PARTICIPATING DENTIST completes the DENTIST and the Diagnostic (TREATMENT) Sections of the CLAIM FORM. The DENTIST Section includes the DENTIST's name, address, SSN or TIN number, license number, and phone number. The DENTIST must also indicate whether x-rays are attached and answer questions regarding TREATMENT that is the result of an accident. The DENTIST must also indicate if dentures, bridges, and crowns are replacements, and if so, the date of prior placement and reason for replacement must be noted.

The Diagnostic Section (TREATMENT) includes services performed (name description and ADA procedure code), including date of service, fee for service, and if applicable, tooth number or letter and tooth surface. For any unusual services, the Remarks Section of the CLAIM FORM must give a brief description. The CLAIM FORM needs to be signed by the DENTIST who performed the services and by the COVERED PARTICIPANT.

- 8.04 PROCESSING THE CLAIM.** If COVERED PARTICIPANT visits a PARTICIPATING DENTIST, the CLAIM will be processed according to the PLAN BENEFITS upon receipt. For COVERED PARTICIPANTS who visit a PARTICIPATING DENTIST, notification of the benefit determination will be sent to the COVERED EMPLOYEE in the form of an Explanation of BENEFITS, which details by service rendered what the PLAN allowed and the COVERED PARTICIPANT's obligation, if any.

If COVERED PARTICIPANT visits a NON-PARTICIPATING DENTIST, the COVERED EMPLOYEE will receive a CLAIM Payment Statement, which will detail by service rendered what the PLAN allowed and the COVERED PARTICIPANT's obligation, if any. The CLAIM Payment Statement will also include a benefit check made payable to the COVERED EMPLOYEE.

- 8.05 INITIAL CLAIM DETERMINATION.** If the CLAIMS ADMINISTRATOR denies all or a portion of the CLAIM, COVERED PARTICIPANT will receive an Explanation of BENEFITS (for COVERED PARTICIPANTS visiting a PARTICIPATING DENTIST) or a CLAIM Payment Statement (for COVERED PARTICIPANTS visiting a NON-PARTICIPATING DENTIST)

indicating the reason for the denial. The denial explanation will be printed at the bottom of the page.

The COVERED EMPLOYEE will be notified within thirty (30) days of the receipt of the CLAIM by CLAIMS ADMINISTRATOR of the benefit determination.

In the case of an URGENT CARE CLAIM, the SUBSCRIBER will be notified within seventy-two (72) hours from the time the CLAIM is received by the CLAIM ADMINISTRATOR of the benefit determination.

8.06 APPEAL OF DENIED CLAIM. If the CLAIMS ADMINISTRATOR has denied a CLAIM, claimant may appeal the denial. Both the claimant and CLAIMS ADMINISTRATOR must take the following steps to complete an appeal (decision review):

- a) Procedures the claimant must follow:
 - 1) Write to the CLAIMS ADMINISTRATOR at the following address:
Customer Service Support, Post Office Box 15965, North Little Rock, Arkansas, 72231 within one-hundred-eighty (180) days of the date on the notice of COVERED PARTICIPANT's CLAIM denial.
 - 2) State why the CLAIM should not have been denied.
 - 3) Include the denial notice and any other documents, data information, or comments that claimant believes may have an influence on the appeal of the CLAIM.
 - 4) If requested, claimant will receive, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the denied CLAIM.
 - 5) For an expedited review of an URGENT CARE CLAIM, the request may be submitted orally (by telephone) or in writing (by facsimile or another similarly expeditious method).
- b) Procedures CLAIMS ADMINISTRATOR must follow for a full and fair appeal:
CLAIMS ADMINISTRATOR:
 - 1) Identify the medical or vocational experts whose advice was obtained and utilized on behalf of CLAIMS ADMINISTRATOR in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.
 - 2) Not consider the initial denial in the review.
 - 3) Conduct a review that includes one or more of the members of the CLAIMS ADMINISTRATOR's Appeals Committee (to be determined at the sole discretion of CLAIMS ADMINISTRATOR), but in no event will the individual who made the initial CLAIM denial, nor the subordinate of that individual be part of the review.
 - 4) Consult a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted initially, nor who is the subordinate of such individual if your denial is based in whole or in part on a medical judgment, including determinations with regard to whether a particular TREATMENT, drug, or other item is experimental, investigational, or not medically necessary or appropriate.
- c) Procedures CLAIMS ADMINISTRATOR must follow to notify claimant of its decision (if adverse):
 - 1) Provide claimant with a notice that includes the following information, to wit:
 - i) The specific reason(s) for the adverse determination.
 - ii) Reference to the specific PLAN provision(s) on which the adverse determination is based.
 - iii) A statement that claimant is entitled to receive, free of charge, access to and copies of all information relevant to the CLAIM.
 - iv) A statement describing any voluntary appeal procedures, if any, and a statement of claimant's right to bring an action under section 502 (a) of the Employee Retirement Income Security Act.
 - v) The internal rule that was relied upon in making the adverse determination.

- vi) If adverse determination is based on a medical necessity or experimental TREATMENT, either an explanation of the scientific or clinical judgment for the determination, or a statement that such explanation will be provided free of charge upon request.
 - vii) The following statement: “You and your PLAN may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.”
- 2) Provide claimant with the aforementioned notice within seventy-two (72) hours if the CLAIM is an URGENT CARE CLAIM.
 - 3) Provide claimant with the aforementioned notice within sixty (60) days if the CLAIM is a post-service CLAIM.

8.07 LEGAL ACTIONS. Any action must be brought within three (3) years from the time proof of loss is required by this PLAN. Notwithstanding the foregoing, an action may only be brought after a COVERED PARTICIPANT has exercised all the review and appeal rights and completed all administrative remedies under this PLAN.

ARTICLE 9. PRIVACY OF PROTECTED HEALTH INFORMATION

- 9.01 PERMITTED USES AND DISCLOSURES.** PLAN ADMINISTRATOR and the CLAIMS ADMINISTRATOR shall USE and/or disclose PROTECTED HEALTH INFORMATION (PHI) received by the CLAIMS ADMINISTRATOR solely for TREATMENT, payment, and HEALTH CARE OPERATIONS as defined under HIPAA and as otherwise required or permitted by HIPAA or federal or state law without the INDIVIDUAL's authorization.
- 9.02 EXCEPTIONS.** PLAN ADMINISTRATOR may USE and disclose PHI for the proper management and administration of EMPLOYER or to carry out their legal responsibilities.
- 9.03 APPROPRIATE SAFEGUARDS.** PLAN ADMINISTRATOR and the CLAIMS ADMINISTRATOR agree that it will implement all appropriate safeguards to prevent USE or DISCLOSURE of PHI.
- 9.04 REPORTING DISCLOSURES OF PHI.** The CLAIMS ADMINISTRATOR shall report to PLAN ADMINISTRATOR or its designated business associate any USE or DISCLOSURES of PHI by the CLAIMS ADMINISTRATOR other than as provided for in the agreement between PLAN ADMINISTRATOR and the CLAIMS ADMINISTRATOR.
- 9.05 AGENTS AND CONTRACTORS.** PLAN ADMINISTRATOR shall ensure that any agent or contractor that will have access to PHI from the CLAIMS ADMINISTRATOR agrees to be bound by the same restrictions, terms, and conditions that apply to CLAIMS ADMINISTRATOR.
- 9.06 ACCESS TO AND AVAILABILITY OF PHI.** If the completed authorization for USE and DISCLOSURE of PROTECTED HEALTH INFORMATION form has been received by PLAN ADMINISTRATOR or the CLAIMS ADMINISTRATOR, the CLAIMS ADMINISTRATOR shall:
- a) Make available to PLAN ADMINISTRATOR or its designated business associate the requested PHI to respond to an INDIVIDUAL's access to PHI. If the CLAIMS ADMINISTRATOR receives a request directly from the INDIVIDUAL, the CLAIMS ADMINISTRATOR shall, within thirty (30) days, forward the request to PLAN ADMINISTRATOR or its designated business associate along with the requested PHI. PLAN ADMINISTRATOR or its designated business associate shall be responsible for the responding to all the individual requests for access to PHI.
 - b) Provide to PLAN ADMINISTRATOR or its designated business associate the requested PHI to respond to a request for amendment and shall incorporate any amendment received from PLAN ADMINISTRATOR or its designated business associate.
 - c) Make available to PLAN ADMINISTRATOR or its designated business associate the requested PHI to respond to an INDIVIDUAL's request for an accounting of DISCLOSURE(s) of PHI. If CLAIMS ADMINISTRATOR receives a request directly from the INDIVIDUAL, the CLAIMS ADMINISTRATOR shall within sixty (60) days forward the request to PLAN ADMINISTRATOR or its designated business associate along with PHI. PLAN ADMINISTRATOR or its designated business associate shall be responsible for responding to all individual requests for accounting DISCLOSURE(s).
- 9.07 AVAILABILITY OF CLAIMS ADMINISTRATOR'S INTERNAL PRACTICES, BOOKS, AND RECORDS.** CLAIMS ADMINISTRATOR agrees to make its internal practices, books, and records relating to the USE and DISCLOSURE of PHI available to the Secretary of Human Services for purposes of determining PLAN ADMINISTRATOR and CLAIMS ADMINISTRATOR comply with this agreement and HIPAA privacy standards.

ARTICLE 10. GENERAL PROVISIONS

- 10.01 PLAN AMENDMENTS.** The EMPLOYER reserves the right to amend or terminate this PLAN at any time. PLAN amendments will be made by action of the EMPLOYER. In addition, premiums and contribution rates may change from time to time as determined by the EMPLOYER.
- 10.02 PROHIBITION OF ASSIGNMENT.** No BENEFITS under this PLAN shall in any manner or to any extent be assigned, alienated, or transferred by any COVERED PARTICIPANT, or be subject to attachment, garnishment, or other legal process, except that PLAN ADMINISTRATOR shall adhere to the terms of any judgment, decree, or court order (including a court's approval of a domestic relations agreement), which is determined to be a Qualified Medical Child Support Order ("QMCSO"), pursuant to the procedures established under the PLAN.
- 10.03 DOES NOT REPLACE WORKER'S COMPENSATION.** This PLAN does not affect any requirements for coverage by Worker's Compensation Insurance.
- 10.04 CONFLICTS.** The terms of the PLAN, along with any amendments or endorsements issued by PLAN ADMINISTRATOR, will in all cases be controlling. Should the wording of the PLAN, along with any amendments or endorsements issued conflict with another document, the PLAN, along with any amendments or endorsements will govern.
- 10.05 RIGHT TO REVIEW CLAIMS AND RECEIVE NECESSARY INFORMATION.** For the purpose of implementing the terms of the coverage under the PLAN, the CLAIMS ADMINISTRATOR may, without the consent of or notice to any person and subject to Article 9, release or obtain from any insurance company or other organization or person any information with respect to any person which it deems necessary for determining BENEFITS payable. The CLAIMS ADMINISTRATOR will have the final determination of whether a CLAIM falls under the eligible BENEFITS listed in this PLAN.
- 10.06 PHYSICAL EXAMINATION.** The CLAIMS ADMINISTRATOR shall, upon the request and at the expense of the PLAN and by a DENTIST of its own choice, have the right and opportunity to physically examine any COVERED PARTICIPANT with respect to the BENEFITS listed in this PLAN.
- 10.07 INTERPRETATION OF THE PLAN.** The PLAN ADMINISTRATOR has the power and the discretionary authority to construe the terms of the PLAN and to determine all questions that arise under it. Such power and authority include, for example, the administrative discretion necessary to resolve issues with respect to an EMPLOYEE's or DEPENDENT's eligibility for BENEFITS, or to interpret any other term contained in plan documents. The PLAN ADMINISTRATOR's interpretations and determinations are binding on all PARTICIPANTS, EMPLOYEES, and former EMPLOYEES.
- 10.08 NOTICE.** All notices under this PLAN must be in writing. Notices for CLAIMS shall be addressed to:

Delta Dental Plan of Arkansas, Inc.
PO Box 15965
Little Rock, Arkansas 72231-5965

Notices to PLAN ADMINISTRATOR shall be sent to the address shown on the General Information page of this document. All notices will be effective forty-eight (48) hours after deposit in the United States mail with fully prepaid postage.

10.09 RIGHT TO RECOVERY. Whenever BENEFITS greater than the maximum amount of allowable BENEFITS are provided, CLAIMS ADMINISTRATOR will have the right to recover any excess. CLAIMS ADMINISTRATOR will recover the excess from any persons, insurance companies, or other organizations involved to whom payment was made. Any COVERED PARTICIPANT covered under this PLAN will execute and deliver any necessary documents and do what is necessary to secure such rights to CLAIMS ADMINISTRATOR on behalf of PLAN ADMINISTRATOR.

10.10 SUBROGATION. EMPLOYER acquires the COVERED PARTICIPANT's legal rights to recovery for payment for dental services the patient required because of the action or fault of another. EMPLOYER has the right to recover from the COVERED PARTICIPANT any payment(s) made by or for the other party. In such cases, EMPLOYER has the right to recover amounts equal to the BENEFITS paid by CLAIMS ADMINISTRATOR, plus all collection costs and attorney's fees.

The CLAIMS ADMINISTRATOR, on behalf of EMPLOYER, has the right to make the recovery by suit, settlement, or otherwise from the person who caused the dental problem or injury. Such recovery may be from the other person, his or her insurance company, or any other source, such as third party motorist coverage.

The COVERED PARTICIPANT must help EMPLOYER or CLAIMS ADMINISTRATOR recover from other sources. COVERED PARTICIPANT must provide all requested information and sign necessary documents. If the COVERED PARTICIPANT fails to help or settles any CLAIM without written consent, EMPLOYER may recover from the COVERED PARTICIPANT. EMPLOYER will be entitled to any recovery received by the COVERED PARTICIPANT and reasonable and necessary attorney's fees and court costs.

10.11 SUBCONTRACTOR(S) AND AGENT(S). EMPLOYER may subcontract certain functions or appoint an agent or agents to act on EMPLOYER's behalf and fulfill expressed, limited duties under this PLAN. Such agent(s) have no authority to change or amend this PLAN.

10.12 LIABILITY. The CLAIMS ADMINISTRATOR, the EMPLOYER, or the PLAN ADMINISTRATOR shall have no liability for any wrongful conduct. This includes but is not limited to tortious conduct, negligence, wrongful acts or omissions, or any other act of any person. This includes but is not limited to DENTISTS, dental assistants, dental hygienists, dental EMPLOYEES, hospitals, or hospital EMPLOYEES receiving or providing services. The CLAIMS ADMINISTRATOR, the EMPLOYER, or the PLAN ADMINISTRATOR shall have no liability for any services, equipment, or facilities, which, for any reason, are unsafe for or unavailable to any COVERED PARTICIPANT.

10.13 RIGHT TO INFORMATION. In order for CLAIMS to be approved, CLAIMS ADMINISTRATOR, upon its request, shall be entitled to receive from any attending or examining DENTIST or from hospitals in which a DENTIST's care is rendered certain information and records. This data will relate to the attendance to, examination of, or TREATMENT rendered to a COVERED PARTICIPANT. The receipt of any COVERED PARTICIPANT of any service constitutes the consent of such COVERED PARTICIPANT to the release to CLAIMS ADMINISTRATOR of all such information and records. The COVERED PARTICIPANT shall execute a medical release as requested by EMPLOYER or the CLAIMS ADMINISTRATOR.

EMPLOYER agrees to provide CLAIMS ADMINISTRATOR current, complete, and correct information in regard to all EMPLOYEES who are entitled to coverage. This will enable CLAIMS ADMINISTRATOR to properly affect coverage and to administer CLAIMS and provide service for all related matters.

10.14 MISREPRESENTATIONS. All statements made by an INDIVIDUAL EMPLOYEE shall be deemed representations and warranties.

10.15 FRAUD NOTICE. Any person who knowingly presents a false or fraudulent CLAIM for payment loss or benefit or knowingly presents false information in an application for BENEFITS is guilty of a crime and may be subject to fines and confinement in prison.

GENERAL PLAN INFORMATION

PLAN NAME University of Arkansas Dental Benefit Plan

TYPE OF PLAN Dental

TAX ID NUMBER 71-6003252

PLAN EFFECTIVE DATE January 1, 2002 (Original Effective Date)
January 1, 2012 (Revision Date)

PLAN YEAR ENDS December 31

EMPLOYER INFORMATION University of Arkansas System
2404 N. University Avenue
Little Rock, AR 72207
(501) 686-2500

PLAN ADMINISTRATOR Delta Dental Plan of Arkansas, Inc.
PO Box 15965
Little Rock, AR 72231-5965
(501) 835-3400

**AGENT FOR SERVICE OF
LEGAL PROCESS** University of Arkansas System
2404 N. University Avenue
Little Rock, AR 72207
(501) 686-2500

**CLAIMS ADMINISTRATOR-
INITIAL CLAIMS** Delta Dental Plan of Arkansas, Inc.
PO Box 15965
Little Rock, AR 72231-5965
(501) 835-3400

**CLAIMS ADMINISTRATOR-
CLAIMS APPEAL** Delta Dental Plan of Arkansas, Inc.
PO Box 15965
Little Rock, AR 72231-5965
(501) 835-3400