



UNIVERSITY OF ARKANSAS

Classic Benefit Plan

SUMMARY PLAN DESCRIPTION

Effective January 1, 2009



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EXCLUSIONS

The following are not covered under this Plan.

1. **Admission to a Hospital Before You Become Covered Under This Summary Plan Description.** If you are admitted to a hospital, Skilled Nursing Facility, or other inpatient facility as a registered inpatient before the date you become covered under this Summary Plan Description, we will not cover any part of your stay in that inpatient facility, or medical services related to that stay, regardless of whether the services were rendered before or after you became covered under this Summary Plan Description.
2. **Abortion.** The Plan will only cover an abortion to save the life of the mother.
3. **Adoption/Surrogate Parenting.** We will not cover services and costs relating to the care of the biological mother of an adopted child, if the biological mother is not covered. We will not cover services and costs related to surrogate parenting.
4. **Against Medical Advice.** We will not cover any costs related to an inpatient admission resulting in the Enrollee's discharge against medical advice.
5. **Air Ambulance.** We will not pay for air ambulance unless the air ambulance service is Medically Necessary due to the patient's critical condition. Coverage will be limited to the regular air ambulance charges for transportation to the nearest Network Hospital having the appropriate facilities to handle the case. If transport to a Network Hospital is not feasible due to the Enrollee's condition, or the distance for our Service Area, we will pay for transport to the nearest appropriate hospital. All air ambulance is subject to review for Medical Necessity.
6. **Alcohol.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol for which the person has been arrested. The arresting officer's determination of intoxication will be sufficient for this exclusion. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol and expenses will be covered for Substance Abuse treatment as specified in this Plan.
7. **Alternative or Complementary Medicine.** We will not cover devices or services that derive from alternative systems of medical practice such as acupuncture, homeopathy or naturopathy, bioelectromagnetic care, herbal medicine, manual healing such as aromatherapy or reflexology, mind/body control such as dance or prayer therapies, or pharmacological and biological therapy such as chelation therapy or metabobolic therapy not yet accepted by mainstream medical practitioners.
8. **Blood.** We will not cover blood, blood plasma or derivatives that are donated or replaced, nor will we cover fees for voluntary blood giving or storage of blood products, except to the extent that a refund or credit is given, or as part of the Transplant Benefit.
9. **Blood Donation.** When you choose to designate either yourself or another person to be a blood donor so that you may receive the designated blood at a future time, we will not cover charges for procurement, storage, or administration of such donated blood or any extra charges associated with designated blood donation.
10. **Care Provided By A Family Member.** We will not cover care provided by an individual who normally resides in your household or is a member of your immediate family, which we define as including parents, siblings, spouses, children, grandparents, aunts, uncles, nieces and nephews.
11. **Care Rendered In Certain Non-Hospital Institutions.** We will not cover care or supplies in convalescent homes or similar institutions, facilities providing primarily custodial or rest care; nor will we cover care or supplies in health resorts, spas, sanitariums, tuberculosis hospitals, residential treatment centers, or infirmaries at camps or schools.

12. **Charges In Excess Of Calendar Year Or Lifetime Maximums.** We will not cover any service, supply or treatment in excess of the calendar year or lifetime maximum as shown in the Schedule of Benefits.
13. **Charges For Missed/Canceled Appointments.** We will not pay for charges for appointments that an Enrollee misses or cancels.
14. **Care in Connection with the Detection and Correction of Structural Imbalance, Distortion or Subluxation.** We will not cover any services or supplies rendered in connection with the diagnosis, detection and correction (by manual or mechanical means) of:
 - a. structural imbalance;
 - b. distortion; or
 - c. subluxationin the human body for the purpose of removing nerve interference and the effects thereof. This exclusion applies when the nerve interference is the result of or related to distortion, misalignment, or subluxation of or in the vertebral column.
15. **Complications.** We will not cover medical or surgical complications resulting from a non-covered service or that are a direct or closely related result of refusal to accept treatment, medicines, or a course of treatment that a Network Provider has recommended or has been determined to be Medically Necessary.
16. **Convenience Items or Services:** Items that are primarily for your convenience. These are items that are not directly related to Covered Medical Services.
17. **Cosmetic Surgery:** Any procedures, services, equipment or supplies provided in connection with elective cosmetic surgery that is intended primarily to improve your appearance or for your psychological benefit. The Plan will, however, cover the following services:
 - a. As required by the Women's Health and Cancer Rights Act of 1998, Provide benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema), and
 - b. cover services and supplies in connection with reconstructive surgery that is necessary to restore part of the body that is injured or deformed by acute trauma, infection or other pathological disease that occurred while you were an enrollee under the Plan, and
 - c. cover reconstructive surgery to correct congenital malformations or anomalies resulting in a functional defect or impairment of a child covered under this Plan.
18. **Custodial Care:** Hospital care, nursing home or skilled nursing facility care, home care or any other service that is custodial in nature. Care is considered custodial when it is primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training. For example, custodial care includes assisting in activities of daily living such as walking, getting in and out of bed, bathing, dressing, eating and taking medicine.
19. **Dental Care.** Under your hospital and medical Benefits, we will not cover: treatment of cavities and extractions; care of the gums or bones supporting the teeth; treatment of periodontal abscess; treatment of dentigerous cysts; removal of soft tissue impacted teeth; orthodontia (including braces); false teeth; orthognathic surgery; or any other dental services you may receive.
20. **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.
21. **Equipment.** We will not cover air conditioners, humidifiers, dehumidifiers, air purifiers, exercise equipment, arch supports, orthotics, or any other type of personal convenience item even if ordered by your Primary Care Physician or other Provider.
22. **Experimental Procedures and Related Equipment and Supplies.** We will not cover procedures or services, including transplants that, in our sole judgment, are experimental or

investigative in nature; nor will we pay for equipment or supplies related to experimental procedures. Experimental procedures include all "experimental" or "investigational" therapies or surgeries that are not generally accepted, as reflected by national scientific and peer medical literature. In addition, any therapy subject to government agency approval must have received final approval before it will be considered for coverage.

23. **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan.
24. **First Aid Supplies.** We will not cover common first aid supplies.
25. **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the purpose of obtaining medical services.
26. **Free Care.** We will not cover any care if the care is furnished to you without charge or would normally be furnished to you without charge. This exclusion will also apply if the care would have been furnished to you without charge if you were not covered under this Summary Plan Description or under any other health benefit plan or other insurance.
27. **Government Programs.** We will not pay for Covered Services to the extent that Benefits for such services are payable under Medicare or any other federal, state or local government program, except that we will pay even though you are eligible for Medicaid.
28. **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.
29. **Illegal acts.** Charges for services received as a result of Injury or Sickness, occurring directly or indirectly, as a result of a Serious Illegal Act by the Covered Person. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required.
30. **Illegal drugs or medications.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan.
31. **Infertility Treatment.** We will cover the diagnostic work-up to confirm diagnosis of infertility. We will not cover services for treatment of infertility such as: artificial insemination, in-vitro fertilization, fertility drugs, sonograms, SCORIF (Stimulated Cycle Oocyte Retrieval Intravaginal Fertilization), IVC (Intravaginal Culture), fertility drugs, sonograms, or other infertility procedures. We will not cover diagnostic procedures or tests performed after a diagnosis of infertility has been confirmed, or that are related to infertility treatment, such as those used to stage fertilization procedures or determine readiness for fertilization.
32. **Instructional Programs.** We will not pay for charges for instructional or educational programs such as, but not limited to, childbirth classes, vocational training or testing, diet programs, nutritional programs or smoking cessation classes.
33. **Mammoplasty.** We will not cover mammoplasty for reasons of augmentation, asymmetry (unrelated to breast reconstruction), or removal of breast implants. Please see item 17 for breast reconstruction coverage.
34. **Mandated or Court Ordered Care.** We will not cover any medical, psychological, or psychiatric care which is the result of a court order or otherwise mandated by a third party (such as, but not limited to, your employer, licensing board, recreation council, or school), unless such care is determined to be Medically or Psychologically Necessary.
35. **Medical Reports.** We will not cover expenses for medical report preparation and presentation, nor will we pay for provider appearances at hearings and court proceedings.

36. **Medical/Surgical Services or Supplies for Control of Obesity or Morbid Obesity.** We will not cover any surgery, medical services or supplies intended for control of either obesity or morbid obesity (such as dietary control, counseling or weight maintenance programs) even if the obesity or morbid obesity aggravates another condition or illness.
37. **Mental Health/Substance Abuse.** Covered Medical Services do not include the following conditions and treatments for mental health and substance abuse services:
- Sexual and Gender Identity Disorders;
 - Treatment for smoking or nicotine addiction;
 - Marital or Relationship Counseling;
 - Psychological testing or neuro-psychological testing for psychological reasons;
 - Outpatient psychotherapy or counseling for personal growth or life and social enrichment;
 - Educational services of any type for any reason.
38. **Non-Compliance with Treatment Recommendations.** We will not cover services that are provided as the result of an Enrollee's refusal to comply with a physician's or other provider's recommendations or orders, or failure to cooperate with a prescribed plan of treatment or recovery.
39. **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.
40. **Non-Referred Services.** Services not provided, ordered or Referred by a Network Physician (except when authorized by QualChoice through its pre-authorization policies and procedures).
41. **Nutritional Counseling.** Benefits are not available for dietary control counseling or weight maintenance programs. However, for Enrollees who are diagnosed with diabetes while covered under the Plan, nutritional counseling may be covered as part of a comprehensive diabetic education program.
42. **Premarital Laboratory Work.** We will not cover premarital laboratory work required by any state or local law.
43. **Private Duty Nurses.** We will not cover private duty nurses.
44. **Private Room.** If you occupy a private room, you will have to pay the difference between the hospital's charges for private room and the hospital's most common charge for semi-private accommodations, unless QualChoice determines that it was Medically Necessary for you to have a private room.
45. **Rehabilitation Services.** We will not cover rehabilitation services primarily intended to improve the level of physical functioning for purposes of enhanced job, athletic or recreational performance, including but not limited to work hardening programs, back schools, and programs of general physical conditioning.
46. **Required Examinations or Services.** We will not cover examinations or services required or recommended by a third party such as those for the purpose of obtaining or maintaining employment, obtaining insurance and/or professional or other licenses, or precedent to engaging in travel, athletic or recreational activities, or attending a school, camp, or other program.
47. **Research or Study.** We will not cover any service provided in connection with research or study.
48. **Residential Care.** Services or treatment in a residential care facility are not covered unless the service or treatment is a result of:
- damage to the spinal cord by trauma, infection, tumor, disease, developmental defect or degenerative disorder or is a result of injury to the brain, and the severity of the damage must result in lack of normal function in three (3) of four (4) areas: paralysis, sensation, bladder control and bowel control.
 - traumatic injury to the brain such as diffuse axonal injury, hypoxic-ischemic injury, contusions, hemorrhage, infarction, hematoma, and intracranial pressure. The severity of the damage

must result in lack of normal function in three (3) of four (4) areas: mobility, language, ability to swallow, and cognition.

The maximum number of days allowed per calendar year is 60 days and requires pre-authorization

49. **Reversal of Sterilization.** We will not cover any procedures or related care to reverse previous sterilization.
50. **Routine Care of Feet.** We will not cover any services or supplies in connection with (1) care of flat feet; (2) supportive devices of the foot, such as arch supports or pelvic/spinal stabilizers; (3) care of corns or calluses; (4) care of toenails; (5) care of fallen arches, weak feet, chronic foot strain; or (6) orthotics for sports use. However, when related to diabetes or circulatory problems, items (3) and (4) and covered if Medically Necessary and there is a Referral from your Primary Care Physician.
51. **Second Surgical Opinion and Consultation with Specialist.** We will not cover both a second surgical opinion and a consultation with the same specialist or a practice partner with respect to the same or related surgical procedure.
52. **Services Not Specified as Covered.** We will not cover any services not specifically described in this Summary Plan Description.
53. **Sex-Change Treatment.** We will not cover surgical procedures or related care to alter your sex from one gender to the other.
54. **Sperm Preservation.** We will not cover charges related to the donation or preservation of sperm.
55. **Temporomandibular Joint Syndrome.** We will not cover charges related to treatment of TMJ.
56. **Third Party Liability Exclusion.** We will not pay any Benefits to an Enrollee to the extent that the Enrollee has received payment, in whole or in part, from a third party, or its insurer, for past or future medical or hospital or other health care charges as the result of the negligence or intentional act of a third party. If an Enrollee makes a claim for Benefits under this Summary Plan Description prior to receiving payment from third party, or its insurer, the Enrollee (or legal representative for a minor or incompetent) agrees to repay us from any amount of money received by the Enrollee from the third party, or its insurer. Please refer to "Subrogation," for further information concerning repayment of Benefits.
57. **Travel and Transportation Expenses.** We will not cover travel and transportation expenses, even though prescribed by a physician, except for emergency ambulance service or ambulance service for transfer. We will cover charges for transportation to and from site of a covered organ transplant (see Transplant Benefits section 2; E)
58. **Travel or Work Related Immunizations.** We will not cover immunizations for the purpose of fulfilling requirements for personal international travel however, immunizations will be covered if work related or for UA business related.
59. **Vision and Hearing Services.** We will not cover hearing examinations, services or tests, eyeglasses, contact lenses, hearing aids and other vision care and hearing care services and supplies, except Covered Services required for the diagnosis and treatment of diseases of, or injury to, the eyes or ears. The Plan will, however, cover one routine eye exam every 12 months.
60. **Vision Correction.** We will not cover eye surgery to improve vision or to correct refractory errors.
61. **War or Act of War.** We will not cover any services relating to any injury or sickness resulting from war or any act of war (declared or undeclared), or in the armed forces of any country if any government plan covers that injury or sickness.
62. **Workers' Compensation.** We will not cover any care or supplies for any injury, condition or disease if payment is available to you under a Workers' Compensation Law or similar legislation. We will not make any payments even if you do not claim the Benefits you are entitled to receive under the Workers' Compensation Law.

NOTE: With respect to exclusions as a result of the source of the injury contained in numbers 6, 29 and 30 above, the exclusion will not apply if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

LIMITATIONS

1. **Major Disaster or Epidemic.** If a major disaster or epidemic occurs, Network Physicians and Network Hospitals will render medical services as is practical according to their best judgment within the limitation of available facilities and personnel. Neither QualChoice nor any Network Provider has any liability or obligation for delay or failure to provide or arrange any such services to the extent the disaster or epidemic causes unavailability of facilities or personnel.
2. **Circumstances Beyond QualChoice's Control.** Services and other covered Benefits could be delayed or made impractical by circumstances not reasonably within the control of QualChoice, such as: complete or partial destruction of facilities; war; riot; civil insurrection; labor disputes; disability of a significant part of hospital or medical group personnel; or similar causes. If so, Network Physicians and Providers will make a good faith effort to provide services and other Benefits covered hereunder. But neither QualChoice nor UA shall have any other liability or obligation on account of such delay or such failure to provide services or other Benefits.
3. **Refusal to Accept Treatment.** You may, for personal reasons, refuse to accept procedures or treatment recommended by Network Physicians. In such case, neither QualChoice nor UA shall have further responsibility to provide care for the condition under treatment, unless you later recant the refusal and agree to follow the recommended treatment or procedure.

IF YOU HAVE ANY QUESTIONS ABOUT BENEFITS OR COVERAGE, PLEASE CALL QUALCHOICE DURING OFFICE HOURS AT (501) 228-7111.

COMPLAINTS & APPEALS

COMPLAINT AND APPEAL PROCEDURE

The University of Arkansas recognizes the need to respond in a timely and effective manner to your questions, concerns and complaints. We contract with QualChoice to administer a Complaints and Appeals procedure on our behalf as described in this section.

Any problem or dispute between a Covered Individual and QualChoice of Arkansas, Inc. or between a Covered Individual and a Network Provider must be dealt with through the Complaint and Appeals process. Such procedure shall include the following steps:

Step 1: Informal Communication

QualChoice welcomes discussion of any problems. Enrollees may discuss any situation with their QualChoice customer service representative. QualChoice will make every effort to resolve these issues in an informal manner. If any complaint is not settled at this level, the Enrollee may proceed to the next step in the process.

Step 2: Formal Complaint - Management Review

A formal complaint may be filed by submitting a "Formal Complaint" regarding the issue. Formal Complaint forms are provided to Enrollees upon request. If the Enrollee wishes, a QualChoice customer service representative will help the Enrollee complete the form. Upon receipt of the Formal Complaint, an officer or other agent of QualChoice will conduct a review of the complaint and respond with a decision as soon as possible, but no later than sixty (60) days after receipt of the written complaint.

Step 3: Appeal Process - University of Arkansas Review

(If the dispute is over a determination of Medical Necessity and the Appeal process described in, "Procedures for Pre-authorization", and there is no resolution, further appeal follows this grievance process from Step 3 forward.)

If not satisfied with the outcome of Step 2, the Enrollee may submit a written "Appeal" and request additional review within 30 days of the outcome of Step 2. This request should state the reasons on which the Appeal is based. Within 15 days of receipt of the written Appeal, QualChoice will respond to the Enrollee indicating the Appeal has been forwarded to the University of Arkansas for review. The University of Arkansas will render a written decision on the appeal within 60 days. The response will explain the reasons for its finding and will include contract language and/or policy upon which the judgment is based. Notification of the decision will be communicated immediately by QualChoice upon receipt from the University.

Emergency Appeals: In an Emergency or in urgent circumstances, you may pursue a complaint or appeal with QualChoice directly by calling QualChoice at (501) 228-7111 or (800) 235-7111.

Time Limits for Complaints and Appeals: QualChoice must receive Written Complaints or Appeals within thirty (30) days following the event that is the issue. Failure to submit a written complaint or appeal within the thirty (30) days constitutes a waiver of all rights against the University of Arkansas and QualChoice of Arkansas, Inc.

Any appeal regarding a determination not to authorize payment due to failure to meet Medical or Psychological Necessity should follow the Utilization Review Appeal process as explained in the written denial letter which will be sent to the member at the time the denial is issued. Any member who disagrees with the outcome of the Utilization Review Appeal process after all appeals have been exhausted, may enter this Complaint and Appeal process at Step 3.

MISCELLANEOUS PROVISIONS

1. NO ASSIGNMENT

You cannot assign any Benefits or monies due under this Plan to any person, corporation, organization or other entity. Any assignments by you will be void and have no effect. Assignment means the transfer to another person, corporation, organization or other entity of your right to the Benefits provided under this Plan.

2. NOTICE

Any notice that The University of Arkansas System or QualChoice gives to an Enrollee will be in writing and mailed to them at the address as it appears on our records. If you have to give UA or QualChoice any notice, it should be in writing and mailed to the address set forth in the General Information section of this Summary Plan Description.

3. YOUR MEDICAL RECORDS AND CONFIDENTIALITY

The Plan Sponsor will provide or make available a privacy notice to all enrollees specifically outlining all uses and disclosures of Protected Health Information, including confidentiality of medical records, for benefit determination and health care operations. You may request a copy of the privacy notice from your Human Resource office or QualChoice.

4. NOTICE OF CLAIM

In order for QualChoice to make payments under this program, QualChoice must receive your claim for Benefits within three hundred, sixty-five (365) days after you receive the service.

5. WHO RECEIVES PAYMENT UNDER THIS PLAN

Payments under this Plan for Covered Medical Services provided in a Network Hospital or by a Network Physician or Network Provider will be made on UA's behalf by QualChoice directly to the hospital, physician or provider. If you receive Covered Medical Services in an Out-of-Network Hospital, or from any other Out-of-Network Provider of care covered under the Plan, QualChoice, on UA's behalf, may pay either you or the hospital or other provider.

6. RECOVERY OF OVERPAYMENTS

On occasion, a payment may be made to or for you when you are not covered, for a service that is not covered, or which is more than is appropriate for that service. When this happens, QualChoice will explain the problem to you, and you must return to QualChoice within sixty (60) days the amount of the mistaken payment, or provide QualChoice with written notice stating the reasons why you may be entitled to such payment. To the extent permitted by applicable law, QualChoice, on UA's behalf, may reduce future payments to you in order to recover any mistaken payment. Overpayments and mistaken payments made to providers will be recovered directly from them

7. COMPLAINTS AND APPEALS PROCEDURE

You are entitled to have any complaint or appeal heard and, under the terms of UA's agreement with QualChoice, QualChoice is obligated to hear and resolve such complaints or appeals, including complaints against Network Physicians and other Network Providers, in an equitable fashion according to the rules and procedures set forth above in section, "Complaints & Appeals."

8. RIGHT TO DEVELOP GUIDELINES

The University of Arkansas System reserves the right to cause QualChoice to develop or adopt criteria that set forth in more detail the instances and procedures when QualChoice, acting on UA's behalf, will make payments on Benefits under the Plan. Examples of the use of the criteria are: to determine whether care was Medically Necessary; whether Emergency care in the

outpatient department of a hospital was Medically Necessary; or whether certain services are skilled care. These criteria will be interpretive and illustrative only and will not be contrary to any term or provision of the Plan. If you have a question about the criteria that apply to a particular Benefit, you may contact QualChoice for further information.

9. REVIEW

If a claim for Benefits is denied, you may obtain a review of the denial through the appeal procedure described in section, "Complaints & Appeals."

10. LIMITATION ON BENEFITS OF THIS PLAN

No person or entity other than the Plan Sponsor, QualChoice and Enrollees is or shall be entitled to bring any action to enforce any provision of the Plan against the University of Arkansas, QualChoice or Enrollees, and the covenants, undertakings, and agreements set forth in the Plan shall be solely for the benefit of, and shall be enforceable only by, The University of Arkansas, QualChoice and the Enrollees covered under the Plan. Nothing herein shall be deemed to authorize an action against the University of Arkansas or to waive its sovereign immunity.

11. APPLICABLE LAW

The Plan, the rights and obligations of The University of Arkansas, QualChoice and Enrollees under the Plan, and any claims or disputes relating thereto, shall be governed by all applicable state and federal laws.

12. HEADINGS

Section and subsection headings contained in this Summary Plan Description are inserted for convenience of reference only, shall not be deemed to be part of this Summary Plan Description for any purpose, and shall not in any way define or affect the meaning, construction or scope of any of the provisions hereof.

13. PRONOUNS

All pronouns and any variations thereof shall be deemed to refer to the masculine, feminine, neuter, singular or plural, as the identity of the person or entity may require.

14. FUNDING

Cost of the Plan. The University of Arkansas System shares the cost of Employee and Dependent coverage under this Plan with the covered Employees.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

COORDINATION OF BENEFITS

Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans—including Medicare—are paying. When a Covered Person is covered by this Plan and another Plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered Children are covered under two or more plans, the plans will coordinate benefits when a claim is received. The University of Arkansas Health Plan includes a coordination of benefits (COB) provision to eliminate duplication of payment for services. There is no COB for prescription drugs and The University of Arkansas Health Plan does not coordinate against the following kinds of coverage:

- Individual policies or contracts
- Medicaid
- School accident coverage
- Supplemental sickness and accident policies

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charges.

How COB Works: If you are covered by more than one group plan, COB guidelines determine which carrier pays for covered services first.

- The plan that pays first is your primary plan. This plan must provide you with the maximum benefits available to you under the plan.
- The plan that pays second is your secondary plan. This plan provides payments toward the balance of the cost of covered services, up to the total allowable expense determined by the carriers.

COB Allowable Expense: Allowable Expense means a health care expense, including deductible, coinsurance or co-payments, that is covered in full or in part by any of the plans covering the person as stated below. This means that an expense or service that is not a Covered Service by any of the plans is not an Allowable Expense.

1. If you are covered by two (2) or more plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fee for a specified benefit is not an Allowable Expense.
2. If you are covered by two (2) or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an Allowable Expense.
3. If you are covered by one plan that calculates its benefits or services on the basis of usual and customary fees and another plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all plans.

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

1. Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
2. Plans with a coordination provision will pay their benefits up to the Allowable Charge:
 - A. The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

- B. The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
- C. The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
- D. When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:
 - i. The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
 - ii. If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.
- E. When a child's parents are divorced or legally separated, these rules will apply:
 - i. This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
 - ii. This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.
 - iii. This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.
 - iv. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.
 - v. For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.
- 3. Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.
- 4. If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

Reduction of Benefits: When this Plan is the secondary plan, we may reduce our benefits so that the total benefits paid or provided by all plans are not more than one hundred percent (100%) of the total COB allowable expenses. We will evaluate each claim for Secondary Benefits as follows:

1. Determine whether services are Covered Services under this Plan.
2. Determine whether there are any unpaid allowable expenses.
3. Pay up to one hundred percent (100%) of the total Allowable Expenses incurred.

Benefits will be reduced, so that benefits payable under the all plans do not total more than the COB Allowable Expenses. When the benefits of this plan are reduced as described, each benefit is reduced in proportion and the charged against any applicable benefit limits or maximums.

Enforcement of Provisions: The University of Arkansas Health Plan will coordinate your benefits, if you properly inform them of your coverage under any other health care plan. We are required to determine if and to what extent you are covered under any other health care plan. You agree to furnish any needed information in order to ensure that claims are processed correctly. Should you fail to provide this information, benefit payments may be delayed.

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

Payments to Other Health Benefits Programs. We may repay to any other Health Care Benefits Plan the amount that it paid for covered services and which we decide we should have paid. These payments are the same as Benefits paid and they satisfy our obligation to a Summary Plan Description Holder, covered dependents, and covered spouses under this Summary Plan Description.

Our Rights to Recover Overpayment. In some cases, we may have made payment mistakenly, such as, where an Enrollee had coverage under another Health Care Benefits Plan. Under these circumstances, it will be necessary for the Summary Plan Description Holder to refund to us the amount of the mistaken payment. We also have the right to recover the mistaken payment from the other Health Care Benefits Plan if we have not already received payment from that other program. You agree to take such further actions, to execute, deliver and file such further documents that we require to help us recover an overpayment or mistaken payment. In accordance with, and to the extent permitted by applicable law, we may reduce our future payments to the Summary Plan Description Holder in order to recover a mistaken payment.

Coordination of this Plan with Automobile Insurance. This Plan will be coordinated with medical benefits available under your or another party's motor vehicle liability insurance coverage including both basic personal injury protection benefits ("PIP") and/or optional motor vehicle insurance to the extent of applicable law. Whenever legally possible, the Plan will be secondary.

Coordination of Benefits in Transplant Cases. Coverage under this Summary Plan Description will be primary where an Enrollee is the donor or the recipient of a transplant that is otherwise covered under this Summary Plan Description. Coverage is not available when an Enrollee is the donor for a transplant that is not covered under this Summary Plan Description or the recipient is not an Enrollee. Please see Section: "Transplant Benefits," for a description of the Benefits that are covered. Coverage of organ and human tissue procurement Benefits (tissue typing, surgical procedure, storage expense and transportation costs) directly related to the donation of an organ or human tissue by another person to the Enrollee (Donation Benefits) will be as follows:

- o If the donor is covered under another Health Care Benefit Plan that includes coverage for donations used in the covered transplant procedure, then the donor's plan will be primary and the University of Arkansas coverage will be secondary.

- If the donor is not covered by any Health Care Benefit Plan or is covered under a Health Care Benefit Plan that excludes from coverage donation benefits, then the University of Arkansas coverage will be primary.

IF YOU HAVE QUESTIONS ABOUT COORDINATION OF BENEFITS, PLEASE CALL QUALCHOICE DURING OFFICE HOURS AT (501) 228-7111.

SUBROGATION

If you are injured or become ill through the act of a third party, the University of Arkansas will provide reimbursement for Covered Services for such injury or sickness. Acceptance of such Covered Services will constitute consent by you to the provisions of this Section. The University of Arkansas will not be required to obtain a separate recovery authorization signed by you as a prerequisite to recovery by QualChoice under this Summary Plan Description against any other party for the cost of such Covered Services. The Plan's recovery rights under this section extend to worker's compensation and uninsured and underinsured motorist coverage.

You agree to protect the University of Arkansas's lien rights if you are injured or become ill through the act of a third party. If you are due money from any other party for the cost of such Covered Services, your University of Arkansas Benefits will be subrogated for you for the purpose of collecting for those Covered Services. The University of Arkansas will have the right to bring suit against any other party in your name to the extent permitted by applicable state law. If you receive payment from any other party by suit or settlement for the cost of Covered Services, you are obligated to reimburse the University of Arkansas, less any pro rata share of the reasonable attorney's fees and costs you sustained in obtaining such recovery.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms: "Covered Person" means anyone covered under the Plan, including minor dependents except as provided by law the plan shall have no obligation.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Recovery from another plan under which the Covered Person is covered. This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements.

You agree to take further actions, to execute, deliver and file further documents and instruments, to furnish such information and assistance, as the University of Arkansas may reasonably require to fully effectuate the terms of this section and to facilitate enforcement of the University of Arkansas's rights under this section. You agree to take no action prejudicing the rights and interests of the University of Arkansas under this section.

CONTINUATION OF BENEFITS

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end.

A notice concerning your COBRA rights will be provided to you at the time you become a participant in the Plan. Also, a notice regarding your rights to elect COBRA coverage will be given when you have a "qualifying event" entitling you to elect COBRA continuation coverage.

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

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

1. Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee.
2. Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order.

Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

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

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

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

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

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

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

What factors should be considered when determining to elect COBRA continuation coverage?

You should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help you avoid such a gap. Second, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy, which does not impose such pre-existing condition exclusions. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the

end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

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

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

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

Is a covered Employee or Qualified Beneficiary responsible for informing the Campus Human Resources Department of the occurrence of a Qualifying Event? Yes, the Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Campus Human Resources Department or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

1. the end of employment or reduction of hours of employment; or
2. death of the employee; or
3. commencement of a proceeding in bankruptcy with respect to the employer; or
4. enrollment of the employee in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Campus Human Resources Department or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Campus Human Resource Department or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Campus Human Resources Department.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the department listed below.

Campus Human Resources Department

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

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

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

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Campus Human Resources Department or its designee receives ***timely notice*** that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

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

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected

for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

1. The last day of the applicable maximum coverage period.
2. The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
3. The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.
4. The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
5. The date, after the date of the election that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
6. In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
 - A. (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
 - B. the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

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

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

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

1. In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

2. In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:
 - A. 36 months after the date the covered Employee becomes enrolled in the Medicare program; or
 - B. 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.
3. In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Spouse, surviving Spouse or Dependent child of the retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the retiree.
4. In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.
5. In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the COBRA Administrator in accordance with the procedures above.

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

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

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

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

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

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

Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage? Since this plan does not have a conversion option for similarly situated non-COBRA beneficiaries, there is no right to enroll in a conversion health plan at the end of COBRA continuation coverage.

Special rules for individuals qualifying for Retiree coverage. For participants qualifying for retiree coverage under the Plan, such individuals will be required to elect between COBRA coverage and retiree coverage under the Plan. Under retiree coverage, HIPAA Family Status Changes, but not HIPAA Special Enrollment rights due to loss of other coverage, applies. Thus, if a dependent is not covered at the time of retiree coverage, a dependent may not be added later as a result of loss of coverage. A dependent may be added to retiree coverage if the retiree adds a dependent through marriage or birth or adoption of a child. If the employee elects COBRA coverage instead of retiree coverage, all HIPAA special enrollment rights to apply during COBRA continuation period.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Campus Human Resources Department informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Campus Human Resources Department.

PLAN ADMINISTRATION

PLAN ADMINISTRATOR. University of Arkansas Medical Benefit Plan is the benefit plan of The University of Arkansas System, the Plan Administrator, also called the Plan Sponsor. An individual may be appointed by The University of Arkansas System to be Plan Administrator and serve at the convenience of the Employer.

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

No legal action may be taken regarding the Plan until all Complaints and Appeal rights, as described in this SPD, have been exhausted. In the event that legal papers need to be served regarding this Plan, service shall be made on the President of the University of Arkansas. Nothing herein shall waive immunities from suit or civil liability to which the Plan, the University of Arkansas system or any officer, trustee or employee of the University of Arkansas are entitled.

This Plan is self-funded by the University of Arkansas System This means the cost of your and your dependents medical care is paid out of monies set asked for that purpose by the UA and from employee contributions. The University of Arkansas System has also obtained special insurance protection in the event of large claims. Other Benefits, either insured or self-funded, may also be provided by the University of Arkansas System and such Benefits (if any) are described in separate documents.

AMENDMENT OR TERMINATION

The University reserves the right to amend this plan at any time upon notice to the participants. The University of Arkansas System reserves the right to terminate the plan in its entirety, or for specific classes of employees, or to change the employee contribution required. The employee contribution required may be different for different classes of eligible employees.

CHOOSEWELL WELLNESS PROGRAM

The University of Arkansas System offers the ChooseWell Wellness Program to members covered under its health program. The ChooseWell Wellness Program is designed to assist members and their dependents in learning how living a healthy lifestyle results in spending less money for healthcare.

Go to www.uasys.edu/choosewell for additional information or call 1-888-795-6810 for information on health coaching, disease management and other programs that are available to you and your covered dependents.

GENERAL INFORMATION

1. **PLAN:** The name of your Plan is the University of Arkansas Medical Benefit Plan.
2. **PLAN EFFECTIVE DATE:** The Original Effective Date of the Plan is November 1, 1994. This Plan Document/Summary Plan Description sets forth the provisions of the Plan, Effective January 1, 2009.
3. **PLAN SPONSOR/EMPLOYER:** The Plan Sponsor is the University of Arkansas System. The address and telephone number of the Plan sponsor is:

The University of Arkansas System
c/o President
2404 N. University Avenue
Little Rock, Arkansas 72207
501-686-2500

4. **PLAN SUPERVISOR:** The University of Arkansas Medical Benefit Plan is supervised and administered by:

QualChoice
P. O. Box 25610
Little Rock, AR 72221-5610

QualChoice is licensed by the State of Arkansas.

5. **PLAN FISCAL YEAR:** The Fiscal Year of the Plan begins on July 1 of each year and will end on June 30 of the following year.
6. **TYPE OF ADMINISTRATION:** Contract Administration.
7. **THE FOLLOWING CAMPUSES OF THE UNIVERSITY OF ARKANSAS SYSTEM PARTICIPATE IN THE UNIVERSITY OF ARKANSAS MEDICAL BENEFIT PLAN:**

University of Arkansas Fayetteville and certain related entities

University of Arkansas Medical Sciences

University of Arkansas at Little Rock

University of Arkansas Cooperative Extension Service

University of Arkansas at Pine Bluff

University of Arkansas at Monticello

University of Arkansas Community College at Batesville

Arkansas School for Mathematics, Sciences, and Arts

Phillips Community College of the University of Arkansas

Plan Sponsor HIPAA Certificate Statement

We understand that medical information about Participants and their health is personal, and we are committed to protecting medical information. As the Employer/Plan Sponsor, the University of Arkansas (henceforth "the Plan Sponsor") agrees to comply with the following restrictions and conditions respecting its use and disclosure of Protected Health Information ("PHI") as defined by federal regulations at 45 C.F.R 164.501, and as may be disclosed to the Plan Sponsor by the Plan. As the Employer/Plan Sponsor, we agree that we will:

1. Not use or further disclose PHI disclosed to us by the Plan other than as permitted or required by the plan documents, or as is required by law, within the meaning of federal regulations establishing Standards for the Privacy of Individually Identifiable Health Information.
2. Ensure that any agents, including a subcontractor to whom we provide PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
3. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
4. Report to the Plan any use or disclosure of PHI of which the Plan Sponsor becomes aware that is inconsistent with the uses and disclosures provided for or permitted in the plan documents;
5. Make records containing PHI that is used to make decisions about a Participant available for inspection and copying by the Participant, or otherwise arrange for the Participant to obtain a copy of such records. Participants will be charged a fee for the cost of copying, mailing or other supplies. In some situations, the Plan or we are allowed to deny this request.
6. Make PHI about Participants available for amendment in response to requests by Participants for amendment of records that they feel contain incomplete or incorrect information about them. Such requests may be denied in certain circumstances, and in such cases Participants will be informed of procedures for disagreeing with amendment denials. We or the Plan may ask that these requests be in writing and provide a reason that supports the request;
7. Make records available to permit Participants to obtain an accounting of certain types of disclosures of PHI about them;
8. Make our internal practices, books, and records relating to the use or disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with regulatory Standards for the Privacy of Individually Identifiable Health Information;
9. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose of the disclosure, except that, if such return or destruction is not feasible, limit further uses and disclosures to those permitted by law; and
10. Ensure that there is adequate separation between the Plan and the Plan Sponsor by providing:
 - A description of individuals who are under the control of the Plan Sponsor and who will have access to PHI to be disclosed to the Plan Sponsor by the Plan, including any employee or person who receives PHI relating to payment under, or health care operations of, or other matters pertaining to, the Plan in the ordinary course of business, and;
 - Restricted access to and use of the PHI by such employees and others to the plan administration functions that the Plan Sponsor performs for the Plan, and;
 - An effective mechanism for resolving any issues related to noncompliance by the above-referenced persons with the requirements of the plan documents.

Selected individuals in the office of Human Resources may utilize PHI in the course of their duties and responsibilities and have trained in accordance with the federal regulations and the Plan Sponsor Policies and Procedures regarding use and disclosures of PHI.

You may receive a list of these individuals by contacting your Human Resource department.