

Benefits

HEALTH PLAN

Summary Plan Description

This brochure is not a contract. Coverage is described in rather general terms; the extent of your coverage at all times is governed by the complete terms of the Plan Document.

Vanderbilt University reserves the right to:

- a) modify, amend, or change the provisions of the Plan, subject to the contract administrator's approval where appropriate;
- b) discontinue any option offered under the Plan at any time;
- c) change the premiums required to be paid by participants at any time; and
- d) discontinue the plan at any time.

This health plan is partially funded by Vanderbilt University and administered by BlueCross BlueShield of Tennessee and Aetna.



HUMAN
RESOURCES

SUMMARY OF HEALTH PLAN BENEFITS

Eligibility

All full-time faculty and full-time regular exempt staff are eligible for coverage immediately. All other full-time regular employees are eligible on the first of the month following 60 days of employment. For employees returning to Vanderbilt, within the specified time frame under the bridging policy (HR-007), eligibility is immediate. In the case of an employee who acquires a dependent after becoming eligible for coverage, the dependent is eligible on the date acquired. For staff moving from regular part-time status to regular full-time status, service while in the regular part-time status counts toward the waiting period for eligibility.

Health Plan Options

The Vanderbilt Health Care Plan for Faculty and Staff (the Plan) includes a choice of three options, including:

- Aetna HealthFund
- Aetna Standard
- BlueCross Advantage P

All eligible faculty and staff are automatically enrolled for individual coverage under the default option (Aetna Standard, employee-only tier), unless within 30 days of eligibility the employee authorizes coverage under one of the other Plan options and/or one of the other tiers. If an employee enrolls for coverage of other family members, both the employee and his or her eligible dependents must be enrolled in the same Plan option.

Coverage Tiers

Vanderbilt offers a four-tiered rate structure:

1. Individual Coverage: Covers the employee only.
2. Individual and Spouse/Certified Domestic Partner: Covers the employee and the employee's spouse or certified domestic partner (see definition).
3. Individual and Child(ren): Covers the employee and all eligible dependent children.
4. Family Coverage: Covers the employee, the employee's spouse or certified domestic partner (see definition), and all eligible dependent children.

See definition of eligible dependents on page 6.

Waiving Health Plan Coverage

In the event that you are covered by another health plan, you may elect to waive coverage under the Vanderbilt Health Care Plan. To waive coverage, you must complete the Benefits Enrollment Form and the Health Plan Waiver form within 30 days of Health Plan eligibility.

Special Enrollment Provisions

If you waive coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days of the event that causes your other coverage to end. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Effective Date of Coverage

Coverage is effective on the date an employee or dependent first becomes eligible for coverage, provided that application for coverage is made no later than 30 days after becoming eligible.

Pre-Existing Conditions

There is no waiting period for coverage of pre-existing conditions under any of the options offered under the Plan.

How to Enroll

You may enroll by completing the Benefits Enrollment Form during orientation at the time you begin work at Vanderbilt.

To enroll a child for whom you are required by court order to provide health insurance coverage, a qualified medical child support order must be provided to the Plan Administrator or its designee for review.

To enroll a certified domestic partner or a dependent of a certified domestic partner, the employee must complete the Vanderbilt University and Medical Center Statement of Domestic Partnership, a tax certification of dependency for health insurance, and register with the office of Human Resources. Once properly registered, the staff member will follow the same steps as required for all other health benefit enrollments. These forms can be obtained by calling the office of the Director of Benefits Administration, Human Resources at 615.322.8303. Coverage for a certified domestic partner and/or his or her dependents does not begin until the registration process is complete.

Changing Coverage

Plan options and coverage tiers may only be changed during Open Enrollment, which generally occurs each October (contact the Office of Benefits Administration for exact dates). If during the Open Enrollment period no change in coverage is elected, the coverage already in effect will continue, if it is still offered. If current coverage is no longer available and no election is made during Open Enrollment, coverage will revert to the default option with individual coverage.

In the event of a qualifying event (see definition) during the plan year, you may change coverage tiers by completing a Notification of Family Status Change form. Supporting documentation must be attached to the form and be submitted to the Office of Benefits Administration within 30 days of the qualifying event that triggered the need for the change in coverage. Faxed forms are not accepted. The effective date of any coverage change due to a qualifying event will be determined based on the supporting documentation provided with the Notification of Family Status Change form.

Termination of Coverage

If a person ceases to be employed by Vanderbilt, individual coverage and coverage for all eligible dependents will terminate at midnight on the last day of the month in which they terminate employment.

Divorce automatically terminates the coverage of the employee's spouse at midnight on the last day of the month in which the divorce is finalized. It is the participant's responsibility to notify Office of Benefits Administration of this change of status within 30 days by filing a Notification of Family Status Change form with qualifying documentation.

Coverage for a dependent child shall end at midnight on the last day of the month in which the child no longer qualifies as a dependent. It is the participant's responsibility to notify Office of Benefits Administration of this change of status within 30 days by filing a Notification of Family Status Change form with qualifying documentation.

Coverage for a certified domestic partner shall end at midnight on the last day of the month in which the relationship terminates. Employees receiving benefits under a domestic partner arrangement must notify the Office of Benefits Administration within 30 days by filing a Termination Statement of Domestic Partnership. A 12-month waiting period must elapse from the date of the Termination Statement signature before an employee can enroll a new domestic partner.

If payment is required and is not made in full within 30 days of the due date, coverage for the employee and his or her dependents shall cease as of the date the payment is due.

For certain qualifying events, arrangements can be made to continue coverage beyond the normal termination date. Your rights to continue group health plan coverage are described in the section entitled "Continuing Group Coverage – COBRA" in this booklet.

If your health care coverage terminates, the Plan Administrator will provide a certificate that documents your coverage for the previous 18 months.

Should Vanderbilt determine to terminate the Plan, written notice will be provided along with information regarding alternatives for coverage and procedures for obtaining the coverage.

Non-Assignment of Benefits

With the exception of Qualified Medical Child Support Orders, Plan participants cannot assign, pledge, borrow against or otherwise promise any benefit payable under the Plan before receipt of that benefit. Interest in the Plan is not subject to the claims of creditors. However, all or a portion of the benefits provided by the Plan, at the option of the Plan, unless the individual requests otherwise in writing, may be paid directly to the person rendering such service. Any payment made by the Plan in good faith pursuant to this provision shall fully discharge the Plan and the Plan Sponsor to the extent of such payment.

General Provisions

Vanderbilt University has the sole and absolute discretion and authority to interpret the terms of the Plan, resolve ambiguities and inconsistencies in the Plan, and make all decisions regarding eligibility and/or entitlement to coverage or benefits.

Vanderbilt University has the right to recover any excess payments or benefits that were not paid in accordance with Plan terms.

Health care benefits under the Plan are not vested. Participation in the Plan does not constitute an employment contract and does not afford any employee a right to continued employment.

COST CONTAINMENT

This section explains cost containment features that are included in the Plan. It is very important that you read this section carefully and become familiar with each of the cost containment features because you will have to make important decisions regarding the health care you use.

Selection of Provider – Physicians and Facilities

Each of the options provide both in- and out-of-network benefits described in the Evidence of Coverage or Summary Booklet of each option. Network directories are available online at BlueCross BlueShield of Tennessee (www.bcbst.com) and Aetna (<http://www.aetna.com/docfind/custom/vanderbilt/>) Web sites.

BlueCross BlueShield of Tennessee for BlueCross Advantage P option, and Aetna for Aetna HealthFund and Aetna Standard options, not Vanderbilt University, have selected the group of health care professionals and facilities for the provider network. Plan participants always have the choice of what services they receive and who provides their health care, regardless of what the Plan covers or pays. The Plan does not provide or ensure the quality of care received.

Deductibles, Copayments, Coinsurance, and Out-of-pocket Maximums

Deductibles, copayments, coinsurance amounts, and out-of-pocket maximums in each of the Plan options are established by Vanderbilt University and are subject to change. To determine the current deductibles, copayments, coinsurance, and/or out-of-pocket maximums, refer to your option's Evidence of Coverage (EOC) or Summary Booklet. Copies are available at <http://hr.vanderbilt.edu/forms>.

Prior Authorization

Prior authorization may be required for certain services in certain options. Failure to follow the prior authorization procedure will result in benefits being reduced or denied.

Refer to your option's EOC or Summary Booklet for more information and specific information related to emergency care.

Plan Payment

The hospitals and physicians that are members of the provider network of the option you have selected may change from time to time. It is advisable to verify a hospital's membership prior to obtaining services. Physicians who participate in the network established for your option have agreed to accept rates negotiated by the health plan option as their charge for participants of this Plan. It is advisable to verify physician membership in the network prior to receiving services. Provider listings are made available on the BlueCross and Aetna Web sites or upon request.

Coordination of Benefits Provision

It is important to understand coordination or non-duplication of benefits if your family members are covered by more than one health plan. These provisions are described in your option's EOC or Summary Booklet.

BlueCross or Aetna may require you to complete a certification stating whether you have other health plan coverage.

Failure to reply to a request for this information will result in the suspension of payments to providers until certification is received.

Maximum Benefit

There is no maximum benefit payable during the individual's lifetime under this Plan.

Subrogation

Subrogation deals with the right of the health care provider to recover payments made on your behalf if you are injured as a result of someone else's action or negligence. Such recovery helps to keep down the cost of your health plan.

For example, if you are injured in an automobile accident caused by someone else; that person's automobile policy may pay for the medical expenses you incur. This Plan has the right to recover from the person who caused the accident, or from his insurance company, any medical expenses that have been paid by this Plan.

Additional details are provided in your option's EOC or Summary Booklet.

Health Plan Exclusions and Limitations

Each health plan option contains its own list of exclusions and limitations for providers, tests, devices, and procedures. It is the employee's responsibility to review exclusions and limitations. Refer to your option's EOC or Summary Booklet for additional information.

Preventive Services

Certain preventive services are covered under each of the options. Refer to your option's EOC or Summary Booklet for additional information.

Prescription Drugs

CAREMARK is Vanderbilt's Pharmacy Benefits Manager. A separate membership identification card for this coverage will be provided. Refer to CAREMARK's Summary Booklet and Web site for specific information regarding the preferred drug list (formulary) and network of participating pharmacies. Your cost for a prescription drug is either a copay or coinsurance amount depending on the tier of drug coverage, such as generic, formulary, non-formulary, or specialty.

Coverage for specialty drugs is available only when filled through one of the Vanderbilt Pharmacies or the CAREMARK mail order program.

Additional information about the prescription drug benefit is available from CAREMARK's handbook, the CAREMARK Web site (www.CAREMARK.com) and the Vanderbilt Human Resources Web site (<http://hr.vanderbilt.edu/benefits/prescription.htm>).

Disease Management

ActiveHealth is Vanderbilt's disease management carrier. The program is designed to help members with chronic conditions manage their health care. Additional information may be found on the Vanderbilt Human Resources Web site (<http://hr.vanderbilt.edu/benefits/diseasemgmt.htm>).

CONTINUING YOUR COVERAGE

Continuation of Group Coverage while on Leave of Absence

If you take an approved leave of absence without pay, you may continue the coverage in force at the time your leave begins. Coverage may be continued throughout the leave period, not to exceed one year for faculty or six months for staff, by paying the required cost of coverage.

Faculty and staff on approved FMLA (Family and Medical Leave Act) leave will continue to receive coverage under the Vanderbilt Health Care Plan at the level, and under the conditions, that such coverage would have been provided if the affected faculty or staff member had continued working. Faculty and staff will be required to continue paying their portion of the monthly cost, either through payroll deduction, if paid leave is taken, or through direct payment, if unpaid leave is taken. If a faculty or staff member does not return from approved leave at the appropriate time, then the University may, under certain circumstances, require that the faculty or staff member reimburse the University for the cost of health coverage paid by the University on the employee's behalf while on leave.

Coverage when Leaving Plan

Unless other arrangements are made, the only coverage provided when leaving the Plan is the benefit for hospital services when a member is hospitalized on the date the Plan is terminated. In this case, benefits for hospital services only will be provided for up to 90 days or until the member is discharged from the hospital, whichever occurs first. These provisions do not apply to a newborn child of a subscriber for whom the Plan Administrator did not receive application for coverage within 31 days following the child's birth.

Continuation Coverage — COBRA

On April 7, 1986, a Federal law was enacted (Public Law 99-272, Title X) requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the Plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage

provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) law. Both you and your spouse should take the time to read this notice carefully.

If you are an employee of Vanderbilt covered by the Plan, you have the right to choose this continuation coverage if you lose your group health coverage under the Plan because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an employee covered by the Vanderbilt Health Care Plan, you have the right to choose continuation coverage for yourself if you lose group health coverage under the Plan for any the following reasons:

1. The death of your spouse;
2. A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
3. Divorce or legal separation from your spouse; or
4. Your spouse becomes eligible for Medicare.

In the case of a dependent child of an employee covered by the Vanderbilt Health Care Plan, he or she has the right to continuation coverage if group health coverage under the Plan is lost for any of the following reasons:

1. The death of an employee;
2. The termination employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with Vanderbilt University;
3. Employee's divorce or legal separation;
4. An employee becomes eligible for Medicare; or
5. The dependent ceases to be a "dependent child" under the Plan.

Under this law, the employee or a family member has the responsibility to inform the Plan Administrator of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the event. Vanderbilt has the responsibility to notify the Plan Administrator of the employee's death, termination of employment, reduction in hours, or Medicare eligibility within 30 days of the event.

When the Plan Administrator is notified that one of these events has happened, you will be notified within 14 days that you have the right to choose continuation coverage. Under the law, you have 60 days from the date you would lose coverage because of one of the events described above to inform the Plan Administrator that you want continuation coverage. If COBRA coverage is elected and payment is remitted to the appropriate office, the coverage is retroactive to the date that coverage would otherwise have been lost by reason of the qualifying event.

If you do not choose continuation coverage, your group health insurance coverage will end.

If you choose continuation coverage, Vanderbilt is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees. A change in the benefits under the plan for active employees will also apply to qualified beneficiaries. You will be allowed to make the same choices as a non-COBRA beneficiary under the Plan, such as during periods of open enrollment. The law requires that you be offered continuation coverage for up to 36 months unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is for up to 18 months. A member who has been classified as disabled by the Social Security Administration at the time of the qualifying event, or within the first 60 days of a qualifying event, may extend continuation coverage. In order to extend coverage for disability beyond 18 months, the member must provide notice of disability within 60 days after the determination of the disability and not later than the end of the first 18 months. If such notice is provided, coverage may be extended up to a maximum of 29 months from the date of the qualifying event, or until the first month that begins more than 30 days after the date of any final determination that the person is no longer disabled (whichever is earlier).

The law also provides that your continuation coverage be terminated for any of the following reasons:

1. Vanderbilt no longer provides group health coverage to any of its employees;
2. The premium for your continuation coverage is not paid on a timely basis;
3. You have or obtain group coverage under another plan, which is not subject to a pre-existing condition limitation or such limitation has been satisfied. However, if other group health coverage is obtained prior to the COBRA election, COBRA coverage may not be discontinued, even if the other coverage continues after the COBRA election;
4. You become eligible for Medicare. However, if Medicare is obtained prior to COBRA election, COBRA coverage may not be discontinued, even if the Medicare coverage continues after the COBRA election; or

5. You do not have to show that you are insurable to choose continuation coverage. However, under the law, you may be required to pay the entire premium for your continuation coverage plus an administrative fee. Once an individual elects COBRA coverage, he has up to 45 days to pay the first premium.

At the end of the 18- or 36-month continuation period, you may be allowed to apply for conversion to an individual health plan. If available, your option's Evidence of Coverage or Summary Booklet will provide additional information.

This law applies to the Group Health Care Plan of Vanderbilt University beginning on July 1, 1986 (under Section 10002(d) of COBRA). If you have any questions about this law, please contact the Plan Administrator, Benefits Administration Office of Human Resources, Vanderbilt University Station B, Box 357700, 2301 Vanderbilt Place, Nashville, TN 37235-7700 (615.322.8330). Also, if you have changed marital status, or you, or your spouse, have changed your address, please notify the Benefits Administration Office at the above address.

DEFINITIONS OF TERMS

Eligible Dependents

1. Your spouse or certified domestic partner. (Certified domestic partner is a person of the same sex that is not related by blood. The partner must not be under 21 years of age, not legally married to anyone else, nor have another domestic partner. This person must be currently in a committed relationship of six months or more duration and reside in a common household sharing joint responsibility for the household with the employee. Certification of domestic partnership must be obtained through the Office of the Director of Benefits, Human Resources.)
2. Your unmarried children from birth to 25 years of age. Children must live with you in a regular parent-child relationship, or reside in a custodial institution for medical reasons or another monitored environment (endorsed by a physician on an annual basis) for medical or behavioral reasons, and depend upon you for more than 70 percent of their support. If a court approved "Qualified Medical Child Support Order" is provided within 31 days of the date issued, the requirement that the child reside with the employee will be waived. They must be children of the employee by birth, legal guardianship or custody, legal adoption or placement in anticipation of adoption, the employee's stepchildren, or the children of the employee's certified domestic partner.
3. Any unmarried children 25 years of age or older who are incapable of self-support because of mental or physical disability, if the disability existed, and is documented with Vanderbilt's Office of Benefits Administration, prior to their reaching the age of 25. Children must live with you in a regular parent-child relationship, or reside in a custodial institution for medical reasons or reside in another monitored environment (endorsed by a physician on an annual basis) for medical or behavioral reasons, and depend upon you for more than 70 percent of their support. They must be children of the employee by birth, legal guardianship or custody, legal adoption or placement in anticipation of adoption, the employee's stepchildren, or the children of the employee's certified domestic partner. The Plan Administrator or its designee must approve the continuation of coverage for this child.

The University reserves the right to audit dependents and may require copies of any legal papers issued to establish a person as your dependent. Only copies of actual court documents issued by the respective courts will be considered as acceptable documentation.

Qualified Medical Child Support Order

A court judgment, decree, or order that:

1. Provides for child support with respect to the child of a group plan participant or provides benefit coverage to such a child, is ordered under state domestic relations law, and relates to benefits under the Plan;
2. Enforces a state medical support law enacted under Medicaid rules;
3. Creates or recognizes the right of the child to receive benefits that the Plan participant or other beneficiary is entitled to under a group plan; and
4. Must include such information as the name and last known mailing address of the Plan participant and each child to which it relates, a reasonable description of the coverage to be provided, the period for which coverage must be provided and each plan to which the order applies.

The HR Benefits Administrator will coordinate the review with legal counsel in a period of no more than 30 days.

Qualifying Event

The birth or adoption of a child; obtaining legal guardianship or custody; a marriage, death, or divorce; certification or termination of a domestic partnership; a change in your spouse's employment that effects your or your spouse's health care coverage; open enrollment allowing change under the spouse's employer coverage; or the termination of the employer contributions for your spouses' insurance coverage. The event status date (e.g., the date of the event or employment is ended, not necessarily the date the coverage is lost) is used to determine the beginning of the 30-day window of time during which a consistent change in the benefit may be made.

Special Enrollment Rights under CHIPRA

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) was enacted by the United States federal government on February 4, 2009. CHIPRA created new special enrollment rights effective April 1, 2009. CHIPRA extended the State Children's Health Insurance Program (SCHIP) through 2013 and renamed it the Children's Health Insurance Program (CHIP). The special enrollment rights under CHIPRA allow the following for qualified Vanderbilt Group Health Plan members:

- If you or your dependent become eligible for state-granted premium assistance, or, you or your dependent's coverage terminates due to a loss of eligibility (as opposed to termination due to failure to pay premiums) under Medicaid, Tennessee's CoverKids program, or a State Children's Health Insurance Plan, you may enroll in the Vanderbilt Group Health Plan. You must request coverage within 60 days of this special-enrollment qualifying event by completing a Notification of Family Status Change Form and providing supporting documentation to the Office of Benefits Administration.
- If your dependent becomes eligible to receive a premium subsidy from the Child Health Insurance Program, you will be allowed under CHIPRA to disenroll (drop) your dependent from the Vanderbilt Group Health Plan. You must request this coverage change within 60 days of this special-enrollment qualifying event by completing a Notification of Family Status Change Form and providing supporting documentation to the Office of Benefits Administration.

Totally Disabled

Your complete inability to perform any and every duty pertaining to your occupation or employment; or

Your dependents complete inability to perform the normal activities of a person of like age and sex.

SUMMARY PLAN DESCRIPTION

Name of Plan Group Health Care Plan for Vanderbilt University

Name of Plan Sponsor Vanderbilt University, Nashville, Tennessee 37235

Employer Identification Number ("EIN") 62-0476822

Plan Number 504

Type of Plan and Plan Benefits

This Plan is an employee welfare benefit plan that provides comprehensive health care benefits.

Type of Administration

Vanderbilt University contracts with BlueCross BlueShield of Tennessee (BCBST) and Aetna for claims administration services. All options under this plan are self-insured.

Name of Plan Administrator/Privacy Officer/Privacy Contact Associate Vice Chancellor for Human Resources, Vanderbilt University, 2525 West End Avenue, Suite 500, Nashville, Tennessee 37235, 615.343.3322.

Service of Legal Process

Service of legal process may be made on the Plan Administrator. Service may be made on BCBST for the BlueCross Advantage P option at the following address: 801 Pine St., Chattanooga, TN, 37402-2555. Service may be made on Aetna for the Aetna HealthFund and Aetna Standard options at 151 Farmington Avenue, Hartford, CT 06156. Service may be made on CAREMARK at Attn: Contracts Administrator, Law Group, 2211 Sanders Road, Northbrook, IL 60062. Service may be made on ActiveHealth at ActiveHealth Management, 102 Madison Avenue, New York, NY 10016.

Eligibility to Participate in the Plan

Your coverage is effective on the first day following the applicable service waiting period.

You may enroll for individual, individual plus spouse/certified domestic partner, individual plus child(ren), or family membership. Coverage for your eligible dependents becomes effective on the date you become eligible, provided you have enrolled for dependent coverage and agree to make the required contributions.

If you do not enroll for dependent coverage on or before the date your dependents are eligible to be covered, coverage for your dependents will become effective as of the date you enroll for dependent coverage, providing you enroll within 30 days from the date you first become eligible for dependent coverage.

You may change coverage tiers by applying within 30 days after a qualifying event (see definition).

Benefits

The Plan provides comprehensive health care coverage, which is described in the provider Evidence of Coverage and Summary Booklet; these booklets are furnished to participants at no cost. Notification is given of changes that may occur in the coverage from time to time. Information in the provider booklets is incorporated in this summary plan description by reference here.

Cost

Vanderbilt and the employee share the cost of individual and dependent coverage. Vanderbilt's portion comes from the general assets of the institution. The amount of the employee's portion will be communicated to participants whenever the amount changes. Each employee can elect annually whether to pay their portion of the premium pre-tax or post-tax.

Plan Year

The Plan's records are kept on a Plan year, which ends each year on June 30.

Filing Claims for Health Care Plan Benefits

Refer to your option's Evidence of Coverage (EOC) or Summary Booklet for claim filing procedures.

Claims Decision Period

A benefits determination is normally made within 45 days after a claim has been filed. If there are special circumstances, which require more time to make a decision, you will be sent a notice within that period, explaining why more time is needed. A determination will, however, be made no later than 90 days from the date the claim was originally filed.

If the claim is denied in whole or in part, you will receive a notice from your option's claims administrator with (a) the reasons for denial, (b) a reference to the plan provisions on which denial is based, (c) if applicable, a description of additional information which may be necessary, and an explanation of why it is necessary, and (d) appropriate information as to the steps to be taken to have your claim reviewed by your option's claims administrator if you do not agree with the denial.

How to Appeal a Claim

If you do not agree with the denial of your claim, you have 180 days to file an appeal. Appeals should be made in writing directly to your option's claims administrator. You should state the reasons why you do not agree with the denial or partial denial and provide any supporting documentation. The option's claims administrator will then review the information and provide a written decision within 60 days. If necessary this period may be extended for an additional 60 days and you will receive written notice of this extension. Refer to your option's EOC or Summary Booklet for additional information.

STATEMENT OF ERISA RIGHTS

As a participant in the Vanderbilt Health Care Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration. Obtain, upon written request to the Plan Administrator, copies of

documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies. Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report. The Group Health Care Plan of Vanderbilt University summary annual reports are posted to <http://hr.vanderbilt.edu/benefits/benefitspackage.htm>.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights. Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Newborns and Mothers Protection Act of 1996

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Mental Health Parity Act of 1996 (MHPA)

Group health plans and health insurance coverage offered in connection with group health plans, which provide both medical and surgical benefits and mental health benefits may not impose an aggregate lifetime dollar limit or annual dollar limit on mental health benefits if it does not also impose such a limit on substantially all of the medical and surgical benefits. If the plan does impose an aggregate lifetime dollar limit or annual dollar limit on substantially all medical and surgical benefits, the plan cannot impose a limit on mental health benefits that is less than that applied to the medical and surgical benefits.

There are many ways under the law that plans and issuers are permitted to use to control plan costs. Group health plans and health insurance coverage offered in connection with group health plans are not required by MHPA to provide mental health benefits. In addition, the law does not affect the terms and conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits under a plan or coverage except as specifically provided in regard to parity of aggregate lifetime limits and annual limits. MHPA protections do not extend to benefits for substance abuse or chemical dependency.

MHPA provisions for group health plans are effective beginning on or after January 1, 1998. MHPA includes a sunset provision under which the MHPA requirements do not apply to benefits for services furnished on or after September 30, 2001.

Women's Health and Cancer Rights Act of 1998

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

Uniformed Services Employment and Reemployment Rights Act of 1994

An employee on uniformed services leave is entitled to the same benefits made available to other employees with similar seniority, status and pay, if they were on furlough or leave of absence. If you are an employee and would otherwise lose coverage under this Plan because of a uniformed services leave, you can continue coverage for yourself and your dependents for the lesser of the length of the leave or 18 months, even if covered by military health care programs. If the uniformed services leave is for less than 31 days, you will pay the same premium contribution as you did while you were an active employee. If the uniformed services leave is for 31 days or more, you may be required to pay 102% of the total premium. If you do not continue coverage during a period of uniformed services leave, your coverage will be reinstated upon reemployment.

Protected Health Information

Protected Health Information (PHI) will be used in the operation of this plan to permit administration and payment of benefits under the Plan. The Plan Sponsor will:

- Use and disclose PHI only as permitted under HIPAA,
- Certify to the group health plan that documents have been amended,
- Create firewalls including identifying employees who can access information,
- Restrict access to those individuals and only for plan administration purposes, and
- Provide a mechanism for resolving non-compliance.

The Notice of Privacy Practices may be found at <http://hr.vanderbilt.edu/forms/index.htm>.

EQUAL OPPORTUNITY

In compliance with federal law, including the provisions of Title VII of the Civil Rights Act of 1964, Title IX of the Education Amendment of 1972, Sections 503 and 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, Executive Order 11246, and the Uniformed Services Employment and Reemployment Rights Act, as amended, Vanderbilt University does not discriminate against individuals on the basis of their race, sex, religion, color, national or ethnic origin, age, disability, or military service in its administration of educational policies, programs, or activities; admissions policies; scholarship and loan programs; athletic or other University-administered programs; or employment. In addition, the University does not discriminate against individuals on the basis of their sexual orientation, gender identity, or gender expression consistent with the University's nondiscrimination policy. Inquiries or complaints should be directed to the Opportunity Development Center, Baker Building, VU Station B #351809, 2301 Vanderbilt Place, Nashville, TN 37235-1809. Telephone 615.322.4705 (V/TDD); fax 615.343.4969.



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