VANDERBILT

HUMAN RESOURCES

# Delta Dental PPO Insurance

Summary Plan Description

# Vanderbilt University

DELTA DENTAL PPO INSURANCE

**EFFECTIVE DATE: January 1, 2021**

7831-1000
7831-2000

This document printed in April 2021 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

# Table of Contents

*Home Office: Nashville, Tennessee*

*Mailing Address: Nashville, TN 37228*

**DELTA DENTAL OF TENNESSEE**
certifies that it insures certain Employees and Dependents for the benefits provided by the following policy(s):

**POLICYHOLDER: Vanderbilt University**

**GROUP POLICY(S)** — COVERAGE
7831-1000 DELTA DENTAL PREMIER OPTION
7831-2000 DELTA DENTAL BASIC OPTION

**EFFECTIVE DATE:** January 1, 2021

This certificate describes the main features of the insurance. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.

This certificate takes the place of any other issued to you on a prior date which described the insurance.

## Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

# Eligibility - Effective Date

## Employee Insurance

This plan is offered to you as an Employee.

**Eligibility for Employee Insurance**

You will become eligible for insurance on the day you complete the waiting period if:

- you are in a Class of Eligible Employees; and
- you are an eligible, full-time Employee; and
- you normally work at least 30 hours a week; and
- you pay any required contribution.

If you were previously insured and your insurance ceased, you must satisfy the Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Employees within one year after your insurance ceased.

**Eligibility for Dependent Insurance**

You will become eligible for Dependent insurance on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

## Waiting Period

None.

**Classes of Eligible Employees**

Each Employee as reported to the insurance company by your Employer.

**Effective Date of Employee Insurance**

You will become insured on the date you elect the insurance by signing an approved payroll deduction or enrollment form, as applicable, but no earlier than the date you become eligible. If you are a Late Entrant, you may elect the insurance only during an Open Enrollment Period. Your insurance will become effective on your hire date.

You will become insured on your first day of eligibility, following your election, if you are in Active Service on that date, or if you are not in Active Service on that date due to your health status.

**Late Entrant – Employee**

You are a Late Entrant if:

- you elect the insurance more than 30 days after you become eligible; or
- you again elect it after you cancel your payroll deduction (if required).

**Open Enrollment Period**

Open Enrollment Period means a period in each calendar year as designated by your Employer.

## Dependent Insurance

For your Dependents to be insured, you will have to pay the required contribution, if any, toward the cost of Dependent Insurance.

Dependents in military service are not eligible.

**Effective Date of Dependent Insurance**

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form (if required), but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

If you are a Late Entrant for Dependent Insurance, the insurance for each of your Dependents will not become effective until Delta Dental agrees to insure that Dependent.

Your Dependents will be insured only if you are insured.

**Late Entrant – Dependent**

You are a Late Entrant for Dependent Insurance if:

- you elect that insurance more than 30 days after you become eligible for it; or
- you again elect it after you cancel your payroll deduction (if required).

# Delta Dental Benefits

### Your Delta Dental Coverage

The information below outlines your coverage and will help you to better understand your Dental Plans. Included is information about which services are covered, which are not, and how much dental services will cost you.

### Customer Care

If you have any questions or concerns about the Dental Plans, Customer Care Representatives are just a toll-free phone call away. They can explain your benefits or help with matters regarding your Dental Plans. For assistance with transfers, specialty referrals, eligibility, second opinions, emergencies, Covered Services, plan benefits, ID cards, location of Dental Offices, conversion coverage or other matters, call Customer Care from any location at 1-800-223-3104. The hearing impaired may contact the state TTY toll-free relay service number listed in their local telephone directory.

### Choice of Dentist

You and your Dependents may choose any Dentist and should decide for yourselves the professional qualification of the Dentist selected. Delta Dental of Tennessee does not furnish covered services directly and instead, pays for licensed Dentists to provide these services. These Dentists are independent contractors who have agreed to accept certain fees for the services they provide to you. Dentists that have not contracted with Delta Dental are referred to as "Non-Participating Dentists."

To obtain a list of Dental Offices near you, visit our website at www.DeltaDentalTN.com or call Customer Care at 1-800-223-3104.

### Clinical Examination

Before approving a claim, DDTN may obtain from any DENTIST or hospital such information and records DDTN may require to administer the BENEFITS.

### Claim for Benefits

To make a claim for BENEFITS, the CLAIM FORM must be properly completed and submitted to DDTN. Electronic claims may be accepted. The DENTIST must maintain the supporting documentation.

### Pre-Treatment Estimate

A DENTIST may file a CLAIM FORM showing the services he or she recommends. DDTN then will pre-estimate the BENEFITS payable under this CONTRACT. Payment will only be made for pre-estimated services if the MEMBER remains eligible and has not exceeded his or her annual maximum benefits. A claim form requesting a pre-treatment estimate may be submitted electronically.

### Proof of Loss

Proof of loss must be furnished to DDTN within 15 months after completion of treatment for which BENEFITS are payable. Any claim filed after this period will be denied.

### Your Payment Responsibility (General Care)

For Covered Services provided by your Dental Office, you will be responsible for any copayments required under the Dental Plans. Amounts which exceed Plan allowances, annual maximum benefits or any other stated Plan limitations are not considered Copayments. These amounts are your responsibility. Your out-of-pocket expenses may be less if you choose a participating Dentist.

### Emergency Dental Care – Reimbursement

An emergency is a dental condition of recent onset and severity which would lead a prudent layperson possessing an average knowledge of dentistry to believe the condition needs immediate dental procedures necessary to control excessive bleeding, relieve severe pain, or eliminate acute infection. If you require emergency dental care, you may seek services from any dentist. Your out-of-pocket expenses may be less if you choose a participating dentist.

- **Emergency Care Away From Home**

  If you have an emergency while you are out of your Service Area or unable to contact your Dental Office, you may receive services from any dentist. Your out-of-pocket expenses may be less if you choose a participating dentist.

### Limitations and Exclusions for All Benefits

DDTN will only pay the BENEFITS stated for each type of dental service described in the schedule or schedules of benefits. Not all dental services are BENEFITS under this contract. BENEFITS will only be provided for MEMBERS who are enrolled on the date of treatment. BENEFITS will be based on the date services were completed. Services must be provided by a DENTIST or properly licensed employee of DENTIST. To be a paid BENEFIT, services must be necessary and must be provided by generally accepted dental practice standards, as determined by the dental profession. DDTN will pay allowable BENEFITS based upon the percentages shown on the Declaration Page. Such percentages will be applied to the lesser of the MAXIMUM PLAN ALLOWANCE or the fees the DENTIST charges for the service.

DDTN will govern this plan as a DELTA USA program and follow applicable Delta USA Processing Policies. A DELTA USA program is a program where DDTN and other Participating Plans have agreed to provide to MEMBERS the BENEFITS set forth in the CONTRACT. DDTN shall be the Control Plan for this CONTRACT. DDTN may act for itself and on behalf of each Participating Plan, for the purposes herein cited.

**Optional Services**

- In cases where alternate or optional methods of treatment exist, BENEFITS are provided for the least costly professionally accepted treatment. This determination is not intended to recommend which treatment should be provided. It is a determination of BENEFITS under terms of the MEMBER's coverage. The DENTIST and MEMBER should decide the course of treatment. If the treatment rendered is other than the covered BENEFIT, the difference between DDTN's allowance and the DENTIST's fee, up to the approved amount, for the actual treatment rendered is due from the MEMBER.
- Payment made by DDTN for any surgical service will include charges for routine post-operative exams or visits.
- In the event a MEMBER transfers from one DENTIST to another during the course of care, DDTN may limit BENEFITS. DDTN will limit BENEFITS to the amount that would have been paid had only one DENTIST rendered the service.

**Exclusions**

DDTN does not pay BENEFITS for:

- Treatment of injury or illness covered by Workers' Compensation or Employer's Liability Laws.
- Services received without cost from any federal, state, or local agency. This exclusion will not apply if prohibited by law.
- Cosmetic surgery or procedures for purely cosmetic reasons unless specifically listed as a BENEFIT.
- Services for congenital (hereditary), hypodontia, or developmental malformations. Such malformations include, but are not limited to, cleft palate, upper and lower jaw malformations. This does not exclude those services provided under Orthodontic BENEFITS, if covered.
- Treatment to restore tooth structure lost from wear or attrition.
- Treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; or treatment to stabilize the teeth. For example: equilibration, periodontal splinting, and double abutments on bridges.
- Oral hygiene and dietary instructions, treatment for desensitizing teeth, prescribed drugs or other medication, experimental procedures, conscious sedation, and extra oral grafts (grafting of tissues from outside the mouth to oral tissues).
- Charges by any hospital or other surgical or treatment facility and any additional fees charged by the DENTIST for treatment in any such facility.
- Diagnosis or treatment for any disturbance of the temporomandibular joints (jaw joints) or myofascial pain dysfunction.
- Services by a DENTIST beyond the scope of his license.
- Dental services for which the MEMBER incurs no charge.
- The portion of dental services charges where charges for such care exceed the charge that would have been made and actually collected if no coverage existed.
- General Anesthesia or IV Sedation is a BENEFIT only when administered by a properly licensed DENTIST. It must take place in a dental office in conjunction with covered surgical procedures or when necessary due to concurrent medical conditions.

**Limitations On Covered Services**

The frequency of certain Covered Services, like cleanings, is limited.

**General Limitations - Dental Benefits**

In addition to the limitations and exclusions shown in the Schedule of Benefits section, Delta Dental of Tennessee does not pay for the following:

- Treatment of injury or illness covered by Workers' Compensation or Employer's Liability Laws
- Services received without cost from any federal, state, or local agency. This exclusion will not apply if prohibited by law.
- Cosmetic surgery or procedures for purely cosmetic reasons unless specifically listed as a benefit.
- Services for congenital (hereditary), hypodontia or developmental malformations. Such malformations include, but are not limited to, cleft palate, or upper and lower jaw malformations. This does not exclude those services provided under Orthodontic benefits, if covered.
- Treatment to restore tooth structure lost from wear or attrition.
- Treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion or treatment to stabilize the teeth. For example: equilibration, periodontal splinting, and double abutments on bridges.
- Oral hygiene and dietary instructions, treatment for desensitizing teeth, prescribed drugs or other medication, experimental procedures, conscious sedation, and extra oral grafts (grafting of tissues from outside the mouth to oral tissues).
- Charges by any hospital or other surgical or treatment facility and any additional fees charged by the dentist for treatment in any such facility.

- Diagnosis or treatment for any disturbance of the temporomandibular joints (jaw joints) or myofascial pain dysfunction unless specifically listed as a benefit.
- Services by a dentist beyond the scope of his or her license.
- Dental services for which the patient incurs no charge.
- Dental services where charges for such services exceed the charge that would have been made and actually collected if no coverage existed.

**Diagnostic & Preventive Benefits, Limitations & Exclusions**

- All oral examinations and cleanings (prophylaxis).
- Oral exams and cleanings, to include any combination of teeth cleanings (prophylaxes, periodontal maintenance procedures and scaling in the presence of inflammation), are limited to two times in any calendar year. Excludes full mouth debridement which is covered once per lifetime. Periodontal maintenance and full mouth debridement procedures covered at the benefit level for Periodontics.
- Members with high-risk health conditions may receive a total of four cleanings, to include periodontal maintenance procedures, in any calendar year. Eligible members include:
- Diabetics with periodontal disease.
- Pregnant women with periodontal disease
- Individuals with renal failure/dialysis.
- Individuals with suppressed immune systems (undergoing chemotherapy or radiation treatment, HIV positive, organ transplant patients, stem cell/bone marrow transplant patients).
- Individuals at high risk for infective endocarditis (such as those with a history of infective endocarditis, certain congenital heart defects, artificial heart valves, heart valve defects, hypertropic cardiomyopathy, or mitral valve prolapse).
- Adult prophylaxis for members under 14 years of age is not allowed.
- Comprehensive oral examinations or extensive oral examinations performed by the same dentist are allowed once within 36 months.
- X-rays.
- One set of bite-wing x-rays are covered in a calendar year.
- Full mouth x-rays and/or panoramic x-rays are covered once within 3 years, unless special need is shown.
- Fluoride. Topical application of fluoride is covered for members up to 19 years of age once per calendar year.
- Space maintainers.
- Space maintainers are covered for missing posterior primary teeth for members 14 years of age or under. Distal shoe space maintainers are a benefit on first permanent molars, limited to children up to age 8. Charges for repairs and adjustments by the same dentist or dental office are not allowed.
- Only one space maintainer is allowed per area per lifetime.

**Sealant Benefits, Limitations & Exclusions**

- Sealants - resin filling used to seal grooves and pits on the chewing surface of permanent molar teeth. • A sealant is a benefit only on the unrestored, decay free chewing surface of the maxillary (upper) and mandibular (lower) permanent first and second molars.
- Sealants are only a benefit on members under 16 years of age.
- Only one benefit will be allowed for each tooth within a lifetime.
- Benefits include repair or replacement within 24 months by the same dentist or dental office.

**Basic Benefits, Limitations & Exclusions**

- Simple extractions.
- General Anesthesia & IV. Sedation is covered only when administered by a properly licensed dentist in a dental office in conjunction with covered surgery procedures or when necessary due to concurrent medical conditions. General anesthesia and IV sedation are limited to one hour. Any additional minutes are disallowed unless clinical documentation supports additional minutes.
- Minor Restorations amalgams (silver fillings) composites (white fillings) and prefabricated stainless steel crown restorations for the treatment of decay.
- •Restorativebenefitsareallowedoncepersurfaceina24 month period, regardless of the number or combinations of procedures requested or performed.
- •The replacement by the same dentist or dental office, of amalgam or composite restorations within 24 months is not allowed.
- •The replacement by the same dentist or dental office of a stainless-steel crown within 24 months of the initial placement is not allowed.
- Gold foil restorations are Optional Services.
- Denture Repairs-services to repair complete or partial dentures.

**Oral Surgery Benefits, Limitations & Exclusions.**

- Oral Surgery complex extractions and other surgical procedures (including pre- and post-operative care). Some procedures are limited to once per lifetime. Excludes procedures that are considered medical procedures.

**Endodontic Benefits, Limitations & Exclusions**

- Endodontia - treatment of the dental pulp (root canal procedures).
- Payment for root canal treatment includes charges for x-rays and temporary restorations.
- Root canal treatment is limited to once in a 24-month period by the same dentist or dental office.
- Post-operative procedures are considered part of the total fee.

**Periodontic Benefits, Limitations & Exclusions**

- Periodontia -treatment of the gums and bones that surround the natural tooth.
- Payment for periodontal surgery shall include charges for three months post-operative care and any surgical re-entry for a three-year period.
- Root planing, curettage and osseous surgery are not a benefit for members under 14 years of age.
- Scaling and root planning procedures are allowed once within 24 months.
- Full mouth debridement covered once per lifetime.
- Periodontal maintenance procedures to include any combination of teeth cleanings (prophylaxes, periodontal maintenance procedures and scaling in the presence of inflammation), are limited to two times in any calendar year. Prophylaxes and scaling in the presence of inflammation procedures covered at the Diagnostic & Preventive Benefit level.
- Localized delivery of antimicrobial agents is not a benefit.
- Guided tissue regeneration limited to once per tooth per lifetime.

**Major Restorative Benefits, Limitations & Exclusions**

- Cast Restorations. Crowns and on lays are benefits for the treatment of visible decay and fractures of hard tooth structure when teeth are so badly damaged that they cannot be restored with amalgam or composite restorations.
- Replacement of crowns or cast restorations received in the previous five years is not a benefit. Payment for cast restorations shall include charges for preparations of tooth and gingiva, impression, temporary restoration, and any re-cementation by the same dentist with in a 12-month period.
- A cast restoration on a tooth that can be restored with an amalgam or composite restoration is not a benefit.
- Procedures for purely cosmetic reasons are not benefits.
- Veneers are payable on incisors, cuspids and bicuspids once per tooth per five-year period when necessary due to fracture or decay for people age 12 and older. Veneers for cosmetic purposes are not Covered Services. Porcelain, gold, or veneer crowns for children under 12 years of age are not a benefit.
- A prefabricated post and core in addition to crown is payable only on an endodontically treated tooth.

**Prosthodontic Benefits, Limitations & Exclusions**

- Prosthodontics. Procedures for construction of fixed bridges, partial or complete dentures and repair of fixed bridges.
- Replacement of any fixed bridges or partial or complete dentures that the member received in the previous five years is not a benefit.
- Payment for a complete or partial denture shall include charges for any necessary adjustment within a six-month period.
- Payment for standard dentures is limited to the maximum allowable fee for a standard partial or complete denture. A standard denture means a removable appliance to replace missing natural, permanent teeth. A standard denture is made by conventional means from acceptable materials. If a denture is constructed by specialized techniques and the fee is higher than the fee allowable for a standard denture, the patient is responsible for the difference.
- Payment for fixed bridges or cast partials for children under 16 years of age is not a benefit. A temporary partial-stayplate denture is a benefit in children 16 years of age or under for missing anterior permanent teeth.
- A posterior bridge where a partial denture is constructed in the same arch is not a covered benefit.
- Temporary partial dentures are a benefit during the healing period for missing upper anterior teeth.
- Temporary or provisional fixed prosthodontics are not separate benefits and should be included in the fee for the permanent prosthesis.
- Complete or Partial Denture Reline and Rebase procedures. Payment for a reline or rebase of a partial or complete denture is limited to once in a three-year period and includes all adjustments required for six months after delivery.

**Implant Benefits, Limitation and Exclusions**

Implants. The surgical placement of an endosteal (in the bone) implant and the connecting abutment are covered benefits.

- Replacement of implants or abutments received in the previous five years is not a benefit.
- The removal of an implant is allowed once per lifetime.
- Specialized techniques are not benefits (i.e.. bone grafts, guided tissue regeneration, precision attachments, etc.)
- Implants are not a benefit for patients under 19 years of age.
- Implant maintenance procedures are allowed once in a 12-month period.

**Orthodontic Benefits, Limitations & Exclusions**

- Orthodontics. Procedures using appliances to treat poor alignment of teeth and/or jaws. Such poor alignment must significantly interfere with function to be a benefit.
- Orthodontic benefits are limited to members shown on the Benefit Summary Page.
- If orthodontic treatment began prior to enrolling in this plan, Delta Dental of Tennessee will begin benefits with the first payment due the dentist after the subscriber or covered dependent becomes eligible.
- Benefits end with the next payment due the dentist after loss of eligibility or immediately if treatment stops.
- Benefits are not paid to repair or replace any orthodontic appliance received.
- Orthodontic benefits do not pay for extractions or other surgical procedures. However, these additional services may be covered under other benefits of this plan.
- The initial payment (initial banding fee) made by Delta Dental of Tennessee for comprehensive treatment will be 33% of the total fee for treatment subject to your copayment percentage and lifetime maximum.
- Subsequent payments will be issued on a regular basis for continuing active orthodontic treatment. Payments will begin in the month following the appliance placement date and are subject to your copayment percentage and lifetime maximum.

**Services Not Covered Under Your Dental Plan**

Delta Dental does not pay benefits for:

- Treatment of injury or illness covered by Workers' Compensation or Employer's Liability Laws.
- Services received without cost from any federal, state, or local agency. This exclusion will not apply if prohibited by law.
- Cosmetic surgery or procedures for purely cosmetic reasons unless specifically listed as a BENEFIT.
- Services for congenital (hereditary), hypodontia, or developmental malformations. Such malformations include, but are not limited to, cleft palate, upper and lower jaw malformations. This does not exclude those services provided under Orthodontic BENEFITS, if covered.
- Treatment to restore tooth structure lost from wear or attrition.
- Treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; or treatment to stabilize the teeth. For example: equilibration, periodontal splinting, and double abutments on bridges.
- Oral hygiene and dietary instructions, treatment for desensitizing teeth, prescribed drugs or other medication, experimental procedures, conscious sedation, and extra oral grafts (grafting of tissues from outside the mouth to oral tissues).
- Charges by any hospital or other surgical or treatment facility and any additional fees charged by the DENTIST for treatment in any such facility.
- Diagnosis or treatment for any disturbance of the temporomandibular joints (jaw joints) or myofascial pain dysfunction.
- Services by a DENTIST beyond the scope of his license.
- Dental services for which the MEMBER incurs no charge.
- The portion of dental service charges where charges for such care exceed the charge that would have been made and actually collected if no coverage existed.
- General Anesthesia or IV Sedation is a BENEFIT only when administered by a properly licensed DENTIST. It must take place in a dental office in conjunction with covered surgical procedures or when necessary due to concurrent medical conditions.

**Appointments**

To make an appointment with your Network Dentist, call the Dental Office that you have selected. When you call, your Dental Office should ask for your identification number and will check your eligibility.

**Broken Appointments**

The time your Network Dentist schedules for your appointment is valuable to you and the dentist. Broken appointments make it difficult for your Dental Office to schedule time with other patients. If you or your enrolled Dependent break an appointment with less than 24-hour notice to the Dental Office, you may be charged a broken appointment fee.

**Office Transfers**

In the event a MEMBER transfers from one DENTIST to another during the course of care, Delta Dental of Tennessee may limit BENEFITS. Delta Dental of Tennessee will limit BENEFITS to the amount that would have been paid had only one DENTIST rendered the service.

**Deductible**

DDTN will not pay BENEFITS until the annual DEDUCTIBLE amount has been met. The annual DEDUCTIBLE per MEMBER and/or per family is shown on the Declaration Page. The DEDUCTIBLE will apply for the calendar year unless noted on the Declaration Page.

The deductible applies to the benefit types as shown on the Declaration Page. Only fees a member pays for services covered under the benefit schedules included in this contract will count towards satisfying the deductible.

Unless noted on the Declaration Page, the deductible and maximums apply each calendar year.

**Maximum**

DDTN will pay up to the Maximum Amount shown on Declaration Page.

## Coordination of Benefits

If a MEMBER is entitled to coverage under more than one insurance policy or benefit program, the BENEFITS of this CONTRACT will be subject to the following conditions:

- If the other program is not primarily a dental program, this program is primary.
- If the other program is for dental coverage, the following rules are applied:
    - The program covering the patient as an employee is primary over a program covering the patient as a dependent.
    - Where the patient is a dependent child: primary dental coverage will be determined by the date of birth of the parents. The coverage of the parent whose date of birth occurs earlier in the calendar year will be primary. For a dependent child of legally separated or divorced parents, the coverage of the parent with legal custody, or the coverage of the custodial parent's spouse (i.e., stepparent) will be primary.
    - If there is a court decree stating that one parent has financial responsibility for a child's health care expenses, any dependent coverage of that parent will be primary toany other dependent coverage.
- When primary coverage cannot be determined according to a) and b), the program which has covered the patient for the longer period will be primary.

If this coverage is primary, BENEFITS will be provided without regard to any other coverage. If this coverage is not primary, BENEFITS are limited to services which are BENEFITS of this CONTRACT that are not fully paid by any other coverage.

**Right to Recovery**

Delta Dental of Tennessee will have the right to recover any BENEFITS greater than the maximum amount of allowable BENEFITS. Delta Dental of Tennessee will recover the excess from any persons to whom the payment was made, insurance companies or other parties involved. Delta Dental of Tennessee may recover overpayments to Providers by auto deduction. Any MEMBER covered under this CONTRACT will execute and deliver any necessary documents and do whatever is needed to secure such rights to Delta Dental of Tennessee. Any recovery by Delta Dental of Tennessee must occur within 18 months of the date the claim was initially paid by Delta Dental of Tennessee. This limit does not apply to MEMBERS who do not provide complete information, were not eligible for coverage, made material misstatements or committed fraud.

**Subrogation**

Delta Dental of Tennessee assumes the MEMBER'S legal rights to recovery for payment for dental services the patient required because of the action or fault of another. Delta Dental of Tennessee has the right to recover from the MEMBER any dental payments made by a third party. In such cases, Delta Dental of Tennessee has the right to recover amounts equal to the BENEFITS paid by Delta Dental of Tennessee.

Delta Dental of Tennessee has the right to make the recovery by suit, settlement or otherwise from the person who caused the dental problem or injury. Such recovery may be from the other person, his or her insurance company, or any other source such as third-party motorist coverage.

The MEMBER must help Delta Dental of Tennessee make a recovery. They must give requested information and sign needed papers. If the MEMBER fails to help Delta Dental of Tennessee, or settles any claim without Delta Dental of Tennessee's written consent, Delta Dental of Tennessee may recover from the MEMBER. Delta Dental of Tennessee will be entitled to any recovery received by the MEMBER. Delta Dental of Tennessee will be entitled to reasonable and necessary attorney's fees and court costs.

## Payment of Benefits

**To Whom Benefits are Paid**

Benefits provided under this CONTRACT will be paid as follows:

- For services provided by a PARTICIPATING DENTIST, payment will be made to the PARTICIPATING DENTIST.
- For services provided by a NON-PARTICIPATING DENTIST, payment will be made to SUBSCRIBER. Payment may be assigned to the DENTIST.

**First and Second Level Review of Claims Denial**

Payment for services is determined in accordance with the specific terms of the SUBSCRIBER's dental plan and/or Delta Dental's agreements with its participating dentists. Delta Dental's payment decisions do not qualify as dental or medical advice. You must make all decisions about the desirability or necessity of dental procedures and services with your dentist.

After a claim is processed, DDTN will make available an Explanation of Benefits (EOB) to the SUBSCRIBER. If any payment for services was denied, the EOB will give the reason why. If your claim was denied in whole or in part so that you must pay some amount of the claim, upon a written request and free of charge, we will provide you with a copy of any internal rule, guideline, or protocol or, if applicable, an explanation of the scientific or clinical judgment relied upon in deciding your claim. If you still believe your claim should have been paid in full, you may ask to have the claim reviewed. Your written request for a formal first level review must be sent within 180 days of your receipt of this EOB to the address listed. You may submit any additional materials you believe support your claim. A decision will be made no later than 30 days from the date we receive your request.

If we again deny the claim, you may request a second level review. The manner in which to seek a second level review will be included with the letter informing you of our first level review decision. The second level review decision will be made no later than 30 days from the date we receive your request. If your claim is denied in whole or in part after both stages, you have the right to seek to have your claim paid by filing a civil action in court within one year from the final denial.

**Termination of Benefits on Loss of Eligibility**

DDTN will not pay BENEFITS for any services received by a patient who is not eligible at the time of treatment. GROUP will repay DDTN for any payments made because of errors or delays in reporting required of the GROUP.

## Termination of Insurance

**Employees**

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- the last day of the calendar month in which your Active Service ends except as described below.
- the date you relocate to an area where the Dental plan is not offered.

Any continuation of insurance must be based on a plan which precludes individual selection.

**Temporary Layoff or Leave of Absence**

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date your Employer stops paying premiums for you; or otherwise cancels your insurance.

**Injury or Sickness**

If your Active Service ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness.

However, your insurance will not continue past the date your Employer stops paying premiums for you or otherwise cancels the insurance.

## ERISA Required Information

The name of the Plan is:

The Group Health Care Plan for Vanderbilt University

The name, address, zip code and business telephone number of the sponsor of the Plan is:

Vanderbilt University

2301 Vanderbilt Place

PMB #407704

Nashville, TN 37240-7704

615-343-4788

Employer Identification Number (EIN)

620476822

Plan Number

513

The name, address, ZIP code and business telephone number of the Plan Administrator is:

Employer named above

The name, address and ZIP code of the person designated as agent for service of legal process is:

Employer named above

The office designated to consider the appeal of denied claims is:

The Delta Dental of Tennessee Claim Office responsible for this Plan.

The cost of the Plan is shared by Employee and

Employer. The Plan's fiscal year ends on 12/31.

The preceding pages set forth the eligibility requirements and benefits provided for you under this Plan.

**Plan Trustees**

A list of any Trustees of the Plan, which includes name, title, and address, is available upon request to the Plan Administrator.

**Plan Type**

The plan is a healthcare benefit plan.

## Definitions

**As used in this policy:**

**"BENEFITS"** means the amounts that DDTN will pay for dental services under this CONTRACT.

**"BENEFIT YEAR"** is the period from January 1 to December 31 of the same calendar year, unless otherwise defined on the Declaration Page. No BENEFITS will be allowed before the EFFECTIVE DATE of the MEMBER'S coverage.

**"CLAIM FORM"** is a request for payment under a dental benefit plan; a statement listing services rendered, the dates of services and itemization of costs. The completed request serves as the basis for payment of benefits. CLAIM FORM also includes claims filed with DDTN electronically.

**"COBRA-MEMBER"** is a MEMBER who ceases to be eligible as a SUBSCRIBER or DEPENDENT, but chooses to continue coverage as allowed under 29 USC § 1161 et seq. or an applicable state continuation of coverage provision.

**"CONTRACT**" is this agreement between DDTN and GROUP, including the Application, Declaration Page, all Schedules and all Endorsements and Amendments as issued by DDTN.

**"CONTRACT TERM"** is the time starting with the EFFECTIVE DATE and ending 12 months later, plus any renewals or extensions unless noted otherwise on the Declaration Page. The CONTRACT TERM will end with the termination or cancellation of the CONTRACT.

**"CONTRACT YEAR"** is the 12 months starting on the EFFECTIVE DATE and each subsequent 12 months while the CONTRACT is in effect.

**"DDTN**" is Delta Dental of Tennessee, a Tennessee Not-for-Profit Corporation. As used in this contract, DDTN may refer to Delta Dental of Tennessee acting on its own behalf or acting on behalf of or in conjunction with a member or members of the Delta Dental Plans Association.

**"DEDUCTIBLE"** is the amount the MEMBER must pay for services in any BENEFIT YEAR before BENEFITS will be paid by DDTN, subject to limitations shown on the Declaration Page.

**"DENTIST"** is a person licensed to practice dentistry when and where services are performed. DENTIST may also apply to auxiliary personnel legally authorized to perform services under the supervision of a person licensed to practice dentistry.

**"DEPENDENT"** is a Dependent of a SUBSCRIBER who is enrolled in this GROUP program.

**"EFFECTIVE DATE"** is 12:01 AM at the GROUP's address on the date the CONTRACT begins, as shown on the Declaration Page.

**"EMPLOYEE"** is an employee of the GROUP who is eligible for enrollment in the GROUP program.

**"GROUP"** is the employer, association or trust named in the Application.

**"MAXIMUM PLAN ALLOWANCE"** is the maximum fee DDTN will pay for a single procedure.

**"MEMBER"** is a SUBSCRIBER or a DEPENDENT who is enrolled in this GROUP's dental program.

**"NON-PARTICIPATING DENTIST"** is any DENTIST who is not a member of DDTN or any other organization that is a member of Delta Dental Plans Association.

**"OPEN ENROLLMENT PERIOD"** is the last month of each CONTRACT YEAR. During this period, EMPLOYEES may change DEPENDENT coverage to be effective on the first day of the next CONTRACT YEAR

**"PARTICIPATING DENTIST"** is a licensed DENTIST who is a member of DDTN or any other organization that is a member of Delta Dental Plans Association, and who has agreed to abide by their rules and regulations.

**"PREMIUM"** is the monthly amount paid by GROUP to DDTN to provide coverage under this CONTRACT.

**"SUBSCRIBER"** is an EMPLOYEE who is enrolled in this GROUP's dental program.

# Federal Requirements

The following pages explain your rights and responsibilities under federal laws and regulations.

### Qualified Medical Child Support Order (QMCSO)

#### Eligibility for Coverage Under a QMCSO

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child, and yourself if you are not already enrolled, within 31 days of the QMCSO being issued.

#### Qualified Medical Child Support Order Defined

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

- the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
- the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
- the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- the order states the period to which it applies; and
- if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage.

#### Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, or the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

### Effect of Section 125 Tax Regulations on This Plan

Your Employer has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax salary reduction put toward the cost of your benefits. Otherwise, you will receive your taxable earnings as cash (salary).

#### A. Coverage Elections

Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed if your Employer agrees and you enroll for or change coverage within 30 days of the following:

- the date you meet the criteria shown in the following Sections B through F.

#### B. Change of Status

A change in status is defined as:

- change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
- change in number of Dependents due to birth, adoption, placement for adoption, or death of a Dependent;
- change in employment status of Employee, spouse or Dependent due to termination or start of employment.
- changes in employment status of Employee, spouse or Dependent resulting in eligibility or ineligibility for coverage;
- changes which cause a Dependent to become eligible or ineligible for coverage.
- A change in coverage due to and consistent with a court order of the Employee or other person to cover a Dependent.

## Eligibility for Coverage for Adopted Children

Any child under the age of 18 who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

### Requirements of Medical Leave Act of 1993 (as amended) (FMLA)

Any provisions of the policy that provide for: continuation of insurance during a leave of absence; and reinstatement of insurance following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993, as amended, where applicable:

**Continuation of Health Insurance During Leave**

Your health insurance will be continued during a leave of absence if:

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993, as amended; and
- you are an eligible Employee under the terms of that Act.

The cost of your health insurance during such leave must be paid, whether entirely by your Employer or in part by you and your Employer.

**Reinstatement of Canceled Insurance Following Leave**

- Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, as amended, any canceled insurance (health, life or disability) will be reinstated as of the date of your return.
- You will not be required to satisfy any eligibility or benefit waiting period or the requirements of any Pre-existing Condition limitation to the extent that they had been satisfied prior to the start of such leave of absence.
- Your Employer will give you detailed information about the Family and Medical Leave Act of 1993, as amended.

## Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short- term or Long-term Disability or Accidental Death & Dismemberment coverage you may have.

**Continuation of Coverage**

For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence.

For leaves of 31 days or more, you may continue coverage for yourself, and your Dependents as follows:

You may continue benefits by paying the required premium to your Employer, until the earliest of the following:

- 24 months from the last day of employment with the Employer;
- the day after you fail to return to work; and
- the date the policy cancels.

**Reinstatement of Benefits (applicable to all coverages)**

If your coverage ends during the leave of absence because you do not elect USERRA or an available conversion plan at the expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if you gave your Employer advance written or verbal notice of your military service leave, and the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.

If your coverage under this plan terminates as a result of your eligibility for military medical and dental coverage and your order to active duty is canceled before your active-duty service commences, these reinstatement rights will continue to apply.

## Claim Determination Procedures Under ERISA

**COBRA Continuation Rights Under Federal Law For You and Your Dependents**

**What is COBRA Continuation Coverage?**

Under federal law, you and/or your Dependents must be given the opportunity to continue health insurance when there is a "qualifying event" that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred, unless you move out of that plan's coverage area or the plan is no longer available. You and/or your Dependents cannot change coverage options until the next open enrollment period.

**When is COBRA Continuation Available?**

For you and your Dependents, COBRA continuation is available for up to 18 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your termination of employment for any reason, other than gross misconduct, or
- your reduction in work hours.
- For your Dependents, COBRA continuation coverage is available for up to 36 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:
- your death;
- your divorce or legal separation; or
- for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

**Who is Entitled to COBRA Continuation?**

Only a "qualified beneficiary" (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals who were covered by the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent children. Each qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if you decline or are not eligible for COBRA continuation.

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, same sex spouses, grandchildren (unless adopted by you), stepchildren (unless adopted by you). Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals' coverage will terminate when your COBRA continuation coverage terminates. The sections titled "Secondary Qualifying Events" and "Medicare Extension For Your Dependents" are not applicable to these individuals.

**Secondary Qualifying Events**

If, as a result of your termination of employment or reduction in work hours, your Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce or legal separation; or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

**Disability Extension**

If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your Dependents is determined by the Social Security Administration (SSA) to be totally disabled under Title II or XVI of the SSA, you and all of your Dependents who have elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event.

To qualify for the disability extension, all of the following requirements must be satisfied:

- SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
- A copy of the written SSA determination must be provided to the Plan Administrator within 60 calendar days after the date the SSA determination is made AND before the end of the initial 18-month continuation period.

If the SSA later determines that the individual is no longer disabled, you must notify the Plan Administrator within 30 days after the date the final determination is made by SSA. The 11-month disability extension will terminate for all covered persons on the

first day of the month that is more than 30 days after the date the SSA makes a final determination that the disabled individual is no longer disabled.

All causes for "Termination of COBRA Continuation" listed below will also apply to the period of disability extension.

**Medicare Extension for Your Dependents**

When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B, or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

**Termination of COBRA Continuation**

COBRA continuation coverage will be terminated upon the occurrence of any of the following:

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- cancellation of the Employer's policy with Delta Dental;
- after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre- existing condition provision. In such case coverage will continue until the earliest of: the end of the applicable maximum period; the date the pre-existing condition provision is no longer applicable; or the occurrence of an event described in one of the first three bullets above;
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

**Employer's Notification Requirements**

Your Employer is required to provide you and/or your Dependents with the following notices:

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse's) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.
- A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
- if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
- if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or

**How to Elect COBRA Continuation Coverage**

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA continuation coverage. You must notify the Plan Administrator of your election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the notice, you and your Dependents will lose the right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent children. You or your spouse may elect continuation coverage on behalf of all the qualified beneficiaries. You are not required to elect COBRA continuation coverage in order for your Dependents to elect COBRA continuation.

**How Much Does COBRA Continuation Coverage Cost?**

Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 102% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated active Employee or family member.

The premium during the 11-month disability extension may not exceed 150% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated active Employee or family member.

For example: If the Employee alone elects COBRA continuation coverage, the Employee will be charged 102% (or 150%) of the active Employee premium. If the spouse or one Dependent child alone elects COBRA continuation coverage, they will be charged 102% (or 150%) of the active Employee premium. If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150%) of the applicable family premium.

**When and How to Pay COBRA Premiums**

**First payment for COBRA continuation**

If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment within those 45 days, you will lose all COBRA continuation rights under the Plan.

**Subsequent payments**

After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

**Grace periods for subsequent payments**

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if your payment is received after the due date, your coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

**You Must Give Notice of Certain Qualifying Events**

If you or your Dependent(s) experience one of the following qualifying events, you must notify the Plan Administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

- Your divorce or legal separation; or
- Your child ceases to qualify as a Dependent under the Plan.
- The occurrence of a secondary qualifying event as discussed under "Secondary Qualifying Events" above (this notice must be received prior to the end of the initial 18- or 29- month COBRA period).

(Also refer to the section titled "Disability Extension" for additional notice requirements.)

Notice must be made in writing and must include: the name of the Plan, name and address of the Employee covered under the Plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

**Newly Acquired Dependents**

If you acquire a new Dependent through marriage, birth, adoption, or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event.

COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

## Equal Opportunity

Vanderbilt is an equal opportunity, affirmative action university. In compliance with federal law, including the provisions of Title IX of the Education Amendments of 1972, Sections 503 and 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act of 1990, Vanderbilt University does not discriminate on the basis of race, sex, religion, color, national or ethnic origin, age, disability, or military service in its administration of educational policies, programs, or activities; its admissions policies; scholarship and loan programs; athletic or other University-administered programs; or employment. In addition, the University does not discriminate on the basis of sexual orientation consistent with University non- discrimination policy. Inquiries or complaints should be directed to the Opportunity Development Officer, Baker Building, Vanderbilt University, PMB 401809, Nashville, Tennessee 37240. Telephone 615.322.4705.

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