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 Medical Center 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.
Delta Dental of Tennessee
240 Venture Circle  Nashville, TN 37228
Phone (800) 223-3104  Fax (615) 244-8108
www.DeltaDentalTN.com

Certificate of Coverage

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Introduction
This Certificate of Coverage (COC) is a guide to your dental plan. It is not the contract between Delta Dental of Tennessee (DDTN) and your group or any member of the plan. Should there be any conflict between the COC and the contract, the contract will prevail.

I. Eligibility and Enrollment of Subscribers and Dependents
As an enrollee in this plan, you may also enroll your dependents.

Dependents are defined as a lawful husband or wife or other relationship as defined by the group or child(ren) from birth to the Dependent Age Limit listed on the Benefit Summary Page. "Child" includes a natural child, step-child, adopted child, foster child or child in the subscriber’s legal custody. A child over the Dependent Age Limit may continue to be eligible. The child must not be able to support them self because of mental incapacity or physical handicap. Such disabling condition must have begun before reaching the Dependent Age Limit. Proof of these facts must be given to DDTN or group within 31 days if requested. Proof will not be required more than once a year.

Dependents in military service are not eligible.

Your dependents must enroll along with you or as soon as they become dependents. If dependents do not enroll at this time, they must wait until the next open enrollment period to enroll. Your dependents may not be enrolled without your enrollment, but you may drop dependent coverage and maintain your coverage.

If you or your dependents drop coverage but still meet all requirements of the plan, you may re-enroll during the first open enrollment period after having been out of the plan for 12 consecutive months except in the event of a qualified life status change.

Your or your dependent’s coverage terminates when you are no longer eligible for benefits as a member of the group. Specific state and federal laws or group policies may allow an extension of membership for a limited time. You should speak to the administrator of your group to see if an extension is available and for how long the benefits could be extended.

DDTN will not pay for any services received by a patient who is not eligible at the time of treatment. Coverage for you and your dependents is only effective after DDTN receives the premium for the period to be covered. If DDTN does not receive the premium when it is due, we may stop paying claims until payment is received. If premiums have not been received within 30 days after the due date, DDTN may cancel the contract with the

DDTN COC 2017 Ortho_Vanderbilt University Medical Medical Center
group. DDTN does not bill individuals for premiums.

This contract may be cancelled upon renewal by DDTN with 30 days prior written notice or by the Group with 15 days prior written notice.

II. Choosing a Dentist
DDTN does not directly provide dental services and therefore is not liable for a dentist's refusal to provide services. It has contracted with "Participating Dentists". These dentists are independent contractors who have agreed to accept certain fees for the service they provide to you. Dentists that have not contracted with Delta Dental are referred to as "Non-Participating Dentists". The fact that a dentist has or has not chosen to participate with DDTN should not be viewed as a statement about their qualifications.

Although you are free to choose any dentist, your out of pocket expenses may be less if you choose a participating dentist. Therefore, you should always ask your dentist if he is a participating dentist or verify with DDTN that your dentist is a participating dentist before receiving any dental services.

DDTN is not responsible for any injuries or damages suffered due to the actions of any dentist.

III. General Provisions
A. Participating dentists will file your claim with DDTN. If you need a claim form for services provided by a non-participating dentist you may contact DDTN which will provide you with a claim form. To be considered for benefits, a claim must be filed within 15 months of the date of service.

B. 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.

C. You may get an estimate of the cost of certain dental procedures before they are done. This estimate is referred to as a pre-treatment Estimate. You may have your dentist send DDTN a claim form detailing the projected treatment and DDTN will give a pre-estimate of the benefits to be paid. A pre-treatment estimate is not a guarantee of payment. Actual benefit payments will be based upon procedures completed and will be subject to continued eligibility along with plan limitations and maximums.

D. If you or your covered dependent receive an injury requiring dental treatment because of the action or fault of another person, and if DDTN is unaware of other coverage, DDTN may pay benefits but would assume the your or your covered dependent's rights to recover from the other person. You and your covered dependent would be required to help DDTN in making such a recovery.

E. This dental plan does not replace any workers' compensation coverage.

F. If you or your covered dependent has two dental coverages, DDTN will coordinate benefits with the other coverage. The following rules will be used to determine which coverage should be primary.
   1. The program covering the patient as an employee is primary over a program covering the patient as a dependant.
   2. 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.
   3. If there is a court decree stating that one parent has financial responsibility for a child's dental care expenses, any dependent coverage of that parent will be primary to any other dependent coverage.

G. After a claim is processed, an Explanation of Benefits (EOB) will be made available to you. If any payment for services was denied, the EOB will give the reason why. If you disagree with the denial you must submit a request in writing asking that the claim be reviewed. Such request should include the reason why you believe the claim was wrongly denied. The request for your first level review must be received by DDTN within 180 days of your receipt of the EOB. DDTN will make a review and may ask for more documents if needed. Unless unusual circumstances arise, a decision will be sent to you within 30
days after DDTN receives the request for review.
If you do not agree with the first level review decision, 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 you do not agree with the second level review decision, you may file civil action in court within one year of the final denial.

IV. Benefits
Not every dental procedure is a benefit of your dental plan nor are they paid at the same level of co-insurance. The Schedule of Benefits in this COC reflects the procedures that DDTN will cover as well as certain limitations and exclusions for these covered benefits. These services will be covered when a dentist or an employee of a dentist who is licensed to perform the service provides them. These services must be necessary and must be provided in accordance with generally accepted dental practice standards. Some allowable procedures are subject to deductibles, maximums, and copayments as described on the Benefit Summary Page.

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

General Limitations and Exclusions
A. Treatment of injury or illness covered by Workers' Compensation or Employer's Liability Laws.
B. Services received without cost from any federal, state or local agency. This exclusion will not apply if prohibited by law.
C. Cosmetic surgery or procedures for purely cosmetic reasons unless specifically listed as a benefit.
D. 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.
E. Treatment to restore tooth structure lost from wear or attrition.
F. 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.
G. 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).
H. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the dentist for treatment in any such facility.
I. Diagnosis or treatment for any disturbance of the temporomandibular joints (jaw joints) or myofacial pain dysfunction unless specifically listed as a benefit.
J. Services by a dentist beyond the scope of his or her license.
K. Dental services for which the patient incurs no charge.
L. Dental services where charges for such services exceed the charge that would have been made and actually collected if no coverage existed.

In the event a member transfers from one dentist to another during the course of treatment, payment by DDTN will be limited to the amount that would have been paid had only one dentist rendered the service.

V. Optional Services
In cases where alternate or optional methods of treatment exist, DDTN will pay 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 the terms of your coverage. The dentist and you or your dependent 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 you. For example, if your benefit plan allows for amalgams only even though a metal or porcelain inlay is suggested by your dentist, DDTN will pay for only the cost of the amalgam.
VI. Schedule of Benefits
In addition to the limitations and exclusions listed in the Schedule of Benefits, the General Limitations and Exclusions found in Section IV of this Certificate of Coverage also apply.

A. Diagnostic & Preventive Benefits, Limitations & Exclusions
- All oral examinations and cleanings (prophylaxis).
  - Standard Oral exams (including comprehensive, periodic, detailed/extensive and periodontal oral evaluations) are limited to no more than one standard exam in any 6 month period.
  - Emergency exams, including limited oral evaluations (exams) are limited to no more than one emergency exam in any 12 month period.
  - Comprehensive oral examinations, detailed/extensive or periodontal exam oral examinations performed by the same dentist are allowed once within 36 months.
  - Re-evaluations and consultations are not covered benefits.
  - Cleanings, to include any combination of teeth cleanings (prophylaxes, periodontal maintenance procedures and scaling in the presence of inflammation), are limited to once in any 6-month period. Periodontal maintenance procedures are subject to additional limitations listed in Periodontic Benefits Limitations & Exclusions and subject to a different coverage level.
  - Adult prophylaxis for members under 14 years of age is not allowed.
- X-rays.
  - One set of bite-wing x-rays are covered in a 12-month period.
  - Full mouth x-rays and/or panoramic x-rays are covered once within 3 years, unless special need is shown. Benefits provided for either include benefits for all necessary intraoral and bitewing films taken on the same day.
- Fluoride. Topical application of fluoride is covered for members up to 19 years of age once in any 12-month period.
- Space maintainers.
  - Space maintainers are covered for missing posterior primary teeth for members 13 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.
  - No more than one re-cementation in any 12-month period.

B. 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.
  - No more than one sealant, preventive resin restoration or resin infiltration per first or second molar per lifetime, for dependents under age 16. Resin infiltrations are subject to a different coverage level see Basic benefits.

C. Basic Benefits, Limitations & Exclusions
- Simple extractions.
- Minor Restorations – amalgams (silver fillings) composites (white fillings) and prefabricated stainless steel crown restorations for the treatment of decay.
- Restorative benefits are allowed once per surface in a 12 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 12 months is not allowed.
- The replacement, by the same dentist or dental office, of a stainless steel crown within 24 month of the initial placement is not allowed.
- The replacement of a stainless steel crown is covered only after 36 months from the date of initial restoration.
- Gold foil restorations and porcelain, composite, and metal inlays are Optional Services.
- Resin infiltrations are limited to no more than one sealant, preventive resin restoration or resin infiltration per first or second molar tooth per lifetime, for dependents under age 16. (Sealant/Preventive resins are subject to a different coverage level as a preventive service.)

**D. 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.
- 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.
- General Anesthesia & IV sedation when performed in conjunction with basic oral surgery are excluded.

**E. 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.
  - No more than one root canal treatment, retreatment, pulpal regeneration or apexification per tooth in 60 month period.

**F. 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 planing procedures are allowed once within 24 months.
  - Localized delivery of antimicrobial agents is not a benefit.
  - Full mouth debridement is allowed once per lifetime.
  - Periodontal maintenance procedures to include prophylaxis (cleanings and scaling in the presence of inflammation) are limited to once in any 6 month period.

Benefits for periodontal maintenance are provided only after active periodontal treatment (surgical or non-surgical), and no sooner than 90 days after completion of such treatment.

**G. Major Restorative Benefits, Limitations & Exclusions**

- Cast Restorations. Crowns and onlays 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.
within 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. Some procedures (ex. Veneers) may be made optional.
- 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.

H. 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.
- Denture Repairs - services to repair complete or partial dentures limited to one repair per denture per 24 months.

I. 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 implant supported prosthesis received in the previous five years is not a benefit.
  - Implant limited to once per tooth per lifetime.
  - The removal of an implant is allowed once per lifetime.
  - Specialized techniques are not benefits (ie. bone grafts, guided tissue regeneration, precision attachments, etc.)
  - Implants are not a benefit for patient’s under 19 years of age.
  - Implant maintenance procedures are allowed once in a 12 month period.
  - Implant debridement is limited to one time per tooth per lifetime.
  - Bone Graft for implant is limited to one per tooth per lifetime.

J. 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, DDTN 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 DDTN 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.
STATEMENT OF ERISA RIGHTS

As a participant in the Dental Care Plan for Vanderbilt University Medical Center (the 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 Dental Care Plan of Vanderbilt University Medical Center summary annual reports are posted to http://hr.mc.vanderbilt.edu/benefits/sar.php.

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 a preexisting 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 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 $147 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 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 Employee Benefits Security Administration.

Pertinent Information

The name of the Plan is:

Dental Care Plan for Vanderbilt University Medical Center

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

Vanderbilt University Medical Center
2525 West End Ave, 5th Floor
Nashville, Tennessee 37203
615-343-7000

Employer Identification Number (EIN): 352528741

Plan Number: 502

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

Chief Human Resources Officer
Vanderbilt University Medical Center Human Resources
2525 West End Ave, 5th Floor
Nashville, Tennessee 37203
615-343-7000

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

Vanderbilt University Medical Center
2525 West End Ave, 5th Floor
Nashville, Tennessee 37203
615-343-7000
Nondiscrimination and Accessibility Notice

Vanderbilt University Medical Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Vanderbilt University Medical Center does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Vanderbilt University Medical Center:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Employee and Labor Relations.

If you believe that Vanderbilt University Medical Center has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Rochelle Johnson, Director, Employee and Labor Relations; 2525 West End Avenue, Suite 500, Nashville, TN 37203; 615.343.4759 (phone); 615.343.2176 (fax); employeerelations.vumc@vanderbilt.edu. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Rochelle Johnson, Director, Employee and Labor Relations, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)


ATTENTION: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-615-322-7378 (TTY: 711).

注意:如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-615-322-7378 (TTY: 711)。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-615-322-7378 (TTY: 711) 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.Appelez le 1-615-322-7378 (ATS : 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-615-322-7378 (TTY: 711) 번으로 전화해 주십시오.


ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-615-322-7378 (телетайп: 711).
Equal Opportunity

In compliance with federal law, including the provisions of Title VII of the Civil Rights Act of 1964, Sections 503 and 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act (ADA) of 1990, the ADA Amendments Act of 2008, Executive Order 11246, the Uniformed Services Employment and Reemployment Rights Act, as amended, and the Genetic Information Nondiscrimination Act of 2008, Vanderbilt University Medical Center (VUMC) does not discriminate against individuals on the basis of their race, sex, sexual orientation, gender identity, religion, color, national or ethnic origin, age, disability, veteran status, or genetic information in its administration of policies, programs, activities or employment. In addition, VUMC does not discriminate against individuals on the basis of their gender expression consistent with VUMC’s anti-harassment, nondiscrimination and anti-retaliation policy.

Rev. 11/2017