This booklet contains summary plan descriptions (SPDs) for VUMC benefit plans. SPDs provide information on what each plan provides, how it operates, when an employee can begin to participate in the plan, how service and benefits are calculated, when benefits becomes vested, when and in what form benefits are paid, and how to file a claim for benefits. If you have questions, please contact the Employee Service Center at 615.343.7000 or human.resources.vumc@vanderbilt.edu.
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.

This health plan is partially funded by Vanderbilt University Medical Center and administered by Aetna and Navitus Health Solution
SUMMARY OF HEALTH PLAN BENEFITS

Eligibility
All full-time faculty and full-time regular staff are eligible for immediate Health Care Plan coverage. In the case of an employee who acquires a spouse, same-sex domestic partner or child after becoming eligible for coverage, this family member is eligible on the date acquired.

Health Plan Options
The Group Health Care Plan for Vanderbilt University Medical Center (the Plan) includes a choice of three options, including:

- Aetna Plus
- Aetna Select
- Aetna HealthFund

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

Coverage Tiers
Vanderbilt offers a four-tiered rate structure:

1. Employee Coverage: Covers the employee only.
2. Employee and Spouse/Same-Sex Domestic Partner: Covers the employee and the employee’s spouse or same-sex domestic partner (see definition on page 6).
3. Employee and Child(ren): Covers the employee and all eligible children.
4. Family Coverage: Covers the employee, the employee’s spouse or same-sex domestic partner (see definition on page 6), and all eligible children.

See definition of eligible family members on page 6.

Salary-based Payroll Deductions for the Health Plan
The cost of medical coverage is based on the employee’s annual Vanderbilt University Medical Center benefits salary, also known as the annual base benefits rate (ABBR). There are five salary bands that will determine monthly cost (refer to the following HR website for more information: http://hr.mc.vanderbilt.edu/benefits.

Waiving Health Plan Coverage
In the event that you are covered by another health plan, you may elect to waive coverage under the Vanderbilt University Medical Center Health Care Plan. To waive coverage, newly hired employees must agree to the conditions of the Health Plan Waiver within the online benefits enrollment tool within 30 days of Health Plan eligibility. During Open Enrollment, you may waive health coverage, but to do so, you must agree to the conditions of the Health Plan Waiver within the Open Enrollment online benefits enrollment tool.

Special Enrollment Provisions
If you waive coverage for yourself or your spouse, same-sex domestic partner or children because of other health insurance coverage, in the future you may be able to enroll yourself or your eligible family members in this Plan. You must follow the Family Status Change/Qualifying Life Event process within My VUMC Benefits within 30 days of the event that causes your other group insurance plan coverage to end, such as the last day of your spouse’s employer-sponsored health coverage. In addition, if you have a new eligible family member as a result of marriage, same-sex domestic partner relationship, birth, adoption, or placement for adoption, you may be able to enroll yourself and your spouse, same-sex domestic partner and/or children, provided that you request enrollment within 30 days after the Family Status Change/Qualifying Life Event date by submitting to the Office of Benefits Administration your completed Family Status Change Form through My VUMC Benefits. A link to My VUMC Benefits is on the Vanderbilt HR homepage, http://hr.mc.vanderbilt.edu/, under the Benefits tab. The Vanderbilt University Medical Center reserves the right to perform periodic eligibility audits that would require documentation to confirm an individual as your eligible family member. Copies of court documents or birth certificates are examples of acceptable documentation.

Effective Date of Coverage
Coverage is effective on the date an employee or eligible family member first becomes eligible for coverage, provided that application for coverage is made no later than 30 days after becoming eligible. The receipt of a membership or identification card from Aetna, or Navitus Health Solutions does not guarantee coverage or eligibility (see Eligibility).
Pre-Existing Conditions
There are no pre-existing condition clauses with any of the medical and pharmacy options offered under the Plan.

How to Enroll
You must enroll by completing the online benefits enrollment process at the time you begin work at Vanderbilt University Medical Center by logging in to the My VUMC Benefits website and following the steps outlined in this HR website: http://hr.mc.vanderbilt.edu/benefits/infomanagers.php. 
To enroll a child for whom you are required by court order to provide health insurance coverage, a qualified medical child support order must be provided to the Plan Administrator or its designee for review.

Changing Coverage
Plan options and coverage tiers may be changed only during Open Enrollment, which generally occurs each Fall (contact the Office of Benefits Administration for exact dates). Your health insurance option will carry over into each eligible Plan Year unless you make changes during Open Enrollment or in the occurrence of a Family Status Change/Qualifying Life Event). Flexible Spending Account elections do not carry over into the next Plan Year, if you choose to participate in Health Care FSA or Dependent Care FSA then you must re-enroll during Open Enrollment for each Plan Year you choose to have coverage.
If you experience a qualifying life event (see definition on page 7) during the plan year, you typically may change coverage tiers only (not your Health Plan Option) by completing the Family Status Change/Qualifying Life Event) online process within My VUMC Benefits within 30 days of the qualifying life event that triggered the need for the change in coverage, such as the loss of your spouse’s employer-sponsored health coverage. The effective date of any coverage change due to a qualifying event will be determined based on the qualified life event. You will be required to pay any missed payroll deductions caused by the effective date of your change. Payroll deductions for a future-dated effective date will not begin until the first of the month in which the effective date begins.

Termination of Coverage
If a person ceases to be employed by Vanderbilt University Medical Center, individual coverage and coverage for his or her eligible spouse, same-sex domestic partner or children will terminate at midnight on the last day of the month in which they terminate employment.
If a dependent is no longer eligible to be covered under the Plan, then coverage for the ineligible dependent will terminate at midnight on the date of the event that causes them to no longer be eligible. Examples:
• A finalized Divorce will terminate the coverage of the employee’s spouse at midnight on the day in which the divorce is signed by the judge and filed with the court. It is the participant’s responsibility to notify Office of Benefits Administration of this change of status within 30 days by completing the online Family Status Change/Qualifying Life Event)process in My VUMC Benefits.
• Coverage for an eligible child shall end at midnight on the last day of the month in which the child no longer qualifies as eligible due to their age. Refer to Definition of Terms, page 6, for age limit eligibility. It is the participant’s responsibility to notify Office of Benefits Administration if the child is eligible for coverage beyond the age of 26 due to a disability. Notification must be made at least 30 days prior to the child’s 26th birthday
• Coverage for a same-sex domestic partner shall end at midnight on the day in which the relationship terminates. Employees receiving benefits under a same-sex domestic partner arrangement must notify the Office of Benefits Administration within 30 days by completing the online Family Status Change/Qualifying Life Event process in My VUMC Benefits.
If payment is required and is not made in full within 30 days of the due date, coverage for the employee and his or her spouse or children shall cease as of midnight of the last day of the month in which coverage was paid. For certain qualifying events, arrangements can be made to continue coverage beyond the normal termination date. Your rights to continue group health plan coverage are described in the section entitled “Continuing Group Coverage – COBRA” in this booklet. If your Plan coverage terminates, the Plan Administrator can provide a certificate that documents your coverage for up to the previous 18 months.
Should Vanderbilt University Medical Center determine to terminate the Plan, written notice will be provided along with information regarding alternatives for coverage and procedures for obtaining the coverage.

Rescission of Health Coverage
The Plan is limited by the Patient Protection and Affordable Care Act (PPACA) from terminating coverage retroactively of an enrollee. A “rescission” covered by the law is a cancellation or discontinuance of health plan coverage that has retroactive effect. The Plan may rescind coverage if it was obtained as a result of fraud or intentional misrepresentation. The Plan is required to give 30 days prior written notice for rescission of coverage. Example of fraud or intentional misrepresentation is an employee claiming
a non-spouse as a spouse, or an ineligible individual as an eligible dependent. Coverage may be retroactively terminated for nonpayment of employee required premiums or contributions toward the cost of coverage, which is not considered a rescission, per the regulations.

The Plan can terminate coverage prospectively upon discovery during an eligibility audit that certain covered dependents do not meet plan criteria for eligibility and there is no intent of fraud or intentional misrepresentation, and when an employee no longer meets the eligibility requirements for the Plan.

**Non-Assignment of Benefits**

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

**General Provisions**

Vanderbilt University Medical Center has the sole and absolute discretion and authority to interpret the terms of the Plan, resolve ambiguities and inconsistencies in the Plan, and make all decisions regarding eligibility and/or entitlement to coverage or benefits. Vanderbilt University Medical Center has the right to recover any excess payments or benefits that were not paid in accordance with Plan terms.

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

**COST CONTAINMENT**

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

**Selection of Provider – Physicians and Facilities**

Each of the options provides both in- and out-of-network benefits described in the Evidence of Coverage or Summary Booklet of each option. The Aetna network directory is available online at [http://www.aetna.com/docfind/custom/vanderbilt/](http://www.aetna.com/docfind/custom/vanderbilt/). Aetna has contracted with a network of health care professionals and facilities. The Vanderbilt University Medical Center Health Plan does not contract directly with these providers. If you use an out-of-network provider, you will be responsible for the cost difference between any billed charges and the reasonable charge for a covered service in addition to the listed maximum out of pocket for your selected Plan option. Refer to the Aetna Evidence of Coverage booklets for the definition of reasonable charge.

Plan participants have the choice of what services they want to receive and who they want to provide their health care, regardless of what the Plan covers or pays.

The Plan neither provides nor ensures the quality of care received. Vanderbilt University Medical Center has partnered with Aetna to build a provider network that will be used within the Health Plan’s three Aetna options. The name of this network is the Vanderbilt Health Affiliated Network (VHAN). You can learn more by visiting this HR website: [http://hr.mc.vanderbilt.edu/benefits/vanderbilt-affiliates/index.php](http://hr.mc.vanderbilt.edu/benefits/vanderbilt-affiliates/index.php)

**Deductibles, Co-payments, Co-insurance, and Out-of-pocket Maximums**

Deductibles, co-payments, co-insurance amounts, and out-of-pocket maximums in each of the Plan options are established by Vanderbilt University Medical Center and are subject to change. To determine the current deductibles, co-payments, co-insurance, and out-of-pocket maximums, refer to your option’s Evidence of Coverage (EOC) or Summary Booklet. Copies are available at [http://hr.mc.vanderbilt.edu/benefits/sbc-eoc.php](http://hr.mc.vanderbilt.edu/benefits/sbc-eoc.php). In addition, a uniform glossary of health coverage and medical terms is available at [http://hr.mc.vanderbilt.edu/benefits/UniformGlossaryTerms.pdf](http://hr.mc.vanderbilt.edu/benefits/UniformGlossaryTerms.pdf).

**Prior Authorization**

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

Refer to your option’s EOC or Summary Booklet for more information and specific information related to emergency care.
Plan Payment
Participating providers (hospitals and physicians) within the network option you selected may change from time to time. Physicians who participate in the network established for your option have agreed to accept reimbursement rates negotiated by the health insurance third-party administrator (Aetna). It is strongly advised to verify your physician’s or hospital’s membership within the network prior to receiving services. Provider listings are made available on the Aetna website or by calling the Aetna customer service phone number listed on your member identification card.

Coordination of Benefits Provision
It is important to understand coordination or non-duplication of benefits if your family members are covered by more than one health plan. These provisions are described in your option’s EOC or Summary Booklet. Aetna may require you to complete an annual certification stating whether or not you have other health plan coverage. Failure to reply to a request for this information will result in the suspension of payments to providers until certification is received.

Maximum Benefit
There is no lifetime maximum benefit that would cap a participant’s coverage under this Plan during his or her lifetime.

Subrogation
Subrogation deals with the right of the health care provider to recover payments made on your behalf if you are injured as a result of someone else’s action or negligence. Such recovery helps to keep down the cost of the Plan. For example, if you are injured in an automobile accident caused by someone else; that person’s automobile policy may pay for the medical expenses you incur. The Plan has the right to recover from the person who caused the accident, or from his insurance company, any medical expenses that have been paid by the Plan. Additional details are provided in your option’s EOC.

Health Plan Exclusions and Limitations
Each health plan option contains its own list of exclusions and limitations for providers, tests, devices, procedures, and other aspects of medical and pharmacy coverage. It is your responsibility to review exclusions and limitations. Refer to your option’s EOC for additional information.

Applied Behavioral Analysis Therapy
Each health plan option includes Applied Behavioral Analysis (ABA) therapy for autism spectrum disorder; it is available through VHAN and Aetna network providers. More information can be found on this HR website: http://hr.mc.vanderbilt.edu/benefits/healthinsurance.php.

Preventive Services
Eligible preventive services are covered under each of the available Plan options. Refer to the following HR website for additional information: http://hr.mc.vanderbilt.edu/benefits/preventivecare.php

Prescription Drugs
Navitus Health Solutions is Vanderbilt University Medical Center’s Pharmacy Benefits Manager. A separate membership identification card for this coverage will be provided. Refer to Navitus Health Solutions’ Summary Booklet and website for specific information regarding the preferred drug list (formulary) and network of participating pharmacies. The Navitus formulary for Vanderbilt University Medical Center (the Formulary) is a list of drugs selected by the pharmacy and therapeutics (P&T) committee. Plan participants are not prohibited from receiving prescriptions for non-formulary drugs, but the Vanderbilt University Medical Center Health Plan is not bound to pay for non-formulary drugs. In other words, if a prescription drug is not on the Navitus formulary, it is not covered and the participant pays the full cost. For drugs on the formulary, your cost is either a co-payment or co-insurance amount depending on the drug. There are five drug levels: maintenance generic, Level 1, Level 2, Level 3 and specialty. A separate annual out-of-pocket maximum for prescription drugs is in place to help you manage your prescription drug costs.

The Plan encourages you to use generics when a generic equivalent is available. If you or your physician choose a Navitus formulary brand-name drug instead of the generic-equivalent, your cost for the brand will be much higher. With this mandatory generic program, you will pay the level 3 co-insurance plus the cost difference between the brand-name drug and the generic drug up to a specified dollar limit.

- **For example:** if the cost of the generic equivalent is $25 and the cost of the brand-name on the Formulary is $100, you will pay the difference of $75 plus the level 3 co-payment not to exceed the total brand-name drug cost of $100.
• Any costs paid for brand-name drugs when a generic-equivalent is available on the Formulary do not apply toward your annual out-of-pocket maximum for prescription drugs.

Coverage for specialty drugs, maintenance generics and 90-day prescriptions are available only when filled through one of the Vanderbilt University Medical Center Outpatient Pharmacies or the Vanderbilt University Medical Center Outpatient Pharmacies Mail Order Program. Additionally, there is no prescription benefit for an out-of-network pharmacy.

Additional information about the prescription drug benefit program is available by calling the toll-free Navitus Health Solutions’ Customer Care telephone number, 866.333.2757, or through their website (http://www.navitus.com), or through the Vanderbilt University Medical Center Human Resources website (http://hr.mc.vanderbilt.edu/benefits/prescription.php).

Smoking Cessation
Each health plan option includes a limited coverage per eligible enrolled Vanderbilt University Medical Center employee and their enrolled dependents to reimburse $300.00 toward any smoking cessation program offered through the Vanderbilt University Medical Center Dayani Center for Health & Wellness. Please refer to this website to learn more about the smoking cessation programs offered through the Vanderbilt University Medical Center Dayani Center for Health & Wellness: http://www.vanderbilthealth.com/dayani/ or this HR website: http://hr.mc.vanderbilt.edu/benefits/tobacco-cessation.php.

CONTINUING YOUR COVERAGE

Continuation of Group Coverage while on Leave of Absence
If you take an approved leave of absence without pay, you may continue the coverage in force at the time your leave begins. Coverage may be continued throughout the leave period by paying the required cost of coverage.

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

Coverage when Leaving Plan
Besides electing COBRA continuation of coverage, the only coverage provided when leaving the Plan is the benefit for hospital services when a member is hospitalized on the date the Plan is terminated. In this case, benefits for hospital services only will be provided for up to 90 days or until the member is discharged from the hospital, whichever occurs first. These provisions do not apply to a newborn child of a subscriber for whom the Plan Administrator did not receive application for coverage within 30 days following the child’s birth.

Continuation Coverage — COBRA
On April 7, 1986, a Federal law was enacted (Public Law 99-272, Title X) requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called “continuation coverage”) at group rates plus an additional 2 percent administrative fee in certain instances where coverage under the Plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) law. Both you, your spouse or same-sex domestic partner should take the time to read this notice carefully.

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

If you are the spouse or same-sex domestic partner of an employee covered by the Plan, you have the right to choose continuation coverage for yourself if you lose group health coverage under the Plan for any of the following reasons:

1. The death of your spouse or same-sex domestic partner;
2. A termination of your spouse or same-sex domestic partner employment (for reasons other than gross misconduct) or reduction in your spouse or same-sex domestic partner’s hours of employment;
3. Divorce or legal separation from your spouse or same-sex domestic partner; or
4. Your spouse or same-sex domestic partner becomes eligible for Medicare.
In the case of a child of an employee covered by the Plan, he or she has the right to continuation coverage if group health coverage under the Plan is lost for any of the following reasons:

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

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

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

If you do not choose continuation coverage, your group health insurance coverage will end (see Coverage when Leaving Plan).

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

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

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

This law applies to the Group Health Care Plan for Vanderbilt University Medical Center beginning on July 1, 1986 (under Section 10002(d) of COBRA). If you have any questions about this law, please contact the Plan Administrator, Office of Benefits Administration, PMB 407700, 2301 Vanderbilt Place, Nashville, TN 37240-7700 (615.343.7000). Also, if you have changed marital status, or you, your spouse or same-sex domestic partner, have changed your address, please notify the Benefits Administration Office at the above address.

**DEFINITIONS OF TERMS**

**Eligible Family Members**

1. Your spouse or same-sex domestic partner. (Same-sex domestic partner is a person of the same sex that is not related by blood. The partner must not be under 21 years of age, not legally married to anyone else, nor have another same-sex domestic partner.)

2. Your children from birth to age 26 as follows:
   a. An employee’s natural child by birth, adopted child, child placed with the employee for adoption, stepchild or foster child and children of same-sex domestic partnership are eligible under the Plan (as defined in section 5000A(f)(2) of the Internal Revenue Code).
   b. Children up to age 18 under legal guardianship or custody of the employee must meet the definition of dependent under the Federal Tax Code for income tax purposes and be able to show supporting documentation (such as the
employee’s claim of dependency for the child on the relevant portion of your most recent IRS Form 1040 federal income tax return) in order to be eligible under the Plan. Children under legal guardianship or custody, who do not meet eligibility requirements above in (a), will lose their coverage eligibility the first day of the month following the month in which they turn 18 years of age (age of majority).

c. Children of the employee’s Vanderbilt University Medical Center same-sex domestic partner are eligible under the Plan as long as they meet eligibility requirements listed above in (a) and (b).

3. Your child 26 years of age or older who is incapable of self-support because of mental or physical disability, and 1) the child is currently enrolled in the Plan and the disability existed prior to the child reaching the age of 26 and 2) the disability is documented with Vanderbilt University Medical Center’s Office of Benefits Administration prior to their reaching the age of 26. To maintain eligibility, Children older than 26 must live with you in a regular parent-child relationship or reside in a custodial institution for medical reasons or reside in another monitored environment (endorsed by a physician on an annual basis) for medical or behavioral reasons, and depend upon you for more than 70 percent of their support. In addition, Children older than 26 must be children of the employee by birth, legal guardianship or custody, legal adoption or placement in anticipation of adoption, the employee’s stepchildren, or the children of the employee’s same-sex domestic partner. Children older than 26 must meet the definition of dependent under the Federal Tax Code for income tax purposes and be able to show supporting documentation (such as the employee’s claim of dependency for the child on the relevant portion of your most recent IRS Form 1040 federal income tax return) in order to be eligible under the Plan. For new or existing employees who have a disabled child over the age 26, the same certification and eligibility criteria are required to confirm the disability with the Plan Administrator or designee, but in addition, the employee must show documentation their dependent has been continuously enrolled in an employer-sponsored group health plan as a certified disabled dependent without any breaks in coverage. The Plan Administrator or designee must approve continuation of coverage for children over the age of 26.

The Vanderbilt University Medical Center reserves the right to perform periodic eligibility audits that would require documentation to confirm an individual as your eligible family member. All plan participants are subject to the annual dependent eligibility audit. Documentation to verify eligibility for dependents covered under the Plan is required for each audit. Copies of court documents or birth certificates are examples of acceptable documentation.

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

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

Qualifying Event
The birth or adoption of a child; obtaining legal guardianship or custody; a marriage, death, or divorce; termination or initiation of a same-sex domestic partnership; a change in your spouse’s or adult child’s employment that effects your or your spouse’s or adult child’s health care coverage; open enrollment allowing change under the spouse’s employer coverage; or the termination of the employer contributions for your spouses’ insurance coverage. The qualifying event date (e.g., the last day of coverage under your spouse’s employer-sponsored health plan) is used to determine the beginning of the 30-day window of time during which a consistent change in the benefit may be made. A provider network change does not qualify a participant to make a mid-year election change. If you or your dependent gains or loses eligibility for coverage under a State Medicaid (TennCare), or CHIP program the Plan will provide 60 days from the date of gain or loss of coverage for you to initiate a Family Status Change/Qualifying Life Event. For all other qualified life events, you will have 30 days from the date of the qualified event to make a special enrollment through the Family Status Change/Qualifying Life Event process.

If your Family Status Change/Qualifying Life Event is audited by Human Resources and it is discovered that you did not have an eligible qualified event to make a mid-year election change through the special enrollment provision of the Family Status Change process, this will be considered intentional misrepresentation or fraud and the Plan will rescind
your coverage back to what your health coverage was prior to the Family Status Change/Qualifying Life Event occurred. Any ineligible health care or pharmacy claims paid by the Plan on your behalf because of this fraud should be repaid to the Plan.

Summary of Benefits and Coverage and Uniform Glossary
The Patient Protection and Affordable Care Act (PPACA) created two new plan documents for participants: Summary of Benefits and Coverage (SBC) and a Uniform Glossary of Health Coverage and Medical Terms. A copy of Vanderbilt University Medical Center’s SBC can be found on this HR website: http://hr.mc.vanderbilt.edu/benefits/sbc-eoc.php.

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

- If you or your child become eligible for state-granted premium assistance, or, you or your child’s coverage terminates due to a loss of eligibility (as opposed to termination due to failure to pay premiums) under Medicaid, Tennessee’s CoverKids program, or a State Children’s Health Insurance Plan, you may enroll in the Plan. You must request coverage within 60 days of this special-enrollment qualifying event by completing the online Family Status Change/Qualifying Life Event process on C2HR.
- If your child becomes eligible to receive a premium subsidy from the Child Health Insurance Program, you will be allowed under CHIPRA to disenroll (drop) your child from the Plan. You must request this coverage change within 60 days of this special-enrollment qualifying event by completing the online Family Status Change/Qualifying Life Event process on C2HR.

Totally Disabled
Your complete inability to perform any and every duty pertaining to your occupation or employment; or, your spouse, same-sex domestic partner or child’s complete inability to perform the normal activities of a person of like age and sex.
SUMMARY PLAN DESCRIPTION

Name of Plan: Health Care Plan for Vanderbilt University Medical Center
Name of Plan Sponsor: Vanderbilt University Medical Center, Nashville, Tennessee 37235
Employer Identification Number ("EIN"): 35-2528741
Plan Number: 501

Type of Plan and Plan Benefits
This Plan is an employee welfare benefit plan that provides comprehensive health care benefits.

Type of Administration
Vanderbilt University Medical Center contracts with Aetna, and Navitus Health Solutions for claims administration services. All options under this plan are self-insured.

Name of Plan Administrator/Privacy Officer/Privacy Contact
Chief Human Resources Officer
Vanderbilt University Medical Center Human Resources
2525 West End Avenue, 5th Floor
Nashville, Tennessee 37203
615.343.7000

Service of Legal Process
Service of legal process may be made on the Plan Administrator. Service may be made on Aetna for the Aetna Plus, Aetna Select and the Aetna HealthFund options at 151 Farmington Avenue, Hartford, CT 06156. Service may be made on Navitus Health Solutions, LLC, 999 Fourier Drive, Madison, WI 53717.

Eligibility to Participate in the Plan
Your coverage is effective on your hire date. You may enroll for employee, employee plus spouse/same-sex domestic partner, employee plus child(ren), or family membership. Coverage for your eligible family members becomes effective on the date you become eligible, provided you have enrolled for appropriate coverage, agree to make the required contributions, and you enroll them within 30 days from the date you first become eligible for family member coverage. You may change coverage tiers by applying within 30 days after a qualifying life event (see definition on page 7).

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

Cost
Vanderbilt University Medical Center and the employee share the cost of the Plan. Vanderbilt University Medical Center’s portion comes from the general assets of the institution. The amount of the employee’s portion will be communicated to participants whenever the amount changes. Each active employee pays his or her portion of the Plan’s cost pre-tax as a payroll deduction.

Plan Year
The Plan records are kept on a Calendar year bases, which begins January 1 and ends on December 31 of each year.

Filing Claims for Health Care Plan Benefits
Refer to your option’s Evidence of Coverage (EOC) or Summary Booklet for claim filing procedures.

Claims Decision Period
A benefits determination is normally made within 45 days after a claim has been filed. If there are special circumstances, which require more time to make a decision, you will be sent a notice within that period, explaining why more time is
needed. A determination will, however, be made no later than 90 days from the date the claim was originally filed. If the claim is denied in whole or in part, you will receive a notice from the claims administrator with (a) the reasons for denial, (b) a reference to the plan provisions on which denial is based, (c) if applicable, a description of additional information which may be necessary, and an explanation of why it is necessary, and (d) appropriate information as to the steps to be taken to have your claim reviewed by the claims administrator if you do not agree with the denial.

How to Appeal a Claim

Medical Appeals for hospital and physician services: If you do not agree with the denial of your claim, you have 180 days to file an appeal. The submission of an appeal does not guarantee coverage, but appeals should be made in writing to the claims administrator. You should state the reasons why you do not agree with the denial or partial denial and provide any supporting documentation. The claims administrator will then review the information and provide a written decision within 60 days. If necessary, this period may be extended for an additional 60 days and you will receive written notice of this extension. Refer to the Evidence of Coverage or Summary booklet regarding the grievance or appeal procedures described therein for your health plan option. You may also contact the customer service department for Aetna at the number listed on your insurance membership card.

Pharmacy appeals for prescription drugs: If you do not agree with the denial of your claim, you have 180 days to file an appeal. If you have questions about how to file a pharmacy appeal, you should call the Navitus Health Solutions Customer Care telephone number, (866)333-2757. The submission of an appeal does not guarantee coverage, but appeals should be made in writing to Navitus. You should state the reasons why you do not agree with the denial or partial denial and provide any supporting documentation. The Navitus claims administrator will then review the information and provide a written decision within 60 days. If necessary, this period may be extended for an additional 60 days and you will receive written notice of this extension. Supporting documentation, such as a physician’s letter and/or a FDA MedWatch form completed by your physician, could be requested as part of the appeal process.

STATEMENT OF ERISA RIGHTS

As a participant in the Group Health 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 Group Health 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, same-sex domestic partner or children if there is a loss of coverage under the Plan as a result of a qualify in life event. You or your eligible family members 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. The Group Health Care Plan for Vanderbilt University Medical Center (the Plan) does not have any pre-existing condition clauses. You should be provided a certificate of creditable coverage, free of charge, 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, employers may subject you to a pre-existing condition exclusion for 12months (18 months for late enrollees) after your enrollment date in your coverage.

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

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

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

Newborns and Mothers Protection Act of 1996
Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Mental Health Parity Act
The Mental Health Parity Act (the “Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008”) was signed into law on October 3, 2008, and the Federal Mental Health Parity (MHP) law went into effect for the Plan January 01, 2010. The Mental Health Parity and Addiction Equity Act requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical or surgical benefits.

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

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

**Uniformed Services Employment and Reemployment Rights Act of 1994**

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

**Protected Health Information**

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

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

Vanderbilt University Medical Center’s *Notice of Privacy Practices* may be found at [http://hr.mc.vanderbilt.edu/benefits/federal-notices.php](http://hr.mc.vanderbilt.edu/benefits/federal-notices.php)
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.
This brochure is not a contract. In the interest of simplicity, coverage is described in rather general terms. The extent of your coverage at all times is governed by the complete terms of the plan documents for the Vanderbilt University Medical Center Retirement Plan, the contracts between Vanderbilt University Medical Center and Fidelity Investments (Fidelity), the Teachers Insurance Annuity Association (TIAA), the College Retirement Equities Fund (CREF), Variable Annuity Life Insurance Company (VALIC) and the contracts between you and Fidelity, TIAA-CREF, VALIC and such other regulated investment companies as the Plan Administrator may designate from time to time pursuant to his authority under the Plan (collectively, the “Contracts”).

ESTABLISHMENT AND PURPOSE OF THE PLAN

This Summary Plan Description summarizes the provisions of the Vanderbilt University Medical Center Retirement Plan (the “Plan”) as of April 30, 2016.

The purpose of the Plan is to provide retirement benefits for the faculty and staff of Vanderbilt University Medical Center and other entities that are eligible to adopt the Plan and do adopt the Plan (collectively, “VUMC”). The Plan is intended to meet the requirements of Section 403(b) and other relevant sections of the Internal Revenue Code (“IRC”), so that the contributions to the Plan will, to the extent allowed by law and elected by the participant, be excluded from the gross income of members of the faculty and staff for the taxable year.

Any conflict between the statements made in this Summary Plan Description and the plan documents for the Plan and/or the Contracts will be subject to and controlled by the provisions more fully set forth in the plan documents and the Contracts, which are available to you upon request at the Plan Administrator’s office as more fully explained in the statement of ERISA rights at the end of this document.

This Summary Plan Description contains a general description of the Plan and a discussion of how the Plan works. This Summary Plan Description is not a contract, nor a guarantee of employment. Nothing contained in this Summary Plan Description gives an Eligible Employee or Plan participant any rights to employment. Eligible Employees and Plan participants employed by VUMC are subject to its policies on discharge, discipline or layoff. If you terminate your employment, your benefit will be based on the provisions of the applicable Plan in effect when you terminate. Because of laws, government regulations and a wide variety of possible exceptions to the situations described in this Summary Plan Description, the information provided here is merely a general summary of the most important provisions and most common situations associated with your participation in the applicable Plan.

While no major revisions to the Plan is planned at this time, you should be aware that changes might occur at some point during your employment and that VUMC retains the right to amend or terminate the Plan at any time. You should know that the Plan Administrator has full power,
authority and discretion to interpret the provisions of the Plan, and its determinations, reached in good faith, of any issue of fact or law under the Plan are final and binding.

ELIGIBILITY

Vanderbilt University Medical Center Retirement Plan

All Eligible Employees of VUMC who are not eligible to participate in the New Faculty Plan are eligible to participate in the Vanderbilt University Medical Center Retirement Plan, generally starting on the first day of the first full month after the date they commence employment with the VUMC.

New Faculty Plan

All Eligible Employees who are newly hired faculty, officers, executive administration or senior exempt staff and are not Highly Compensated Employees are eligible to participate in the New Faculty Plan, generally starting on the first day of the first full month after the date they commence employment with VUMC.

An Eligible Employee will cease to be eligible to participate in the New Faculty Plan once he or she ceases to be a faculty employee (or general officer, executive administration or senior exempt staff), ceases to be a non-Highly Compensated Employee, or has completed one (1) Year of Eligibility Service. If the employee is still an Eligible Employee at that time, he or she will immediately become eligible to participate in the Vanderbilt University Medical Center Retirement Plan. No employee may participate in both the Vanderbilt University Medical Center Retirement Plan and the New Faculty Plan at the same time.

SOURCES OF CONTRIBUTIONS TO THE PLAN

Mandatory Deferrals and Mandatory Matching Contributions

Mandatory Deferrals – Each Eligible Employee who is eligible to participate in the Vanderbilt University Medical Center Retirement Plan, who is on the VUMC payroll, and has completed one (1) Year of Eligibility Service must make Mandatory Deferrals to that Plan from his or her Salary. Similarly, each Eligible Employee who is eligible to participate in the New Faculty Plan, and who is on the VUMC payroll must make Mandatory Deferrals to that Plan from his or her Salary. An employee is on the VUMC payroll for this purpose only if he or she is classified as a common law employee and is paid directly by the VUMC.

Mandatory Deferrals begin as soon as practical after an employee becomes subject to the requirement to make them, which generally is the first pay period of the first full month after that date.
The amount of the Mandatory Deferrals is 3% of Salary for most employees, but is 6.47% of Salary for Vanderbilt Medical Group (VMG) faculty and is not required for employees in a collective bargaining unit who have elected not to participate in the union-sponsored plan for union employees and instead to participate in the Plan.

*Mandatory Matching Contributions* – VUMC also makes matching contributions with respect to participants’ Mandatory Deferrals, subject to certain limitations. These matching contributions are referred to as “Mandatory Matching Contributions.” The amount of the Mandatory Matching Contributions is determined as follows:

- For an Eligible Employee who has completed one (1) Year of Eligibility Service or is eligible to participate in the New Faculty Plan, the amount is 100% of the employee’s Mandatory Deferrals up to 3% of Salary.

However, the following employees are not required to participate in Mandatory Deferrals or eligible to receive Mandatory Matching Contributions or Matching Contributions:

- Employees who have not attained age twenty-one (21);
- Employees in a collective bargaining unit who participate in a union-sponsored plan;
- Employees in Vanderbilt Temporary Services or the temporary nurse registry staff;
- Part-time faculty members (except those designated as “full-status, partial-load”);
- Full-time temporary faculty members; and
- Faculty members whose positions include the term “adjunct,” “adjoint,” “visiting,” “emeritus,” or “in-residence.”

**Elective Deferrals and Regular Matching Contributions**

*Elective Deferrals* – Each Eligible Employee who is eligible to participate in the Vanderbilt University Medical Center Retirement Plan is eligible to make Elective Deferrals to that Plan from his or her Salary. Similarly, each Eligible Employee who is eligible to participate in the New Faculty Plan is eligible to make Elective Deferrals to that Plan from his or her Salary.

Elective Deferrals are voluntary, are in addition to any Mandatory Deferrals, and require completion of a Salary Reduction Agreement. They begin as soon as practical after the Salary Reduction Agreement is received in Human Resources, which generally is within 1 to 2 pay periods after it is received. The most current Salary Reduction Agreement must be used and it must be completed in its entirety to be accepted. There is no requirement that an employee participate in any other benefit or coverage arrangement offered by VUMC to make Elective Deferrals.
Matching Contributions – VUMC also makes matching contributions with respect to participants’ Elective Deferrals, subject to certain limitations. These matching contributions are referred to simply as “Matching Contributions.” The amount of the Matching Contributions is determined as follows:

- For an Eligible Employee who has completed one (1) Year of Eligibility Service or is eligible to participate in the New Faculty Plan, the amount is 100% of the employee’s Elective Deferrals up to 2% of Salary, but only if the employee has elected to make Elective Deferrals of at least 2% of Salary in addition to Mandatory Deferrals.

- For an Eligible Employee with one Year of Eligibility Service in a collective bargaining unit who has elected not to participate in the union-sponsored plan for union employees and instead to participate in the Plan, the amount is 100% of the employee’s Elective Deferrals up to 5% of Salary, but only if the employee has elected to make Elective Deferrals of at least 5% of Salary.

Elective Deferrals up to the 2% and 5% limits described above may be referred to as “voluntary” Elective Deferrals. Elective Deferrals in excess of these limits may be made, but they will not be matched.

The employees listed above who are not eligible to receive Mandatory Matching Contributions also are not eligible to receive Matching Contributions.

After-Tax Roth Contributions

An Eligible Employee may allocate part or all of the employee’s Elective Deferrals to a Roth 403(b) account on his or her Salary Reduction Agreement. Elective Deferrals to a Roth 403(b) account are subject to tax at the time they are contributed, but subsequent distributions are not subject to tax provided certain IRC requirements are satisfied. No employee will be permitted to make any after-tax contributions to the Plan other than Roth 403(b) contributions.

Reemployment

An Eligible Employee who previously completed one Year of Eligibility Service with VUMC and is reemployed by VUMC will be required to participate in the Vanderbilt University Medical Center Retirement Plan and will be eligible to receive Mandatory Matching Contributions and Matching Contributions provided he or she is not in one of the classes of employees excluded from the Plan or from making Mandatory Deferrals or receiving such contributions (See “ELIGIBILITY,” above) and provided he or she has not lost credit for the Year of Eligibility Service on account of the break in service. It is the employee’s responsibility to notify Human Resources, in writing, of prior employment with VUMC.
Contributions During a Leave of Absence

If an Eligible Employee is absent from work because of a bona fide leave of absence, Mandatory Deferrals and Elective Deferrals under the Plan will continue to the extent that Salary continues and the Salary Reduction Agreement is not revised, and Matching Contributions and Mandatory Matching Contributions will continue subject to the employee’s continued deferrals and the general qualifications under the Plan for receiving such contributions.

Contributions While on Long-Term Disability

If an employee, at the time of his or her approved disability by VUMC’s Long-term Disability insurance carrier, is covered by the disability waiver of premium benefit, contributions to the applicable Plan on behalf of the employee will continue after the long-term disability benefit has been approved under the terms of the Long-term Disability Insurance contract in place at the time and subject to applicable law and any other limits set forth by the insurance coverage policy with the VUMC’s long-term disability carrier.

Uniform Services Employment and Reemployment Rights Act of 1994 (USERRA)

Individuals reemployed under the provision of USERRA will be treated as not having incurred a break in service with VUMC by reason of such employee’s period or periods of service in the Uniformed Services. An employee will be entitled to benefits that are contingent on Mandatory Deferrals or Elective Deferrals only to the extent that the employee makes such payments. No such payments may exceed the amount the employee would have been permitted or required to contribute had the employee remained continuously employed by VUMC throughout the period of service in the Uniformed Services.

Payments to the applicable Plan will be made beginning with the date of reemployment. Such payments will be made over a period of time that is three times the period of the employee’s service in the Uniformed Services; such payment period will not exceed five years.

For the purposes of computing VUMC’s liability or the employee’s contributions, the employee’s compensation during the period of service will be computed:

- as the rate the employee would have received but for the period of Uniformed Service, or
- on the basis of the employee’s average rate of compensation during the 12-month period immediately preceding such period.

Contributions under the provisions of USERRA and Section 414(u) of the IRC are not treated as contributions in the year the contributions are made, but in the year to which they relate for the purposes of the Section 402(g) and Section 415 limits.
LIMITS ON CONTRIBUTIONS TO THE PLAN

The Plan and the IRC limit the maximum contributions you may make to the Plan. The limits set by law are subject to change on an annual basis.

Limits on Elective Deferrals

General Limit – An employee’s Elective Deferrals for a year may not exceed the limit in Section 402(g) of the IRC. The limit is $18,000 in 2016, unless one of the special rules described below applies.

Special 403(b) Lifetime Catch-Up Contribution Limit – The special 403(b) Lifetime Catch-Up Contribution limit is available only to employees who elected to take advantage of the limit before April 1, 2015. If you have completed at least 15 years of service, you might be eligible to make Elective Deferrals to the applicable Plan of up to $3,000 per year more than the general Section 402(g) limit. These additional contributions are called “403(b) Lifetime Catch-Up Contributions.” A “year of service” for this purpose generally means each full year during which you were a full-time employee of VUMC, plus fractional credit for each part of a year during which you were either a full-time employee for a part of a year or a part-time employee of VUMC. 403(b) Lifetime Catch-Up Contributions are subject to a $15,000 lifetime cap, and also a cap based on the amount of your previous total Elective Deferrals to the Plan.

Special Age 50 Catch-Up Contribution Limit – If you will be age 50 or older by the end of the Plan Year, and have otherwise deferred the maximum amount allowed under the applicable Plan due to IRC and Plan limits and/or restrictions, you are eligible to make additional Elective Deferrals to the applicable Plan in excess of the general Section 402(g) limit. These additional contributions are called “Age 50 Catch-Up Contributions.” The maximum dollar amount of age 50 catch-up contributions is $6,000 for 2016, and is adjusted for cost-of-living after 2016 to the extent provided under the Code.

Coordination of Contributions with Other Defined Contribution Plans – The contribution limits under Section 402(g) generally apply to all the elective deferrals an employee makes. An employee participating in two salary reduction plans with separate employers must count all the elective deferrals made under both plans in applying the limit. This includes contributions to another Section 403(b) plan, a Section 401(k) plan, or a SIMPLE (Savings Incentive Match Plan for Employees) retirement account under Section 408(p). Any Employee making contributions to other retirement accounts must notify and report the contributions to Human Resources by contacting the Employee Service Center. However, contributions to a Section 457(b) plan are not combined with contributions to plans governed by Section 403(b) or Section 401(k) when applying the limits.

Correction of Excess Elective Contributions – An employee’s Elective Deferrals in excess of the Section 402(g) limit, and the applicable earnings or losses, will be distributed to the employee as
taxable compensation no later than April 15 of the next following Plan Year or as soon as administratively practicable. The Plan Administrator will take elective deferrals under other salary reduction plans that are subject to the same Section 402(g) limit into account in determining whether Elective Deferrals under the applicable Plan exceed the Section 402(g) limit if the employee provides information about the other elective deferrals that is accepted by the Plan Administrator.

The Plan Administrator or the relevant retirement account vendor, as the case may be, shall determine, in a uniform and nondiscriminatory manner, whether the distribution of excess Elective Deferrals for a year will be made first from the participant’s pre-tax Elective Deferrals or Roth Elective Deferrals, or a combination of both, to the extent both Elective Deferrals and Roth Elective Deferrals were made for the year, or may allow the participant to specify otherwise.

Matching Contributions with respect to excess Elective Deferrals will be forfeited.

**Limits on Mandatory Deferrals, Mandatory Matching and Matching Contributions**

An employee’s Mandatory Deferrals, Mandatory Matching Contributions and Matching Contributions are based, in part, on the employee’s Salary. The amount of Salary that may be taken into account for this purpose may not exceed the limit in Section 401(a)(17) of the IRC, which is $265,000 in 2016.

Under Section 401(m) of the IRC, Matching Contributions must satisfy a special test to be sure they do not discriminate in favor of Highly Compensated Employees. VUMC may make additional contributions, called “Qualified Nonelective Contributions,” for non-Highly Compensated Employees to help ensure that this test is satisfied. If the test is not satisfied, Matching Contributions which exceed the allowable limit, and the applicable earnings or losses, will be distributed to Highly Compensated Employees as taxable compensation no later than the last day of the next following Plan Year.

**Overall Limit on All Contributions**

An employee’s total Mandatory Deferrals, Elective Deferrals (excluding any Age 50 Catch-Up Contribution), Mandatory Matching Contributions and Matching Contributions may not exceed the limit in Section 415 of the IRC, which is $53,000 in 2016 (or 100% of your includible compensation, if that is less).

Under Section 415 of the IRC, employees who hold 50% or greater ownership of another company and participate in the other company’s qualified retirement plan, must report contributions made to that plan on an annual basis to Human Resources for purposes of
aggregating total contributions for this purpose. Forms to report these contributions are available on the Human Resources website.

**INVESTMENT OF CONTRIBUTIONS**

**Funding Medium/Retirement Account Vendors**

The Plan is administered by Fidelity Investments. Additional information may be found in the literature provided to participants free of charge on Fidelity NetBenefits: [www.netbenefits.com/VUMC](http://www.netbenefits.com/VUMC).

Contributions are deposited to mutual fund accounts or to other investment options offered through Fidelity, as directed by each participant. The participant must complete the appropriate applications in order for the Fidelity Custodial Accounts to be established. If no application, or an incomplete application, is submitted prior to eligibility, the contributions will be placed in a default account as indicated in the Plan documents or as otherwise established by the Plan with one or more of the available retirement account vendors.

[TIAA-CREF and VALIC annuities, are frozen as funding options after April 1, 2015.]

**General Rules Regarding Allocation of Contributions**

Plan contributions will be forwarded to Fidelity in the proportion elected by the participant if a Salary Reduction Agreement is on file. Contributions will be designated as Mandatory Deferrals and/or Elective Deferrals or both.

The participant may change his or her allocations for future contributions as frequently as permitted by the Plan Administrator but subject to the limitations imposed by the retirement account vendor.

**Designation of Participant’s Contributions**

Contributions to the Fidelity account may be designated to any one of several of the portfolios offered by Fidelity to participants in all of the Plan.

**Designation of Matching Contributions**

Matching Contributions and Mandatory Matching Contributions on behalf of a participant will be contributed to the participant’s account on a before-tax basis and will be invested in the same manner as the respective designations by such participant for the first 3% Mandatory Deferrals and the first 2% of his or her Elective Deferrals.
Investment Statements

The retirement account vendors send each participant a quarterly report of premiums and benefits that summarizes the status of his or her account. These reports may be received via postal mail or electronically. Similar reports or benefits illustrations may be obtained by a participant upon termination of employment or at any other time by writing directly to the respective retirement account vendor.

The participant is responsible for reviewing these reports for accuracy and reporting necessary corrections before the issuance of the next report in order to obtain full and timely correction. VUMC will not be responsible for correction of a participant account error after six (6) months from the contribution date.

It is the responsibility of the participant to notify VUMC and the applicable retirement account vendor of any change of name and/or address.

RETIREMENT AND OTHER PAYOUT OPTIONS

Vesting

All contributions are immediately vested and are under the investment control of the participant, subject to the investment rules or restrictions of the Plan or applicable retirement account vendor.

Minimum Distributions

With certain exceptions, benefits must commence, to each participant, no later than April 1 following the end of the calendar year in which he or she reaches age 70½ or retires, whichever occurs last. Minimum distributions are not eligible to be rolled over to another qualified retirement plan.

Retirement Distributions

Fidelity: Upon retirement, the participant will be entitled, under the terms of his or her Custodial Account, to receive a lump sum distribution of the balance of all funds or periodic payments. Arrangements may be made to convert funds to an Annuity providing lifetime income with various options including survivor benefits.

TIAA-CREF and VALIC: Upon retirement, the participant will be entitled, under the terms of his or her Annuity Contracts, to receive a monthly or other periodic income under one of the options set forth in such Contracts. All options provide a lifetime income for the participant and all options except one also provide for income to a spouse or other Beneficiary. If permitted by the account the funds are in, a lump sum distribution may also be elected.
Descriptions of the income options are contained in the investment company packets available on the vendor websites.

**Distributions Upon Termination of Employment**

If a participant in the Plan terminates employment and requests distribution of a portion or the balance of his or her account, VUMC must first verify termination of employment. Such distributions must also meet the conditions under which the insurance or investment company will make distributions.

Distribution will result in the payment to the participant of the portion of the account value attributable to his or her contributions and employer contributions, less any administrative charges. Amounts paid to the participant upon distribution will be in full satisfaction of the participant’s right to retirement and/or death benefits attributable to such amount distributed.

Additional information about these conditions and charges can be obtained from Human Resources.

**Spousal Rights**

*Pre-Retirement Joint and Survivor Benefits for Spouse* – In accordance with the law, the Plan provides that, unless waived by the spouse, the surviving spouse of a participant who dies before the date on which the participant becomes entitled to receive benefits will be entitled to a death benefit that is at least equal to one-half of the participant’s TIAA-CREF, VALIC, and Fidelity accounts. This benefit is payable in the form of a pre-retirement survivor Annuity (unless another available form is elected by the spouse). The remaining one-half of the participant’s accounts will be payable as a benefit to his or her Beneficiary.

Under the law, after reaching age 35 (or at any time after termination of employment with VUMC, regardless of age), a married participant, with the written consent of his or her spouse, may elect in writing to waive this pre-retirement survivor Annuity to the participant’s spouse in favor of payment to another Beneficiary.

*Post-Termination and Post-Retirement Joint and Survivor Benefits for Spouse* – Unless otherwise elected, any participant who is married when he or she becomes entitled to receive benefits will have his or her benefits paid in the form of a joint and survivor Annuity. That is, by periodic payments to the participant during his or her life and thereafter to the surviving spouse for life in the amount of fifty percent (50%) of the amount payable to the participant. This survivor benefit can be waived by the spouse by electing another form of payment at the time of distribution on forms currently provided by Fidelity, TIAA-CREF and VALIC.

The Plan Administrator will be entitled to rely on a participant’s indication of marital status if such indication was submitted to VUMC at least six months prior to the distribution date.
Further information about spousal rights to the survivor Annuity and the waiver may be obtained from Human Resources.

**Qualified Domestic Relations Orders (QDROs)** – The anti-assignment and alienation rules under ERISA and the IRC are intended to ensure that a participant’s retirement benefits are available to provide financial support during the participant’s retirement years. The law allows a limited exception to provide for the assignment of retirement benefits through a QDRO. Under this exception, a QDRO may assign some or all of a participant’s retirement benefits to an Alternative Payee.

The Plan Administrator or trustees will provide the Alternative Payee with access to plan information and participant benefit information that is sufficient to prepare a QDRO. This information may include the summary plan description, relevant plan documents, and a statement of the participant’s account information.

Under Federal law the Plan Administrator is initially responsible for determining whether a domestic relations order is qualified. This determination must be made within a reasonable time and the Plan Administrator must then promptly notify the participant and each Alternative Payee of the determination. It is the opinion of the Department of Labor that jurisdiction to challenge a plan administrator’s decision about the qualified status of a domestic relations order lies exclusively with the Federal courts.

While the status of the domestic relations order is being determined, ERISA requires that the Plan Administrator or trustees separately account for the amounts that would be payable to an Alternative Payee if the order is determined to be qualified. The law does not require the Plan Administrator or trustees to preserve the segregated amounts for more than 18 months. The 18-month period begins on the first date that the order would require payment to the Alternate Payee after the Plan receives the order.

**In-Service Hardship Withdrawals**

Hardship withdrawals are subject to Internal Revenue Code § 1.401(k)-1(d)(3)(iii)(B) and § 1.403(b)-6(d)(2) and the terms of the custodial agreement. Hardship withdrawals will be considered taxable income and may be subject to a 10% penalty if withdrawals occur prior to age 59½. Withdrawal of benefits before termination of employment or age 59½ may be made only on Elective Deferrals made by the participant and only on account of an immediate and heavy financial need, defined as:

- Expenses incurred or necessary for medical care, described in Section 213(d) of the Code, of the Participant, the Participant's spouse or dependents, or the Participant's primary Beneficiary (as defined in Q&A-5 of IRS Notice 2007-7);

- Costs directly related to the purchase of a principal residence for the participant (excluding mortgage payments);
• Payment of tuition and related educational fees for the next 12-months of postsecondary education for the participant, the participant’s spouse, children or dependents, or the participants primary Beneficiary;

• Payments necessary to prevent the eviction of the participant from the participant’s principal residence or foreclosure on the mortgage on that residence;

• Funeral or burial expenses for the participant’s deceased parent, spouse, child or dependent, or the participant’s primary Beneficiary; or

• Expenses to repair damage to the Participant's principal residence that would qualify for a casualty loss deduction under IRC Section 165 (determined without regard to whether the loss exceeds 10% of adjusted gross income).

A withdrawal in a case of an immediate and heavy financial need is limited to the amount necessary to satisfy the hardship. A withdrawal is considered necessary to satisfy an immediate and heavy financial need of the Participant only if:

• The withdrawal is not in excess of the amount of the immediate and heavy financial need (including amounts necessary to pay any federal, state or local income taxes or penalties reasonably anticipated to result from the withdrawal);

• The participant has obtained all withdrawals, other than hardship withdrawals, and all nontaxable loans under all plans maintained by VUMC (except to the extent such actions would be counterproductive to alleviating the financial need); and

• Under all plans of VUMC, the Participant is suspended from making any Elective Deferrals for a period of six (6) months from the date the withdrawal payment is made.

The total amount of hardship withdrawals under this Plan may not exceed the total amount of the Participant's Elective Deferrals held in accounts at Fidelity. No more than two (2) hardship withdrawals may be made per calendar year, and all hardship withdrawals are subject to appropriate verification. No hardship withdrawal may be made from any investment earnings, Mandatory Deferrals, Matching Contributions, Mandatory Matching Contributions, Qualified Nonelective Contributions, Rollover Contributions or frozen Annuity Contracts held at TIAA-CREF or VALIC. The participant must initiate renewed participation in the voluntary portion after six months, if desired, by submitting an appropriate Salary Reduction Agreement.

**In-Service Withdrawals**

Subject to the terms of the applicable custodial agreement or Annuity Contract, a participant may withdraw any amount from the participant’s account at any time after he or she attains age 59½, regardless of whether the participant has terminated employment. Any such withdrawal is
subject to the notice and spousal consent requirements regarding the availability of a joint and survivor Annuity.

**Reservist and Active-Duty Distributions**

Subject to the terms of the applicable custodial agreement or Annuity Contract, a participant may withdraw any amount from the participant’s account if he or she, by reason of being a member of a reserve component of the military, is ordered or called to active duty for a period of more than 180 days or for an indefinite period that is made during the period beginning on the date of such order or call to duty and ending at the close of the active duty period.

Subject to the terms of the applicable custodial agreement or Annuity Contract, a participant will be treated as having a severance of employment for distribution purposes during any period the participant is performing service in the Uniformed Services. A participant who elects to receive a distribution pursuant to this rule will be suspended from making any Elective Deferrals for a period of six months from the date the distribution is made.

**Distributions of Small Accounts**

Subject to the terms of the applicable custodial agreement or Annuity Contract, distributions may be made in the form of a lump-sum payment, without the consent of the participant or his or her Beneficiary, for any account with a balance of $1,000 or less.

**Loans**

Taking a loan allows active participants to borrow money from Elective Deferrals within the applicable Plan. How much is available depends on the amount of elective contributions you currently have in the Plan and whether you have other outstanding loans. The amount of the loan must be at least $1,000, and only one loan is permitted at a time (disregarding any loans from frozen Annuity Contracts). Loans may be made only from pre-tax Elective Deferrals (not Roth Elective Deferrals) and rollover contributions. Effective April 1, 2015, new loans may not be made from Annuity Contracts. A new loan will not be allowed if any default occurs on any loan by the participant or Beneficiary. No loan may be made to a married Participant unless the Participant obtains the consent of his/her spouse, if any, to the use of the Account as security for the loan. Contact Fidelity for the amount available, interest rate, applicable fees and to apply for a loan.

**Death Benefits**

If a participant dies prior to the commencement of retirement benefit payments as described above, the full current value of the Annuity and Custodial Account accumulation, including the portion attributable to Plan contributions made by VUMC, is then payable, to the Beneficiary or Beneficiaries named by the participant. Benefits are payable in either a single sum, or if the
participant had an Annuity, under any one of the income options offered by the insurance company. Other payout options may be available if the Beneficiary is a surviving spouse.

**TRANSFERS AND ROLLOVERS**

**Transfers and Rollovers into the Plan**

The Plan accepts rollovers of Eligible Rollover Distributions from other Eligible Retirement Plans if they are taxable distributions or nontaxable distributions from Roth elective deferral accounts. Only active participants in the Plan may roll over money into the Plan. Such rollover contributions may be made in the form of cash only. The Plan Administrator may require documentation from the distributing plan to effectuate the rollover and to confirm that it is an Eligible Retirement Plan. Subaccounts will be established for any rollover contributions.

**Transfers and Rollovers out of the Plan**

Funds may also be rolled over from the Plan to another Eligible Retirement Plan without being subject to tax provided that they are properly rolled over and the participant is eligible for a distribution. A proper rollover requires:

- that all or a portion of the balance be paid to the participant in an Eligible Rollover Distribution;
- the participant rolls any distributions he or she receives to Eligible Retirement Plan; and
- that the rollover be completed within 60 days of the participant’s receipt of the distribution.

Distributions that are not properly rolled over are includible in the participant’s gross income and may be subject to a tax penalty for early withdrawal. Unless the rollover is made in the form of a Direct Rollover, all Eligible Rollover Distributions are subject to 20% mandatory income tax withholding, even if they are subsequently properly rolled over. If an Eligible Rollover Distribution is less than $500, the distributee will not have the option of rolling over only a portion of the distribution. Generally surviving spouses and Alternate Payees under QDROs are treated the same as participants for purposes of these rules. However, distributions to nonspouse Beneficiaries generally may be made only to Individual Retirement Accounts or annuities (“IRAs”) described in Section 408(a) or 408(b) of the IRC that are established on behalf of the Beneficiary and will be treated as inherited IRAs.

Direct rollovers are not allowed for distributions of less than $200.

A direct rollover of a distribution from a Roth subaccount under an applicable Plan will be made only to another Roth subaccount in an Eligible Retirement Plan or a Roth IRA described in
Section 408A. The $200 limit and $500 rule above apply separately to distributions from Roth subaccounts and taxable distributions.

APPLICATION FOR BENEFITS

Benefits provided by TIAA-CREF and VALIC annuities and Fidelity mutual funds or other investment options to which Plan contributions have been applied, will be payable by TIAA-CREF, VALIC and Fidelity upon receipt by each respective company of a satisfactorily completed application for benefits and supporting documents. The insurance or investment companies will provide the necessary instruction to the participant or Beneficiary. The Plan is required to verify that the participant has either separated from service or reached the required age, and that appropriate spousal consent has been provided, before distributions are allowed.

INFORMATION AND CLAIMS PROCEDURES

Requests for information, claims, or service of legal process concerning eligibility, participation, contributions, or other aspects of the Plan should be directed in writing to the Plan Administrator of the applicable Plan. The following rules describe the claims procedure under the Plan:

Filing a claim for benefits – A claim or request for plan benefits is filed when the requirements of a reasonable claim-filing procedure have been met. A claim is considered filed when a written communication is made to the Plan Administrator.

Processing the claim – The Plan Administrator must process the claim within 90 days after the claim is filed. If an extension of time for processing is required, written notice must be given to the participant before the end of the initial 90-day period. The extension notice must indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render its final decision. In no event can the extension period exceed a period of 90 days from the end of the initial 90-day period.

Denial of claim – If a claim is wholly or partially denied, the Plan Administrator must notify the participant within 90 days following receipt of the claim (or 180 days in the case of an extension for special circumstances). The notification must state the specific reason or reasons for the denial, specific references to pertinent plan provisions on which the denial is based, a description of any additional material or information necessary to perfect the claim, and appropriate information about the steps to be taken if the participant wishes to submit the claim for review. If notice of the denial of a claim is not furnished within the 90/180-day period, the claim is considered denied and the participant must be permitted to proceed to the review stage.

Review procedure – A participant or a participant’s duly authorized representative has at least 60 days after receipt of a claim denial to appeal the denied claim to an appropriate named fiduciary or individual designated by the fiduciary and to receive a full and fair review of the claim. As part of the review, the participant must be allowed to see all plan documents and other papers
that affect the claim and must be allowed to submit issues and comments and argue against the denial in writing.

**Decision on review** – The Plan Administrator must conduct the review and decide the appeal within 60 days after the request for review is made. If special circumstances require an extension of time for processing (such as the need to hold a hearing if the Plan procedure provides for such a hearing), the participant must be furnished with written notice of the extension, which can be no later than 120 days after receipt of a request for review. The decision on review must be written in clear and understandable language and must include specific reasons for the decision as well as specific references to the pertinent Plan provisions on which the decision is based. For a Plan with a committee or board of trustees designated as the appropriate named fiduciary, a decision does not have to be made within the 60-day limit if the committee or board meets at least four times a year (about every 90 days). Instead, it must be made at the first meeting after the request is filed, except that when a request is made less than 30 days before a meeting, the decision can wait until the date of the second meeting following the Plan’s receipt of request for review. If a hearing must be held, the committee can wait to decide until the first meeting after the hearing. However, it must notify the participant and explain the delay, which can be no later than the third meeting of the committee or board following the Plan’s receipt of the request for review. If the decision on review is not made within the time limits specified above, the appeal will be considered denied. If appeal is denied, in whole or in part, the participant has a right to file suit in a state or federal court.

Requests for information concerning the TIAA-CREF Annuity Contract and their terms, conditions, and interpretations thereof, claims thereunder, any requests for review of denial of such claims, and service of legal process shall be subject to similar procedures and should be directed in writing to the Account Administrator, TIAA-CREF, 730 Third Avenue, New York, NY 10017-3206.

Requests for information concerning the VALIC Annuity Contract and their terms, conditions, and interpretations thereof, claims thereunder, any requests for review of denial of such claims, and service of legal process shall be subject to similar procedures and should be directed in writing to the Account Administrator, VALIC, PO Box 15648, Amarillo, TX 79105-5648.

Requests for information concerning the Fidelity mutual fund accounts and their terms, conditions, and interpretations thereof, claims thereunder, any requests for review of denial of such claims, and service of legal process shall be subject to similar procedures and should be directed in writing to the Account Administrator, Fidelity, P.O. Box 770002, Cincinnati, OH 45273-0090.

**AMENDMENTS**

The Plan may be amended only by or on the authority of the Board of Directors of Vanderbilt University Medical Center. The Board of Directors may delegate its power and duties with
respect to the Plan, including its authority to amend the Plan, to one or more officers or other employees of VUMC, provided that such delegation shall be set forth in writing.

**NO TAX ADVICE**

Although VUMC will make reasonable efforts to assist employees in their tax planning, VUMC will accept no liability for the tax consequences to employees who make excess contributions to a Plan beyond the annual limitations prescribed by the IRC. Faculty and staff must take personal responsibility for tax planning when executing their Salary Reduction Agreements.

Distributions received from your Plan account, including VUMC contributions and earnings, are subject to federal income tax as you receive the payments. Besides normal federal income taxes, an additional 10% tax applies to benefits received before age 59½, unless an exemption is allowed by current tax law.

VUMC recommends that you consult a professional tax advisor before you request a distribution from the Plan. Also, for more specific information on the tax treatment of distributions from qualified retirement plans, contact your local IRS office or call 1-800-TAX-FORM and ask for: IRS Publication 575, *Pension and Annuity Income*, IRS Publication 590, *Individual Retirement Arrangements*, or IRS Form 4972, *Tax on Lump-Sum Distributions*.

**DEFINITION OF TERMS**

**Age 50 Catch-Up Contributions**

Are defined on page 6.

**Alternative Payee**

An individual who is assigned the right to receive all or part of a participant’s benefits in accordance with a QDRO. An Alternate Payee cannot be anyone other than a spouse, former spouse, child, or other dependent of a participant.

**Annuity**

A contract that provides income for a specified period of time, often for life.

**Annuity Contract**

Refers either specifically to an Annuity Contract under Section 403(b)(1) or to any Section 403(b) funding vehicle, including a Custodial Account.
Beneficiary

The person or persons you name to receive any benefits provided by a benefits plan in the case of your death.

Contracts

Are defined on page 1.

Custodial Account

A type of funding vehicle under which assets are held by a bank or other person approved by the Commissioner of the IRS and invested in regulated investment company stock (mutual funds) as required by Section 403(b)(7) of the IRC.

Elective Deferrals

Contributions that arise because of an employee’s election, through a Salary Reduction Agreement, to accept a reduction in Salary in exchange for equivalent contributions to a Plan. They do not include contributions made pursuant to one-time irrevocable elections at initial eligibility to participate in a Plan nor contributions made as a condition of employment. Elective Deferrals are subject to FICA taxes.

Eligible Employee

Any employee except:

- A post-doctoral fellow or trainee performing services that are exempt from social security taxes;

- An employee who normally works fewer than 20 hours per week. An employee normally works fewer than 20 hours per week if, for the 12-month period beginning on the date the employee’s employment commenced, VUMC reasonably expects the employee to work fewer than 1,000 Hours of Service in such period, and, for each Plan Year ending after the close of that 12-month period, the employee has worked fewer than 1,000 Hours of Service in the preceding 12-month period; and

- A nonresident alien described in Section 410(b)(3)(C) of the IRC.

Eligible Retirement Plan

A qualified plan described in Section 401(a) of the IRC, an annuity plan described in Section 403(a) of the IRC, an annuity contract described in Section 403(b) of the IRC, an individual retirement account or annuity described in Section 408(a) or 408(b) of the IRC, or an eligible plan.
plan under Section 457(b) of the IRC that is maintained by a state and that agrees to separately account for amounts transferred into such plan from a Plan, and that accepts an Eligible Rollover Distribution.

**Eligible Rollover Distribution**

Any distribution of all or any portion of the balance to the credit of the distributee under a Plan, except the following and any other amounts excluded under applicable law:

- any distribution that is one of a series of substantially equal periodic payments made for the life (or life expectancy) of the distributee or the joint lives (or joint life expectancies) of the distributee and the distributee’s designated Beneficiary, or for a period of 10 years or more;
- any minimum distribution that is required under Section 401(a)(9) of the IRC;
- any hardship distribution;
- any distribution(s) that is reasonably expected to total less than $200 during a year;
- any corrective distribution of excess amounts under Sections 402(g), 401(m), and/or 415 of the IRC and income allocable thereto; or
- any loan that is treated as deemed distributions pursuant to Section 72(p) of the IRC.

**Employee**

Any common law Employee of VUMC or a Related Employer.

**403(b) Lifetime Catch-Up Contributions**

Are defined on page 6.

**Highly Compensated**

An employee is a Highly Compensated Employee for a particular calendar year (the determination year) if in the year preceding the determination year the employee received compensation in excess of a specified indexed amount ($120,000 in 2016). Only the compensation that is paid during the determination year and determined in accordance with IRC rules and regulations is counted.
Hour of Service

Each hour for which an employee is paid or entitled to payment by VUMC for the performance of his or her duties, including hours for which back pay has been awarded or agreed to by VUMC.

An Hour of Service also includes each hour for which an employee is paid or entitled to payment for reasons (such as vacation, sickness, or disability) other than for the performance of duties during the applicable period, provided that no hours will be credited to an employee on account of payments under a plan maintained solely to comply with applicable workers’ compensation, unemployment compensation, or disability insurance laws, and further provided that no more than 501 Hours of Service will be credited to an employee on account of any single continuous period during which the employee performs no duties. Hours of Service other than those credited for the performance of duties are determined by dividing payments received by or due the employee for such hours by the most recent hourly rate of compensation to the employee for the performance of duties. These hours generally are credited to the employee for the computation period or periods in which the units of time on which such payments are calculated occur, beginning with the first unit of time to which the payment relates.

The number of Hours of Service for employees for whom time records are kept is determined from University records. Hours of Service are determined in accordance with Section 2530.200b-2(b) of the ERISA regulations, as the same is amended from time to time.

Individual Retirement Accounts or IRAs

Are defined on page 14.

Mandatory Deferrals

Contributions that arise because of an employee’s agreement, as a condition of employment, to accept a reduction in Salary in exchange for equivalent contributions to a Plan.

Mandatory Matching Contributions

Are defined on page 3.

Matching Contributions

Are defined on page 4.

Plan

Is defined on page 1.
Plan Administrator

Is defined on page 24.

Plan Year

Is defined on page 25.

Qualified Domestic Relations Order or QDRO

A court judgment, decree, or order that:

- is made pursuant to state domestic relations law;
- relates to the provisions of child support, alimony payments, or marital property rights for the benefit of a spouse, former spouse, child, or other dependent of a participant;
- creates or recognizes the existence of an Alternative Payee’s right to receive, or assigns to an Alternative Payee the right to receive, all or a portion of the benefits payable with respect to a participant under a pension plan; and
- includes certain information and meets certain other requirements.

Qualified Nonelective Contributions

Are defined on page 7.

Roth Elective Deferrals

Elective Deferrals that are designated irrevocably by the Eligible Employee at the time of the Salary reduction election as Roth Elective Deferrals pursuant to Section 4.5 or 5.4.

Salary

An employee’s compensation received from VUMC or a related entity and required to be reported as wages on Form W-2, including any Elective Deferrals or other amounts contributed or deferred by VUMC or a related entity at the election of the employee that otherwise would be included in such compensation, and including the amount of the parsonage allowance in the case of participants who receive a parsonage allowance, but excluding:

- Mandatory Deferrals (except for the purpose of determining the amount of Mandatory Deferrals, Elective Deferrals, and Matching Contributions), Mandatory Matching Contributions, Matching Contributions or Qualified Nonelective Contributions made under a Plan;
• amounts paid after the severance from employment, except for compensation that otherwise would be paid for a payroll period that begins before severance from employment and compensation described in Section 1.415(c)-2(e)(3)(i) (certain compensation paid within 2½ months after severance from employment) of the Treasury Regulations; or

• bonuses and overtime pay, any salary supplement paid to a faculty employee for retirement planning purposes, and any fringe benefits of any kind.

**Salary Reduction Agreement**

A written or electronic agreement in which an employee agrees to accept a reduction in Salary in exchange for equivalent contributions to a Plan.

**Summary Plan Description**

This document.

**Uniformed Services**

Members of the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

**VMG Employee**

Any Eligible Employee who is a faculty member of the Vanderbilt University School of Medicine or the School of Nursing holding a full-time appointment and who may engage in the professional practice of medicine through which the patients so treated may be billed for these services and who is approved for membership in the Vanderbilt Medical Group, or any successor internal operating division ("VMG") by the VMG Board as required by the governing documents of the VMG.

**VUMC**

Is defined on page 1.

**Year of Eligibility Service**

A 12-month period starting with the employee’s original date of employment (or anniversary date of such employment) during which the employee has completed 1,000 or more hours of service. If any person in an eligible category of employment does not complete the required hours of service as set forth above by the first anniversary date of employment, the hours
completed do not count toward establishing a Year of Eligibility Service, and a new start must be made toward meeting the hours test during the second year of employment. For an employee whose employment commences on January 1 of any year, the computation period shall include that day, even though it is a VUMC holiday. For this purpose, in the discretion of VUMC, employees may be credited with Hours of Service for, and computation periods may include, service for another entity, including an entity that is merged into or consolidated with VUMC or another adopting employer.

If an employee completes a 12-month period consisting of 500 or less Hours of Service, such a 12-month period constitutes a one-year “break in service.” If the employee has no accrued benefit when the break in service occurs, the employee’s Hours of Service before the break will not be counted when the employee returns to work (and thus the employee will not have any Years of Eligibility Service) if the employee’s number of consecutive one-year breaks in service equals or exceeds the employee’s total years of service earned before the break and the number of consecutive one-year breaks in service is at least five.

Solely for purposes of determining whether a one-year “break in service” has occurred, an Hour of Service also includes each normal work hour, not other credited, during which an individual is absent from work by reason of the individual’s pregnancy, the birth of a child of the individual, or the placement of a child with the individual in connection with the adoption of such child by the individual, or for purposes of caring for such child for the period immediately following such birth or placement.

**SUMMARY PLAN DESCRIPTION**

**Name of Plan**

Vanderbilt University Medical Center Retirement Plan

**Name of Employer or Plan Sponsor**

Vanderbilt University Medical Center, Nashville, Tennessee 37232

**Employer Identification Number (“EIN”)**

35-2528741

**Plan Number**

001 – Vanderbilt University Medical Center Retirement Plan
Type of Plan

Each Plan is a defined contribution retirement plan regulated by Section 403(b) of the IRC. The Plan is not insured by the Pension Benefit Guaranty Corporation, a governmental agency which insures benefits under certain types of plans, because that agency does not insure the payment of benefits under a defined contribution plan.

Type of Administration

Benefits are provided under the terms and conditions of the Retirement Plan agreement between VUMC and TIAA-CREF, VALIC, and Fidelity.

Name of Plan Administrator

The Plan Administrator for the Plan is the Chief Human Resources Officer, or such other person or persons who may be appointed by the Chief Executive Officer of VUMC. Please direct correspondence to: Chief Human Resources Officer, Vanderbilt University 2525 West End Avenue, 5th Floor, Nashville, Tennessee 37203, (615) 343-7000

Service of Legal Process

Service of legal process may be made on a Plan trustee or the Plan Administrator. Addresses for the insurance and investment companies can be found in the section titled Information and Claims Procedures.

Plan Insurance

Each TIAA-CREF or VALIC Annuity Contract or Fidelity Custodial Account established under the applicable Plan is intended to provide a retirement or death benefit and is solely the property of the individual participant. All benefits under this plan are provided solely through individually owned mutual fund accounts and/or fully funded Annuity Contracts and, therefore, are neither subject to nor covered by federal plan termination insurance.

Consequences of Section 403(b) Failures

In the event that the applicable Plan is determined to not satisfy the requirements of Section 403(b) the Plan would lose its Section 403(b) status. This would result in additional income tax withholding, FICA and FUTA taxes, FICA and FUTA withholding, and excise taxes. Should the Plan correct its failures in accordance with one of the Service’s correction programs, these taxes and withholding will not be required. However, corrections of failures may result in other tax consequences.
Plan Year

The “Plan Year” is January 1 through December 31 of each year. Records are maintained on the calendar-year basis for each participant.

Statement of ERISA Rights

As a participant in the Vanderbilt University Medical Center Retirement 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. You may:

- Examine, without charge, at the Plan Administrator’s office, all documents governing the Plan, including 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 Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including 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 a copy of this summary annual report.

- Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age 62 for staff and age 65 for faculty) and if so, what your benefits would be at normal retirement age if you stopped working under the Plan now. This statement must be requested in writing and is not required to be given more than once every 12-months. The Plan must provide the statement free of charge.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a pension benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge,
and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan, and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order, 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 Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 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.
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.
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INTRODUCTION

This Dental Evidence of Coverage (“Dental EOC”) is included in the Dental Group Agreement between BlueCross BlueShield of Tennessee, Inc. (“We”, “Us”, “Our” or the “Plan”) and Your Group. This Dental EOC describes the terms and conditions of Your Coverage from the Plan through the Group, and includes all riders and attachments, which are incorporated herein by reference. It replaces and supersedes any Dental EOC that You have previously received from Your Group or the Plan.

PLEASE READ THIS DENTAL EOC CAREFULLY. IT DESCRIBES YOUR RIGHTS AND DUTIES AS A SUBSCRIBER. IT IS IMPORTANT TO READ THE ENTIRE DENTAL EOC. CERTAIN SERVICES ARE NOT COVERED BY THE PLAN. OTHER COVERED SERVICES ARE LIMITED. THE PLAN WILL NOT PAY FOR ANY SERVICE NOT SPECIFICALLY LISTED AS A COVERED SERVICE, EVEN IF A DENTAL CARE PROVIDER RECOMMENDS OR ORDERS THAT NON-COVERED SERVICE. (SEE ATTACHMENTS A-D.)

The Group has delegated discretionary authority to make any benefit determinations to the Plan. It has also granted the authority to construe the terms of Your Coverage to the Plan. The Plan shall be deemed to have properly exercised that authority unless it abuses its discretion when making such determinations, whether or not the Group’s benefit plan is subject to ERISA. The Group retains the authority to determine whether You or Your dependents are eligible for Coverage.

ANY GRIEVANCE RELATED TO YOUR COVERAGE UNDER THIS DENTAL EOC SHALL BE RESOLVED IN ACCORDANCE WITH THE “GRIEVANCE PROCEDURE” SECTION OF THIS DENTAL EOC.

In order to make it easier to read and understand this Dental EOC, defined words are capitalized. Those words are defined in the “DEFINITIONS” section of this Dental EOC.

Please contact one of the Plan’s customer service representatives, at the number listed on Your membership ID card, if You have any questions when reading this Dental EOC. The customer service representatives are also available to discuss any other matters related to Your Coverage from the Plan.

BENEFIT ADMINISTRATION ERROR

If there is an error in administering the benefits under this Dental EOC, the Plan may provide additional benefits or recover any overpayments from any person, insurance company, or plan. No such error may be used to demand more benefits than those otherwise due under this Dental EOC. The Plan complies with applicable laws governing the recovery of overpayments to providers.
NOTIFICATION OF CHANGE IN STATUS

Changes in Your status can affect the service under Your Plan. To make sure Your Plan works correctly, please notify the customer service department at the number listed on Your membership ID card when You or Your Covered Dependents change:

- Name;
- Address;
- Telephone number;
- Employment; or
- Status of any other dental or health coverage You may have.

Please notify the Plan of any eligibility or status changes for You or Your Covered Dependents, including:

- The marriage or death of a family member;
- Divorce;
- Adoption;
- Termination of employment;
HOW THE DENTAL PROGRAM WORKS

DentalBlue™ Coverage is designed to promote cost-effective care and provide a simple method for filing claims. Two important features include the network of participating dentists (Network Dentists) and the Predetermination of Benefits program.

NETWORK DENTISTS

To reduce Your out-of-pocket expense, You should receive services from a Network Dentist. When You have dental work performed by a Network Dentist, You simply present Your membership ID card. The Network Dentist will file the necessary paperwork. We will make payment directly to the Network Dentist.

A listing of Network Dentists is provided to Your Group. There will be additions and deletions from time to time. Be sure to ask Your Dentist to confirm any change in his/her participation. You may also call Our customer service department, or You may check the most current directory information at Our website, www.bcbst.com. Click on Network Directories.

You can go to the Dentist of Your choice, regardless of whether he/she is a Network Dentist. However, Your out-of-pocket expense is less when You use a Network Dentist.

PAYMENT FOR AN OUT-OF-NETWORK DENTIST

If You select a Dentist who is not participating in the Preferred Dental Care Plan (an Out-of-Network Dentist), that Dentist can bill You for any amount not Covered by this Dental EOC.

In addition, if You select an Out-of-Network Dentist, You may have to file the claim Yourself. You are responsible for the difference between the Billed Charges and the Maximum Allowable Charge for a Covered Service, if an Out-of-Network Dentist’s Billed Charges are more than the Maximum Allowable Charge for such Services.

PREDETERMINATION OF BENEFITS

The Predetermination of Benefits program allows You and Your Dentist to know exactly what kinds of treatment are Covered. If a course of treatment will exceed $200.00, the treatment plan should be submitted for review before the work starts. In order to review the treatment plan, a description of each service and charge should be submitted along with all supporting aids such as pre-operative x-rays.

To obtain a Predetermination of Benefits response, Your Dentist submits a claim form and checks the box “Dentist’s Pre-Treatment Estimate” after Your initial examination and before treatment begins. You and Your Dentist are then notified what benefits are available, and what payments, if any, You must make.

ACCEPTED BARRIER TECHNIQUES AND PRECAUTIONS TO PROTECT DENTISTS, THEIR STAFF, AND THE PUBLIC FROM CONTRACTING OR SPREADING DISEASE ARE RECOMMENDED. HOWEVER, WE CANNOT CONFIRM THE HEALTH STATUS OF ANY DENTIST.
ELIGIBILITY

Your Group chooses the classes of employees who are eligible for Coverage under the Plan. The eligibility requirements Your Group has selected are in Attachment D Eligibility to this Dental EOC. They are also on file in Your Group’s human resource department.

ENROLLMENT

Eligible Employees may enroll for Coverage for themselves and their eligible dependents as set forth in this section. No person is eligible to re-enroll, if the Plan previously terminated his or her Coverage for cause.

A. Initial Enrollment Period

Eligible Employees may enroll for Coverage for themselves and their eligible dependents within the first 31 days after becoming eligible for Coverage. The Subscriber must: (1) include all requested information; (2) sign; and (3) submit an Enrollment Form to the Plan during that initial enrollment period.

B. Open Enrollment Period

Eligible Employees shall be entitled to apply for Coverage for themselves and eligible dependents during the Group’s Open Enrollment Period. You must: (1) include all requested information; (2) sign; and (3) submit an Enrollment Form to the Plan during that Open Enrollment Period. Employees who become eligible for Coverage other than during an Open Enrollment Period, may apply for Coverage for themselves and eligible dependents within 31 days of becoming eligible for Coverage, or during a subsequent Open Enrollment Period.

C. Adding Dependents

After the Subscriber is Covered, he or she may apply to add a dependent, who becomes eligible after the Subscriber enrolled, as follows:

1. A newborn child of the Subscriber or the Subscriber’s spouse is Covered from the moment of birth. The Subscriber must enroll that child within 31 days of the child’s date of birth. A legally adopted child (including children placed with the Subscriber for the purposes of adoption) will be Covered as of the date of adoption or placement for adoption. Children for whom the Subscriber or the Subscriber’s spouse has been appointed legal guardian by a court of competent jurisdiction will be Covered from the moment the child is placed in the Subscriber’s physical custody. The Subscriber must enroll the child within thirty-one (31) days from the date that the Subscriber acquires the child.

If the Subscriber fails to do so, and an additional premium is required to Cover the child, the Plan will not Cover the child after thirty-one (31) days from the date the Subscriber acquired the child. If no additional premium is required to provide Coverage to the child, the Subscriber’s failure to enroll the child does not make the child ineligible for Coverage.

However, the Plan cannot add the newborn or newly acquired child to the Subscriber’s Coverage until notified. This may delay claims processing.
2. Any other new dependent (e.g., if the Subscriber marries) may be added as a Covered Dependent if the Subscriber completes and submits a signed Enrollment Form to the Plan within 31 days of the date that person first becomes eligible for Coverage.

3. The Subscriber or the Subscriber’s eligible dependent who did not apply for Coverage within 31 days of first becoming eligible for Coverage under this Plan may enroll if:
   a. the Subscriber or the Subscriber’s eligible dependent had other health care coverage at the time Coverage under this Plan was previously offered; and
   b. the Subscriber stated, in writing, when Coverage under this Plan was previously offered, that such other coverage was the reason for declining Coverage under this Plan; and
   c. such other coverage is exhausted (if the other coverage was continuation coverage under COBRA) or the other coverage was terminated because the Subscriber or the Subscriber’s eligible dependent ceased to be eligible due to involuntary termination or Group contributions for such coverage ended; and
   d. the Subscriber or the Subscriber’s eligible dependent applies for Coverage under this Plan and the Plan receives the change form within 31 days after the loss of the other coverage.

D. Late Enrollment

Employees or their dependents who do not enroll when first becoming eligible for Coverage under (A), (B) or (C), above, may be enrolled:

1. During a subsequent Open Enrollment Period; or

2. If the Employee acquires a new dependent, and he or she applies for Coverage within 31 days.

E. Enrollment upon Change in Status

If You qualify for a change in status, as outlined below, You may be eligible to change Your Coverage other than during the Open Enrollment Period. You must request the change within 31 days of the change in status. Any change in the Subscriber’s elections must be consistent with the change in status.

Subscribers must submit a change form to the Group representative to notify the Plan of any changes in their status or the status of a Covered Dependent within thirty-one (31) days from the date of the event causing that change in status. Such events include, but are not limited to: (1) marriage or divorce; (2) death of the Employee’s spouse or dependent; (3) change in dependency status; (4) Medicare eligibility; (5) coverage by another Payor; (6) birth or adoption of a child; (7) termination of employment, or commencement of employment, of the Employee’s spouse; (8) switching from part-time to full-time, or from full-time to part-time status by the Employee or the Employee’s spouse.
EFFECTIVE DATE OF COVERAGE

If You are eligible, have enrolled and have paid or had the premium for Coverage paid on Your behalf, Coverage under this Dental EOC shall become effective on the earliest of the following dates, subject to the Actively at Work Rule set out below:

A. **Effective Date of Dental Group Agreement**

   Coverage shall be effective on the effective date of the Dental Group Agreement, if all eligibility requirements are met as of that date.

B. **Enrollment During an Open Enrollment Period**

   Coverage shall be effective on the first day of the month following the Open Enrollment Period, unless otherwise agreed to by the Group and the Plan.

C. **Enrollment During an Initial Enrollment Period**

   Coverage shall be effective on the first day of the month following the Plan’s receipt of the eligible Employee’s Enrollment Form, unless otherwise agreed to by the Group and the Plan.

D. **Newly Eligible Employees**

   Coverage will become effective after You become eligible, having met all the eligibility requirements as specified in the Dental Group Agreement; or

E. **Newly Eligible Dependents**

   1. Dependents acquired as the result of an Employee’s marriage – Coverage will be effective on the first day of the marriage, unless otherwise agreed to by the Group or Plan.

   2. Newborn children of the Employee or the Employee’s spouse - Coverage will be effective as of the date of birth.

   3. Dependents adopted or placed for adoption with an Employee – Coverage will be effective as of the date of adoption or placement for adoption, whichever is first.

   For Coverage to be effective, the dependent must be enrolled, and the Plan must receive any required premium for the Coverage, as set out in the “Enrollment” section.

F. **Eligibility For Extension of Benefits From a Prior Carrier**

   If the Plan replaces another group dental plan and a Member is Totally Disabled and eligible for an extension of Coverage from the prior group dental plan, Coverage shall not become effective under this Plan until the expiration of that extension of Coverage.

G. **Actively at Work Rule**

   If an eligible Employee is not Actively at Work on the date Coverage would otherwise become effective, Coverage for the Employee and all of his or her Covered Dependents will be deferred until the Employee is Actively at Work. This is not applicable if the eligible Employee is an eligible retiree.
TERMINATION OF COVERAGE

A. Termination or Modification of Coverage by the Plan or the Group

The Plan or the Group may modify or terminate the Dental Group Agreement. Notice to the Group of the termination or modification of the Dental Group Agreement is deemed to be notice to all Members. The Group is responsible for notifying You of such a termination or modification of Your Coverage.

All Members’ Coverage through the Dental Group Agreement will change or terminate at 12:00 midnight on the date of such modification or termination. The Group’s failure to notify You of the modification or termination of Your Coverage does not continue or extend Your Coverage beyond the date that the Dental Group Agreement is modified or terminated. You have no vested right to Coverage under this Dental EOC following the date of the termination of the Dental Group Agreement.

B. Loss of Eligibility

Your Coverage will terminate if You do not continue to meet the eligibility requirements agreed to by the Group and the Plan during the term of the Dental Group Agreement. See Attachment D: Eligibility for details regarding Loss of Eligibility. A Covered Dependent loses eligibility when You lose eligibility.

C. Termination of Coverage for Cause

The Plan may terminate Your Coverage for cause if:

1. The Plan does not receive the required premium for Your Coverage when it is due. The fact that You have made a premium contribution to the Group will not prevent the Plan from terminating Your Coverage if the Group fails to submit the full premium for Your Coverage to the Plan when due; or

2. You fail to make a required Member Payment; or

3. You fail to cooperate with the Plan as required by this Dental EOC; or

4. You have made a material misrepresentation or committed fraud against the Plan. This provision includes, but is not limited to, furnishing incorrect or misleading information or permitting the improper use of the membership ID card.

D. Right To Request A Hearing

You may appeal the termination of Your Coverage for cause, as explained in the Grievance Procedure section of this Dental EOC. The fact that You have appealed shall not postpone or prevent the Plan from terminating Your Coverage. If Your Coverage is reinstated as part of the Grievance Procedure, You may submit any claims for services rendered after Your Coverage was terminated to the Plan for consideration in accordance with the Claims Procedure section of this Dental EOC.
E. Payment For Services Rendered After Termination of Coverage

Services received after Coverage terminates are not Covered, even if BCBST has pre-determined benefits for the dental services. However, if You are incurring expenses for Covered Services and this Coverage ends, benefits will be available as follows:

1. Charges for dentures will be paid if:
   a. the impression was made prior to the date Coverage ends;
   b. the denture was ordered prior to the date Coverage ends;
   c. the denture is placed in the mouth within 30 days from the date Coverage ends; and
   d. the Employer’s new Dental insurer is not responsible for paying these charges.

2. Charges for fixed bridgework, crowns and inlays will be paid if:
   a. the tooth or teeth were prepared prior to the date Coverage ends;
   b. the impression was taken prior to the date Coverage ends;
   c. the bridgework, crown or inlay was ordered prior to the date Coverage ends;
   d. the work is seated in the mouth within 30 days from the date Coverage ends; and
   e. the Employer’s new Dental insurer is not responsible for paying these charges.

3. Charges for endodontic treatment, including root canal therapy, will be paid if:
   a. the tooth was opened prior to the date Coverage ends;
   b. the procedure is completed within 30 days from the date Coverage ends; and
   c. the Employer’s new Dental insurer is not responsible for paying these charges.
GENERAL PROVISIONS

CLAIMS AND PAYMENT

When You receive Covered Services, either You or the Dentist must submit a claim form to Us. We will review the claim and let You or the Dentist know if We need more information, before We pay or deny the claim.

A. Claims

There are several terms to describe a claim: pre-service claim; post-service claim; and a claim for Urgent Care.

1. A pre-service claim is any claim that requires approval of a Covered Service in advance of obtaining dental care as a condition of receipt of a Covered Service, in whole or in part.

2. A post-service claim is a claim for a Covered Service that is not a pre-service claim – the dental care has already been provided to You. Only post-service claims can be billed to the Plan, or You.

3. Urgent Care is dental care or treatment that, if delayed or denied, could seriously jeopardize: (1) Your life or health; or (2) Your ability to regain maximum function. Urgent Care is also dental care or treatment that, if delayed or denied, in the opinion of a physician with knowledge of Your dental condition, would subject You to severe pain that cannot be adequately managed without the dental care or treatment. A claim for denied Urgent Care is always a pre-service claim.

B. Claims Billing

1. You should not be billed or charged for Covered Services rendered by Network Dentists, except for required Member payments. The Network Dentist will submit the claim directly to Us.

2. You will be billed all charges for Non-covered Services rendered by Network Dentists. Network discounts do not apply to these Non-covered Services.

3. You may be charged or billed by an Out-of-Network Dentist for Covered Services rendered by that Dentist. If You use an Out-of-Network Dentist, You are responsible for the difference between Billed Charges and the Maximum Allowable Charge for a Covered Service.

   a. If You are charged, or receive a bill, You must submit a claim to Us.

   b. To be reimbursed, You must submit the claim within 1 year and 90 days from the date a Covered Service was received. If You do not submit a claim, within the 1 year and 90 day time period, it will not be paid.

   c. If it is not reasonably possible to submit the claim within the 1 year and 90 day time period, the claim will not be invalidated or reduced. We may require verification of the reason for such delay.

4. You may request a claim form from Our customer service department. We will send You a claim form within 15 days. You must submit proof of payment acceptable to Us with the claim form. We may also request additional information or documentation if it is reasonably necessary to make a Coverage decision concerning a claim.
5. A Network Dentist or an Out-of-Network Dentist may refuse to render services, or reduce or terminate a service that has been rendered, or require You to pay for what You believe should be a Covered Service. If this occurs:

   a. You may submit a claim to Us to obtain a Coverage decision (Predetermination of Benefits) concerning whether the Plan will Cover that service.

   b. You may request a claim form from Our customer service department. We will send You a claim form within 15 days. We may request additional information or documentation if it is reasonably necessary to make a Coverage decision concerning a claim.

6. Dentists may bill or charge for Covered Services differently. Network Dentists are reimbursed based on Our agreement with them. Different Network Dentists have different reimbursement rates for different services. Your out-of-pocket expenses can be different from Dentist to Dentist.

7. You are also responsible for the providers’ charges for Non-covered Services as defined in this Dental EOC. Network discounts do not apply to these Non-covered Services.

C. Payment

1. If You received Covered Services from a Network Dentist, We will pay the Network Dentist directly. These payments are made according to the Plan’s agreement with that Network Dentist. You authorize assignment of benefits to that Network Dentist.

2. If You received Covered Services from an Out-of-Network Dentist, You must submit, in a timely manner, a completed claim form for Covered Services. If the claim does not require further investigation, We will reimburse You. If You have not paid the Dentist, We may make payment for Covered Services to either the Dentist or to You, at Our discretion. Our payment fully discharges Our obligation related to that claim.

3. If the Dental Group Agreement is terminated, all claims for Covered Services rendered prior to the termination date must be submitted to the Plan within 1 year and 90 days from the date the Covered Services was received.

4. We will pay benefits within 30 days after we receive a claim form that is complete. Claims are processed in accordance with current industry standards, and based on Our information at the time We receive the claim form.

5. When a claim is paid or denied, in whole or in part, We will produce an Explanation of Benefits (EOB). This will describe how much was paid to the Dentist, and also let You know if You owe an additional amount to that Dentist. The Plan will make the EOB available to you at www.bcbst.com, or by calling the customer service department, at the number listed on Your membership ID card.

6. You are responsible for paying any applicable Copayments, Coinsurance, or Deductible amounts to the Dentist. If We pay such amounts to a healthcare provider on Your behalf, We may collect those cost-sharing amounts directly from You.

Payment for Covered Services is more fully described in Attachment C: Schedule of Benefits.
D. Assignment

1. If You assign payment for a claim to a Dentist, We must honor that assignment, in most circumstances. If You have paid the Dentist, and also assigned payment for the claim to the Dentist, You must request repayment from that Dentist.

E. Complete Information

Whenever You need to file a claim Yourself, We can process it for You more efficiently if You complete a claim form. This will ensure that You provide all the information needed. Most Dentists will have claim forms, or You can request them from Us by calling Our customer service department at the number listed on Your membership ID card.

Mail all claim forms to:

BCBST Claims Service Center
1 Cameron Hill Circle
Chattanooga, Tennessee 37402
CONTINUATION OF COVERAGE

Federal Law

If the Dental Group Agreement remains in effect, but Your Coverage under this Dental EOC would otherwise terminate, the Group may offer You the right to continue Coverage. This right is referred to as “COBRA Continuation Coverage” and may occur for a limited time subject to the terms of this Section and the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA.)

A. Eligibility

If You have been Covered by the Plan on the day before a qualifying event, You may be eligible for COBRA Continuation Coverage. The following are qualifying events for such Coverage:

1. Subscribers. Loss of Coverage because of:
   - The termination of employment except for gross misconduct.
   - A reduction in the number of hours worked by the Subscriber.

2. Covered Dependents. Loss of Coverage because of:
   - The termination of the Subscriber’s Coverage as explained in subsection (a) above.
   - The death of the Subscriber.
   - Divorce or legal separation from the Subscriber.
   - The Subscriber becomes entitled to Medicare.
   - A Covered Dependent reaches the Limiting Age.

B. Enrolling for COBRA Continuation Coverage

The Group shall notify You of Your rights to enroll for COBRA Continuation Coverage after:

1. The Subscriber’s termination of employment, reduction in hours worked, death or entitlement to Medicare coverage; or

2. The Subscriber or Covered Dependent notifies the Group, in writing, within 60 days after any other qualifying event set out above.

You have 60 days from the later of the date of the qualifying event or the date that You receive notice of the right to COBRA Continuation Coverage to enroll for such Coverage. The Group or the Plan will send You the forms that should be used to enroll for COBRA Continuation Coverage. If You do not send the Enrollment Form to the Group within that 60-day period, You will lose the right to COBRA Continuation Coverage under this section. If You are qualified for COBRA Continuation Coverage and receive services that would be Covered Services before enrolling and submitting the Payment for such Coverage, You will be required to pay for those services. The Plan will reimburse You for Covered Services, less required Member payments, after You enroll and pay the premium for Coverage, and submit a claim for those Covered Services as set forth in the Claim Procedure section of this Dental EOC.
C. **Premium Payment**

You must pay any premium required for COBRA Continuation Coverage to the Plan at the address indicated on the premium notice. If You do not enroll when first becoming eligible, the premium due for the period between the date You first become eligible and the date You enroll for COBRA Continuation Coverage must be paid to the Group within 45 days after the date You enroll for COBRA Continuation Coverage. After enrolling for COBRA Continuation Coverage, all premiums are due and payable on a monthly basis as required by the Group. If the premium is not received by the Plan on or before the due date, whether or not the premium was paid to the Group, Coverage will be terminated, for cause, effective as of the last day for which premium was received as explained in the Termination of Coverage Section, above. The Plan may use a third party vendor to collect the COBRA premium payment.

D. **Coverage Provided**

If You enroll for COBRA Continuation Coverage, You will continue to be Covered under the Dental Group Agreement and this Dental EOC. The COBRA Continuation Coverage is subject to the conditions, limitations and exclusions of this Dental EOC and the Dental Group Agreement. The Plan and the Group may agree to change the Dental Group Agreement and/or this Dental EOC. The Group may also decide to change insurers. If this happens after You enroll for COBRA Continuation Coverage, Your Coverage will be subject to such changes.

E. **Duration of Eligibility for COBRA Continuation Coverage**

COBRA Continuation Coverage is available for a maximum of:

1. 18 months if the loss of Coverage is caused by termination of employment or reduction in hours of employment; or

2. 29 months of Coverage. If, as a qualified beneficiary who has elected 18 months of COBRA Continuation Coverage, You are determined to be disabled within the first 60 days of COBRA Continuation Coverage, You can extend Your COBRA Continuation Coverage for an additional 11 months, up to 29 months. Also, the 29 months of COBRA Continuation Coverage is available to all non-disabled qualified beneficiaries in connection with the same qualifying event. “Disabled” means disabled as determined under Title II or XVI of the Social Security Act. In addition, the disabled qualified beneficiary must:
   a. Notify the Employer or the administrator of the disability determination within 60 days after the determination of disability and before the close of the initial 18-month Coverage period; and
   b. Notify the Employer or the administrator within 30 days of the date of a final determination that the qualified beneficiary is no longer disabled; or

3. 36 months of Coverage if the loss of Coverage is caused by:
   a. the death of the Subscriber;
   b. loss of dependent child status under the Plan;
c. the Subscriber becomes entitled to Medicare; or  
d. divorce or legal separation from the Subscriber; or  

4. 36 months for other qualifying events. If, a Covered Dependent is eligible for 18 months of COBRA Continuation Coverage as described above, and there is a second qualifying event (e.g. divorce), You may be eligible for 36 months of COBRA Continuation Coverage from the date of the first qualifying event.

F. Termination of COBRA Continuation Coverage

After You have elected COBRA Continuation Coverage, that Coverage will terminate either at the end of the applicable 18, 29 or 36 month eligibility period or, before the end of that period, upon the date that:

1. The premium for such Coverage is not submitted when due; or
2. You become Covered as either a Subscriber or dependent by another group dental care plan, and that coverage is as good as or better than the COBRA Continuation Coverage; or
3. The Dental Group Agreement is terminated; or
4. You become entitled to Medicare Coverage; or
5. The date that You, are otherwise eligible for 29 months of COBRA Continuation Coverage, are determined to no longer be disabled for purposes of the COBRA Law.

G. Continued Coverage During a Family and Medical Leave Act (FMLA) Leave of Absence

Under the Family and Medical Leave Act, Subscribers may be able to take:

- up to 12 weeks of unpaid leave from employment due to certain family or medical circumstances, or
- in some instances, up to 26 weeks of unpaid leave if related to certain family members’ military service related hardships.

Contact the Employer to find out if this provision applies. If it does, Members may continue health coverage during the leave, but must continue to pay the conversion options portion of the premium that the Subscriber would pay if he or she were actively working. Coverage will be subject to suspension or cancellation if the Subscriber fails to pay the premium on time. If the Subscriber takes a leave and Coverage is cancelled for any reason during that leave, Members may resume Coverage when the Subscriber returns to work without waiting for an Open Enrollment Period.

H. Continued Coverage During a Military Leave of Absence

A Subscriber may continue his or her Coverage and Coverage for his or her Dependents during military leave of absence in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994. When the Subscriber returns to work from a military leave of absence, the Subscriber will be given credit for the time the Subscriber was Covered under the Plan prior to the leave. Check with the Employer to see if this provision applies. If it does, Members may continue health coverage during the leave, but must continue to pay the conversion options portion of the premium that the Subscriber would pay if he or she were actively working. Coverage will be subject to suspension or cancellation if the Subscriber fails to pay the premium on time.
I. Continued Coverage During Other Leaves of Absence

Your Employer may allow Subscribers to continue their Coverage during other leaves of absence. Continuous coverage during such leave of absence is permitted for up to 6-months. Please check with Your human resources department to find out how long a Subscriber may take a leave of absence.

A Subscriber will also have to meet these criteria to have continuous Coverage during a leave of absence:

1. Your Employer continues to consider the Subscriber an Employee, and all other Employee benefits are continued;
2. The leave is for a specific period of time established in advance; and
3. The purpose of the leave is documented.

You may apply for Federal or State Continuation or Conversion, if the Subscriber’s leave lasts longer than the permitted amount of time.

Members may continue health coverage during the leave, but must continue to pay the conversion options portion of the premium that the Subscriber would pay if he or she were actively working. Coverage will be subject to suspension or cancellation if the Subscriber fails to pay the premium on time.

J. The Trade Adjustment Assistance Reform Act of 2002

The Trade Adjustment Assistance Reform Act of 2002 (TAARA) may have added to Your COBRA rights. If You lost Your job because of import competition or shifts of production to other countries, You may have a second COBRA Continuation election period. If You think this may apply to You, check with Your Employer or the Department of Labor.
CONTINUATION OF COVERAGE

State Law

A. State Continuation Coverage

If the Dental Group Agreement remains in effect, but Your Coverage under this Dental EOC would otherwise terminate, the Group may offer the Subscriber the right to continue Coverage for a limited period of time according to State law ("State Continuation Coverage").

1. Eligibility

You are eligible for State Continuation Coverage if You have been continuously covered under the Group’s dental plan or a plan that it replaced for at least three (3) months prior to the date Your Coverage terminates under the Dental Group Agreement, for any reason, except the termination of the Dental Group Agreement entirely or for an insured class.

2. Enrolling for State Continuation Coverage

The Group will notify Members eligible for State Continuation Coverage about how to enroll for such Coverage on or before the date their Coverage would otherwise terminate under the Dental Group Agreement. You must request State Continuation Coverage in writing and pay the amount required in advance.

3. Premium Payment

You must pay the quarterly premium for State Continuation Coverage to the Group at the time and place specified by the Group.

4. Coverage Provided

Members enrolled for State Continuation Coverage will continue to be Covered under the Dental Group Agreement and this Dental EOC for the remainder of the month that Coverage would otherwise end and the greater of:

   a. Three (3) months; or
   b. Six (6) months after Your pregnancy ends, if You are pregnant at the time Your Coverage would otherwise terminate; or
   c. Fifteen (15) months for Your Covered Dependents if Coverage ends because of divorce or Your death.

5. Termination of State Continuation Coverage

State Continuation Coverage will terminate upon the earliest of the following:

   a. The end of the applicable period in subsection 4, above; or
   b. The end of the period for which You paid for Coverage; or
   c. The termination date of the Dental Group Agreement; or
   d. The date You become eligible for Coverage under another group dental plan.

REMINDER: Check with the Employer to determine if You are eligible for any continuation of Coverage.
COORDINATION OF BENEFITS

This Dental EOC includes the following Coordination of Benefits (COB) provision, which applies when a Member has coverage under more than one group dental care "Plan." A COB provision is one that is intended to avoid claims payment delays, to aid in prompt payment, and avoid duplication of benefits.

Rules of this Section determine whether the benefits available under this Dental EOC are determined before or after those of another Plan. In no event, however, will benefits under this Dental EOC, or the Group Agreement, be increased because of this provision. The benefits under this Dental EOC may be reduced when another Plan determines its benefits first.

If this COB provision applies, the order of benefits determination rules should be looked at first. Those rules determine whether the benefits of this Plan are determined before or after those of another Plan.

1. Definitions

The following terms apply to this provision:

a. "Plan" means any form of medical or dental coverage with which coordination is allowed. "Plan" includes:

(1) Group, blanket, or franchise insurance;
(2) A group BlueCross Plan, BlueShield Plan;
(3) Group or group-type coverage through HMOs or other prepayment, group practice and individual practice plans;
(4) Coverage under labor management trust Plans or employee benefit organization Plans;
(5) Coverage under government programs to which an employer contributes or makes payroll deductions;
(6) Coverage under a governmental Plan or coverage required or provided by law;
(7) Medical benefits coverage in group, group-type, and individual automobile “no-fault” and traditional automobile “fault” type contracts;
(8) Coverage under Medicare and other governmental benefits; and
(9) Any other arrangement of health coverage for individuals in a group.

b. “Plan” does not include individual or the individual’s family:

(1) Insurance contracts;
(2) Subscriber contracts;
(3) Coverage through Health Maintenance (HMO) organizations;
(4) Coverage under other prepayment, group practice and individual practice plans;
(5) Public medical assistance programs (such as TennCare);
(6) Group or group-type hospital indemnity benefits of $100 per day or less;
(7) School accident-type coverages.
Each Contract or other arrangement for coverage is a separate Plan. Also, if an arrangement has two parts and COB rules apply to only one of the two, each of the parts is a separate Plan.

c. "This Plan" refers to the part of the Dental Group Agreement under which benefits for health care expenses are provided.

The term "Other Plan" applies to each arrangement for benefits or services, as well as any part of such an arrangement that considers the benefits and services of other Contracts when benefits are determined.

d. Primary Plan/Secondary Plan.

(1) The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering You.

(2) When This Plan is a Primary Plan, its benefits are determined before those of the Other Plan. We do not consider the Other Plan's benefits.

(3) When This Plan is a Secondary Plan, its benefits are determined after those of the Other Plan and may be reduced because of the Other Plan's benefits.

(4) When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more Other Plans, and may be a Secondary Plan as to a different Plan or Plans.

e. “Allowable Expense” means a necessary, reasonable and customary item of expense when the item of expense is covered at least in part by one or more Plans covering the Member for whom the claim is made.

(1) When a Plan provides benefits in the form of services, the reasonable cash value of a service is deemed to be both an Allowable Expense and a benefit paid.

(2) We will determine only the benefits available under This Plan. You are responsible for supplying Us with information about Other Plans so We can act on this provision.

f. “Claim Determination Period” means an Annual Benefit Period. However, it does not include any part of a year during which You have no coverage under This Plan, or any part of a year prior to the date this COB provision or a similar provision takes effect.

2. Order of Benefit Determination Rules

This Plan determines its order of benefits using the first of the following rules which applies:

a. Non-Dependent/Dependent

The benefits of the Plan which covers the person as an Employee, Member, or Subscriber (that is, other than as a Dependent) are determined before those of the Plan which covers the person as a Dependent, except that:

(1) if the person is also a Medicare beneficiary and,
(2) if the rule established by the Social Security Act of 1965 (as amended) makes Medicare secondary to the Plan covering the person as a Dependent of an active Employee, then the order of benefit determination shall be:

− benefits of the Plan of an active Employee covering the person as a Dependent;
− Medicare;
− benefits of the Plan covering the person as an Employee, Member, or Subscriber.

b. Dependent Child/Parents Not Separated or Divorced

Except as stated in Paragraph (c) below, when This Plan and another Plan cover the same child as a Dependent of different persons, called "parents:"

(1) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but

(2) If both parents have the same birthday, the benefits of the Plan that covered the parent longer are determined before those of the Plan that covered the other parent for a shorter period of time.

(3) However, if the Other Plan does not have the rule described immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the Other Plan will determine the order of benefits.

c. Dependent Child/Separated or Divorced Parents

If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

(1) First, the Plan of the parent with custody of the child;
(2) Then, the Plan of the spouse of the parent with the custody of the child; and
(3) Finally, the Plan of the parent not having custody of the child.

(4) However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(5) If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined above, Dependent Child/Parents Not Separated or Divorced.

d. Active/Inactive Employee
The benefits of a Plan that covers a person as an Employee who is neither laid off nor retired (or as that Employee’s dependent), are determined before those of a Plan that covers that person as a laid off or retired Employee (or as that Employee’s dependent). If the Other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this Rule is ignored, and other applicable rules control the order of benefit determination.

e. Longer/Shorter Length of Coverage

If none of the above Rules determines the order of benefits, the benefits of the Plan which has covered an Employee, Member, or Subscriber longer are determined before those of the Plan which has covered that person for the shorter term.

(1) To determine the length of time a person has been covered under a Plan, two Plans shall be treated as one if the claimant was eligible under the second within twenty-four hours after the first ended.

(2) The start of the new Plan does not include:

- A change in the amount or scope of a Plan's benefits;
- A change in the entity which pays, provides, or administers the Plan's benefits;
- A change from one type of Plan to another (such as, from a single Employer Plan to that of a multiple Employer plan).

(3) The claimant’s length of time covered under a Plan is measured from the claimant’s first date of coverage under that Plan. If that date is not readily available, the date the claimant first became a Member of the Group shall be used as the date from which to determine the length of time the claimant’s coverage under the present Plan has been in force.

f. Plans with Excess and Other Non-conforming COB Provisions

Some Plans declare their coverage "in excess" to all Other Plans, "always Secondary," or otherwise not governed by COB rules. These Plans are called "Non-complying Plans."

This Plan coordinates its benefits with a Non-complying Plan as follows:

(1) If This Plan is the Primary Plan, it will provide its benefits on a primary basis.

(2) If This Plan is the Secondary Plan, it will provide benefits first, but the amount of benefits and liability of This Plan will be limited to the benefits of a Secondary Plan.

(3) If the Non-complying Plan does not provide information needed to determine This Plan's benefits within a reasonable time after it is requested, This Plan will assume that the benefits of the Non-complying Plan are the same as the benefits of This Plan and provide benefits accordingly. However, this Plan must adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the Non-complying Plan.

(4) If:
(a) The Non-complying Plan reduces its benefits so that the Employee, Subscriber or Member receives less in benefits than he or she would have received had the Complying Plan paid, or provided its benefits as the Secondary Plan, and the Non-complying Plan paid or provided its benefits as the Primary Plan; and

(b) Governing state law allows the right of subrogation set forth below;

then the Complying Plan shall advance to You, or on Your behalf, an amount equal to such difference. However, in no event shall the Complying Plan advance more than the Complying Plan would have paid, had it been the Primary Plan, less any amount it previously paid. In consideration of such advance, the Complying Plan shall be subrogated to all Your rights against the Non-complying Plan. Such advance by the Complying Plan shall also be without prejudice it may have against the Non-complying Plan in the absence of such subrogation.

3. Effect on the Benefits of this Plan

This provision applies where there is a basis for a claim under This Plan and the Other Plan and when benefits of This Plan are determined as a Secondary Plan.

a. Benefits of This Plan will be reduced when the sum of:

(1) The benefits that would be payable for the Allowable Expenses under This Plan, in the absence of this COB provision; and

(2) The benefits that would be payable for the Allowable Expenses under the Other Plan(s), in the absence of provisions with a purpose similar to that of this COB provision, whether or not a claim for benefits is made;

exceed Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the Other Plan(s) do not total more than Allowable Expenses.

b. When the benefits of This Plan are reduced as described above, each benefit is reduced proportionately, and is then charged against any applicable benefit limit of This Plan.

4. Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. We have the right to decide which facts We need. We may get needed facts from, or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to pay the claim.

5. Facility of Payment

A payment under Another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount would then be treated as if it were a benefit paid under This Plan. We will not have to pay that amount again. The term “Payment Made” includes providing benefits in the form of services; in which case, Payment Made means reasonable cash value of the benefits provided in the form of services.

6. Right of Recovery
If the amount of the payments made by the Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of:

(a) The persons it has paid or for whom it has paid;

(b) Insurance companies; or

(c) Other organizations.

The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

7. Are You Also Covered by Medicare?

If You are also Covered by Medicare, We follow the Medicare Secondary Payor (MSP) rules to determine Your benefits. If Your Employer has 20 or fewer employees, the MSP rules might not apply. Please contact customer service at the toll free number on Your membership ID card if You have any questions.
I. INTRODUCTION

Our Grievance procedure (the “Procedure”) is intended to provide a fair, quick and inexpensive method of resolving any and all Disputes with the Plan. Such Disputes include: any matters that cause You to be dissatisfied with any aspect of Your relationship with the Plan; any Adverse Benefit Determination concerning a Claim; or any other claim, controversy, or potential cause of action You may have against the Plan. Please contact the customer service department at the number listed on Your membership ID card: (1) to file a Claim; (2) if You have any questions about this Dental EOC or other documents related to Your Coverage (e.g. an explanation of benefits or monthly claims statement); or (3) to initiate a Grievance concerning a Dispute.

1. This Procedure is the exclusive method of resolving any Dispute. Exemplary or punitive damages are not available in any Grievance or litigation, pursuant to the terms of this Dental EOC. Any decision to award damages must be based upon the terms of this Dental EOC.

2. The Procedure can only resolve Disputes that are subject to Our control.

3. You cannot use this Procedure to resolve a claim that a Dentist was negligent. Network Dentists are independent contractors. They are solely responsible for making treatment decisions in consultation with their patients. You may contact the Plan; however, to complain about any matter related to the quality or availability of services, or any other aspect of Your relationship with Dentists.

4. This Procedure incorporates the definitions of: (1) Adverse Benefit Determination; (2) urgent care; and (3) pre-service and post-service claims (“Claims”), which are in the Employee Retirement Income Security Act of 1974 (“ERISA”); Rules and Regulations for Administration and Enforcement; Claims Procedure (the “Claims Regulation”).

5. An Adverse Benefit Determination is any denial, reduction, termination or failure to provide or make payment for what You believe should be a Covered Service.
   a. If a Dentist does not render, or reduces or terminates a service that has been rendered, or requires You to pay for what You believe should be a Covered Service, You may submit a Claim to the Plan to obtain a determination concerning whether the Plan will cover that service.
   b. Dentists may also appeal an Adverse Benefit Determination through the Plan's Provider dispute resolution procedure.
   c. A Plan determination will not be an Adverse Benefit Determination if: (1) a Dentist is required to hold You harmless for the cost of services rendered; or (2) until the Plan has rendered a final Adverse Benefit Determination in a matter being appealed through the Provider dispute resolution procedure.

6. You may request a form from the Plan to authorize another person to act on Your behalf concerning a Dispute.
7. The Plan and You may agree to skip one or more of the steps of this Procedure if it will not help to resolve Our Dispute.

8. Any Dispute will be resolved in accordance with applicable Tennessee or Federal laws and regulations, the Dental Group Agreement and this Dental EOC.

II. DESCRIPTION OF THE REVIEW PROCEDURES

A. Inquiry

An Inquiry is an informal process that may answer questions or resolve a potential Dispute. You should contact a consumer advisor if You have any questions about how to file a Claim or to attempt to resolve any Dispute. Making an Inquiry does not stop the time period for filing a Claim or beginning a Dispute. You do not have to make an Inquiry before filing a Grievance.

B. Grievance

You must submit a written request asking the Plan to reconsider an Adverse Benefit Determination, or take a requested action to resolve another type of Dispute (Your "Grievance"). You must begin the Dispute process within 180 days from the date We issue notice of an Adverse Benefit Determination from the Plan or from the date of the event that is otherwise causing You to be dissatisfied with the Plan. If You do not initiate a Grievance within 180 days of when We issue an Adverse Benefit Determination, You may give up the right to take any action related to that Dispute.

Contact the customer service department at the number listed on Your membership ID card for assistance in preparing and submitting Your Grievance. They can provide You with the appropriate form to use in submitting a Grievance. This is the first level Grievance procedure and is mandatory.

1. Grievance Hearing

After the Plan has received and reviewed Your Grievance, Our first level Grievance committee will meet to consider Your Grievance and any additional information that You or others submit concerning that Grievance. In Grievances concerning urgent care or pre-service Claims, the Plan will appoint one or more qualified reviewer(s) to consider such Grievances. Individuals involved in making prior determinations concerning Your Dispute are not eligible to be voting members of the first level Grievance committee or reviewers. The Committee or reviewers have full discretionary authority to make eligibility, benefit and/or claim determinations, pursuant to the Dental Group Agreement. Such determinations shall be subject to the review standards applicable to ERISA plans, even if the Dental Group Agreement is not otherwise governed by ERISA.

2. Written Decision

The committee or reviewers will consider the information presented, and the chairperson will send You a written decision concerning Your Grievance as follows:

(a) For a pre-service claim, within 30 days of receipt of Your request for review;
(b) For a post-service claim, within 60 days of receipt of Your request for review; and
(c) For a pre-service, urgent care claim, within 72 hours of receipt of Your request for review.

The decision of the Committee will be sent to You in writing and will contain:

(a) A statement of the committee’s understanding of Your Grievance;
(b) The basis of the committee’s decision; and
(c) Reference to the documentation or information upon which the committee based its decision. The Plan will send You a copy of such documentation or information, without charge, upon written request.

C. Second Level Grievance Procedure

You may file a written request for reconsideration within 90 days after We issue the first level Grievance committee’s decision. This is called a second level Grievance. Information on how to submit a second level Grievance will be provided to You in the decision letter following the first level Grievance review.

If Your Dental Group Agreement is governed by ERISA, You also have the right to bring a civil action against the Plan to obtain the remedies available pursuant to Sec. 502(a) of ERISA (“ERISA Actions”) after completing the mandatory first level Grievance process.

The Plan may require You to exhaust each step of this Procedure in any Dispute that is not an ERISA Action.

Your decision concerning whether to file a second level Grievance has no effect on Your rights to any other benefits under the Plan. If You file a second level Grievance concerning an ERISA Action, We agree to toll any time defenses or restrictions affecting Your right to bring a civil action against the Plan until the second level committee makes its decision. Any person involved in making a decision concerning Your Dispute (e.g. first level committee members) will not be a voting member of the second level Grievance committee.

1. Grievance Hearing

(1) You may request an in-person or telephonic hearing before the second level Grievance committee. You may also request that the second level Grievance committee reconsider the decision of the first level committee, even if You do not want to participate in a hearing concerning Your Grievance. If You wish to participate, Our representatives will promptly contact You to explain the hearing process and schedule the time, date and place for that hearing.

(2) In either case, the second level committee will meet and consider all relevant information presented about Your Grievance, including:

(a) Any new, relevant information that You submit for consideration; and
(b) Information presented during the hearing. Second level Grievance committee members and You will be permitted to question each other and any witnesses during the hearing. You will also be permitted to make a closing statement to the committee at the end of the hearing.
(c) If You wish to bring a personal representative with You to the hearing, You must 
notify Us at least 5 days in advance and provide the name, address and telephone 
number of Your personal representative.

2. Written Decision

After the hearing, the second level committee will meet in closed session to make a 
decision concerning Your Grievance. That decision will be sent to You in writing. The 
written decision will contain:

(a) A statement of the second level committee’s understanding of Your Grievance;
(b) The basis of the second level committee's decision; and
(c) Reference to the documentation or information upon which the second level 
committee based its decision. Upon written request, We will send You a copy of 
any such documentation or information, without charge.

D. Independent Review of Medical Necessity Determinations or Coverage Rescissions

If Your Grievance involves a Medical Necessity or a Coverage rescission determination, then 
either: (1) after completion of the mandatory first level Grievance; or (2) after completion of 
the mandatory first level Grievance immediately followed by completion of the second level 
Grievance, You may request that the Dispute be submitted to a neutral third party, selected 
by the Plan, to independently review and resolve such Dispute(s). If You request an 
independent review following the mandatory first level Grievance, You waive Your right to a 
second level Grievance and Your right to present testimony during the Grievance Procedure. 
Your request for independent review must be submitted in writing within 180 days after the 
date You receive notice of the committee’s decision. Receipt shall be deemed to have 
occurred no more than two days after the date of issuance of the committee’s decision. Any 
person involved in making a decision concerning Your Dispute will not be a voting member of 
the independent review panel or committee.

Your decision concerning whether to request independent review has no effect on Your 
rights to any other benefits under the Plan. If You request independent review of an ERISA 
Action, We agree to toll any time defenses or restrictions affecting Your right to bring a civil 
action against the Plan, until the independent reviewer makes its decision.

The Plan will pay the fee charged by the independent review organization and its reviewers 
if You request that the Plan submit a Dispute to independent review. You will be 
responsible for any other costs that You incur to participate in the independent review 
process, including attorney’s fees.

The Plan will submit the necessary information to the independent review entity within 5 
business days after receiving Your request for review. The Plan will provide copies of Your 
file, excluding any proprietary information to You, upon written request. The reviewer may 
also request additional medical information from You. You must submit any requested 
information, or explain why that information is not being submitted, within 5 business days 
after receiving that request from the reviewer.

The reviewer must submit a written determination to the Plan and You within 45 days after 
receipt of the independent review request. In the case of a life threatening condition, the
decision must be issued within 72 hours after receiving the review request. Except in cases involving a life-threatening condition, the reviewer may request an extension of up to 5 business days to issue a determination to consider additional information submitted by the Plan or You.

The reviewer’s decision must state the reasons for the determination based upon: (1) the terms of this Dental EOC and the Dental Group Agreement; (2) Your medical condition; and (3) information submitted to the reviewer. The reviewer’s decision may not expand the terms of Coverage of the Dental Group Agreement.

No action at law or in equity shall be brought to recover on this EOC until 60 days after written proof of loss has been furnished as required by this EOC. No such action shall be brought beyond 3 years after the time written proof of loss is required to be furnished.
DEFINITIONS

Defined terms are capitalized. When defined words are used in this Dental EOC, they have the meaning set forth in this section.

**Actively At Work** – The performance of all an Employee’s regular duties for the Group on a regularly scheduled workday at the location where such duties are normally performed. An Employee will be considered to be Actively At Work on a non-scheduled work day (which would include a scheduled vacation day) only if the Employee is Actively At Work on the last regularly scheduled work day. An Employee who is not at work due to a health-related factor shall be treated as Actively At Work for purposes of determining Eligibility.

**Annual Benefit Period** - The 12-month period under which Your benefits are administered, as noted in Attachment C: Schedule of Benefits.

**Benefit Maximum** - The total amount of benefits available for services under this Dental EOC during the Benefit Year, or during the Member’s lifetime. (See Attachment C: Schedule of Benefits.)

**Billed Charges** – The amount that a Dentist charges for services rendered. Billed Charges may be different from the amount that the Plan determines to be the Maximum Allowable Charge for services.

**Coinsurance** – The amount stated as a percentage of the Maximum Allowable Charge for a Covered Service, that is Your responsibility during the Annual Benefit Period after any Deductible is satisfied. The Coinsurance percentage is calculated as 100%, minus the percentage Payment of the Maximum Allowable Charge as specified in Attachment C: Schedule of Benefits.

**Covered Dependent** - A Subscriber’s family members who: (1) meet the eligibility requirements of this Dental EOC; (2) have been enrolled for Coverage; and (3) for whom the Plan has received the applicable premium for Coverage.

**Covered Family Members** – A Subscriber and his or her Covered Dependents.

**Covered Services, Coverage or Covered** - Those necessary and appropriate services and supplies that are set forth in Attachment A: Covered Services and Limitations on Covered Services of this Dental EOC, (which is incorporated by reference). Covered Services are subject to all the terms, conditions, exclusions and limitations of the Dental Group Agreement and this Dental EOC.

**Deductible** - The dollar amount, specified in Attachment C: Schedule of Benefits, which You must incur and pay for Covered Services during an Annual Benefit Period before the Plan provides benefits for such services.

Any balance of charges (the difference between Billed Charges and the Maximum Allowable Charge) is not considered when determining if You have satisfied a Deductible.

**Dental Group Agreement or Agreement** – The arrangements between the Plan and the Group, including this Dental EOC, the Employer Group Application, any riders, any amendments, and any attachments to the Agreement or this Dental EOC. If there is any conflict between the Dental Group Agreement and this Dental EOC, the Dental Group Agreement shall be controlling.

**Dentist** - A doctor of dentistry, duly licensed and qualified under applicable laws to practice dentistry at the time and place Covered Services are performed; Dentist is defined to include
any dental professional that is duly licensed and qualified to perform Covered Services at the
time and place Covered Services are performed.

**Effective Date** - The date Your Coverage under this EOC begins.

**Employee** – A person who fulfills all eligibility requirements established by the Group and the Plan.

**Enrollment Form** – A form or application which must be completed in full by the eligible
Employee before he or she will be considered for Coverage under the Plan.


**Family Deductible** – The maximum dollar amount, specified in Attachment C: Schedule of Benefits
that a Subscriber and Covered Dependents must incur and pay for Covered Services during an
Annual Benefit Period before the Plan provides benefits for such Services. Once the Family
Deductible amount has been satisfied by 3 or more Covered Family Members during an Annual
Benefit Period, the Deductible will be considered satisfied for all Covered Family Members for the
remainder of that Annual Benefit Period.

Any balance of charges (the difference between Billed Charges and the Maximum Allowable
Charge) is not considered when determining if the Family Deductible has been satisfied.

**Group or Employer** – A corporation, partnership, union or other entity that is eligible for group
coverage under State and Federal laws; and the Plan’s Underwriting Guidelines; and that enters
into an Agreement with the Plan to provide Coverage to its Employees and their eligible
dependents.

**Incapacitated Child** – an unmarried child who is, and continues to be, both (1) incapable of self-
sustaining employment by reason of intellectual or physical disability (what used to be called
mental retardation or physical handicap); and (2) chiefly dependent upon the Subscriber or
Subscriber’s spouse for economic support and maintenance.

a. If the child reaches this Plan’s limiting age while Covered under this Plan, proof of such
incapacity and dependency must be furnished within 31 days of when the child reaches the
Limiting Age.

b. Incapacitated dependents of Subscribers of new groups, or of Subscribers who are newly
eligible under this Plan, are eligible for Coverage if they were covered under the Subscriber’s
or the Subscriber’s spouse’s previous health benefit plan. We may ask You to furnish proof
of the incapacity and dependency upon enrollment, and for proof that the child continues to
meet the conditions of incapacity and dependency, but not more frequently than annually.

**Limiting Age (or Dependent Child Limiting Age)** - The age at which a child will no longer be
considered an eligible Dependent.

**Maximum Allowable Charge** - The amount that the Plan, at its discretion, has determined to be
the maximum amount payable for a Covered Service. For Covered Services provided by
Network Dentists, that determination will be based upon the Plan’s contract with a Network
Dentist for Covered Services rendered by that Dentist. For Covered Services provided by Out-of-
Network Dentists, the amount payable will be based upon the Plan’s fee schedule for the
Covered Services rendered by Out-of-Network Dentists.

**Member, You, Your** - Any person enrolled as a Subscriber or Covered Dependent, according to
the terms of the Group’s Plan.
**Necessary Dental Care** – Any treatment or service prescribed by a Dentist that the Plan determines to be necessary and appropriate.

**Network Dentist** - A Dentist who has signed a Preferred Dental Agreement with the Plan.

**Non-covered Services** - Services that:
(a) exceed the benefit period and/or age limitations of the Plan as listed in Attachment A: Covered Services and Limitations on Covered Services;
(b) are listed in Attachment B: Other Exclusions;
(c) are beyond the limitations set forth in Attachment C: Schedule of Benefits, including Deductibles, Coinsurance and amounts above the Benefit Maximums; and
(d) are not Necessary Dental Care.

**Out-of-Network Dentist** - A Dentist who has not signed a Preferred Dental Agreement with the Plan.

**Subscriber** - An Employee who meets all applicable eligibility requirements, has enrolled for Coverage and for whom the Plan has received applicable premium for Coverage.

**Treatment Plan** - A written report by a Dentist showing the recommended treatment of any dental disease, defect or injury for a Member.

**Waiting Period** – The time that must pass before a Member is eligible to be Covered for benefits under the Plan or under Class C or Class D.
ATTACHMENT A: COVERED SERVICES AND LIMITATIONS ON COVERED SERVICES

The Preferred Dental Care program provides a wide range of benefits to Cover most services associated with dental care.

Plan benefits are based on the Maximum Allowable Charge for Necessary Dental Care as described in this Attachment A and provided in accordance with the benefit schedule set forth in this Dental EOC’s Attachment C: Schedule of Benefits.

This Attachment sets forth Covered Services, limitations, and exclusions (services not Covered), and is arranged according to type of services. Some groups of services such as orthodontia, although listed in this section, may not be covered under all plans. There are also certain circumstances when services are not covered. Please also refer to Attachment B: Other Exclusions and Attachment C: Schedule of Benefits to determine Your benefits under this Plan.

If more than one procedure or course of treatment:
− can be used to accomplish the same treatment goal; and
− meets generally accepted standards of professional dental care; and
− offers a favorable prognosis for the patient’s condition;

benefits may be based on the lowest cost procedure or treatment. This will be at Our sole discretion.

If a Member transfers from the care of one Dentist to another during the course of treatment, or if more than one Dentist renders services for one dental procedure, benefits will not exceed those that would have been provided had one Dentist rendered the service.

The Group chooses the classes of Employees who are eligible for Coverage under the Plan. The Group also determines the Waiting Periods for the classes of benefits under the Plan. The eligibility requirements the Group has selected are in Attachment D: Eligibility to this Dental EOC. They are also on file in the Group’s human resource department.

I. Diagnostic Services
   A. Exams
      1. Covered
         a. Standard exams including comprehensive, periodic, detailed/extensive and periodontal oral evaluations (exams).
         b. Emergency exams, including limited oral evaluations (exams).
      2. Limitations
         a. No more than one standard exam in any 6 month period.
         b. No more than one emergency exam in any 12 month period.
         c. No more than one comprehensive, detailed/extensive, or periodontal exam in any 36-month period.
3. Exclusions
   a. Re-evaluations and consultations.

B. X-rays
   1. Covered
      a. Full mouth series, intraoral and bitewing radiographs (x-rays).
   2. Limitations
      a. No more than one full mouth set of x-rays in any 36-month period. A full mouth set of x-rays is defined as either an intraoral complete series or panoramic x-ray. Benefits provided for either include benefits for all necessary intraoral and bitewing films taken on the same day.
      b. No more than four bitewing films in any 12-month period. Bitewing films must be taken on the same date of service.
   3. Exclusions
      a. Extraoral, skull and bone survey, sialography, TMJ, and tomographic survey x-ray films, cephalometric films and diagnostic photographs. Cephalometric films and diagnostic photographs may be Covered as orthodontic benefits under Coverage D.

II. Preventive Services
   A. Prophylaxis (Cleanings)
      1. Covered
         a. Adult and child prophylaxis (cleaning).
      2. Limitations
         a. No more than one of any prophylaxis or periodontal maintenance procedure in any 6-month period.
         b. Periodontal maintenance procedures are subject to additional limitations listed below under Basic Periodontics in Section VI, and may be subject to a different Coverage level under Attachment C: Schedule of Benefits.
   B. Fluoride Treatment
      1. Covered
         a. Topical fluoride treatments, performed with or without a prophylaxis.
      2. Limitations
         a. No more than one fluoride treatment in any 12-month period.
         b. Fluoride must be applied separately from prophylaxis paste.
         c. Covered only for Covered Dependents under age 19.
C. Other Preventive Services

1. Covered
   a. Sealants, preventive resin restorations, space maintainers.

2. Limitations
   a. No more than 1 sealant, preventive resin restoration, or resin infiltration per first or second molar tooth per lifetime, for Dependents under age 16. Resin infiltrations are subject to a different Coverage level under Attachment C: Schedule of Benefits.
   b. Space maintainers for Dependents under age 14, no more than one recementation in any 12 month period.

3. Exclusions
   a. Nutritional and tobacco counseling, oral hygiene instructions.

III. Basic Restorative Services

A. Fillings and Stainless Steel Crowns

1. Covered
   a. Amalgam restorations (silver fillings), resin composite restorations (tooth colored fillings), resin infiltrations, stainless steel crowns.

2. Limitations
   a. No more than one amalgam or resin restoration per tooth surface in any 12 month period.
   b. Replacement of existing amalgam and resin composite restorations Covered only after 12 months from the date of initial restoration.
   c. Replacement of stainless steel crowns Covered only after 36 months from the date of initial restoration.
   d. No more than 1 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 additional limitations listed under Preventive Services, and may be subject to a different Coverage level under Attachment C: Schedule of Benefits.)

3. Exclusions
   a. Gold foil restorations.

B. Other Basic Restorative Services

1. Covered
   a. Palliative (emergency) treatment for the relief of pain.
   b. Repair of full and partial dentures.
2. Limitations
   a. No more than one repair per denture per 24 months.

IV. Major Restorative & Prosthodontic Services

A. Single Tooth Restorations
   1. Covered
      a. Crowns (resin, porcelain, ¾ cast, and full cast), inlays and onlays (metallic, resin and porcelain), and veneers.
   2. Limitations
      a. Only for the treatment of severe carious lesions or severe fracture on permanent teeth, and only when teeth cannot be adequately restored with an amalgam or resin composite restoration (filling).
      b. For permanent teeth only.
      c. For Dependents under age 12, benefits will not be provided for cast crowns or laminate veneers.
      d. Replacement of single tooth restorations or fixed partial dentures. Covered only after 60 months from the date of initial placement.
   3. Exclusions
      a. Temporary and provisional crowns.

B. Multiple Tooth Restorations – Bridges
   1. Covered
      a. Fixed partial dentures (bridges), including pontics, retainers, and abutment crowns, inlays, and onlays (resin, porcelain, ¾ and full cast).
   2. Limitations
      a. Only for treatment where a missing tooth or teeth cannot be adequately restored with a removable partial denture.
      b. For permanent teeth only, no benefits for Dependents under age 16.
      c. Replacement of fixed partial dentures or single tooth restorations. Covered only after 60 months from the date of initial placement.
   3. Exclusions
      a. Interim pontic and retainer crowns.

C. Removable Prosthodontics (Dentures)
   1. Covered
      a. Complete, immediate and partial dentures.
   2. Limitations
a. If, in the construction of a denture, the Member and the Dentist decide on a personalized restoration or to employ special rather than standard techniques or materials, benefits provided shall be limited to those which would otherwise be provided for the standard procedures or materials (as determined by the Plan).

b. Benefits are not provided for Dependents under age 16.

c. Replacement of removable dentures Covered only after 60 months from the date of initial placement.

3. Exclusions
   a. Interim (temporary) dentures.

D. Other Major Restorative & Prosthodontic Services

1. Covered
   a. Crown and bridge services including core buildups, post and core, recementation, and repair.
   b. Denture services including adjustment, relining, rebasing and tissue conditioning.
   c. Implants and Implant supported prosthetics, including local anesthetic.

2. Limitations
   a. The benefits provided for crown and bridge restorations include benefits for the services of crown preparation, temporary or prefabricated crowns, impressions and cementation.
   b. Benefits will not be provided for a core build-up separate from those provided for crown construction, except in those circumstances where benefits are provided for a crown because of severe carious lesions or fracture is so extensive that retention of the crown would not be possible.
   c. Post and core services are Covered only when performed in conjunction with a Covered crown or bridge.
   d. Crown inlay, onlay, veneer and bridge repair and re-cementation are Covered separately only after 12 months from the date of initial placement.
   e. Denture adjustments are Covered separately from the denture only after 6 months from the date of initial placement.
   f. No more than one denture reline or rebase in any 36 month period.
   g. Implant limited to one per tooth per lifetime.
   h. Bone graft for implant is limited to one per tooth per lifetime.
   i. Implant debridement is limited to one time per lifetime per tooth.
j. Replacement of implant supported prosthesis is covered only after 60 months from the date of any prosthesis placement.

3. Exclusions
   a. Other major restorative services including protective restoration and coping.
   b. Other prosthodontic services including overdenture, precision attachments, connector bars, stress breakers and coping metal.
   c. Temporary and interim implant abutment.

V. Endodontics (treatment of the dental pulp or root canal)

A. Basic Endodontics
   1. Covered
      a. Pulpotomy, pulpal therapy.
   2. Limitations
      a. For primary teeth only.
      b. Not Covered when performed in conjunction with major endodontic treatment.
      c. The benefits for basic endodontic treatment include benefits for x-rays, pulp vitality tests, and protective restoration provided in conjunction with basic endodontic treatment. However, pulp vitality tests and protective restorations are not Covered when billed separately from other endodontic services.
   3. Exclusions
      a. Pulpal debridement.

B. Major Endodontics
   1. Covered Services
      a. Root canal treatment and re-treatment, apexification, pulpal regeneration, apicoectomy services, root amputation, retrograde filling, hemisection, pulp cap.
   2. Limitations
      a. No more than 1 root canal treatment, re-treatment, pulpal regeneration, or apexification per tooth in 60 month period.
      b. No more than one apicoectomy per root per lifetime.
      c. The benefits for major endodontic treatment include benefits for x-rays, pulp vitality tests, pulpotomy, pulpectomy and protective restoration and temporary filling material provided in conjunction with major endodontic treatment. However, pulp vitality tests and protective restorations are not Covered when billed separately from other endodontic services.
3. Exclusions
   a. Implantation, canal preparation, and incomplete endodontic therapy.

VI. Periodontics

A. Basic Periodontics

1. Covered
   a. Non-surgical periodontics, including periodontal scaling and root planing, full mouth debridement and periodontal maintenance procedure.

2. Limitations
   a. No more than one periodontal scaling and root planing per quadrant in any 24-month period.
   b. No more than 1 full mouth debridement per lifetime.
   c. No more than one of any prophylaxis (cleanings) or periodontal maintenance procedure in any 6-month period. Cleanings are subject to additional limitations listed under Preventive Services, and may be subject to a different Coverage level under Attachment C: Schedule of Benefits.
   d. 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.
   e. Benefits for periodontal scaling and root planing, full mouth debridement, periodontal maintenance and prophylaxis are not provided when more than one of these procedures is performed on the same day.

3. Exclusions
   a. Provisional splinting, scaling in the presence of gingival inflammation, antimicrobial medication and dressing changes.

B. Major Periodontics

1. Covered
   a. Surgical periodontics including gingivectomy, gingivoplasty, gingival flap procedure, crown lengthening, osseous surgery and bone and tissue grafting.
   b. Benefits provided for major periodontics include benefits for services related to 90 days of postoperative care.

2. Limitations
   a. No more than one major periodontal surgical procedure in any 36 month period.

3. Exclusions
   a. Tissue regeneration and apically positioned flap procedure.
VII. Oral Surgery

A. Basic Oral Surgery

1. Covered
   a. Non-surgical or simple extractions.

2. Limitations
   a. Benefits provided for basic oral surgery include benefits for suturing and postoperative care.

3. Exclusions
   a. Benefits for general anesthesia or intravenous sedation when performed in conjunction with basic oral surgery.

B. Major Oral Surgery

1. Covered
   a. Surgical extractions (including removal of impacted teeth), coronectomy, and other oral surgical procedures typically not Covered under a medical plan.
   b. Benefits provided for major oral surgery include benefits for local anesthesia, suturing and postoperative care.

2. Limitations
   a. Benefits for general anesthesia or intravenous (IV) sedation are provided only in connection with major oral surgery procedures, and only when provided by a Dentist licensed to administer such agents.

3. Exclusion
   a. Oral surgery typically Covered under a medical plan, including but not limited to, excision of lesions and bone tissue, treatment of fractures, suturing, wound and other repair procedures, TMJ and related procedures.
   b. Orthognathic surgery and treatment for congenital malformations.

VIII. Orthodontics

A. Orthodontic Services (straightening and alignment of teeth)

1. Covered
   a. Exams, photographic images, diagnostic casts, cephalometric x-rays, installation and adjustment of orthodontic appliances and treatment to reduce or eliminate an existing malocclusion.
2. Limitations
   a. The need for orthodontic services must be diagnosed, identifying a handicapping malocclusion that is both abnormal and correctable, and a Treatment Plan must be submitted to and approved by the Plan.
   b. The Plan reserves the right to review the Member’s dental records, including necessary x-rays, photographs, and models to determine whether orthodontic treatment is Covered.
   c. Orthodontic services may be limited to Dependents under a specified age limit, as defined on Attachment C: Schedule of Benefits.
   d. Orthodontic services may be limited by a Maximum Allowable Charge, Annual Benefit Period Deductible and lifetime maximum as defined on Attachment C: Schedule of Benefits. Multiple occurrences of orthodontic treatment may be allowed subject to the lifetime maximum.
   e. All orthodontic services shall be deemed to have been concluded on the last date treatment performed during Member’s Coverage, even if a prior approved Treatment Plan has not been completed.

3. Exclusions
   a. Replacement or repair of any lost, stolen and damaged appliance furnished under the Treatment Plan.
   b. Surgical procedures to aid in orthodontic treatment.
ATTACHMENT B: EXCLUSIONS FROM COVERAGE

This Dental EOC does not provide benefits for the following services, supplies or charges:

1. Dental services received from a dental or medical department maintained by or on behalf of an Employer, mutual benefit association, labor union, trustee or similar person or group.

2. Services or supplies not listed as Covered Services under Attachment A, Covered Services and Limitations on Covered Services.

3. Charges for services performed by You or Your spouse, or Your or Your spouse’s parent, sister, brother or child.

4. Services rendered by a Dentist beyond the scope of his or her license.

5. Dental services which are free, or for which You are not required or legally obligated to pay or for which no charge would be made if You had no dental Coverage.

6. Dental services to the extent that charges for such services exceed the charge that would have been made and collected if no Coverage existed hereunder.

7. Dental services covered by any medical insurance coverage, or by any other non-dental contract or certificate issued by BlueCross BlueShield of Tennessee or any other insurance company, carrier, or plan. For example, removal of impacted teeth, tumors of lip and gum, accidental injuries to the teeth, etc.

8. Any court-ordered treatment of a Member unless benefits are otherwise payable.

9. Courses of treatment undertaken before You become Covered under this program.

10. Any services performed after You cease to be eligible for Coverage, except as shown under the Payment For Services Rendered After Termination of Coverage section.

11. Dental care or treatment not specifically listed in Attachment C: Schedule of Benefits.

12. Any treatment or service that the Plan determines is not Necessary Dental Care that does not offer a favorable prognosis that does not meet generally accepted standards of professional dental care, or that is experimental in nature.

13. Services or supplies for the treatment of work related illness or injury, regardless of the presence or absence of workers’ compensation coverage. This exclusion does not apply to injuries or illnesses of an employee who is (1) a sole-proprietor of the Group; (2) a partner of the Group; or (3) a corporate officer of the Group, provided the officer filed an election not to accept Workers’ Compensation with the appropriate government department.

14. Charges for any hospital or other surgical or treatment facility and any additional fees charged by a Dentist for treatment in any such facility.

15. Dental services with respect to congenital malformations or primarily for cosmetic or aesthetic purposes. This does not exclude those services provided under Orthodontic benefits (if applicable.)

16. Replacement of tooth structure lost from wear or attrition.
17. Dental services resulting from loss or theft of a denture, crown, bridge or removable orthodontic appliance.

18. Charges for a prosthetic device that replaces one or more lost, extracted or congenitally missing teeth before Your Coverage becomes effective under the Plan unless it also replaces one or more natural teeth extracted or lost after Your Coverage became effective.

19. Diagnosis for, or fabrication of, adjustment or maintenance and cleaning of maxillofacial prosthesis, appliances or restorations necessary to correct bite problems or restore the occlusion or correct temporomandibular joint dysfunction (TMJ) or associated muscles.

20. Diagnostic dental services such as diagnostic tests and oral pathology services.

21. Adjunctive dental services including all local and general anesthesia, sedation, and analgesia (except as provided under major oral surgery).

22. Charges for the treatment of desensitizing medicaments, drugs, occlusal guards and adjustments, mouthguards, microabrasion, behavior management, and bleaching.

23. Charges for the treatment of professional visits outside the dental office or after regularly scheduled hours or for observation.

24. Charges for the inhalation of nitrous oxide/analgesia, anxiolysis.
### ATTACHMENT C: SCHEDULE OF BENEFITS

**Product Name:** DentalBlue Traditional Plan  
**Group Name:** Vanderbilt University Medical Center  
**Group Number:** 129952  
**Benefits Effective:** May 1, 2016

<table>
<thead>
<tr>
<th>Deductible</th>
<th>Individual</th>
<th>Family</th>
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<td>Annual Benefit Period</td>
<td>$50</td>
<td>3 x Individual</td>
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<tr>
<td>Applies to Coverages B C and D only</td>
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</table>

<table>
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<tr>
<th>Maximums</th>
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<tbody>
<tr>
<td>Applies to Coverage B and C</td>
<td>$1,500 per Annual Benefit Period</td>
</tr>
<tr>
<td>Coverage D</td>
<td>$1,000 per lifetime</td>
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</table>

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Benefit Percentages</th>
<th>Waiting Period</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coverage A</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exams</td>
<td>100%</td>
<td>None</td>
</tr>
<tr>
<td>X-rays</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **Coverage B**   |                     |                |
| Basic Restorative | 80%                | None           |
| Basic Oral Surgery |                   |                |

| **Coverage C**   |                     |                |
| Major Restorative | 50%                | None           |
| Endodontics      |                     |                |
| Major Oral Surgery |                   |                |
| Periodontics     |                     |                |
| Implants         |                     |                |

| **Coverage D**   |                     |                |
| Orthodontics     | 50%                 | 12 months      |
| Dependents under age 19 |            |                |

<table>
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<tr>
<th>Annual Benefit Period</th>
<th>January 1 - December 31</th>
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In addition to the Coinsurance percentage, You are responsible for the difference between the Billed Charges and the Maximum Allowable Charge for Covered Services if the Billed Charges of an Out-of-Network Dentist are more than the Maximum Allowable Charge for such Services.

Network discounts do not apply to Non-covered Services.
EVIDENCE OF COVERAGE

ATTACHMENT D: ELIGIBILITY

Any Employee of the Group and his/her family dependents, who meet the eligibility requirements of this Section, will be eligible for Coverage under the Group Agreement if properly enrolled for Coverage and upon payment of the required Premium for such Coverage. If there is any question about whether a person is eligible for Coverage, the Employer shall make final eligibility determinations in accordance with the requirements of this EOC and the Group Agreement. At the group or Employer’s request, this plan may not cover Spouses or dependent children. Check with your benefits representative for full details.

A. Subscriber

To be eligible to enroll as a Subscriber, an Employee must:

1. Be a full-time Employee of the Group who is Actively at Work; and
2. Satisfy all eligibility requirements of the Employer and Group Agreement; and
3. Enroll for Coverage by (a) submitting a completed and signed Enrollment Form or other required documentation to the Plan, or (b) submitting a completed Enrollment Form or other required documentation electronically to the Plan.

For leaves of absence, please refer to the Continuation of Coverage section of this EOC.

B. Covered Dependents

You can apply for Coverage for Your dependents. You must list Your dependents on the Enrollment Form. To qualify as a Covered Dependent, each dependent must meet all dependent eligibility criteria established by the Employer, satisfy all eligibility requirements of the Dental Group Agreement and be either:

1. The Subscriber’s current spouse as defined by the Employer, which may include a Domestic Partner; or
2. The Subscriber’s or the Subscriber’s spouse’s: (1) natural child; (2) legally adopted child (including children placed with the Subscriber for the purpose of adoption); (3) step-child(ren); or (4) children for whom the Subscriber or the Subscriber’s spouse are legal guardians; who are less than 26 years old; or
3. A child of the Subscriber or the Subscriber’s spouse for whom a Qualified Medical Child Support Order has been issued.
4. An Incapacitated Child of the Subscriber or Subscriber’s spouse.

Dependents who permanently reside outside the United States are not eligible for Coverage under the EOC.

Subscribers who are not U.S. citizens, do not reside in the United States, and work at an Employer’s location not located in the United States, are not eligible for Coverage under the EOC.

The Employer’s determination of eligibility under the terms of this provision shall be conclusive.

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The Plan reserves the right to require proof of eligibility including, but not limited to, a certified copy of any Qualified Medical Child Support Order or certification of Full-Time Student status.

C. Loss of Eligibility

Coverage for a Member who has lost his/her eligibility shall automatically terminate at 12:00 midnight on the day that loss of eligibility occurred.
ATTACHMENT E: STATEMENT OF ERISA RIGHTS

For the purposes of this Attachment E, the term, “Plan” means the employee welfare benefit plan sponsored by the Plan Sponsor (usually, the Employer.) The Employee Retirement Income Security Act of 1974 (ERISA) entitles You, as a Member of the group under this Plan, to:

1. Examine, without charge, at the office of the Plan Administrator (Plan Sponsor, usually the Employer) and at other specified locations, such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements, and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions;

2. Obtain copies of all plan documents and other plan information upon written request to the plan administrator (plan sponsor, i.e., the Employer.) The administrator may make a reasonable charge for these copies; and

3. Receive a summary of the plan’s annual financial report. The plan administrator (plan sponsor, usually the Employer) is required by law to furnish each participant with a copy of this summary annual report.

4. Obtain a statement telling You whether You have a right to receive a pension at normal retirement age and if so, what Your benefits would be at normal retirement age if You stop working under the Plan now. If You do not have a right to a pension, the statement will tell You how many more years You have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The Plan must provide the statement free of charge.

5. Continue Your health care Coverage if there is a loss of Coverage under the Plan as a result of a qualifying event. You may have to pay for such Coverage. Review the Continuation of Coverage section of this EOC for the rules governing Your COBRA Continuation Coverage rights.

In addition to creating rights for the Subscribers and other Employees, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan are called “fiduciaries” of the plan. They must handle the plan prudently and in the interest of Subscriber’s and other plan participants and beneficiaries. No one, including the Employer, the union, or any other person, may fire the Subscriber or otherwise discriminate against the Subscriber in any way to prevent the Subscriber from obtaining a welfare benefit or exercising rights under ERISA. If Your claim for welfare benefits is denied, in whole or in part, You must receive an explanation of the reason for the denial. You have the right to have the plan review Your claim and reconsider it.

Under ERISA, there are steps You can take to enforce the above rights.

For instance, if You request materials 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 (plan sponsor, i.e., Your Employer) to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If Your claim for benefits is denied or ignored, in whole or in part, You may file suit in a state or federal court. If 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 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, it may order You to pay these expenses if it finds Your claim is frivolous.

If You have any questions about Your Plan, You should contact the Plan Administrator (Plan Sponsor, usually, Your Employer). 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 Sponsor, You should contact the nearest Office of the Employee Benefits Security Administration, U. S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 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.
ATTACHMENT F

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

LEGAL OBLIGATIONS

BlueCross BlueShield of Tennessee, Inc. and some subsidiaries and affiliates (BlueCross) are required to maintain the privacy of all health plan information, which may include Your: name, address, diagnosis codes, etc. as required by applicable laws and regulations (hereafter referred to as “legal obligations”); provide this notice of privacy practices to all members, inform members of the company’s legal obligations; and advise members of additional rights concerning their health plan information. BlueCross must follow the privacy practices contained in this notice from its effective date, until this notice is changed or replaced.

BlueCross reserves the right to change privacy practices and the terms of this notice at any time, as permitted by the legal obligations. Any changes made in these privacy practices will be effective for all health plan information that is maintained, including health plan information created or received before the changes are made. All members will be notified of any changes by receiving a new notice of the company’s privacy practices.

You may request a copy of this notice of privacy practices at any time by contacting BlueCross at the address on the back of this notice.

ORGANIZATIONS COVERED BY THIS NOTICE

This notice applies to the privacy practices of BlueCross BlueShield of Tennessee, Inc. and its subsidiaries or affiliated covered entities. Medical information about Our subscribers and members may be shared with each other as needed for treatment, payment or health care operations.

USES AND DISCLOSURES OF MEDICAL INFORMATION

Your health plan information may be used and disclosed for treatment, payment, and health care operations, for example:

TREATMENT: Your health plan information may be disclosed to a health care provider that asks for it to provide treatment.

PAYMENT: Your health plan information may be used or disclosed to pay claims for services or to coordinate benefits, which are covered under Your health insurance policy.

HEALTH CARE OPERATIONS: Your health plan information may be used and disclosed to determine premiums, conduct quality assessment and improvement activities, to engage in
care coordination or case management, accreditation, conducting and arranging legal services, fraud prevention and investigation, wellness, disease management, and for other similar administrative purposes.

**AUTHORIZATIONS:** You may provide written authorization to use Your medical information or to disclose it to anyone for any purpose. You may revoke Your authorization in writing at any time. That revocation will not affect any use or disclosure permitted by Your authorization while it was in effect. BlueCross cannot use or disclose Your health plan information except those described in this notice, without Your written authorization. Examples of where an authorization would be required: Most uses and disclosures of psychotherapy notes (if recorded by a covered entity), uses and disclosures for marketing purposes, disclosures that constitute a sale of PHI, other uses and disclosures not described in this notice.

**PERSONAL REPRESENTATIVE:** Your health plan information may be disclosed to a family member, friend or other person as necessary to help with Your health care or with payment for Your health care. You must agree that the company may do so, as described in the Individual Rights section of this notice.

**PLAN SPONSORS:** Your health plan information, and the health plan information of others enrolled in Your group health plan, may be disclosed to Your Plan sponsor in order to perform Plan administration functions. Please see Your Plan documents for a full description of the uses and disclosures the Plan sponsor may make of Your health plan information in such circumstances.

**UNDERWRITING:** Your health plan information may be received for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a health insurance or benefits contract. If the company does not issue that contract, Your health plan information will not be used or further disclosed for any other purpose, except as required by law; Additionally, health plans are prohibited from using or disclosing genetic information of an individual for underwriting purposes pursuant to the Genetic Information Nondiscrimination Act of 2008 (GINA).

**MARKETING:** Your health plan information may be used to provide information about health-related benefits, services or treatment alternatives that may be of interest to You. Your health plan information may be disclosed to a business associate assisting Us in providing that information to You. We will not market products or services other than health-related products or services to You unless You affirmatively opt-in to receive information about non-health products or services We may be offering. You have the right to opt out of fundraising communications.

**RESEARCH:** Your health plan information may be used or disclosed for research purposes, as allowed by law.

**YOUR DEATH:** If You die, Your health plan information may be disclosed to a coroner, medical examiner, funeral director or organ procurement organization.

**AS REQUIRED BY LAW:** Your health plan information may be used or disclosed as required by state or federal laws.
COURT OR ADMINISTRATIVE ORDER: Health plan information may be disclosed in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances.

VICTIM OF ABUSE: If You are reasonably believed to be a victim of abuse, neglect, domestic violence or other crimes, health plan information may be released to the extent necessary to avert a serious threat to Your health or safety or to the health or safety of others. Health plan information may be disclosed, when necessary, to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

MILITARY AUTHORITIES: Health plan information of Armed Forces personnel may be disclosed to Military authorities under certain circumstances. Health plan information may be disclosed to authorized federal officials as required for lawful intelligence, counterintelligence, and other national security activities.

INDIVIDUAL RIGHTS

1. DESIGNATED RECORD SET: You have the right to look at or get copies of Your health plan information, with limited exceptions. You must make a written request, using a form available from the Privacy Office, to obtain access to Your health plan information. If You request copies of Your health plan information, You will be charged $.25 per page, $10 per hour for staff time required to copy that information, and postage if You want the copies mailed to You. If You request an alternative format, the charge will be based upon the cost of providing Your health plan information in the requested format. If You prefer, the company will prepare a summary or explanation of Your health plan information for a fee. For a more detailed explanation of the fee structure, please contact the Privacy Office. The company requires advance payment before copying Your health plan information.

2. ACCOUNTING OF DISCLOSURES: You have the right to receive an accounting of any disclosures of Your health plan information made by the company or a business associate for any reason, other than treatment, payment, or health care operations purposes within the past six years. This accounting will include the date the disclosure was made, the name of the person or entity the disclosure was made to, a description of the health plan information disclosed, the reason for the disclosure, and certain other information. If You request an accounting more than once in a 12-month period, there may be a reasonable cost-based charge for responding to those additional requests. Please contact the Privacy Office for a more detailed explanation of the fees charged for such accountings.

3. RESTRICTION REQUESTS: You have the right to request restrictions on the company’s use or disclosure of Your health plan information. The company is not required to agree to such requests. The company will only restrict the use or disclosure of Your health plan information as set forth in a written agreement that is signed by a representative of the Privacy Office on behalf of the company.

4. BREACH NOTICE: You have the right to notice following a breach of unsecured protected health information. The notice of a breach of unsecured protected health information shall at a minimum include the following: The date of the breach, the type of data disclosed in the breach, who made the non-permitted access, use or disclosure of unsecured protected health information and who received the non-permitted disclosure, and what corrective business action was or will be taken to prevent further non-permitted access, uses or disclosures of unsecured protected health information.
5. **CONFIDENTIAL COMMUNICATIONS:** If You reasonably believe that sending health plan information to You in the normal manner will endanger You, You have the right to make a written request that the company communicate that information to You by a different method or to a different address. If there is an immediate threat, You may make that request by calling a BlueCross BlueShield of Tennessee Customer Service Representative or the Privacy Officer at 1-888-455-3824. Follow up with a written request is required as soon as possible. The company must accommodate Your request if it is reasonable, specifies how and where to communicate with You, and continues to permit collection of Premium and payment of claims under Your health plan.

6. **AMENDMENT REQUESTS:** You have the right to make a written request that the company amend Your health plan information. Your request must explain why the information should be amended. The company may deny Your request if the health plan information You seek to amend was not created by the company or for other reasons permitted by its legal obligations. If Your request is denied, the company will provide a written explanation of the denial. If You disagree, You may submit a written statement that will be included with Your health plan information. If the company accepts Your request, reasonable efforts will be made to inform the people that You designate about that amendment. Any future disclosures of that information will be amended.

7. **RIGHT TO REQUEST WRITTEN NOTICE:** If You receive this notice on the company’s web site or by electronic mail (e-mail), You may request a written copy of this notice, by contacting the Privacy Office.

**QUESTIONS AND COMPLAINTS**

If You want more information concerning the company’s privacy practices or have questions or concerns, please contact the Privacy Office.

If You are concerned that: (1) the company has violated Your privacy rights; (2) You disagree with a decision made about access to Your health plan information or in response to a request You made to amend or restrict the use or disclosure of Your health plan information; (3) to request that the company communicate with You by alternative means or at alternative locations; please contact the privacy office.

You may also submit a written complaint to the U.S. Department of Health and Human Services. The company will furnish the address where You can file a complaint with the U.S. Department of Health and Human Services upon request.

The company supports Your right to protect the privacy of Your health plan information. There will be no retaliation in any way if You choose to file a complaint with BlueCross BlueShield of Tennessee or subsidiaries or affiliates, or with the U.S. Department of Health and Human Services.

**BlueCross BlueShield of Tennessee, Inc.**
**The Privacy Office**
**1 Cameron Hill Circle**
**Chattanooga, TN 37402**
**(888) 455-3824**

BCBST – PDC – EOC 2008

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GENERAL LEGAL PROVISIONS

INDEPENDENT LICENSEE OF THE BLUECROSS BLUESHIELD ASSOCIATION

BlueCross BlueShield of Tennessee, Inc. is an independent corporation operating under a license from the BlueCross BlueShield Association (the “Association.”) That license permits BlueCross BlueShield of Tennessee, Inc. to use the Association’s service marks within its assigned geographical location. BlueCross BlueShield of Tennessee, Inc. is not a joint venturer, agent or representative of the Association nor any other independent licensee of the Association.

SUBROGATION AND RIGHT OF RECOVERY

The Group has agreed that the Plan shall be subrogated to and/or have the right to recover amounts paid to provide Covered Services to Group Members for illnesses or injuries caused by third parties, including the right to recover the reasonable value of prepaid services rendered by Network Dentists.

When this Plan is primary, the Plan shall have first lien against any payment, judgment or settlement of any kind that a Member receives from or on behalf of such third parties for medical expenses, for the costs of Covered Services and any costs of recovering such amounts from those third parties. The Plan may notify those parties of its lien without notice to or consent from those Members.

The Plan may enforce its rights of subrogation and recovery against, without limitation, any tort feasors, other responsible third parties or against available insurance coverages, including underinsured or uninsured motorist coverages. Such actions may be based in tort, contract or other cause of action to the fullest extent permitted by law.

The Group has agreed that Members shall be required to promptly notify the Plan if they are involved in an incident that gives rise to such rights for subrogation and recovery to enable the Plan to protect its rights under this section. Members are also required to cooperate with the Plan and to execute any documents that the Plan deems necessary to protect its rights under this section.

If a Member settles any claim or action without Our consent against any third party, that Member shall be deemed to have been made whole by the settlement and the Plan shall be entitled to immediately collect the present value of its rights as the first priority claim from the settlement fund. Any such proceeds of settlement or judgment shall be held in trust by the Member for the benefit of the Plan. The Plan shall also be entitled to recover reasonable attorneys’ fees incurred in collecting proceeds held by the Member in such circumstances.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

A Subscriber may continue his or her Coverage and Coverage for his or her Dependents during military leave of absence in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994. When the Subscriber returns to work from a military leave of absence, the Subscriber will be given credit for the time the Subscriber was covered under the Plan prior to the leave. Check with the Employer to see if this provision applies.
Cigna Dental Care
DHMO Insurance

Summary Plan Description

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

CIGNA DENTAL CARE INSURANCE

EFFECTIVE DATE: May 1, 2016

CN001
3339835

This document printed in May, 2016 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.
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CIGNA HEALTH AND LIFE INSURANCE COMPANY
a Cigna company (hereinafter called Cigna) certifies that it insures certain Employees for the benefits provided by the following policy(s):

POLICYHOLDER: Vanderbilt University Medical Center

GROUP POLICY(S) — COVERAGE
3339835 - DHMO  CIGNA DENTAL CARE INSURANCE

EFFECTIVE DATE: May 1, 2016

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.

Anna Krishtul, Corporate Secretary

HC-CER17 04-10 V1
**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 New Employee Group 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.

Initial Employee Group: You are in the Initial Employee Group if you are employed in a class of employees on the date that class of employees becomes a Class of Eligible Employees as determined by your Employer.

New Employee Group: You are in the New Employee Group if you are not in the Initial Employee Group.

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
Initial Employee Group: None.
New Employee Group: 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 the first day of the month after the end of that Open Enrollment Period in which you elect it.

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.

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 Cigna 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).

Choice of Dental Office
When you elect Employee Insurance, you may select a Dental Office from the list provided by CDH. If your first choice of a Dental Office is not available, you will be notified by CDH of your designated Dental Office, based on your alternate selection. You and each of your insured Dependents may select your own designated Dental Office. No Dental Benefits are covered unless the Dental Service is received from your designated Dental Office, referred by a Network General Dentist at that facility to a specialist approved by CDH, or
otherwise authorized by CDH, except for Emergency Dental Treatment. A transfer from one Dental Office to another Dental Office may be requested by you through CDH. Any such transfer will take effect on the first day of the month after it is authorized by CDH. A transfer will not be authorized if you or your Dependent has an outstanding balance at the Dental Office.

Dental Benefits – Cigna Dental Care

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

Member Services
If you have any questions or concerns about the Dental Plan, Member Services Representatives are just a toll-free phone call away. They can explain your benefits or help with matters regarding your Dental Office or Dental Plan. 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 Member Services from any location at 1-800-Cigna24. The hearing impaired may contact the state TTY toll-free relay service number listed in their local telephone directory.

Other Charges – Patient Charges
Your Patient Charge Schedule lists the dental procedures covered under your Dental Plan. Some dental procedures are covered at no charge to you. For other Covered Services, the Patient Charge Schedule lists the fees you must pay when you visit your Dental Office. There are no deductibles and no annual dollar limits for services covered by your Dental Plan.

Your Network General Dentist should tell you about Patient Charges for Covered Services, the amount you must pay for non-Covered Services and the Dental Office's payment policies. Timely payment is important. It is possible that the Dental Office may add late charges to overdue balances.

Your Patient Charge Schedule is subject to annual change. Cigna Dental will give written notice to your Group of any change in Patient Charges at least 60 days prior to such change. You will be responsible for the Patient Charges listed on the Patient Charge Schedule that is in effect on the date a procedure is started.

Choice of Dentist
You and your Dependents should have selected a Dental Office when you enrolled in the Dental Plan. If you did not, you must advise Cigna Dental of your Dental Office selection prior to receiving treatment. The benefits of the Dental Plan are available only at your Dental Office, except in the case of an emergency or when Cigna Dental otherwise authorizes payment for out-of-network benefits.

You may select a network Pediatric Dentist as the Network General Dentist for your dependent child under age 7 by calling Member Services at 1-800-Cigna24 for a list of network Pediatric Dentists in your Service Area or, if your Network General Dentist sends your child under age 7 to a network Pediatric Dentist, the network Pediatric Dentist’s office will have primary responsibility for your child’s care. Your Network General Dentist will provide care for children 7 years and older. If your child continues to visit the Pediatric Dentist after his/her 7th birthday, you will be fully responsible for the Pediatric Dentist’s Usual Fees. Exceptions for medical reasons may be considered on a case-by-case basis.

If for any reason your selected Dental Office cannot provide your dental care, or if your Network General Dentist terminates from the network, Cigna Dental will let you know and will arrange a transfer to another Dental Office. Refer to the Section titled "Office Transfers" if you wish to change your Dental Office.

To obtain a list of Dental Offices near you, visit our website at myCigna.com, or call the Dental Office Locator at 1-800-Cigna24. It is available 24 hours a day, 7 days per week. If you would like to have the list faxed to you, enter your fax number, including your area code. You may always obtain a current Dental Office Directory by calling Member Services.

Your Payment Responsibility (General Care)
For Covered Services provided by your Dental Office, you will be charged the fees listed on your Patient Charge Schedule. For services listed on your Patient Charge Schedule at any other dental office, you may be charged Usual Fees. For non-Covered Services, you are responsible for paying Usual Fees.

If, on a temporary basis, there is no Network General Dentist in your Service Area, Cigna Dental will let you know and you may obtain Covered Services from a non-network Dentist. You will pay the non-network Dentist the applicable Patient Charge for Covered Services. Cigna Dental will pay the non-network Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge.

See the Specialty Referrals section regarding payment responsibility for specialty care.

All contracts between Cigna Dental and network Dentists state that you will not be liable to the network Dentist for any sums owed to the network Dentist by Cigna Dental.
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. You should contact your Network General Dentist if you have an emergency in your Service Area.

- Emergency Care Away From Home
  If you have an emergency while you are out of your Service Area or unable to contact your Network General Dentist, you may receive emergency Covered Services as defined above from any general dentist. Routine restorative procedures or definitive treatment (e.g. root canal) are not considered emergency care. You should return to your Network General Dentist for these procedures. For emergency Covered Services, you will be responsible for the Patient Charges listed on your Patient Charge Schedule. Cigna Dental will reimburse you the difference, if any, between the dentist’s Usual Fee for emergency Covered Services and your Patient Charge, up to a total of $50 per incident. To receive reimbursement, send appropriate reports and x-rays to Cigna Dental at the address listed for your state on the front of this booklet.

- Emergency Care After Hours
  There is a Patient Charge listed on your Patient Charge Schedule for emergency care rendered after regularly scheduled office hours. This charge will be in addition to other applicable Patient Charges.

Limitations on Covered Services

Listed below are limitations on services when covered by your Dental Plan:

- Frequency – The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.

- Pediatric Dentistry – Coverage for treatment by a Pediatric Dentist ends on your child's 7th birthday. Effective on your child’s 7th birthday, dental services must be obtained from a Network General Dentist; however, exceptions for medical reasons may be considered on an individual basis.

- Oral Surgery – The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Your Patient Charge Schedule lists any limitations on oral surgery.

- Periodontal (gum tissue and supporting bone) Services – Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule.

Localized delivery of antimicrobial agents is limited to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule.

- Clinical Oral Evaluations – When this limitation is noted on the Patient Charge Schedule, periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under 3 years of age are limited to a combined total of 4 evaluations during a 12 consecutive month period.

- Surgical Placement of Implant Services – When covered on the Patient Charge Schedule, surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant are limited to one per year with replacement of a surgical implant frequency limitation of one every 10 years.

- Prosthesis Over Implant – When covered on the Patient Charge Schedule, a prosthetic device, supported by an implant or implant abutment is considered a separate distinct service(s) from surgical placement of an implant. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only covered if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.

General Limitations - Dental Benefits

No payment will be made for expenses incurred or services received:

- for or in connection with an Injury arising out of, or in the course of, any employment for wage or profit;

- for charges which would not have been made in any facility, other than a Hospital or a Correctional Institution owned or operated by the United States Government or by a state or municipal government if the person had no insurance;

- to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received;

- for charges which the person is not legally required to pay;

- for charges which would not have been made if the person had no insurance;

- due to injuries which are intentionally self-inflicted.

Services Not Covered Under Your Dental Plan

Listed below are the services or expenses which are NOT covered under your Dental Plan and which are your responsibility at the dentist's Usual Fees. There is no coverage for:

- services not listed on the Patient Charge Schedule.

- services provided by a non-network Dentist without Cigna Dental's prior approval (except in emergencies).
• services related to an injury or illness paid under workers' compensation, occupational disease or similar laws.
• services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
• services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.
• cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless the service is specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your Patient Charge Schedule, only the use of take-home bleaching gel with trays is covered; other types of bleaching methods are not covered.
• general anesthesia, sedation and nitrous oxide, unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, general anesthesia and IV Sedation are covered when medically necessary and provided in conjunction with Covered Services performed by an Oral Surgeon or Periodontist. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.
• prescription medications.
• procedures, appliances or restorations if the main purpose is to: change vertical dimension (degree of separation of the jaw when teeth are in contact); restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction; or restore the occlusion.
• replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.
• surgical placement of a dental implant; repair, maintenance or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant, unless specifically listed on your Patient Charge Schedule.
• services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
• procedures or appliances for minor tooth guidance or to control harmful habits.
• hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for network Dentist charges for covered services performed at a hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination.)
• the completion of crowns, bridges, dentures or root canal treatment already in progress on the effective date of your Cigna Dental coverage.

myCigna.com
**Appointments**

To make an appointment with your network Dentist, call the Dental Office that you have selected. When you call, your Dental Office will 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 hours notice to the Dental Office, you may be charged a broken appointment fee.

**Office Transfers**

If you decide to change Dental Offices, we can arrange a transfer. You should complete any dental procedure in progress before transferring to another Dental Office. To arrange a transfer, call Member Services at 1-800-Cigna24. To obtain a list of Dental Offices near you, visit our website at myCigna.com, or call the Dental Office Locator at 1-800-Cigna24. Your transfer request will take about 5 days to process. Transfers will be effective the first day of the month after the processing of your request. Unless you have an emergency, you will be unable to schedule an appointment at the new Dental Office until your transfer becomes effective. There is no charge to you for the transfer; however, all Patient Charges which you owe to your current Dental Office must be paid before the transfer can be processed.

**Specialty Care**

Your Network General Dentist at your Dental Office has primary responsibility for your professional dental care. Because you may need specialty care, the Cigna Dental network includes the following types of specialty dentists:

- Pediatric Dentists – children's dentistry.
- Periodontists – treatment of gums and bone.
- Oral Surgeons – complex extractions and other surgical procedures.
- Orthodontists – tooth movement.

When specialty care is needed, your Network General Dentist must start the referral process. X-rays taken by your Network General Dentist should be sent to the Network Specialty Dentist.

**Specialty Referrals**

**In General**

Upon referral from a Network General Dentist, your Network Specialty Dentist will submit a specialty care treatment plan to Cigna Dental for payment authorization, except for Pediatric Dentistry and Endodontics, for which prior authorization is not required. You should verify with the Network Specialty Dentist that your treatment plan has been authorized for payment by Cigna Dental before treatment begins.

When Cigna Dental authorizes payment to the Network Specialty Dentist, the fees or no-charge services listed on the Participant Charge Schedule in effect on the date each procedure is started will apply, except as set out in the Orthodontics section. Treatment by the Network Specialty Dentist must begin within 90 days from the date of Cigna Dental’s authorization. If you are unable to obtain treatment within the 90-day period, please call Member Services to request an extension. Your coverage must be in effect when each procedure begins.

For non-Covered Services or if Cigna Dental does not authorize payment to the Network Specialty Dentist for Covered Services, including Adverse Determinations, you must pay the Network Specialty Dentist’s Usual Fee. If you have a question or concern regarding an authorization or a denial, contact Member Services.

After the Network Specialty Dentist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment. If you visit a Network Specialty Dentist without a referral or if you continue to see a Network Specialty Dentist after you have completed specialty care, it will be your responsibility to pay for treatment at the dentist’s Usual Fees.

When your Network General Dentist determines that you need specialty care and a Network Specialty Dentist is not available, as determined by Cigna Dental, Cigna Dental will authorize a referral to a non-Network Specialty Dentist. The referral procedures applicable to specialty care will apply. In such cases, you will be responsible for the applicable Patient Charge for Covered Services. Cigna Dental will reimburse the non-network Dentist the difference, if any, between his or her Usual Fee and the applicable Patient Charge. For non-Covered Services or services not authorized for payment, including Adverse Determinations, you must pay the dentist’s Usual Fee.

**Orthodontics** - (This section is only applicable if Orthodontics is listed on your Patient Charge Schedule.)

**Definitions** –

- **Orthodontic Treatment Plan and Records** – the preparation of orthodontic records and a treatment plan by the Orthodontist.
- **Interceptive Orthodontic Treatment** – treatment prior to full eruption of the permanent teeth, frequently a first phase preceding comprehensive treatment.
- **Comprehensive Orthodontic Treatment** – treatment after the eruption of most permanent teeth, generally the final phase of treatment before retention.
• Retention (Post Treatment Stabilization) – the period following orthodontic treatment during which you may wear an appliance to maintain and stabilize the new position of the teeth.

Patient Charges
The Patient Charge for your entire orthodontic case, including retention, will be based upon the Patient Charge Schedule in effect on the date of your visit for Treatment Plan and Records. However, if banding/appliance insertion does not occur within 90 days of such visit; your treatment plan changes; or there is an interruption in your coverage or treatment, a later change in the Patient Charge Schedule may apply.

The Patient Charge for Orthodontic Treatment is based upon 24 months of interceptive and/or comprehensive treatment. If you require more than 24 months of treatment in total, you will be charged an additional amount for each additional month of treatment, based upon the Orthodontist's Contract Fee. If you require less than 24 months of treatment, your Patient Charge will be reduced on a prorated basis.

Additional Charges
You will be responsible for the Orthodontist's Usual Fees for the following non-Covered Services:

• incremental costs associated with optional/elective materials, including but not limited to ceramic, clear, lingual brackets, or other cosmetic appliances;
• orthognathic surgery and associated incremental costs;
• appliances to guide minor tooth movement;
• appliances to correct harmful habits; and
• services which are not typically included in orthodontic treatment. These services will be identified on a case-by-case basis.

Orthodontics in Progress
If orthodontic treatment is in progress for you or your Dependent at the time you enroll, the fee listed on the Patient Charge Schedule is not applicable. Please call Member Services at 1-800-Cigna24 to find out if you are entitled to any benefit under the Dental Plan.

Complex Rehabilitation/Multiple Crown Units
Complex rehabilitation is extensive dental restoration involving 6 or more "units" of crown, and/or bridge and/or implant supported prosthesis (including crowns and bridges) in the same treatment plan. Using full crowns (caps), and/or fixed bridges and/or implant supported prosthesis (including crowns and bridges) which are cemented in place, your Network General Dentist will rebuild natural teeth, fill in spaces where teeth are missing and establish conditions which allow each tooth to function in harmony with the occlusion (bite). The extensive procedures involved in complex rehabilitation require an extraordinary amount of time, effort, skill and laboratory collaboration for a successful outcome. Complex rehabilitation will be covered when performed by your Network General Dentist after consultation with you about diagnosis, treatment plan and charges. Each tooth or tooth replacement included in the treatment plan is referred to as a "unit" on your Patient Charge Schedule. The crown, and bridge and/or implant supported prosthesis (including crowns and bridges) charges on your Patient Charge Schedule are for each unit of crown or bridge. You pay the per unit charge for each unit of crown, and/or bridge and/or implant supported prosthesis (including crowns and bridges) PLUS an additional charge for each unit when 6 or more units are prescribed in your Network General Dentist's treatment plan.

Note: Complex rehabilitation only applies for implant supported prosthesis, when implant supported prosthesis are specifically listed on your Patient Charge Schedule.

Coordination of Benefits
Under this dental plan Coordination of Benefits rules apply to specialty care only.

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.

Definitions
For the purposes of this section, the following terms have the meanings set forth below:

Plan
Any of the following that provides benefits or services for medical or dental care or treatment:

• Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
• Governmental benefits as permitted by law, excepting Medicaid, Medicare and Medicare supplement policies.
• Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Closed Panel Plan
A Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or
contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

**Primary Plan**
The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

**Secondary Plan**
A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

**Allowable Expense**
A necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

**Claim Determination Period**
A calendar year, but does not include any part of a year during which you are not covered under this policy or any date before this section or any similar provision takes effect.

**Reasonable Cash Value**
An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

**Order of Benefit Determination Rules**
A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;
- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child;
  - then, the Plan of the parent not having custody of the child, and
  - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result,
the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

**Effect on the Benefits of This Plan**

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than 100% of the total of all Allowable Expenses.

The difference between the amount that this Plan would have paid if this Plan had been the Primary Plan, and the benefit payments that this Plan had actually paid as the Secondary Plan, will be recorded as a benefit reserve for you. Cigna will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

As each claim is submitted, Cigna will determine the following:

- Cigna’s obligation to provide services and supplies under this policy;
- whether a benefit reserve has been recorded for you; and
- whether there are any unpaid Allowable Expenses during the Claim Determination Period.

If there is a benefit reserve, Cigna will use the benefit reserve recorded for you to pay up to 100% of the total of all Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero and a new benefit reserve will be calculated for each new Claim Determination Period.

**Recovery of Excess Benefits**

If Cigna pays charges for benefits that should have been paid by the Primary Plan, or if Cigna pays charges in excess of those for which we are obligated to provide under the Policy, Cigna will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

Cigna will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

**Right to Receive and Release Information**

Cigna, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

**Expenses for Which a Third Party May Be Responsible**

Cigna shall, to the extent permitted by law, be subrogated to all rights, claims or interests which you may have against such party for dental expenses and shall automatically have a lien upon the proceeds of any recovery by you from such party to the extent of any benefits paid for such expenses under the Policy. Cigna’s right of subrogation is second to your right to be fully compensated for damages. You or your representative shall execute such documents as may be required to secure Cigna’s subrogation rights.

To the extent that benefits are provided or paid under this Policy, you agree that if you fully recover damages from a third party, you will refund to Cigna the amount actually paid for such Covered Expenses by Cigna less any amount required to cover damages in full, from the amount you actually received from the third party for such Covered Expenses at the time that the third party’s liability is determined and satisfied, whether by settlement, judgment arbitration or award or otherwise.

**Payment of Benefits**

**To Whom Payable**

Dental Benefits are assignable to the provider. When you assign benefits to a provider, you have assigned the entire amount of the benefits due on that claim. If the provider is overpaid because of accepting a patient’s payment on the charge, it is the provider’s responsibility to reimburse the patient. Because of Cigna’s contracts with providers, all claims from contracted providers should be assigned.

Cigna may, at its option, make payment to you for the cost of any Covered Expenses from a Non-Participating Provider.
even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependents are responsible for reimbursing the provider.

If any person to whom benefits are payable is a minor or, in the opinion of Cigna is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

When one of our participants passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

Payment as described above will release Cigna from all liability to the extent of any payment made.

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna will have the right: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment. Recovery of overpayment is limited to 18 months from the date the claim was paid. However, this 18 month time limit will not apply if the insured does not provide complete information, was not eligible for coverage or if material misstatements or fraud have occurred.

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 upon permanent breakdown of your relationship with your Dentist as determined by CDH, after at least two opportunities to transfer to another Dental Office.
- 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.
- the date, as determined by Cigna, of a continuing lack of participating Dental Office in your area.
- the date upon a determination of fraud or misuse of dental services and/or dental facilities.

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 premium for you; or otherwise cancels your insurance. However, your insurance will not be continued for more than 60 days past the date your Active Service ends.

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 premium for you or otherwise cancels the insurance.

Dependents

Your insurance for all of your Dependents will cease on the earliest date below:

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- with respect to your Dental benefits, the date upon permanent breakdown of your relationship with your Dentist as determined by CDH, after at least one
opportunity to transfer to another participating Dental Office.

- the date Dependent Insurance is canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

### Dental Benefits Extension

An expense incurred in connection with a Dental Service that is completed after a person’s benefits cease will be deemed to be incurred while he is insured if:

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the device installed or delivered to him within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

There is no extension for any Dental Service not shown above. This extension of benefits does not apply if insurance ceases due to nonpayment of premiums.

### 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 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 H.

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, strike, lockout, beginning or end of unpaid leave of absence, including under the Family and Medical Leave Act (FMLA), or change in worksite;

• changes in employment status of Employee, spouse or Dependent resulting in eligibility or ineligibility for coverage;
• change in residence of Employee, spouse or Dependent to a location outside of the Employer’s network service area; and
• changes which cause a Dependent to become eligible or ineligible for coverage.

C. Court Order
A change in coverage due to and consistent with a court order of the Employee or other person to cover a Dependent.

D. Medicare or Medicaid Eligibility/Entitlement
The Employee, spouse or Dependent cancels or reduces coverage due to entitlement to Medicare or Medicaid, or enrolls or increases coverage due to loss of Medicare or Medicaid eligibility.

E. Change in Cost of Coverage
If the cost of benefits increases or decreases during a benefit period, your Employer may, in accordance with plan terms, automatically change your elective contribution.

When the change in cost is significant, you may either increase your contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option you have elected, you may elect another available benefit option. When a new benefit option is added, you may change your election to the new benefit option.

F. Changes in Coverage of Spouse or Dependent Under Another Employer’s Plan
You may make a coverage election change if the plan of your spouse or Dependent: incurs a change such as adding or deleting a benefit option; allows election changes due to Change in Status, Court Order or Medicare or Medicaid Eligibility/Entitlement; or this Plan and the other plan have different periods of coverage or open enrollment periods.

G. Reduction in work hours
If an Employee’s work hours are reduced below 30 hours/week (even if it does not result in the Employee losing eligibility for the Employer’s coverage); and the Employee (and family) intend to enroll in another plan that provides Minimum Essential Coverage (MEC). The new coverage must be effective no later than the 1st day of the 2nd month following the month that includes the date the original coverage is revoked.

H. Enrollment in Qualified Health Plan (QHP)
The Employee must be eligible for a Special Enrollment Period to enroll in a QHP through a Marketplace or the Employee wants to enroll in a QHP through a Marketplace during the Marketplace’s annual open enrollment period; and the disenrollment from the group plan corresponds to the
intended enrollment of the Employee (and family) in a QHP through a Marketplace for new coverage effective beginning no later than the day immediately following the last day of the original coverage.

Eligibility for Coverage for Adopted Children

Any child who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance, if otherwise eligible as a Dependent, 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.

The provisions in the “Exception for Newborns” section of this document that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

Group Plan Coverage Instead of Medicaid

If your income and liquid resources do not exceed certain limits established by law, the state may decide to pay premiums for this coverage instead of Medicaid, if it is cost effective. This includes premiums for continuation coverage required by federal law.

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 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.
Your Employer may charge you and your Dependents up to 102% of the total premium.
Following continuation of health coverage per USERRA requirements, you may convert to a plan of individual coverage according to any “Conversion Privilege” shown in your certificate.

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.
You and your Dependents will be subject to only the balance of a waiting period that was not yet satisfied before the leave began. 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

Procedures Regarding Medical Necessity Determinations
In general, health services and benefits must be Medically Necessary to be covered under the plan. The procedures for determining Medical Necessity vary, according to the type of service or benefit requested, and the type of health plan.
You or your authorized representative (typically, your health care provider) must request Medical Necessity determinations according to the procedures described below, in the Certificate, and in your provider’s network participation documents as applicable.

When services or benefits are determined to be not Medically Necessary, you or your representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described in the Certificate, in your provider’s network participation documents, and in the determination notices.

Postservice Medical Necessity Determinations
When you or your representative requests a Medical Necessity determination after services have been rendered, Cigna will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Cigna’s control Cigna will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.
If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

Postservice Claim Determinations
When you or your representative requests payment for services which have been rendered, Cigna will notify you of the claim payment determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Cigna’s control, Cigna will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request. However, if more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

Notice of Adverse Determination
Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination:
- the specific reason or reasons for the adverse determination;
- reference to the specific plan provisions on which the determination is based;
- a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
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 declare or are not eligible for COBRA continuation.

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, 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 Cigna;
- 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
  - in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

**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 that 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.

**COBRA Continuation for Retirees Following Employer’s Bankruptcy**
If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to the Employer under Title 11 of the United States Code, you may be entitled to COBRA continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your...
covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under “Termination of COBRA Continuation” above.

**Interaction With Other Continuation Benefits**
You may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

**ERISA Required 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:
Chief Human Resources Officer
Vanderbilt University Medical Center Human Resources
2525 West End Avenue, 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:
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 Cigna 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 Type**
The plan is a healthcare benefit plan.

**Collective Bargaining Agreements**
You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective bargaining agreements and if a particular Employer is a sponsor. A copy is available for examination from the Plan Administrator upon written request.

**Discretionary Authority**
The Plan Administrator delegates to Cigna the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to Cigna the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

**Plan Modification, Amendment and Termination**
The Employer as Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other plan term or condition, and to terminate the whole plan or any part of it. Contact the Employer for the procedure by which benefits may be changed or terminated, by which the eligibility of classes of employees may be changed or terminated, or by which part or all of the Plan may be terminated. No consent of any participant is required to terminate, modify, amend or change the Plan.

Termination of the Plan together with termination of the insurance policy(s) which funds the Plan benefits will have no adverse effect on any benefits to be paid under the policy(s) for any covered medical expenses incurred prior to the date that policy(s) terminates. Likewise, any extension of benefits under the policy(s) due to you or your Dependent's total disability which began prior to and has continued beyond the date the policy(s) terminates will not be affected by the Plan termination. Rights to purchase limited amounts of life and medical insurance to replace part of the benefits lost because the policy(s) terminated may arise under the terms of the policy(s). A subsequent Plan termination will not affect the extension of benefits and rights under the policy(s).

Your coverage under the Plan’s insurance policy(s) will end on the earliest of the following dates:
- the date you leave Active Service (or later as explained in the Termination Section;)

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**Plan Trustees**
A list of any Trustees of the Plan, which includes name, title and address, is available upon request to the Plan Administrator.
• the date you are no longer in an eligible class;
• if the Plan is contributory, the date you cease to contribute;
• the date the policy(s) terminates.
See your Plan Administrator to determine if any extension of benefits or rights are available to you or your Dependents under this policy(s). No extension of benefits or rights will be available solely because the Plan terminates.

Statement of Rights
As a participant in 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 and union halls, 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 Employee Benefits Security Administration.
• obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The 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 person under the Plan with a copy of this summary financial report.

Continue Group Health Plan Coverage

• continue health care coverage for yourself, your 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 the documents governing the Plan on the rules governing your federal continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people 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. If your claim for a welfare benefit is denied or ignored 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.

Enforce Your Rights
Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of documents governing the plan or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance with Your Questions
If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security 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.

Dental Conversion Privilege
Any Employee or Dependent whose Dental Insurance ceases for a reason other than failure to pay any required contribution or cancellation of the policy may be eligible for coverage under another Dental Insurance Policy underwritten by Cigna; provided that: he applies in writing and pays the first premium
to Cigna within 31 days after his insurance ceases; and he is not considered to be overinsured.

CDH or Cigna, as the case may be, or the Policyholder will give the Employee, on request, further details of the Converted Policy.

Conversion is not available if your insurance ceased due to:

- nonpayment of required premiums;
- selection of alternate dental insurance by your group;
- fraud or misuse of the Dental Plan.

**Notice of an Appeal or a Grievance**

The appeal or grievance provision in this certificate may be superseded by the law of your state. Please see your explanation of benefits for the applicable appeal or grievance procedure.

**The Following Will Apply To Residents of Tennessee**

**When You Have a Complaint or an Appeal**

For the purposes of this section, any reference to "you," "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

**Start with Member Services**

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call our toll-free number and explain your concern to one of our Customer Service representatives. You can also express that concern in writing. Please call or write to us at the following:

Customer Services Toll-Free Number or address that appears on your Benefit Identification card, explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

**Appeals Procedure**

Cigna has a two step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call or write to us at the toll-free number or address on your Benefit Identification card, explanation of benefits or claim form.

**Level-One Appeal**

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level-one appeals, we will respond in writing with a decision within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

**Level-Two Appeal**

If you are dissatisfied with our level-one appeal decision, you may request a second review. To start a level-two appeal, follow the same process required for a level-one appeal.

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness, the Committee will consult with at least one Dentist reviewer in the same or similar specialty as the care under consideration, as determined by Cigna's Dentist reviewer. You may present your situation to the Committee in person or by conference call.

For level-two appeals we will acknowledge in writing that we have received your request and schedule a Committee review. For postservice claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five
working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

**Appeal to the State of Tennessee**

You have the right to contact the Department of Commerce and Insurance for assistance at any time. The Commissioner's Office may be contacted at the following address and telephone number:

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37423
800-342-4029

**Notice of Benefit Determination on Appeal**

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

**Relevant Information**

Relevant Information is any document, record, or other information which was relied upon in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

**Legal Action**

If your plan is governed by ERISA, you have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the Level-One and Level-Two Appeal processes. If your Appeal is expedited, there is no need to complete the Level-Two process prior to bringing legal action.

**Definitions**

**Active Service**

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.
- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

**Adverse Determination**

An Adverse Determination is a decision made by Cigna Dental that it will not authorize payment for certain limited specialty care procedures. Any such decision will be based on the necessity or appropriateness of the care in question. To be considered clinically necessary, the treatment or service must be reasonable and appropriate and must meet the following requirements. It must:

- be consistent with the symptoms, diagnosis or treatment of the condition present;
- conform to commonly accepted standards of treatment;
- not be used primarily for the convenience of the member or provider of care; and
- not exceed the scope, duration or intensity of that level of care needed to provide safe and appropriate treatment.
Requests for payment authorizations that are declined by Cigna Dental based upon the above criteria will be the responsibility of the member at the dentist’s Usual Fees.

Cigna Dental Health (herein referred to as CDH)
CDH is a wholly-owned subsidiary of Cigna Corporation that, on behalf of Cigna, contracts with Participating General Dentists for the provision of dental care. CDH also provides management and information services to Policyholders and Participating Dental Facilities.

Contract Fees
Contract Fees are the fees contained in the Network Specialty Dentist agreement with Cigna Dental which represent a discount from the provider’s Usual Fees.

Covered Services
Covered Services are the dental procedures listed in your Patient Charge Schedule.

Dental Office
Dental Office means the office of the Network General Dentist(s) that you select as your provider.

Dental Plan
The term Dental Plan means the managed dental care plan offered through the Group Contract between Cigna Dental and your Group.

Dentist
The term Dentist means a person practicing dentistry or oral surgery within the scope of his license. It will also include a provider operating within the scope of his license when he performs any of the Dental Services described in the policy.

Dependent
Dependents are:
- your lawful spouse; or
- your Domestic Partner; and
- any child of yours who is:
  - less than 26 years old.
  - 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability. Proof of the child's condition and dependence must be submitted to Cigna within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, Cigna may require proof of the continuation of such condition and dependence.

The term child means a child born to you or a child legally adopted by you, including that child from the first day of placement in your home regardless of whether the adoption has become final. It also includes a steppchild, a foster child, or a child for whom you are the legal guardian. If your Domestic Partner has a child, that child will also be included as a Dependent.

Benefits for a Dependent child will continue until the last day of the calendar month in which the limiting age is reached.
**Domestic Partner**
A Domestic Partner is defined as a person of the same sex who:
- shares your permanent residence;
- has resided with you for no less than one year;
- is no less than 18 years of age;
- is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements: common ownership of real property or a common leasehold interest in such property; community ownership of a motor vehicle; a joint bank account or a joint credit account; designation as a beneficiary for life insurance or retirement benefits or under your partner's will; assignment of a durable power of attorney or health care power of attorney; or such other proof as is considered by Cigna to be sufficient to establish financial interdependency under the circumstances of your particular case;
- is not a blood relative any closer than would prohibit legal marriage; and
- has signed jointly with you, a notarized affidavit attesting to the above which can be made available to Cigna upon request.

In addition, you and your Domestic Partner will be considered to have met the terms of this definition as long as neither you nor your Domestic Partner:
- has signed a Domestic Partner affidavit or declaration with any other person within twelve months prior to designating each other as Domestic Partners hereunder;
- is currently legally married to another person; or
- has any other Domestic Partner, spouse or spouse equivalent of the same or opposite sex.

You and your Domestic Partner must have registered as Domestic Partners, if you reside in a state that provides for such registration.

The section of this certificate entitled "COBRA Continuation Rights Under Federal Law" will not apply to your Domestic Partner and his or her Dependents.

**Employee**
The term Employee means a full-time employee of the Employer who is currently in Active Service. The term does not include employees who are part-time or temporary or who normally work less than 30 hours a week for the Employer.

**Employer**
The term Employer means the Policyholder and all Affiliated Employers.

**Group**
The term Group means the Employer, labor union or other organization that has entered into a Group Contract with Cigna Dental for managed dental services on your behalf.

**Medicaid**
The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

**Medicare**
The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.
Network General Dentist
A Network General Dentist is a licensed dentist who has signed an agreement with Cigna Dental to provide general dental care services to plan members.

Network Specialty Dentist
A Network Specialty Dentist is a licensed dentist who has signed an agreement with Cigna Dental to provide specialized dental care services to plan members.

Patient Charge Schedule
The Patient Charge Schedule is a separate list of covered services and amounts payable by you.

Subscriber
The subscriber is the enrolled employee or member of the Group.

Usual Fee
The customary fee that an individual Dentist most frequently charges for a given dental service.

Specialist
The term Specialist means any person or organization licensed as necessary: who delivers or furnishes specialized dental care services; and who provides such services upon approved referral to persons insured for these benefits.
Vanderbilt University Medical Center

EXTRATERRITORIAL LEGISLATION

EFFECTIVE DATE: May 1, 2016

ETALLD16A
3339835

This document printed in April, 2016 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.
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CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER

Policyholder: Vanderbilt University Medical Center  
Rider Eligibility: Each Employee as noted within this certificate rider  
Policy No. or Nos.: 3339835  
Effective Date: May 1, 2016

This rider forms a part of the certificate issued to you by Cigna describing the benefits provided under the policy(ies) specified above. This rider replaces any other issued to you previously.

IMPORTANT INFORMATION

For Residents of States other than the State of Tennessee:

State-specific riders contain provisions that may add to or change your certificate provisions.

The provisions identified in your state-specific rider, attached, are ONLY applicable to Employees residing in that state. The state for which the rider is applicable is identified at the beginning of each state specific rider in the "Rider Eligibility" section.

Additionally, the provisions identified in each state-specific rider only apply to:

(a) Benefit plans made available to you and/or your Dependents by your Employer;
(b) Benefit plans for which you and/or your Dependents are eligible;
(c) Benefit plans which you have elected for you and/or your Dependents;
(d) Benefit plans which are currently effective for you and/or your Dependents.

Please refer to the Table of Contents for the state-specific rider that is applicable for your residence state.

Anna Krishtul, Corporate Secretary

HC-ETRDR
CERTIFICATE RIDER – Arkansas Residents

Rider Eligibility: Each Employee who is located in Arkansas

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Arkansas for group insurance plans covering insureds located in Arkansas. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

Eligibility - Effective Date

Dependent Insurance

Exception for Newborns

Any Dependent child born while you are insured will become insured on the date of his birth if you elect Dependent Insurance no later than 90 days after his birth. If you do not elect to insure your newborn child within such 90 days, coverage for that child will end on the 90th day. No benefits for expenses incurred beyond the 90th day will be payable.

Definitions

Dependent

The term child means a child born to you or a child legally adopted by you from the date you file a petition for adoption.

Certification Rider – Indiana Residents

Rider Eligibility: Each Employee who is located in Indiana

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Indiana group insurance plans covering insureds located in Indiana. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

Notice to Policyholders Regarding Filing Complaints with the Department of Insurance

Questions regarding your policy or coverage should be directed to:

Cigna Health and Life Insurance Company
1-800-Cigna24

If you need the assistance of the governmental agency that regulates insurance; or have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.in.gov/idoi.
Definitions

Dependent
The term child means a legally adopted child including: a child who has been placed with you for adoption provided the child is not removed from placement prior to legal adoption or a child for whom entry of an order granting custody to you has been made.

CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – Minnesota Residents

Rider Eligibility: Each Employee who is located in Minnesota

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Minnesota group insurance plans covering insureds located in Minnesota. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

Dental Benefits – Cigna Dental Care

Your Payment Responsibility (General Care)
If Covered Services are provided by a non-Network Dentist without authorization, Cigna Dental will pay 50% of the value of the benefits you would have received if the services had been performed by a Network General Dentist. You will be responsible for the difference between this payment and the non-Network Dentist’s Usual Fee. The schedule of payments for non-Network Dentists is available from CDH upon request.

Services Not Covered Under Your Dental Plan
The services or expenses listed below are NOT covered under your Dental Plan and are your responsibility at the dentist's Usual Fees. There is no coverage for:

- procedures, appliances or restorations if the main purpose is to: change vertical dimension (degree of separation of the jaw when teeth are in contact) or restore teeth which have been damaged by attrition, abrasion, erosion and/or abfraction.

Specialty Care
Minnesota mandates coverage for the following procedures:

- plans that provide dependent coverage must provide coverage for a dependent child. Newborn infants are covered from the moment of birth. Such coverage must consist of benefits for an injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, including oral surgery and orthodontic procedures necessary for the treatment or management of cleft lip or cleft palate. If orthodontic services are eligible for coverage under this plan and another plan that is not dental coverage, then this plan shall be primary and the other plan shall be secondary in regard to the coverage described in this section.

- the surgical and non-surgical treatment of temporomandibular joint disorder and craniomandibular disorder. Such coverage shall be the same as for any other joint in the body.

Specialty Referrals

In General
If you choose to visit a non-Network Specialty Dentist, Cigna Dental will pay 50% of the value of the benefit you would have received if the services had been performed by a Network Specialty Dentist. You will be responsible for the difference between this payment and the non-Network Specialty Dentist’s Usual Fee.
Termination Of Insurance
Employees and Dependents

Special Continuation of Dental Insurance
If your Dental Insurance would otherwise cease because of a reduction in the number of hours you work or your termination of employment for any reason other than gross misconduct, you may continue the insurance by paying the required premium to the Employer. The insurance may be continued until the earliest of:

- 18 months from the date your Active Service ends;
- the last day for which you have paid the required premium;
- the date you become eligible for insurance under another group policy for dental benefits, including Medicare, unless you have a pre-existing condition for which the new policy limits coverage, in which case coverage under this Plan will continue until the pre-existing condition limitation has been satisfied, unless coverage under this Plan otherwise ends in accordance with this section;
- the date the policy cancels.

The Employer will notify you of your right to elect such continuation.

You must elect to continue insurance within 60 days of the later of:

- the date notice of the right to continue insurance is received;
- or
- the date the insurance would otherwise cease.

If your insurance is being continued, as outlined above, the insurance for any of your Dependents insured on the date your insurance would otherwise cease may be continued, subject to the above provisions. The insurance will continue until the earlier of:

- the date your insurance ceases; or
- with respect to any one Dependent, the date that Dependent no longer qualifies as a Dependent.

When this Special Provision ceases, the provisions of the "Dental Conversion Privilege" section will apply for your Dependents.

For Dependents of Deceased Employee
If you die while insured for your Dependents, the insurance for your Dependents will be continued in accordance with the "Dependent Dental Insurance After Your Death" provision.

However, if the Dependents elect to continue the insurance beyond the last day of the "Dependent Dental Insurance After Your Death" provision, they must notify the Employer within 90 days of your death and pay the required premium. Such continued insurance will cease on the earliest date below:

- the date coverage ends due to the Dependents' failure to make payment of the required premium;
- the date the insurance for your Dependents would have ceased if you had not died;
- the date the Dependent ceases to qualify as a Dependent, except as provided in the "Continuation for Dependent Children" provision;
- the date the Dependent becomes insured under another group health plan, including Medicare, except as provided in the "Continuation for Dependent Children" provision;
- the date the policy cancels.

Dependent Insurance After Divorce or Legal Separation
The Dental Expense Insurance for:

- your insured spouse; and
- any insured child who would cease to qualify as your Dependent as a result of your divorce or legal separation;
- may be continued, with premium payment, if you are required by decree to provide continued Dental Expense Insurance for them. However, the insurance on those Dependents will cease on the earliest date below:

- the date coverage ends due to your failure to make payment of the required premium;
- the date your insurance ceases;
- the date your Dependent ceases to qualify as a Dependent, other than due to the spouse's remarriage;
- the date the insurance for your Dependents would otherwise cease.

To have Dependent Dental Insurance continued, you must notify the Employer of the decree and pay any required contribution to the Employer within 30 days after the Dependent Dental Insurance would otherwise cease.

If you die, any other terms which continue Dependent Dental Insurance after your death will apply.

The Continuation for Dependent Children provision and Dental Conversion Privilege will be available when this Dependent Dental Insurance ceases.

Reinstatement of Insurance
If your coverage ceases because of active duty in: the armed forces of the United States, or the National Guard, the insurance for you and your Dependents will be reinstated after your deactivation, provided that:

- you apply for such reinstatement within 90 days after deactivation; and
• you are otherwise eligible.

Such reinstatement will be without the application of a new waiting period.

**CIGNA HEALTH AND LIFE INSURANCE COMPANY**, a Cigna company (hereinafter called Cigna)

**CERTIFICATE RIDER – Nevada Residents**

Rider Eligibility: Each Employee who is located in Nevada

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Nevada group insurance plans covering insureds located in Nevada. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

**Definitions**

If Domestic Partners are covered under the plan, then the following applies:

**Domestic Partner**

A Domestic Partner is defined as a person of the same or opposite sex who:

• shares your permanent residence;

• has resided with you for no less than one year;

• is no less than 18 years of age;

• is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements: common ownership of real property or a common leasehold interest in such property; community ownership of a motor vehicle; a joint bank account or a joint credit account; designation as a beneficiary for life insurance or retirement benefits or under your partner's will; assignment of a durable power of attorney or health care power of attorney; or such other proof as is considered by Cigna to be sufficient to establish financial interdependency under the circumstances of your particular case;

• is not a blood relative any closer than would prohibit legal marriage; and

• has signed jointly with you, a notarized affidavit attesting to the above which can be made available to Cigna upon request.

In addition, you and your Domestic Partner will be considered to have met the terms of this definition as long as neither you nor your Domestic Partner:

• has signed a Domestic Partner affidavit or declaration with any other person within twelve months prior to designating each other as Domestic Partners hereunder;

• is currently legally married to another person; or

• has any other Domestic Partner, spouse or spouse equivalent of the same or opposite sex.

You and your Domestic Partner must have registered as Domestic Partners, if you reside in a state that provides for such registration.
The section of this certificate entitled "COBRA Continuation Rights Under Federal Law" will not apply to your Domestic Partner and his or her Dependents.

CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – Oklahoma Residents

Rider Eligibility: Each Employee who is located in Oklahoma

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Oklahoma group insurance plans covering insureds located in Oklahoma. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

Dental Benefits – Cigna Dental Care

Any Licensed Dentist

Services listed on the Patient Charge Schedule are covered if performed by any licensed Dentist. A non-Network Dentist is paid the same amount for a service as a Network Dentist. However, a non-Network Dentist will charge his/her Usual Fee for services, not the Contract Fee. Therefore the member co-pays listed on the Patient Charge Schedule do not apply to services provided by a non-Network Dentist.

Specialty services listed on the Patient Charge Schedule are covered if performed by any licensed Dentist. A non-network Dentist is paid the same amount for a service as a Network Specialty Dentist. However, a non-network Dentist will charge his/her Usual Fee for services, not the Contract Fee. Therefore the member co-pays listed on the Patient Charge Schedule do not apply to services provided by a non-network Dentist.

Any licensed Dentist may perform complex rehabilitation and charge his or her Usual Fee. A non-network Dentist will be paid the same amount for complex rehabilitation as would a Network General Dentist and therefore the member co-pays listed on the Patient Charge do not apply to services provided by a non-network Dentist.

CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – Oregon Residents

Rider Eligibility: Each Employee who is located in Oregon

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Oregon group insurance plans covering insureds located in Oregon. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

Definitions

Dependent

The term child means a child born to you. It also means:

- a child legally adopted by you, including that child from the date of placement. Coverage for such child will include the necessary care and treatment of conditions existing prior to the date of placement including medically diagnosed congenital defects or birth abnormalities, regardless of any pre-existing condition limitation in the policy.
CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – South Carolina Residents

Rider Eligibility: Each Employee who is located in South Carolina

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of South Carolina group insurance plans covering insureds located in South Carolina. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

Definitions

Dependent
The term child means a child born to you, a child legally adopted by you or an adopted child of whom you have custody according to the decree of the court provided you have paid premiums. Adoption proceedings must be instituted by you, and completed within 31 days after the child’s birth date, and a decree of adoption must be entered within one year from the start of proceedings, unless extended by court order due to the child’s special needs. It also includes a stepchild who lives with you.

Eligibility - Effective Date

Employee Insurance
Late Entrant - Employee
You are a Late Entrant if:
- you elect the insurance more than 31 days after you become eligible; or
- you again elect it after you cancel your payroll deduction (if required).

Dependent Insurance
Late Entrant – Dependent
You are a Late Entrant for Dependent Insurance if:
- you elect that insurance more than 31 days after you become eligible for it; or
- you again elect it after you cancel your payroll deduction (if required).
CIGNA HEALTH AND LIFE INSURANCE COMPANY

POLICYHOLDER: Vanderbilt University Medical Center

ADDRESS: Nashville, Tennessee

ACCOUNT/GROUP NUMBER: 3339835

Group Insurance Policy and Policy Number

CIGNA DENTAL CARE INSURANCE 3339835-DHMO

Effective Date: 05/01/2016

Anniversary Date: 01/01

This policy is issued in Tennessee and shall be governed by its laws.

This Policy contains the terms under which the Insurance Company agrees to insure certain Employees and pay benefits.

The Insurance Company and the Policyholder have agreed to all of the terms of this policy.

Anna Krishtul, Corporate Secretary

Matthew G. Manders, President

Wilbur E. Parsell, Registrar
Tennessee state law requires insurers to deliver the following notice to policyholders.

NOTICE CONCERNING COVERAGE
LIMITATIONS AND EXCLUSIONS UNDER THE
TENNESSEE LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION ACT

Residents of Tennessee who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers’ care in selecting companies that are well managed and financially stable.

The Tennessee Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Tennessee. You should not rely on coverage by the Tennessee Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

Tennessee Life and Health Insurance Guaranty Association
1200 One Nashville Place
150 4th Avenue North
Nashville TN 37219-2433

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37243

The state law that provides for this safety-net coverage is called the Tennessee Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law’s coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone’s rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE
Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by an insurer authorized to conduct business in Tennessee. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE
However, persons holding such policies are not protected by this association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
• their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Association also does not provide coverage for:

• any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

• any policy of reinsurance (unless an assumption certificate was issued);

• interest rate yields that exceed an average rate;

• dividends;

• credits given in connection with the administration of a policy by a group contract holder;

• employers’ plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);

• unallocated annuity contracts (which give rights to group contract holders, not individuals), unless qualified under Section 403(b) of the Internal Revenue Code, except that even if qualified under Section 403(b), unallocated annuities issued to employee benefit plans protected by the federal Pension Benefit Guaranty Corporation are not covered.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out: The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. Within this overall $300,000 limit, the association will not pay more than $100,000 in cash surrender values, $100,000 in health insurance benefits, $100,000 in present value of annuities, or $300,000 in life insurance death benefits — again, regardless of the number of policies and contracts there were with the same company, and no matter how many different types of coverages.
NOTICE

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however, and is not available at all for some policies.

COVERAGE IS NOT PROVIDED FOR YOUR POLICY OR ANY PORTION OF IT THAT IS NOT GUARANTEED BY THE INSURER OR FOR WHICH YOU HAVE ASSUMED THE RISK, SUCH AS A VARIABLE CONTRACT SOLD BY PROSPECTUS.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

Tennessee Life and Health Insurance Guaranty Association
1200 One Nashville Place
150 4th Avenue North
Nashville, TN 37219-2433

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37243
## Policy Contents

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## Certificate Contents

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THE INSURANCE SCHEDULE

The terms set forth herein and in the Certificate(s) listed below describe the insurance underwritten by the Insurance Company. These Certificates are included in and made a part of the policy(ies). Each Certificate is identified by a Certificate Number (CN).

Any reference in the certificate to "you" or "yours" refers to the Employee.

An Employee in any of the classes shown below may be insured but only for the policy(ies) listed for his Employee Class. The Effective Date shown below is the date on which a policy becomes effective for an Employee Class.

An Employee will become eligible and insured in accordance with the terms of the "Eligibility" and "Effective Date" sections of the Certificate.

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PREMIUMS

PREMIUM PAYMENT. The first premium will be due on the Effective Date. After that, premium will be due monthly unless the Policyholder and the Insurance Company agree on some other method of premium payment. The Policyholder and the Insurance Company may agree to change the method of premium payment from time to time. Premiums are payable at the Home Office of the Insurance Company or to an authorized agent of the Insurance Company.

PREMIUM DUE DATE. After the Effective Date, the Premium Due Date will be the first of the month. The Anniversary Date will be the first of the month when the policy becomes effective. If the Policyholder and the Insurance Company agree that premiums will be paid on a quarterly, semiannual or annual basis, the Premium Due Date will be at the appropriate regular interval, quarterly, semiannually or annually. Premiums must be received at the Home Office or by an authorized agent of the Insurance Company on the Premium Due Date or the policy will be cancelled except as set forth in the Grace Period.

MONTHLY STATEMENT DATE. If premiums are to be paid monthly, the Monthly Statement Date will be the same as the Premium Due Date. If premiums are to be paid on a quarterly, semiannual or annual basis, the Monthly Statement Date will be the day in each month with the same number as the Premium Due Date.

MONTHLY PREMIUM STATEMENT. If premiums are due monthly, a Monthly Premium Statement will be prepared as of the Premium Due Date. If premiums are due quarterly, semiannually or annually, a Monthly Premium Statement will be prepared as of the Monthly Statement Date for the time from the Monthly Statement Date to the next Premium Due Date. This Monthly Statement will reflect any pro rata premium charges and credits due to changes in the number of insured persons and changes in insurance amounts that took place in the preceding month.

SIMPLIFIED ACCOUNTING. To simplify the accounting process, premium adjustments will be made on the Monthly Statement Date that is the same as or next follows the date that:

- A person becomes insured.
- The amount of insurance on a person changes, but not due to a revision of The Schedule.
- A person ceases to be insured.

MONTHLY PREMIUM RATE FOR DENTAL INSURANCE. The monthly premium rate for Dental Insurance is determined by written agreement between the Policyholder and Cigna Health and Life Insurance Company.

DENTAL INSURANCE PREMIUM. The monthly premium for Dental Insurance will be calculated as follows:

- Multiply the number of Employees insured on the Premium Due Date in each rate class by the premium rate in effect on that date for that class.
- Add the results.

CHANGE IN METHOD OF PREMIUM PAYMENT. If premiums are to be paid other than monthly, the method of calculation is the same. However, the rate for each class is first changed to quarterly, semiannual or annual rates by multiplying them by 2.9852, 5.9557 or 11.8227, respectively. All results are taken to the nearer cent. If the Policyholder and the Insurance Company agree to a change in the method of premium payment or to a change in the Anniversary Date, a pro rata adjustment will be made in the premium due.

CHANGES IN PREMIUM RATES. Any premium rate may be changed by the Insurance Company from time to time with at least 31 days advance written notice. No such change will be made until 12 months after the Effective Date. An increase will not be made more often than once in a 12-month period. If an increase in premium rates takes place on a date...
that is not a Premium Due Date, a pro rata premium will be due on the date of the increase. The pro rata premium will apply for the increase from the date of the increase to the next Premium Due Date. If a decrease in premium rates takes place on a date that is not a Premium Due Date, a pro rata credit will be granted. The pro rata credit will apply for the decrease from the date of the decrease to the next Premium Due Date.

The Insurance Company may change rates with at least 30 days advance written notice if, following the latter of the effective date or renewal date, the enrolled population either increases or decreases by 10% or more.

As of any Anniversary Date after the policy has been in force for 12 months, the Insurance Company may grant a credit in such amount as it may determine, based on experience. The experience under this policy may be combined with the experience under other contracts issued by the Insurance Company or its affiliates and covering the policyholder or its employees.

The Insurance Company may change rates immediately if, in its opinion, its liability is altered by any change in state or federal law or by a revision in the insurance under the policy. Any such change in rates will take effect on the effective date of the change in law or change in the insurance.
CANCELLATION OF POLICY

The Policyholder may cancel the policy as of any Premium Due Date by giving written notice to the Insurance Company before the date.

The Insurance Company may cancel the policy due to the following reasons only:

- with at least 90 days prior written notice, if the Insurance Company ceases to offer coverage of this type, in accordance with applicable state or federal law;
- in accordance with the Grace Period provision shown below, if the premium is not received at the Home Office or by an authorized agent of the Insurance Company when due;
- immediately, if the Employer has performed an act or practice that constitutes fraud or has intentionally misrepresented a material fact;
- with at least 30 days prior written notice, if the number of insured Employees or if the number of insured Dependents fails to meet the minimum required per group participation rules; or for failure to comply with any other material plan provision relating to Employer contributions or group participation rules;
- if the Insurance Company withdraws from the health insurance market with prior written notice and in accordance with applicable state or federal law;
- in accordance with any applicable state law, if it is determined that the size of the Employer group has changed, making such group eligible for a guaranteed issued small group product;
- in accordance with any applicable state or federal law, if prior notice is given to the Employer;
- as to an Employer member of an association to which this policy is issued, when the Employer’s membership in the association ceases, in accordance with applicable state or federal law.

Coverage will cease at midnight on the date on which termination occurs, unless otherwise stated above.

Uniform Modification of Coverage. At renewal, the provisions of this policy may be modified to reflect product revisions which have been uniformly made to this product.

GRACE PERIOD. If, before a Premium Due Date, the Policyholder has not given written notice to the Insurance Company that the policy is to be canceled, a Grace Period of 31 days will be granted for the payment of each premium after the initial premium. The policy will stay in effect during that time. If any premium is not received at the home office or by an authorized agent of the Insurance Company by the end of the Grace Period, the policy will automatically be canceled at the end of the Grace Period; except that, if the Policyholder has given written notice in advance of an earlier date of cancellation, the policy will be canceled as of the earlier date. The Policyholder will be liable to the Insurance Company for any unpaid premium for the time the policy was in force.
MISCELLANEOUS PROVISIONS

EXECUTION OF POLICY. The policy is executed at the Home Office of the Insurance Company. The Post Office address of the Insurance Company is Hartford, Connecticut.

CONSIDERATION. The policy is issued to the Policyholder in consideration of the application and payment of premiums.

INSURANCE DATA. The Policyholder will give the Insurance Company all of the data that it needs to calculate the premium and all other data that it may reasonably require. Failure of the Policyholder to give this data will not void or continue an Employee's insurance. The Insurance Company has the right to examine the Policyholder's records relative to these benefits at any reasonable time while the policy is in effect. It also has this right until all rights and obligations under the policy are finally determined.

MALE PRONOUN. The male pronoun as used herein will be deemed to include the female.
PROVISIONS

ENTIRE CONTRACT. The entire contract will be made up of the policy, the certificate(s), the application of the Policyholder, a copy of which is attached to the policy and all subsequent versions of the policy, and the applications, if any, of the Employees.

POLICY CHANGES. Changes may be made in the policy only by amendment signed by the Policyholder and by the Insurance Company acting through its President, Vice President, Secretary, or Assistant Secretary. No agent may change or waive any terms of the policy.

STATEMENTS NOT WARRANTIES. All statements made by the Policyholder or by an insured Employee will, in the absence of fraud, be deemed representations and not warranties. No statement made by the Policyholder or by the Employee to obtain insurance will be used to avoid or reduce the insurance unless it is made in writing and is signed by the Policyholder or the Employee and a copy is sent to the Policyholder, the Employee or his Beneficiary.

CLAIM. Notice of claim, Claim Forms and Proof of Loss provisions do not apply to services received from, or upon referral by, a Participating Dental Facility or a Participating Dentist.

NOTICE OF CLAIM. Written notice of claim must be given to the Insurance Company within 30 days after the occurrence or start of the loss on which claim is based.

If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonably possible.

CLAIM FORMS. When the Insurance Company receives the notice of claim, it will give to the claimant, or to the Policyholder for the claimant, the claim forms it uses for filing proof of loss. If the claimant does not get these claim forms within 15 days after the Insurance Company receives notice of claim, he will be considered to have met the proof of loss requirements if he submits written proof of loss within 90 days after the date of loss. This proof must describe the occurrence, character and extent of the loss for which claim is made.

PROOF OF LOSS. Written proof of loss must be given to the Insurance Company within 90 days after the date of the loss for which claim is made. If written proof of loss is not given in that time, the claim will not be invalidated nor reduced if it is shown that written proof of loss was given as soon as was reasonably possible.

PHYSICAL EXAMINATION. The Insurance Company, at its own expense, will have the right to examine any person for whom claim is pending as often as it may reasonably require.

LEGAL ACTIONS. No action at law or in equity will be brought to recover on the policy until at least 60 days after proof of loss has been filed with the Insurance Company. No action will be brought at all unless brought within 3 years after the time within which proof of loss is required by the policy.

TIME LIMITATIONS. If any time limit set forth in the policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity is less than that permitted by the law of the state in which the Employee lives when the policy is issued, then the time limit provided in the policy is extended to agree with the minimum permitted by the law of that state.

CERTIFICATES. The Insurance Company will issue to the Policyholder for delivery to each insured Employee an individual certificate. The Policyholder will be responsible for distributing the certificates to its Employees. The certificate
will show the benefits provided under the policy. It will set forth any changes in benefits due to age and to whom benefits
will be paid. Nothing in the certificate will change or void the terms of the policy.

NOTICE OF TERMINATION OF ELIGIBILITY. Written notice of the termination of eligibility of any Employee or
Dependent must be given to the Insurance Company within (60) days of the loss of eligibility. If such notice is not received
by the Insurance Company within (60) days of the date of loss of eligibility for an Employee or Dependent, then the
Employer shall be responsible for all claims for that Employee or Dependent incurred through the (60th) day prior to the
Insurance Company's receipt of notice of termination of eligibility for the Employee or Dependent.
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.
NATIONAL GUARDIAN LIFE INSURANCE COMPANY  
(called "We", "Our", and "Us")  
2 East Gilman Street  Madison, Wisconsin 53701

GROUP VISION CARE INSURANCE CERTIFICATE

Underwritten by:  National Guardian Life Insurance Company  
Two East Gilman Street  
P.O. Box 1191  
Madison, WI  53701-1191

Administrator:  Superior Vision Services, Inc.  
11101 White Rock Road  
Rancho Cordova, CA  95670

This Certificate explains the vision insurance coverage under the Group Policy (the Policy) issued to the Policyholder.

The Policyholder and the Group Policy Number are shown in the Certificate Schedule page.

This, together with the Schedule of Benefits, forms Your Certificate of Insurance while covered under the Policy. It replaces any previous Certificates of Insurance issued under the Policy to You.

This Certificate provides a general description of Your vision care benefits. All benefits are governed by the terms and conditions of the Policy. The Policy alone constitutes the entire contract between the Policyholder and Us. You may examine the Policy during regular business hours by contacting the Policyholder.

Kimberly A. Shaul, Secretary  
Mark Solverud, President

NON-PARTICIPATING

THIS IS A LEGAL CONTRACT – PLEASE READ YOUR CERTIFICATE CAREFULLY

NV109FCTV2 3/07  
National Guardian Life Insurance Company  
Page 1  
Group Policyholder: Vanderbilt University Medical Center  
Group Policy Number: 34091
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**PART I. CERTIFICATE SCHEDULE**

<table>
<thead>
<tr>
<th>Policyholder:</th>
<th>Vanderbilt University Medical Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Policy Number:</td>
<td>34091</td>
</tr>
<tr>
<td>Effective Date:</td>
<td>May 1, 2016</td>
</tr>
<tr>
<td>Initial Term:</td>
<td>20 Months</td>
</tr>
<tr>
<td>Eligible Classes:</td>
<td>All full-time employees working at least 30 hours per week</td>
</tr>
<tr>
<td>Waiting Period:</td>
<td>Date of hire</td>
</tr>
<tr>
<td>Mode of Premium Payment:</td>
<td>MONTHLY</td>
</tr>
<tr>
<td>Method of Premium Payment:</td>
<td>Remitted by Policyholder</td>
</tr>
<tr>
<td>Premium Due Date:</td>
<td>1st of every month</td>
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</table>
PART II. SCHEDULE OF BENEFITS

<table>
<thead>
<tr>
<th>FREQUENCY OF SERVICES</th>
<th>Your Certificate is on a Rolling Benefit Plan Basis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision Exam:</td>
<td>Once every 12 Months</td>
</tr>
<tr>
<td>Eyeglass Lenses:</td>
<td>Once every 12 Months</td>
</tr>
<tr>
<td>Frames:</td>
<td>Once every 24 Months</td>
</tr>
<tr>
<td>Contact Lenses:</td>
<td>Once every 12 Months</td>
</tr>
<tr>
<td>Contact Lens Fit:</td>
<td>Once every 12 Months</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CO-PAY (PER INSURED)</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network Providers:</td>
</tr>
<tr>
<td>Vision Exam: $15</td>
</tr>
<tr>
<td>Eyeglass Lenses/Frames: $15</td>
</tr>
<tr>
<td>Contact Lens Fit: $15</td>
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</tbody>
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<table>
<thead>
<tr>
<th>BENEFITS AND ALLOWANCES</th>
<th>In-Network Providers:</th>
<th>Out-of-Network Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision Exam:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ophthalmologist (M.D.)</td>
<td>Covered in Full</td>
<td>$34 Allowance</td>
</tr>
<tr>
<td>Optometrist (O.D.)</td>
<td>Covered in Full</td>
<td>$26 Allowance</td>
</tr>
<tr>
<td>Materials - Eyeglass Lenses:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Vision</td>
<td>Covered in Full</td>
<td>$32 Allowance</td>
</tr>
<tr>
<td>Progressive</td>
<td>Covered up to the providers retail trifocal amount</td>
<td>$57 Allowance</td>
</tr>
<tr>
<td>Bifocals</td>
<td>Covered in Full</td>
<td>$46 Allowance</td>
</tr>
<tr>
<td>Trifocals</td>
<td>Covered in Full</td>
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</tr>
<tr>
<td>Lenticular</td>
<td>Covered in Full</td>
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<tr>
<td>Materials - Frames: 2</td>
<td>$130 Allowance</td>
<td>$65 Allowance</td>
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<tr>
<td>Materials - Contact Lenses: 4</td>
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</tr>
<tr>
<td>Non-Elective</td>
<td>Covered in Full</td>
<td>$210 Allowance</td>
</tr>
<tr>
<td>Elective</td>
<td>$120 Allowance</td>
<td>$100 Allowance</td>
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<tr>
<td>Contact Lens Fit:</td>
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<td></td>
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<tr>
<td>Standard</td>
<td>Covered in Full</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Specialty</td>
<td>$50 Allowance</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

1 Where an "Allowance" is shown, you are responsible for paying any charges in excess of the Allowance.

2 If you use the services of an In-Network Provider but take advantage of a sale, coupon, or other in-store special, the Provider may require that you pay in full and submit your receipt for reimbursement at the Out-of-Network allowance.

3 Eyeglass Lenses and Frames are paid in lieu of the Contact Lenses benefit.

4 The contact lenses benefit is paid in lieu of Eyeglass Lenses and Frames.
PART III. DEFINITIONS

Administrator - The entity which provides complete service and facilities for the writing and servicing of the Policy as agreed to in a contract with Us.

Claim - A request for payment of benefits under this Certificate.

Co-Pay – An Insured’s share of the costs for Covered Services or Materials that are provided by an In-Network Provider. The Co-Pay is paid directly to the Provider at the time services are rendered. Co-Pay amounts are listed in the Schedule of Benefits.

Contact Lenses, Elective – Elective contact lenses refer to contact lenses an Insured chooses to wear instead of eyeglasses for reasons of comfort or appearance.

Contact Lenses, Non-Elective – Non-elective Contact Lenses refer to contact lenses that are prescribed solely for the purpose of correcting one (1) of the following medical conditions. These conditions prevent the Insured from achieving a specified level of visual acuity (performance) through the wearing of conventional eyeglasses:

1. Aphakia (after cataract surgery). A pair of prescription single vision or multifocal eyeglass lenses and an eyeframe can be provided in addition to Non-Elective Contact Lenses for this condition.
2. When visual acuity cannot be corrected to twenty/seventy (20/70) in the better eye except through the use of Contact Lenses (must be twenty/sixty (20/60) or better).
3. Anisometropia of 4.0 diopters or more, provided visual acuity improves to twenty/sixty (20/60) or better in the weak eye.

Reimbursement of Non-Elective Contact Lenses will be considered as payment in full if utilizing the services of an In-Network Provider. This benefit provides coverage for the Materials only. It does not include the Contact Lens Fitting fee.

Covered Dependent – Means an Eligible Dependent who is insured under this Certificate.

Covered Services or Materials – Means the Vision Exam services and Materials that qualify for benefits under the Group Policy. Covered Services or Materials are shown in the Schedule of Benefits.

Eligible Class – Means the group of people who are eligible for coverage under the Group Policy. The Members of the Eligible Classes are shown in the Certificate Schedule. Each Member of the Eligible Class will qualify for insurance on the date He completes the required Waiting Period, if any.

Eligible Dependent - Means a person listed below:
1. Your spouse or lawful Domestic Partner;
2. Your unmarried dependent child under age 19, who is your natural or adopted child, step-child, foster child, or child for whom you are a legal guardian and who is primarily dependent on You for support and maintenance.
3. Your unmarried child age 19 or older but less than age 26 who is:
   a. Not regularly employed on a full-time basis;
   b. Primarily dependent upon You for support and maintenance; and
   c. Enrolled as a full-time student in an accredited educational institution or licensed trade school.
4. Your unmarried child who has reached age 19 and who is:
   a. Primarily dependent upon You for support and maintenance; and
   b. In incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder or physical handicap.

Proof of the child’s incapacity or dependency must be furnished to Us for an already enrolled child who reaches the age limitation, or when You enroll a new disabled child under the plan.
Eyeglass Lenses – A standard glass or plastic (CR39) lens, which is optically clear, that will fit an eyeglass frame with a lens size less than 61mm in length. Standard multifocal lenses include segments through flat top thirty-five (35) for plastic bifocal and lenticular lenses, through flat top twenty-eight (28) for glass trifocals, and through flat top thirty-five (35) for plastic trifocals.

He, Him and His – Refers to the male or female gender.

Immediate Family Member – An Insured’s parent, step-parent, spouse, child, step-child, brother or sister.

Initial Term - The period following the group’s initial effective date and shown in the Certificate Schedule. Rates are guaranteed not to change during this period.

In-Network Provider - An Ophthalmologist, Optometrist or Optician who has entered into an agreement with the Administrator to provide Covered Services or Materials at an agreed to cost. When an In-Network Provider is used, the Insured will generally incur less out-of-pocket cost for the services rendered.

In-Network Provider Directory - A list of In-Network Providers and the services they are contracted for in Your area. The list will be updated periodically.

Insured – Means You (the Insured Member) and each Covered Dependent.

Insured Member – Means a person:
1. who is a Member of an Eligible Class; and
2. who has qualified for insurance by completing the Waiting Period, if any; and
3. for whom insurance under the Policy has become effective.

Late Entrant – Any Member or Eligible Dependent enrolling more than 31 days after first becoming eligible for coverage. Benefits may be limited for Late Entrants. See the sections titled “Limitations.”

Materials – Means corrective Eyeglass Lenses, Frames and Contact Lenses.

Member – Means a person who belongs to an Eligible Class of the Policyholder.

Ophthalmologist- A person who is licensed by the state in which he or she practices as a Doctor of Medicine or Osteopathy and is qualified to practice within the medical specialty of ophthalmology. The Ophthalmologist cannot be 1) the Insured; 2) an Immediate Family Member; or 3) retained by the Policyholder.

Optician – A person or business that grinds and/or dispenses Eyeglass Lenses and Contact Lenses prescribed by either an Optometrist or Ophthalmologist. The Optician cannot be: 1) the Insured; 2) an Immediate Family Member; or 3) retained by the Policyholder. The Optician must be licensed by the state in which services are rendered, if such state requires licensing.

Optometrist – A person licensed to practice optometry as defined by the laws of the state in which services are rendered. The Optometrist cannot be 1) the Insured; 2) an Immediate Family Member; or 3) retained by the Policyholder.

Out-of-Network Provider – An Ophthalmologist, Optometrist or Optician who is not an In-Network Provider. These providers have not entered into an agreement with Us to limit their charges. They are not listed in the In-Network Provider Directory.

Plano Lens - A lens that has no refractive power.

Policyholder – The entity stated on the front page of the Policy.
Re-enrollee - Any insured who terminated his coverage, and then subsequently re-enrolled for coverage at a later date. Benefits may be limited for Re-enrollees.

Rolling Benefit Plan - Benefits begin anew twelve (12) or twenty-four (24) months from the date of service.

Vision Exam - An examination of principal vision functions. A Vision Exam includes, but is not limited to, case history, examination for pathology or anomalies, job visual analysis, refraction, visual field testing and tonometry, if indicated. The exam must be consistent with the community standards, rules and regulations of the jurisdiction in which the provider's practice is located.

You or Your - The insured Member.

Waiting Period - The period of time a Member must wait before he is eligible for coverage. The Waiting Period, if any, is specified in the Policyholder's Group Application and shown in the Certificate Schedule.

PART IV. ELIGIBILITY AND ENROLLMENT

A. ELIGIBILITY

To be eligible for coverage under the Policy, an individual must:
1. be a Member of an Eligible Class of the Policyholder, as defined in the Certificate Schedule; and
2. satisfy the Waiting Period, if any.

The Member's Eligible Dependents are also eligible for coverage, provided that dependent coverage is provided under the Policy.

Dual Eligibility Status: If both a Member and his spouse or Domestic Partner are in an Eligible Class of the Policyholder, enrollment will not default to the Policyholder's rules.

B. ENROLLMENT

The term "Enrollment" means written or electronic application for coverage on an enrollment form furnished or approved by Us. Coverage will not become effective until the Members have enrolled themselves and their Eligible Dependents, and paid the required premium, if any.

Initial Enrollment: Members should enroll themselves and their Eligible Dependents within 31 days of the Waiting Period. Individuals who enroll after this time are considered Late Entrants.

Open Enrollment: Members may enroll themselves and their Eligible Dependents during an open enrollment period. Open enrollment is a period of time specified by the Policyholder. It usually occurs once each Calendar Year but may, at the Policyholder's discretion, occur more frequently. Other changes may also be restricted to Open Enrollment periods.

Late Entrants: Members who do not enroll themselves or their Eligible Dependents within the Initial Enrollment period, may not enroll until the next Open Enrollment period unless there is a change in family status, as described below.

Change in Family Status: Members may enroll or change their coverage if a change in family status occurs, provided written application to enroll is made within thirty (30) days of the event. A change in family status means any of the following events:
1. Marriage or Domestic Partnership;
2. Divorce or legal separation;
3. Birth or adoption of a child;
4. Death of a spouse or child;
5. Other changes as permitted by the Policyholder.
PART V. INDIVIDUAL EFFECTIVE DATES

Your coverage will be effective on the later of the following dates, provided that any required premium is paid to Us:

1. the Policyholder’s Effective Date, shown on the Certificate Schedule; or
2. the date You meet all the Eligibility and Enrollment requirements.

For Eligible Dependents acquired after Your effective date of coverage, by reason of marriage, Domestic Partnership, birth or adoption, coverage is effective the date specified by the Policyholder. This is subject to our receipt of the required Enrollment and payment of the premium, if any.

Newborn Coverage: Any child born to You or Your Covered Dependent spouse or Domestic Partner is covered from the moment of birth to thirty-one (31) days or until released from the hospital. A notice of birth, together with any additional premium, must be submitted to Us within thirty-one (31) days of the birth in order to continue the coverage beyond the initial thirty-one (31) day period.

Adopted Children: A child adopted by You is covered from the date of placement. Coverage will continue unless the child’s placement is disrupted prior to legal adoption. A notice of placement for adoption, together with any additional premium, must be submitted to Us within thirty-one (31) days of the placement in order to continue the coverage beyond the initial thirty-one (31) day period.

PART VI. INDIVIDUAL TERMINATION DATES

Coverage for You and all Covered Dependents stops on the earliest of the following dates:

1. the date the Policy terminates;
2. the date the Policyholder’s coverage terminates under the Policy;
3. the last day of the month in which You are no longer an eligible Member;
4. the date You die;
5. on any premium due date, if full payment for Your insurance is not made within thirty-one (31) days following the premium due date.

In addition, coverage for each Covered Dependent stops on the earliest of:

1. the date He is no longer an Eligible Dependent;
2. the date We receive your request to terminate Covered Dependent coverage. This is subject to any limitation imposed by the Policyholder as to when a change is permitted; e.g. under an Open Enrollment period.

PART VII. INDIVIDUAL PREMIUMS

Members may be required to contribute, either in whole or in part, to the cost of their insurance. This is subject to the terms established by the Policyholder. Your premium contributions, if required, are remitted to Us in one (1) of two (2) ways:

1. You contribute to the cost of the insurance through the Policyholder, who then submits payment to Us; or
2. You pay Your premiums directly to Us.

The Certificate Schedule shows the method of premium payment.

The first premium is due on the Effective Date. Premiums after the first are due on the Premium Due Date or within the grace period.

Grace Period: A grace period of thirty-one (31) days is granted for the payment of each premium due after the first. The coverage stays in force if the premium is paid during this grace period, unless We are given written notice that the insurance is to be ended before the Grace Period. We may require payment of any pro-rata premium for the time the insurance was in effect during the Grace Period.

Right to Change Premiums: We have the right to change the premium rates on any premium due date on or after the Initial Term. After the Initial Term, We will not increase the premium rates more than once in a twelve (12) month period. We will give the Policyholder written notice at least forty-five (45) days in advance of any change. All changes in rates are subject to terms outlined in the Policy.
PART VIII. DESCRIPTION OF COVERAGE

We pay a benefit if an Insured receives Covered Services or Materials at the allowable Frequency while his coverage under this Certificate is in force. An Insured may choose to receive vision care services from either an In-Network Provider or an Out-of-Network Provider. If an In-Network Provider is chosen, the Insured will generally incur less out-of-pocket cost (unless the Policyholder has selected an In-Network Provider Plan only.)

A. In-Network Benefits
When You enroll for coverage, an In-Network Provider Directory will be made available to You with the names, phone numbers and addresses of In-Network Providers. A provider's status may occasionally change. We recommend that You call the Administrator to verify the provider's participation status in the network. You may change providers at any time without notice to the Administrator.

When benefits are payable for Covered Services or Materials received from an In-Network Provider, We will pay the In-Network Provider directly, based on the In-Network benefits shown in the Schedule of Benefits. The Insured pays any required Co-Pay and any charges above the covered benefits to the In-Network Provider. The In-Network Provider takes care of claims submission and administrative services.

Note Exception: If you use the services of an In-Network Provider but take advantage of a sale, coupon, or other in-store special, the Provider may require that you pay in full and submit Your receipt for reimbursement at the Out-of-Network reimbursement.

Limited In-Network benefits may be payable for certain add-on Materials. These items, if any, are shown in the Supplement To Schedule Of Benefits.

Both the Co-Pay and the Frequency for Covered Services or Materials are shown in the Schedule of Benefits.

B. Out-of-Network Benefits
If an Insured chooses to use an Out-of-Network Provider, You must pay the provider in full for the services and materials purchased. It is your responsibility to send us a Claim by submitting the itemized invoice or receipt to us. (See the “Notice of Claim” provision.) Any Co-Pay that applies should not be paid to the Out-of-Network Providers, as it will be deducted from Us at the time the claim is processed.

When benefits are payable for Covered Services or Materials received from an Out-of-Network Provider, We will reimburse you up to the amount of Out-of-Network benefits shown in the Schedule of Benefits, less any Co-Pay.

C. Covered Services or Materials
Covered Services or Materials are shown in the Schedule of Benefits. In order to be a Covered Service or Material, the services or materials must be furnished to an Insured:

1. To check or improve their vision condition;
2. Within the allowable Frequency shown in the Schedule of Benefits;
3. By an Ophthalmologist, Optometrist or Optician, regardless of whether such provider is an In-Network or Out-of-Network Provider.

In no event will coverage exceed the lesser of:
1. the actual cost incurred of the Covered Services or Materials; or
2. the limits of coverage shown in the Schedule of Benefits.

PART IX. LIMITATIONS AND EXCLUSIONS

The Contact Lenses benefit is paid in lieu of Eyeglass Lenses and Frames. An Insured is eligible to receive benefits under the Eyeglass Lenses Benefit or the Frame benefit only after the Contact Lenses benefit Frequency has ended.

The Eyeglass Lenses benefit and the Eyeglass Frame benefit is paid in lieu of the Contact Lenses benefit. An Insured is eligible to receive benefits under the Contact Lenses benefit only after the Eyeglass Lenses benefit Frequency has ended.

NVIGRPCTV2 5/07
National Guardian Life Insurance Company
Group Policyholder: Vanderbilt University Medical Center
Group Policy Number 34091
Coverage for a Late Entrant or Re-Enrollee is limited to the Vision Exam benefit during the first twenty-four (24) months after such person's effective date of coverage.

Exclusions
No benefits are payable for the any of the following conditions, procedures and/or materials, unless otherwise specifically listed as a covered benefit in the Schedule of Benefits:

1. Replacement frames and/or lenses, except at normal intervals when covered services are otherwise available;
2. Plano or non-prescription lenses or sunglasses;
3. Orthoptics, vision training and any associated supplemental testing;
4. Frame cases;
5. Low (subnormal) vision aids or anisoktonic lenses;
6. Medical and surgical treatment of the eyes;
7. Charges incurred after (a) the Policy ends; or (b) the Insured's coverage under the Policy ends, except as stated in the Policy;
8. Experimental or non-conventional treatment or device;
9. Any eye examination or corrective eyewear required by an Employer as a condition of employment;
10. Services and materials provided by another vision plan except in the case of Coordination of Benefits;
11. Services for which benefits are paid by Worker's Compensation;
12. Benefits provided under the employee's medical insurance except in the case of Coordination of Benefits;
13. Blended bifocal lenses
14. Groove, Drill or Notch, and Roll and Polish;
15. Two (2) pairs of glasses, in lieu of bifocals, trifocals or progressives;
16. Coating on lenses (Factory scratch coat, anti-reflective, sunglass colors, etc.)
17. Cosmetic items;
18. Faceted lenses
19. High-Index Lenses
20. Laminated Lenses
21. Oversize Lenses — any lens with an eye size of 61 mm or greater
22. Photochromic (Transition) lenses
23. Polaroid lenses
24. Polished bevel lenses
25. Polycarbonate lenses
26. Prism lenses
27. Slab-off lenses
28. Tints (except Pink tint #1 and #2)
29. Ultra-violet tint or coating
30. Additional cost for contact lenses over the allowance
31. Additional cost for a frame over the allowance
32. Progressive Power Lenses*

*Progressive Power Lens Benefit. If this type of lens is not a covered benefit under your Certificate, the Provider will apply the retail charge for standard trifocal lenses against the charge for the style of progressive lens You have selected. You pay the Provider the difference, if any, between the two (2).

PART X. CLAIM PROVISIONS

A. In-Network Claims
When an Insured receives services from an In-Network Provider, the provider will handle all claims and administrative services for You. In-Network Providers submit charges directly to the Administrator. (Note the exception under Part VIII.A, "In-Network Benefits.)

B. Out-of-Network Claims
In order to pay benefits for Covered Services or Materials provided by an Out-of-Network Provider, You must furnish written proof of loss. Your Claim must be sufficient to identify the Insured, the name of the Policyholder and Your Group Policy Number. Claim forms are available through the Administrator, or You may submit itemized receipts for services.
C. Notice of Claim
Written notice of claim must be given to Us within twenty (20) days after the loss starts or as soon as reasonably possible. Notice should be sent to Our Administrator at the following address:

National Guardian Life Insurance Company
c/o Superior Vision Services, Inc.
P.O. Box 967
Rancho Cordova, CA 95741

D. Claim Forms
When the Administrator receives notice of Claim that does not contain all necessary information, forms for filing proof of loss will be sent to You along with a request for the missing information. If these forms are not sent within fifteen (15) days after receiving notice of claim, You will meet the proof of loss requirements if the Administrator is given written proof of the nature and extent of the loss within the time stated in the Proof of Loss provision.

E. Proof Of Loss
Written proof of loss must be given to the Administrator within ninety (90) days after the loss begins. We will not deny nor reduce any claim if it was not reasonably possible to give proof of loss in the time required. In any event, proof must be given to the Administrator within one (1) year after it is due, unless You are legally incapable of doing so.

F. Payment Of Claims
Benefits will be paid within thirty (30) days after our Administrator receives written proof of loss. Benefits will be paid to You unless an Assignment of Benefits has been requested by the Insured. Benefits due and unpaid at Your death will be paid to Your estate. Any payment made by Us in good faith pursuant to this provision will fully release Us to the extent of such payment.

G. Time of Payment of Claims
Benefits payable under this Policy will be paid immediately upon Our receipt of written proof of loss.

H. Overpayments
If we pay a benefit and it is later shown that a lesser amount should have been paid, We will be entitled to a refund of the excess. This applies to payments made to You, to a Covered Dependent, or to the provider of the Covered Services or Materials.

PART XI. COORDINATION OF BENEFITS (COB)

This provision applies when an Insured has vision coverage under more than one Plan, as defined below. The benefits payable between the Plans will be coordinated.

A. DEFINITIONS RELATED TO COB

1. Allowable Expense: An expense that is considered a covered charge, at least in part, by one or more of the Plans. When a Plan provides benefits by services, reasonable cash value of each service will be treated as both an Allowable Expense and a benefit paid.

2. Coordination of Benefits: Taking other Plans into account when We pay benefits.

3. Plan: Any plan, including this one that provides benefits or services for vision services on either a group or individual basis. "Plan" includes group and blanket insurance and self-insured and prepaid plans. It includes government plans, plans required or provided by statute (except Medicaid), and no fault insurance (when allowed by law). "Plan" shall be treated separately for that part of a plan that reserves the right to coordinate with benefits or services of other plans and that part which does not.

4. Primary Plan: The Plan that, according to the rules for the Order of Benefit Determination, pays benefits before all other Plans.

B. BENEFIT COORDINATION

Benefits will be adjusted so that the total payment under all Plans is no more than 100 percent of the Insured's Allowable Expense. In no event will total benefits paid exceed the total payable in the absence of COB.
If an Insured’s benefits paid under this Plan are reduced due to COB, each benefit will be reduced proportionately. Only the amount of any benefit actually paid will be charged against any applicable benefit maximum.

C. THE ORDER OF BENEFIT DETERMINATION

1. When this is the Primary Plan, We will pay benefits as if there were no other Plans.

2. When a person is covered by a Plan without a COB provision, the Plan without the provision will be the Primary Plan.

3. When a person is covered by more than one Plan with a COB provision, the order of benefit payment is as follows:

   a. Non-dependent/Dependent. A Plan that covers a person other than as a dependent will pay before a Plan that covers that person as a dependent.

   b. Dependent Child/Parents Not Separated or Divorced. For a dependent child, the Plan of the parent whose birthday occurs first in the Calendar Year will pay benefits first. If both parents have the same birthday, the Plan that has covered the dependent child for the longer period will pay first. If the other Plan uses gender to determine which Plan pays first, We will also use that basis.

   c. Dependent Child/Separated or Divorced Parents. If two or more Plans cover a person as a Dependent of separated or divorced parents, benefits for the child are determined in the following order:

      i. The Plan of the parent who has responsibility for providing insurance as determined by a court order;

      ii. The Plan of the parent with custody of the child;

      iii. The Plan of the spouse of the parent with custody; and

      iv. The Plan of the parent without custody of the child.

   d. Dependent Child/Joint Custody: If the joint custody court decree does not specifically state which parent is responsible for the child’s medical expenses, the rules as shown for Dependent Child/Parents Not Separated or Divorced shall apply.

   e. Active/Inactive Employee. The Plan which covers the person as an employee who is neither laid off nor retired (or as that employee’s dependent) is Primary over the Plan which covers that person as a laid off or retired employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored.

   f. Longer/Shorter Length of Coverage. When an order of payment is not established by the above, the Plan that has covered the person for the longer period of time will pay first.

D. Right to Receive and Release Needed Information

We may release to, or obtain from, any other insurance company, organization or person information necessary for COB. This will not require the consent of, or notice to You or any claimant. You are required to give Us information necessary for COB.

E. Right to Make Payments To Another Plan

COB may result in payments made by another Plan that should have been made by Us. We have the right to pay such other Plan all amounts it paid which would otherwise have been paid by Us. Amounts so paid will be treated as benefits paid under this Plan. We will be discharged from liability to the extent of such payments.

F. Right to Recovery

COB may result in overpayments by Us. We have the right to recover any excess amounts paid from any person, insurance company or other organization to whom, or for whom, payments were made.
PART XII. GRIEVANCE PROCEDURE

If a claim for benefits is wholly or partially denied, the Insured will be notified in writing of such denial and of his right to file a grievance and the procedure to follow. The notice of denial will state the specific reason for the denial of benefits. Within sixty (60) days of receipt of such written notice an Insured may file a grievance and make a written request for review to:

National Guardian Life Insurance Company  
c/o Superior Vision Services, Inc.  
P.O. Box 967  
Rancho Cordova, CA 95741

We will resolve the grievance within thirty (30) calendar days of receiving it. If we are unable to resolve the grievance within that period, the time period may be extended another thirty (30) calendar days if we notify in writing the person who filed the grievance. The notice will include advice as to when resolution of the grievance can be expected and the reason why additional time is needed.

The Insured or someone on his/her behalf also has the right to appear in person before Our grievance committee to present written or oral information and to question those people responsible for making the determination that resulted in the grievance. The Insured will be informed in writing of the time and place of the meeting at least seven (7) calendar days before the meeting.

For purposes of this Grievance Procedure, a grievance is a written complaint submitted in accordance with the above Grievance Procedure by or on behalf of an Insured regarding dissatisfaction with the administration of claims practices or provision of services of this plan provider plan relative to the Insured.

In situations requiring urgent care, grievances will be resolved within seventy-two (72) hours of receiving the grievance.

PART XIII. GENERAL PROVISIONS

Cancellation: We may cancel the Policy at any time by providing at least sixty (60) days advance written notice to the Policyholder. The Policyholder may cancel the Policy at any time by providing written notice to Us, effective upon Our receipt on the notice or the date specified in the notice, if later. In the event of such cancellation by either Us or the Policyholder, We shall promptly return on a pro rata basis any unearned premium paid as required by the law of the state in which the Policy is issued. The Policyholder shall promptly pay on a pro rata basis the earned premium which has not been paid, if any. Such cancellation shall be without prejudice to any claim originating prior to the effective date of such cancellation.

Legal Actions: No legal action may be brought to recover on the Policy before sixty (60) days after written proof of loss has been furnished as required by the Policy. No such action may be brought after three (3) years from the time written proof of loss is required to be furnished.
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.
This is merely a summary of the main features of the Plan and not a detailed description of all of its provisions. If, in the future, the provisions should change for any reason, you will be provided with a summary of the changes.

If, for any reason, there is an omission or misstatement in this summary, or any difference between this summary and the Plan Document, the Plan Document will in all respects control and govern.
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INTRODUCTION TO THE FLEXIBLE SPENDING ACCOUNT PLAN

The Flexible Spending Account (FSA) Plan is a benefit plan offered to eligible employees of Vanderbilt University Medical Center (“Vanderbilt University Medical Center”). There are two types of accounts available to you: Health Care FSA and Dependent Day Care FSA. These accounts allow you to pay for eligible health care and dependent day care with pre-tax dollars (for further information see “Contributions”).

A Health Care FSA is used for eligible health care expenses incurred by you or your dependents. A Dependent Day Care FSA is used for eligible dependent day care expenses you must pay so that you (and your spouse, if you are married) can work or attend school. You may participate in a Health Care FSA and/or a Dependent Day Care FSA (for further information see “Expenses”). Money allocated to each account cannot be used to pay for a claim on another account. For example, money allocated for dependent day care expenses cannot be used to pay for a medical service.

You make contributions to your account(s) through payroll deductions. These deductions are made before taxes are taken out and, because these deductions lower your taxable salary, you may pay less in taxes.

When you incur eligible Health Care and/or Dependent Day Care expenses covered under your account(s), you submit a reimbursement request form, with the required third-party documentation, to Benefit Express. Benefit Express will review your claim and, if approved, reimburse you for eligible expenses.

It is very important that you estimate your expenses carefully. Internal Revenue Service (IRS) regulations require that if you do not incur eligible medical and dependent day care expenses by the end of the Plan Year, you must forfeit any money remaining in your health care and dependent day care accounts. This is known as the “use-it-or-lose-it” rule.

For Health Care and Dependent Day Care FSA’s, you may submit reimbursement requests throughout the Plan Year. The Plan Year includes the IRS Grace Period. Claims must be filed by the end of the Run-Out Period after the end of the Plan Year.

The amount in your Health Care and Dependent Day Care FSA as of the end of the grace period (and after the processing of all of your claims for the Plan Year and the grace period) will be forfeited and credited to pay administrative expenses incurred by Vanderbilt University Medical Center. In this case, you will have no further claim to any funds remaining in your account for any reason, except as specified in other sections of the Plan. For purposes of this section, the term “grace period” means a period of 75 days after the end of the Plan Year. Grace Period - The Plan allows active participant 75 days after the end of the Plan Year (until March 15th) to submit claims incurred during the period of eligibility.

Definitions for terms in bold face type may be found in the Definition of Terms section at the end of this document.

Please read this Summary Plan Description carefully. It summarizes the provisions of the Plan and will help you to take full advantage of this benefit provided to you by Vanderbilt University Medical Center.
Vanderbilt University Medical Center offers the Flexible Spending Account Plan to all eligible employees as a supplementary benefit. Questions about this benefit may be directed to:

Benefit Express
1700 East Golf Road, Suite 1000
Schaumburg, IL 60173
GENERAL PLAN INFORMATION

PLAN NAME

The official name of this benefit is the Health and Dependent Care Reimbursement plan for Vanderbilt University Medical Center. It may also be referred to as the “Plan” or the “FSA.”

PLAN IDENTIFICATION

504

TYPE OF PLAN

A Cafeteria Plan under Code Section 125.

PERIOD OF COVERAGE

The period of coverage for this Plan is a 12 month period beginning on January 1st and ending on December 31st.

PLAN YEAR

The Plan Year for incurred expenses is from January 1 through December 31. Expenses may not be carried over from one Plan Year to the next. Health Care and Dependent Day Care claims for incurred expenses may be submitted until the Run-Out Period after the end of the Plan Year.

PLAN ADMINISTRATOR

Vanderbilt University Medical Center is the Plan Administrator. The Plan Administrator has the discretionary authority to resolve any questions regarding the Plan, including the authority to interpret the terms of the Plan and to determine eligibility for and entitlement to the Plan benefits. The Plan Administrator assumes all duties and responsibilities, including fiduciary duties imposed upon the Plan Administrator by ERISA. The address of the Plan Administrator is:

Vanderbilt University Medical Center
2525 West End Avenue, 5th Floor
Nashville, TN 37203

The company has contracted with Benefit Express to provide day-to-day:

- Processing of the Plan reimbursement requests
- Determination of expense and dependent eligibility
- Documentation for claims, and
- Opinions on claims appeals
You may direct questions regarding any of these issues to:

Benefit Express
1700 East Golf Road, Suite 1000
Schaumburg, IL 60173
Phone: 844-489-3745 Fax: 253-793-3766

PLAN FUNDING

All expenses reimbursed through this Plan are funded by the pre-tax contributions to the employee’s FSA account(s). You may receive information concerning your account balances by contacting Benefit Express at 877-837-5017 or by contacting your local Human Resource department.

LEGAL ACTIONS

All legal processes should be served to:

Vanderbilt University Medical Center
2525 West End Avenue, 5th Floor
Nashville, TN 37203
ELIGIBILITY

You are eligible to participate in the Plan if you are a Full Time Exempt Faculty, Full Time Exempt Staff, Full Time Non-Exempt Staff or House Staff employee who works 30 or more hours per week. If you were not at work on the day coverage would begin, your coverage will become effective on the day you return to work.

Part Time Staff employees who work less than 30 hours per week, as well as temporary contract employees, sole proprietors and partners in a partnership or 2% or greater shareholders in an S-corporation are not eligible to participate in the Plan.

DEPENDENT STATUS

Under your Health Care FSA, eligible dependents are any individual who is your tax dependent, but not applying the requirements that (1) an individual who is the dependent of another taxpayer is treated as having no dependents, (2) a married individual who files a joint return cannot be a dependent, and (3) gross income of a "qualifying relative" must be less than the exemption amount and with the following exception, (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child’s support for the calendar year, is treated as a dependent of both parents).

For purposes of this section a “qualifying relative” is defined as an individual who (1) has a relationship with the taxpayer as set forth in federal law, such as child, brother or sister, or father or mother, (2) receives over one-half of his or her support from the taxpayer and (3) has income that does not exceed the exemption amount for the tax year.

Any reimbursements for expenses for your child will be tax free, if he or she has not reached age 27 during the year.

Under your Dependent Day Care FSA, dependents are defined as your children who are younger than the age of thirteen and any dependent adult (including your spouse) who is physically or mentally disabled and unable to care for him/herself. Children and adults that you do not claim as dependents on your federal income taxes and any children age thirteen and older do not qualify as eligible dependents under your Dependent Day Care FSA. Under certain circumstances, the custodial parent may be reimbursed through their Dependent Day Care FSA for childcare, even if the child is not claimed as a dependent for tax purposes. Please contact a qualified tax expert for advice if you are unsure if you can claim your child as a dependent for your FSA under IRS rules.
ENROLLMENT

Annually, you may enroll in the FSA Plan during Vanderbilt University Medical Center Open Enrollment Period. Open enrollment occurs during the fourth quarter of each year. Your enrollment during this period will be effective for the coming plan year. For example: Open enrollment for the Plan Year 2016 occurred during October of 2015.

If you are hired during the plan year, you may enroll on the first of the month following 90 days of employment. If you qualify to begin participation you must complete your enrollment no more than 30 days after your hire date. If you enroll after the Open Enrollment period, the maximum amount you may contribute to the Plan will be prorated.

If you experience a Qualifying Change in Life Status, you may enroll or make changes in your contributions to an existing Health Care or Dependent Day Care FSA within 30 days of the qualifying change in life status. If you qualify to begin or change your participation you must complete your enrollment within 30 days of your Qualifying Change in Life Status. The change in your contribution must correspond to your change in life status. The Plan Administrator will evaluate requests for changes in contributions on a case-by-case basis. Documentation of the change in life status may be required. If you enroll or change your contribution election to your existing FSA due to a Qualifying Change in Life Status the maximum amount you may contribute to your account will be pro-rated for the remainder of the plan year.

If you choose not to enroll in a Health Care or Dependent Day Care FSA when you are first eligible, you may then only enroll during Vanderbilt University Medical Center’s next Open Enrollment period or if you experience a Qualifying Change in Life Status.

If you leave employment with Vanderbilt University Medical Center and return within the same calendar year, you may resume your previous level of benefit. Your payroll deductions will be adjusted accordingly. You would need to re-enroll in the benefit to resume participation.

Termination in the Plan will be effective on the date of your termination from the company.

You must re-enroll during the Open Enrollment period each year if you wish to continue to participate in the FSA Plan.
CONTRIBUTIONS

You decide how much to contribute to your FSA within certain minimum and maximum limitations. Your annual contribution must meet the criteria set below.

- The minimum annual contribution is $104.
- The maximum contribution for a Health Care FSA is $2,550 per year.
- The maximum contribution for a Dependent Day Care FSA is $5,000 per year. If you are married and filing separate tax returns, your maximum contribution for a Dependent Day Care FSA is $2,500 per year. If you are married and your spouse participates in a separate Dependent Day Care FSA, your maximum contribution is $2,500 per year.

All contributions to the FSA must be made through payroll deductions. IRS regulations do not allow contributions from one FSA to be transferred to another FSA for any reason.

CHANGING YOUR CONTRIBUTION

You may only change your contribution to the Health Care FSA and Dependent Day Care FSA during the year if you experience a Qualifying Change in Life Status. Qualifying changes in life status are limited to:

- Marriage, divorce, or legal separation
- Birth, adoption, or placement of a child for adoption
- Death of spouse or dependent
- Change in spouse’s employment – loss of employment, commencement of employment, full-time to part-time, or part-time to full-time, disability
- Change in employee’s employment - loss of employment, full-time to part-time, or part-time to full-time, disability

You may change your contribution due to one of the above life status changes, however, you may not increase or decrease your election so that your contribution is less than or greater than the allowable limits under the Plan. Also, you may not decrease your contribution to a level so that your annual contribution would equal less than the amount already reimbursed to you.

Your change in contribution must be necessary and consistent with your Qualifying Change in Life Status.

- You may not reduce your Health Care FSA election during a Plan Year; however,
- You may cancel Health Care FSA participation completely. You may not change your Health Care FSA election during the year as a result of changes in your medical, dental or vision plans.
- You may change or terminate your Dependent Day Care FSA election only if the Change in Life Status event affects the eligibility of dependent day care expenses for the available tax exclusion.
- You may change your future Dependent Day Care contributions to correspond with a change by your dependent day care provider. For example: if you terminate one dependent day care service provider and hire a new dependent day care service provider, you may change coverage to reflect the cost of the new service provider; and, if you terminated a dependent day care service provider because a relative becomes available to take care of the child at no charge, you may cancel coverage.
The Administrator may modify your election(s) downward during the Plan Year if you are a key employee or a highly compensated individual (as defined by the Code), if this is necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

Any new contribution election will remain in effect unless you experience another Qualifying Change in Life Status.

**LEAVE OF ABSENCE, PARTICIPATION, AND CONTRIBUTIONS**

If you take a qualifying leave of absence under the Family and Medical Leave Act of 1993 (FMLA), Vanderbilt University Medical Center may elect to continue Health Care FSA coverage while you are on paid leave. If so, you will make your contribution on a pre-tax salary reduction basis.

If you take an approved unpaid leave of absence (or paid FMLA leave where coverage is not required to be continued), you may choose to continue your participation in the Health Care FSA Plan. You will not make contributions to the Health Care FSA while on leave of absence. Your pre-tax contributions will be re-amortized at the time you return to active status.

**AUTOMATIC REDUCTION OR TERMINATION OF ELECTION**

If your compensation available for contribution to the Plan is reduced so that you are not able to contribute the full amount you agreed to contribute at enrollment, your level of contributions and the amount you are entitled to withdraw from your account will automatically be reduced for the remainder of the Plan Year to the amount of salary available for contribution. The amount of the reduction will be taken first from your account for dependent care expense reimbursement, and the balance of the reduction amount shall be taken from your account for health expense reimbursement. Your participation in the Plan will automatically terminate on the day you terminate employment with Vanderbilt University Medical Center or change employment status from full-time to part-time. Any amounts then credited to your account for health expense reimbursement or dependent care expense reimbursement may be used for these respective expenses which you incurred during the coverage period of that year before the date of termination of your participation in the Plan.
EXPENSES

Eligible and ineligible expenses for a Health Care FSA and/or a Dependent Day Care FSA may change from year to year due to changes in tax laws. The lists below are only meant to provide a general outline for eligible and ineligible expenses. Before you enroll, you may want to contact Benefit Express, toll free, at 1-877-837-5017 to determine if a particular expense is eligible under current tax laws. A complete description of eligible expenses can also be found in the Internal Revenue Service Publication 502.

HEALTH CARE FSA – ELIGIBLE EXPENSES

“Eligible health care expenses” mean expenses incurred by you and/or your dependents for “medical care” as defined in Code Sections 213(d). Generally, this means an item for which you could have claimed a medical care expense deduction on an itemized federal income tax return (without regard to any threshold limitation or time of payment) for which you have not otherwise been reimbursed or could be reimbursed from insurance or from some other source.

You, your spouse, or an eligible dependent must incur these expenses. Only those expenses incurred while you are a participant in the Flexible Spending Account Plan are eligible for reimbursement.

FSA ELIGIBLE HEALTH CARE EXPENSES

- Acupuncture
- Alcoholism Treatment
- Ambulance
- Artificial Limb
- Autoette/Wheelchair
- Bandages
- Braille Books and Magazines
- Chiropractor
- Christian Science Practitioner (for medical care)
- Coinsurance
- Crutches
- Deductibles
- Diagnostic Services
- Disabled Dependent Medical Care
- Drug/Alcohol Addiction Treatment (including lodging and meals, if necessary for treatment)
- Drugs and Medicines (prescribed by a physician)
- Durable Medical Equipment
- Guide Dog
- Hearing Aids and Hearing Exams
- Home Care
- Hospital Services
- Inpatient care for treatment of mental or physical handicap
- Laboratory Fees
- LASIK Surgery
- Lead Based Paint Removal (to prevent a child who has, or has had, lead poisoning from eating the paint would qualify)
- Learning Disability counseling (If prescribed by a physician)
- Lodging Essential to Medical Care (e.g. out of town hotel stay to see a specialist to treat a medical condition)
- Maternity Care and Related Services
- Medical Services (Physician, Surgeon, Specialists)
• Medicine prescribed by a physician
• Mentally Disabled, Special Home for
• Nursing Services (in home if recommended by physician)
• Organ Donor's Medical Expense and Transportation
• Osteopath
• Oxygen
• Prosthesis
• Psychiatric Care
• Psychoanalysis
• Psychologist
• Routine Physical Exam-Wellness Visit, Well Woman Exam
• Special Education (with physician’s recommendation payments made for a mentally impaired or physically disabled person)
• Special Medical Equipment such as wheelchairs, crutches, and orthopedic shoes
• Sterilization
• Smoking Assist Programs
• Surgery
• Telephone/Television for the Hearing Impaired
• Therapy
• Transplants
• Transportation Essential to Medical Care (e.g. taxi, bus, train fare to physician’s office)
• Vasectomy
• Weight-loss Program Prescribed by a Physician as Part of a Treatment Program
• Wig (to replace hair loss due to disease)
• X-rays

ELIGIBLE DENTAL EXPENSES
• Crowns
• Dentures
• Orthodontics (braces, etc.)
• Preventative and basic procedures (e.g. Teeth cleaning, exam)
• Root canals
• Tooth extractions

ELIGIBLE EYE CARE EXPENSES
Optometric services and medical expenses for eyeglasses and contact lenses needed for medical reasons are reimbursable. Eye exams and expenses for contact lens solutions are also reimbursable. However, premiums for contact lens replacement insurance are not reimbursable. Other vision services that are covered include:
• Contact lens cases
• Corrective swim goggles
• Eye charts
• Eyeglass cases
• Eyeglass cleaning supplies such as cleaning cloths
• Reading glasses
• Eyeglass repair or repair kits
• Safety glasses when the lenses correct visual acuity
• Sunglasses or sunglass clips when the lenses correct visual acuity
• Vision shaping
ELIGIBLE OVER-THE-COUNTER MEDICATION EXPENSES THAT REQUIRE A PHYSICIAN’S PRESCRIPTION

Section 9003 of the Affordable Care Act established a new uniform standard for medical expenses. For any expenses incurred on or after January 1, 2011 distributions from health FSAs and HRAs will be allowed to reimburse the cost of over-the-counter medicines or drugs only if they are purchased with a prescription. This new rule does not apply to reimbursements for the cost of insulin, which will continue to be permitted, even if purchased without a prescription.

For any eligible expenses incurred on or after January 1, 2011, they at will require a physician’s prescription for reimbursement may include, but are not limited to:

- Acetaminophen
- Acne products
- Allergy products
- Antacid remedies
- Antibiotic creams/ointments
- Anti-fungal foot sprays/creams
- Aspirin
- Baby care products
- Cold remedies (including shower vapor tabs and vapor units)
- Cough syrups and drops
- Eye drops
- Ibuprofen
- Laxatives
- Migraine remedies
- Motion sickness
- Nasal sprays
- Pain relievers
- Sleep aids
- Topical creams for itching, stinging, burning, pain relief, sore healing or insect bites

ELIGIBLE OVER-THE-COUNTER MEDICATION EXPENSES

Items that will continue to be eligible without a physician’s prescription after January 1, 2011 include, but are not limited to:

- Band aids
- Bandages and wraps
- Braces and supports
- Catheters
- Contact lens solutions and supplies
- Contraceptives and family planning items
- Denture adhesives
- Insulin and diabetic supplies
- Diagnostic tests and monitors and first aid supplies, peroxide and rubbing alcohol
HEALTH CARE FSA – INELIGIBLE EXPENSES

The items or services listed below are currently ineligible for reimbursement from the Health Care FSA. Please note that any expense incurred prior to your first participation date or after your plan termination date are ineligible for reimbursement. Also, any expense that you claim as a deductible on your federal income tax form is ineligible for reimbursement.

ITEMS NOT ELIGIBLE FOR FSA REIMBURSEMENT

- Adoption - the cost of the adoption itself is not covered, however health-related expenses such as physicals for the adoptive parents and pre-adoption counseling may be covered
- Age Management Systems (Cenegenics)
- Annual medical contract fees for exclusive provider care
- Breast Pump, Shields, Gel Pads
- Clothing
- Cosmetic Procedures
- Cushions
- Dental bleaching or any other teeth whitening
- Dental Enamel Micro-Abrasion
- Domestic help fees (for services of a non-medical nature)
- Driving Lessons
- Electric toothbrush replacement brushes
- Electrolysis or hair removal
- Facial Tissues, Antiviral
- Finance charges
- Fluoride - Expenses paid for over-the-counter fluorides such as toothpaste with fluoride, or fluoride mouth wash or rinse
- Glycerin Shakes
- Hair loss treatments (non-prescription) such as over-the-counter medications are not covered. However, prescription medications prescribed by a physician to treat a medical condition are covered.
- Hair transplant
- Health club dues/memberships, for general well-being unless part of a medically prescribed regimen to treat a specific condition. Physician's diagnosis letter required.
- Insurance premiums of any kind. (See exceptions for HRA and HSA.)
- Interest
- Lactation Consultation
- Laetrile, even if prescribed by a Physician
- Late charges
- Late payment interest
- Lens replacement insurance
- Marijuana, even if prescribed for medicinal purposes
- Massage therapy for general well-being, unless accompanied by a physician's diagnosis letter
- Medicine flavorings
- Missed appointment fees
- Over-the-counter items which are items not categorized as a medicine or drug and may include, but are not limited to, nail clippers, pumice stones, feminine hygiene products, etc., are not
reimbursable, unless accompanied by a physician’s diagnosis letter. Over-the-counter toiletries or personal hygiene items which may include, but are not limited to shampoo, toothpaste, conditioners, hand creams, deodorant, shaving cream, razors, dental floss, body powders, hair gels/sprays, make-up, nail polish accessories, soap, mouthwash, etc., are not reimbursable.

- Pastoral Counseling
- Personal Trainer
- Physical therapy treatments for general well-being
- Pill bags
- Postage
- Pre-seed moisturizers
- Saddle Soap
- Savings Club
- Shampoo that is non-medicated
- Spider vein therapy such as with sclerosing agent injections are considered cosmetic. However, if the therapy is for other than a diagnosis of spider vein therapy the charges are reimbursable when accompanied by a physician’s diagnosis letter.
- Supplements - taken for general well-being.
- Tanning lotions without sun protection
- Tips paid for taxi fares, etc.
- Ultrasound - 4D/Elective
- Union dues
- Vitamins taken for general well-being
- Warranties
- Weight loss program food or convenience items such as water bottles
- Weight loss machines

For more information about what items are, and are not, deductible Health Care Expenses, consult IRS Publication 502 (Medical and Dental Expenses), under the headings “What Medical Expenses are Deductible:” and “What Expenses Are Not Deductible?” Review the Publication with caution because it was meant only to help taxpayers figure out their tax deductions, not to explain what is reimbursable under a Health Care FSA.

DEPENDENT DAY CARE FSA – ELIGIBLE EXPENSES

“Dependent Day Care expenses” means employment-related expenses incurred on behalf of any Dependent:

- Under age 13 for whom you are entitled to claim a dependent exemption on your federal income tax return (if you are a divorced parent, a child is your Dependent if you have custody of the child, even if you are not entitled to claim the dependency exemption); or

- Spouse or a person who is your dependent under federal tax law (even if you cannot claim the dependency exemption on your federal income tax return), who is physically or mentally incapable of self-care.

The following list is meant to provide a guideline for you to determine if an expense is eligible for reimbursement.

ELIGIBLE EXPENSES

- Day care
- Nursery School
- After-school care programs
- Day camp
• Elder care
• Home healthcare worker

Claims must be expenses necessary for you (and your spouse, if married) to work, look for work or attend school. Expenses incurred because your spouse is physically or mentally incapable of self-care are also eligible.

DEPENDENT DAY CARE FSA – INELIGIBLE EXPENSES

The items or services listed below are currently ineligible for reimbursement from the Dependent Day Care FSA. Please note that any expense incurred prior to your first participation date or after your plan termination date is ineligible for reimbursement. Also, any expense that you claim as a deductible on your federal income tax form is ineligible for reimbursement.

INELIGIBLE EXPENSES

• Any expenses incurred prior to your enrollment date
• Any payment for childcare to a person who can also be claimed by the employee as a dependent
• Any payment for child care to a relative under the age of 19 to provide care for your dependents
• Over-night camp
• Clothing or equipment required for camp
• Educational fees
• Field trip fees
• Weekend or evening-out babysitting

INCURRING EXPENSES

For expenses to be reimbursed to you, they must have been incurred during the Plan Year. This occurs when the service is provided, not when the expense is paid. Note, if you have paid for the expense but if the services have not yet been rendered, then the expense has not been incurred for this purpose.

If you pay for your child’s day care on the first day of the month for care given during the entire month, the expense has not been incurred until the end of that month.

You may not be reimbursed for any expenses incurred before the Plan Year begins, before your specific effective date in the Plan, after the close of the Plan Year, or after a separation from service (unless you elect COBRA Coverage for the Health Care account).
REIMBURSEMENT

When you incur an eligible expense, you must submit a request for reimbursement on the Flexible Spending Account Reimbursement Request Form to Benefit Express. Supporting documentation must accompany all FSA reimbursement requests. IRS Guidelines require the submission of third party documentation which includes:

- DATE OF SERVICE
- FOR WHOM SERVICE WAS PROVIDED
- NAME OF PERSON/GROUP PROVIDING SERVICES (For Dependent Day Care expenses, it must include the providers Federal Tax ID number, or Social Security Number)
- DESCRIPTION OF SERVICE
- TOTAL COST OF SERVICE

Acceptable documentation generally includes an Explanation of Benefits (EOB) from your medical insurance carrier and/or a receipt from your provider detailing the date of service, description of service and total cost of the service. CANCELLED CHECKS, CREDIT CARD RECEIPTS OR STATEMENTS, OR BALANCE FORWARD STATEMENTS are not acceptable forms of documentation.

Reimbursement of over-the-counter medications and supplies may require copies of box-tops and/or a physician’s note.

The request must also include a written statement from you that the expense has not been reimbursed or is not reimbursable under any other plan. Signing the Reimbursement Form includes the required statement that you have not already received reimbursement for the requested amount(s).

Under your Health Care FSA, you can be reimbursed up to the amount you elected to contribute for that year less any amounts already paid to you, regardless of the amount you have contributed when you submit the claim. Under your Dependent Day Care FSA, you can be reimbursed up to the balance in your account at the time payment is made.

Generally, requests received by the end of business day Tuesday (CST) will be reviewed on Wednesday and Thursday and approved payments will be processed on Friday (subject to holiday schedules and a 15-day extension for matters beyond the Administrator’s control). The Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary to decide your claim.

The minimum reimbursement amount is $25.00. Approved claims will be accumulated until the total payment exceeds $25.00 before payment is made. However, at the end of each Plan Year, you will be allowed to submit any amount to close out your account for the year.

To have your claims processed as soon as possible, please note that it is not necessary for you to have actually paid the bill for an expense – only for you to have incurred the expense, and certify that it is not being paid for or reimbursed from any other source.

Claims for expenses incurred during the Plan Year must be submitted no later than the Run-Out Period at the end of the Plan Year.
You may obtain a Flexible Spending Account Reimbursement Request Form from and must submit your request for reimbursement with substantiating documentation to:

Benefit Express  
1700 East Golf Road, Suite 1000  
Schaumburg, IL 60173  
Phone: 844-489-3745  
Fax: 253-793-3766

FORFEITURES

If your expenses during the Plan year are less than the annual amount that you elected, you will **not** be entitled to receive any direct or indirect payment for the difference. The difference will be forfeited. This is known as the “use it or lose it rule” imposed by the IRS.

Forfeited amounts will be used by the Plan to offset reasonable administrative expenses and future costs.

Any payments that are unclaimed (for example, uncashed benefit checks) for 180 days or more after the check was issued will be forfeited.

DENYING CLAIMS

If your claim is denied, in whole or in part, you will be notified in writing within 30 days of the date your claim was received of the reason(s) your claim has been denied. These reasons include but are not limited to ineligible expenses per IRS regulations, submission of claims incurred prior to or after the benefit effective or termination date, incorrectly completed reimbursement form or no supporting documentation, or unacceptable supporting documentation.

If you feel a claim was incorrectly denied, you should contact Benefit Express and ask for a review of your claim.

Your appeal must be made in writing within 180 days of the denial. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court. Your written appeal should state the reason(s) that you feel your claim should not have been denied. It should include any additional facts and/or documents that you feel support your claim.

Your claim will be reconsidered and you will receive written notice of the decision within 60 days. All interpretations of the Plan Administrator will be final and binding.
TAX IMPLICATIONS – INCOME TAXES AND SOCIAL SECURITY

When you establish a Health Care FSA, and/or a Dependent Day Care FSA, you choose to have a certain amount deducted from your paycheck each week. This deduction is made before taxes are calculated. Therefore, your taxable income is lower. In addition, you are not taxed on the money you take out of your account to pay for eligible expenses.

However, expenses that are reimbursed to you through your FSA cannot be included as itemized deductions on your federal income tax form. You may wish to consult a tax advisor to determine if you will pay less in taxes by using a FSA to pay for your eligible expenses or by itemizing your eligible expenses on your tax form.

FSA contributions are not subject to Social Security taxes (FICA), Medicare, state income taxes (except in New Jersey and Pennsylvania), and some local income taxes.

Because you do not pay Social Security taxes on your FSA contributions, your benefits from Social Security may be reduced slightly.

FSA EFFECTS ON OTHER EMPLOYEE BENEFITS

Contributions to a Flexible Spending Account will not affect your Life Insurance, 403(b), Short-term Disability or Long-term Disability. These benefits will continue to be based on your salary without regard to any amounts contributed to your FSA.

COORDINATION OF BENEFITS

You and/or your Dependents may be covered by other company sponsored health and welfare plans. If so, benefits from that plan and benefits under the Medical, Dental and/or Vision Benefits are coordinated so both plans do not pay for the same expenses.

If both you and your spouse work for Vanderbilt University Medical Center, you cannot claim each other as dependents and submit claims for benefits twice. Only one of you can claim your children as Dependents.

If you are both participating in a Flexible Spending Account, you cannot submit the same claim twice.
COBRA COVERAGE

Under COBRA, Vanderbilt University Medical Center is required to provide you and your qualified dependents with the opportunity to reimburse medical care, dental care and/or vision care expenses under the Plan for a limited period of time, unless your participation was terminated due to gross misconduct. This coverage is paid by you or your Qualified Dependents when certain defined events occur that otherwise would cause you and/or your Qualified Dependents to lose coverage. Guidelines and timetables that pertain to FSA administration for active employees will also apply to individuals covered under COBRA.

Please note that COBRA coverage will not be offered if you or your Qualified Dependents were not eligible for benefits prior to your qualifying event.

Following a qualifying event (described below), Vanderbilt University Medical Center must offer you and your Qualified Dependents the opportunity to participate in the Health Care FSA Benefit on an after-tax basis through the remainder of the year in which you qualify for COBRA (as explained below). The opportunity to elect the same coverage that you had at the time the qualifying event occurred extends to all Qualified Dependents. This allows you to be reimbursed for expenses that you incur after your qualifying event, but before the end of the calendar year. You may not re-enroll in the cafeteria plan during any annual enrollment for any calendar year that follows your qualifying event.

QUALIFIED DEPENDENT

This term refers to your spouse and/or dependent child(ren) who are or were covered under one of the Vanderbilt University Medical Center plans on the day before the qualifying event, and who have experienced a qualifying event that leads to a loss of coverage. This also includes a child who is born or placed for adoption with you during the period of COBRA coverage. Whether an individual is a Qualified Dependent is important because each qualified dependent has a separate right to elect COBRA coverage. COBRA documents may use the term “qualified beneficiary” which refers to you and your Qualified Dependents.

Please remember that if you did not enroll any of your dependents in any of the Vanderbilt University Medical Center plans (for whatever reason) prior to a qualifying event, even though they were otherwise eligible, they will not be considered Qualified Dependents for COBRA coverage.

QUALIFYING EVENT

COBRA coverage is offered to you and/or your Qualified Dependents when a qualifying event occurs. A qualifying event is defined as a loss of coverage due to one of the following reasons:

- Your death,
- A change of your employment status, such as your termination of employment from Vanderbilt University Medical Center or a reduction in your working hours,
- Your divorce or legal separation,
- The bankruptcy of Vanderbilt University Medical Center,
- You or any of your qualified beneficiaries are on military leave,
- You elect Medicare as primary coverage, or
- Your dependent child loses eligibility for coverage.
Coverage in effect at the time of the qualifying event terminates on the date that the qualifying life event occurs.

COBRA coverage for the Health Care FSA will terminate:

- If you fail to make a timely COBRA premium payment. An initial premium payment following the election of COBRA coverage is considered timely if received within 45 days of such election. Any subsequent premium is considered timely if it is paid within 30 days from the due date.
- Vanderbilt University Medical Center terminates the Health Care FSA.
- You notify the Administrator that you wish to cancel your coverage.

COBRA OFFER

When Vanderbilt University Medical Center receives notice of a qualifying event, the COBRA Administrator is required to notify you and your Qualified Dependents in writing of your COBRA rights. If you, your spouse and dependent child(ren) live together at the same address, the Administrator satisfies this requirement by mailing one notice addressed to you. The notice will be mailed to your current address on file. It is important to keep your current address information on file with Vanderbilt University Medical Center and COBRA Administrator. Following Vanderbilt University Medical Center’s receipt of notice of the qualifying event, Vanderbilt University Medical Center has 30 days to notify the COBRA Administrator from the qualifying event or the loss of coverage, whichever is later. The COBRA Administrator has 14 days from the date of receiving notice of any qualifying event to mail the notification.

COBRA ELECTION

Once you and your Qualified Dependents receive notice of your COBRA rights from the appropriate administrator, you have 60 days from the date of the notification, or the date your coverage terminates (whichever is later), to elect COBRA coverage. You or your Qualified Dependents elect COBRA coverage by completing and returning the election form, sent with the notice, to the appropriate administrator at the address listed on the form by the deadline indicated above.

Qualified Dependents may waive their rights to COBRA coverage rather than make a COBRA election. However, qualified dependents are permitted to revoke such waiver at any time during the 60-day election period if they change their minds and decide to elect COBRA coverage. Once the 60-day election period ends, the waiver cannot be revoked.

DEPENDENT RIGHTS TO COBRA FOR THE FSA PLAN

Qualified Dependents do not have an independent right to make their own after-tax contributions to a cafeteria plan.

COST FOR COBRA

The premium that you are charged for COBRA coverage for the Health Care FSA is based on your monthly contribution before your employment terminated. You may be charged no more than 102%
of your normal contribution amount. The additional 2% above the premium cost covers Vanderbilt University Medical Center Vanderbilt University Medical Center's cost of administering COBRA.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

A Qualified Medical Child Support Order (QMCSO) is an order or judgment from a state court, or an order issued through an administrative process under state law, directing the Plan Administrator to cover children under the Plan. If the Administrator receives a QMCSO, the Plan Administrator may be required by law to comply with the order allowing an employee's child(ren) to be covered under the Plan. The child(ren) will be covered according to the terms of the QMCSO, and applicable law. The company will determine the validity of any medical child support order that it receives and will notify affected participants of any action taken in response to any order received. No coverage is provided if you do not have custody of the children while the QMCSO evaluation is pending.

CERTIFICATE OF CREDITABLE COVERAGE

When you or your Dependents coverage ends, the company will automatically will mail a certificate of creditable coverage to your home.

This certificate can be used, in accordance with HIPAA, to prove you were covered under a health plan for a certain length of time. The certificate will prove that you had coverage for a maximum of 18 months. You can use this certificate to offset and possibly eliminate pre-existing condition exclusions that may apply under group health plans in which you later participate.

OTHER FEDERAL MANDATES

Because the Health Care FSA is considered as a group health plan under federal law, many federal mandates will apply to you coverage under the Plan. The following is a summary of each mandate.

The Newborns’ and Mothers’ Health Protection Act of 1996: The Health Care FSA under the Plan generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending medical care provider from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable) after consulting with the mother. In any case, federal law prohibits the Plan from requiring that a medical care provider obtain authorization for a length of stay that is less than or equal to 48 (or 96) hours.

Coverage for Mastectomy: Federal law requires the Health Care FSA under Plan to provide coverage for the following services to an individual receiving Plan benefits in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications at all stages of mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

Coverage for breast reconstruction and related services will be subject to deductibles and co-insurance amounts that are consistent with those that apply to other benefits under the Plan.

Michelle’s Law: Michelle’s Law provides continued benefits under the Health Care FSA for dependent children who are covered under the Plan as a student but lose their student status because they take a medically necessary leave of absence from school.
As a result, if your child is no longer a student, as defined in the Plan, because he or she is on a medically necessary leave of absence, your child may continue to be covered under the Plan for up to one year from the beginning of the leave of absence.

This continued coverage applies if, immediately before the first day of the leave of absence, your child was (1) covered under the Plan and (2) enrolled as a student at a post-secondary educational institution (includes colleges and universities).

For purposes of this continued coverage, a “medically necessary leave of absence” means a leave of absence from a post-secondary educational institution, or any change in enrollment of the child at the institution, that:

- begins while the child is suffering from a serious illness or injury,
- is medically necessary, and
- causes the child to lose student status for purposes of coverage under the plan.

The coverage provided to dependent children during any period of continued coverage:

- is available for up to one year after the first day of the medically necessary leave of absence, but ends earlier if coverage under the Plan would otherwise terminate, and
- stays the same as if your child had continued to be a covered student and had not taken a medically necessary leave of absence.

If any expenses provided by the Plan are changed during this one-year period, the Plan must provide the changed coverage for the dependent child for the remainder of the medically necessary leave of absence unless, as a result of the change, the Plan no longer provides coverage for dependent children.

If you believe your child is eligible for this continued coverage, the child’s treating physician must provide a written certification to the plan stating that your child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

**Coordination With COBRA Continuation Coverage:** If your child is eligible for Michelle's Law's continued coverage and loses coverage under the Plan at the end of the continued coverage period, continuation coverage under COBRA will be available at the end of Michelle's Law's coverage period and a COBRA notice will be provided at that time.

**Genetic Information Nondiscrimination Act of 2008 (“GINA”):** The Genetic Information Nondiscrimination Act of 2008 (“GINA”) prohibits the Plan from discriminating against individuals on the basis of genetic information in providing any the benefits under the Health Care FSA.

GINA generally:

- Prohibits the Plan from adjusting premium or contribution amounts for a group on the basis of genetic information;
- Prohibits the Plan from requesting or mandating that an individual or family member of an individual undergo a genetic test, provided that such prohibition does not limit the authority of a health care professional to request an individual to undergo a genetic test, or preclude a group health plan from obtaining or using the results of a genetic test in making a determination regarding payment;
• Allows the Plan to request, but not mandate, that a participant or beneficiary undergo a genetic test for research purposes if the Plan does not use the information for underwriting purposes and meets certain disclosure requirements; and

• Prohibits the Plan from requesting, requiring, or purchasing genetic information for underwriting purposes, or with respect to any individual in advance of or in connection with such individual’s enrollment.

Mental Health and Substance Abuse Benefit: The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") imposes significant new requirements on the Plan that offer mental health and substance abuse benefits. Current law prohibits health plans from imposing lower annual and lifetime limits on mental health coverage than on other types of medical coverage. The MHPAEA further limits other types of financial and non-financial limitations that plans may impose on mental health coverage and substance abuse benefits. Some of the MHPAEA’s key provisions are as follows:

• Financial limitations—including limitations on deductibles, copayments, coinsurance, and out-of-pocket expenses—imposed on mental health and substance abuse benefits may not be higher than those imposed on other types of medical coverage;

• The Plan may not place limits on the scope or duration of treatment for mental health or substance abuse that are more restrictive than for other types of medical treatment;

• The Plan must provide, upon request, information to plan participants and providers regarding the criteria for determining whether mental health or substance abuse treatment is medically necessary, and the reasons for denial of coverage; and

• Coverage of mental health and substance abuse benefits by out-of-network providers must be on par with out-of-network coverage for medical treatment.

PRIVACY RIGHTS

Disclosures of enrollment/disenrollment information permitted - The Plan may disclose to your company information on whether you are participating in the Health Care, or are enrolled in or have disenrolled. For purposes of this article, “Protected Health Information” ("PHI") means individually identifiable health information that is maintained or transmitted by a covered entity, subject to specified exclusions as provided in federal regulations. For purposes of this article, Electronic Protected Health Information or Electronic PHI means PHI that is transmitted by or maintained in electronic media.

Uses and disclosures of summary health information permitted - The Plan may disclose Summary Health Information to your company, provided your company requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (b) modifying, amending, or terminating the Plan.

“Summary Health Information” means information that (a) summarizes the claims history, claims, expenses, or type of claims experienced by individuals for whom your company had provided health benefits under the Plan; and (b) from which the information has been deleted, except that the geographic information need only be aggregated to the level of a five-digit zip code.

Required uses and disclosures of PHI permitted for plan administrative purposes - Unless otherwise permitted by law, and subject to the conditions of disclosure and obtaining written certification, the Plan (or an insurance company on behalf of the Plan) may disclose PHI and Electronic PHI to your company, provided your company uses or discloses such PHI and Electronic PHI only for Plan administration purposes. “Plan administration purposes” means administration functions performed by your company on behalf of the Plan, such as quality assurance, claims processing, auditing, and
monitoring. Plan administration functions do not include functions performed by your company in connection with any other benefit or benefit plan of your company, and they do not include any employment-related functions.

Enrollment and disenrollment functions performed by your company are performed on behalf of you and your dependents, and are not Plan administration functions. Enrollment and disenrollment information held by the company is held in its capacity as the plan sponsor and is not PHI.

Notwithstanding the provisions of this Plan to the contrary, in no event shall your company be permitted to use or disclose PHI in a manner that is inconsistent with federal regulations.

**PHI to be disclosed for plan administration purposes** - Your company agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Plan, your company shall:

- not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;
- ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan, agrees to the same restrictions and conditions that apply to your company with respect to PHI;
- not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of your company;
- report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for;
- make available PHI to comply with HIPAA's right to access in accordance with federal regulations;
- make available PHI for amendment and incorporate any amendments to PHI in accordance with federal regulations;
- make available the information required to provide an accounting of disclosures in accordance with federal regulations;
- make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA’s privacy requirements;
- if feasible, return or destroy all PHI received from the Plan that your company still maintains, in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and.
- ensure that the adequate separation between the Plan and your Company (i.e. the “firewall”), required in federal regulations, is established.

Your company further agrees that it creates, receives, maintains or transmits any Electronic PHI (other than enrollment/disenrollment information and Summary Health Information and information disclosed pursuant to a signed authorization that complies with the federal requirements which are not subject to these restrictions) on behalf of the Plan, it will:
• implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives maintains or transmits on behalf of the Plan;

• ensure that the adequate separation between the Plan and your company (i.e., the firewall), is supported by reasonable and appropriate security measures;

• ensure that any agent, including a subcontractor, to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and

• report to the Plan any security incident of which it becomes aware, as follows: your Company will report to the Plan, with such frequency and at such times as agreed, the aggregate number of unsuccessful, unauthorized attempts to access, use, disclose, modify, or destroy Electronic PHI or to interfere with systems operations in an information system containing Electronic PHI; in addition the Company will report to the Plan as soon as feasible any successful unauthorized access, use disclosure, modification or destruction of Electronic PHI or interference with systems operations in an information system containing Electronic PHI.

Those permitted to disclose information - Your company shall allow those classes of employees or other persons in your Company’s control designated by your Company to be given access to PHI. No other persons shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use PHI to the extent necessary to perform the plan administration functions that your company performs for the Plan. In the event that any of these specified employees do not comply with the provisions of this Section, that employee shall be subject to disciplinary action by your company for non-compliance pursuant to your company’s employee discipline and termination procedures.

Your company shall ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the persons designated above create, receive, maintain, or transmit Electronic PHI on behalf of the Plan.

PHI to be disclosed to your company - The Plan shall disclose PHI to your company only upon the receipt of a certification by your company that the Plan has been amended to incorporate the provisions of federal regulations, and that your company agrees to the conditions of disclosure set forth in this summary.

AMENDMENT AND TERMINATION OF PLAN

Vanderbilt University Medical Center reserves the right to amend or terminate this Flexible Spending Account Plan at any time. Any amendment or termination of the Plan will not affect the right of Plan participants to reimbursement for eligible expenses they incur prior to said amendment or termination. Any amendment or termination of the Plan shall become effective as of the end of a pay period.

STATEMENT OF ERISA RIGHTS

Participants in the Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500) filed by the Plan with the U.S. Department of Labor.

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.

In addition to creating rights for Plan participants, ERISA imposes obligations upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of all Plan participants. No one, including Vanderbilt University Medical Center Vanderbilt University Medical Center, a union, or any other person, may fire an employee or discriminate against an employee to prevent the employee from obtaining any benefit under the Plan or exercising their rights under ERISA.

If claims for benefits under the Plan are denied, in whole or in part, the participant must receive a written explanation of the reason for the denial. The participant has the right to have the Plan review and reconsider the claim.

Under ERISA, there are steps participants can take to enforce their rights. For instance, if material is requested from the Plan and the material is not received within thirty (30) days, the participant may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials and pay the participant up to $110 a day until the materials are received, unless the materials were not provided for reasons beyond the control of the Plan Administrator. If a claim for benefits is denied or ignored in whole or in part, the participant may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan’s money, or if participants are discriminated against for asserting their rights, participants may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who will pay the costs and legal fees. If the participant is successful, the court may order the person who is sued to pay these costs and fees. If the participant loses, the court may order the participant to pay the costs and fees: for example, if it finds the participant’s claim frivolous.

Participants should contact the Plan Administrator for questions about the Plan. For questions about this statement or about rights under ERISA, participants 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.
DEFINITION OF TERMS

Annual Contribution – represents the total dollar amount you want to have deducted from your annual salary. The total annual amount you elect to deduct will be divided equally among your paychecks throughout the Plan Year. The Annual Contribution is subject to minimum and maximum limitations. If you begin participation in an FSA midyear, your annual contribution limitations will be prorated for the time remaining in the Plan Year.

COBRA – means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Dependent – means any individual who is your tax dependent, with the following exception, (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child’s support for the calendar year) is treated as a dependent of both parents. In addition, any child under age 26 will be treated as a dependent.

The Plan will provide benefits in accordance with the requirements of any Qualified Medical Child Support Order (QMCSO), even if the child does not meet the definition of “Dependent”.

Dependent Day Care FSA – an account that allows you to contribute your pre-tax dollars to pay for eligible dependent day care expenses you incur throughout the Plan Year.

Eligible Dependents – are those dependents that you claim on your federal income tax form or any child under age 26. Under certain circumstances, the custodial parent may be reimbursed through their Dependent Day Care FSA for childcare, even if the child is not claimed as a dependent for tax purposes. Please contact a qualified tax expert for advice if you are unsure if you can claim your child as a dependent for your FSA under IRS rules.

Eligible Expenses – are those expenses that can be reimbursed to you through your FSA. These expenses meet the requirements set forth by the Internal Revenue Code regulating Flexible Spending Accounts.

ERISA – means the Employee Retirement Income Security Act of 1974, as amended from time to time.

Flexible Spending Account or FSA or Plan – is a benefit that allows employees to set aside a portion of their pre-tax earnings to pay for eligible expenses throughout the Plan Year.

Grace Period - The Plan allows active participant 75 days after the end of the Plan Year (until March 15th) to submit claims incurred during the period of eligibility.

Health Care FSA – an account that allows you to contribute your pre-tax dollars to pay for eligible medical, dental, and vision expenses you incur throughout the Plan Year.

HIPAA - the Health Insurance Portability and Accountability Act of 1996, which is a far-reaching legislation designed to improve the portability of health coverage and to make other changes to the health care delivery system.

Incurred Expense – an expense is considered incurred when an eligible service has been delivered.

Maximum Contribution – is the maximum dollar amount you are allowed to contribute to your FSA. The exact dollar amounts for the maximum monthly and annual contributions allowed may be found in the Contributions Section of this document.

Minimum Contribution – is the minimum dollar amount you are allowed to contribute to your FSA. The exact dollar amounts for the minimum monthly and annual contributions allowed may be found in the Contributions Section of this document.
**Plan Administrator** – the party with the discretionary authority to interpret Plan documents. The **Plan Administrator** assumes all responsibilities imposed by ERISA.

**Plan Year** – The 12-month period beginning on January 1 and ending on December 31.

**Qualifying Change in Life Status** – is defined by the IRS as an event caused by marriage, divorce, addition or loss of a dependent, change in your employment from full-time to part-time or vice-versa, or a change in spouse’s employment. When a change in family status occurs, you are eligible to enroll in an **FSA** Plan, change your contribution amount(s), or stop your **Plan** participation. If you elect to change your contribution amount(s) due to a qualifying change in family status, that contribution change must be consistent with your change in family status. For example, if you experience a loss of a dependent, you may only decrease your contributions, not increase them.

**Run-out Period** - The **Plan** allows active participant 120 days after the end of the Plan Year (until April 15th) to submit claims incurred during the period of eligibility.
Health Reimbursement Account

[formerly the “Flexible Reimbursement Account (FRA)”] for Vanderbilt University Medical Center

Summary Plan Description

- Prior to January 2009, this Vanderbilt University Medical Center benefit was referred to as “Flexible Reimbursement Account (FRA).”
- The Internal Revenue Service name for this type of plan is “Health Reimbursement Account.”
- Beginning January 1, 2009, Vanderbilt University Medical Center refers to this benefit using the IRS terminology, “Health Reimbursement Account (HRA).”

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.
YOUR HEALTH REIMBURSEMENT ACCOUNT

Eligibility
To be eligible for the Health Reimbursement Account (HRA), faculty or staff must have begun employment on or before December 31, 2004. Faculty and staff whose employment began on or after April 1, 1996, become eligible after having been employed at Vanderbilt University Medical Center on a full-time regular basis for a continuous period of at least five years and having been enrolled in the Vanderbilt University Medical Center Group Health Care Plan for Faculty and Staff with no break in coverage for those five years. Faculty and staff who began full-time employment before April 1, 1996, and therefore were already receiving this benefit, are not subject to the five-year continuous employment requirement. If, at any time, an employee opts out of coverage under the Vanderbilt University Medical Center Group Health Care Plan for Faculty and Staff, eligibility, and the ability to accrue the five-year service requirement, is relinquished.

Credits to Your Account
Vanderbilt University Medical Center pays the full cost of the HRA, depositing $25 per Plan (calendar) month into an account for each eligible faculty and staff member starting with the first month in which they become eligible.

Expenses that Are Eligible for Reimbursement
Charges must be for health care services and supplies provided (1) on or after the date you first become eligible under the HRA Plan and (2) filed within the Run-out Period in order to be reimbursed. Charges for health care services and supplies provided during a Plan Year (January 1 to December 31, including the Grace Period) cannot be carried forward into the next Plan Year for reimbursement.

For example, assume a participant has an account balance of $50 as of December 31, the end of the Plan Year. On December 27, the participant received health care services costing $75. As there is only $50 in the account, only $50 can be reimbursed. The remaining $25 cannot be reimbursed in the next Plan Year because the services were not provided in that next Plan Year.

Health Care Expenses
You may be reimbursed for the following health care expenses for you and your eligible dependents:

- MEDICAL expenses, including the unpaid portion of medical claims (for example, deductibles and out-of-pocket portion of covered expenses, including, for example, prescription copays), routine physical examinations, prescribed preventive care, and reconstructive surgery.
- DENTAL services, including oral surgery, orthodontics, prosthodontics, periodontics, and endodontics.
- VISION care, including expenses for eye examinations, prescription glasses, and contact lenses.
- HEARING care, including examinations and hearing aids.

How to Request Reimbursement
**MasterCard Debit Card:** The health care debit card issued by Benefit Express, “Benefit Card”, can be used like a credit card to access HRA funds for eligible expenses by swiping the card at the point of purchase with an authorized merchant [contact Benefit Express, 1-877-837-5017, for a current list of authorized merchants]. You must keep all receipts and check your online monthly statements in case you need to verify card purchases by faxing or mailing receipts and a claim form to Benefit Express (or the Internal Revenue Service in case of a tax audit). If you have unverified expenses of any amount, your card(s) will be suspended until proper verification is provided to Benefit Express. Vanderbilt University Medical Center does not accept liability for inappropriate use of the health care debit card. If you use the card after termination of employment from Vanderbilt University Medical Center, you will be required to pay back any amounts charged after your termination date. You must notify Benefit Express immediately of any loss or theft of your card(s) by calling 877.837.5017.

According to Internal Revenue Service regulations, beginning January 1, 2009, the health care debit cards can only be used at merchants who have installed an inventory information approval system (IIAS) and completed the IIAS certification process. IIAS allows only eligible items to be purchased with health care debit cards and makes using the card easier because you should not need to verify card transactions completed at IIAS merchants.

**Reimbursement Form:** The Benefit Express reimbursement request form can be obtained from the Human Resources website (http://hr.mc.vanderbilt.edu), under the Benefits tab click on My VUMC Benefits. Once you log in with your VUnetID and ePassword you will be directed to the My VUMC Benefits website. Scroll down to “Reimbursement Accounts” and click on "View My Reimbursement Account", then My Accounts, then Forms & Documents. Attach copies of bills, receipts, or Explanations of Benefits showing: 1) name of person incurring the expense, 2) date of the expense, 3) description of the expense (including name of provider), and 4) amount of the expense. You should retain a full copy of any claim form submitted in your files. Requests for reimbursement should be faxed to Benefit Express using their fax: 253.793.3766 or mailed to: Benefit Express, 1700 East Golf Road, Suite 1000, Schaumburg, IL 60173. Reimbursement checks will be mailed to your address listed in My VUMC Benefits, unless you are registered for direct deposit.
Express Claims: You may use My VUMC Benefits to submit claims. Click on “View My Reimbursement Account” and follow the instructions to submit claims online. You are still responsible for submitting receipts or Explanations of Benefits to verify online claims. You may upload, fax or mail that verification to Benefit Express as a follow-up to submitting an online claim.

Additional Reimbursement Information

- If you elect to participate in a Flexible Spending Account (FSA), reimbursement will be paid from the FSA account first. Once FSA funds are exhausted, medical expense reimbursement will be paid from the HRA.
- In order to be eligible for reimbursement from your HRA, expenses cannot be eligible for reimbursement under any other group benefit plan. If you have any doubt, submit a claim to the insurance company first.
- Reimbursements cannot exceed the balance in the account. If the request is more than the amount in your account, an additional payment will be automatically made when sufficient funds are available, except that eligible expenses may only be reimbursed in the Plan Year in which they are incurred.
- Requests for reimbursement for services provided in the Plan Year must be completed and submitted by the Run-out Period, April 15 of the following year. Requests received after this date will not be entitled to reimbursement for that Plan Year.
- Should you terminate your employment, retire, or change your employment status (full-time to part-time), you will have until the Run-out Period from the date of termination, retirement, or status change in which to submit reimbursement requests. Only expenses which were incurred before your termination, retirement, or status change date and while you were covered under the HRA Plan will be eligible for reimbursement.
- If you have a balance in your account at the end of a Plan Year (December 31) it will be carried forward into the next Plan Year, if Internal Revenue Service regulations permit. However, claim amounts in excess of the balance at the end of the Plan Year will not be eligible for reimbursement in the following Plan Year. Previous year balances cannot be carried forward until all claims have been paid and books are closed for the Plan Year, usually in May.
- The Benefit Express debit card will not have a balance in January until January’s payroll deposits the first $25 for the Plan Year. You should not attempt to use your card in January.
- If you elect to waive out of Vanderbilt University Medical Center’s Group Health Plan, you will no longer be entitled to receive the HRA benefit. The remaining balance in your account at the time of such waiver will be available for reimbursement of eligible claims until the Run-out Period from the effective date of the Health Plan Waiver.
- If you are on an approved leave of absence without pay, claims incurred and placed during the leave are eligible to be reimbursed under the HRA.

If you have a question about your account, you may call Benefit Express toll-free at 877.837.5017 or Vanderbilt University Medical Center Employee Service Center at 615.343.7000. To access your account information online, visit the My VUMC Benefits link under Benefits on the Human Resources website, http://hr.mc.vanderbilt.edu.

Protected Health Information

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

- Use and disclose PHI only as permitted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA),
- Certify to the group health Plan that documents have been amended,
- Create firewalls including identifying employees who can access information,
- Restrict access to those individuals and only for Plan administration purposes, and
- Provide a mechanism for resolving non-compliance.

PLAN INFORMATION

Name of Plan Health Reimbursement Account (HRA) [formerly the “Flexible Reimbursement Account (FRA)”] for Faculty and Staff of Vanderbilt University Medical Center

Name of Plan Sponsor Vanderbilt University Medical Center, Nashville, Tennessee

Employer Identification Number (“EIN”) 35-2528741

Plan Number 505

Type of Plan This Plan is a benefit welfare plan funded by Vanderbilt University Medical Center. It allows you to receive reimbursement for qualified medical expenses.

Type of Administration Vanderbilt University Medical Center contracts with Benefit Express for claims administration services.

Name of Plan Administrator Chief Human Resources Officer, Vanderbilt University Medical Center Human Resources, 2525 West End Avenue, 5th Floor, Nashville, Tennessee 37203, 615.343.7000
Name of Plan Administrator/Privacy Officer/Privacy Contact: Chief Human Resources Officer, Vanderbilt University Medical Center Human Resources, 2525 West End Avenue, 5th Floor, Nashville, Tennessee 37203, 615.343.7000

Legal Service: Service of legal process may be made on Chief Human Resources Officer, Vanderbilt University Medical Center Human Resources, 2525 West End Avenue, 5th Floor, Nashville, Tennessee 37203, 615.343.7000. Service may be made on Benefit Express Services, LLC, 1700 E. Golf Road, Suite 1000, Schaumburg, IL, 60173.

Name and Address of the Plan Supervisor: The Plan Supervisor is appointed by the Plan Sponsor to supervise the day-to-day affairs of the Plan. The Plan Supervisor is Director of Benefits Administration, Vanderbilt University Medical Center Human Resources, 2525 West End Avenue, 5th Floor, Nashville, Tennessee 37203, 615.343.7000.

Plan Year: The Plan's records are kept on a Plan Year, the 12-month period ending each December 31.

Grace Period: As set out in Prop. Treas. Reg. §§ 1.125-1 and 1.125-2, the Plan Year is extended through the Grace Period until March 15. Expenses for qualified benefits incurred during the Grace Period may be paid or reimbursed from benefits or contributions remaining unused at the end of the immediately preceding Plan Year.

Run-out Period: The Plan allows participants 105 days after the end of the Plan Year (until April 15th) to submit claims incurred during the period of eligibility.

CLAIM REVIEW PROCEDURE

From the date your notice of claim is received, the Plan Administrator has 90 days in which to review the claim to determine whether benefits are payable in accordance with the terms and provisions of the Plan. Under specific circumstances, the Plan Administrator may require an extension of this 90-day period in which case you will receive written notice from the Plan Administrator, prior to the end of the initial 90 days, informing you of the need for an extension. This extension period allows the Plan Administrator an additional 90 days to review your claim. During this period, the Plan Administrator may require additional information in order to make a determination of your claim. If additional information is required, you will receive a request, in writing, specifying the nature of the information needed and an explanation as to why it is needed.

If Internal Revenue Service regulations applicable to Vanderbilt University Medical Center's Plan are altered, it may not be possible to carry forward any unused balance in your account. In this event, you may forfeit the unused balance. Likewise, if there is an unused balance in your account after you terminate employment, die, retire, or change employment status, including the Run-out Period, it will be forfeited.

If you are not notified of the claim status within 90 days and you have not been notified that the extension period has been applied, you may request a review of your claim by following the procedure outlined under “Claim Review Procedure.”

If your claim has been approved, you will receive the appropriate benefit from Vanderbilt University Medical Center.

How to Appeal a Claim

If your claim for benefits is denied in whole or in part, you will receive written notice of such denial within the 90-day period stated above (or 180 days if the extension period is required).

Each written notice of denial shall set forth:

1. The specific reason(s) for the denial of the claim.
2. A specific reference to the provision(s) of the Plan upon which the denial is based; and
3. Notice of your right to have the denial reviewed by the Plan Administrator.

Appeal Review Procedure

If you receive a written notice of denial, you or your duly authorized representative may request a review of the claim by giving written notice to the Plan Administrator. This request for a review must be made to the Plan Administrator within 60 days of the receipt of denial by the Plan Administrator. If such request is not made within 60 days, you will be deemed to have waived your right to a review by the Plan Administrator.

Once the Plan Administrator receives a request for a review, a prompt review of the claim will take place. You or your duly authorized representative have the right to review documents that might have a bearing on the claim, including the documents which establish and control the Plan, and to submit issues and comments that you feel might affect the outcome of the review. In connection with this review, the Plan Administrator may request and require pertinent documents regarding your claim.

Upon completion of a full and complete review, the Plan Administrator will notify you in writing of the results, citing Plan provision(s) that control the decision. The Plan Administrator has 60 days to notify you of his decision unless special circumstances require an extension of time. If an extension is required, the Plan Administrator shall notify you of the need for an extension before the end of the initial 60-day period for completing the review procedure. This means that the Plan Administrator will have an additional 60 days to notify you of the decision on your originally denied claim.
CONTINUING HRA COVERAGE — COBRA
If you are an employee of Vanderbilt University Medical Center covered by the Group Health Care Plan and eligible for the HRA, you have a right to choose continuation of the HRA if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reason other than gross misconduct on your part). You may extend the coverage by paying 102 percent of the premium ($25.50 per month) and continuing your health care coverage under COBRA. Each premium paid will extend the period during which claims are eligible for reimbursement. All other rules under COBRA apply.

STATEMENT OF ERISA RIGHTS
As a participant in the Vanderbilt University Medical Center Health Reimbursement Account, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to:

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as work sites and union halls, all plan documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.
- Receive a copy 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.

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 best 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. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial.

You have the right to have the Plan Administrator review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials 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, 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. 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. 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, you should contact the nearest area office of the U.S. Labor-Management Service Administration, Department of Labor.

In compliance with federal law, including the provisions of Title IX of the Education Amendments of 1972 and Sections 503 and 504 of the Rehabilitation Act of 1973, Vanderbilt University Medical Center does not discriminate on the basis of race, sex, religion, color, national or ethnic origin, age, handicap, or military service in its administration of education policies, programs, or activities; its admissions policies; scholarship and loan programs; athletic or other Vanderbilt University Medical Center administered programs; or employment. Inquiries or complaints should be directed to the Chief Human Resources Officer, Vanderbilt University Medical Center Human Resources, 2525 West End Avenue, 5th Floor, Nashville, Tennessee 37203, 615.343.7000.

Revised 3/31/2016
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.
YOUR BENEFIT PLAN

Vanderbilt University Medical Center

All Full-Time Exempt and Non-Exempt Employees

Basic Life Insurance
Supplemental Life Insurance
Dependent Life Insurance
Voluntary Accidental Death and Dismemberment Insurance

Certificate Date: April 30, 2016
TO OUR EMPLOYEES:

All of us appreciate the protection and security insurance provides.

This certificate describes the benefits that are available to you. We urge you to read it carefully.

Vanderbilt University Medical Center
CERTIFICATE OF INSURANCE

Metropolitan Life Insurance Company ("MetLife"), a stock company, certifies that You and Your Dependents are insured for the benefits described in this certificate, subject to the provisions of this certificate. This certificate is issued to You under the Group Policy and it includes the terms and provisions of the Group Policy that describe Your insurance. **PLEASE READ THIS CERTIFICATE CAREFULLY.**

This certificate is part of the Group Policy. The Group Policy is a contract between MetLife and the Policyholder and may be changed or ended without Your consent or notice to You.

**Policyholder:** Vanderbilt University Medical Center

**Group Policy Number:** 160933-1-G

**Type of Insurance:** Term Life & Accidental Death and Dismemberment Insurance

**MetLife Toll Free Number(s):**
- FOR CLAIM INFORMATION
  - FOR LIFE CLAIMS: 1-800-638-6420

**THIS CERTIFICATE ONLY DESCRIBES TERM LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE.**

**FOR CALIFORNIA RESIDENTS:** REVIEW THIS CERTIFICATE CAREFULLY. IF YOU ARE 65 OR OLDER ON YOUR EFFECTIVE DATE OF THIS CERTIFICATE, YOU MAY RETURN IT TO US WITHIN 30 DAYS FROM THE DATE YOU RECEIVE IT AND WE WILL REFUND ANY PREMIUM YOU PAID. IN THIS CASE, THIS CERTIFICATE WILL BE CONSIDERED TO NEVER HAVE BEEN ISSUED.

THE BENEFITS OF THE POLICY PROVIDING YOUR COVERAGE ARE GOVERNED PRIMARILY BY THE LAW OF A STATE OTHER THAN FLORIDA.

THE GROUP INSURANCE POLICY PROVIDING COVERAGE UNDER THIS CERTIFICATE WAS ISSUED IN A JURISDICTION OTHER THAN MARYLAND AND MAY NOT PROVIDE ALL THE BENEFITS REQUIRED BY MARYLAND LAW.

WE ARE REQUIRED BY STATE LAW TO INCLUDE THE NOTICE(S) WHICH APPEARS ON THIS PAGE AND IN THE NOTICE(S) SECTION WHICH烽UOWS THIS PAGE. PLEASE READ THE(SE) NOTICE(S) CAREFULLY.
IMPORTANT NOTICE

To obtain information or make a complaint:

You may call MetLife’s toll free telephone number for information or to make a complaint at:

1-800-638-6420

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007
Web: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim, you should contact MetLife first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR CERTIFICATE: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener información o para presentar una queja:

Usted puede llamar al número de teléfono gratuito de MetLife’s para obtener información o para presentar una queja al:

1-800-638-6420

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos, o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007
Sitio Web: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES: Si tiene una disputa relacionada con su prima de seguro o con una reclamación usted debe comunicarse con MetLife primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU CERTIFICADO: Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.
NOTICE FOR RESIDENTS OF LOUISIANA, MONTANA, NEW MEXICO, TEXAS, UTAH AND WASHINGTON

The Definition Of Child Is Modified For The Coverages Listed Below:

For Louisiana Residents (Accidental Death and Dismemberment Insurance):

The term also includes Your grandchildren residing with You. The age limit for children and grandchildren will not be less than 26, regardless of the child’s or grandchild’s marital status, student status or full-time employment status. Your natural child, adopted child, stepchild or grandchild under age 26 will not need to be supported by You to qualify as a Child under this insurance. In addition, marital status will not prevent or cease the continuation of insurance for a mentally or physically handicapped child or grandchild past the age limit.

For Montana Residents (Accidental Death and Dismemberment Insurance):

The term also includes newborn infants of any person insured under this certificate. The age limit for children will not be less than 25, regardless of the child’s student status or full-time employment status. Your natural child, adopted child or stepchild under age 25 will not need to be supported by You to qualify as a child under this insurance.

For New Mexico Residents (Accidental Death and Dismemberment Insurance):

The age limit for children will not be less than 25, regardless of the child’s student status or full-time employment status. Your natural child, adopted child or stepchild will not be denied accidental death and dismemberment insurance coverage under this certificate because:

- that child was born out of wedlock;
- that child is not claimed as Your dependent on Your federal income tax return; or
- that child does not reside with You.

For Texas Residents (Life Insurance):

The term also includes Your grandchildren. The age limit for children and grandchildren will not be less than 25, regardless of the child’s or grandchild’s student status or full-time employment status. Your natural child, adopted child or stepchild under age 25 will not need to be supported by You to qualify as a Child under this insurance. In addition, grandchildren must be able to be claimed by You as a dependent for Federal Income Tax purposes at the time You applied for Insurance.

For Texas Residents (Accidental Death and Dismemberment Insurance):

The term also includes Your grandchildren. The age limit for children and grandchildren will not be less than 25, regardless of the child’s or grandchild’s student status, full-time employment status or military service status. Your natural child, adopted child or stepchild under age 25 will not need to be supported by You to qualify as a Child under this insurance. In addition, grandchildren must be able to be claimed by You as a dependent for Federal Income Tax purposes at the time You applied for Insurance.
For Utah Residents (Voluntary Accidental Death and Dismemberment Insurance):

The age limit for children will not be less than 26, regardless of the child’s student status or full-time employment status. Your natural child, adopted child or stepchild under age 26 will not need to be supported by You to qualify as a Child under this insurance. The term includes an unmarried child who is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law and who has been continuously covered under an Accidental Death and Dismemberment plan since reaching age 26, with no break in coverage of more than 63 days, and who otherwise qualifies as a Child except for the age limit. Proof of such handicap must be sent to Us within 31 days after:

- the date the Child attains the limiting age in order to continue coverage; or
- You enroll a Child to be covered under this provision;

and at reasonable intervals after such date, but no more often than annually after the two-year period immediately following the date the Child qualifies for coverage under this provision.

For Washington Residents (Voluntary Accidental Death and Dismemberment Insurance):

The age limit for children will not be less than 26, regardless of the child’s marital status, student status, or full-time employment status. Your natural child, adopted child or stepchild under age 26 will not need to be supported by You to qualify as a Child under this insurance.
NOTICE FOR RESIDENTS OF WASHINGTON

LIFE INSURANCE: ACCELERATED BENEFIT OPTION (ABO)

The Life Insurance accelerated benefit does not and is not intended to qualify as long-term care under Washington state law. Washington state law prevents this accelerated life benefit from being marketed or sold as long-term care.
NOTICE FOR RESIDENTS OF ALL STATES

LIFE INSURANCE BENEFITS WILL BE REDUCED IF AN ACCELERATED BENEFIT IS PAID

DISCLOSURE: The Life Insurance accelerated benefit offered under this certificate is intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986. If this benefit qualifies for such favorable tax treatment, the benefit will be excludable from Your income and not subject to federal taxation. Tax laws relating to accelerated benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which You could receive an accelerated benefit excludable from income under federal law.

DISCLOSURE: Receipt of an accelerated benefit may affect Your, Your Spouse’s or Your family’s eligibility for public assistance programs such as Medical Assistance (Medicaid), Aid to Families with Dependent Children (AFDC), Supplementary Social Security Income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such payment will affect Your, Your Spouse’s and Your family’s eligibility for public assistance.
NOTICE FOR RESIDENTS OF ARKANSAS

If You have a question concerning Your coverage or a claim, first contact the Policyholder or group account administrator. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

If You are still concerned after contacting both the Policyholder and MetLife, You should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201
(501) 371-2640 or (800) 852-5494
NOTICE FOR RESIDENTS OF CALIFORNIA

IMPORTANT NOTICE

TO OBTAIN ADDITIONAL INFORMATION, OR TO MAKE A COMPLAINT, CONTACT THE POLICYHOLDER OR METLIFE AT:

METROPOLITAN LIFE INSURANCE COMPANY
ATTN: CONSUMER RELATIONS DEPARTMENT
500 SCHOOLHOUSE ROAD
JOHNSTOWN, PA 15904

1-800-438-6388

IF, AFTER CONTACTING THE POLICYHOLDER AND/OR METLIFE, YOU FEEL THAT A SATISFACTORY SOLUTION HAS NOT BEEN REACHED, YOU MAY FILE A COMPLAINT WITH THE CALIFORNIA DEPARTMENT OF INSURANCE DEPARTMENT AT:

DEPARTMENT OF INSURANCE
CONSUMER SERVICES
300 SOUTH SPRING STREET
LOS ANGELES, CA 90013

WEBSITE: http://www.insurance.ca.gov/

1-800-927-4357 (within California)
1-213-897-8921 (outside California)
NOTICE FOR RESIDENTS OF GEORGIA

IMPORTANT NOTICE

The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.
NOTICE FOR RESIDENTS OF IDAHO

If You have a question concerning Your coverage or a claim, first contact the Policyholder. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

If You are still concerned after contacting both the Policyholder and MetLife, You should feel free to contact:

Idaho Department of Insurance
Consumer Affairs
700 West State Street, 3rd Floor
PO Box 83720
Boise, Idaho 83720-0043
1-800-721-3272 (for calls placed within Idaho) or 208-334-4250 or www.DOI.Idaho.gov
NOTICE FOR RESIDENTS OF ILLINOIS

IMPORTANT NOTICE

To make a complaint to MetLife, You may write to:

MetLife
200 Park Avenue
New York, New York 10166

The address of the Illinois Department of Insurance is:

Illinois Department of Insurance
Public Services Division
Springfield, Illinois 62767
NOTICE FOR RESIDENTS OF INDIANA

Questions regarding your policy or coverage should be directed to:

Metropolitan Life Insurance Company
1-800-438-6388

If you (a) need the assistance of the government agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaint can be filed electronically at www.in.gov/doi
NOTICE FOR MASSACHUSETTS RESIDENTS

CONTINUATION OF ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

1. If Your AD&D Insurance ends due to a Plant Closing or Covered Partial Closing, such insurance will be continued for 90 days after the date it ends.

2. If Your AD&D Insurance ends because:
   - You cease to be in an Eligible Class; or
   - Your employment terminates;

for any reason other than a Plant Closing or Covered Partial Closing, such insurance will continue for 31 days after the date it ends.

Continuation of Your AD&D Insurance under the CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT subsection will end before the end of continuation periods shown above if You become covered for similar benefits under another plan.

Plant Closing and Covered Partial Closing have the meaning set forth in Massachusetts Annotated Laws, Chapter 151A, Section 71A.
NOTICE FOR RESIDENTS OF MINNESOTA

This is a life insurance policy which pays accelerated death benefits at your option under conditions specified in the policy. This policy is not a long-term care policy meeting the requirements of sections M.S.62A.46 to 62A.56 or chapter 62S.
NOTICE FOR RESIDENTS OF MINNESOTA
CONTINUATION OF BASIC OR SUPPLEMENTAL OR DEPENDENT LIFE INSURANCE WITH PREMIUM PAYMENT

If Your Life Insurance ends due to termination of Your employment for any reason other than gross misconduct, You may continue such insurance for You or Your Dependents.

If You are eligible for continuation of Life insurance, Your employer will notify You of:

- Your right to elect to continue Life Insurance for You or Your Dependents;
- the amount You must pay each month to Your employer to keep such insurance in force;
- instructions for payment; and
- the time that payments are due.

The amount of the premium You will be required to pay for continuation of Life Insurance will not exceed 102 percent of the amount of premium required to be paid for active employees in Your class for such insurance (this includes any premium amounts paid by the employer as well as the employee).

You will have 60 days within which to elect to continue Life Insurance under this section. The 60 day period begins to run on the date Life Insurance would otherwise end or on the date upon which notice of the right to continue Life Insurance is received, whichever is later. If You or Your Dependents die during the 60 day election period, we will consider You to have elected to continue Life Insurance under this section.

If Your employer fails to notify You of Your right to continue insurance under this section, or fails to forward a required premium to Us that You have paid, causing insurance for You or Your Dependents to end, then Your employer will become liable for these benefits to the same extent as, and in place of, us.

If You continue Life Insurance under this section, any reductions in Life Insurance that would have applied if You were Actively at Work apply to the continued insurance.

Continuation of Life Insurance under this section will end on the earliest of:

- the date the group policy ends for all employees or for the class of employees to which you belonged when Your Active Work ceased;
- the date you fail to make a required premium payment when due;
- the date you become covered for life insurance under this or any other group term life insurance plan;
- with respect to Your Spouse or Domestic Partner, the date Your marriage ends in divorce or annulment;
- with respect to a Child, the date the Child no longer qualifies as a Child for purposes of Life Insurance;
- with respect to You or Your Dependents, the date You or Your Dependents reach any applicable age limits; or
- the end of 18 months following the date Your Active Work ended.

When a continuation under this section ends, You or Your Dependents may buy an individual policy of life insurance from Us. The details of this option are described in the section LIFE INSURANCE: CONVERSION OPTION FOR YOU and LIFE INSURANCE: CONVERSION OPTION FOR YOUR DEPENDENTS entitled LIFE INSURANCE: CONVERSION OPTION FOR YOU and LIFE INSURANCE: CONVERSION OPTION FOR YOUR DEPENDENTS. For the purpose of that section, the end of this continuation will be considered the end of your employment.
Effect of Previous Conversion

If You or Your Dependents converted Life Insurance to an individual policy, We will only pay Life Insurance under this section if such individual policy is returned to Us. If it is returned to Us, We will refund to You, Your estate, or Your Dependents estate, as applicable, the premiums paid for such policy without interest, less any debt incurred under such policy.

If such individual policy is not returned to Us, We will pay the life insurance in effect under the individual policy.

We will not pay insurance under both the Group Policy and the individual policy.
NOTICE FOR RESIDENTS OF MISSOURI

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

EXCLUSIONS

If You reside in Missouri the exclusion for "suicide or attempted suicide" is as follows:
"suicide or attempted suicide while sane"

LIFE INSURANCE

GENERAL PROVISIONS

If You reside in Missouri the suicide provision is as follows:

Suicide
If You commit suicide within 1 year from the date Life Insurance for You takes effect, We will not pay such insurance and Our liability will be limited as follows:

• any premium paid by You will be returned to the Beneficiary.
• any premium paid by the Policyholder will be returned to the Policyholder.

If You commit suicide within 1 year from the date an increase in Your Life Insurance takes effect, We will pay to the Beneficiary the amount of Insurance in effect on the day before the increase. Any premium You paid for the increase will be returned to the Beneficiary. Any premium paid by the Policyholder for the increase will be returned to the Policyholder.

If a Dependent commits suicide within 1 year from the date Life Insurance for such Dependent takes effect, We will not pay such insurance and Our liability will be limited as follows:

• any premium paid by You will be returned to the Beneficiary.
• any premium paid by the Policyholder will be returned to the Policyholder.

If a Dependent commits suicide within 1 year from the date an increase in Life Insurance for such Dependent takes effect, We will pay to the Beneficiary the amount of Insurance in effect on the day before the increase. Any premium You paid for the increase will be returned to the Beneficiary. Any premium paid by the Policyholder for the increase will be returned to the Policyholder.
NOTICE FOR RESIDENTS OF NEW MEXICO

If a Child is insured for Accidental Death and Dismemberment Insurance under this certificate and You are not the custodial parent, notify Us that such is the case and provide Us with the name and address of the custodial parent. After receipt of such notice We will:

(1) provide such information to the custodial parent as may be necessary for the Child to obtain benefits through that insurance;

(2) permit the custodial parent or the provider, with the custodial parent's approval, to submit claims for covered services without the approval of the non-custodial parent; and

(3) make payments on claims submitted in accordance with Paragraph (2) of this subsection directly to the custodial parent, the provider or the state Medicaid agency.

If You are required by a court or administrative order to provide Accidental Death and Dismemberment Insurance for a Child, and You are eligible to provide such insurance for that child, We will:

(1) permit You to enroll a Child who is otherwise eligible for such insurance without regard to any enrollment season restrictions;

(2) if You are enrolled but fail to make application to obtain insurance for such Child, We will enroll the Child for insurance upon application of the Child's other parent, the state agency administering the Medicaid program or the state agency administering 42 U.S.C. Sections 651 through 669, the child support enforcement program; and

(3) We will not disenroll or eliminate insurance for such Child unless the insurer is provided satisfactory written evidence that:

   (a) the court or administrative order is no longer in effect; or

   (b) the Child is or will be enrolled in comparable health insurance through another insurer that will take effect not later than the effective date of disenrollment.

We will not impose requirements on a state agency that has been assigned the rights of an individual eligible for medical assistance under the Medicaid program and insured for Accidental Death and Dismemberment Insurance with Us that are different from requirements applicable to an agent or assignee of any other individual so insured.
NOTICE FOR RESIDENTS OF NORTH DAKOTA

GENERAL PROVISIONS

If You reside in North Dakota the suicide provision is as follows:

Suicide

If You commit suicide within 1 year from the date Life Insurance for You takes effect, We will not pay such insurance and Our liability will be limited as follows:

• any premium paid by You will be returned to the Beneficiary.
• any premium paid by the Policyholder will be returned to the Policyholder.

If You commit suicide within 1 year from the date an increase in Your Life Insurance takes effect, We will pay to the Beneficiary the amount of Insurance in effect on the day before the increase. Any premium You paid for the increase will be returned to the Beneficiary. Any premium paid by the Policyholder for the increase will be returned to the Policyholder.

If a Dependent commits suicide within 1 year from the date Life Insurance for such Dependent takes effect, We will not pay such insurance and Our liability will be limited as follows:

• any premium paid by You will be returned to the Beneficiary.
• any premium paid by the Policyholder will be returned to the Policyholder.

If a Dependent commits suicide within 1 year from the date an increase in Life Insurance for such Dependent takes effect, We will pay to the Beneficiary the amount of Insurance in effect on the day before the increase. Any premium You paid for the increase will be returned to the Beneficiary. Any premium paid by the Policyholder for the increase will be returned to the Policyholder.
NOTICE FOR RESIDENTS OF PENNSYLVANIA

Accidental Death and Dismemberment Insurance for a Dependent Child may be continued past the age limit if that Child is a full-time student and insurance ends due to the Child being ordered to active duty (other than active duty for training) for 30 or more consecutive days as a member of the Pennsylvania National Guard or a Reserve Component of the Armed Forces of the United States.

Insurance will continue if such Child:

- re-enrolls as a full-time student at an accredited school, college or university that is licensed in the jurisdiction where it is located;
- re-enrolls for the first term or semester, beginning 60 or more days from the child’s release from active duty;
- continues to qualify as a Child, except for the age limit; and
- submits the required Proof of the child’s active duty in the National Guard or a Reserve Component of the United States Armed Forces.

Subject to the Date Insurance For Your Dependents Ends subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS, this continuation will continue until the earliest of the date:

- the insurance has been continued for a period of time equal to the duration of the child’s service on active duty; or
- the child is no longer a full-time student.
NOTICE FOR RESIDENTS OF TEXAS

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS’ COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS’ COMPENSATION SYSTEM.
NOTICE FOR RESIDENTS OF TEXAS

LIFE INSURANCE: ACCELERATED BENEFIT OPTION (ABO)

The laws of the state of Texas mandate that the terms "Terminally Ill" and "Terminal Illness" when used in the LIFE INSURANCE: ACCELERATED BENEFIT OPTION (ABO) FOR YOU provision means that due to injury or sickness, You are expected to die within 24 months of the date You request payment of an Accelerated Benefit.
Notice of Protection Provided by
Utah Life and Health Insurance Guaranty Association

This notice provides a brief summary of the Utah Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, health, or annuity insurance company becomes financially unable to meet its obligations and is taken over by its insurance regulatory agency. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - $500,000 in death benefits
  - $200,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits
  - $500,000 in long-term care insurance benefits
  - $500,000 in disability income insurance benefits
  - $500,000 in other types of health insurance benefits
- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

**Note:** Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. Coverage is conditioned on residency in this state and there are substantial limitations and exclusions. For a complete description of coverage, consult Utah Code, Title 3 IA, Chapter 28.

Insurance companies and agents are prohibited by Utah law to use the existence of the Association or its coverage to encourage you to purchase insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between Utah law and this notice, Utah law will control.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.utlifega.org or contact:

Utah Life and Health Insurance Guaranty Assoc.
60 East South Temple, Suite 500
Salt Lake City UT 84111
(801) 320-9955

Utah Insurance Department
3110 State Office Building
Salt Lake City UT 84114-6901
(801) 538-3800

A written complaint about misuse of this Notice or the improper use of the existence of the Association may be filed with the Utah Insurance Department at the above address.
NOTICE FOR RESIDENTS OF VIRGINIA

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event You need to contact someone about this insurance for any reason please contact Your agent. If no agent was involved in the sale of this insurance, or if You have additional questions You may contact the insurance company issuing this insurance at the following address and telephone number:

MetLife
200 Park Avenue
New York, New York 10166
Attn: Corporate Consumer Relations Department

To phone in a claim related question, You may call Claims Customer Service at:
1-800-275-4638

If You have been unable to contact or obtain satisfaction from the company or the agent, You may contact the Virginia State Corporation Commission’s Bureau of Insurance at:

The Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
1-877-310-6560 - toll-free
1-804-371-9944 - fax
www.scc.virginia.gov - web address
ombudsman@scc.virginia.gov - email
NOTICE FOR RESIDENTS OF WASHINGTON

LIFE INSURANCE

GENERAL PROVISIONS

The suicide provision is not applicable to residents of Washington.
NOTICE FOR RESIDENTS OF WISCONSIN

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? - If You are having problems with Your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve Your problem.

MetLife
Attn: Corporate Consumer Relations Department
200 Park Avenue
New York, New York 10166
1-800-438-6388

You can also contact the OFFICE OF THE COMMISSIONER OF INSURANCE, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the OFFICE OF THE COMMISSIONER OF INSURANCE by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517 outside of Madison or 608-266-0103 in Madison.
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SCHEDULE OF BENEFITS

This schedule shows the benefits that are available under the Group Policy. You and Your Dependents will only be insured for the benefits:

- for which You and Your Dependents become and remain eligible;
- which You elect, if subject to election; and
- which are in effect.

The amount of insurance that We will pay will be decreased by the amount of any contributions due and unpaid to Us for that insurance.

BENEFIT AMOUNTS AND HIGHLIGHTS

How We Will Pay Benefits

Unless the Beneficiary requests payment by check, when the Certificate states that We will pay benefits in "one sum" or a "single sum", We may pay the full benefit amount:

- by check;
- by establishing an account that earns interest and provides the Beneficiary with immediate access to the full benefit amount; or
- by any other method that provides the Beneficiary with immediate access to the full benefit amount.

Other modes of payment may be available upon request. For details, call Our toll free number shown on the Certificate Face Page.

Life Insurance For You

Basic Life Insurance

For Noncontributory Basic Life Insurance:

For Active Employees .................................................. An amount equal to 1 times Your Basic Annual Earnings, as determined by the Policyholder, rounded to the next higher dollar

Maximum Basic Life Benefit ........................................ $500,000

Accelerated Benefit Option .............................................. Up to 50% of Your Basic Life amount not to exceed $250,000
Supplemental Life Insurance

For Active Employees who elect:

Option 1 ................................................................. An amount equal to 1 times Your Basic Annual Earnings, as determined by the Policyholder, rounded to the next higher dollar

Option 2 ................................................................. An amount equal to 2 times Your Basic Annual Earnings, as determined by the Policyholder, rounded to the next higher dollar

Option 3 ................................................................. An amount equal to 3 times Your Basic Annual Earnings, as determined by the Policyholder, rounded to the next higher dollar

Maximum Supplemental Life Benefit .................... $500,000

Non-Medical Issue Amount ................................. The lesser of 3 times Your Basic Annual Earnings or $500,000

Accelerated Benefit Option ................................. Up to 50% of Your Supplemental Life amount not to exceed $250,000

Maximum Basic Life and Supplemental Life Benefit Combined ......................................................... $1,000,000
SCHEDULE OF BENEFITS (continued)

ESTATE RESOLUTION SERVICES

The following Estate Resolution Services are provided at no additional cost to individuals insured for Group Supplemental Life Insurance coverage as described below. If You are eligible to receive these Estate Resolution Services and You or Your Spouse (for the Will Preparation Service) or You or Your Spouse or a Beneficiary (for the Probate Service) would like to speak with a representative from Hyatt Legal Plans or get the name of a Plan Attorney that you can speak with about these Services, please call (800) 821-6400.

THE FOLLOWING APPLIES TO RESIDENTS OF ALL STATES OTHER THAN TEXAS

Will Preparation Service

If You elect Group Supplemental Life Insurance coverage, a Will Preparation Service (the “Service”) will be made available to You, through a MetLife affiliate (the “Affiliate”), while Your Group Supplemental Life Insurance coverage is in effect. This Service will be made available at no cost to You. It enables You to have a will prepared for You and Your Spouse free of charge by attorneys designated by the Affiliate. If You have a will prepared by an attorney not designated by the Affiliate, You must pay for the attorney’s services directly. Upon Proof of such payment, You will be reimbursed for the attorney’s services in an amount equal to the lesser of the amount You paid for the attorney’s services and the amount customarily reimbursed for such services by the Affiliate.

Probate Service

If You become insured for Group Supplemental Life Insurance coverage and You or Your Spouse die while such Group Supplemental Life Insurance coverage is in effect, a probate benefit (the “Benefit”) will be made available to Your estate in the event of Your death or to Your Spouse's estate in the event of Your Spouse's death. Such benefit will be made available through a MetLife affiliate (“Affiliate”).

The Benefit provides for certain probate services to be made available, free of charge by attorneys designated by the Affiliate. If probate services are provided by an attorney not designated by the Affiliate, the estate of the deceased must pay for those attorney’s services directly. Upon Proof of such payment, the estate of the deceased will be reimbursed for the attorney’s services in an amount equal to the lesser of the amount such estate paid for the attorney’s services and the amount customarily reimbursed for such services by the Affiliate.

This Benefit will be provided at no cost to You and will end on the date Your Group Supplemental Life Insurance coverage ends.
THE FOLLOWING APPLIES TO RESIDENTS OF TEXAS ONLY

Will Preparation Service

If You elect Group Supplemental Life Insurance coverage, a Will Preparation Service (the “Service”) will be made available to You through a MetLife affiliate (the “Affiliate”), as agreed to by the Policyholder and MetLife, while Your Group Supplemental Life Insurance coverage is in effect under this Policy.

Will Preparation Service means a service covering the preparation of wills and codicils for You and Your Spouse. The creation of any testamentary trust is covered. The Will Preparation Service does not include tax planning.

This Service will be made available at no cost to You. It enables You to have a will prepared for You and Your Spouse free of charge by attorneys designated by the Affiliate. If You have a will prepared by an attorney not designated by the Affiliate, You must pay for the attorney’s services directly. Upon Proof of such payment, You will be reimbursed for the attorney’s services in an amount equal to the lesser of the amount You paid for the attorney’s services and the amount customarily reimbursed for such services by the Affiliate.

Probate Service

If You become insured for Group Supplemental Life Insurance coverage and You or Your Spouse die while such Group Supplemental Life Insurance coverage is in effect, a probate benefit (the “Benefit”) will be made available to Your estate in the event of Your death or to Your Spouse’s estate in the event of Your Spouse’s death. Such benefit will be made available through a MetLife affiliate (“Affiliate”).

The Benefit includes attorney representation and payment of legal fees for the executor or administrator of the estate of the deceased including representation for the preparation of all documents and all of the court proceedings needed to transfer probate assets from the estate of the deceased to applicable heirs; and the completion of correspondence necessary to transfer non-probate assets such as proceeds from insurance policies, joint bank accounts, stock accounts or a house; and associated tax filings.

The Benefit provides for such services to be made available, free of charge by attorneys designated by the Affiliate. If probate services are provided by an attorney not designated by the Affiliate, the estate of the deceased must pay for those attorney’s services directly. Upon Proof of such payment, the estate of the deceased will be reimbursed for the attorney’s services in an amount equal to the lesser of the amount such estate paid for the attorney’s services and the amount customarily reimbursed for such services by the Affiliate.

This Benefit will be provided at no cost to You and will end on the date Your Group Supplemental Life Insurance coverage ends.
Accidental Death and Dismemberment Insurance (AD&D) For You

Full Amount for Voluntary AD&D

For Active Employees: An amount, elected by You, which is a multiple of $10,000

Maximum Voluntary Accidental Death and Dismemberment Full Amount: The lesser of 10 times Your Basic Annual Earnings or $500,000

Additional Benefits:

- Seat Belt Benefit: Yes
- Air Bag Use Benefit: Yes
- Child Care Benefit: Yes
- Child Education Benefit: Yes
- Spouse Education Benefit: Yes
- Hospital Confinement Benefit: Yes
- Workplace Felonious Assault Benefit: Yes
- Human Immunodeficiency Virus (HIV) Benefit: Yes
- Rehabilitative Physical Therapy Benefit: Yes
- Therapeutic Counseling Benefit: Yes
- Parental Care Benefit: Yes
- COBRA Continuation Benefit: Yes
- Common Carrier Benefit: Yes
- Job-Related Injury Benefit: Yes

The Common Carrier Benefit is an amount equal to the Full Amount.

The Job-Related Benefit is an amount equal to the Full Amount.

Schedule of Covered Losses for Voluntary Accidental Death and Dismemberment Insurance

All amounts listed are stated as percentages of the Full Amount.
Covered Losses

Loss of life .................................................................................. 100%
Loss of a hand permanently severed at or above the wrist but below the elbow ................................................. 50%
Loss of a foot permanently severed at or above the ankle but below the knee ...................................................... 50%
Loss of an arm permanently severed at or above the elbow .................................................................................. 75%
Loss of a leg permanently severed at or above the knee ................................................................................... 75%
Loss of sight in one eye ........................................................................... 50%

**Loss of sight** means permanent and uncorrectable loss of sight in the eye. Visual acuity must be 20/200 or worse in the eye or the field of vision must be less than 20 degrees.

Loss of any combination of hand, foot, or sight of one eye, as defined above ........................................................................... 100%
Loss of the thumb and index finger of same hand .................... 25%

**Loss of thumb and index finger of same hand** means that the thumb and index finger are permanently severed through or above the third joint from the tip of the index finger and the second joint from the tip of the thumb.

Loss of speech and loss of hearing.................................................. 100%
Loss of speech or loss of hearing ................................................... 50%

**Loss of speech** means the entire and irrecoverable loss of speech that continues for 6 consecutive months following the accidental injury.

**Loss of hearing** means the entire and irrecoverable loss of hearing in both ears that continues for 6 consecutive months following the accidental injury.

Paralysis of both arms and both legs ............................................. 100%
Paralysis of both legs ...................................................................... 50%
Paralysis of the arm and leg on either side of the body .............. 50%
Paralysis of one arm or leg.............................................................. 25%

**Paralysis** means loss of use of a limb, without severance. A Physician must determine the paralysis to be permanent, complete and irreversible.

Brain Damage .................................................................................. 100%

**Brain Damage** means permanent and irreversible physical damage to the brain causing the complete inability to perform all the substantial and material functions and activities normal to everyday life. Such damage must manifest itself within 30 days of the accidental injury, require a hospitalization of at least 5 days and persists for 12 consecutive months after the date of the accidental injury.
SCHEDULE OF BENEFITS (continued)

Coma ........................................................................................................... 1% monthly beginning on the 7th day of the Coma for the duration of the Coma to a maximum of 60 months

**Coma** means a state of deep and total unconsciousness from which the comatose person cannot be aroused. Such state must begin within 30 days of the accidental injury and continue for 7 consecutive days.

Third-degree burn(s) ........................................................................... A percentage of the Full Amount equal to the percentage of body surface suffering third-degree burns

If You Are Age 65 Or Older

If you are age 65 or older on Your effective date of insurance, the appropriate percentage from the following table will be applied to the amount of Your **Basic and Supplemental Life Insurance** on Your effective date of insurance.

If you are under age 65 on Your effective date of insurance, the amounts of Your **Basic Life and Supplemental Life Insurance** on and after age 65 will be determined by applying the appropriate percentage from the following table to the amount of Your insurance in effect on the day before Your 65th birthday:

<table>
<thead>
<tr>
<th>Age of Employee</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>65 but less than 70</td>
<td>67%</td>
</tr>
<tr>
<td>70 but less than 75</td>
<td>45%</td>
</tr>
<tr>
<td>75 but less than 80</td>
<td>30%</td>
</tr>
<tr>
<td>80 or older</td>
<td>20%</td>
</tr>
</tbody>
</table>

**Life Insurance For Your Dependents**

**For Noncontributory Dependent Life Insurance:**

For Your Spouse ............................................................................... $5,000

For each of Your Children ............................................................ $2,500
Accidental Death and Dismemberment Insurance (AD&D) For Your Dependents

Full Amount for Voluntary AD&D

- Spouse and Child(ren) ........................................... An amount equal to: (a) 40% for Your Spouse Only; and (b) 10% for each Child; of Your Voluntary Accidental Death and Dismemberment Insurance
- Spouse Only ........................................................ An amount equal to 50% of Your Voluntary Accidental Death and Dismemberment Insurance
- For each of Your Children
  - Child(ren) Only ............................................................ An amount equal to 15% of Your Voluntary Accidental Death and Dismemberment Insurance for each Child

Additional Benefits:

- Seat Belt Benefit .......................................................... Yes
- Air Bag Use Benefit...................................................... Yes
- Child Care Benefit........................................................ Yes
- Child Education Benefit.............................................. Yes
- Spouse Education Benefit............................................ NONE
- Hospital Confinement Benefit..................................... Yes
- Workplace Felonious Assault Benefit ......................... NONE
- Human Immunodeficiency Virus (HIV) Benefit............. NONE
- Rehabilitative Physical Therapy Benefit ..................... Yes
- Therapeutic Counseling Benefit .................................. Yes
- Parental Care Benefit.................................................. Yes
- COBRA Continuation Benefit ....................................... NONE
- Common Carrier Benefit ............................................ Yes
- Job-Related Injury Benefit ........................................ NONE

The Common Carrier Benefit is an amount equal to the Full Amount.
SCHEDULE OF BENEFITS (continued)

Schedule of Covered Losses for Voluntary Accidental Death and Dismemberment Insurance

All amounts listed are stated as percentages of the Full Amount.

Covered Losses

Loss of life ................................................................................... 100%
Loss of a hand permanently severed at or above
the wrist but below the elbow...................................................... 50%
Loss of a foot permanently severed at or above
the ankle but below the knee...................................................... 50%
Loss of an arm permanently severed at or above the elbow...... 75%
Loss of a leg permanently severed at or above the knee........... 75%
Loss of sight in one eye .............................................................. 50%

Loss of sight means permanent and uncorrectable loss of sight in the eye. Visual acuity
must be 20/200 or worse in the eye or the field of vision must be less than 20 degrees.

Loss of any combination of hand, foot, or sight of one eye, as
defined above ................................................................. 100%
Loss of the thumb and index finger of same hand.............. 25%

Loss of thumb and index finger of same hand means that the thumb and index finger
are permanently severed through or above the third joint from the tip of the index finger
and the second joint from the tip of the thumb.

Loss of speech and loss of hearing ............................................ 100%
Loss of speech or loss of hearing .............................................. 50%

Loss of speech means the entire and irrecoverable loss of speech that continues for 6
consecutive months following the accidental injury.

Loss of hearing means the entire and irrecoverable loss of hearing in both ears that
continues for 6 consecutive months following the accidental injury.

Paralysis of both arms and both legs....................................... 100%
Paralysis of both legs.............................................................. 50%
Paralysis of the arm and leg on either side of the body....... 50%
Paralysis of one arm or leg .................................................... 25%

Paralysis means loss of use of a limb, without severance. A Physician must determine
the paralysis to be permanent, complete and irreversible.

Brain Damage ................................................................... 100%

Brain Damage means permanent and irreversible physical damage to the brain causing
the complete inability to perform all the substantial and material functions and activities
normal to everyday life. Such damage must manifest itself within 30 days of the
accidental injury, require a hospitalization of at least 5 days and persists for 12
consecutive months after the date of the accidental injury.
Coma ........................................................................................................ 1% monthly beginning on the 7th day of the Coma for the duration of the Coma to a maximum of 60 months.

Coma means a state of deep and total unconsciousness from which the comatose person cannot be aroused. Such state must begin within 30 days of the accidental injury and continue for 7 consecutive days.

Third-degree burn(s) ........................................................................ A percentage of the Full Amount equal to the percentage of body surface suffering third-degree burns.
DEFINITIONS

As used in this certificate, the terms listed below will have the meanings set forth below. When defined terms are used in this certificate, they will appear with initial capitalization. The plural use of a term defined in the singular will share the same meaning.

**Actively at Work or Active Work** means that You are performing all of the usual and customary duties of Your job on a Full-Time basis. This must be done at:

- the Policyholder’s place of business;
- an alternate place approved by the Policyholder; or
- a place to which the Policyholder’s business requires You to travel.

You will be deemed to be Actively at Work during weekends or Policyholder approved vacations, holidays or business closures if You were Actively at Work on the last scheduled work day preceding such time off.

**Basic Annual Earnings** means Your gross annual rate of pay as determined by Your Policyholder, excluding overtime and other extra pay. "Basic Annual Earnings" for You if You are a salesman includes commissions and/or bonuses which shall be averaged for the most recent 12 month period.

**Beneficiary** means the person(s) to whom We will pay insurance as determined in accordance with the GENERAL PROVISIONS section.

**Child** means the following: (for residents of Louisiana, Montana, New Mexico, Texas, Utah and Washington, the Child Definition is modified as explained in the notice pages of this certificate - please consult the Notice)

Your natural child, adopted child (including a child from the date of placement with the adopting parents until the legal adoption) or stepchild (including the child of a Domestic Partner); and who, in each case, is:

- under age 19, unmarried and supported by You; or
- under age 23 and who is:
  1. unmarried;
  2. supported by You;
  3. not employed on a full-time basis; and
  4. a full-time student at an accredited school, college or university that is licensed in the jurisdiction where it is located. A person who, while enrolled as a full-time student:
      a. leaves school because of a medically necessary leave of absence; and
      b. whose absence is certified in Writing as necessary by a Physician;

      will be considered to have the status of a full-time student for the lesser of: (i) 12 months or (ii) the length of the certified leave of absence.

For the purposes of determining who may become covered for insurance, the term does not include any person who is on active duty in the military of any country or international authority; however, active duty for this purpose does not include weekend or summer training for the reserve forces of the United States, including the National Guard.
DEFINITIONS (continued)

**Common Carrier** means a government regulated entity that is in the business of transporting fare paying passengers.

**The term does not include:**

- chartered or other privately arranged transportation;
- taxis;
- limousines.

**Contributory Insurance** means insurance for which the Policyholder requires You to pay any part of the premium.

Contributory Insurance includes: Supplemental Life Insurance and Voluntary Accidental Death and Dismemberment Insurance.

**Dependent(s)** means Your Spouse and/or Child.

**Domestic Partner** means each of two people, one of whom is an employee of the Policyholder, who:

- have registered as each other’s domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available; or
- are of the same or opposite sex and have a mutually dependent relationship so that each has an insurable interest in the life of the other. Each person must be:
  1. 18 years of age or older;
  2. unmarried;
  3. the sole domestic partner of the other person and have been so for the immediately preceding 6 months;
  4. sharing a primary residence with the other person and have been so sharing for the immediately preceding 6 months; and
  5. not related to the other in a manner that would bar their marriage in the jurisdiction in which they reside.

A Domestic Partner affidavit attesting to the existence of an insurable interest in one another’s lives must be completed and Signed by the employee.

**Full-Time** means Active Work of at least 30 hours per week on the Policyholder's regular work schedule for the eligible class of employees to which You belong.

**Hospital** means a facility which is licensed as such in the jurisdiction in which it is located and:

- provides a broad range of medical and surgical services on a 24 hour a day basis for injured and sick persons by or under the supervision of a staff of Physicians; and
- provides a broad range of nursing care on a 24 hour a day basis by or under the direction of a registered professional nurse.
DEFINITIONS (continued)

Hospitalized means:

- admission for inpatient care in a Hospital;
- receipt of care in the following:
  - a hospice facility;
  - an intermediate care facility; or
  - a long term care facility; or
- receipt of the following treatment, wherever performed:
  - chemotherapy;
  - radiation therapy; or
  - dialysis.

Job-Related Injury means any injury:

- for which You are entitled to benefits under a workers’ compensation or similar law, or any arrangement that provides for similar compensation; or
- arising out of employment for wage or profit.

Noncontributory Insurance means insurance for which the Policyholder does not require You to pay any part of the premium.

Physician means:

- a person licensed to practice medicine in the jurisdiction where such services are performed; or
- any other person whose services, according to applicable law, must be treated as Physician’s services for purposes of the Group Policy. Each such person must be licensed in the jurisdiction where he performs the service and must act within the scope of that license. He must also be certified and/or registered if required by such jurisdiction.

The term does not include:

- You;
- Your Spouse; or
- any member of Your immediate family including Your and/or Your Spouse’s:
  - parents;
  - children (natural, step or adopted);
  - siblings;
  - grandparents; or
  - grandchildren.
DEFINITIONS (continued)

Proof means Written evidence satisfactory to Us that a person has satisfied the conditions and requirements for any benefit described in this certificate. When a claim is made for any benefit described in this certificate, Proof must establish:

- the nature and extent of the loss or condition;
- Our obligation to pay the claim; and
- the claimant's right to receive payment.

Proof must be provided at the claimant's expense.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

Spouse means Your lawful spouse. Wherever the term "Spouse" appears in the certificate it shall, unless otherwise specified, be read to include Your Domestic Partner.

For the purposes of determining who may become covered for insurance, the term does not include any person who is on active duty in the military of any country or international authority; however, active duty for this purpose does not include weekend or summer training for the reserve forces of the United States, including the National Guard.

We, Us and Our mean MetLife.

Written or Writing means a record which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

You and Your mean an employee who is insured under the Group Policy for the insurance described in this certificate.
ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

ELIGIBLE CLASS(ES)

All Full-Time exempt and non-exempt employees of the Policyholder.

DATE YOU ARE ELIGIBLE FOR INSURANCE

You may only become eligible for the insurance available for Your eligible class as shown in the SCHEDULE OF BENEFITS.

For exempt employees:

If You are in an eligible class on April 30, 2016, You will be eligible for the insurance described in this certificate on that date.

If You enter an eligible class after April 30, 2016, You will be eligible for insurance on the date You enter that class.

For non-exempt employees:

You will be eligible for the insurance described in this certificate on the later of:

1. April 30, 2016; and
2. the day after the date you complete 3 months of continuous service as an employee of the Policyholder.

ENROLLMENT PROCESS

If You are eligible for insurance, You may enroll for such insurance by completing the required form. In addition, You must give evidence of Your Insurability satisfactory to Us at Your expense if You are required to do so under the section entitled EVIDENCE OF INSURABILITY. If You enroll for Contributory Insurance, You must also give the Policyholder Written permission to deduct premiums from Your pay for such insurance. You will be notified by the Policyholder how much You will be required to contribute.

DATE YOUR INSURANCE TAKES EFFECT

Rules for Noncontributory Insurance

When You complete the enrollment process for Noncontributory Insurance, such insurance will take effect on the date You become eligible, provided You are Actively at Work on that date.

If You are not Actively at Work on the date the Noncontributory Insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

Rules for Contributory Insurance

If You request Contributory Insurance before the date You become eligible for such insurance, such insurance will take effect as follows:

- if You are not required to give evidence of Your insurability, such insurance will take effect on the date You become eligible, provided You are Actively at Work on that date.

- if You are required to give evidence of Your insurability and We determine that You are insurable, such insurance will take effect on the first day of the month following the date We state in Writing, provided You are Actively at Work on that date. You are not required to give evidence of Your insurability for Voluntary Accidental Death and Dismemberment Insurance and such insurance will take effect even if Your Life Insurance does not take effect.
ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

If You request Contributory Insurance **within 30 days of** the date You become eligible for such insurance, such insurance will take effect as follows:

- if You are **not required** to give evidence of Your insurability, such benefit will take effect on the later of:
  - the date You become eligible for such benefit; and
  - the date You enroll provided You are Actively at Work on that date.

- if You are **required** to give evidence of Your insurability and We determine that You are insurable, such insurance will take effect on the first of the month following the date We state in Writing, provided You are Actively at Work on that date. You are not required to give evidence of Your insurability for Voluntary Accidental Death and Dismemberment Insurance and such insurance will take effect even if Your Life Insurance does not take effect.

If You request Contributory Insurance **more than 30 days after** the date You become eligible for such insurance, You must give evidence of Your insurability satisfactory to us. You must give such evidence at Your expense. If We determine that You are insurable, such insurance will take effect on the first day of the month following the date We state in Writing, if You are Actively at Work on that date.

If You complete the enrollment process for Voluntary Accidental Death and Dismemberment Insurance **more than 30 days after** the date You become eligible for such insurance, Voluntary Accidental Death and Dismemberment Insurance does not require evidence of Your insurability and will take effect on the date of Your request.

**Enrollment Due to a Qualifying Event**

You may enroll for insurance for which You are eligible or change the amount of Your insurance if You have a Qualifying Event.

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

**Qualifying Event** includes:

- marriage;
- the birth, adoption or placement for adoption of a dependent child;
- divorce, legal separation or annulment;
- the death of a dependent;
- Your dependent's ceasing to qualify as a dependent under this insurance or under other group coverage; or
- a change in Your or Your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes You or Your dependent to gain or lose eligibility for group coverage.

If You have a Qualifying Event, You will have 30 days from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The insurance enrolled for, or changes to Your insurance made as a result of a Qualifying Event will take effect on the first day of the month following the date of Your request, if You are Actively at Work on that date.

If You are not Actively at Work on the date an amount of insurance would otherwise take effect, that amount of insurance will take effect on the day You resume Active Work.
ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

For Basic Life Insurance

Increase in Insurance

An increase in insurance due to an increase in Your earnings will take effect on the first day of the month following the date of the increase in Your earnings.

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

Decrease in Insurance

A decrease in insurance due to a decrease in Your earnings will take effect on the first day of the month following the date of change.

For Supplemental Life and Voluntary Accidental Death and Dismemberment Insurance

Increase in Insurance

An increase in insurance due to an increase in Your earnings will take effect as follows:

- if You are required to give evidence of insurability for the entire increase in insurance and We approve Your evidence of insurability, the increase will take effect on the first day of the month. If We do not approve Your evidence of insurability, or You do not submit evidence of insurability, the increase in insurance will not take effect.

- if You are required to give evidence of insurability for a portion of the increase in insurance:
  - the portion of the increase in insurance that is not subject to evidence of insurability will take effect on the first day of the month following the date of the increase in Your earnings.
  - if We approve Your evidence of insurability, the portion of the increase in insurance that is subject to evidence of insurability will take effect on the first day of the month. If We do not approve Your evidence of insurability or You do not submit evidence of insurability, the increase in insurance will not take effect.

- if You are not required to give evidence of insurability, the increase will take effect on the first day of the month following the date of the increase in Your earnings.

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

Decrease in Insurance

A decrease in insurance due to a decrease in Your earnings will take effect on the first day of the month following the date of change.
DATE YOUR INSURANCE ENDS

Your insurance will end on the earliest of:

for all coverages

1. the date the Group Policy ends; or
2. the date insurance ends for Your class; or
3. the date You cease to be in an Eligible Class; or
4. the end of the period for which the last premium has been paid for You; or
5. the date Your employment ends; Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT; or
6. the date You retire in accordance with the Policyholder's retirement plan.

Please refer to the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOU for information concerning the option to convert to an individual policy of life insurance if Your Life Insurance ends.

In certain cases insurance may be continued as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.
ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS

ELIGIBLE CLASS(ES) FOR DEPENDENT INSURANCE

All Full-Time exempt and non-exempt employees of the Policyholder.

DATE YOU ARE ELIGIBLE FOR DEPENDENT INSURANCE

You may only become eligible for the Dependent insurance available for Your eligible class as shown in the SCHEDULE OF BENEFITS.

For exempt employees:

You will be eligible for Dependent insurance described in this certificate on the latest of:

1. April 30, 2016; and
2. the date You enter a class eligible for insurance; and
3. the date You obtain a Dependent.

For non-exempt employees:

You will be eligible for Dependent insurance described in this certificate on the latest of:

1. April 30, 2016;
2. the date You enter a class eligible for insurance;
3. the date You obtain a Dependent; and
4. the day after the date You complete 3 months of continuous services as an employee of the Policyholder.

ENROLLMENT PROCESS

In order to enroll for Life Insurance for Your Dependents, You must either (a) already be enrolled for Basic Life Insurance for You or (b) enroll at the same time for Basic Life Insurance for You.

If You become eligible for Dependent insurance, You may enroll for such insurance by providing Us with the information We require for each Dependent to be insured. If You enroll for Contributory Insurance, You must also give the Policyholder written permission to deduct premiums from Your pay for such insurance. You will be notified by the Policyholder how much You will be required to contribute.

Once You have enrolled one Child for a Dependent insurance benefit, each succeeding Child will automatically be covered for such insurance on the date that Child qualifies as a Dependent.

DATE INSURANCE TAKES EFFECT FOR YOUR DEPENDENTS

Rules for Noncontributory Dependent Insurance

For Dependents You Have When You Become Eligible For Dependent Insurance

If You complete the enrollment process for Noncontributory Dependent Insurance, the insurance will take effect for each enrolled Dependent on the date You become eligible, provided You are Actively at Work on that date.

If You are not Actively at Work on the date the Noncontributory Dependent Insurance would otherwise take effect, the insurance will take effect for each enrolled Dependent on the day You resume Active Work.
ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (continued)

For Dependents You Obtain After You Become Eligible For Dependent Insurance

If You obtain a Dependent after You become eligible for a Dependent insurance benefit, You may enroll the Dependent for such benefit within 30 days after the date the Dependent qualifies as a Dependent as defined in this certificate. The Dependent insurance benefit for the Dependent will take effect on the later of:

- the date You become eligible for such benefit; and
- the date You enroll
  provided You are Actively at Work on that date.

If You complete the enrollment process for any Dependent more than 30 days after the date the Dependent qualifies as a Dependent, the benefit will take effect on the date We state in Writing.

Once You have enrolled one Child for a Dependent insurance benefit, each succeeding Child will automatically be covered for such insurance on the date that Child qualifies as a Dependent.

If You are not Actively at Work on the date the Noncontributory Dependent Insurance benefit would otherwise take effect, the benefit will take effect on the day You resume Active Work.

Rules for Contributory Dependent Insurance

For Dependents You Have When You Become Eligible For Dependent Insurance

If You complete the enrollment process for Dependent Life and Dependent Accidental Death and Dismemberment and Voluntary Accidental Death and Dismemberment Insurance, the insurance will take effect for each enrolled Dependent on the first day of the month following the date You become eligible for such insurance, if You are Actively at Work on that date.

If You request Dependent Life insurance within 30 days of the date You become eligible for such insurance, such insurance will take effect as follows:

- if the Dependent is not required to give evidence of insurability, the insurance for those Dependents will take effect on the later of:
  - the date You become eligible for such insurance; and
  - the date You enroll;
  provided You are Actively at Work on that date; or
- if the Dependent is required to give evidence of Your insurability and We determine that all Dependents are insurable, such insurance will take effect on the date We state in Writing, provided You are Actively at Work on that date.

If You request Contributory Dependent Life insurance more than 30 days after the date You become eligible for such insurance, You must give evidence of Your insurability satisfactory to us. You must give such evidence at Your expense. If We determine that You are insurable, such insurance will take effect on the date We state in Writing, if You are Actively at Work on that date.

Once You have enrolled one Child for a Dependent insurance benefit, each succeeding Child will automatically be covered for such insurance on the date that Child qualifies as a Dependent.

If You are not Actively at Work on the date the Dependent Life and Dependent Accidental Death and Dismemberment and Voluntary Accidental Death and Dismemberment Insurance would otherwise take effect, the insurance will take effect on the day You resume Active Work.
ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (continued)

For Dependents You Obtain After You Become Eligible For Dependent Insurance

If You obtain a Dependent after You become eligible for Dependent Life and Dependent Accidental Death and Dismemberment and Voluntary Accidental Death and Dismemberment insurance, You may enroll the Dependent for such insurance after the date the Dependent qualifies as a Dependent as defined in this certificate. The Dependent insurance for the Dependent will take effect:

- on the later of:
  - the date You become eligible for such insurance; and
  - the date You enroll;

  provided You are Actively at Work on that date.

Once You have enrolled one Child for a Dependent insurance benefit, each succeeding Child will automatically be covered for such insurance on the date that Child qualifies as a Dependent.

If You are not Actively at Work on the date the Dependent Life and Dependent Accidental Death and Dismemberment and Voluntary Accidental Death and Dismemberment Insurance would otherwise take effect, the insurance will take effect on the day You resume Active Work.

Enrollment Due to a Qualifying Event

You may enroll for Dependent insurance for which You are eligible if You have a Qualifying Event.

Qualifying Event includes:

- marriage
- birth, adoption or placement for adoption of a dependent child
- divorce, legal separation or annulment
- death of a dependent
- Your dependent's ceasing to qualify as a dependent under this insurance or under other group coverage
- a change in Your or Your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes You or Your dependent to gain or lose eligibility for group coverage

If You have a Qualifying Event, You will have 30 days from the date of that change to make a request. This request must be consistent with the nature of the Qualifying Event. The insurance enrolled for or changes to Your insurance made as a result of a Qualifying Event will take effect for each enrolled Dependent as follows:

- if the Dependent is not required to give evidence of insurability, such insurance will take effect on the first day of the month following the date of Your request, if You are Actively at Work on that date.
- if the Dependent is required to give evidence of insurability and We determine that the Dependent is insurable, such insurance will take effect on the first day of the month following the date We state in Writing, if You are Actively at Work on that date.
ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (continued)

Once You have enrolled one Child for a Dependent insurance benefit, each succeeding Child will automatically be covered for such insurance on the date that Child qualifies as a Dependent.

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS

A Dependent’s insurance will end on the earliest of:

1. for Dependent Life Insurance, the date all of the Life Insurance under the Group Policy ends; or
2. for Dependent Voluntary Accidental Death and Dismemberment Insurance, the date all of Your Accidental Death and Dismemberment Insurance under the Group Policy ends; or
3. the date You die; or
4. the date the Group Policy ends; or
5. the date Your Employee Life Insurance under the Group Policy ends; or
6. the date Insurance for Your Dependents ends under the Group Policy; or
7. the date the Group Policy ends for Your class; or
8. the date the person ceases to be a Dependent; or
9. the date Your employment ends; Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT; or
10. for a Dependent Spouse, the date You Spouse attains age 70; or
11. the date You retire in accordance with the Policyholder’s retirement plan; or
12. the end of the period for which the last premium has been paid for the Dependent.

Please refer to the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOUR DEPENDENTS for information concerning the option to convert to an individual policy of life insurance if Life Insurance for a Dependent ends.

In certain cases insurance may be continued as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.
SPECIAL RULES FOR GROUPS PREVIOUSLY COVERED UNDER OTHER GROUP LIFE AND AD&D INSURANCE

The following rules will apply if the Life and AD&D Insurance under this Group Policy replaces other group Life and AD&D insurance provided to You by the Policyholder.

**Prior Plan** means the group life and AD&D insurance underwritten by another insurer and provided to You by the Policyholder on the day before the Replacement Date.

**Replacement Date** means the effective date of the Life and AD&D Insurance under this Group Policy.

**Rules if You and Your Dependents were Covered Under the Prior Plan on the Day Before the Replacement Date:**

1. **Actively at Work on the Replacement Date** - If You and Your Dependent(s) were covered under the Prior Plan on the day before the Replacement Date and You are Actively at Work in an eligible class on the Replacement Date, You will be insured under this Group Policy for an amount of Life and AD&D Insurance referred to as Active Employee Coverage. The amount of the Active Employee Coverage on the Replacement Date will be the amount of Life Insurance described in the SCHEDULE OF BENEFITS.

2. **Not Actively at Work on the Replacement Date** - If You and Your Dependent(s) were covered under the Prior Plan on the day before the Replacement Date and You are not Actively at Work on the Replacement Date, but You would otherwise be a member of an eligible class if You were Actively at Work on the Replacement Date, You will be insured under this Group Policy for an amount of Life and AD&D Insurance referred to as Transition Coverage. The amount of the Transition Coverage on the Replacement Date will be the lesser of:
   - the amount of group life and AD&D insurance in effect under the Prior Plan, and
   - the amount of Life and AD&D Insurance available under this Group Policy for the eligible class to which You belong.

While Transition Coverage is in effect, the amount of coverage will continue to be determined in accordance with the provisions of the plan used to determine the amount of Transition Coverage on the Replacement Date.

If You are not Actively at Work on the Replacement Date due to a disability, Transition Coverage will remain in effect on and after the Replacement Date until the earliest of:
   - the date You return to Active Work as a member of an eligible class, at which time Active Employee Coverage will supersede the Transition Coverage;
   - the date Life and AD&D Insurance would otherwise end in accordance with the terms and conditions of this certificate;
   - the date on which Your life and AD&D insurance under the Prior Plan would have ended for any reason other than the Prior Plan ending;
   - the date You are approved for extension of life and AD&D insurance without premium payment under the terms of Prior Plan; and
   - if the Prior Plan provided for extension of life and AD&D insurance without premium payment during a period of disability, the last day of the 12-month period following the Replacement Date.
SPECIAL RULES FOR GROUPS PREVIOUSLY COVERED UNDER OTHER GROUP LIFE AND AD&D INSURANCE (continued)

In any other case where You are not Actively at Work on the Replacement Date, Transition Coverage will remain in effect on and after the Replacement Date until the earliest of:

- the date You return to Active Work as a member of an eligible class, at which time Active Employee Coverage will supersede the Transition Coverage; and
- the date Life and AD&D Insurance would otherwise end in accordance with the terms and conditions of this certificate.

Rules if You and Your Dependents were NOT Covered Under the Prior Plan on the Day Before the Replacement Date:

1. You will be eligible for the Life and AD&D Insurance under this Group Policy when You meet the eligibility requirements for such insurance as described in ELIGIBILITY PROVISIONS: INSURANCE FOR YOU and ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS; and

2. We will credit any time accumulated toward any eligibility waiting period under the Prior Plan to the satisfaction of any eligibility Waiting Period required to be met under this Life and AD&D Insurance.
CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT (For MN Residents see Minnesota Notice Page)

FOR MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN

Insurance for a Dependent Child may be continued past the age limit if the child is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law. Proof of such handicap must be sent to Us within 31 days after the date the Child attains the age limit and at reasonable intervals after such date.

Subject to the DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS, insurance will continue while such Child:

- remains incapable of self-sustaining employment because of a mental or physical handicap; and
- continues to qualify as a Child, except for the age limit.

FOR FAMILY AND MEDICAL LEAVE

Certain leaves of absence may qualify for continuation of insurance under the Family and Medical Leave Act of 1993 (FMLA), or other legally mandated leave of absence or similar laws. Please contact the Policyholder for information regarding such legally mandated leave of absence laws.

AT THE POLICYHOLDER’S OPTION

The Policyholder has elected to continue insurance by paying premiums for employees who cease Active Work in an eligible class for any of the reasons specified below.

1. if You cease Active Work due to injury or sickness, for a period in accordance with the Policyholder's general practice for an employee in Your job class;
2. if You cease Active Work due to part-time work, for a period in accordance with the Policyholder's general practice for an employee in Your job class;
3. if You cease Active Work due to layoff, for a period in accordance with the Policyholder's general practice for an employee in Your job class;
4. if You cease Active Work due to any other Policyholder approved leave of absence, for a period in accordance with the Policyholder's general practice for an employee in Your job class.

The Policyholder's general practice for employees in a job class determines which employees with the above types of absences are to be considered as still insured and for how long among persons in like situations.

At the end of any of the continuation periods listed above, Your insurance will be affected as follows:

- if You resume Active Work in an eligible class at this time, You will continue to be insured under the Group Policy;
- if You do not resume Active Work in an eligible class at this time, Your employment will be considered to end and Your insurance will end in accordance with the DATE YOUR INSURANCE ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOU.

If Your insurance ends, Your Dependents’ insurance will also end in accordance with the DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS.
EVIDENCE OF INSURABILITY

We require evidence of insurability satisfactory to Us as follows:

1. in order to become covered for an amount of Supplemental Life Insurance greater than the Non-Medical Issue Amount as shown in the SCHEDULE OF BENEFITS.
   
   If You do not give Us evidence of Your insurability, or if such evidence of insurability is not accepted by Us as satisfactory, the amount of Your Supplemental Life Insurance will be limited to the Non-Medical Issue Amount.

2. if Your Basic Annual Earnings increase so that the amount of Your Supplemental Life Insurance which is at or below the Non-Medical Issue Amount would increase to an amount above the Non-Medical Issue Amount as shown in the SCHEDULE OF BENEFITS.
   
   If You do not give Us evidence of insurability or the evidence of insurability is not accepted by Us as satisfactory, the increase in Your Supplemental Life Insurance will be limited to the Non-Medical Issue Amount.

3. if You make a request during an annual enrollment period to increase the amount of Your Supplemental Life Insurance.
   
   If You do not give Us evidence of insurability or the evidence of insurability is not accepted by Us as satisfactory, the amount of your Supplemental Life Insurance will not be increased.

4. if You make a request due to a Qualifying Event to increase the amount of Your Supplemental Life Insurance.
   
   If You do not give Us evidence of insurability or the evidence of insurability is not accepted by Us as satisfactory, the amount of your Supplemental Life Insurance will not be increased.

5. if You make a late request during an annual enrollment period for Supplemental Life Insurance. A late request is one made more than 30 days after You become eligible.
   
   If You do not give Us evidence of insurability or the evidence of insurability is not accepted by Us as satisfactory, You will not be covered for Supplemental Life Insurance.

6. if You make a late request due to a Qualifying Event for Supplemental Life Insurance. A late request is one made more than 30 days after You become eligible.
   
   If You do not give Us evidence of insurability or the evidence of insurability is not accepted by Us as satisfactory, You will not be covered for Supplemental Life Insurance.

The evidence of insurability is to be given at Your expense.
LIFE INSURANCE: FOR YOU

If You die, Proof of Your death must be sent to Us. When We receive such Proof with the claim, We will review the claim and, if We approve it, will pay the Beneficiary the Life Insurance in effect on the date of Your death.

PAYMENT OPTIONS

We will pay the Life Insurance in one sum. Other modes of payment may be available upon request. For details, call Our toll free number shown on the Certificate Face Page.
LIFE INSURANCE: FOR YOUR DEPENDENTS

If a Dependent dies, Proof of the Dependent’s death must be sent to Us. When We receive such Proof with the claim, We will review the claim and, if We approve it, will pay the Beneficiary the Life Insurance in effect on the life of such Dependent on the date of death.

PAYMENT OPTIONS

We will pay the Life Insurance in one sum. Other modes of payment may be available upon request. For details, call Our toll free number shown on the Certificate Face Page.
LIFE INSURANCE: ACCELERATED BENEFIT OPTION (ABO) FOR YOU

For purposes of this section, the term “ABO Eligible Life Insurance” refers to each of Your Life Insurance benefits for which the Accelerated Benefit Option is shown as available in the SCHEDULE OF BENEFITS.

If You become Terminally Ill, You or Your legal representative have the option to request Us to pay ABO Eligible Life Insurance before Your death. This is called an accelerated benefit. The request must be made while ABO Eligible Life Insurance is in effect.

Terminally Ill or Terminal Illness means that due to injury or sickness, You are expected to die within 6 months.

Requirements For Payment of an Accelerated Benefit

Subject to the conditions and requirements of this section, We will pay an accelerated benefit to You or Your legal representative if:

- the amount of each ABO Eligible Life Insurance benefit to be accelerated equals or exceeds $10,000; and
- the ABO Eligible Life Insurance to be accelerated has not been assigned; and
- We have received Proof that You are Terminally Ill.

We will only pay an accelerated benefit for each ABO Eligible Life Insurance benefit once.

Proof of Your Terminal Illness

We will require the following Proof of Your Terminal Illness:

- a completed accelerated benefit claim form;
- a signed Physician’s certification that You are Terminally Ill; and
- an examination by a Physician of Our choice, at Our expense, if We request it.

You or Your legal representative should contact the Policyholder to obtain a claim form and information regarding the accelerated benefit.

Upon Our receipt of Your request to accelerate benefits, We will send You a letter with information about the accelerated benefit payment You requested. Our letter will describe the amount of the accelerated benefits We will pay and the amount of Life Insurance remaining after the accelerated benefit is paid.

Accelerated Benefit Amount

We will pay an accelerated benefit up to the percentage shown in the SCHEDULE OF BENEFITS for each ABO Eligible Life Insurance benefit in effect for You, subject to the following:

**Maximum Accelerated Benefit Amount.** The maximum amount We will pay for each ABO Eligible Life Insurance benefit is shown in the SCHEDULE OF BENEFITS.

**Scheduled Reduction of an ABO Eligible Life Insurance Benefit.** If an ABO Eligible Life Insurance benefit is scheduled to reduce within the 6 month period after the date You or Your legal representative request an accelerated benefit, We will calculate the accelerated benefit using the amount of such ABO Eligible Life Insurance that will be in effect immediately after the reduction(s) scheduled for such period.
LIFE INSURANCE: ACCELERATED BENEFIT OPTION (ABO) FOR YOU (continued)

Scheduled End of an ABO Eligible Life Insurance Benefit. If an ABO Eligible Life Insurance benefit is scheduled to end within 6 months after the date You or Your legal representative request an accelerated benefit, We will not pay an accelerated benefit for such ABO Eligible Life Insurance benefit.

Previous Conversion of an ABO Eligible Life Insurance Benefit. We will not pay an accelerated benefit for any amount of ABO Eligible Life Insurance which You previously converted under the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOU.

We will pay the accelerated benefit in one sum unless You or Your legal representative select another payment mode.

Effect of Payment of an Accelerated Benefit

On Contribution for Your Life Insurance. After We pay the accelerated benefit, any future contributions for Life Insurance You are required to pay will be waived.

On Your Life Insurance at Your death. The amount of Life Insurance that We will pay at Your death will be decreased by the amount of the accelerated benefit paid by Us.

On Your Life Insurance at conversion. The amount to which You are entitled to convert under the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOU will be decreased by the amount of the accelerated benefit paid by Us.

On Your Accidental Death and Dismemberment Insurance. Payment of an accelerated benefit will not affect Your Accidental Death and Dismemberment Insurance.

Date Your Option to Accelerate Benefits Ends

The accelerated benefit option will end on the earliest of:

- the date that is 2 years prior to Your normal date of retirement;
- the date you obtain age 63;
- date the ABO Eligible Life Insurance ends;
- the date You or Your legal representative assign all ABO Eligible Life Insurance; or
- the date You or Your legal representative have accelerated all ABO Eligible Life Insurance benefits.
LIFE INSURANCE: CONVERSION OPTION FOR YOU

If Your life insurance ends or is reduced for any of the reasons stated below, You have the option to buy an individual policy of life insurance ("new policy") from Us during the Application Period in accordance with the conditions and requirements of this section. This is referred to as the "option to convert". Evidence of Your insurability will not be required.

When You Will Have the Option to Convert

You will have the option to convert when:

A. Your life insurance ends because:
   - You cease to be in an eligible class;
   - Your employment ends;
   - this Group Policy ends, provided You have been insured for life insurance for at least 5 continuous years; or
   - this Group Policy is amended to end all life insurance for an eligible class of which You are a member, provided You have been insured for at least 5 continuous years; or

B. Your life insurance is reduced:
   - on or after the date You attain age 60;
   - because You change from one eligible class to another; or
   - due to an amendment of this Group Policy.

If You opt not to convert a reduction in the amount of Your life insurance as described above, You will not have the option to convert that amount at a later date.

A reduction in the amount of Your life insurance as a result of the payment of an accelerated benefit will not give rise to a right to convert under this section.

Application Period

If You opt to convert Your life insurance for any of the reasons stated above, We must receive a completed conversion application form from You within the Application Period described below.

If You are given Written notice of the option to convert within 15 days before or after the date Your life insurance ends or is reduced, the Application Period begins on the date that such life insurance ends or is reduced and expires 31 days after such date.

If You are given Written notice of the option to convert more than 15 days after the date Your life insurance ends or is reduced, the Application Period begins on the date such life insurance ends or is reduced and expires 15 days from the date of such notice. In no event will the Application Period exceed 91 days from the date Your life insurance ends or is reduced.

Option Conditions

The option to convert is subject to the following:

A. Our receipt within the Application Period of:
   - Your Written application for the new policy; and
   - the premium due for such new policy;
LIFE INSURANCE: CONVERSION OPTION FOR YOU (continued)

B. the premium rates for the new policy will be based on:
   - Our rates then in use;
   - the form and amount of insurance for which you apply;
   - Your class of risk; and
   - Your age;

C. the new policy may be on any form then customarily offered by Us excluding term insurance;

D. the new policy will be issued without an accidental death and dismemberment benefit, an accelerated benefit option, a waiver of premium benefit or any other rider or additional benefit; and

E. the new policy will take effect on the 32nd day after the date Your life insurance ends or is reduced; this will be the case regardless of the duration of the Application Period.

Maximum Amount of the New Policy

If Your Life Insurance ends due to the end of this Group Policy or the amendment of this Group Policy to end all life insurance for an eligible class of which You are a member, the maximum amount of insurance that You may elect for the new policy is the lesser of:

- the amount of Your life insurance that ends under this Group Policy less the amount of life insurance for which You become eligible under any group policy within 31 days after the date insurance ends under this Group Policy; or
- $10,000.

If Your life insurance ends or is reduced due to the Policyholder’s organizational restructuring, the maximum amount of insurance that You may elect for the new policy is the amount of Your life insurance that ends under this Group Policy less the amount of life insurance for which You become eligible under any other group policy within 31 days after the date insurance ends under this Group Policy.

If Your life insurance ends or is reduced for any other reason, the maximum amount of insurance that You may elect for the new policy is the amount of Your life insurance which ends under this Group Policy.

ADDITIONAL PROVISIONS IF YOU DIE

If You Die Within 31 Days After Your Life Insurance Ends Or Is Reduced

If You die within 31 days after Your life insurance ends or is reduced by an amount You are entitled to convert, Proof of Your death must be sent to Us. When We receive such Proof with the claim, We will review the claim and if We approve it will pay the Beneficiary. The amount We will pay is the amount You were entitled to convert.

The amount You were entitled to convert will not be paid as insurance under both a new individual conversion policy and the Group Policy.
LIFE INSURANCE: CONVERSION OPTION FOR YOUR DEPENDENTS

If life insurance for a Dependent ends or is reduced for any of the reasons stated below, You or that Dependent will have the option to buy from Us an individual policy of life insurance on the life of the Dependent (“new policy”) during the Application Period in accordance with the conditions and requirements of this section. This is referred to as “the option to convert”. Evidence of the Dependent’s insurability will not be required.

When You or a Dependent Will Have the Option to Convert

You will have the option to convert life insurance for a Dependent when:

A. life insurance for the Dependent ends because:
   - You cease to be in an eligible class;
   - Your employment ends;
   - this Group Policy ends, provided You have been insured for life insurance for the Dependent for at least 5 continuous years; or
   - this Group Policy is amended to end all life insurance for Dependents for an eligible class of which You are a member, provided You have been insured for life insurance for the Dependent for at least 5 continuous years; or

B. life insurance for the Dependent is reduced:
   - on or after the date You attain age 60;
   - because You change from one eligible class to another; or
   - due to an amendment of this Group Policy.

A Dependent will have the option to convert when:

- life insurance for such Dependent ends because that Dependent ceases to qualify as a Dependent as defined in this certificate, or
- You die.

If You opt not to convert a reduction in the amount of life insurance for a Dependent, You will not have the option to convert that amount at a later date.

You must notify the Policyholder in the event that a Dependent ceases to qualify as a Dependent as defined in this certificate.

Application Period

If You or a Dependent opt to convert as stated above, We must receive a completed conversion application form within the Application Period described below.

If Written notice of the option to convert is given within 15 days before or after the date life insurance for a Dependent ends or is reduced, the Application Period begins on the date that such life insurance ends or is reduced and expires 31 days after such date.

If Written notice of the option to convert is given more than 15 days after the date life insurance for the Dependent ends or is reduced, the Application Period begins on the date such life insurance ends or is reduced and expires 15 days from the date of such notice. In no event will the Application Period exceed 91 days from the date Life Insurance for the Dependent ends or is reduced.
LIFE INSURANCE: CONVERSION OPTION FOR YOUR DEPENDENTS (continued)

Option Conditions

The option to convert is subject to the following:

A. Our receipt within the Application Period of:
   - a Written application for the new policy for the Dependent; and
   - the premium due for such new policy;

B. the premium rates for the new policy will be based on:
   - Our rates then in use;
   - the form and amount of insurance which is applied for;
   - the Dependent's class of risk; and
   - the Dependent's age;

C. the new policy may be on any form then customarily offered by Us excluding term insurance;

D. the new policy will be issued without an accidental death and dismemberment benefit, an accelerated benefit option, waiver of premium benefit or any other rider or additional benefit; and

E. the new policy will take effect on the 32nd day after the date Life Insurance for the Dependent ends or is reduced; this will be the case regardless of the duration of the Application Period.

Maximum Amount of the New Policy

If Life Insurance for a Dependent ends due to the end of this Group Policy or the amendment of this Group Policy to end all life insurance for Dependents for an eligible class of which You are a member, the maximum amount of insurance that may be elected for the new policy is the lesser of:

- the amount of Life Insurance for the Dependent that ends under this Group Policy less the amount of life insurance for Dependents for which You become eligible under any group policy within 31 days after the date insurance ends under this Group Policy; or
- $10,000.

If life insurance for a Dependent ends or is reduced due to the Policyholder’s organizational restructuring, the maximum amount of insurance that may be elected for the new policy is the amount of life insurance for the Dependent that ends under this Group Policy less the amount of life insurance for dependents for which You become eligible under any other group policy within 31 days after the date insurance ends under this Group Policy.

If Your life insurance for a Dependent ends or is reduced for any other reason, the maximum amount of insurance that You may elect for the new policy is the amount of Your life insurance for a Dependent that ends under this Group Policy.

ADDITIONAL PROVISIONS IF A DEPENDENT DIES

If a Dependent Dies Within the 31 Days After Life Insurance for a Dependent Ends Or Is Reduced

If a Dependent dies within 31 days after the date life insurance for the Dependent ends or is reduced by an amount eligible for convert, Proof of the Dependent’s death must be sent to Us. When we receive such Proof with the claim, We will review the claim and if We approve it, will pay the Beneficiary. The amount We will pay is the amount that could have been converted.

The amount that could have been converted will not be paid as insurance under both a new individual conversion policy and the Group Policy.
ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

If You or a Dependent sustain an accidental injury that is the Direct and Sole Cause of a Covered Loss described in the SCHEDULE OF BENEFITS, Proof of the accidental injury and Covered Loss must be sent to Us. When We receive such Proof We will review the claim and, if We approve it, will pay the insurance in effect on the date of the injury.

Direct and Sole Cause means that the Covered Loss occurs within 12 months of the date of the accidental injury and was a direct result of the accidental injury, independent of other causes.

We will deem a loss to be the direct result of an accidental injury if it results from unavoidable exposure to the elements and such exposure was a direct result of an accident.

PRESCRIPTION OF DEATH

You and/or a Dependent will be presumed to have died as a result of an accidental injury if:

- the aircraft or other vehicle in which You and/or a Dependent were traveling disappears, sinks, or is wrecked; and
- the body of the person who has disappeared is not found within 1 year of:
  - the date the aircraft or other vehicle was scheduled to have arrived at its destination, if traveling in an aircraft or other vehicle operated by a Common Carrier; or
  - the date the person is reported missing to the authorities, if traveling in any other aircraft or other vehicle.

EXCLUSIONS (See notice page for residents of Missouri)

We will not pay benefits under this section for any loss caused or contributed to by:

1. physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;
2. infection, other than infection occurring in an external accidental wound or from food poisoning;
3. suicide or attempted suicide;
4. intentionally self-inflicted injury;
5. service in the armed forces of any country or international authority. However, service in reserve forces does not constitute service in the armed forces, unless in connection with such reserve service an individual is on active military duty as determined by the applicable military authority other than weekend or summer training. For purposes of this provision reserve forces are defined as reserve forces of any branch of the military of the United States or of any other country or international authority, including but not limited to the National Guard of the United States or the national guard of any other country;
6. any incident related to:
   - travel in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger;
   - travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight;
   - parachuting or otherwise exiting from an aircraft while such aircraft is in flight, except for self-preservation;
   - travel in an aircraft or device used:
     - for testing or experimental purposes;
     - by or for any military authority; or
     - for travel or designed for travel beyond the earth’s atmosphere;
7. committing or attempting to commit a felony;
ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (continued)

8. the voluntary intake or use by any means of:
   • any drug, medication or sedative, unless it is:
     • taken or used as prescribed by a Physician; or
     • an "over the counter" drug, medication or sedative taken as directed;
   • alcohol in combination with any drug, medication, or sedative; or
   • poison, gas, or fumes; or

9. war, whether declared or undeclared; or act of war, insurrection, rebellion or active participation in a riot.

10. a non Job-Related Injury.

Exclusion for Intoxication

We will not pay benefits under this section for any loss if the injured party is intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the incident.

Intoxicated means that the injured person’s blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.

COMMON DISASTER

If You and Your Spouse are injured in the same accident and die within 365 days as a result of injuries in such accident, the Full Amount that we will pay for Your Spouse’s loss of life will be increased to equal the Full Amount payable for Your loss of life.

BENEFIT PAYMENT

For loss of Your life, We will pay benefits to Your Beneficiary.

For any other loss sustained by You, or for any loss sustained by a Dependent, We will pay benefits to You.

If You or a Dependent sustain more than one Covered Loss due to an accidental injury, the amount We will pay, on behalf of any such injured person, will not exceed the Full Amount.

We will pay benefits in one sum. Other modes of payment may be available upon request. For details call Our toll free number shown on the Certificate Face Page.

If You and any Dependent die within a 24 hour period, We will pay the Dependent’s Accidental Death and Dismemberment Insurance to the Beneficiary receiving payment of Your Accidental Death and Dismemberment Insurance including payment of any Additional Benefits, or We may pay Your estate. If a Beneficiary is a minor or is incompetent to receive payment, We will pay that person’s guardian.

APPLICABILITY OF PROVISIONS

The provisions set forth in this ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section apply to all Accidental Death and Dismemberment Insurance – Additional Benefit sections included in this certificate except as may otherwise be provided in such Additional Benefit sections.
ADDITIONAL BENEFIT: SEAT BELT USE

If You or a Dependent die as a result of an accidental injury, We will pay this additional Seat Belt Use benefit if:

1. We pay a benefit for loss of life under the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section;
2. this benefit is in effect on the date of the injury; and
3. We receive Proof that the deceased person:
   - was in an accident while driving or riding as a passenger in a Passenger Car;
   - was wearing a Seat Belt which was properly fastened at the time of the accident; and
   - died as a result of injuries sustained in the accident.

A police officer investigating the accident must certify that the Seat Belt was properly fastened. A copy of such certification must be submitted to Us with the claim for benefits.

**Passenger Car** means any validly registered four-wheel private passenger car, four-wheel drive vehicle, sports-utility vehicle, pick-up truck or mini-van. It does not include any commercially licensed car, any private car being used for commercial purposes, or any vehicle used for recreational or professional racing.

**Seat Belt** means any restraint device that:

- meets published United States Government safety standards;
- is properly installed by the car manufacturer; and
- is not altered after the installation.

The term includes any child restraint device that meets the requirements of state law.

**BENEFIT AMOUNT**

The Seat Belt Use benefit is an additional benefit equal to 10% of the Full Amount shown in the SCHEDULE OF BENEFITS. However, the amount We will pay for this benefit will not be less than $1,000 or more than $25,000.

If it is unclear whether the Seat Belt was properly fastened, the Seat Belt Use benefit is $1,000.

**BENEFIT PAYMENT**

For loss of Your life, We will pay benefits to Your Beneficiary.

For loss of a Dependent’s life, We will pay benefits to You.
ADDITIONAL BENEFIT: AIR BAG USE

If You or a Dependent die as a result of an accidental injury, We will pay this additional benefit if:

1. We pay a benefit for loss of life under the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section;
2. this benefit is in effect on the date of the injury; and
3. We receive Proof that the deceased person:
   - was in an accident while driving or riding as a passenger in a Passenger Car equipped with an Air Bag(s);
   - was riding in a seat protected by an Air Bag;
   - was wearing a Seat Belt which was properly fastened at the time of the accident; and
   - died as a result of injuries sustained in the accident.

A police officer investigating the accident must certify that the Seat Belt was properly fastened and that the Passenger Car in which the deceased was traveling was equipped with Air Bags. A copy of such certification must be submitted to Us with the claim for benefits.

Passenger Car means any validly registered four-wheel private passenger car, four-wheel drive vehicle, sports-utility vehicle, pick-up truck or mini-van. It does not include any commercially licensed car, any private car being used for commercial purposes, or any vehicle used for recreational or professional racing.

Seat Belt means any restraint device that:
- meets published United States government safety standards;
- is properly installed by the car manufacturer; and
- is not altered after the installation.

The term includes any child restraint device that meets the requirements of state law.

Air Bag means an inflatable restraint device that:
- meets published United States government safety standards;
- is properly installed by the car manufacturer; and
- is not altered after the installation.

BENEFIT AMOUNT

The Air Bag Use Benefit is an additional benefit equal to 5% of the Full Amount shown in the SCHEDULE OF BENEFITS. However, the amount We will pay for this benefit will not be less than $1,000 or more than $10,000.

If it is unclear whether the Seat Belt was properly fastened or that the seat in which the deceased was traveling was protected by Air Bags, the Air Bag Use benefit is $1,000.

BENEFIT PAYMENT

For loss of Your life, We will pay benefits to Your Beneficiary.

For a loss of a Dependent’s life, We will pay benefits to You.
ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (continued)

ADDITIONAL BENEFIT: CHILD CARE

If You or Your Spouse die as a result of an accidental injury, We will pay this additional Child Care benefit if:

1. We pay a benefit for loss of such person's life under the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section;
2. this benefit is in effect on the date of the injury; and
3. We receive Proof that:
   • on the date of death a Child was enrolled in a Child Care Center; or
   • within 12 months after the date of death a Child was enrolled in a Child Care Center.

Child Care Center means a facility that:

• is operated and licensed according to the law of the jurisdiction where it is located; and
• provides care and supervision for children in a group setting on a regularly scheduled and daily basis.

BENEFIT AMOUNT

For each Child who qualifies for this benefit, We will pay an amount equal to the Child Care Center charges incurred for a period of up to 4 consecutive years, not to exceed:

• an annual maximum of $5,000; and
• an overall maximum of 3% of the Full Amount shown in the SCHEDULE OF BENEFITS.

In the event that both You and Your Spouse die such that each death would cause a payment to be made for a Child under this Additional Benefit, the following rules apply:

• the annual maximum will be 2 times the amount stated above;
• the overall maximum will be equal to the stated percentage applied to the sum of the Full Amounts shown in the SCHEDULE OF BENEFITS for both You and Your Spouse; and
• in no event will the amount paid under all Child Care benefits exceed the amount of Child Care charges incurred.

We will not pay for Child Care Center charges incurred after the date a Child attains age 12.

We may require Proof of the Child’s continued enrollment in a Child Care Center during the period for which a benefit is claimed.

BENEFIT PAYMENT

We will pay this benefit quarterly when We receive Proof that Child Care Center charges have been paid. Payment will be made to the person who pays such charges on behalf of the Child.

If this benefit is in effect on the date You or Your Spouse die and there is no Child who could qualify for it, We will pay $1,000 to Your Beneficiary in one sum.
ADDITIONAL BENEFIT: CHILD EDUCATION

If You or Your Spouse die as a result of an accidental injury, We will pay this additional Child Education benefit if:

1. We pay a benefit for loss of such person’s life under the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section;
2. this benefit is in effect on the date of the injury; and
3. We receive Proof that on the date of death a Child was:
   - enrolled as a full-time student in an accredited college, university or vocational school above the 12th grade level; or
   - at the 12th grade level and, within one year after the date of death, enrolls as a full-time student in an accredited college, university or vocational school.

BENEFIT AMOUNT

For each Child who qualifies for this benefit, We will pay an amount equal to the tuition charges incurred for a period of up to 4 consecutive academic years, not to exceed:

- an academic year maximum of $5,000; and
- an overall maximum of 2% of the Full Amount shown in the SCHEDULE OF BENEFITS.

In the event that both You and Your Spouse die such that each death would cause a payment to be made for a Child under this Additional Benefit, the following rules apply:

- the academic year maximum will be 2 times the amount stated above;
- the overall maximum will be equal to the stated percentage applied to the sum of the Full Amounts shown in the SCHEDULE OF BENEFITS for both You and Your Spouse; and
- in no event will the amount paid under all Child Education benefits exceed the amount of tuition incurred.

We may require Proof of the Child’s continued enrollment as a full-time student during the period for which a benefit is claimed.

BENEFIT PAYMENT

We will pay this benefit semi-annually when We receive Proof that tuition charges have been paid. Payment will be made to the person who pays such charges on behalf of the Child.

If this benefit is in effect on the date of death and there is no Child who could qualify for it, We will pay $1,000 to Your Beneficiary in one sum.
ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (continued)

ADDITIONAL BENEFIT: SPOUSE EDUCATION

If You die as a result of an accidental injury, We will pay this additional Spouse Education benefit if:

1. We pay a benefit for loss of life under the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section;
2. this benefit is in effect on the date of the injury; and
3. We receive Proof that:
   • on the date of Your death, Your Spouse was enrolled as a full-time student in an accredited school; or
   • within 12 months after the date of Your death, Your Spouse enrolls as a full-time student in an accredited school.

BENEFIT AMOUNT

We will pay an amount equal to the tuition charges incurred for a period of up to 1 academic year, not to exceed:

• an academic year maximum of $5,000; and
• an overall maximum of 5% of the Full Amount shown in the SCHEDULE OF BENEFITS.

We may require Proof of the Spouse’s continued enrollment as a full-time student during the period for which a benefit is claimed.

BENEFIT PAYMENT

We will pay this benefit semi-annually when We receive Proof that tuition charges have been paid. Payment will be made to the Spouse.

If this benefit is in effect on the date You die and there is no Spouse who could qualify for it, We will pay $1,000 to Your Beneficiary in one sum.
ADDITIONAL BENEFIT: HOSPITAL CONFINEMENT

Subject to the provisions of the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE, We will pay this additional benefit if:

1. We receive Proof that You or a Dependent are confined in a Hospital as a result of an accidental injury which is the direct cause of such confinement independent of other causes; and
2. this benefit is in effect on the date of the injury.

BENEFIT AMOUNT

We will pay an amount for each full month of Hospital Confinement equal to the lesser of:

- 1% of the Full Amount shown in the SCHEDULE OF BENEFITS; and
- $2,500.

We will pay this benefit on a monthly basis beginning on the 4th day of confinement, for up to 12 months of continuous confinement. This benefit will be paid on a pro-rata basis for any partial month of confinement.

We will only pay benefits for one period of continuous confinement for any accidental injury. That period will be the first period of confinement that qualifies for payment.

BENEFIT PAYMENT

Benefit payments will be made monthly. Payment will be made to You.
ADDITIONAL BENEFIT: WORKPLACE FELONIOUS ASSAULT

We will pay this additional benefit if:

1. We pay a benefit for a loss resulting from an accidental injury to You, under the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section;

2. We receive Proof that the accidental injury was caused by a Felonious Assault committed at the Policyholder’s place of business or while You are engaged in the business of the Policyholder, except if You:
   - are working at home; or
   - are commuting to or from Your regular place of employment;

3. the Felonious Assault must be committed by someone other than:
   - You; or
   - an employee of the Policyholder; and

4. this benefit is in effect on the date of the injury.

Felonious Assault means an assault committed during the commission of a felony as defined by the laws of the jurisdiction in which the act was committed.

BENEFIT AMOUNT

We will pay an amount equal to the lesser of:

- 20% of the Full Amount shown in the SCHEDULE OF BENEFITS; or
- $20,000.

BENEFIT PAYMENT

We will pay this benefit in one sum to You, if alive, otherwise to Your Beneficiary.
ADDITIONAL BENEFIT: HUMAN IMMUNODEFICIENCY VIRUS (HIV)

We will pay the benefit described in this section if, while this benefit is in effect, You sustain an accidental injury in the performance of Your occupational duties and We receive Proof that:

- You completed a Workers Compensation injury report and gave it to the Policyholder within 48 hours of the injury;
- You submitted to a blood test(s) for the Human Immunodeficiency Virus (HIV) and AIDS Related Complex (ARC) within 48 hours of the injury, the results of which were negative; and
- You test positive for HIV or ARC within 1 year after the date of the injury.

BENEFIT AMOUNT

We will pay an amount equal to 20% of the Full Amount shown in the SCHEDULE OF BENEFITS.

BENEFIT PAYMENT

We will pay this benefit in one sum to You, if alive, otherwise to Your Beneficiary.
ADDITIONAL BENEFIT: REHABILITATIVE PHYSICAL THERAPY

We will pay this additional benefit if:

1. We pay a benefit for a loss resulting from an accidental injury to You or a Dependent, under the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section;
2. We receive Proof that rehabilitative physical therapy has been prescribed within 90 days of the Covered Loss by the attending Physician as necessary to treat a physical condition resulting from the Covered Loss; and
3. this benefit is in effect on the date of the injury.

Such rehabilitative physical therapy must be provided within 1 year of the prescription by a Physician or therapist licensed to provide the therapy in the jurisdiction where such services are performed.

BENEFIT AMOUNT

We will pay an amount equal to the least of:

- the actual charges incurred for such Rehabilitative Physical Therapy;
- 10% of the Full Amount shown in the SCHEDULE OF BENEFITS; or
- $10,000.

BENEFIT PAYMENT

We will pay this benefit quarterly when We receive Proof that charges for Rehabilitative Physical Therapy have been paid. Payment will be made to You.
ADDITIONAL BENEFIT: THERAPEUTIC COUNSELING

We will pay this additional benefit if:

1. We pay a benefit for a loss resulting from an accidental injury to You or a Dependent, under the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section;

2. We receive Proof that therapeutic counseling has been prescribed for
   - You;
   - Your Spouse; or
   - Your natural, adopted or stepchildren;

   within 90 days of the Covered Loss by the attending Physician as necessary to treat an emotional or psychological condition resulting from the Covered Loss; and

3. this benefit is in effect on the date of the injury.

Such therapeutic counseling must be provided within 1 year of the prescription by a Physician, therapist or counselor licensed to provide the counseling in the jurisdiction where such services are performed.

BENEFIT AMOUNT

We will pay an amount equal to the least of:

- the actual charges incurred for such Therapeutic Counseling;
- 10% of the Full Amount shown in the SCHEDULE OF BENEFITS; or
- $10,000.

BENEFIT PAYMENT

We will pay this benefit quarterly when We receive Proof that charges for Therapeutic Counseling have been paid. Payment will be made the person who paid such charges.
ADDITIONAL BENEFIT: PARENTAL CARE

If You or Your Spouse die as a result of an accidental injury, We will pay this additional Parental Care benefit if:

1. We pay a benefit for loss of life under the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section;
2. this benefit is in effect on the date of the injury; and
3. We receive Proof that:
   • the deceased insured is survived by one or more of the following persons:
     • parent;
     • grandparent;
     • parent in-law; or
     • grandparent in-law; and
   • such surviving person(s) is:
     • supported by You or Your Spouse to the extent that such person(s) was claimed as a dependent on Your or Your Spouse's Federal Income Tax return for the calendar year preceding the accident;
     • dependent upon You or Your Spouse for more than 50% of the cost of:
       • residing in a licensed nursing care facility;
       • home health care; or
       • enrollment in a day care program; or
     • living with You or Your Spouse in Your or Your Spouse home.

BENEFIT AMOUNT

We will pay an amount equal to the lesser of:

• 10% of the Full Amount shown in the SCHEDULE OF BENEFITS; or
• $10,000.

on behalf of each such dependent person.

BENEFIT PAYMENT

We will pay this benefit in one sum to the dependent person or their legal representative.

If this benefit is in effect on the date You and Your Spouse die and there is no dependent person who could qualify for it, We will pay $1,000 to the Beneficiary in one sum.
ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (continued)

ADDITIONAL BENEFIT: COBRA CONTINUATION

If You die as a result of an accidental injury, We will pay this additional benefit if:

1. We pay a benefit for loss of life under the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section;
2. this benefit is in effect on the date of the injury; and
3. We receive Proof that Your Dependents have elected to continue their group medical insurance as permitted under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985.

We will require a completed and signed copy of the COBRA election form and Proof that each required COBRA premium payment for which reimbursement is requested, has been made.

BENEFIT AMOUNT

We will pay an amount equal to the group medical insurance premiums paid, subject to the following:

- a maximum benefit period of 3 years;
- an annual maximum of $3,000; and
- an overall maximum of 10% of the Full Amount shown in the SCHEDULE OF BENEFITS.

BENEFIT PAYMENT

We will pay the COBRA Continuation benefit quarterly when We receive Proof that group medical insurance premiums have been paid. Payment will be made to Your Spouse. If there is no Spouse on the date of Your death, We will pay the benefit to the person who incurred the premiums due for any Child’s COBRA continuation.

If this benefit is in effect on the date You die and there is no Dependent who qualifies for COBRA Continuation, We will pay $1,000 to Your Beneficiary in one sum.
ADDITIONAL BENEFIT: COMMON CARRIER

If You or a Dependent die as a result of an accidental injury, We will pay this additional benefit if:

1. We pay a benefit for loss of life under the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section;
2. this benefit is in effect on the date of the injury; and
3. We receive Proof that the injury resulting in the deceased’s death occurred while traveling in a Common Carrier.

BENEFIT AMOUNT

The Common Carrier Benefit is shown in the SCHEDULE OF BENEFITS.

BENEFIT PAYMENT

For loss of Your life, We will pay benefits to Your Beneficiary.

For a loss of a Dependent's life, We will pay benefits to You.
ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (continued)

ADDITIONAL BENEFIT: JOB-RELATED INJURY

If You die as a result of an accidental injury, We will pay this additional benefit if:

1. We pay a benefit for loss of life under the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section;
2. this benefit is in effect on the date of the injury; and
3. We receive Proof that You sustained an accidental Job-Related Injury that is the Direct and Sole Cause of Your death.

BENEFIT AMOUNT

The Job-Related Injury Benefit is shown in the SCHEDULE OF BENEFITS.

BENEFIT PAYMENT

For loss of Your life, We will pay benefits to Your Beneficiary.
FILING A CLAIM

CLAIMS FOR LIFE INSURANCE BENEFITS

When there has been the death of an insured person, notify the Policyholder. This notice should be given to the Policyholder as soon as is reasonably possible after the death. The claim form will be sent to the beneficiary or beneficiaries of record.

The beneficiary or beneficiaries should complete the claim form and send it and Proof of the death to Us as instructed on the claim form.

When We receive the claim form and Proof, We will review the claim and, if We approve it, We will pay benefits subject to the terms and provisions of this certificate and the Group Policy. The benefit amount may be reduced by the amount of any due and unpaid contributions to premium outstanding at the time We make payment.
FILING A CLAIM

CLAIMS FOR ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

When there has been a Covered Loss, notify the Policyholder. This notice should be given to the Policyholder as soon as is reasonably possible but in any case within 20 days of the Covered Loss. The claim form will be sent to You or the beneficiary or beneficiaries of record.

The claim form should be completed and sent along with Proof of the Covered Loss to Us as instructed on the claim form. If You or the beneficiary have not received a claim form within 15 days of giving notice of the claim, Proof may be sent using any form sufficient to provide Us with the required Proof.

The claimant must give us Proof no later than 90 days after the date of the Covered Loss.

If notice of claim or Proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice or Proof are given as soon as is reasonably possible.

When We receive the claim form and Proof, We will review the claim and, if We approve it, We will pay benefits subject to the terms and provisions of this certificate and the Group Policy. The benefit amount may be reduced by the amount of any due and unpaid contributions to premium outstanding at the time We make payment.

**Time Limit on Legal Actions.** A legal action on a claim may only be brought against Us during a certain period. This period begins 60 days after the date Proof is filed and ends 3 years after the date such Proof is required.
Assignment

The rights and benefits under the Group Policy are not assignable prior to a claim for benefits, except as required by law. We are not responsible for the validity of an assignment.

Beneficiary

You may designate a Beneficiary in Your application or enrollment form. You may change Your Beneficiary at any time. To do so, You must send a Signed and dated, Written request to the Policyholder using a form satisfactory to Us. Your Written request to change the Beneficiary must be sent to the Policyholder within 30 days of the date You Sign such request.

You do not need the Beneficiary’s consent to make a change. When We receive the change, it will take effect as of the date You Signed it. The change will not apply to any payment made in good faith by Us before the change request was recorded.

If two or more Beneficiaries are designated and their shares are not specified, they will share the insurance equally.

If there is no Beneficiary designated or no surviving designated Beneficiary at Your death, We may determine the Beneficiary to be on or more of the following who survive You:

- Your Spouse or Domestic Partner;
- Your child(ren);
- Your parent(s); or
- Your sibling(s).

Instead of making payment to any of the above, We may pay Your estate. Any payment made in good faith will discharge our liability to the extent of such payment. If a Beneficiary or a payee is a minor or incompetent to receive payment, We will pay the person’s guardian.

For Your Life Insurance for Your Dependents, We will pay You as the Beneficiary if alive. If you are not alive, We may determine the Beneficiary to be one or more of the following who survive You:

- Your Spouse or Domestic Partner;
- Your child(ren);
- Your parent(s); or
- Your sibling(s).

Instead of making payment to any of the above, We may pay Your estate. Any payment made in good faith will discharge our liability to the extent of such payment.

If You and any Dependent die within a 24 hour period, We will pay the Dependent's Life Insurance to the Beneficiary receiving payment of your Life Insurance or We may pay Your estate. If a Beneficiary or a payee is a minor or incompetent to receive payment, We will pay that person's guardian.
GENERAL PROVISIONS (continued)

Suicide (See notice page for residents of Missouri) (See notice page for residents of North Dakota) (See notice page for residents of Washington)

For Basic and Supplemental Life

If You commit suicide within 2 years from the date Life Insurance for You takes effect, We will not pay such insurance and Our liability will be limited as follows:

- any premium paid by You will be returned to the Beneficiary; and
- any premium paid by the Policyholder will be returned to the Policyholder.

If You commit suicide within 2 years from the date an increase in Your Life Insurance takes effect, We will pay to the Beneficiary the amount of Insurance in effect on the day before the increase. Any premium You paid for the increase will be returned to the Beneficiary. Any premium paid by the Policyholder for the increase will be returned to the Policyholder.

For Dependent Life

If a Dependent commits suicide within 2 years from the date Life Insurance for such Dependent takes effect, We will not pay such insurance and Our liability will be limited as follows:

- any premium paid by You will be returned to the Beneficiary; and
- any premium paid by the Policyholder will be returned to the Policyholder.

If a Dependent commits suicide within 2 years from the date an increase in Life Insurance for such Dependent takes effect, We will pay to the Beneficiary the amount of Insurance in effect on the day before the increase. Any premium You paid for the increase will be returned to the Beneficiary. Any premium paid by the Policyholder for the increase will be returned to the Policyholder.

Entire Contract

Your insurance is provided under a contract of group insurance with the Policyholder. The entire contract with the Policyholder is made up of the following:

1. the Group Policy and its Exhibits, which include the certificate(s);
2. the Policyholder's application; and
3. any amendments and/or endorsements to the Group Policy.

Incontestability: Statements Made by You

Any statement made by You will be considered a representation and not a warranty. We will not use such statement to avoid insurance, reduce benefits or defend a claim unless the following requirements are met:

1. the statement is in a Written application or enrollment form;
2. You have Signed the application or enrollment form; and
3. a copy of the application or enrollment form has been given to You or Your Beneficiary.

We will not use Your statements which relate to insurability to contest life insurance after it has been in force for 2 years during Your life. In addition, We will not use such statements to contest an increase or benefit addition to such insurance after the increase or benefit has been in force for 2 years during Your life, unless the statement is fraudulent.
GENERAL PROVISIONS (continued)

Misstatement of Age

If Your or Your Dependent’s age is misstated, the correct age will be used to determine if insurance is in effect and, as appropriate, We will adjust the benefits and/or premiums.

Conformity with Law

If the terms and provisions of this certificate do not conform to any applicable law, this certificate shall be interpreted to so conform.

Physical Exams

If a claim is submitted for insurance benefits other than life insurance benefits, We have the right to ask the insured to be examined by a Physician(s) of Our choice as often as is reasonably necessary to process the claim. We will pay the cost of such exam.

Autopsy

We have the right to make a reasonable request for an autopsy where permitted by law. Any such request will set forth the reasons We are requesting the autopsy.
THIS SUMMARY PLAN DESCRIPTION IS EXPRESSLY MADE PART OF THE VANDERBILT UNIVERSITY MEDICAL CENTER TERM LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PLAN AND IS LEGALLY ENFORCEABLE AS PART OF THE PLAN WITH RESPECT TO ITS TERMS AND CONDITIONS. IN THE EVENT THERE IS NO OTHER PLAN DOCUMENT, THIS DOCUMENT SHALL SERVE AS A SUMMARY PLAN DESCRIPTION AND SHALL ALSO CONSTITUTE THE PLAN.

ERISA INFORMATION

NAME AND ADDRESS OF EMPLOYER AND PLAN ADMINISTRATOR

Vanderbilt University Medical Center Human Resources
2525 West End Ave, 5th Floor
Nashville, TN 37203

EMPLOYER IDENTIFICATION NUMBER: 35-2528741

<table>
<thead>
<tr>
<th>PLAN NUMBER</th>
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<td>503</td>
<td>Voluntary Accidental Death and Dismemberment Insurance</td>
<td>Employee Welfare Plan</td>
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</table>

TYPE OF ADMINISTRATION

The above listed benefits are insured by Metropolitan Life Insurance Company ("MetLife").

AGENT FOR SERVICE OF LEGAL PROCESS

For disputes arising under the Plan, service of legal process may be made upon the Plan Administrator at the above address. For disputes arising under those portions of the Plan insured by MetLife, service of legal process may be made upon MetLife at one of its local offices, or upon the supervisory official of the Insurance Department in the state in which you reside.

ELIGIBILITY FOR INSURANCE; DESCRIPTION OR SUMMARY OF BENEFITS

Your MetLife certificate describes the eligibility requirements for insurance provided by MetLife under the Plan. It also includes a detailed description of the insurance provided by MetLife under the Plan.

PLAN TERMINATION OR CHANGES

The group policy sets forth those situations in which the Employer and/or MetLife have the rights to end the policy.

The Employer reserves the right to change or terminate the Plan at any time. Therefore, there is no guarantee that you will be eligible for the insurance described herein for the duration of your employment. Any such action will be taken only after careful consideration.

Your consent or the consent of your beneficiary is not required to terminate, modify, amend, or change the Plan.

In the event Your insurance ends in accordance with the DATE YOUR INSURANCE ENDS and DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS subsections of Your certificate, you may still be eligible to receive benefits. The circumstances under which benefits are available are described in Your MetLife certificate.
CONTRIBUTIONS TO PREMIUM

If you enroll for Supplemental Life Insurance and Voluntary Accidental Death and Dismemberment Insurance coverage, you are required to make contributions to premiums.

Premium rates are set by MetLife.

PLAN YEAR

The Plan's fiscal records are kept on a Plan year basis beginning each January 1st and ending on the following December 31st.

QUALIFIED DOMESTIC RELATIONS ORDERS/QUALIFIED MEDICAL CHILD SUPPORT ORDERS

You and your beneficiaries can obtain, without charge, from the Plan Administrator a copy of any procedures governing Qualified Domestic Relations Orders (QDRO) and Qualified Medical Child Support Orders (QMCSO).

CLAIMS INFORMATION

Procedures for Presenting Claims for Life and Accidental Death and Dismemberment Benefits

All claim forms needed to file for benefits under the group insurance program can be obtained from the Employer who will also be ready to answer questions about the insurance benefits and to assist the claimant in filing claims. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully.

Routine Questions

If there is any question about a claim payment, an explanation may be requested from the Employer who is usually able to provide the necessary information.

Claim Submission

In submitting claims for life and accidental death and dismemberment benefits ("Benefits"), the claimant must complete the appropriate claim form and submit the required Proof as described in the certificate.

Claim forms must be submitted in accordance with the instructions on the claim form.

Initial Determination

After MetLife receives a claim for Benefits, MetLife will review the claim and notify the claimant of its decision to approve or deny the claim.

Such notification will be provided to the claimant within a reasonable period, not to exceed 90 days from the date we received the claim, unless MetLife notifies the claimant within that period that there are special circumstances requiring an extension of time of up to 90 additional days.

If MetLife denies the claim in whole or in part, the notification of the claims decision will state the reason why the claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. The notification will also include a description of the Plan review procedures and time limits, including a statement of the claimant's right to bring a civil action if the claim is denied after an appeal.
Appealing the Initial Determination

In the event a claim has been denied in whole or in part, the claimant can request a review of the claim by MetLife. This request for review should be sent in writing to Group Insurance Claims Review at the address of MetLife's office which processed the claim within 60 days after the claimant received notice of denial of the claim. When requesting a review, the claimant should state the reason the claimant believes the claim was improperly denied and submit in writing any written comments, documents, records or other information the claimant deems appropriate. Upon the claimant's written request, MetLife will provide the claimant free of charge with copies of relevant documents, records and other information.

MetLife will re-evaluate all the information, will conduct a full and fair review of the claim, and the claimant will be notified of the decision. Such notification will be provided within a reasonable period not to exceed 60 days from the date we received the request for review, unless MetLife notifies the claimant within that period that there are special circumstances requiring an extension of time of up to 60 additional days.

If MetLife denies the claim on appeal, MetLife will send the claimant a final written decision that states the reason(s) why the appealed claim is being denied, references any specific Plan provision(s) on which the denial is based, any voluntary appeal procedures offered by the Plan, and a statement of the claimant's right to bring a civil action if the claim is denied after an appeal. Upon written request, MetLife will provide the claimant free of charge with copies of documents, records and other information relevant to the claim.

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries

In carrying out their respective responsibilities under the Plan, the Plan Administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

STATEMENT OF ERISA RIGHTS

The following statement is required by federal law and regulation.

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all 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, all Plan documents, including insurance contracts 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 Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The 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.

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 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 $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a 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 Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security 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.

FUTURE OF THE PLAN

It is hoped that This Plan will be continued indefinitely, but Vanderbilt University Medical Center reserves the right to change or terminate the Plan in the future. Any such action would be taken only after careful consideration.

The Board of Directors of Vanderbilt University Medical Center shall be empowered to amend or terminate the Plan or any benefit under the Plan at any time.
Supplementary ERISA Information For Legal Services

The ERISA information set forth above which pertains to Group Supplemental Life Insurance also applies to Legal Services Insurance – Will Preparation Benefit and Estate Resolution Benefit, except as noted below:

Coverage

Legal Services Insurance – Will Preparation Benefit and Estate Resolution Benefit

Type of Administration

Legal Services Insurance – Will Preparation Benefit and Estate Resolution Benefit are insured by Metropolitan Property and Casualty Insurance Company ("Metropolitan"). In either case, benefits are administered by Hyatt Legal Plans, Inc.

Agent for Service of Legal Process

For disputes arising under those portions of the Plan insured by Metropolitan Property and Casualty Insurance Company ("Metropolitan"), service of legal process may be made upon Metropolitan (Hyatt Legal Plans of Florida, Inc.) at one of its local offices, or upon the supervisory official of the Insurance Department in the state in which you reside.

Eligibility For Insurance; Description or Summary of Benefits

Your Metropolitan Property and Casualty Insurance Company ("Metropolitan") certificate describes the eligibility requirements for insurance under the Plan. It also includes a detailed description of the insurance provided by Metropolitan Property and Casualty Insurance Company ("Metropolitan") under the Plan.

Plan Termination or Changes

The Group Legal Services policy sets forth those situations in which the Employer and/or Metropolitan Property and Casualty Insurance Company ("Metropolitan") have the right to end the Group Legal Services policy.

Contributions

No contribution is required for Legal Services Insurance – Will Preparation Benefit and Estate Resolution Benefit.

Claims Information

Claims information for Legal Services Insurance – Will Preparation Benefit and Estate Resolution Benefit is contained under the sub-section "How the Group Legal Services Plan Works" in the Legal Services Plan Certificate of Coverage.
The following notice applies to residents of Texas only:

For information about the Will Preparation Service and Estate Resolution Service, you may contact the provider, Hyatt Legal Plans, Inc. by phone.

Phone: 1-800-821-6400
The following Hyatt Legal Plans certificate (MP&C GLS 04 Cert.-WP) applies to residents of all states other than Texas.
HYATT LEGAL PLANS INSURANCE
MetLife Auto & Home
Metropolitan Property and Casualty Insurance Company
700 Quaker Lane, Warwick, RI 02887

Legal Services Plan
Certificate of Coverage

This Legal Services Plan is insured by Metropolitan Property and Casualty Insurance Company; a Rhode Island company with its principal place of business at 700 Quaker Lane, Warwick, Rhode Island, 02887. Administrative services are provided under the policy by Hyatt Legal Plans, Inc. (“Hyatt”), a Delaware Corporation and an affiliate of Metropolitan Property and Casualty Insurance Company. Any reference to Hyatt is as the Administrator of the Plan.

This certificate certifies that You are insured for the Covered Legal Services described in this certificate, subject to the provisions of this certificate. This certificate is issued to You under the Group Legal Services Policy and it includes the terms and provisions of the Group Legal Services Policy that describe Your insurance. Please read this certificate carefully.

Name and Address of Policyholder: Vanderbilt University Medical Center
1161 21st Avenue South, D-3300 MCN
Nashville, TN 37232

Group Policy Effective Date: April 30, 2016

Contacting Hyatt Legal Plans
You may contact the Plan Administrator, Hyatt Legal Plans, Inc. by phone or mail.
Phone: 1-800-821-6400
Mail: 1111 Superior Avenue
Cleveland, OH 44114-2507

Definitions

Covered Legal Services means a service covering the preparation of wills and codicils for You and Your lawful spouse. The creation of any testamentary trust is covered. The service does not include tax planning.

Eligible Employee means each employee who is insured under the Policyholder’s plan of group supplemental life insurance with Metropolitan Life Insurance Company (MetLife).

Legal Services Plan or Plan means the group policy to provide insurance for Covered Legal Services.

Metropolitan means Metropolitan Property and Casualty Insurance Company.

Plan Attorney means an attorney who has contracted with Metropolitan or the Administrator to provide Covered Legal Services.

We, Us and Our means the Administrator.

You and Your means the Eligible Employee.

How the Group Legal Services Plan Works

To use the Group Legal Services Plan, You can call Hyatt. You should be prepared to identify Yourself as a participant in the Group Legal Services Plan. If You call Hyatt, the Client Service Representative who answers the call will:

- make an initial determination of whether and to what extent the matter is covered;
- give a case number (a new case number will be needed for each new matter);
- give the telephone number(s) and location of the Plan Attorney(s) most convenient to You; and
- answer questions about the Plan.
You can decide to use a Plan Attorney or a non-Plan Attorney.

If You decide to use a Plan Attorney, the Plan Attorney will provide You with the Covered Legal Services described above.

If You decide to use a non-Plan Attorney, You must notify Hyatt. Hyatt will send You a claim form and informational material including a Non-Plan Attorney Fee Schedule. After the matter is finished, the claim form must be completed and returned to Hyatt with the attorney’s final bill. Within 60 days of Hyatt’s receipt of the completed claim form and final bill, We will pay You up to the amount stated in the Non-Plan Attorney Fee Schedule. You will be responsible for making payment to the non-Plan Attorney for any expenses or fees incurred in excess of the amount paid by Hyatt. If a claim is denied in whole or in part, You may ask Hyatt for a written statement with the reason(s) for the denial and with information as to the steps that need to be taken to appeal the denial.

Requirements for Coverage

All Eligible Employees are participants in the Plan. Because this is a Non-Contributory Plan, You do not need to contribute to the cost of Your coverage. An employee will be a participant in the Plan on the later of the Group Policy Effective Date; or the date he or she becomes an Eligible Employee.

How Insurance Coverage Ends

Your insurance coverage will end upon the first of the following to occur: the date the group policy ends; the last day of the month in which You cease to be an Eligible Employee. If insurance coverage ends, service will continue to be covered for any matter that was open and pending when insurance coverage ended.

Assignment

Covered Legal Services provided under this certificate are not assignable.

Other Important Information

Plan Attorneys may not request or accept additional compensation from You for providing Covered Legal Services, except for payments required to be made to third parties. You have the right to complain to the state bar association about the conduct of an attorney who provides Covered Legal Services under the Plan. If, at any time, You have a question or concern about the service You have received, please call Hyatt to let Us know. Hyatt and Metropolitan will work hard to fix the problem to Your satisfaction.

Nothing contained in this certificate is intended to interfere with Your freedom of choice in the selection of an attorney or with the attorney-client relationship.

FOR RESIDENTS OF MASSACHUSETTS
Complaints about the operation of the plan or quality of the attorneys may be made by calling 800-821-6400. The complaint will be resolved during the call or through the intervention of a representative who will contact the attorney and member to resolve the matter in most cases within 72 hours.
THIS IS THE END OF THE HYATT LEGAL PLANS INSURANCE CERTIFICATE.
The following Hyatt Legal Plans certificate (MP&C GLSC 07 P) applies to residents of all states other than Texas.
HYATT LEGAL PLANS INSURANCE
Certificate Rider

Group Policy No.: 160933-1-G
Policyholder: Vanderbilt University Medical Center
Effective Date: April 30, 2016

1. The DEFINITIONS section of the certificate will be revised to replace the definition of Covered Legal Services as follows:

**Covered Legal Services means the following:**

Estate Resolution Services - Certain probate services to be made available to the Eligible Employee’s or the Spouse’s estate upon the Eligible Employee’s or the Spouse’s death, respectively. These services provide representation and payment of legal fees for the executor or administrator of the Eligible Employee’s or the Spouse’s estate and include all court proceedings needed to transfer probate assets from the Eligible Employee’s or the Spouse’s estate to the Eligible Employee’s or the Spouse’s heirs, respectively; the correspondence necessary to transfer non-probate assets such as proceeds from insurance policies, joint bank accounts, stock accounts or a house; and associated tax filings. The service also includes telephone and office consultations with beneficiaries related to probating the covered estate.

2. The following definitions will be added to the DEFINITIONS section of the certificate:

**Spouse** means the Eligible Employee’s lawful spouse or Qualified Domestic Partner or Civil Union Partner.

**Qualified Domestic Partner or Civil Union Partner** means a person who qualifies for coverage (a) as a domestic partner or civil union partner under another employee benefit provided by the Policyholder or (b) as required by applicable law.

METROPOLITAN PROPERTY AND CASUALTY INSURANCE COMPANY

By:

[Signature]
President

[Signature]
Secretary

Administrative services are provided under this policy by Hyatt Legal Plans, Inc. (“Hyatt”), a Delaware Corporation and an affiliate of Metropolitan Property and Casualty Insurance Company. Any reference to Hyatt is as the Administrator of the Plan.
Legal Services Plan
Certificate of Coverage

This Legal Services Plan is insured by Metropolitan Property and Casualty Insurance Company; a Rhode Island company with its principal place of business at 700 Quaker Lane, Warwick, Rhode Island, 02887. Administrative services are provided under the policy by Hyatt Legal Plans, Inc. (“Hyatt”), a Delaware Corporation and an affiliate of Metropolitan Property and Casualty Insurance Company. Any reference to Hyatt is as the administrator of the Covered Legal Services described in this certificate.

This certificate certifies that if you are an Eligible Employee, you are insured for the Covered Legal Services described in this certificate, subject to the provisions of this certificate. This certificate is issued under the Group Legal Services Policy and includes the terms and provisions of the Group Legal Services Policy that describe this insurance. Please read this certificate carefully.

Name and Address of Policyholder: Vanderbilt University Medical Center
1161 21st Avenue South, D-3300 MCN
Nashville, TN 37232

Group Policy Effective Date: April 30, 2016

Contacting Hyatt Legal Plans
Hyatt Legal Plans Inc. may be contacted by phone or mail as follows:

Phone: 1-800-821-6400
Mail: 1111 Superior Avenue
Cleveland, OH 44114-2507

Definitions

Covered Legal Services means the following probate services to be made available to Your estate upon Your death: Probate services to provide attorney representation and payment of legal fees for the executor or administrator of Your estate including representation for the preparation of all documents and all of the court proceedings needed to transfer probate assets from Your estate to Your heirs; and the completion of correspondence necessary to transfer non-probate assets such as proceeds from insurance policies, joint bank accounts, stock accounts or a house; and associated tax filings.

Eligible Employee means each employee who is insured under the Policyholder’s plan of group supplemental life insurance with Metropolitan Life Insurance Company (MetLife).

Legal Services Plan or Plan means the group policy to provide insurance for Covered Legal Services.

Metropolitan means Metropolitan Property and Casualty Insurance Company.

Plan Attorney means an attorney who has contracted with Metropolitan or Hyatt Legal Plans to provide Covered Legal Services.

We, Us and Our means Hyatt Legal Plans, Inc.

You and Your means an Eligible Employee.
How the Group Legal Services Plan Works

To use the Group Legal Services Plan, the executor or administrator of Your estate should call Hyatt and be prepared to identify themselves as the executor or administrator of the estate. When calling Hyatt, the Client Service Representative who answers the call will:

- make an initial determination of whether and to what extent the matter is covered;
- give a case number (a new case number will be needed for each new matter);
- give the telephone number(s) and location of the nearest Plan Attorney(s); and
- answer questions about the Plan.

The executor or administrator of Your estate can decide to use a Plan Attorney or a non-Plan Attorney.

If a Plan Attorney is used, the Plan Attorney will provide the Covered Legal Services described above.

If a non-Plan Attorney is used, the executor or administrator of the estate must notify Hyatt. Hyatt will send a claim form and informational material including a Non-Plan Attorney Fee Schedule. After the matter is finished, the claim form must be completed and returned to Hyatt with the attorney’s final bill. Within 60 days of Hyatt’s receipt of the completed claim form and final bill, Hyatt will pay the estate for covered legal services an amount equal to the lesser of the amount the estate paid for the attorney’s services and the amount stated in the Non-Plan Attorney Fee Schedule. The estate will be responsible for making payment to the non-Plan Attorney for any expenses, costs and/or fees incurred in excess of the amount paid by Hyatt.

If a claim is denied in whole or in part, Hyatt may be asked to provide a written statement with the reason(s) for the denial and with information as to the steps that need to be taken to appeal the denial.

Exclusions

The following are not covered:

- matters in which there is a conflict of interest between the executor, administrator, any beneficiary or heir and Your estate;
- any disputes with the Policyholder, Employer, Plan Attorneys, MetLife and/or any of its affiliates;
- any disputes involving statutory benefits;
- will contests or litigation outside probate court;
- appeals;
- court costs, filing fees, recording fees, transcripts, witness fees, expenses to a third party, judgments or fines; and
- frivolous or unethical matters.

Requirements for Coverage

All Eligible Employees are participants in the Plan. Because this is a Non-Contributory Plan, Eligible Employees do not need to contribute to the cost of coverage. An employee will be a participant in the Plan on the later of the Group Policy Effective Date; or the date he or she becomes an Eligible Employee.

How Insurance Coverage Ends

Your insurance coverage will end upon the first of the following to occur:

- the date the Group Legal Services Policy ends, or
- the last day of the month in which You cease to be an Eligible Employee.
Other Important Information

Plan Attorneys may not request or accept additional compensation for providing Covered Legal Services, except for expenses or payments required to be made to third parties. Complaints regarding the conduct of an attorney who provides Covered Legal Services under the Plan may be made to the state bar association. If, at any time, a question or concern arises about the Covered Legal Services received, please call Hyatt Legal Plans, Inc. Hyatt and Metropolitan will work hard to fix the problem. Nothing contained in this certificate is intended to interfere with freedom of choice in the selection of an attorney or with the attorney-client relationship.

FOR RESIDENTS OF MASSACHUSETTS
Complaints about the operation of the plan or quality of the attorneys may be made by calling 1-800-821-6400. The complaint will be resolved during the call or through the intervention of a representative who will contact the attorney and member to resolve the matter in most cases within 72 hours.
THIS IS THE END OF THE HYATT LEGAL PLANS INSURANCE CERTIFICATE.
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.
Vanderbilt University Medical Center

Your Group Short Term Disability Plan

Policy No. 410295 011

Underwritten by Unum Life Insurance Company of America

6/7/2016
CERTIFICATE OF COVERAGE

Unum Life Insurance Company of America (referred to as Unum) welcomes you as a client.

This is your certificate of coverage as long as you are eligible for coverage and you become insured. You will want to read it carefully and keep it in a safe place.

Unum has written your certificate of coverage in plain English. However, a few terms and provisions are written as required by insurance law. If you have any questions about any of the terms and provisions, please consult Unum's claims paying office. Unum will assist you in any way to help you understand your benefits.

If the terms and provisions of the certificate of coverage (issued to you) are different from the policy (issued to the policyholder), the policy will govern. Your coverage may be cancelled or changed in whole or in part under the terms and provisions of the policy.

The policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. When making a benefit determination under the policy, Unum has discretionary authority to determine your eligibility for benefits and to interpret the terms and provisions of the policy.

For purposes of effective dates and ending dates under the group policy, all days begin at 12:01 a.m. and end at 12:00 midnight at the Policyholder's address.

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122
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BENEFITS AT A GLANCE

SHORT TERM DISABILITY PLAN

This short term disability plan provides financial protection for you by paying a portion of your income while you are disabled. The amount you receive is based on the amount you earned before your disability began. In some cases, you can receive disability payments even if you work while you are disabled.

EMPLOYER'S ORIGINAL PLAN

EFFECTIVE DATE: April 30, 2016

POLICY NUMBER: 410295 011

ELIGIBLE GROUP(S):

All full-time Vanderbilt University Medical Center employees in active employment in the United States with the Employer on or after January 1, 2014, excluding Officers, Faculty, temporary and seasonal employees

MINIMUM HOURS REQUIREMENT:

Employees must be regularly scheduled to work at least 30 hours per week.

WAITING PERIOD:

For employees in an eligible group on or before April 30, 2016: First of the month following 30 days of continuous active employment

For employees entering an eligible group after April 30, 2016: First of the month following 30 days of continuous active employment

REHIRE:

If your employment ends and you are rehired within 12 months, your previous work while in an eligible group will apply toward the waiting period. All other policy provisions apply.

WAIVE THE WAITING PERIOD:

For employees who were previously enrolled under policy number 224887:

If you have been continuously employed by your Employer for a period of time equal to your waiting period, Unum will waive your waiting period when you enter an eligible group. All other policy provisions apply.

CREDIT PRIOR SERVICE:

Unum will apply any prior period of work with your Employer toward the waiting period to determine your eligibility date.

WHO PAYS FOR THE COVERAGE:

You pay the cost of your coverage.

ELIMINATION PERIOD:

14 days for disability due to an injury
14 days for disability due to a sickness

Benefits begin the day after the elimination period is completed.
WEEKLY BENEFIT:

66.67% of weekly earnings to a maximum benefit of $2,500 per week

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered under this plan.

MAXIMUM PERIOD OF PAYMENT:

24 weeks (does not include elimination period)

For disabilities due to live birth only:
You will receive a minimum of 6 weeks of benefits. (does not include elimination period)

Premium payments are required for your coverage while you are receiving payments under this plan.

Your Short Term Disability plan does not cover disabilities due to an occupational sickness or injury.

REHABILITATION AND RETURN TO WORK ASSISTANCE BENEFIT:

10% of your gross disability payment to a maximum benefit of $250 per week.

In addition, we will make weekly payments to you for 3 weeks following the date your disability ends if we determine you are no longer disabled while:
- you are participating in the Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

OTHER FEATURES:

Continuity of Coverage

Minimum Benefit

Pre-Existing: 6/12

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section.

The plan includes enrollment, risk management and other support services related to your Employer's Benefit Program.
CLAIM INFORMATION
SHORT TERM DISABILITY

WHEN DO YOU NOTIFY UNUM OF A CLAIM?

We encourage you to notify us of a claim as soon as possible, so that a claim decision can be made in a timely manner. Telephonic notice as authorized by us or written notice of claim should be provided within 30 days after the date your disability begins. However, you must provide Unum written proof of your claim no later than 90 days after your elimination period. If it is not possible to give proof within 90 days, it must be given no later than 1 year after the time proof is otherwise required except in the absence of legal capacity.

If you choose to file a written notice of claim, the claim form is available from your Employer, or you can request a claim form from us. If you do not receive the form from Unum within 15 days of your request, send Unum written proof of claim without waiting for the form.

You must notify us immediately when you return to work in any capacity.

HOW DO YOU FILE A CLAIM?

You may file notice of claim by telephonic means. The telephone number is available through your Employer. You will be required to sign an authorization form in order for Unum to obtain medical information from your attending physician. Should Unum be unable to obtain your medical information, we will send a letter and appropriate forms to you for completion to be returned to us by the date determined in the letter.

If you choose to file written notice of claim, you and your Employer must fill out your own sections of the claim form and then give it to your attending physician. Your physician should complete his or her section of the form and send it directly to Unum.

WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?

Your proof of claim, provided at your expense, must show:

- that you are under the regular care of a physician;
- the appropriate documentation of your weekly earnings;
- the date your disability began;
- the cause of your disability;
- the extent of your disability, including restrictions and limitations preventing you from performing your regular occupation; and
- the name and address of any hospital or institution where you received treatment, including all attending physicians.

We may request that you send proof of continuing disability indicating that you are under the regular care of a physician. This proof, provided at your expense, must be received within 45 days of a request by us.

In some cases, you will be required to give Unum authorization to obtain additional medical information and to provide non-medical information as part of your proof of
claim, or proof of continuing disability. Unum will deny your claim, or stop sending you payments, if the appropriate information is not submitted.

TO WHOM WILL UNUM MAKE PAYMENTS?

Unum will make payments to you.

WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?

Unum has the right to recover any overpayments due to:

- fraud;
- any error Unum makes in processing a claim; and
- your receipt of deductible sources of income.

You must reimburse us in full. We will determine the method by which the repayment is to be made.

Unum will not recover more money than the amount we paid you.
GENERAL PROVISIONS

WHAT IS THE CERTIFICATE OF COVERAGE?

This certificate of coverage is a written statement prepared by Unum and may include attachments. It tells you:

- the coverage for which you may be entitled;
- to whom Unum will make a payment; and
- the limitations, exclusions and requirements that apply within a plan.

WHEN ARE YOU ELIGIBLE FOR COVERAGE?

If you are working for your Employer in an eligible group, the date you are eligible for coverage is the later of:

- the plan effective date; or
- the day after you complete your waiting period.

WHEN DOES YOUR COVERAGE BEGIN?

You pay 100% of the cost yourself. You will be covered at 12:01 a.m. on the latest of:

- the date you are eligible for coverage, if you apply for insurance on or before that date;
- the date you apply for insurance, if you apply within 31 days after your eligibility date; or
- the date Unum approves your application, if evidence of insurability is required.

Evidence of insurability is required if you:

- are a late applicant, which means you apply for coverage more than 31 days after the date you are eligible for coverage; or
- voluntarily cancelled your coverage and are reapplying.

An evidence of insurability form can be obtained from your Employer.

WHAT IF YOU ARE ABSENT FROM WORK ON THE DATE YOUR COVERAGE WOULD NORMALLY BEGIN?

If you are absent from work due to injury, sickness, temporary layoff or leave of absence, your coverage will begin on the date you return to active employment.

ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE TEMPORARILY NOT WORKING?

If you are on a temporary layoff, and if premium is paid, you will be covered through the end of the month that immediately follows the month in which your temporary layoff begins.

If you are on a leave of absence, and if premium is paid, you will be covered for up to 24 months following the date your leave of absence begins.
ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE NOT WORKING DUE TO A PLANT CLOSING?

Massachusetts Residents only
If you are not working due to a plant closing (as defined in Section 71A of Chapter 151A of the Massachusetts Insurance Statutes), and if premium is paid, you will be covered up to 90 days from the date you were no longer in active employment. If you become covered under any other group disability plan, your coverage under this policy or plan will end.

WHEN WILL CHANGES TO YOUR COVERAGE TAKE EFFECT?

Once your coverage begins, any increased or additional coverage will take effect immediately if you are in active employment or if you are on a covered layoff or leave of absence. If you are not in active employment due to injury or sickness, any increased or additional coverage will begin on the date you return to active employment.

Any decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

WHEN DOES YOUR COVERAGE END?

Non-Massachusetts Residents Only
Your coverage under the policy or a plan ends on the earliest of:

- the date the policy or a plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered;
- the last day of the period for which you made any required contributions; or
- the last day you are in active employment except as provided under the covered layoff or leave of absence provision.

Unum will provide coverage for a payable claim which occurs while you are covered under the policy or plan.

Massachusetts Residents Only
Your coverage under the policy or a plan ends on the earliest of:

- the date the policy or a plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered;
- the last day of the period for which you made any required contributions; or
- the last day you are in active employment except as provided under the covered layoff, leave of absence and plant closing provisions, or as noted below.

If you end employment, coverage will be extended for 31 days. But if you become eligible for any other group disability insurance or any other arrangement, this extension of coverage will end.

Unum will provide coverage for a payable claim which occurs while you are covered under the policy or plan.
WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?

You can start legal action regarding your claim 60 days after proof of claim has been given and up to 3 years from the time proof of claim is required, unless otherwise provided under federal law.

HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?

Unum considers any statements you or your Employer make in a signed application for coverage a representation and not a warranty. If any of the statements you or your Employer make are not complete and/or not true at the time they are made, we can:

- reduce or deny any claim; or
- cancel your coverage from the original effective date.

We will use only statements made in a signed application as a basis for doing this.

If the Employer gives us information about you that is incorrect, we will:

- use the facts to decide whether you have coverage under the plan and in what amounts; and
- make a fair adjustment of the premium.

HOW WILL UNUM HANDLE INSURANCE FRAUD?

Unum wants to ensure you and your Employer do not incur additional insurance costs as a result of the undermining effects of insurance fraud. Unum promises to focus on all means necessary to support fraud detection, investigation, and prosecution.

It is a crime if you knowingly, and with intent to injure, defraud or deceive Unum, or provide any information, including filing a claim, that contains any false, incomplete or misleading information. These actions, as well as submission of materially false information, will result in denial of your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. Unum will pursue all appropriate legal remedies in the event of insurance fraud.

DOES THE POLICY REPLACE OR AFFECT ANY WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE?

The policy does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

DOES YOUR EMPLOYER ACT AS YOUR AGENT OR UNUM'S AGENT?

For purposes of the policy, your Employer acts on its own behalf or as your agent. Under no circumstances will your Employer be deemed the agent of Unum.
SHORT TERM DISABILITY

BENEFIT INFORMATION

**HOW DOES UNUM DEFINE DISABILITY?**

You are disabled when Unum determines that:

- you are limited from performing the **material and substantial duties** of your **regular occupation** due to your **sickness** or **injury**; and
- you have a 20% or more loss in weekly earnings due to the same sickness or injury.

You must be under the regular care of a physician in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

We may require you to be examined by a physician, other medical practitioner and/or vocational expert of our choice. Unum will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require you to be interviewed by an authorized Unum Representative.

**HOW LONG MUST YOU BE DISABLED BEFORE YOU ARE ELIGIBLE TO RECEIVE BENEFITS?**

You must be continuously disabled through your **elimination period**.

If your disability is the result of an injury that occurs while you are covered under the plan, your elimination period is 14 days.

If your disability is the result of a sickness, your elimination period is 14 days.

**CAN YOU SATISFY YOUR ELIMINATION PERIOD IF YOU ARE WORKING?**

Yes, provided you meet the definition of disability.

**WHEN WILL YOU BEGIN TO RECEIVE PAYMENTS?**

You will begin to receive payments when we approve your claim, providing the elimination period has been met and you are disabled. We will send you a payment weekly for any period for which Unum is liable.

After the elimination period, if you are disabled for less than 1 week, we will send you 1/7th of your payment for each day of disability.

**HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED?**

We will follow this process to figure your payment:

1. Multiply your weekly earnings by 66.67%.
2. The maximum weekly benefit is $2,500.
3. Compare the answer from Item 1 with the maximum weekly benefit. The lesser of these two amounts is your **gross disability payment**.
4. Subtract from your gross disability payment any **deductible sources of income**.

The amount figured in Item 4 is your **weekly payment**.

**WHAT ARE YOUR WEEKLY EARNINGS?**

"Weekly Earnings" means your gross weekly income from your Employer, not including shift differential, in effect just prior to your date of disability. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan or flexible spending account. It does not include income received from commissions, bonuses, overtime pay or any other extra compensation or income received from sources other than your Employer.

**WHAT WILL WE USE FOR WEEKLY EARNINGS IF YOU BECOME DISABLED DURING A COVERED LAYOFF OR LEAVE OF ABSENCE?**

If you become disabled while you are on a covered layoff or leave of absence, we will use your weekly earnings from your Employer in effect just prior to the date your absence begins.

**HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED AND WORKING?**

We will send you the weekly payment if you are disabled and your weekly disability earnings, if any, are less than 20% of your weekly earnings.

If you are disabled and your weekly **disability earnings** are from 20% through 80% of your weekly earnings, you will receive payments based on the percentage of income you are losing due to your disability. We will follow this process to figure your payment:

1. Subtract your disability earnings from your weekly earnings.
2. Divide the answer in Item 1 by your weekly earnings. This is your percentage of lost earnings.
3. Multiply your weekly payment as shown above by the answer in Item 2.

This is the amount Unum will pay you for each week.

Unum may require you to send proof of your disability earnings each week. We will adjust your weekly payment based on your disability earnings.

As part of your proof of disability earnings, we can require that you send us appropriate financial records which we believe are necessary to substantiate your income.

**HOW CAN WE PROTECT YOU IF YOUR DISABILITY EARNINGS FLUCTUATE?**

If your disability earnings routinely fluctuate widely from week to week, Unum may average your disability earnings over the most recent 3 weeks to determine if your claim should continue.
If Unum averages your disability earnings, we will not terminate your claim unless the average of your disability earnings from the last 3 weeks exceeds 80% of weekly earnings.

We will not pay you for any week during which disability earnings exceed 80% of weekly earnings.

**WHAT ARE DEDUCTIBLE SOURCES OF INCOME?**

Unum will subtract from your gross disability payment the following deductible sources of income:

1. The amount that you receive or are entitled to receive as disability income or disability retirement payments under any:
   - state compulsory benefit **act or law**.
   - other group insurance plan.
   - governmental retirement system.

2. The amount that you receive:
   - under a **salary continuation** or **accumulated sick leave** plan.
   - under Title 46, United States Code Section 688 (The Jones Act).
   - from a third party (after subtracting attorney’s fees) by judgment, settlement or otherwise.

3. The amount that you receive as retirement payments under any governmental retirement system. Retirement payments do not include payments made at the later of age 62 or normal retirement age under your Employer's retirement plan which are attributable to contributions you made on a post tax basis to the system.

   Regardless of how retirement payments are distributed, Unum will consider payments attributable to your post tax contributions to be distributed throughout your lifetime.

   Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Unum will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

4. The amount that you:
   - receive as disability payments under your Employer's **retirement plan**.
   - voluntarily elect to receive as retirement payments under your Employer's retirement plan.
   - receive as retirement payments when you reach the later of age 62 or normal retirement age, as defined in your Employer's retirement plan.

   Disability payments under a retirement plan will be those benefits which are paid due to disability and do not reduce the retirement benefit which would have been paid if the disability had not occurred.

   Retirement payments will be those benefits which are based on your Employer's
contribution to the retirement plan. Disability benefits which reduce the retirement benefit under the plan will also be considered as a retirement benefit.

Regardless of how the retirement funds from the retirement plan are distributed, Unum will consider your and your Employer's contributions to be distributed simultaneously throughout your lifetime.

Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Unum will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

5. The amount that you, your spouse and your children receive or are entitled to receive as disability payments because of your disability under:

- the United States Social Security Act.
- the Canada Pension Plan.
- the Quebec Pension Plan.
- any similar plan or act.

Unum will only subtract deductible sources of income which are payable as a result of the same disability.

**WHAT ARE NOT DEDUCTIBLE SOURCES OF INCOME?**

Unum will not subtract from your gross disability payment income you receive from, but not limited to, the following:

- 401(k) plans
- profit sharing plans
- thrift plans
- tax sheltered annuities
- stock ownership plans
- non-qualified plans of deferred compensation
- pension plans for partners
- military pension and disability income plans
- credit disability insurance
- franchise disability income plans
- a retirement plan from another Employer
- individual retirement accounts (IRA)
- individual disability income plans
- no fault motor vehicle plans

**WHAT IF SUBTRACTING DEDUCTIBLE SOURCES OF INCOME RESULTS IN A ZERO BENEFIT? (Minimum Benefit)**

The minimum weekly payment is: $25.

Unum may apply this amount toward an outstanding overpayment.

However, the minimum weekly payment will not be paid if you are receiving salary continuation or accumulated sick leave payments from your Employer.
WHAT IF UNUM DETERMINES YOU MAY QUALIFY FOR DEDUCTIBLE INCOME BENEFITS?

When we determine that you may qualify for benefits under Item(s) 1 and 5 in the deductible sources of income section, we will estimate your entitlement to these benefits. We can reduce your payment by the estimated amounts if such benefits:

- have not been awarded; and
- have not been denied; or
- have been denied and the denial is being appealed.

Your Short Term Disability payment will NOT be reduced by the estimated amount if you:

- apply for the disability payments under Item(s) 1 and 5 in the deductible sources of income section and appeal your denial to all administrative levels Unum feels are necessary; and
- sign Unum’s payment option form. This form states that you promise to pay us any overpayment caused by an award.

If your payment has been reduced by an estimated amount, your payment will be adjusted when we receive proof:

- of the amount awarded; or
- that benefits have been denied and all appeals Unum feels are necessary have been completed. In this case, a lump sum refund of the estimated amount will be made to you.

If you receive a lump sum payment from any deductible sources of income, the lump sum will be pro-rated on a weekly basis over the time period for which the sum was given. If no time period is stated, the sum will be pro-rated on a weekly basis to the end of the maximum period of payment.

HOW LONG WILL UNUM CONTINUE TO SEND YOU PAYMENTS?

Unum will send you a payment each week up to the **maximum period of payment**. Your maximum period of payment is 24 weeks during a continuous period of disability. (does not include elimination period)

For disabilities due to live birth only:
You will receive a minimum of 6 weeks of benefits. (does not include elimination period)

WHEN WILL PAYMENTS STOP?

We will stop sending you payments and your claim will end on the earliest of the following:

- when you are able to work in your regular occupation on a **part-time basis** but you do not;
- the end of the maximum period of payment;
- the date you are no longer disabled under the terms of the plan, unless you are eligible to receive benefits under Unum’s Rehabilitation and Return to Work Assistance program;
- the date you fail to submit proof of continuing disability;
- after 12 months of payments if you are considered to reside outside the United States or Canada. You will be considered to reside outside these countries when you have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits;
- the date your disability earnings exceed the amount allowable under the plan;
- the date you die.

**WHAT DISABILITIES ARE NOT COVERED UNDER YOUR PLAN?**

Your plan does not cover any disabilities caused by, contributed to by, or resulting from your:

- **occupational sickness or injury**, however, Unum will cover disabilities due to occupational sicknesses or injuries for partners or sole proprietors who cannot be covered by a workers' compensation law.
- intentionally self-inflicted injuries.
- active participation in a riot.
- loss of a professional license, occupational license or certification.
- commission of a crime for which you have been convicted.
- pre-existing condition.

Your plan will not cover a disability due to war, declared or undeclared, or any act of war.

Unum will not pay a benefit for any period of disability during which you are incarcerated.

**WHAT IS A PRE-EXISTING CONDITION?**

You have a pre-existing condition if:

- you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 6 months just prior to your effective date of coverage; and
- the disability begins in the first 12 months after your effective date of coverage.

*Note:* The pre-existing condition provision does not apply to any employee who has satisfied the pre-existing condition provision under policy number 224887.

**WHAT HAPPENS IF YOU RETURN TO WORK FULL TIME AND YOUR DISABILITY OCCURS AGAIN?**

1. If your current disability is related to or due to the same cause(s) as your prior disability for which Unum made a payment:

   Unum will treat your current disability as part of your prior claim and you will not have to complete another elimination period when you are performing any occupation for your Employer on a full time basis for 30 consecutive days or less.

   If you return to work on the 31st day, your current disability will be treated as a new claim. The new claim will be subject to all of the provisions of this plan and you will be required to satisfy a new elimination period.
2. If your current disability is unrelated to your prior disability for which Unum made an payment:

    Unum will treat your current disability as part of your prior claim and you will not have to complete another elimination period when you are performing any occupation for your Employer on a full time basis for less than 1 full day.

    Your disability, as outlined above, will be subject to the same terms of the plan as your prior claim.

    If you do not satisfy Item 1 or 2 above, your disability will be treated as a new claim and will be subject to all of the policy provisions.

    If you become entitled to payments under any other group short term disability plan, you will not be eligible for payments under the Unum plan.
SHORT TERM DISABILITY

OTHER BENEFIT FEATURES

WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN YOUR EMPLOYER CHANGES INSURANCE CARRIERS TO UNUM? (Continuity of Coverage)

When the plan becomes effective, Unum will provide coverage for you if:

- you are not in active employment because of a sickness or injury; and
- you were covered by the prior policy.

Your coverage is subject to payment of premium.

Your payment will be limited to the amount that would have been paid by the prior carrier. Unum will reduce your payment by any amount for which your prior carrier is liable.

WHAT IF YOU HAVE A DISABILITY DUE TO A PRE-EXISTING CONDITION WHEN YOUR EMPLOYER CHANGES INSURANCE CARRIERS TO UNUM? (Continuity of Coverage)

Unum may send a payment if your disability results from a pre-existing condition if, you were:

- in active employment and insured under the plan on its effective date; and
- insured by the prior policy at the time of change.

In order to receive a payment you must satisfy the pre-existing condition provision under:

1. the Unum plan; or
2. the prior carrier’s plan, if benefits would have been paid had that policy remained in force.

If you do not satisfy Item 1 or 2 above, Unum will not make any payments.

If you satisfy Item 1, we will determine your payments according to the Unum plan provisions.

If you only satisfy Item 2, we will administer your claim according to the Unum plan provisions. However, your payment will be the lesser of:

a. the weekly benefit that would have been payable under the terms of the prior plan if it had remained inforce; or
b. the weekly payment under the Unum plan.

Your benefits will end on the earlier of the following dates:

1. the end of the maximum benefit period under the plan; or
2. the date benefits would have ended under the prior plan if it had remained in force.
HOW CAN UNUM’S REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM HELP YOU RETURN TO WORK?

Unum has a vocational Rehabilitation and Return to Work Assistance program available to assist you in returning to work. We will determine whether you are eligible for this program, at our sole discretion. In order to be eligible for rehabilitation services and benefits, you must be medically able to engage in a return to work program.

Your claim file will be reviewed by one of Unum’s rehabilitation professionals to determine if a rehabilitation program might help you return to gainful employment. As your file is reviewed, medical and vocational information will be analyzed to determine an appropriate return to work program.

We will make the final determination of your eligibility for participation in the program.

We will provide you with a written Rehabilitation and Return to Work Assistance plan developed specifically for you.

The rehabilitation program may include at our sole discretion, but is not limited to, the following services and benefits:

- coordination with your Employer to assist you to return to work;
- adaptive equipment or job accommodations to allow you to work;
- vocational evaluation to determine how your disability may impact your employment options;
- job placement services;
- resume preparation;
- job seeking skills training; or
- education and retraining expenses for a new occupation.

WHAT ADDITIONAL BENEFITS WILL UNUM PAY WHILE YOU PARTICIPATE IN A REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM?

We will pay an additional disability benefit of 10% of your gross disability payment to a maximum benefit of $250 per week.

This benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount such as Deductible Sources of Income.

In addition, we will make weekly payments to you for 3 weeks following the date your disability ends if we determine you are no longer disabled while:

- you are participating in the Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

This benefit payment may be paid in a lump sum.
WHEN WILL REHABILITATION AND RETURN TO WORK ASSISTANCE BENEFITS END?

Benefits for the Rehabilitation and Return to Work Assistance program will end on the earliest of the following dates:

- the date Unum determines that you are no longer eligible to participate in Unum's Rehabilitation and Return to Work Assistance program; or
- any other date on which weekly payments would stop in accordance with this plan.
GLOSSARY

ACTIVE EMPLOYMENT means you are working for your Employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under Eligible Group(s) in each plan.

Your work site must be:

- your Employer's usual place of business;
- an alternative work site at the direction of your Employer, including your home; or
- a location to which your job requires you to travel.

Normal vacation is considered active employment. Temporary and seasonal workers are excluded from coverage.

DEDUCTIBLE SOURCES OF INCOME means income from deductible sources listed in the plan which you receive or are entitled to receive while you are disabled. This income will be subtracted from your gross disability payment.

DISABILITY EARNINGS means the earnings which you receive while you are disabled and working, plus the earnings you could receive if you were working to your maximum capacity.

ELIMINATION PERIOD means a period of continuous disability which must be satisfied before you are eligible to receive benefits from Unum.

EMPLOYEE means a person who is in active employment in the United States with the Employer.

EMPLOYER means the Policyholder, and includes any division, subsidiary or affiliated company named in the policy.

EVIDENCE OF INSURABILITY means a statement of your medical history which Unum will use to determine if you are approved for coverage. Evidence of insurability will be at Unum's expense.

GOVERNMENTAL RETIREMENT SYSTEM means a plan which is part of any federal, state, county, municipal or association retirement system, including but not limited to, a state teachers retirement system, public employees retirement system or other similar retirement system for state or local government employees providing for the payment of retirement and/or disability benefits to individuals.

GRACE PERIOD means the period of time following the premium due date during which premium payment may be made.

GROSS DISABILITY PAYMENT means the benefit amount before Unum subtracts deductible sources of income and disability earnings.

HOSPITAL OR INSTITUTION means an accredited facility licensed to provide care and treatment for the condition causing your disability.
**INJURY** means a bodily injury that is the direct result of an accident and not related to any other cause. Injury which occurs before you are covered under the plan will be treated as a sickness. Disability must begin while you are covered under the plan.

**INSURED** means any person covered under a plan.

**LAW, PLAN OR ACT** means the original enactments of the law, plan or act and all amendments.

**LAYOFF** or **LEAVE OF ABSENCE** means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by your Employer.

Your normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

**LIMITED** means what you cannot or are unable to do.

**MATERIAL AND SUBSTANTIAL DUTIES** means duties that:
- are normally required for the performance of your regular occupation; and
- cannot be reasonably omitted or modified.

**MAXIMUM CAPACITY** means, based on your restrictions and limitations, the greatest extent of work you are able to do in your regular occupation, that is reasonably available.

**MAXIMUM PERIOD OF PAYMENT** means the longest period of time Unum will make payments to you for any one period of disability.

**OCCUPATIONAL SICKNESS OR INJURY** means a sickness or injury that was caused by or aggravated by any employment for pay or profit.

**PART-TIME BASIS** means the ability to work and earn between 20% and 80% of your weekly earnings.

**PAYABLE CLAIM** means a claim for which Unum is liable under the terms of the policy.

**PHYSICIAN** means:
- a person performing tasks that are within the limits of his or her medical license; and
- a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

Unum will not recognize you, or your spouse, children, parents or siblings as a physician for a claim that you send to us.

**PLAN** means a line of coverage under the policy.
**PRE-EXISTING CONDITION** means a condition for which you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines for your condition during the given period of time as stated in the plan.

**REGULAR CARE** means:

- you personally visit a physician as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- you are receiving the most appropriate treatment and care which conforms with generally accepted medical standards, for your disabling condition(s) by a physician whose specialty or experience is the most appropriate for your disabling condition(s), according to generally accepted medical standards.

**REGULAR OCCUPATION** means the occupation you are routinely performing when your disability begins. Unum will look at your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer or at a specific location.

**RETIREMENT PLAN** means a defined contribution plan or defined benefit plan. These are plans which provide retirement benefits to employees and are not funded entirely by employee contributions. Retirement Plan does not include any plan which is part of any governmental retirement system.

**SALARY CONTINUATION OR ACCUMULATED SICK LEAVE** means continued payments to you by your Employer of all or part of your weekly earnings, after you become disabled as defined by the Policy and includes paid time off (PTO). This continued payment must be part of an established plan maintained by your Employer for the benefit of all employees covered under the Policy. Salary continuation or accumulated sick leave does not include compensation paid to you by your Employer for work you actually perform after your disability begins. Such compensation is considered disability earnings, and would be taken into account in calculating your weekly payment.

**SICKNESS** means an illness or disease. Disability must begin while you are covered under the plan.

**WAITING PERIOD** means the continuous period of time (shown in each plan) that you must be in active employment in an eligible group before you are eligible for coverage under a plan.


**WEEKLY BENEFIT** means the total benefit amount for which an employee is insured under this plan subject to the maximum benefit.

**WEEKLY EARNINGS** means your gross weekly income from your Employer as defined in the plan.

**WEEKLY PAYMENT** means your payment after any deductible sources of income have been subtracted from your gross disability payment.

**YOU** means an employee who is eligible for Unum coverage.
ERISA

Additional Summary Plan Description Information

If the policy provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. These provisions, together with your certificate of coverage, constitute the summary plan description. The summary plan description and the policy constitute the Plan. Benefit determinations are controlled exclusively by the policy, your certificate of coverage and the information contained in this document.

Name of Plan:
Group Disability Plan for Vanderbilt University Medical Center

Name and Address of Employer:
Vanderbilt University Medical Center
Attn: Benefits Administration
2525 West End, 5th Floor
Nashville, Tennessee
37203

Plan Identification Number:
 a. Employer IRS Identification #: 35-2528741
 b. Plan #: 509

Type of Welfare Plan:
Disability Income

Type of Administration:
The Plan is administered by the Plan Administrator. Benefits are administered by the insurer and provided in accordance with the insurance policy issued to the Plan.

ERISA Plan Year Ends:
December 31

Plan Administrator, Name, Address, and Telephone Number:
Vanderbilt University Medical Center
Attn: Chief Human Resources Officer
2525 West End, 5th Floor
Nashville, Tennessee
37203
(615) 343-7000

Vanderbilt University Medical Center is the Plan Administrator and named fiduciary of the Plan, with authority to delegate its duties. The Plan Administrator may designate Trustees of the Plan, in which case the Administrator will advise you separately of the name, title and address of each Trustee.

Agent for Service of Legal Process on the Plan:
Vanderbilt University Medical Center
Attn: Chief Human Resources Officer
Service of legal process may also be made upon the Plan Administrator, or a Trustee of the Plan, if any.

**Funding and Contributions:**
The Plan is funded by insurance issued by Unum Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122 (hereinafter referred to as "Unum") under policy number 410295 011. Contributions to the Plan are made as stated under "WHO PAYS FOR THE COVERAGE" in the Certificate of Coverage.

**EMPLOYER'S RIGHT TO AMEND THE PLAN**
The Employer reserves the right, in its sole and absolute discretion, to amend, modify, or terminate, in whole or in part, any or all of the provisions of the Plan (including any related documents and underlying policies), at any time and for any reason or no reason. Any amendment, modification, or termination must be in writing and endorsed on or attached to the Plan.

**EMPLOYER'S RIGHT TO REQUEST POLICY CHANGE**
The Employer can request a policy change. Only an officer or registrar of Unum can approve a change. The change must be in writing and endorsed on or attached to the policy.

**MODIFYING OR CANCELLING THE POLICY OR A PLAN UNDER THE POLICY**
The policy or a plan under the policy can be cancelled:

- by Unum; or
- by the Employer.

Unum may cancel or modify the policy or a plan if:

- there is less than 25% participation of those eligible employees who pay all or part of their premium for a plan; or
- the Employer does not promptly provide Unum with information that is reasonably required;
- the Employer fails to perform any of its obligations that relate to the policy;
- fewer than 15 employees are insured under a plan;
- the premium is not paid in accordance with the provisions of the policy that specify whether the Employer, the employee, or both, pay(s) the premiums;
- the Employer does not promptly report to Unum the names of any employees who are added or deleted from the eligible group;
- Unum determines that there is a significant change, in the size, occupation or age of the eligible group as a result of a corporate transaction such as a merger, divestiture, acquisition, sale, or reorganization of the Employer and/or its employees; or
- the Employer fails to pay any portion of the premium within the 45 day grace period.
If Unum cancels or modifies the policy or a plan for reasons other than the Employer's failure to pay premium, a written notice will be delivered to the Employer at least 31 days prior to the cancellation date or modification date. The Employer may cancel the policy or a plan if the modifications are unacceptable.

If any portion of the premium is not paid during the grace period, Unum will either cancel or modify the policy or plan automatically at the end of the grace period. The Employer is liable for premium for coverage during the grace period. The Employer must pay Unum all premium due for the full period each plan is in force.

The Employer may cancel the policy or a plan by written notice delivered to Unum at least 31 days prior to the cancellation date. When both the Employer and Unum agree, the policy or a plan can be cancelled on an earlier date. If Unum or the Employer cancels the policy or a plan, coverage will end at 12:00 midnight on the last day of coverage.

If the policy or a plan is cancelled, the cancellation will not affect a payable claim.

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. To complete your claim filing, Unum must receive the claim information it requests from you (or your authorized representative), your attending physician and your Employer. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Unum directly.

CLAIMS PROCEDURES

Unum will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if Unum both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you of the circumstances requiring the extension of time and the date by which Unum expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30 day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your claim without that information.

If your claim for benefits is wholly or partially denied, the notice of adverse benefit determination under the Plan will:

- state the specific reason(s) for the determination;
- reference specific Plan provision(s) on which the determination is based;
- describe additional material or information necessary to complete the claim and why such information is necessary;
- describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to bring a lawsuit.
under Section 502(a) of ERISA following an adverse determination from Unum on appeal; and

- disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

**APPEAL PROCEDURES**

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If Unum determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). Unum will notify you in writing if an additional 45 day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45 day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by Unum and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, Unum will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of your claim, Unum will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:

- the specific reason(s) for the determination;
- a reference to the specific Plan provision(s) on which the determination is based;
- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);

- a statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision;

- the statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and

- the statement that "You or your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency".

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

YOUR RIGHTS UNDER ERISA

As a participant in 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, all documents governing the Plan, including insurance contracts, 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 Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, 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.

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 or any other person, may fire you or otherwise
discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or 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, if, for example, 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 Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security 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.

OTHER RIGHTS

Unum, for itself and as claims fiduciary for the Plan, is entitled to legal and equitable relief to enforce its right to recover any benefit overpayments caused by your receipt of disability earnings or deductible sources of income from a third party. This right of recovery is enforceable even if the amount you receive from the third party is less than the actual loss suffered by you but will not exceed the benefits paid you under the policy. Unum and the Plan have an equitable lien over such sources of income until any benefit overpayments have been recovered in full.

DISCRETIONARY ACTS

The Plan, acting through the Plan Administrator, delegates to Unum and its affiliate Unum Group discretionary authority to make benefit determinations under the Plan. Unum and Unum Group may act directly or through their employees and agents or further delegate their authority through contracts, letters or other documentation or
procedures to other affiliates, persons or entities. Benefit determinations include determining eligibility for benefits and the amount of any benefits, resolving factual disputes, and interpreting and enforcing the provisions of the Plan. All benefit determinations must be reasonable and based on the terms of the Plan and the facts and circumstances of each claim.

Once you are deemed to have exhausted your appeal rights under the Plan, you have the right to seek court review under Section 502(a) of ERISA of any benefit determinations with which you disagree. The court will determine the standard of review it will apply in evaluating those decisions.
Residents of Tennessee who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in the state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers’ care in selecting companies that are well-managed and financially stable.

The state law that provides for this safety-net coverage is called the Tennessee Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law’s coverages, exclusions and limits. This summary does not cover all provisions of the law or describe all of the conditions and limitations relating to coverage. This summary does not in any way change anyone’s rights or obligations under the act or the rights or obligations of the Guaranty Association.

**COVERAGE**

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer authorized to conduct business in Tennessee. Health insurance includes disability and long term care policies. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

**EXCLUSIONS FROM COVERAGE**

However, persons holding such policies are not protected by this Guaranty Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contractholder;
- employers’ plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Guaranty Association is obligated to pay out. The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. For any one insured life, the Guaranty Association guarantees payments up to a stated maximum no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. These aggregate limits per life are as follows:

- $300,000 for policies and contracts of all types, except as described in the next point
- $500,000 for basic hospital, medical and surgical insurance and major medical insurance issued by companies that become insolvent after January 1, 2010.

Within these overall limits, the Guaranty Association cannot guarantee payment of benefit greater than the following:

- life insurance death benefits - $300,000
- life insurance cash surrender value - $100,000
- present value of annuity benefits for companies insolvent before July 1, 2009 - $100,000
- present value of annuity benefits for companies insolvent after June 30, 2009 - $250,000
- health insurance benefits for companies declared insolvent before January 1, 2010 - $100,000
- health insurance benefits for companies declared insolvent on or after January 1, 2010:
  - $100,000 for limited benefits and supplemental health coverages
  - $300,000 for disability and long term care insurance
  - $500,000 for basic hospital, medical and surgical insurance or major medical insurance

The Tennessee Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Tennessee. You should not rely on coverage by the Tennessee Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer for which you have assumed the risk, such as a variable contract sold by prospectus.
Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Tennessee Life and Health Insurance Guaranty Association
1200 One Nashville Place
150 4th Avenue North
Nashville, Tennessee 37219

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, Tennessee 37243
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.
Vanderbilt University Medical Center

Your Group Short Term Disability Plan

Policy No. 410296 011

Underwritten by Unum Life Insurance Company of America

6/21/2016
CERTIFICATE OF COVERAGE

Unum Life Insurance Company of America (referred to as Unum) welcomes you as a client.

This is your certificate of coverage as long as you are eligible for coverage and you become insured. You will want to read it carefully and keep it in a safe place.

Unum has written your certificate of coverage in plain English. However, a few terms and provisions are written as required by insurance law. If you have any questions about any of the terms and provisions, please consult Unum's claims paying office. Unum will assist you in any way to help you understand your benefits.

If the terms and provisions of the certificate of coverage (issued to you) are different from the policy (issued to the policyholder), the policy will govern. Your coverage may be cancelled or changed in whole or in part under the terms and provisions of the policy.

The policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

For purposes of effective dates and ending dates under the group policy, all days begin at 12:01 a.m. and end at 12:00 midnight at the Policyholder's address.

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122
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BENEFITS AT A GLANCE

SHORT TERM DISABILITY PLAN

This short term disability plan provides financial protection for you by paying a portion of your income while you are disabled. The amount you receive is based on the amount you earned before your disability began and the weekly benefit option that you chose. In some cases, you can receive disability payments even if you work while you are disabled.

EMPLOYER'S ORIGINAL PLAN

EFFECTIVE DATE: April 30, 2016

PLAN YEAR:

April 30, 2016 to January 1, 2017 and each following January 1 to January 1

POLICY NUMBER: 410296 011

ELIGIBLE GROUP(S):

All full-time Vanderbilt University Medical Center employees and residents in active employment in the United States with the Employer, excluding faculty & temporary and seasonal employees

MINIMUM HOURS REQUIREMENT:

Employees must be working at least 30 hours per week.

WAITING PERIOD:

For employees in an eligible group on or before April 30, 2016: Effective date of coverage

For employees entering an eligible group after April 30, 2016: First of the month following one year of active employment

You must be in continuous active employment in an eligible group during the specified waiting period.

REHIRE:

If your employment ends and you are rehired within 12 months, your previous work while in an eligible group will apply toward the waiting period. All other policy provisions apply.

WAIVE THE WAITING PERIOD:

For employees who were previously enrolled under policy number 415507:

If you have been continuously employed by your Employer for a period of time equal to your waiting period, Unum will waive your waiting period when you enter an eligible group. All other policy provisions apply.

CREDIT PRIOR SERVICE:

Unum will apply any prior period of work with your Employer toward the waiting period to determine your eligibility date.

WHO PAYS FOR THE COVERAGE:

Option 1

Your Employer pays the cost of your coverage.

Option 2

You and your Employer share the cost of your coverage.
ELIMINATION PERIOD:

14 days for disability due to an injury
14 days for disability due to a sickness

Benefits begin the day after the elimination period is completed.

WEEKLY BENEFIT:

Option 1

66.6667% of weekly earnings to a maximum benefit of $308 per week

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered under this plan.

Option 2

66.6667% of weekly earnings to a maximum benefit of $2,192 per week

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered under this plan.

MAXIMUM PERIOD OF PAYMENT:

24 weeks (does not include elimination period)

For disabilities due to live birth only:
You will receive a minimum of 6 weeks of benefits. (does not include elimination period)

Premium payments are required for your coverage while you are receiving payments under this plan.

Your Short Term Disability plan does not cover disabilities due to an occupational sickness or injury.

REHABILITATION AND RETURN TO WORK ASSISTANCE BENEFIT:

10% of your gross disability payment to a maximum benefit of $250 per week.

In addition, we will make weekly payments to you for 3 weeks following the date your disability ends if we determine you are no longer disabled while:
- you are participating in the Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

OTHER FEATURES:

Minimum Benefit

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section.

The plan includes enrollment, risk management and other support services related to your Employer’s Benefit Program.
CLAIM INFORMATION
SHORT TERM DISABILITY

WHEN DO YOU NOTIFY UNUM OF A CLAIM?

We encourage you to notify us of a claim as soon as possible, so that a claim decision can be made in a timely manner. Telephonic notice as authorized by us or written notice of claim should be provided within 30 days after the date your disability begins. However, you must provide Unum written proof of your claim no later than 90 days after your elimination period. If it is not possible to give proof within 90 days, it must be given no later than 1 year after the time proof is otherwise required except in the absence of legal capacity.

If you choose to file a written notice of claim, the claim form is available from your Employer, or you can request a claim form from us. If you do not receive the form from Unum within 15 days of your request, send Unum written proof of claim without waiting for the form.

You must notify us immediately when you return to work in any capacity.

HOW DO YOU FILE A CLAIM?

You may file notice of claim by telephonic means. The telephone number is available through your Employer. You will be required to sign an authorization form in order for Unum to obtain medical information from your attending physician. Should Unum be unable to obtain your medical information, we will send a letter and appropriate forms to you for completion to be returned to us by the date determined in the letter.

If you choose to file written notice of claim, you and your Employer must complete your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum.

WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?

Your proof of claim, provided at your expense, must show:

- that you are under the regular care of a physician;
- the appropriate documentation of your weekly earnings;
- the date your disability began;
- the cause of your disability;
- the extent of your disability, including restrictions and limitations preventing you from performing your regular occupation; and
- the name and address of any hospital or institution where you received treatment, including all attending physicians.

We may request that you send proof of continuing disability indicating that you are under the regular care of a physician. This proof, provided at your expense, must be received within 45 days of a request by us.

In some cases, you will be required to give Unum authorization to obtain additional medical information and to provide non-medical information as part of your proof of
claim, or proof of continuing disability. Unum will deny your claim, or stop sending you payments, if the appropriate information is not submitted.

**TO WHOM WILL UNUM MAKE PAYMENTS?**

Unum will make payments to you.

**WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?**

Unum has the right to recover any overpayments due to:

- fraud;
- any error Unum makes in processing a claim; and
- your receipt of deductible sources of income.

You must reimburse us in full. We will determine the method by which the repayment is to be made.

Unum will not recover more money than the amount we paid you.
GENERAL PROVISIONS

WHAT IS THE CERTIFICATE OF COVERAGE?

This certificate of coverage is a written statement prepared by Unum and may include attachments. It tells you:

- the coverage for which you may be entitled;
- to whom Unum will make a payment; and
- the limitations, exclusions and requirements that apply within a plan.

WHEN ARE YOU ELIGIBLE FOR COVERAGE?

If you are working for your Employer in an eligible group, the date you are eligible for coverage is the later of:

- the plan effective date; or
- the day after you complete your waiting period.

WHEN DOES YOUR COVERAGE BEGIN?

When you become eligible for coverage under the plan, your Employer will automatically enroll you under Option 2 in the plan. Your coverage will begin at 12:01 a.m. on the date you are eligible for coverage. If you do not want Option 2 under the plan, you may choose to decline this coverage and you will be covered under the Employer paid Option 1 at 12:01 a.m. on the date you are eligible for coverage.

If you decline Option 2 coverage and later apply for Option 2 coverage, evidence of insurability will be required.

WHEN CAN YOU CHANGE YOUR COVERAGE BY CHOOSING ANOTHER OPTION?

You can increase or decrease your coverage at any time during the plan year. Evidence of insurability is required if you increase to Option 2. An evidence of insurability form can be obtained from your Employer.

An increase in coverage will begin at 12:01 a.m. on the first of the month following the date Unum approves your evidence of insurability form.

A decrease in coverage will begin at 12:01 a.m. on the day after you request the decrease.

If you end employment and are rehired within the same plan year, you may be insured on your eligibility date for the coverage that you had under the plan when you ended employment.

WHAT HAPPENS IF YOU RETURN TO AN ELIGIBLE GROUP?

If you return to an eligible group with 12 months from the date you became ineligible you will automatically be enrolled in the plan without evidence of insurability for the same amount of insurance you had just prior to the date you became ineligible.
WHAT IF YOU ARE ABSENT FROM WORK ON THE DATE YOUR COVERAGE WOULD NORMALLY BEGIN?

If you are absent from work due to injury, sickness, temporary layoff or leave of absence, your coverage will begin on the date you return to active employment.

ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE TEMPORARILY NOT WORKING?

If you are on a temporary layoff, and if premium is paid, you will be covered through the end of the month that immediately follows the month in which your temporary layoff begins.

If you are on a leave of absence, and if premium is paid, you will be covered for up to 24 months following the date in which your leave of absence begins.

ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE NOT WORKING DUE TO A PLANT CLOSING?

Massachusetts Residents Only
If you are not working due to a plant closing (as defined in Section 71A of Chapter 151A of the Massachusetts Insurance Statutes), and if premium is paid, you will be covered up to 90 days from the day you were no longer in active employment. If you become covered under any other group disability plan, your coverage under this policy or plan will end.

WHEN WILL CHANGES TO YOUR COVERAGE TAKE EFFECT?

Once your coverage begins, any increased or additional coverage due to a change in your weekly earnings or due to a plan change requested by your Employer will take effect immediately if you are in active employment or if you are on a covered layoff or leave of absence. If you are not in active employment due to injury or sickness, any increased or additional coverage will begin on the date you return to active employment.

Any decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

WHEN DOES YOUR COVERAGE END?

Non-Massachusetts Residents Only
Your coverage under the policy or a plan ends on the earliest of:

- the date the policy or a plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered;
- the last day of the period for which you made any required contributions; or
- the last day you are in active employment except as provided under the covered layoff or leave of absence provision.

Unum will provide coverage for a payable claim which occurs while you are covered under the policy or plan.
Massachusetts Residents Only
Your coverage under the policy or a plan ends on the earliest of:

- the date the policy or a plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered;
- the last day of the period for which you made any required contributions; or
- the last day you are in active employment except as provided under the covered
  layoff, leave of absence and plant closing provisions, or as noted below.

If you end employment, coverage will be extended for 31 days. But if you become
eligible for any other group disability insurance or any other arrangement, this
extension of coverage will end.

Unum will provide coverage for a payable claim which occurs while you are covered
under the policy or plan.

WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?

You can start legal action regarding your claim 60 days after proof of claim has been
given and up to 3 years from the time proof of claim is required, unless otherwise
provided under federal law.

HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE
BE USED?

Unum considers any statements you or your Employer make in a signed application
for coverage a representation and not a warranty. If any of the statements you or
your Employer make are not complete and/or not true at the time they are made, we
can:

- reduce or deny any claim; or
- cancel your coverage from the original effective date.

We will use only statements made in a signed application as a basis for doing this.

If the Employer gives us information about you that is incorrect, we will:

- use the facts to decide whether you have coverage under the plan and in what
  amounts; and
- make a fair adjustment of the premium.

HOW WILL UNUM HANDLE INSURANCE FRAUD?

Unum wants to ensure you and your Employer do not incur additional insurance
costs as a result of the undermining effects of insurance fraud. Unum promises to
focus on all means necessary to support fraud detection, investigation, and
prosecution.

It is a crime if you knowingly, and with intent to injure, defraud or deceive Unum, or
provide any information, including filing a claim, that contains any false, incomplete
or misleading information. These actions, as well as submission of materially false
information, will result in denial of your claim, and are subject to prosecution and
punishment to the full extent under state and/or federal law. Unum will pursue all appropriate legal remedies in the event of insurance fraud.

**DOES THE POLICY REPLACE OR AFFECT ANY WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE?**

The policy does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

**DOES YOUR EMPLOYER ACT AS YOUR AGENT OR UNUM’S AGENT?**

For purposes of the policy, your Employer acts on its own behalf or as your agent. Under no circumstances will your Employer be deemed the agent of Unum.
SHORT TERM DISABILITY

BENEFIT INFORMATION

HOW DOES UNUM DEFINE DISABILITY?

You are disabled when Unum determines that:

- you are limited from performing the **material and substantial duties** of your **regular occupation** due to your **sickness** or **injury**; and
- you have a 20% or more loss in weekly earnings due to the same sickness or injury.

You must be under the regular care of a physician in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

We may require you to be examined by a physician, other medical practitioner and/or vocational expert of our choice. Unum will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require you to be interviewed by an authorized Unum Representative.

HOW LONG MUST YOU BE DISABLED BEFORE YOU ARE ELIGIBLE TO RECEIVE BENEFITS?

You must be continuously disabled through your **elimination period**.

If your disability is the result of an injury that occurs while you are covered under the plan, your elimination period is 14 days.

If your disability is the result of a sickness, your elimination period is 14 days.

CAN YOU SATISFY YOUR ELIMINATION PERIOD IF YOU ARE WORKING?

Yes, provided you meet the definition of disability.

WHEN WILL YOU BEGIN TO RECEIVE PAYMENTS?

You will begin to receive payments when we approve your claim, providing the elimination period has been met and you are disabled. We will send you a payment weekly for any period for which Unum is liable.

After the elimination period, if you are disabled for less than 1 week, we will send you 1/7th of your payment for each day of disability.

HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED?

We will follow this process to figure your payment:

**OPTION 1**

1. Multiply your weekly earnings by 66.6667%.
2. The maximum **weekly benefit** is $308.
3. Compare the answer from Item 1 with the maximum weekly benefit. The lesser of these two amounts is your **gross disability payment**.
4. Subtract from your gross disability payment any **deductible sources of income**.

The amount figured in Item 4 is your **weekly payment**.

**OPTION 2**

1. Multiply your weekly earnings by 66.6667%.
2. The maximum **weekly benefit** is $2,192.
3. Compare the answer from Item 1 with the maximum weekly benefit. The lesser of these two amounts is your **gross disability payment**.
4. Subtract from your gross disability payment any **deductible sources of income**.

The amount figured in Item 4 is your **weekly payment**.

**WHAT ARE YOUR WEEKLY EARNINGS?**

"Weekly Earnings" means your gross weekly income from your Employer, not including shift differential, in effect just prior to your date of disability. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan or flexible spending account. It does not include income received from commissions, bonuses, overtime pay or any other extra compensation or income received from sources other than your Employer.

**WHAT WILL WE USE FOR WEEKLY EARNINGS IF YOU BECOME DISABLED DURING A COVERED LAYOFF OR LEAVE OF ABSENCE?**

If you become disabled while you are on a covered layoff or leave of absence, we will use your weekly earnings from your Employer in effect just prior to the date your absence begins.

**HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED AND WORKING?**

We will send you the weekly payment if you are disabled and your weekly disability earnings, if any, are less than 20% of your weekly earnings.

If you are disabled and your weekly **disability earnings** are from 20% through 80% of your weekly earnings, you will receive payments based on the percentage of income you are losing due to your disability. We will follow this process to figure your payment:

1. Subtract your disability earnings from your weekly earnings.
2. Divide the answer in Item 1 by your weekly earnings. This is your percentage of lost earnings.
3. Multiply your weekly payment as shown above by the answer in Item 2.

This is the amount Unum will pay you for each week.

Unum may require you to send proof of your disability earnings each week. We will adjust your weekly payment based on your disability earnings.
As part of your proof of disability earnings, we can require that you send us appropriate financial records which we believe are necessary to substantiate your income.

**HOW CAN WE PROTECT YOU IF YOUR DISABILITY EARNINGS FLUCTUATE?**

If your disability earnings routinely fluctuate widely from week to week, Unum may average your disability earnings over the most recent 3 weeks to determine if your claim should continue.

If Unum averages your disability earnings, we will not terminate your claim unless the average of your disability earnings from the last 3 weeks exceeds 80% of weekly earnings.

We will not pay you for any week during which disability earnings exceed 80% of weekly earnings.

**WHAT ARE DEDUCTIBLE SOURCES OF INCOME?**

Unum will subtract from your gross disability payment the following deductible sources of income:

1. The amount that you receive or are entitled to receive as disability income or disability retirement payments under any:
   - state compulsory benefit act or law.
   - other group insurance plan.
   - governmental retirement system.

2. The amount that you receive:
   - under a salary continuation or accumulated sick leave plan.
   - under Title 46, United States Code Section 688 (The Jones Act).
   - from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise.

3. The amount that you receive as retirement payments under any governmental retirement system. Retirement payments do not include payments made at the later of age 62 or normal retirement age under your Employer's retirement plan which are attributable to contributions you made on a post tax basis to the system.

   Regardless of how retirement payments are distributed, Unum will consider payments attributable to your post tax contributions to be distributed throughout your lifetime.

   Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Unum will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

4. The amount that you:
   - receive as disability payments under your Employer's retirement plan.
- voluntarily elect to receive as retirement payments under your Employer's retirement plan.
- receive as retirement payments when you reach the later of age 62 or normal retirement age, as defined in your Employer's retirement plan.

Disability payments under a retirement plan will be those benefits which are paid due to disability and do not reduce the retirement benefit which would have been paid if the disability had not occurred.

Retirement payments will be those benefits which are based on your Employer's contribution to the retirement plan. Disability benefits which reduce the retirement benefit under the plan will also be considered as a retirement benefit.

Regardless of how the retirement funds from the retirement plan are distributed, Unum will consider your and your Employer's contributions to be distributed simultaneously throughout your lifetime.

Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Unum will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

Unum will only subtract deductible sources of income which are payable as a result of the same disability.

WHAT ARE NOT DEDUCTIBLE SOURCES OF INCOME?

Unum will not subtract from your gross disability payment income you receive from, but not limited to, the following:

- 401(k) plans
- profit sharing plans
- thrift plans
- tax sheltered annuities
- stock ownership plans
- non-qualified plans of deferred compensation
- pension plans for partners
- military pension and disability income plans
- credit disability insurance
- franchise disability income plans
- a retirement plan from another Employer
- individual retirement accounts (IRA)
- individual disability income plans
- no fault motor vehicle plans

WHAT IF SUBTRACTING DEDUCTIBLE SOURCES OF INCOME RESULTS IN A ZERO BENEFIT? (Minimum Benefit)

The minimum weekly payment is: $25.

Unum may apply this amount toward an outstanding overpayment.

However, the minimum weekly payment will not be paid if you are receiving salary continuation or accumulated sick leave payments from your Employer.
WHAT IF UNUM DETERMINES YOU MAY QUALIFY FOR DEDUCTIBLE INCOME BENEFITS?

When we determine that you may qualify for benefits under Item(s) 1 in the deductible sources of income section, we will estimate your entitlement to these benefits. We can reduce your payment by the estimated amounts if such benefits:

- have not been awarded; and
- have not been denied; or
- have been denied and the denial is being appealed.

Your Short Term Disability payment will NOT be reduced by the estimated amount if you:

- apply for the disability payments under Item(s) 1 in the deductible sources of income section and appeal your denial to all administrative levels Unum feels are necessary; and
- sign Unum’s payment option form. This form states that you promise to pay us any overpayment caused by an award.

If your payment has been reduced by an estimated amount, your payment will be adjusted when we receive proof:

- of the amount awarded; or
- that benefits have been denied and all appeals Unum feels are necessary have been completed. In this case, a lump sum refund of the estimated amount will be made to you.

If you receive a lump sum payment from any deductible sources of income, the lump sum will be pro-rated on a weekly basis over the time period for which the sum was given. If no time period is stated, the sum will be pro-rated on a weekly basis to the end of the maximum period of payment.

HOW LONG WILL UNUM CONTINUE TO SEND YOU PAYMENTS?

Unum will send you a payment each week up to the **maximum period of payment**. Your maximum period of payment is 24 weeks during a continuous period of disability. (does not include elimination period)

For disabilities due to live birth only:
You will receive a minimum of 6 weeks of benefits. (does not include elimination period)

WHEN WILL PAYMENTS STOP?

We will stop sending you payments and your claim will end on the earliest of the following:

- when you are able to work in your regular occupation on a **part-time basis** but you do not;
- the end of the maximum period of payment;
- the date you are no longer disabled under the terms of the plan, unless you are eligible to receive benefits under Unum's Rehabilitation and Return to Work Assistance program;
- the date you fail to submit proof of continuing disability;
- after 12 months of payments if you are considered to reside outside the United States or Canada. You will be considered to reside outside these countries when you have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits;
- the date your disability earnings exceed the amount allowable under the plan;
- the date you die.

**WHAT DISABILITIES ARE NOT COVERED UNDER YOUR PLAN?**

Your plan does not cover any disabilities caused by, contributed to by, or resulting from your:

- **occupational sickness or injury**, however, Unum will cover disabilities due to occupational sicknesses or injuries for partners or sole proprietors who cannot be covered by a workers' compensation law.
- intentionally self-inflicted injuries.
- active participation in a riot.
- loss of a professional license, occupational license or certification.
- commission of a crime for which you have been convicted.

Your plan will not cover a disability due to war, declared or undeclared, or any act of war.

Unum will not pay a benefit for any period of disability during which you are incarcerated.

**WHAT HAPPENS IF YOU RETURN TO WORK FULL TIME AND YOUR DISABILITY OCCURS AGAIN?**

1. If your current disability is related to or due to the same cause(s) as your prior disability for which Unum made a payment:

   Unum will treat your current disability as part of your prior claim and you will not have to complete another elimination period when you are performing any occupation for your Employer on a full time basis for 14 consecutive days or less.

   If you return to work on the 15th day, your current disability will be treated as a new claim. The new claim will be subject to all of the provisions of this plan and you will be required to satisfy a new elimination period.

2. If your current disability is unrelated to your prior disability for which Unum made a payment:

   Unum will treat your current disability as part of your prior claim and you will not have to complete another elimination period when you are performing any occupation for your Employer on a full time basis for less than 1 full day.

   Your disability, as outlined above, will be subject to the same terms of the plan as your prior claim.
If you do not satisfy Item 1 or 2 above, your disability will be treated as a new claim and will be subject to all of the policy provisions.

If you become entitled to payments under any other group short term disability plan, you will not be eligible for payments under the Unum plan.
SHORT TERM DISABILITY

OTHER BENEFIT FEATURES

HOW CAN UNUM’S REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM HELP YOU RETURN TO WORK?

Unum has a vocational Rehabilitation and Return to Work Assistance program available to assist you in returning to work. We will determine whether you are eligible for this program. In order to be eligible for rehabilitation services and benefits, you must be medically able to engage in a return to work program.

Your claim file will be reviewed by one of Unum’s rehabilitation professionals to determine if a rehabilitation program might help you return to gainful employment. As your file is reviewed, medical and vocational information will be analyzed to determine an appropriate return to work program.

We will make the final determination of your eligibility for participation in the program.

We will provide you with a written Rehabilitation and Return to Work Assistance plan developed specifically for you.

The rehabilitation program may include, but is not limited to, the following services and benefits:

- coordination with your Employer to assist you to return to work;
- adaptive equipment or job accommodations to allow you to work;
- vocational evaluation to determine how your disability may impact your employment options;
- job placement services;
- resume preparation;
- job seeking skills training; or
- education and retraining expenses for a new occupation.

WHAT ADDITIONAL BENEFITS WILL UNUM PAY WHILE YOU PARTICIPATE IN A REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM?

We will pay an additional disability benefit of 10% of your gross disability payment to a maximum benefit of $250 per week.

This benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount such as Deductible Sources of Income.

In addition, we will make weekly payments to you for 3 weeks following the date your disability ends if we determine you are no longer disabled while:

- you are participating in the Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

This benefit payment may be paid in a lump sum.
WHEN WILL REHABILITATION AND RETURN TO WORK ASSISTANCE BENEFITS END?

Benefits for the Rehabilitation and Return to Work Assistance program will end on the earliest of the following dates:

- the date Unum determines that you are no longer eligible to participate in Unum's Rehabilitation and Return to Work Assistance program; or
- any other date on which weekly payments would stop in accordance with this plan.
GLOSSARY

ACTIVE EMPLOYMENT means you are working for your Employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under Eligible Group(s) in each plan.

Your work site must be:
- your Employer's usual place of business;
- an alternative work site at the direction of your Employer, including your home; or
- a location to which your job requires you to travel.

Normal vacation is considered active employment. Temporary and seasonal workers are excluded from coverage.

DEDUCTIBLE SOURCES OF INCOME means income from deductible sources listed in the plan which you receive or are entitled to receive while you are disabled. This income will be subtracted from your gross disability payment.

DISABILITY EARNINGS means the earnings which you receive while you are disabled and working, plus the earnings you could receive if you were working to your maximum capacity.

ELIMINATION PERIOD means a period of continuous disability which must be satisfied before you are eligible to receive benefits from Unum.

EMPLOYEE means a person who is in active employment in the United States with the Employer.

EMPLOYER means the Policyholder, and includes any division, subsidiary or affiliated company named in the policy.

GOVERNMENTAL RETIREMENT SYSTEM means a plan which is part of any federal, state, county, municipal or association retirement system, including but not limited to, a state teachers retirement system, public employees retirement system or other similar retirement system for state or local government employees providing for the payment of retirement and/or disability benefits to individuals.

GRACE PERIOD means the period of time following the premium due date during which premium payment may be made.

GROSS DISABILITY PAYMENT means the benefit amount before Unum subtracts deductible sources of income and disability earnings.

HOSPITAL OR INSTITUTION means an accredited facility licensed to provide care and treatment for the condition causing your disability.

INJURY means a bodily injury that is the direct result of an accident and not related to any other cause. Injury which occurs before you are covered under the plan will be treated as a sickness. Disability must begin while you are covered under the plan.

INSURED means any person covered under a plan.
LAW, PLAN OR ACT means the original enactments of the law, plan or act and all amendments.

LAYOFF or LEAVE OF ABSENCE means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by your Employer.

Your normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

LIMITED means what you cannot or are unable to do.

MATERIAL AND SUBSTANTIAL DUTIES means duties that:
- are normally required for the performance of your regular occupation; and
- cannot be reasonably omitted or modified.

MAXIMUM CAPACITY means, based on your restrictions and limitations, the greatest extent of work you are able to do in your regular occupation, that is reasonably available.

MAXIMUM PERIOD OF PAYMENT means the longest period of time Unum will make payments to you for any one period of disability.

OCCUPATIONAL SICKNESS OR INJURY means a sickness or injury that was caused by or aggravated by any employment for pay or profit.

PART-TIME BASIS means the ability to work and earn between 20% and 80% of your weekly earnings.

PAYABLE CLAIM means a claim for which Unum is liable under the terms of the policy.

PHYSICIAN means:
- a person performing tasks that are within the limits of his or her medical license; and
- a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

Unum will not recognize you, or your spouse, children, parents or siblings as a physician for a claim that you send to us.

PLAN means a line of coverage under the policy.

REGULAR CARE means:
- you personally visit a physician as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- you are receiving the most appropriate treatment and care which conforms with generally accepted medical standards, for your disabling condition(s) by a physician.
whose specialty or experience is the most appropriate for your disabling condition(s),
according to generally accepted medical standards.

**REGULAR OCCUPATION** means the occupation you are routinely performing when
your disability begins. Unum will look at your occupation as it is normally performed in
the national economy, instead of how the work tasks are performed for a specific
employer or at a specific location.

**RETIREMENT PLAN** means a defined contribution plan or defined benefit plan. These
are plans which provide retirement benefits to employees and are not funded entirely by
employee contributions. Retirement Plan does not include any plan which is part of any
governmental retirement system.

**SALARY CONTINUATION OR ACCUMULATED SICK LEAVE** means continued
payments to you by your Employer of all or part of your weekly earnings, after you
become disabled as defined by the Policy. This continued payment must be part of an
established plan maintained by your Employer for the benefit of all employees covered
under the Policy. Salary continuation or accumulated sick leave does not include
compensation paid to you by your Employer for work you actually perform after your
disability begins. Such compensation is considered disability earnings, and would be
taken into account in calculating your weekly payment.

**SICKNESS** means an illness or disease. Disability must begin while you are covered
under the plan.

**WAITING PERIOD** means the continuous period of time (shown in each plan) that you
must be in active employment in an eligible group before you are eligible for coverage
under a plan.


**WEEKLY BENEFIT** means the total benefit amount for which an employee is insured
under this plan subject to the maximum benefit.

**WEEKLY EARNINGS** means your gross weekly income from your Employer as defined
in the plan.

**WEEKLY PAYMENT** means your payment after any deductible sources of income have
been subtracted from your gross disability payment.

**YOU** means an employee who is eligible for Unum coverage.
ERISA

Additional Summary Plan Description Information

If the policy provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. These provisions, together with your certificate of coverage, constitute the summary plan description. The summary plan description and the policy constitute the Plan. Benefit determinations are controlled exclusively by the policy, your certificate of coverage and the information contained in this document.

Name of Plan:
Group Disability Plan for Vanderbilt University Medical Center

Name and Address of Employer:
Vanderbilt University Medical Center
Attn: Benefits Administration
2525 West End, 5th Floor
Nashville, Tennessee
37203

Plan Identification Number:
a. Employer IRS Identification #: 35-2528741
b. Plan #: 509

Type of Welfare Plan:
Disability Income

Type of Administration:
The Plan is administered by the Plan Administrator. Benefits are administered by the insurer and provided in accordance with the insurance policy issued to the Plan.

ERISA Plan Year Ends:
December 31

Plan Administrator, Name, Address, and Telephone Number:
Vanderbilt University Medical Center
Attn: Chief Human Resources Officer
2525 West End, 5th Floor
Nashville, Tennessee
37203
(615) 343-7000

Vanderbilt University Medical Center is the Plan Administrator and named fiduciary of the Plan, with authority to delegate its duties. The Plan Administrator may designate Trustees of the Plan, in which case the Administrator will advise you separately of the name, title and address of each Trustee.

Agent for Service of Legal Process on the Plan:
Vanderbilt University Medical Center
Attn: Chief Human Resources Officer
Service of legal process may also be made upon the Plan Administrator, or a Trustee of the Plan, if any.

**Funding and Contributions:**

The Plan is funded by insurance issued by Unum Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122 (hereinafter referred to as "Unum") under policy number 410296 011. Contributions to the Plan are made as stated under "WHO PAYS FOR THE COVERAGE" in the Certificate of Coverage.

**EMPLOYER'S RIGHT TO AMEND THE PLAN**

The Employer reserves the right, in its sole and absolute discretion, to amend, modify, or terminate, in whole or in part, any or all of the provisions of the Plan (including any related documents and underlying policies), at any time and for any reason or no reason. Any amendment, modification, or termination must be in writing and endorsed on or attached to the Plan.

**EMPLOYER'S RIGHT TO REQUEST POLICY CHANGE**

The Employer can request a policy change. Only an officer or registrar of Unum can approve a change. The change must be in writing and endorsed on or attached to the policy.

**MODIFYING OR CANCELLING THE POLICY OR A PLAN UNDER THE POLICY**

The policy or a plan under the policy can be cancelled:

- by Unum; or
- by the Employer.

Unum may cancel or modify the policy or a plan if:

- there is less than 25% participation of those eligible employees who pay all or part of their premium for a plan; or
- there is less than 100% participation of those eligible employees for an Employer paid plan;
- the Employer does not promptly provide Unum with information that is reasonably required;
- the Employer fails to perform any of its obligations that relate to the policy;
- fewer than 25 employees are insured under a plan;
- the premium is not paid in accordance with the provisions of the policy that specify whether the Employer, the employee, or both, pay(s) the premiums;
- the Employer does not promptly report to Unum the names of any employees who are added or deleted from the eligible group;
- Unum determines that there is a significant change, in the size, occupation or age of the eligible group as a result of a corporate transaction such as a merger, divestiture, acquisition, sale, or reorganization of the Employer and/or its employees; or
- the Employer fails to pay any portion of the premium within the 45 day grace period.

If Unum cancels or modifies the policy or a plan for reasons other than the Employer's failure to pay premium, a written notice will be delivered to the Employer at least 31 days prior to the cancellation date or modification date. The Employer may cancel the policy or a plan if the modifications are unacceptable.

Unum also reserves the right to set a participation requirement for each coverage option under a plan and to cancel an option if the participation requirement is not met.

If any portion of the premium is not paid during the grace period, Unum will either cancel or modify the policy or plan automatically at the end of the grace period. The Employer is liable for premium for coverage during the grace period. The Employer must pay Unum all premium due for the full period each plan is in force.

The Employer may cancel the policy or a plan by written notice delivered to Unum at least 31 days prior to the cancellation date. When both the Employer and Unum agree, the policy or a plan can be cancelled on an earlier date. If Unum or the Employer cancels the policy or a plan, coverage will end at 12:00 midnight on the last day of coverage.

If the policy or a plan is cancelled, the cancellation will not affect a payable claim.

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. To complete your claim filing, Unum must receive the claim information it requests from you (or your authorized representative), your attending physician and your Employer. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Unum directly.

CLAIMS PROCEDURES

Unum will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if Unum both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you of the circumstances requiring the extension of time and the date by which Unum expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30 day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your claim without that information.

If your claim for benefits is wholly or partially denied, the notice of adverse benefit determination under the Plan will:

- state the specific reason(s) for the determination;
- reference specific Plan provision(s) on which the determination is based;

- describe additional material or information necessary to complete the claim and why such information is necessary;

- describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal; and

- disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

**APPEAL PROCEDURES**

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If Unum determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). Unum will notify you in writing if an additional 45 day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45 day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by Unum and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, Unum will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of your claim, Unum will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:
- the specific reason(s) for the determination;

- a reference to the specific Plan provision(s) on which the determination is based;

- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);

- a statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision;

- the statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and

- the statement that "You or your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency".

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

YOUR RIGHTS UNDER ERISA

As a participant in 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, all documents governing the Plan, including insurance contracts, 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 Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, 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.
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 or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or 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, if, for example, 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 Employee Benefits Security Administration, U.S. Department of Labor, or the Division of Technical Assistance and Inquiries, Employee Benefits Security 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.

OTHER RIGHTS

Unum, for itself and as claims fiduciary for the Plan, is entitled to legal and equitable relief to enforce its right to recover any benefit overpayments caused by your receipt of disability earnings or deductible sources of income from a third party. This right of recovery is enforceable even if the amount you receive from the third party is less than the actual loss suffered by you but will not exceed the benefits paid you under the policy. Unum and the Plan have an equitable lien over such sources of income until any benefit overpayments have been recovered in full.
Residents of Tennessee who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in the state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers’ care in selecting companies that are well-managed and financially stable.

The state law that provides for this safety-net coverage is called the Tennessee Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law or describe all of the conditions and limitations relating to coverage. This summary does not in any way change anyone’s rights or obligations under the act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer authorized to conduct business in Tennessee. Health insurance includes disability and long term care policies. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Guaranty Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contractholder;
- employers’ plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals).

**LIMITS ON AMOUNT OF COVERAGE**

The act also limits the amount the Guaranty Association is obligated to pay out. The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. For any one insured life, the Guaranty Association guarantees payments up to a stated maximum no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. These aggregate limits per life are as follows:

- $300,000 for policies and contracts of all types, except as described in the next point
- $500,000 for basic hospital, medical and surgical insurance and major medical insurance issued by companies that become insolvent after January 1, 2010.

Within these overall limits, the Guaranty Association cannot guarantee payment of benefit greater than the following:

- life insurance death benefits - $300,000
- life insurance cash surrender value - $100,000
- present value of annuity benefits for companies insolvent before July 1, 2009 - $100,000
- present value of annuity benefits for companies insolvent after June 30, 2009 - $250,000
- health insurance benefits for companies declared insolvent before January 1, 2010 - $100,000
- health insurance benefits for companies declared insolvent on or after January 1, 2010:
  - $100,000 for limited benefits and supplemental health coverages
  - $300,000 for disability and long term care insurance
  - $500,000 for basic hospital, medical and surgical insurance or major medical insurance

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The Tennessee Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Tennessee. You should not rely on coverage by the Tennessee Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is **NOT** provided for your policy or any portion of it that is not guaranteed by the insurer for which you have assumed the risk, such as a variable contract sold by prospectus.
Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Tennessee Life and Health Insurance Guaranty Association
1200 One Nashville Place
150 4th Avenue North
Nashville, Tennessee 37219

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, Tennessee 37243
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.
Vanderbilt University Medical Center

Your Group Long Term Disability Plan

Policy No. 410297 011

Underwritten by Unum Life Insurance Company of America

6/17/2016
CERTIFICATE OF COVERAGE

Unum Life Insurance Company of America (referred to as Unum) welcomes you as a client.

This is your certificate of coverage as long as you are eligible for coverage and you become insured. You will want to read it carefully and keep it in a safe place.

Unum has written your certificate of coverage in plain English. However, a few terms and provisions are written as required by insurance law. If you have any questions about any of the terms and provisions, please consult Unum's claims paying office. Unum will assist you in any way to help you understand your benefits.

If the terms and provisions of the certificate of coverage (issued to you) are different from the policy (issued to the policyholder), the policy will govern. Your coverage may be cancelled or changed in whole or in part under the terms and provisions of the policy.

The policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. When making a benefit determination under the policy, Unum has discretionary authority to determine your eligibility for benefits and to interpret the terms and provisions of the policy.

For purposes of effective dates and ending dates under the group policy, all days begin at 12:01 a.m. and end at 12:00 midnight at the Policyholder's address.

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122
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BENEFITS AT A GLANCE

LONG TERM DISABILITY PLAN

This long term disability plan provides financial protection for you by paying a portion of your income while you are disabled. The amount you receive is based on the amount you earned before your disability began and the monthly benefit option that you chose. In some cases, you can receive disability payments even if you work while you are disabled.

EMPLOYER'S ORIGINAL PLAN
EFFECTIVE DATE: April 30, 2016

PLAN YEAR:
April 30, 2016 to January 1, 2017 and each following January 1 to January 1

POLICY NUMBER: 410297 011

ELIGIBLE GROUP(S):

Group 1
All full-time Vanderbilt University Medical Center Faculty Members in active employment in the United States with the Employer, excluding temporary and seasonal employees

Group 2
All full-time Vanderbilt University Medical Center Staff Members in active employment in the United States with the Employer, excluding temporary and seasonal employees

MINIMUM HOURS REQUIREMENT:
Employees must be regularly scheduled to work at least 30 hours per week.

WAITING PERIOD:

All Faculty Members with a full-time appointment, All Full-Time Staff Members excluding House Staff
For employees in an eligible group on or before April 30, 2016: First of the month coincident with or next following 12 months of continuous active employment

For employees entering an eligible group after April 30, 2016: First of the month coincident with or next following 12 months of continuous active employment

Note: The 12 month requirement will be waived for new hires that can certify, on an official CERTIFICATION OF PRIOR COVERAGE FORM provided by Vanderbilt, that they were covered by a group long term disability policy at least 90 days prior to being hired by Vanderbilt. Once approved the 12 month waiting period is waived, and continuity of coverage is provided for the pre-existing requirement.

You must be in continuous active employment in an eligible group during the specified waiting period.

House Staff
For employees in an eligible group on or before April 30, 2016: None
For employees entering an eligible group after April 30, 2016: None

REHIRE:
If your employment ends and you are rehired within 12 months, your previous work while in an eligible group will apply toward the waiting period. All other policy provisions apply.
WAIVE THE WAITING PERIOD:

For employees who were previously enrolled under policy number 224888:

If you have been continuously employed by your Employer for a period of time equal to your waiting period, Unum will waive your waiting period when you enter an eligible group. All other policy provisions apply.

CREDIT PRIOR SERVICE:

Unum will apply any prior period of work with your Employer toward the waiting period to determine your eligibility date.

WHO PAYS FOR THE COVERAGE:

Option 1
Your Employer pays the cost of your coverage.

Option 2
You and your Employer share the cost of your coverage.

ELIMINATION PERIOD:

180 days
Accumulation Period: 360 days

Benefits begin the day after the elimination period is completed.

MONTHLY BENEFIT:

Option 1
60% of monthly earnings to a maximum benefit of $1,200 per month.

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered or may have limited coverage under this plan.

Option 2
60% of monthly earnings to a maximum benefit of $33,000 per month.

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered or may have limited coverage under this plan.

MAXIMUM PERIOD OF PAYMENT:

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</tr>
<tr>
<td>Age 70 and over</td>
<td>1 year</td>
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</table>

No premium payments are required for your coverage while you are receiving payments under this plan.

REHABILITATION AND RETURN TO WORK ASSISTANCE BENEFIT:

10% of your gross disability payment to a maximum benefit of $1,000 per month.

In addition, we will make monthly payments to you for 3 months following the date your disability ends if we determine you are no longer disabled while:
- you are participating in the Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

**DEPENDENT CARE EXPENSE BENEFIT:**

While you are participating in Unum's Rehabilitation and Return to Work Assistance program, you may receive payments to cover certain dependent care expenses limited to the following amounts:

Dependent Care Expense Benefit Amount: $400 per month, per dependent

Dependent Care Expense Maximum Benefit Amount: $1,000 per month for all eligible dependent care expenses combined

**TOTAL BENEFIT CAP:**

The total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 100% of your monthly earnings. However, if you are participating in Unum's Rehabilitation and Return to Work Assistance program, the total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 110% of your monthly earnings.

**OTHER FEATURES:**

Continuity of Coverage
Conversion
Minimum Benefit
Pre-Existing: 3/3/12
Retirement Income Protection
Survivor Benefit

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section.

The plan includes enrollment, risk management and other support services related to your Employer's Benefit Program.
CLAIM INFORMATION
LONG TERM DISABILITY

WHEN DO YOU NOTIFY UNUM OF A CLAIM?

We encourage you to notify us of your claim as soon as possible, so that a claim decision can be made in a timely manner. Telephonic notice as authorized by us or written notice of a claim should be provided within 30 days after the date your disability begins. However, you must provide Unum written proof of your claim no later than 90 days after your elimination period. If it is not possible to give proof within 90 days, it must be given no later than 1 year after the time proof is otherwise required except in the absence of legal capacity.

If you choose to file a written notice of claim, the claim form is available from your Employer, or you can request a claim form from us. If you do not receive the form from Unum within 15 days of your request, send Unum written proof of claim without waiting for the form.

You must notify us immediately when you return to work in any capacity.

HOW DO YOU FILE A CLAIM?

You may file notice of claim by telephonic means. The telephone number is available through your Employer. You will be required to sign an authorization form in order for Unum to obtain medical from your attending physician. Should Unum be unable to obtain your medical information, we will send a letter and appropriate forms to you for completion to be returned to us by the date determined in the letter.

WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?

Your proof of claim, provided at your expense, must show:

- that you are under the regular care of a physician;
- the appropriate documentation of your monthly earnings;
- the date your disability began;
- the cause of your disability;
- the extent of your disability, including restrictions and limitations preventing you from performing your regular occupation; and
- the name and address of any hospital or institution where you received treatment, including all attending physicians.

We may request that you send proof of continuing disability indicating that you are under the regular care of a physician. This proof, provided at your expense, must be received within 45 days of a request by us.

In some cases, you will be required to give Unum authorization to obtain additional medical information and to provide non-medical information as part of your proof of claim, or proof of continuing disability. Unum will deny your claim, or stop sending you payments, if the appropriate information is not submitted.

TO WHOM WILL UNUM MAKE PAYMENTS?

Unum will make payments to you.
WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?

Unum has the right to recover any overpayments due to:

- fraud;
- any error Unum makes in processing a claim; and
- your receipt of deductible sources of income.

You must reimburse us in full. We will determine the method by which the repayment is to be made.

Unum will not recover more money than the amount we paid you.
GENERAL PROVISIONS

WHAT IS THE CERTIFICATE OF COVERAGE?

This certificate of coverage is a written statement prepared by Unum and may include attachments. It tells you:

- the coverage for which you may be entitled;
- to whom Unum will make a payment; and
- the limitations, exclusions and requirements that apply within a plan.

WHEN ARE YOU ELIGIBLE FOR COVERAGE?

If you are working for your Employer in an eligible group, the date you are eligible for coverage is the later of:

- the plan effective date; or
- the day after you complete your waiting period.

WHEN DOES YOUR COVERAGE BEGIN?

When you become eligible for coverage under the plan, your Employer will automatically enroll you under Option 2 in the plan. Your coverage will begin at 12:01 a.m. on the date you are eligible for coverage. If you do not want Option 2 coverage under the plan, you may choose to decline this coverage and you will be covered under the Employer paid Option 1.

WHEN CAN YOU CHANGE YOUR COVERAGE BY CHOOSING ANOTHER OPTION?

You can increase or decrease your coverage at any time. Evidence of insurability is required if you increase to Option 2. An evidence of insurability form can be obtained from your Employer.

An increase in coverage will begin on the first of the month following the date Unum approves your evidence of insurability form. A decrease in coverage will begin at 12:01 a.m. on the day after you request the decrease.

If you end employment and are rehired within the same plan year, you may be insured on your eligibility date for the coverage that you had under the plan when you ended employment.

WHAT IF YOU ARE ABSENT FROM WORK ON THE DATE YOUR COVERAGE WOULD NORMALLY BEGIN?

If you are absent from work due to injury, sickness, temporary layoff or leave of absence, your coverage will begin on the date you return to active employment.

ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE TEMPORARILY NOT WORKING?

If you are on a temporary layoff, and if premium is paid, you will be covered for up to 1 month following the date your temporary layoff begins.
If you are on a leave of absence, and if premium is paid, you will be covered for up to 24 months following the date your leave of absence begins.

**ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE NOT WORKING DUE TO A PLANT CLOSING?**

**Massachusetts Residents Only**

If you are not working due to a plant closing (as defined in Section 71A of Chapter 151A of the Massachusetts Insurance Statutes), and if premium is paid, you will be covered up to 90 days from the date you were no longer in active employment. If you become covered under any other group disability plan, your coverage under this policy or plan will end.

**WHEN WILL CHANGES TO YOUR COVERAGE TAKE EFFECT?**

Once your coverage begins, any increased or additional coverage due to a change in your monthly earnings or due to a plan change requested by your Employer will take effect immediately if you are in active employment or if you are on a covered layoff or leave of absence. If you are not in active employment due to injury or sickness, any increased or additional coverage will begin on the date you return to active employment.

Any decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

**WHEN DOES YOUR COVERAGE END?**

**Non- Massachusetts Residents**

Your coverage under the policy or a plan ends on the earliest of:

- the date the policy or a plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered;
- the last day of the period for which you made any required contributions; or
- the last day you are in active employment except as provided under the covered layoff or leave of absence provision.

Unum will provide coverage for a payable claim which occurs while you are covered under the policy or plan.

**Massachusetts Residents**

Your coverage under the policy or a plan ends on the earliest of:

- the date the policy or a plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered;
- the last day of the period for which you made any required contributions; or
- the last day you are in active employment except as provided under the covered layoff, leave of absence and plant closing provisions, or as noted below.

If you end employment, coverage will be extended for 31 days. But if you become eligible for any other group disability insurance or any other arrangement, this extension of coverage will end.
Unum will provide coverage for a payable claim which occurs while you are covered under the policy or plan.

**WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?**

You can start legal action regarding your claim 60 days after proof of claim has been given and up to 3 years from the time proof of claim is required, unless otherwise provided under federal law.

**HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?**

Unum considers any statements you or your Employer make in a signed application for coverage a representation and not a warranty. If any of the statements you or your Employer make are not complete and/or not true at the time they are made, we can:

- reduce or deny any claim; or
- cancel your coverage from the original effective date.

We will use only statements made in a signed application as a basis for doing this.

If the Employer gives us information about you that is incorrect, we will:

- use the facts to decide whether you have coverage under the plan and in what amounts; and
- make a fair adjustment of the premium.

**HOW WILL UNUM HANDLE INSURANCE FRAUD?**

Unum wants to ensure you and your Employer do not incur additional insurance costs as a result of the undermining effects of insurance fraud. Unum promises to focus on all means necessary to support fraud detection, investigation, and prosecution.

It is a crime if you knowingly, and with intent to injure, defraud or deceive Unum, or provide any information, including filing a claim, that contains any false, incomplete or misleading information. These actions, as well as submission of materially false information, will result in denial of your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. Unum will pursue all appropriate legal remedies in the event of insurance fraud.

**DOES THE POLICY REPLACE OR AFFECT ANY WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE?**

The policy does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

**DOES YOUR EMPLOYER ACT AS YOUR AGENT OR UNUM'S AGENT?**

For purposes of the policy, your Employer acts on its own behalf or as your agent. Under no circumstances will your Employer be deemed the agent of Unum.
LONG TERM DISABILITY

BENEFIT INFORMATION

HOW DOES UNUM DEFINE DISABILITY?

You are disabled when Unum determines that:

- you are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury; and
- you have a 20% or more loss in your indexed monthly earnings due to the same sickness or injury.

After 24 months of payments, you are disabled when Unum determines that due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience.

You must be under the regular care of a physician in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

We may require you to be examined by a physician, other medical practitioner and/or vocational expert of our choice. Unum will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require you to be interviewed by an authorized Unum Representative.

HOW LONG MUST YOU BE DISABLED BEFORE YOU ARE ELIGIBLE TO RECEIVE BENEFITS?

You must be continuously disabled through your elimination period. The days that you are not disabled will not count toward your elimination period.

Your elimination period is 180 days.

In addition, if you return to work while satisfying your elimination period, and are no longer disabled, you may satisfy your elimination period within the accumulation period. You do not need to be continuously disabled through your elimination period if you are satisfying your elimination period under this provision. If you do not satisfy the elimination period within the accumulation period, a new period of disability will begin.

Your accumulation period is 360 days.

You are not required to have a 20% or more loss in your indexed monthly earnings due to the same injury or sickness to be considered disabled during the elimination period.

CAN YOU SATISFY YOUR ELIMINATION PERIOD IF YOU ARE WORKING?

Yes. If you are working while you are disabled, the days you are disabled will count toward your elimination period.
WHEN WILL YOU BEGIN TO RECEIVE PAYMENTS?

You will begin to receive payments when we approve your claim, providing the elimination period has been met and you are disabled. We will send you a payment monthly for any period for which Unum is liable.

HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED?

We will follow this process to figure your payment:

OPTION 1

1. Multiply your monthly earnings by 60%.
2. The maximum monthly benefit is $1,200.
3. Compare the answer from Item 1 with the maximum monthly benefit. The lesser of these two amounts is your gross disability payment.
4. Subtract from your gross disability payment any deductible sources of income.

The amount figured in Item 4 is your monthly payment.

OPTION 2

1. Multiply your monthly earnings by 60%.
2. The maximum monthly benefit is $33,000.
3. Compare the answer from Item 1 with the maximum monthly benefit. The lesser of these two amounts is your gross disability payment.
4. Subtract from your gross disability payment any deductible sources of income.

The amount figured in Item 4 is your monthly payment.

WILL UNUM EVER PAY MORE THAN 100% OF MONTHLY EARNINGS?

The total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 100% of your monthly earnings. However, if you are participating in Unum's Rehabilitation and Return to Work Assistance program, the total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 110% of your monthly earnings.

WHAT ARE YOUR MONTHLY EARNINGS?

Faculty Not on Grant Rotation, All Full-Time Staff Members
"Monthly Earnings" means your gross monthly income from your Employer, not including shift differential, in effect just prior to your date of disability. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan or flexible spending account. It does not include income received from commissions, bonuses, overtime pay or any other extra compensation or income received from sources other than your Employer.

Faculty on Grant Rotation
"Monthly Earnings" means your gross monthly income from your Employer, not including Shift Differential, in effect just prior to your date of disability or just prior to your grant rotation if you were on a grant rotation on your disability date. It includes your total income before taxes. It is prior to any deductions made for pre-tax...
contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay or any other extra compensation, or income received from sources other than your Employer.

**WHAT WILL WE USE FOR MONTHLY EARNINGS IF YOU BECOME DISABLED DURING A COVERED LAYOFF OR LEAVE OF ABSENCE?**

If you become disabled while you are on a covered layoff or leave of absence, we will use your monthly earnings from your Employer in effect just prior to the date your absence begins.

**HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED AND WORKING?**

We will send you the monthly payment if you are disabled and your monthly disability earnings, if any, are less than 20% of your indexed monthly earnings, due to the same sickness or injury.

If you are disabled and your monthly disability earnings are from 20% through 80% of your indexed monthly earnings, due to the same sickness or injury, Unum will figure your payment as follows:

During the first 12 months of payments, while working, your monthly payment will not be reduced as long as disability earnings plus the gross disability payment does not exceed 100% of indexed monthly earnings.

1. Add your monthly disability earnings to your gross disability payment.
2. Compare the answer in Item 1 to your indexed monthly earnings.

If the answer from Item 1 is less than or equal to 100% of your indexed monthly earnings, Unum will not further reduce your monthly payment.

If the answer from Item 1 is more than 100% of your indexed monthly earnings, Unum will subtract the amount over 100% from your monthly payment.

After 12 months of payments, while working, you will receive payments based on the percentage of income you are losing due to your disability.

1. Subtract your disability earnings from your indexed monthly earnings.
2. Divide the answer in Item 1 by your indexed monthly earnings. This is your percentage of lost earnings.
3. Multiply your monthly payment by the answer in Item 2.

This is the amount Unum will pay you each month.

Unum may require you to send proof of your monthly disability earnings at least quarterly. We will adjust your payment based on your quarterly disability earnings.

As part of your proof of disability earnings, we can require that you send us appropriate financial records which we believe are necessary to substantiate your income.

After the elimination period, if you are disabled for less than 1 month, we will send you 1/30 of your payment for each day of disability.
HOW CAN WE PROTECT YOU IF YOUR DISABILITY EARNINGS FLUCTUATE?

If your disability earnings routinely fluctuate widely from month to month, Unum may average your disability earnings over the most recent 3 months to determine if your claim should continue.

If Unum averages your disability earnings, we will not terminate your claim unless the average of your disability earnings from the last 3 months exceeds 80% of indexed monthly earnings.

We will not pay you for any month during which disability earnings exceed 80% of indexed monthly earnings.

WHAT ARE DEDUCTIBLE SOURCES OF INCOME?

Unum will subtract from your gross disability payment the following deductible sources of income:

1. The amount that you receive or are entitled to receive under:
   - a workers’ compensation law.
   - an occupational disease law.
   - any other act or law with similar intent.

2. The amount that you receive or are entitled to receive as disability income or disability retirement payments under any:
   - state compulsory benefit act or law.
   - other group insurance plan.
   - governmental retirement system.

3. The amount that you, your spouse and your children receive or are entitled to receive as disability payments because of your disability under:
   - the United States Social Security Act.
   - the Canada Pension Plan.
   - the Quebec Pension Plan.
   - any similar plan or act.

4. The amount that you receive as retirement payments or the amount your spouse and children receive as retirement payments because you are receiving retirement payments under:
   - the United States Social Security Act.
   - the Canada Pension Plan.
   - the Quebec Pension Plan.
   - any similar plan or act.

5. The amount that you receive as retirement payments under any governmental retirement system. Retirement payments do not include payments made at the later of age 62 or normal retirement age under your Employer’s retirement plan which are attributable to contributions you made on a post tax basis to the system.
Regardless of how retirement payments are distributed, Unum will consider payments attributable to your post tax contributions to be distributed throughout your lifetime.

Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Unum will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

6. The amount that you:

- receive as disability payments under your Employer's retirement plan.
- voluntarily elect to receive as retirement payments under your Employer's retirement plan.
- receive as retirement payments when you reach the later of age 62 or normal retirement age, as defined in your Employer's retirement plan.

Disability payments under a retirement plan will be those benefits which are paid due to disability and do not reduce the retirement benefit which would have been paid if the disability had not occurred.

Retirement payments will be those benefits which are based on your Employer's contribution to the retirement plan. Disability benefits which reduce the retirement benefit under the plan will also be considered as a retirement benefit.

Regardless of how the retirement funds from the retirement plan are distributed, Unum will consider your and your Employer's contributions to be distributed simultaneously throughout your lifetime.

Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Unum will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

7. The amount that you receive under Title 46, United States Code Section 688 (The Jones Act).

8. The amount that you receive under the mandatory portion of any "no fault" motor vehicle plan.

9. The amount that you receive under a salary continuation or accumulated sick leave plan.

10. The amount that you receive from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise.

With the exception of retirement payments, Unum will only subtract deductible sources of income which are payable as a result of the same disability.

We will not reduce your payment by your Social Security retirement income if your disability begins after age 65 and you were already receiving Social Security retirement payments.
WHAT ARE NOT DEDUCTIBLE SOURCES OF INCOME?

Unum will not subtract from your gross disability payment income you receive from, but not limited to, the following:

- 401(k) plans
- profit sharing plans
- thrift plans
- tax sheltered annuities
- stock ownership plans
- non-qualified plans of deferred compensation
- pension plans for partners
- military pension and disability income plans
- credit disability insurance
- franchise disability income plans
- a retirement plan from another Employer
- individual retirement accounts (IRA)
- individual disability income plans

WHAT IF SUBTRACTING DEDUCTIBLE SOURCES OF INCOME RESULTS IN A ZERO BENEFIT? (Minimum Benefit)

The minimum monthly payment is the greater of:

- $100; or
- 10% of your gross disability payment.

Unum may apply this amount toward an outstanding overpayment.

WHAT HAPPENS WHEN YOU RECEIVE A COST OF LIVING INCREASE FROM DEDUCTIBLE SOURCES OF INCOME?

Once Unum has subtracted any deductible source of income from your gross disability payment, Unum will not further reduce your payment due to a cost of living increase from that source.

WHAT IF UNUM DETERMINES YOU MAY QUALIFY FOR DEDUCTIBLE INCOME BENEFITS?

When we determine that you may qualify for benefits under Item(s) 1, 2 and 3 in the deductible sources of income section, we will estimate your entitlement to these benefits. We can reduce your payment by the estimated amounts if such benefits:

- have not been awarded; and
- have not been denied; or
- have been denied and the denial is being appealed.

Your Long Term Disability payment will NOT be reduced by the estimated amount if you:

- apply for the disability payments under Item(s) 1, 2 and 3 in the deductible sources of income section and appeal your denial to all administrative levels Unum feels are necessary; and
- sign Unum's payment option form. This form states that you promise to pay us any overpayment caused by an award.

If your payment has been reduced by an estimated amount, your payment will be adjusted when we receive proof:

- of the amount awarded; or
- that benefits have been denied and all appeals Unum feels are necessary have been completed. In this case, a lump sum refund of the estimated amount will be made to you.

If you receive a lump sum payment from any deductible sources of income, the lump sum will be pro-rated on a monthly basis over the time period for which the sum was given. If no time period is stated, we will use a reasonable one.

**HOW LONG WILL UNUM CONTINUE TO SEND YOU PAYMENTS?**

Unum will send you a payment each month up to the **maximum period of payment**. Your maximum period of payment is based on your age at disability as follows:

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<td>1 year</td>
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**WHEN WILL PAYMENTS STOP?**

We will stop sending you payments and your claim will end on the earliest of the following:

- during the first 24 months of payments, when you are able to work in your regular occupation on a **part-time basis** but you do not;
- after 24 months of payments, when you are able to work in any gainful occupation on a part-time basis but you do not;
- if you are working and your monthly disability earnings exceed 80% of your indexed monthly earnings, the date your earnings exceed 80%;
- the end of the maximum period of payment;
- the date you are no longer disabled under the terms of the plan, unless you are eligible to receive benefits under Unum's Rehabilitation and Return to Work Assistance program;
- the date you fail to submit proof of continuing disability;
- after 12 months of payments if you are considered to reside outside the United States or Canada. You will be considered to reside outside these countries when you have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits;
- the date you die.

**WHAT DISABILITIES HAVE A LIMITED PAY PERIOD UNDER YOUR PLAN?**

The lifetime cumulative maximum benefit period for all disabilities due to **mental illness** is 24 months. Only 24 months of benefits will be paid even if the disabilities:

- are not continuous; and/or
- are not related.

Unum will continue to send you payments beyond the 24 month period if you meet one or both of these conditions:

1. If you are confined to a hospital or institution at the end of the 24 month period, Unum will continue to send you payments during your confinement.

   If you are still disabled when you are discharged, Unum will send you payments for a recovery period of up to 90 days.

   If you become reconfined at any time during the recovery period and remain confined for at least 14 days in a row, Unum will send payments during that additional confinement and for one additional recovery period up to 90 more days.

2. In addition to Item 1, if, after the 24 month period for which you have received payments, you continue to be disabled and subsequently become confined to a hospital or institution for at least 14 days in a row, Unum will send payments during the length of the reconfinement.

Unum will not pay beyond the limited pay period as indicated above, or the maximum period of payment, whichever occurs first.

Unum will not apply the mental illness limitation to dementia if it is a result of:

- stroke;
- trauma;
- viral infection;
- Alzheimer’s disease; or
- other conditions not listed which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.

**WHAT DISABILITIES ARE NOT COVERED UNDER YOUR PLAN?**

Your plan does not cover any disabilities caused by, contributed to by, or resulting from your:

- intentionally self-inflicted injuries.
- active participation in a riot.
- loss of a professional license, occupational license or certification.
- attempt to commit or commission of a crime.
- commission of a crime for which you have been convicted.
- pre-existing condition.

Your plan will not cover a disability due to war, declared or undeclared, or any act of war.

Unum will not pay a benefit for any period of disability during which you are incarcerated.
WHAT IS A PRE-EXISTING CONDITION?

You have a pre-existing condition when you apply for coverage when you first become eligible if:

- you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage; and
- the disability begins in the first 12 months after your effective date of coverage unless you have been treatment free for 3 consecutive months after your effective date of coverage.

Note: The pre-existing condition provision does not apply to any employee who has satisfied the pre-existing condition provision under policy number 224888.

WHAT HAPPENS IF YOU RETURN TO WORK FULL TIME WITH THE POLICYHOLDER AND YOUR DISABILITY OCCURS AGAIN?

If you have a recurrent disability, Unum will treat your disability as part of your prior claim and you will not have to complete another elimination period if:

- you were continuously insured under the plan for the period between the end of your prior claim and your recurrent disability; and
- your recurrent disability occurs within 6 months from the end of your prior claim.

Your recurrent disability will be subject to the same terms of the plan as your prior claim and will be treated as a continuation of that disability.

Any disability which occurs after 6 months from the date your prior claim ended will be treated as a new claim. The new claim will be subject to all of the policy provisions, including the elimination period.

If you become entitled to payments under any other group long term disability plan, you will not be eligible for payments under the Unum plan.
LONG TERM DISABILITY

OTHER BENEFIT FEATURES

WHAT BENEFITS WILL BE PROVIDED TO YOU OR YOUR FAMILY IF YOU DIE OR ARE TERMINALLY ILL? (Survivor Benefit)

When Unum receives proof that you have died, we will pay your eligible survivor a lump sum benefit equal to 6 months of your gross disability payment if, on the date of your death:

- your disability had continued for 180 or more consecutive days; and
- you were receiving or were entitled to receive payments under the plan.

If you have no eligible survivors, payment will be made to your estate, unless there is none. In this case, no payment will be made.

However, we will first apply the survivor benefit to any overpayment which may exist on your claim.

You may receive your 6 month survivor benefit prior to your death if you have been diagnosed as terminally ill.

We will pay you a lump sum amount equal to 6 months of your gross disability payment if:

- you have been diagnosed with a terminal illness or condition;
- your life expectancy has been reduced to less than 12 months; and
- you are receiving monthly payments.

Your right to exercise this option and receive payment is subject to the following:

- you must make this election in writing to Unum; and
- your physician must certify in writing that you have a terminal illness or condition and your life expectancy has been reduced to less than 12 months.

This benefit is available to you on a voluntary basis and will only be payable once.

If you elect to receive this benefit prior to your death, no 6 month survivor benefit will be payable upon your death.

WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN YOUR EMPLOYER CHANGES INSURANCE CARRIERS TO UNUM? (Continuity of Coverage)

When the plan becomes effective, Unum will provide coverage for you if:

- you are not in active employment because of a sickness or injury; and
- you were covered by the prior policy.

Your coverage is subject to payment of premium.

Your payment will be limited to the amount that would have been paid by the prior carrier. Unum will reduce your payment by any amount for which your prior carrier is liable.
WHAT IF YOU HAVE A DISABILITY DUE TO A PRE-EXISTING CONDITION WHEN YOUR EMPLOYER CHANGES INSURANCE CARRIERS TO UNUM? (Continuity of Coverage)

Unum may send a payment if your disability results from a pre-existing condition if, you were:

- in active employment and insured under the plan on its effective date; and
- insured by the prior policy at the time of change.

In order to receive a payment you must satisfy the pre-existing condition provision under:

1. the Unum plan; or
2. the prior carrier's plan, if benefits would have been paid had that policy remained in force.

If you do not satisfy Item 1 or 2 above, Unum will not make any payments.

If you satisfy Item 1, we will determine your payments according to the Unum plan provisions.

If you only satisfy Item 2, we will administer your claim according to the Unum plan provisions. However, your payment will be the lesser of:

a. the monthly benefit that would have been payable under the terms of the prior plan if it had remained in force; or
b. the monthly payment under the Unum plan.

Your benefits will end on the earlier of the following dates:

1. the end of the maximum benefit period under the plan; or
2. the date benefits would have ended under the prior plan if it had remained in force.

WHAT INSURANCE IS AVAILABLE IF YOU END EMPLOYMENT? (Conversion)

If you end employment with your Employer, your coverage under the plan will end. You may be eligible to purchase insurance under Unum’s group conversion policy. To be eligible, you must have been insured under your Employer's group plan for at least 12 consecutive months. We will consider the amount of time you were insured under the Unum plan and the plan it replaced, if any.

You must apply for insurance under the conversion policy and pay the first quarterly premium within 31 days after the date your employment ends.

Unum will determine the coverage you will have under the conversion policy. The conversion policy may not be the same coverage we offered you under your Employer's group plan.

You are not eligible to apply for coverage under Unum's group conversion policy if:
- you are or become insured under another group long term disability plan within 31 days after your employment ends;
- you are disabled under the terms of the plan;
- you recover from a disability and do not return to work for your Employer;
- you are on a leave of absence; or
- your coverage under the plan ends for any of the following reasons:
  • the plan is cancelled;
  • the plan is changed to exclude the group of employees to which you belong;
  • you are no longer in an eligible group;
  • you end your working career or retire and receive payment from any Employer's retirement plan; or
  • you fail to pay the required premium under this plan.

**WILL UNUM CONTINUE YOUR CONTRIBUTION TO YOUR PENSION PLAN IF YOU ARE DISABLED? (Retirement Income Protection)**

If you are receiving disability payments and have been a participant in the pension plan, we will pay your Employer or designee an extra benefit to be deposited into the plan on your behalf.

We will pay your Employer or its designee 10% of your monthly earnings, not to exceed the maximum allowable by law.

If you are disabled and working and your monthly disability earnings are from 20% through 80% of your indexed monthly earnings, the benefit will be based on the percentage of income you are losing due to your disability according to the following steps.

1. Subtract your disability earnings from your indexed monthly earnings;
2. Divide the answer in Step 1 by your indexed monthly earnings. This is your percentage of lost earnings.
3. Multiply your extra monthly benefit by the percentage of lost earnings calculated in Step 2.

This is the amount payable to your Employer or its designee for contribution into your Pension plan or, if the plan can not accept contributions for you, into a flexible premium deferred annuity that is established and maintained by you.

**HOW CAN UNUM’S REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM HELP YOU RETURN TO WORK?**

Unum has a vocational Rehabilitation and Return to Work Assistance program available to assist you in returning to work. We will determine whether you are eligible for this program, at our sole discretion. In order to be eligible for rehabilitation services and benefits, you must be medically able to engage in a return to work program.

Your claim file will be reviewed by one of Unum’s rehabilitation professionals to determine if a rehabilitation program might help you return to gainful employment. As your file is reviewed, medical and vocational information will be analyzed to determine an appropriate return to work program.

We will make the final determination of your eligibility for participation in the program.
We will provide you with a written Rehabilitation and Return to Work Assistance plan developed specifically for you.

The rehabilitation program may include at our sole discretion, but is not limited to, the following services and benefits:

- coordination with your Employer to assist you to return to work;
- adaptive equipment or job accommodations to allow you to work;
- vocational evaluation to determine how your disability may impact your employment options;
- job placement services;
- resume preparation;
- job seeking skills training; or
- education and retraining expenses for a new occupation.

**WHAT ADDITIONAL BENEFITS WILL UNUM PAY WHILE YOU PARTICIPATE IN A REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM?**

We will pay an additional disability benefit of 10% of your gross disability payment to a maximum benefit of $1,000 per month.

This benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount such as Deductible Sources of Income. However, the Total Benefit Cap will apply.

In addition, we will make monthly payments to you for 3 months following the date your disability ends if we determine you are no longer disabled while:

- you are participating in the Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

This benefit payment may be paid in a lump sum.

**WHEN WILL REHABILITATION AND RETURN TO WORK ASSISTANCE BENEFITS END?**

Benefits for the Rehabilitation and Return to Work Assistance program will end on the earliest of the following dates:

- the date Unum determines that you are no longer eligible to participate in Unum's Rehabilitation and Return to Work Assistance program; or
- any other date on which monthly payments would stop in accordance with this plan.

**WHAT ADDITIONAL BENEFIT IS AVAILABLE FOR DEPENDENT CARE EXPENSES TO ENABLE YOU TO PARTICIPATE IN UNUM'S REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM?**

While you are participating in Unum's Rehabilitation and Return to Work Assistance program, we will pay a Dependent Care Expense Benefit when you are disabled and you:
1. are incurring expenses to provide care for a child under the age of 15; and/or
2. start incurring expenses to provide care for a child age 15 or older or a family member who needs personal care assistance.

The payment of the Dependent Care Expense Benefit will begin immediately after you start Unum's Rehabilitation and Return to Work Assistance program.

Our payment of the Dependent Care Expense Benefit will:

1. be $400 per month, per dependent; and
2. not exceed $1,000 per month for all dependent care expenses combined.

To receive this benefit, you must provide satisfactory proof that you are incurring expenses that entitle you to the Dependent Care Expense Benefit.

Dependent Care Expense Benefits will end on the earlier of the following:

1. the date you are no longer incurring expenses for your dependent;
2. the date you no longer participate in Unum's Rehabilitation and Return to Work Assistance program; or
3. any other date payments would stop in accordance with this plan.
OTHER SERVICES

These services are also available from us as part of your Unum Long Term Disability plan.

**HOW CAN UNUM HELP YOUR EMPLOYER IDENTIFY AND PROVIDE WORKSITE MODIFICATION?**

A worksite modification might be what is needed to allow you to perform the material and substantial duties of your regular occupation with your Employer. One of our designated professionals will assist you and your Employer to identify a modification we agree is likely to help you remain at work or return to work. This agreement will be in writing and must be signed by you, your Employer and Unum.

When this occurs, Unum will reimburse your Employer for the cost of the modification, up to the greater of:

- $1,000; or
- the equivalent of 2 months of your monthly benefit.

This benefit is available to you on a one time only basis.

**HOW CAN UNUM’S SOCIAL SECURITY CLAIMANT ADVOCACY PROGRAM ASSIST YOU WITH OBTAINING SOCIAL SECURITY DISABILITY BENEFITS?**

In order to be eligible for assistance from Unum’s Social Security claimant advocacy program, you must be receiving monthly payments from us. Unum can provide expert advice regarding your claim and assist you with your application or appeal.

Receiving Social Security benefits may enable:

- you to receive Medicare after 24 months of disability payments;
- you to protect your retirement benefits; and
- your family to be eligible for Social Security benefits.

We can assist you in obtaining Social Security disability benefits by:

- helping you find appropriate legal representation;
- obtaining medical and vocational evidence; and
- reimbursing pre-approved case management expenses.
GLOSSARY

ACCUMULATION PERIOD means the period of time from the date disability begins during which you must satisfy the elimination period.

ACTIVE EMPLOYMENT means you are working for your Employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under Eligible Group(s) in each plan.

Your work site must be:

- your Employer's usual place of business;
- an alternative work site at the direction of your Employer, including your home; or
- a location to which your job requires you to travel.

Normal vacation is considered active employment. Temporary and seasonal workers are excluded from coverage.

ANNUAL ENROLLMENT PERIOD means a period of time before the beginning of each plan year.

DEDUCTIBLE SOURCES OF INCOME means income from deductible sources listed in the plan which you receive or are entitled to receive while you are disabled. This income will be subtracted from your gross disability payment.

DEPENDENT means:

- your child(ren) under the age of 15; and
- your child(ren) age 15 or over or a family member who requires personal care assistance.

DISABILITY EARNINGS means the earnings which you receive while you are disabled and working, plus the earnings you could receive if you were working to your maximum capacity.

ELIMINATION PERIOD means a period of continuous disability which must be satisfied before you are eligible to receive benefits from Unum.

EMPLOYEE means a person who is in active employment in the United States with the Employer.

EMPLOYER means the Policyholder, and includes any division, subsidiary or affiliated company named in the policy.

GAINFUL OCCUPATION means an occupation that is or can be expected to provide you with an income at least equal to 80% of your indexed monthly earnings within 12 months of your return to work.

GOVERNMENTAL RETIREMENT SYSTEM means a plan which is part of any federal, state, county, municipal or association retirement system, including but not limited to, a state teachers retirement system, public employees retirement system or other similar retirement system for state or local government employees providing for the payment of retirement and/or disability benefits to individuals.
GRACE PERIOD means the period of time following the premium due date during which premium payment may be made.

GROSS DISABILITY PAYMENT means the benefit amount before Unum subtracts deductible sources of income and disability earnings.

HOSPITAL OR INSTITUTION means an accredited facility licensed to provide care and treatment for the condition causing your disability.

INDEXED MONTHLY EARNINGS means your monthly earnings adjusted on each anniversary of benefit payments by the lesser of 10% or the current annual percentage increase in the Consumer Price Index. Your indexed monthly earnings may increase or remain the same, but will never decrease.

The Consumer Price Index (CPI-U) is published by the U.S. Department of Labor. Unum reserves the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-U.

Indexing is only used as a factor in the determination of the percentage of lost earnings while you are disabled and working and in the determination of gainful occupation.

INJURY means a bodily injury that is the direct result of an accident and not related to any other cause. Disability must begin while you are covered under the plan.

INSURED means any person covered under a plan.

LAW, PLAN OR ACT means the original enactments of the law, plan or act and all amendments.

LAYOFF or LEAVE OF ABSENCE means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by your Employer.

Your normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

LIMITED means what you cannot or are unable to do.

MATERIAL AND SUBSTANTIAL DUTIES means duties that:
- are normally required for the performance of your regular occupation; and
- cannot be reasonably omitted or modified.

MAXIMUM CAPACITY means, based on your restrictions and limitations:
- during the first 24 months of disability, the greatest extent of work you are able to do in your regular occupation, that is reasonably available.
- beyond 24 months of disability, the greatest extent of work you are able to do in any occupation, that is reasonably available, for which you are reasonably fitted by education, training or experience.

MAXIMUM PERIOD OF PAYMENT means the longest period of time Unum will make payments to you for any one period of disability.
MENTAL ILLNESS means a psychiatric or psychological condition classified in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM), published by the American Psychiatric Association, most current as of the start of a disability. Such disorders include, but are not limited to, psychotic, emotional or behavioral disorders, or disorders relatable to stress. If the DSM is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the American Psychiatric Association as of the start of a disability.

MONTHLY BENEFIT means the total benefit amount for which an employee is insured under this plan subject to the maximum benefit.

MONTHLY EARNINGS means your gross monthly income from your Employer as defined in the plan.

MONTHLY PAYMENT means your payment after any deductible sources of income have been subtracted from your gross disability payment.

PART-TIME BASIS means the ability to work and earn between 20% and 80% of your indexed monthly earnings.

PAYABLE CLAIM means a claim for which Unum is liable under the terms of the policy.

PENSION PLAN means a plan which provides retirement benefits and which is not wholly funded by employee contributions. The term shall not include a profit sharing plan, a thrift plan, an individual retirement account (IRA), a tax sheltered annuity (TSA), a stock ownership plan or a non-qualified plan of deferred compensation.

PHYSICIAN means:
- a person performing tasks that are within the limits of his or her medical license; and
- a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

Unum will not recognize you, or your spouse, children, parents or siblings as a physician for a claim that you send to us.

PLAN means a line of coverage under the policy.

PRE-EXISTING CONDITION means a condition for which you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines for your condition during the given period of time as stated in the plan.

RECURRENT DISABILITY means a disability which is:
- caused by a worsening in your condition; and
- due to the same cause(s) as your prior disability for which Unum made a Long Term Disability payment.
REGULAR CARE means:

- you personally visit a physician as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- you are receiving the most appropriate treatment and care which conforms with generally accepted medical standards, for your disabling condition(s) by a physician whose specialty or experience is the most appropriate for your disabling condition(s), according to generally accepted medical standards.

REGULAR OCCUPATION means the occupation you are routinely performing when your disability begins. Unum will look at your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer or at a specific location.

RETIREMENT PLAN means a defined contribution plan or defined benefit plan. These are plans which provide retirement benefits to employees and are not funded entirely by employee contributions. Retirement Plan does not include any plan which is part of any governmental retirement system.

SALARY CONTINUATION OR ACCUMULATED SICK LEAVE means continued payments to you by your Employer of all or part of your monthly earnings, after you become disabled as defined by the Policy. This continued payment must be part of an established plan maintained by your Employer for the benefit of all employees covered under the Policy. Salary continuation or accumulated sick leave does not include compensation paid to you by your Employer for work you actually perform after your disability begins. Such compensation is considered disability earnings, and would be taken into account in calculating your monthly payment.

SICKNESS means an illness or disease. Disability must begin while you are covered under the plan.

SURVIVOR, ELIGIBLE means your spouse, if living; otherwise your children under age 25 equally.

TREATMENT FREE means you have not received medical treatment, consultation, care or services including diagnostic measures, or taken prescribed drugs or medicines for the pre-existing condition.

WAITING PERIOD means the continuous period of time (shown in each plan) that you must be in active employment in an eligible group before you are eligible for coverage under a plan.


YOU means an employee who is eligible for Unum coverage.
ERISA

Additional Summary Plan Description Information

If the policy provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. These provisions, together with your certificate of coverage, constitute the summary plan description. The summary plan description and the policy constitute the Plan. Benefit determinations are controlled exclusively by the policy, your certificate of coverage and the information contained in this document.

Name of Plan:
Group Long Term Disability Plan for Vanderbilt University Medical Center

Name and Address of Employer:
Vanderbilt University Medical Center
Attn: Benefits Administration
2525 West End, 5th Floor
Nashville, Tennessee
37203

Plan Identification Number:
a. Employer IRS Identification #: 35-2528741
b. Plan #: 509

Type of Welfare Plan:
Disability Income

Type of Administration:
The Plan is administered by the Plan Administrator. Benefits are administered by the insurer and provided in accordance with the insurance policy issued to the Plan.

ERISA Plan Year Ends:
December 31

Plan Administrator, Name, Address, and Telephone Number:
Vanderbilt University Medical Center
Attn: Chief Human Resources Officer
2525 West End, 5th Floor
Nashville, Tennessee
37203
(615) 343-7000

Vanderbilt University Medical Center is the Plan Administrator and named fiduciary of the Plan, with authority to delegate its duties. The Plan Administrator may designate Trustees of the Plan, in which case the Administrator will advise you separately of the name, title and address of each Trustee.

Agent for Service of Legal Process on the Plan:
Vanderbilt University Medical Center
Attn: Chief Human Resources Officer
Service of legal process may also be made upon the Plan Administrator, or a Trustee of the Plan, if any.

**Funding and Contributions:**
The Plan is funded by insurance issued by Unum Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122 (hereinafter referred to as "Unum") under policy number 410297 011. Contributions to the Plan are made as stated under "WHO PAYS FOR THE COVERAGE" in the Certificate of Coverage.

**EMPLOYER'S RIGHT TO AMEND THE PLAN**
The Employer reserves the right, in its sole and absolute discretion, to amend, modify, or terminate, in whole or in part, any or all of the provisions of the Plan (including any related documents and underlying policies), at any time and for any reason or no reason. Any amendment, modification, or termination must be in writing and endorsed on or attached to the Plan.

**EMPLOYER'S RIGHT TO REQUEST POLICY CHANGE**
The Employer can request a policy change. Only an officer or registrar of Unum can approve a change. The change must be in writing and endorsed on or attached to the policy.

**MODIFYING OR CANCELLING THE POLICY OR A PLAN UNDER THE POLICY**
The policy or a plan under the policy can be cancelled:

- by Unum; or
- by the Employer.

Unum may cancel or modify the policy or a plan if:

- there is less than 25% participation of those eligible employees who pay all or part of their premium for a plan; or
- there is less than 100% participation of those eligible employees for an Employer paid plan;
- the Employer does not promptly provide Unum with information that is reasonably required;
- the Employer fails to perform any of its obligations that relate to the policy;
- fewer than 25 employees are insured under a plan;
- the premium is not paid in accordance with the provisions of the policy that specify whether the Employer, the employee, or both, pay(s) the premiums;
- the Employer does not promptly report to Unum the names of any employees who are added or deleted from the eligible group;
- Unum determines that there is a significant change, in the size, occupation or age of the eligible group as a result of a corporate transaction such as a merger, divestiture, acquisition, sale, or reorganization of the Employer and/or its employees; or
- the Employer fails to pay any portion of the premium within the 45 day grace period.

If Unum cancels or modifies the policy or a plan for reasons other than the Employer's failure to pay premium, a written notice will be delivered to the Employer at least 31 days prior to the cancellation date or modification date. The Employer may cancel the policy or a plan if the modifications are unacceptable.

Unum also reserves the right to set a participation requirement for each coverage option under a plan and to cancel an option if the participation requirement is not met.

If any portion of the premium is not paid during the grace period, Unum will either cancel or modify the policy or plan automatically at the end of the grace period. The Employer is liable for premium for coverage during the grace period. The Employer must pay Unum all premium due for the full period each plan is in force.

The Employer may cancel the policy or a plan by written notice delivered to Unum at least 31 days prior to the cancellation date. When both the Employer and Unum agree, the policy or a plan can be cancelled on an earlier date. If Unum or the Employer cancels the policy or a plan, coverage will end at 12:00 midnight on the last day of coverage.

If the policy or a plan is cancelled, the cancellation will not affect a payable claim.

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. To complete your claim filing, Unum must receive the claim information it requests from you (or your authorized representative), your attending physician and your Employer. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Unum directly.

CLAIMS PROCEDURES

Unum will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if Unum both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you of the circumstances requiring the extension of time and the date by which Unum expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30 day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your claim without that information.

If your claim for benefits is wholly or partially denied, the notice of adverse benefit determination under the Plan will:

- state the specific reason(s) for the determination;
- reference specific Plan provision(s) on which the determination is based;

- describe additional material or information necessary to complete the claim and why such information is necessary;

- describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal; and

- disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

**APPEAL PROCEDURES**

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If Unum determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). Unum will notify you in writing if an additional 45 day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45 day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by Unum and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, Unum will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of your claim, Unum will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:
- the specific reason(s) for the determination;

- a reference to the specific Plan provision(s) on which the determination is based;

- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);

- a statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision;

- the statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and

- the statement that "You or your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency".

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

YOUR RIGHTS UNDER ERISA

As a participant in 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, all documents governing the Plan, including insurance contracts, 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 Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, 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.
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 or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or 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, if, for example, 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 Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security 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.

OTHER RIGHTS

Unum, for itself and as claims fiduciary for the Plan, is entitled to legal and equitable relief to enforce its right to recover any benefit overpayments caused by your receipt of disability earnings or deductible sources of income from a third party. This right of recovery is enforceable even if the amount you receive from the third party is less than the actual loss suffered by you but will not exceed the benefits paid you under the policy. Unum and the Plan have an equitable lien over such sources of income until any benefit overpayments have been recovered in full.
DISCRETIONARY ACTS

The Plan, acting through the Plan Administrator, delegates to Unum and its affiliate Unum Group discretionary authority to make benefit determinations under the Plan. Unum and Unum Group may act directly or through their employees and agents or further delegate their authority through contracts, letters or other documentation or procedures to other affiliates, persons or entities. Benefit determinations include determining eligibility for benefits and the amount of any benefits, resolving factual disputes, and interpreting and enforcing the provisions of the Plan. All benefit determinations must be reasonable and based on the terms of the Plan and the facts and circumstances of each claim.

Once you are deemed to have exhausted your appeal rights under the Plan, you have the right to seek court review under Section 502(a) of ERISA of any benefit determinations with which you disagree. The court will determine the standard of review it will apply in evaluating those decisions.
Residents of Tennessee who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in the state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers’ care in selecting companies that are well-managed and financially stable.

The state law that provides for this safety-net coverage is called the Tennessee Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law or describe all of the conditions and limitations relating to coverage. This summary does not in any way change anyone’s rights or obligations under the act or the rights or obligations of the Guaranty Association.

**COVERAGE**

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer authorized to conduct business in Tennessee. Health insurance includes disability and long term care policies. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

**EXCLUSIONS FROM COVERAGE**

However, persons holding such policies are not protected by this Guaranty Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contractholder;
- employers’ plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Guaranty Association is obligated to pay out. The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. For any one insured life, the Guaranty Association guarantees payments up to a stated maximum no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. These aggregate limits per life are as follows:

- $300,000 for policies and contracts of all types, except as described in the next point
- $500,000 for basic hospital, medical and surgical insurance and major medical insurance issued by companies that become insolvent after January 1, 2010.

Within these overall limits, the Guaranty Association cannot guarantee payment of benefit greater than the following:

- life insurance death benefits - $300,000
- life insurance cash surrender value - $100,000
- present value of annuity benefits for companies insolvent before July 1, 2009 - $100,000
- present value of annuity benefits for companies insolvent after June 30, 2009 - $250,000
- health insurance benefits for companies declared insolvent before January 1, 2010 - $100,000
- health insurance benefits for companies declared insolvent on or after January 1, 2010:
  - $100,000 for limited benefits and supplemental health coverages
  - $300,000 for disability and long term care insurance
  - $500,000 for basic hospital, medical and surgical insurance or major medical insurance

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The Tennessee Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Tennessee. You should not rely on coverage by the Tennessee Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is **NOT** provided for your policy or any portion of it that is not guaranteed by the insurer for which you have assumed the risk, such as a variable contract sold by prospectus.
Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Tennessee Life and Health Insurance Guaranty Association
1200 One Nashville Place
150 4th Avenue North
Nashville, Tennessee 37219

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, Tennessee 37243
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)


ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 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.

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）。

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

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MELLOHIYA: اگر بیان فارسی انجام می‌دهید، خدمات بهداشت و بهداشت نامحدود را که آن را به قابلیت کامل لرک فکری، اتصال برقرار کرده‌ایم: 1-615-322-7378 (TTY: 711).


注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。1-615-322-7378（TTY: 711）まで、お電話にてご連絡ください。


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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.

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