

# Summary Plan Description Emory Traditional Dental Plan

EMORY



*Effective as of January 1, 2018*

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The purpose of this Summary Plan Description (“SPD”) is to provide you with a summary of your Benefits and other important information under the Traditional Dental Plan. Claims under this plan are administered by Aetna. This is one of the dental plan options available in the Emory University Dental Plan (The “Plan”).

## **Important Notice**

The Traditional Dental Plan is established by Emory voluntarily and may be amended or terminated at any time by Emory, in its sole discretion. Amendments may, among other things, affect eligibility, contribution rates, benefits coverage, reimbursement rates, procedures, participation, etc., at any time, regardless of whether the individual is participating in the benefit plans at the time of amendment, and even after an individual retires. The Plan Administrator has the discretionary authority to interpret the provisions of the Plan and SPD, and its decisions are final and binding. Nothing in the SPD or the Plan gives, or is intended to give any person the right to be retained in Emory’s employment or to interfere with Emory’s right to terminate the employment of any person.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires employer dental plans to maintain the privacy of your dental information and to provide you with a notice of the Plan’s legal duties and privacy practices with respect to your dental information. The notice will describe how the Plan may use or disclose your dental information and under what circumstances it may share your dental information without your authorization (generally, to carry out treatment, payment or dental care operations). In addition, the notice will describe your rights with respect to your dental information. Refer to the Plan’s privacy notice for more information. You can obtain a copy of the notice by contacting the Emory University Benefits Department at 404-727-7613.

It is Emory’s policy and intent to comply with all applicable provisions of HIPAA and the related regulations. Emory will investigate fully any complaint that it or the Plan has not complied with such laws and regulations and will take steps to remedy any violations should they occur. If you believe that the Plan has violated a provision of HIPAA, you are encouraged to share your complaint with Emory by contacting the Emory University Benefits Department at 404-727-7613. Emory will not retaliate or otherwise discriminate against you if you assert a complaint or take any other action which is protected under HIPAA.

Effective Date: January 1, 2018

## **Eligibility**

### **Employees**

Your eligibility date, if you are then in an Eligible Class, is the effective date of this Plan. Otherwise, it is the date you start working for Emory or, if later, the date you enter the eligible class. You are in an Eligible Class for coverage under this Plan if you are:

- A regular full-time or half-time (at least 20 hours per week) employee of Emory.
- A temporary full-time employee on an assignment at Emory University scheduled for at least six consecutive months.
- An Emory retiree who has returned to work at least half-time (at least 20 hours per week).
- An Emory retiree who satisfies the eligibility requirement in effect on the date of his or her retirement or during Annual Enrollment, and who is notified by the Plan Administrator of his or her eligibility to enroll in retiree dental benefits.

Individuals classified in Emory's sole discretion as part-time temporary employees or full-time temporary employees scheduled to work less than six consecutive months, are not in an Eligible Class and are not eligible to participate in the Plan.

### **Dependents**

If you elect coverage, your dependents may also be eligible for coverage. Eligible dependents include:

#### **Your Legal Spouse**

Spouse includes your opposite sex or same sex spouse. This does not include registered domestic partnerships, civil unions or similar formal relationships recognized under state law.

#### **Your Child**

Child includes your natural or adopted child. Also a child in the process of being adopted, step-child or any child for whom you have legal custody.

A child is eligible:

- Up to age 26; or
- Regardless of age, if fully disabled and unmarried, provided he or she became fully disabled either:
  - Prior to age 19; or
  - Between the ages of 19 and 26, if that child was covered by the Plan when the disability occurred.

Your child is fully disabled if:

- He or she is not able to earn his or her own living because of mental or physical disability which started prior to the date he or she reached the maximum age for dependent children; and

- He or she depends chiefly on you for financial support and maintenance.

Proof that your child is fully disabled must be submitted to Aetna no later than 31 days after the date your child reaches the maximum age for eligibility (or within 31 days of your employment, if later).

Coverage for a fully disabled child will cease on the first to occur of:

- Cessation of the disability;
- Failure to provide proof to the Plan Administrator that the disability continues;
- Failure to have any exam required by the Plan Administrator; or
- Termination of dependent child coverage for any reason other than reaching the maximum age for eligibility.

Emory will have the right to require proof of the continuation of the disability. Emory also has the right to have your child examined as often as needed while the disability continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age for dependent coverage.

### **Your Surviving Spouse and/or Child(ren)**

#### **Emory University**

The spouse may continue to participate in the dental plan at the active employee rate to age 65, if an employee dies and has at least 10 years of service and is at least 55 years old. If the employee was eligible to retire with dental benefits, the spouse may remain on the active employee plan until age 65 and then may continue coverage by paying the retiree rate. Children may remain on the plan until age 26. Only eligible dependents covered prior to the employee's death may continue coverage.

If upon death, an employee does not meet the 10 years of service and 55 years of age eligibility criteria, the spouse and/or child(ren) may continue to participate in the dental plan under COBRA. Emory will subsidize the COBRA premium for six months.

#### **Emory Healthcare**

If an employee dies and at time of death met the grandfathered retiree benefits eligibility rules listed below, the covered spouse and child(ren) may enroll for the retiree dental plan. Children may remain on the plan until age 26 unless disabled (see eligibility for Children). If covered spouse and child(ren) do not enroll in the dental plan at time of employee's death, they may enroll during the next Annual Benefits Enrollment period for coverage effective January 1 of the New Year.

If upon death, an employee does not meet the grandfathered retiree benefits eligibility rules then the spouse and/or child(ren) may continue to participate in the dental plan under COBRA.

#### **Retiree Dental Eligibility Rules for Emory Healthcare Employees**

To be eligible for the grandfathered retiree dental plan an employee (and covered dependents) must be enrolled at the time of retirement and meet the following criteria:

- Employed at Emory University Hospital or Emory University Hospital Midtown on the payroll in a benefits eligible position prior to January 1, 2003;
- Minimum 55 years of age;
- 10 or more years of consecutive benefits eligible service;
- Meet "Rule of 75", defined as current age + years of service equals at least 75 years; and

- No breaks in benefits eligible service since December 31, 2002.

If a retiree-dental-eligible employee resigns from EHC or moves to a PRN, Registry or part-time position that is non-benefits-eligible, the employee will lose his/her eligibility for the EHC retiree dental plan.

### **Retiree Dental Coverage for Emory Clinic Staff**

To be eligible for retiree dental coverage, you must be enrolled at the time of retirement and meet the following criteria:

- Employed at Emory Clinic on the payroll in benefits-eligible position prior to July 1, 1983;
- Minimum 55 years of age;
- 20 or more years of consecutive benefits-eligible service, or at least 60 years of age with 15 or more consecutive years of benefits-eligible service;
- Meet “Rule of 75,” defined as current age + years of service = at least 75 years; and
- No breaks in benefits-eligible service since July 1, 1983.

If a retiree-dental-eligible employee resigns from EHC or moves to a PRN, Registry or part-time position that is non-benefits-eligible, the employee will lose his/her eligibility for the EHC retiree dental plan.

### **Retiree and Covered Participants**

Enrollees who are in an eligible retiree class [including their child(ren) and/or spouses] may elect to continue dental coverage under the Traditional Dental Plan. A retiree enrolled in dental coverage, who marries mid-year, may add a spouse within 31 days of the family status change. However, the retiree and/or spouse/surviving spouse of such retiree, who is not enrolled in dental coverage at the time of retirement, will not be able to enroll until the next annual enrollment period. Eligible child(ren) may remain covered under the plan until age 26.

***Important Note:*** *No person may be covered both as an employee and dependent of another employee and no person may be covered as a dependent of more than one employee of Emory.*

### **Enrolling Ineligible Individuals**

It is your responsibility to report a change in a spouse’s or dependent’s eligibility. Premiums paid in error due to your delay in reporting a change in eligibility will not be refunded. If the wrong birth date of a child is entered on an application, the child has no coverage for the period for which he or she is not legally eligible. Your and your dependents’ Plan coverage may also be terminated or suspended for engaging in misrepresentation or fraud against the Plan, including filing or participating in filing a false, misleading or fraudulent claim for benefits, allowing your ID card to be used by an individual who is not enrolled in the Plan, providing false or misleading information regarding a spouse or dependent, enrolling an individual who does not satisfy the eligibility criteria or failing to timely drop an enrolled individual when he/she no longer satisfies the eligibility criteria.

Emory reserves the right to audit at any time the status of your enrolled spouse and dependent children to determine if they meet the eligibility criteria. During an audit, you may be required to provide proof of eligibility. If you cannot provide sufficient proof that an enrolled individual meets the eligibility criteria, he/she will be dis-enrolled from the Plan, possibly retroactively.

If Emory determines that misrepresentation has occurred, it may also terminate or suspend your coverage, require repayment of the ineligible individual's prior claims, require payment of the total value of the ineligible individual's coverage or take other corrective action.

If you or a dependent has been classified by Emory as ineligible and you or your dependent are reclassified into an eligible class, either by an action of the employer, Plan Administrator, or a governmental or judicial authority, you or your dependent will be eligible to participate only prospectively following such reclassification, assuming all other eligibility requirements are met.

## **Enrollment Procedure**

Enrolling is easy and available 24 hours a day via Employee Self-Service or e-Vantage through your employer's homepage. You must enroll within 31 days of your eligibility date. If you miss the enrollment period, you will not be able to enroll in the plan until the next annual enrollment period, unless you qualify under a Family Status Change or a Special Enrollment Period, as described below. Elections made during annual enrollment are effective the following January 1.

You and Emory share the cost of your dental coverage. Unless you are a retiree, by electing coverage under the Plan, you are also electing to have your contributions deducted from your pay on a pre-tax basis through the cafeteria plan. If the cost of coverage changes, your deductions will be automatically adjusted accordingly. Contributions depend on the coverage you choose. You will receive information on your contributions when you enroll via Employee Self Service or e-Vantage.

## **Annual Enrollment**

Once you enroll for coverage under this Plan, the coverage will remain in effect unless you make a change during annual enrollment or you have a family status change or other special enrollment right which would allow you to change your coverage as described below. Changes made during annual enrollment will be effective January 1 of the year following the enrollment.

## **Family Status Changes**

A family status change is an event that may allow you to change your election for this Plan. If one of the situations below applies, you may enroll within 31 days of the event. If you do not enroll within 31 days of the event, you will not be able to enroll until the next annual enrollment period. Family status changes include:

- Your marriage, divorce, or annulment;
- Birth of your child;
- Placement with you of a foster child or child for adoption;
- A change in the employment of your spouse or dependent, which affects his or her benefits eligibility, including termination or commencement of employment or a change in worksite;
- An event that would make a dependent child no longer eligible for coverage, such as his or her 26<sup>th</sup> birthday; or
- The death of your dependent.

## **Special Enrollment**

If one of the situations below applies, you may enroll yourself and/or your eligible dependents within 31 days of the event. If you do not enroll within 31 days of the event, you will be not able to enroll until the next annual enrollment period.

## **Loss of Other Health Care Coverage**

You or your dependents may qualify for a special enrollment period if you did not enroll yourself or your dependent when you first became eligible or during any subsequent annual enrollments because, at that time you or your dependents were covered under other creditable coverage. You may enroll within 31 days of losing other creditable coverage because of one of the following:

- Termination of the Plan;
- Loss of eligibility under the Plan;
- Death, divorce or legal separation; or
- COBRA coverage period ends.

## **Other Events Which May Entitle You to Mid-Year Changes**

In addition to the family status changes and special enrollment rights mentioned above you may also have the right to change your coverage within 31 days of the event if one of the following events occurs:

- The employer sponsored cafeteria plan or benefit plan in which your spouse or dependent participates has a different period of coverage than this Plan and your spouse or dependent makes coverage changes under his or her plan based on that coverage period; spouse or dependents effective when their new coverage election takes effect.
- A new dental benefit option is added and you want to switch to the new option.
- There is a significant increase in the cost of coverage for the option you have selected and you wish to switch to another option for the remainder of the year.
- If you have a new dependent as a result of marriage, birth, adoption or placement for adoption you also have a special enrollment right and you may be able to enroll yourself and your dependents in the Plan.

If you have a family status change, special enrollment right or another event that entitles you to make mid-year changes, you have 31 days from the date of the event to change your coverage. By creating a family status change, you are certifying the event and the event date. In addition, your changes must be consistent with your changes in family status or special enrollment right or other event. For example, if you are married and elect family coverage that covers your spouse and your only child, and your child turns 26 and no longer qualifies as a dependent, you may change your coverage to employee and spouse, but not to employee only or no coverage.

## **Effective Date of Coverage**

### **Employees**

Your coverage will take effect on the later to occur of:

- Your date of hire (if you are eligible right away); or
- The date you became eligible (for example, if you worked fewer than 20 hours per week and transfer to a position in which you work at least 20 hours per week).

If you do not elect coverage within 31 days of your eligibility date, you will not be eligible to enroll in coverage until the next annual enrollment period unless you have a family status change or another event that entitles you to make a mid-year change.

## Dependents

Coverage for your dependents will take effect on your eligibility date if you have properly enrolled each such dependent within 31 days from your eligibility event. You must report any new dependents, and provide the required information in a timely manner, for that dependent to be covered, even if it does not affect your required contributions for coverage. If you do not enroll dependents within 31 days of any dependent's eligibility date, you will not be able to enroll them until the next annual enrollment period unless there is a family status change or other event that entitles you to make a mid-year change.

## Child Who Must Be Covered Due to a Qualified Medical Child Support Order (QMCSO)

Emory will extend group dental benefits to an employee's non-custodial child(ren) as required by a qualified medical child support order. Dependent coverage will become effective as soon as administratively possible. ***Important Note:*** As legally defined, upon receipt of a qualified order, Emory will enroll a non-custodial child(ren) and the employee (if not enrolled) without employee consent.

## Termination of Coverage

Your current coverage under the Plan will end on the last day of the month in which one of the following events occurs:

- You are no longer employed by Emory (unless you qualify and enroll as a retiree, and make the required payments);
- You discontinue paying for coverage under COBRA;
- Your eligibility for coverage under COBRA ends;
- You lose your eligibility under the Plan; or
- You stop paying for your coverage.

Your dependent's coverage will end on the last day of the month that:

- Your coverage ends and dependent coverage is not available under COBRA, or your dependent elects not to continue coverage;
- Your dependent discontinues payments for coverage under COBRA;
- You die and your dependent does not elect coverage under COBRA or is not eligible for coverage under COBRA;
- Your dependent loses his or her eligibility under the Plan and does not elect coverage under COBRA or is not eligible for coverage under COBRA; or
- Your dependent's eligibility for coverage under COBRA ends.

**Note:** If you stop making contributions, your coverage will end on the last day of the month for which a full contribution was credited.

## Dental Benefits Chart

	In-Network	Out-of-Network <sup>1</sup>
<b>Preventive Services</b> (routine and deep cleanings, X-rays, sealant, etc.)	\$0	\$0
<b>Basic Services</b> (filling, root canal, etc.)	10% After Deductible	20% After Deductible
<b>Major Restorative</b> (crown, bridge, etc.)	50% After Deductible	50% After Deductible
<b>Calendar Year Deductible<sup>2</sup></b>	\$50/person \$150/family	\$50/person \$150/family
<b>Annual Maximums</b>	\$1,500/person	\$1,500/person
<b>Orthodontia</b> Deductible Co-insurance Lifetime Maximum	None 50% \$1,500	None 50% \$1,500

<sup>1</sup> R&C applies, refer to the Definitions section

<sup>2</sup> Waived for Preventive Services

## Your Dental Benefits

This Plan will pay Benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no Benefits are payable for expenses incurred before coverage has commenced or after coverage has terminated; even if the expenses were incurred as a result of an accident, injury, or disease which occurred, commenced, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

When a single charge is made for a series of services, each service will bear a pro rata share of the expense. The pro rata share will be determined by the Claims Administrator. Only the pro rata share of the expense will be considered to have been an expense incurred on the date of such service.

Although a specific service may be listed as a covered expense, it may not be covered unless it is necessary for the prevention, diagnosis or treatment of a dental condition. There are exclusions, deductible and co-insurance features, and stated maximum benefit amounts.

All maximums included in this Plan are combined maximums between In-Network and Out-of-Network, where applicable, unless specifically stated otherwise.

## Provider Networks

To obtain a listing of network providers:

- Call Aetna Member services at (877) 238-6200
- Log-on to Aetna Navigator at <http://www.aetna.com/docfind/custom/emory>

In-Network Providers give you the maximum benefit available under the Plan. Out-of-Network providers are not contracted with the network; therefore, your out-of-pocket cost may be higher. Under this Plan, the Claims Administrator will pay claims up to the Reasonable and Customary Amount. You will be responsible for charges which exceed this amount.

## Advance Claim Review

Before starting a course of treatment for which dentist's charges are expected to be \$350 or more, details of the proposed course of treatment and charges to be made should be filed in acceptable form with the Claims Administrator. The Claims Administrator will then estimate the benefits. You and the dentist will be told what the charges are before treatment starts.

Some services may be given before advance claim review is made. These are oral exams, including prophylaxis and X-rays, and treatment of any traumatic injury or condition which:

- Occurs unexpectedly;
- Requires immediate diagnosis and treatment; and
- Is characterized by symptoms such as severe pain and bleeding.

A course of treatment is a planned program of one or more services or supplies to treat a dental condition. The condition must be diagnosed by the attending dentist as a result of an oral exam. The treatment may be given by one or more dentists. The course of treatment starts on the date a dentist first gives a service to correct or treat such dental condition.

### **Important Note:**

As a part of advance claim review and as part of proof of any claim:

- The Claims Administrator has the right to require an oral exam of the person. This will be done at no cost to you.
- You must give the Claims Administrator all diagnostic and evaluative material which may be required. These include X-rays, models, charts, and written reports.

The benefits for a course of treatment may be for a lesser amount than would otherwise be paid if advance claim review is not made or if any required verifying material is not furnished. In this event, benefits will be reduced by the amount of covered dental expenses that the Claims Administrator cannot verify.

## Covered Dental Expenses

Certain dental expenses are covered. These are the dentist's charges for the services and supplies listed below, which for the condition being treated, are necessary and customarily used nationwide and deemed

by the profession to be appropriate. They must meet broadly accepted national standards of dental practice.

## **Preventive Services**

### **Visits and X-Rays**

- Office visit during regular office hours, for oral examination limited to two per year
- Prophylaxis (cleaning) (limited to two treatments per year). One “deep cleaning” CPT 4355 may be substituted for a prophylaxis cleaning once in a 24-month period of time.
- Topical application of fluoride (limited to one course of treatment per year and to children under age 16)
- Sealants, per tooth (limited to one application every 3 years for permanent molars only, and to children under age 16)
- Bitewing X-rays (limited to one per year)
- Complete X-ray series, including bitewings if necessary, or panoramic film (limited to 1 set every 3 years)
- Vertical bitewing X-rays (limited to 1 set every 3 years)

## **Basic Services**

### **Restorative Dentistry**

Excludes inlays, crowns (other than prefabricated stainless steel or resin) and bridges. (Multiple restorations in one surface will be considered as a single restoration.)

- Amalgam Restorations - Primary Teeth
- Amalgam Restorations - Permanent Teeth
- Resin Restorations
- Sedative Fillings
- Pin retention - per tooth, in addition to amalgam or resin restoration
- Extractions, including local anesthetics.
- Repair to full and partial denture including repair to cast framework and replacing missing or broken teeth.

### **Endodontics**

- Pulp capping
- Pulpotomy
- Apexification/recalcification
- Apicoectomy
- Root Canal Therapy, including necessary X-rays
- Recementation of inlay, crown or bridge

## **Major Restorative**

Cast or processed restorations and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge.

### Inlays/Onlays - Metallic or Porcelain/Ceramic

- Inlay, one or more surfaces

- Onlay, two or more surfaces

#### Inlays/Onlays - Resin

- Inlay, one or more surfaces
- Onlay, two or more surfaces

#### Labial Veneers

- Laminate-chairside
- Resin laminate - laboratory
- Porcelain laminate - laboratory

#### Crowns

- Resin
- Resin with noble metal
- Resin with base metal
- Porcelain
- Porcelain with noble metal
- Porcelain with base metal
- Base metal (full cast)
- Noble metal (full cast)
- Metallic (3/4 cast post and core)

#### Pontics

- Base metal (full cast)
- Noble metal (full cast)
- Base metal (full cast)
- Porcelain with noble metal
- Porcelain with base metal
- Resin with noble metal
- Resin with base metal
- Removable Bridge (unilateral). One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics
- Dentures and Partials. (Fees for dentures and partial dentures include relines, rebases, and adjustments within six months after installation. Fees for relines and rebases include adjustments within six months after installation. Specialized techniques and characterizations are not eligible.)
- Complete upper denture
- Complete lower denture
- Partial upper or lower, resin base (including any conventional clasps, rests, and teeth)
- Partial upper or lower, cast metal base with resin saddles (including any conventional clasps, rests, and teeth)
- Stress breakers
- Interim partial denture (stayplate), anterior only
- Office reline
- Laboratory reline
- Special tissue conditioning, per denture
- Rebase, per denture
- Adjustment to denture more than six months after installation
- Full and Partial Denture Repairs

### Oral Surgery

- Impacted Tooth Removal (partially bony or completely bony)

### Space Maintainers

Includes all adjustments within six months after installation.

- Fixed (unilateral or bilateral)
- Removable (unilateral or bilateral)

## **Orthodontic Treatment**

Coverage for orthodontic treatment is limited to those services and supplies listed on the Dental Care Schedule that applies.

A dentist's charges for services and supplies for orthodontic treatment are included as Covered Dental Expenses. In addition to all other terms of this dental benefit:

- The benefit rate will be the payment percentage for orthodontic treatment.
- Benefits will not exceed the Orthodontic Maximum for all expenses incurred by a family member in his or her lifetime. (It applies even if there is a break in coverage.)

*Coverage is not provided for any charges for an orthodontic procedure if an active appliance for that orthodontic procedure has been installed before the first day on which the person became a covered person for the benefit.*

## **Limitations**

### **Alternate Treatment Rule**

If more than one service can be used to treat a covered person's dental condition, the Claims Administrator may decide to authorize coverage only for a less costly covered service provided that both of the following terms are met:

- The service selected must be deemed by the dental profession to be an appropriate method of treatment; and
- The service selected must meet broadly accepted national standards of dental practice.

### **Replacement Rule**

The replacement of; addition to; or modification of existing dentures, crowns, casts or processed restorations, removable bridges or fixed bridgework is covered only if one of the following terms is met:

- The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed. Comprehensive Dental Expense Coverage must have been in force for the covered person when the extraction took place.
- The existing denture, crown, cast, or processed restoration, removable bridge, or bridgework cannot be made serviceable, and was installed at least five years before its replacement.
- The existing denture is an immediate temporary one to replace one or more natural teeth extracted while the person is covered, and cannot be made permanent, and replacement by a permanent denture is required. The replacement must take place within 12 months from the date of initial installation of the immediate temporary denture.

### **Tooth Missing But Not Replaced Rule**

Coverage for the first installation of removable dentures; removable bridges; and fixed bridgework is subject to the requirements that such dentures; removable bridges; and fixed bridgework are (i) needed to replace one or more natural teeth that were removed while this policy was in force for the covered person; and (ii) are not abutments to a partial denture; removable bridge; or fixed bridge installed during the prior five years.

### **Benefit Maximums**

<b>Maximum</b>	<b>Amount</b>
Annual Dental Maximum per Person	<b>\$1,500</b>
Orthodontia Lifetime Maximum per Person	<b>\$1,500</b>

### **General Exclusions Applicable to Your Dental Benefits**

Coverage is not provided for the following charges:

- Covered Dental Expenses do not include and no benefits are payable for charges for any dental services and supplies which are covered under any other plan of group benefits provided by Emory.
- Those for services and supplies to diagnose or treat a disease or injury that is an occupational injury or disease.
- Those for services not listed in the covered dental expenses that applies; except as specifically provided.
- Those for replacement of a lost, missing, or stolen appliance, and those for replacement of appliances that have been damaged due to abuse, misuse, or neglect.
- Those for dentures, crowns, inlays, onlays, bridgework or other appliances or services used for the purpose of splinting, to alter vertical dimension to restore occlusion, or correcting attrition, abrasion, or erosion for any of the following services:
  - An appliance, or modification of one, if an impression for it was made before the person became a covered person;
  - A crown, bridge, or cast or processed restoration, if a tooth was prepared for it before the person became a covered person;
  - Root canal therapy, if the pulp chamber for it was opened before the person became a covered person.
- Those for services intended for treatment of any jaw joint disorder; except as specifically provided.
- Those for space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.
- Those for orthodontic treatment; except as specifically provided.
- Those for general anesthesia and intravenous sedation, unless done in conjunction with another necessary covered service.

- Those for treatment by other than a dentist; except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a dentist.
- Those for services given by an Out-of-Network Provider to the extent that the charges exceed the amount payable for the services.
- Those for a crown, cast or processed restoration unless it is treatment for decay or traumatic injury and teeth cannot be restored with a filling material or the tooth is an abutment to a covered partial denture or fixed bridge.
- Those for pontics, crowns, cast or processed restorations made with high noble metals; except as specifically provided.
- Those for surgical removal of impacted wisdom teeth only for orthodontic reasons; except as specifically provided.
- Those for services needed solely in connection with non-covered services.
- Those for services done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

## **Effect of Benefits under Other Plans**

### **Coordination of Benefits - Other Plans Not Including Medicare**

This Coordination of Benefits (COB) provision applies to this Plan when an employee (or former employee or eligible retiree) or the employee's (or former employee's or eligible retiree's) covered dependent has medical and/or dental coverage under more than one Plan. "Plan" is defined herein.

### **Right to Receive and Release Needed Information**

Certain facts about dental coverage and services are needed to apply these COB rules and to determine Benefits under this Plan and other Plans. This Plan has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

### **Right of Recovery**

If the amount of the payments made by this Plan is more than it should have paid under this COB provision, this Plan may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the Benefits or services provided for the Covered Person. The "amount of the payments made" includes the reasonable cash value of any Benefits provided in the form of services.

The order of benefit determination rules as discussed below determines which Plan will pay as the primary Plan. The primary Plan pays first without regard to the possibility that another Plan may cover some expenses. A secondary Plan pays after the primary Plan and may reduce the Benefits it pays so that payments from all group Plans do not exceed 100% of the total Allowable Expense. When two or more Plans pay Benefits, the rules for determining the order of payment are as follows:

- The primary Plan pays or provides its Benefits as if the secondary Plan or Plans did not exist.
- A Plan that does not contain a Coordination of Benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are

superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide Out-of-Network benefits.

- A Plan may consider the Benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
- The first of the following rules that describes which Plan pays its Benefits before another Plan is the rule to use:

**Non-Dependent or Dependent.** The Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the Plan that covers the person as a dependent is secondary.

However, if the person is a Medicare beneficiary, and as a result of federal law, Medicare is a secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee) then the order of Benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Plan is primary.

**Child Covered Under More Than One Plan.** The order of Benefits when a child is covered by more than one Plan is:

The primary Plan is the Plan of the parent whose birthday is earlier in the year if:

- The parents are married;
- The parents are not separated (whether or not they ever have been married); or
- A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage; or
- If both parents have the same birthday, the Plan that covered either of the parents longer is primary.

If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Claim Determination Periods or Plan years commencing after the Plan is given notice of the court decree.

If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of Benefits is:

- The Plan of the Custodial Parent;
- The Plan of the spouse of the Custodial Parent;
- The Plan of the non-Custodial Parent; and then
- The Plan of the spouse of the non-Custodial Parent.

**Active or Inactive Employee.** The Plan that covers a person as an employee, who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. 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. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the above rule.

**Continuation Coverage.** If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Plan, the Plan covering the person as an employee,

member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. 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.

**Longer or Shorter Length of Coverage.** The Plan that covered the person as an employee, member or subscriber longer is primary.

If the preceding rules do not determine the primary Plan, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan under this provision. In addition, this Plan will not pay more than it would have paid had it been primary.

## **Additional Provisions**

In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

This document describes the main features of this Plan. Additional provisions are described elsewhere in the plan document on file with Emory. If you have any questions about the terms of this Plan or about the proper payment of Benefits, you may obtain more information from Emory.

Emory hopes to continue this Plan indefinitely, but as with all group Plans; this Plan may be changed or discontinued as to all or any class of employees.

## **Assignments**

Your rights and benefits under the Plan cannot be assigned, sold or transferred to any person, including your dental provider. The only exception is under a qualified medical child support order ("QMCSO"). Any purported assignments of benefits or rights under the Plan that a dental provider or any other person or entity requests that you execute (and/or has you execute) are void and will not apply to the Plan.

At its option, the Plan may accept claims filed by a dental provider and may make payments for covered services directly to a dental provider. However, these activities will not constitute an assignment of dental benefits or rights under the Plan or a waiver of the Plan's anti-assignment rules. Further, a direct payment to a dental provider will not constitute an assignment of dental benefits or rights under the Plan. Any purported assignments of benefits or rights under the Plan are void and will not apply to the Plan.

The Plan may also make payments directly to you. Payments, as well as notice regarding the receipt and/or adjudication of claims, may also be made to an alternate recipient or that person's custodial parent or authorized representative under a qualified medical child support order. If the Plan makes a payment, this will fulfill the Plan's obligation to pay for covered services. The Plan is not responsible for paying dental provider invoices that are balance-billed to you.

## **Reimbursement Provision**

If a Covered Person suffers a loss or an injury caused by the act or omission of a third party, the Benefits in this Plan for such loss or injury will be paid only if the Covered Person, or his or her legally authorized representative, agrees in writing to:

- Pay the Claims Administrator up to the amount of the Benefits received under this Plan subject to applicable law if damages are collected. Damages may be collected by action at law, settlement, or otherwise.

- Provide the Claims Administrator a lien in the amount of the benefit paid. This lien may be filed with the third party, his or her agent, or a court which has jurisdiction in the matter. The payment and the lien referred to above shall be made or provided to the Claims Administrator in its capacity as the provider of administrative services to this Plan.

### **Subrogation and Right of Recovery Provision**

As used throughout this provision, the term Responsible Party means any party actually, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person's injuries, illness, or condition, including the liability insurer of such party, or any insurance carrier providing medical expense or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

The Plan's subrogation right is a first priority right and must be satisfied in full prior to any of your or your representative's other claims, regardless of whether you are fully compensated for your damages. The Plan expressly rejects and overrides any default rule that the plan does not have a right of subrogation until you or your dependent have been fully compensated. Neither the make-whole doctrine nor the common fund doctrine apply to the Plan.

The Plan shall be subrogated to all rights of recovery a Covered Person has against any Responsible Party with respect to any damages collected from a Responsible Party whether by action at law, settlement or compromise, by a Covered Person or his/her legal representative as a result of a Covered Person's injuries or illness, to the full extent of Benefits provided or to be provided by the Plan.

In addition, if a Covered Person receives any payment from any Responsible Party as a result of an injury, illness, or condition, the Plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts this Plan has paid and will pay as a result of that injury, illness, or condition, up to and including the full amount the Covered Person receives from all Responsible Parties. Further, the Plan will automatically have a first priority equitable lien, to the extent of Benefits advanced, upon any recovery whether by settlement, judgment or otherwise, that a Covered Person receives from any Responsible Party as a result of the Covered Person's injuries, illness, or condition. The amount of the lien is equal to the amount of prior and future benefits paid by the Plan. The Plan also has a right to impose a constructive trust on the process awarded, transferred or paid by or on behalf of a third party to you, your dependents and any other person or entity holding the proceeds, including a legal representative or trust.

The Plan Administrator, or its delegate, has the sole authority and discretion to decide whether to pursue any right of recovery in favor of the Plan.

By accepting Benefits (whether the payment of such Benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person acknowledges that this Plan's recovery rights are a first priority claim against all Responsible Parties and are to be paid to the Plan before any other claim for the Covered Person's damages. This Plan shall be entitled to full reimbursement on a first-dollar basis from any Responsible Party payments, even if such payment to the Plan will result in a recovery to the Covered Person which is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained. The Plan is not required to participate in or pay court costs or attorney fees to the attorney hired by the Covered Person to pursue the Covered Person's damage claim.

The terms of this entire subrogation and right of recovery provision shall apply, and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the dental

benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than dental expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering or non-economic damages only.

The Covered Person shall fully cooperate with the Plan's efforts to recover its Benefits paid. It is the duty of the Covered Person to notify the Plan within thirty (30) days of the date when any notice is given to any party, including an attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injuries or illness sustained by the Covered Person. The Covered Person shall provide all information requested by the Plan, the Claim Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request. Failure to provide this information may result in the termination of dental benefits for the Covered Person or the institution of court proceedings against the Covered Person. The Plan may, in addition to remedies provided elsewhere in the Plan and/or under the law, set off from any future benefits otherwise payable under the Plan the value of benefits advanced under this section to the extent not recovered by the Plan.

The Covered Person shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all Benefits provided by the Plan.

In the event that any claim is made that any part of this right of recovery provision is ambiguous, or if questions arise concerning the meaning or intent of any of its terms, the Plan Administrator for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

By accepting Benefits (whether the payment of such Benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such Benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him/her by reason of his/her present or future domicile.

### **Recovery of Overpayment**

If a benefit payment is made by the Claims Administrator, to or on behalf of any Covered Person, which exceeds the benefit amount such Covered Person is entitled to receive in accordance with the terms of the group contract, this Plan has the right:

- To require the return of the overpayment on request;
- To reduce by the amount of the overpayment, any future benefit payment made to; or
- On behalf of that Covered Person or another person in his or her family.

Such right does not affect any other right of recovery this Plan may have with respect to such overpayment.

### **Reporting of Claims**

A claim must be submitted to the Claims Administrator in writing. It must give proof of the nature and extent of the loss. Emory has claim forms.

All claims should be reported promptly. The deadline for filing a claim for any Benefits is 90 days after the date of the loss causing the claim.

If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will still be accepted if you file as soon as possible. But unless you are legally incapacitated, you may file no later than 2 years after the deadline.

### **Payment of Benefits**

Benefits will be paid as soon as the necessary proof to support the claim is received. All benefits are payable to Core Providers or In-Network Providers or to you. However, this Plan has the right to pay any dental benefits to the service provider. This Plan may pay up to \$1,000 of any benefit to any of your relatives whom it believes are fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

### **Records of Expenses**

Keep complete records of the expenses of each Covered Person. They will be required when a claim is made. In particular, make sure to keep the following:

- Names of physicians, dentists and others who furnish services;
- Dates expenses are incurred; and
- Copies of all bills and receipts.

### **Legal Action**

No legal action can be brought against the Plan to recover under any benefit after three (3) years from the deadline for filing claims or, if the claim does not relate to a claim for benefits subject to a deadline for filing claims under the Plan, within two years of the date when you knew or should have known of the actions or events, giving rise to your claim.

### **Filing an Appeal**

#### **Eligibility for Coverage, Participation and Contributions**

The Plan Administrator has the discretionary authority to make all determinations relating to eligibility for coverage, participation, contributions or other administrative aspects of the Plan. You may file a claim with regard to any of these administrative issues with the Plan Administrator and appeal adverse claim decisions to the Plan Administrator.

## **How to File Your Appeal**

To appeal an adverse administrative decision, submit your letter of appeal and any pertinent documents via regular mail to:

Emory University  
Employee Benefits Department  
Official Appeal  
1599-001-1AP  
1599 Clifton Road NE  
Atlanta, Georgia 30322

**or** by fax to:

Emory University  
Employee Benefits Department  
Official Appeal  
(404) 727-7145

**or** as an attachment by email to:

[HRBENF@emory.edu](mailto:HRBENF@emory.edu)

Your appeal request should include your name, employee number and any other comments, documents, records and/or other information you would like to have considered, whether or not submitted originally. You will have 180 days from receiving notification of a denial of eligibility for coverage, participation and/or contributions to file an appeal with the Plan Administrator. Your appeal will be acknowledged within 15 working days of receipt. You will be notified of a decision with regard to your appeal not later than 30 days after the appeal is received. This period may be extended up to 15 days and a representative of the Plan Administrator will contact you to indicate a delay with regard to a determination of your appeal.

If you are dissatisfied with an appeal decision, you may file a second-level appeal with the Plan Administrator within 60 days of receipt of the decision with regard to your first appeal. The Plan Administrator will notify you of the decision with regard to your second appeal not later than 45 days after the appeal is received.

## **Health Plan Appeals for Claims Payment**

You may file claims for Plan Benefits with the Claims Administrator and appeal adverse claim decisions, either yourself or through an authorized representative. To file a claim and/or appeal:

For Dental Claims:

Aetna  
Attn: National Account CRT  
P. O. Box 14463  
Lexington, KY 40512  
Fax: (859) 455-8650

If your claim (or appeals) is denied in whole or in part, you will receive a written notice of the denial from the Claims Administrator. The notice will include:

- Information that enables you to identify the claim involved (including, if applicable, the date of service, the provider and the claim amount), and a statement describing the availability, upon request, of the diagnosis and treatment codes (and their meanings);
- The specific reason(s) for the adverse determination, including the denial code (and its meaning), and a description of any standard that was used in the denial;
- Reference to the specific plan provisions on which the determination was based;
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- A description of the plan's review procedures (except for notices on appeals) and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA, following an adverse benefit determination on review;
- 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 information relevant to the claim;
- If the adverse benefit determination was based on an internal rule, guideline, protocol or other similar criterion, the specific rule, guideline, protocol or criterion will be provided free of charge, or a statement that such a rule, guideline, protocol or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request;
- If the adverse benefit determination is based on the medical necessity or experimental or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided, or a statement will be included that such explanation will be provided free of charge, upon request;
- A description of available external review processes, including information on how to initiate the appeal;
- The availability of, and contact information for, an applicable health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.

### **Urgent Care**

The Plan allows emergency dental care for palliative treatment and is subject to state requirements. [See Advance Claim Review for information on traumatic injury or condition.]

### **Other Claims (Pre-Service and Post-Service)**

If the Plan requires you to obtain advance approval of a service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

For other claims (post-service claims), you will be notified of the decision not later than 30 days after receipt of the claim.

For a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside the Plan's control. In that case, you will be notified of the extension before the end of the initial 15 or 30-day period. For example, the time permitted may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the Plan's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims that name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to a Plan representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

### **Ongoing Course of Treatment**

If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the Plan intends to terminate or reduce Benefits for the previously authorized course of treatment so that you will have an opportunity to appeal the decision and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

You may file an appeal in writing. The denial notice will include the address where the appeal can be sent. If your appeal is of an urgent nature, you may call at the toll-free phone number on the front of your ID card. Your request should include the group name (that is, Emory), your name, Social Security Number or other identifying information shown on the front of the Explanation of Benefits form, and any other comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial claim.

Your appeal will be acknowledged within five working days of receipt. You will have 180 days following receipt of an adverse benefit decision to appeal the decision to the Claims Administrator. You will be notified of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. A copy of the specific rule, guideline or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by you or your authorized representative. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information relevant to the claim.

If your claim is a claim involving urgent care, an expedited appeal may be initiated by a telephone call to Member Services. The Claims Administrator's Member Services telephone number is on your Identification Card. You or your authorized representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your authorized representative and the Plan by telephone, facsimile, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with the appeal decision on a claim involving urgent care, you may file a second level appeal with the Claims Administrator. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal with the Claims Administrator within 60 days of receipt of the level one appeal decision. The Claims Administrator will notify you of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

If you do not agree with the final determination on review, you have the right to bring a civil action under Section 502(a) of ERISA, if applicable.

### **Full and Fair Review Rules**

The Plan will provide you with any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim, such evidence to be provided as soon as possible and sufficiently in advance of the date on which the notice of the appeal determination is required to be provided as set forth above so that you have a reasonable opportunity to respond prior to that date.

Before the Plan can issue a final determination on an appeal based on a new or additional rationale, you must be provided with the rationale, and the rationale must be provided as soon as possible and sufficiently in advance of the date on which the appeal determination is required to be provided to give you a reasonable opportunity to respond prior to that date.

The Plan Administrator, or its delegate, has the exclusive discretionary authority to construe and to interpret the Plan, to decide all questions of eligibility for benefits and to determine the amount of such benefits, and its decisions on such matters are final and conclusive. If any exercise of this discretionary authority is reviewed by a court, arbitrator, or any other tribunal, it will be reviewed under the arbitrary and capricious standard (i.e., the abuse of discretion standard). Benefits under the Plan will be paid only if the Plan Administrator or Claims Administrator decides in its discretion that the applicant is entitled to them.

### **Retrospective Record Review**

The purpose of retrospective review is to retrospectively analyze potential quality and utilization issues, initiate appropriate follow-up action based on quality or utilization issues, and review all appeals of inpatient concurrent review decisions for coverage and payment of healthcare services. The Claims Administrators' effort to manage the services provided to the Covered Persons includes the retrospective review of claims submitted for payment, and of medical records submitted for potential quality and utilization concerns.

## Summary of ERISA Information

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA).

Plan Name: Emory University Traditional Dental Plan

Plan Sponsor: Emory University  
Attn: Vice President for Human Resources  
1599 Clifton Road NE, First Floor  
Atlanta, GA 30322

Employer Identification Number: 58-0566256  
Plan Number: 502  
Type of Plan: Welfare (dental benefits)

Type of Administration: Administrative Services Contract with the following claims administrators:  
  
Aetna Life Insurance Company  
151 Farmington Avenue  
Hartford, CT 06156

Plan Administrator: Emory University  
Attn: Vice President for Human Resources  
1599 Clifton Road NE, First Floor  
Atlanta, GA 30322

Agent for Service of Legal Process: Emory University  
Office of the General Counsel  
201 Dowman Drive  
101 Administration Building  
Atlanta, GA 30322

Plan Year: January 1 - December 31

Source of Contributions: Participants and Emory share in the cost of this Plan

Procedure for Amending the Plan: Emory may amend the Plan at any time, even after retirement, by a written instrument signed by a senior officer of Emory University. Some terms are described only in the SPD and the SPD can be revised at any time (without a formal amendment to the Plan)

Trustee: Emory University  
Attn: Vice President for Human Resources  
1599 Clifton Road NE, First Floor  
Atlanta, GA 30322

## **ERISA 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 provides that all Plan participants shall be entitled to:

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, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is 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, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an 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.

Receive a copy of the procedures used by the Plan for determining a qualified medical child support order (QMCSO).

## **Continue Group Health Care Plan Coverage**

You may be able to continue health care coverage for yourself, your spouse or your 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.

In accordance with federal law (PL 99-272) as amended, Covered Persons have the right to continue their health expense coverage under certain circumstances. You or your dependents may continue any health expense coverage then in effect, if coverage would terminate for the reasons specified in sections A or B below. You and your dependents may be required to pay up to 102% of the full cost to the Plan of this continued coverage or as to a disabled individual whose coverage is being continued for 29 months in accordance with section A, up to 150% of the full cost to the Plan of this continued coverage for any month after the 18th month. Subject to the payment of any required contribution, health expense coverage may also be provided for any dependents you acquire while the coverage is being continued. Coverage for these dependents will be subject to the terms of this Plan regarding the addition of new dependents.

When making the decision of whether to elect COBRA continuation coverage, you should consider that there may be other coverage options for you and your family. For example, you may be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums right away. Being eligible for COBRA does not limit your eligibility for this coverage or a tax credit through the Marketplace. However, once you elect COBRA, these options are affected. Before you make a decision to enroll in coverage offered through the Marketplace, you can see what premiums, deductibles and out-of-pocket costs will be. You should compare plans so that you can see which coverage is right for you. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage, you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible. When you lose job-based health coverage, it is important that you choose carefully between COBRA continuation coverage and other coverage options, because once you have made your choice, it can be difficult or impossible to switch to another coverage option.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area, or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa)

Continuation shall be available as follows:

- A. Continuation of Coverage on Termination of Employment or Loss of Eligibility. If your coverage would terminate due to termination of your employment for any reason other than gross misconduct or your loss of eligibility under this Plan due to a reduction in the number of hours you work, you may elect to continue coverage for yourself and your dependents or your dependents may each elect to continue their own coverage. This election must include an agreement to pay any required contribution. You or your dependents must elect to continue coverage within 60 days of the later to occur of the date coverage would terminate and the date Emory informs you or your eligible dependents of any rights under this section.

Coverage will terminate on whichever of the following is the earliest to occur:

- The end of an 18-month period after the date of the event that would have caused coverage to terminate.
- The end of a 29-month period after the date of the event that would have caused coverage to terminate, but only if prior to the end of the above 18-month period, you or your dependent provides notice to Emory, in accordance with section D below, that you or your dependent has been determined to have been disabled under Title II or XVI of the Social Security Act on the date of, or within 60 days of, the event that would have caused coverage to terminate. Coverage may be continued for the individual determined to be disabled and for any family member (employee or dependent) of the disabled individual for whom coverage is already being continued and for your newborn or newly adopted child who was added after the date continued coverage began.
- The date Emory no longer provides a group dental plan.
- The date any required contributions are not made.
- The first day after the date of the election that the individual becomes covered under another group health plan. However, continued coverage will not terminate until such time that the individual is no longer affected by a preexisting condition exclusion or limitation under such other group health Plan.
- The first day after the date of the election that the individual becomes enrolled in benefits under Medicare.

As to all individuals whose coverage is being continued in accordance with the terms of the second bulleted item above, the first day of the month that begins more than 30 days after the date of the final determination under Title II or XVI of the Social Security Act that the disabled individual whose coverage is being so continued is no longer disabled but in no event shall such coverage terminate prior to the end of the 18-month period described in the first bulleted item above.

B. Continuation of Coverage under Other Circumstances. If coverage for a dependent would terminate due to:

- Your death;
- Your divorce;
- Your ceasing to pay any required contributions for coverage as to a dependent spouse from whom you are legally separated;
- The dependent ceasing to be a dependent child as defined under this Plan; or
- The dependent's loss of eligibility under this Plan because you become entitled to benefits under Medicare

The dependent may elect to continue his or her own coverage. The election to continue coverage must be made within 60 days of the later to occur of the date coverage would terminate and the date Emory informs your dependents, subject to any notice requirements in section D below, of their continuation rights under this section. The election must include an agreement to pay any required contribution.

C. Coverage for a dependent will terminate on the first to occur of:

- The end of a 36-month period after the date of the event that would have caused coverage to terminate.
- The date Emory no longer provides a group dental plan.
- The date any required contributions are not made.
- The first day after the date of the election that the dependent becomes covered under another group health Plan. However, continued coverage will not terminate until such time that the dependent is no longer affected by a preexisting condition exclusion or limitation under such other group health Plan.
- The first day after the date of the election that the dependent becomes enrolled in benefits under Medicare.

D. Multiple Qualifying Events - If coverage for you or your dependents is being continued for a period specified under section A, and during this period one of the qualifying events under the above section B occurs, this period may be increased. In no event will the total period of continuation provided under this provision for any dependent be more than 36 months. Such a qualifying event, however, will not act to extend coverage beyond the original 18-month period for any dependents (other than a newborn or newly adopted child) who were added after the date continued coverage began.

E. Notice Requirements

If coverage for you or your dependents:

- Is being continued for 18 months in accordance with section A; and
- It is determined under Title II or XVI of the Social Security Act that you or your dependent was disabled on the date of, or within 60 days of the event in section A that would have caused coverage to terminate you or your dependent must notify Emory of such determination within 60 days after the date of the determination and within 30 days after the date of any final determination that you or your dependent is no longer disabled.

If coverage for a dependent would terminate due to:

- Your divorce;

- Your ceasing to pay any required contributions for coverage as to a dependent spouse from whom you are legally separated; or
- Your dependent ceasing to be a dependent child as defined under this Plan (you or your dependent must provide notice to Emory of the occurrence of the event). This notice must be given within 60 days after the later of the occurrence of the event and the date coverage would terminate due to the occurrence of the event. If notice is not provided within the above specified time periods, continuation under this section will not be available to you or your dependents.

F. Continuation of Coverage During an Approved Leave of Absence Granted to Comply with Federal Law.

If you cease active employment due to an approved leave of absence, in accordance with the Family and Medical Leave Act of 1993 (FMLA), coverage will be continued for the length of the approved leave under the same terms and conditions which would have applied had you continued in active employment provided you make the required contributions.

Coverage will not continue beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date Emory determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate. If coverage terminates because your approved FMLA leave is deemed terminated by Emory, you may, on the date of such termination, be eligible for COBRA continuation beginning on such date.

If you return to work for Emory following the date Emory determines the approved FMLA leave is terminated, your coverage under this Plan will be in force as though you had continued in active employment rather than going on an approved FMLA leave. If your coverage had terminated during the leave, you can again enroll upon returning to work when your FMLA leave terminates, provided you make request for such coverage within 31 days of the date Emory determines the approved FMLA leave to be terminated. If you do not enroll within 31 days, you cannot later enroll until you have an enrollment period or a mid-year enrollment event.

If the employee chooses to continue coverage during the leave, the employee will be given the same health care benefits that would have been provided if the employee were working, with the same premium contribution ratio. If the employee's premium for continued membership in the Plan is more than 30 days late, the Employer will send written notice to the employee. It will tell the employee that his or her membership will be terminated and what the date of the termination will be if payment is not received by that date. This notice will be mailed at least 15 days before the termination date.

## **USERRA Continuation Coverage**

If you or your dependents lose coverage under the Plan due to your qualifying service in the uniformed services, you have the right to elect to continue such coverage under Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). To be entitled to USERRA rights, you must give advance notice of your service unless it is impossible or unreasonable under the circumstances to give such notice or giving such notice is precluded by military necessity. Service in the uniformed services includes duty on a voluntary or involuntary basis in the Armed Forces (including the Coast Guard and the

Reserves), the Army National Guard, the Air National Guard, and the commissioned corps of the Public Health Service.

Your right to continued health coverage under USERRA is very similar, but not identical, to your right to continued health coverage under COBRA. In those instances, where your rights under COBRA and USERRA are not the same, whichever law gives you the greater benefit will apply. The administrative policies and procedures, which govern your right to COBRA continuation coverage, also apply to your right to USERRA continuation coverage, with a few limited exceptions.

Any election that you make under COBRA will also be an election to continue your health coverage under USERRA. If, however, you are unable to elect COBRA within the required period because of military necessity or because it is impossible or unreasonable for you to do so, the period for electing USERRA coverage will be tolled until the military necessity is abated or it is no longer impossible or unreasonable for you to make the required election. The period for electing COBRA coverage, however, will not be tolled in this situation.

You are the only one that has the right to make an election under USERRA to continue health coverage for yourself and any covered dependents. Your covered dependents do not have an independent right to make an election for USERRA continuation coverage. As a result, if you do not elect USERRA / COBRA coverage on behalf of your covered dependents, your covered dependents will still have a right to elect to continue their health coverage under COBRA, but they will not be entitled to receive any additional benefits provided under USERRA.

If you elect to continue health coverage for yourself (or your covered dependents) under USERRA, you must pay 102% of the full premium elected (the same rate as COBRA) at the same time as the premium for COBRA coverage is due. However, if your uniformed service period is less than 31 days, you are not required to pay more for health coverage than you would be required to pay as an active employee.

USERRA continuation coverage will generally continue for up to 24 months following the date your leave of absence begins. However, this coverage will terminate earlier if any one of the following events occurs:

- A premium payment is not made within the required time;
- You fail to return to work within the time required under USERRA following the completion of your service in the uniformed services; or
- You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

Although COBRA coverage and USERRA coverage begin at the same time, they do not end at the same time. COBRA coverage continues for up to 18 months (although, if certain events occur, it can be extended), while USERRA coverage continues for to 24 months as described above. On the other hand, there are certain events, like your failure to return to work at the end of your service or a dishonorable discharge, which cause your USERRA coverage to terminate early but which do not cause COBRA coverage to terminate. In that situation, even if your USERRA coverage terminates, you may still be entitled to continued health coverage under COBRA.

## **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 Plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in your interest and that of other Plan participants and beneficiaries. No one, including Emory 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 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 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 and pay 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. In addition, if you disagree with the Plan’s decision or lack thereof concerning the 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.

### **Restriction of Venue**

Any claim, suit or action filed in court or any other tribunal in connection with the Plan by or on behalf of a Claimant shall only be brought or filed in the United States District Court for the Northern District of Georgia.

### **Assistance with Your Questions**

If you have any questions about the 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 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.

## Definitions

When used in this SPD, the following words and phrases have the meaning explained herein.

**Active Employee** - means an employee who is working as a regular full-time or half-time (at least 20 hours per week) employee or as a temporary full-time employee on an assignment at Emory University scheduled for at least six months.

**Benefits** - Your right to payment for Covered Dental Services that are available under the Plan. Your right to benefits is subject to the terms, conditions, limitations and exclusions of the Plan.

**Calendar Year Deductible** - The amount of Covered Dental Expenses you pay each plan year before Benefits are paid. There is a calendar year Deductible that applies to each person.

**Claims Administrator** - The companies (including affiliates) that provide certain claim administration services for the Plan is Aetna.

**Claim Determination Period** - The calendar year.

**Co-insurance** - A percentage of the charge that you are responsible for, after deductibles.

**Cosmetic Procedures** - Procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator on behalf of this Plan.

**Covered Dental Expense(s)** - The cost of Covered Dental Services(s) that are included in this Plan when calculating Benefits payable.

**Covered Person** - This is either the employee, retired employee, or an enrolled dependent, but this term applies only while the person is enrolled under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

**Custodial Parent** - A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

**Deductible** - The amount of Covered Expense you must pay each year before any Plan Benefits begin.

**Dentist** - A legally qualified dentist. Also, a physician who is licensed to do the dental work he or she performs.

**Emory** - Shall mean Emory University and its schools, operating divisions and affiliates and any/all entities controlled by Emory University either directly or indirectly, including but not limited to, the Carter Center, Inc., Emory Healthcare Inc., Emory Children's Center Inc., The Emory Clinic Inc., Emory Specialty Associates, LLC, Emory /Saint Joseph's, Inc., Saint Joseph's Hospital of Atlanta, Inc., The Medical Group of Saint Joseph's, LLC, EHCA Johns Creek, LLC d/b/a Emory Johns Creek Hospital.

**Excluded Amount** - A charge made by a provider that is not covered under the Plan.

**In-Network Providers** - Providers that are part of, or who have contracts with the Claims Administrators. To locate a participating provider or facility, call 1-877-238-6200, or access [www.aetna.com/docfind/custom/emory](http://www.aetna.com/docfind/custom/emory).

**Necessary** - A service or supply furnished by a particular provider is necessary if the Claims Administrator determines that it is appropriate for the diagnosis, the care or the treatment of the disease or injury involved. To be appropriate, the service or supply must:

- Be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition;
- Be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; and
- As to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

In no event will the following services or supplies be considered to be necessary:

- Those that do not require the technical skills of a medical, a mental health or a dental professional; or
- Those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any healthcare provider or healthcare facility; or
- Those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined; or
- Those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

**Negotiated Charge** - This is the maximum charge an In-Network Provider has agreed to make as to any service or supply for the purpose of the Benefits under this Plan.

**Non-Occupational Disease or Injury** - A non-occupational disease is a disease that does not arise out of (or in the course of) any work for pay or profit or result in any way from a disease that does. A disease will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- Is covered under any type of workers' compensation law; and
- Is not covered for that disease or injury under such law.

**Orthodontic Treatment** - This is any medical service or supply or dental service or supply that is furnished to prevent, diagnose or to correct a misalignment of the teeth, bite or of the jaws or jaw joint relationship, whether or not for the purpose of relieving pain. Not included is the installation of a space maintainer or a surgical procedure to correct malocclusion.

**Out-of-Network Providers** - Providers who are not participating/contracted with the Claims Administrator. Out-of-pocket will be higher when seeking care from these providers.

**Plan** - Any Plan providing benefits or services by reason of medical or dental care or treatment, which benefits or services are provided by one of the following:

- Group, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;

- Other prepaid coverage under service plan contracts, or under group or individual practice;
- Uninsured arrangements of group or group-type coverage;
- Labor-management trusted Plans, labor organization Plans, employer organization Plans, or employee benefit organization Plans;
- Medical benefits coverage in a group, group-type, and individual automobile “no-fault” and traditional automobile “fault” type contracts;
- Medicare or other governmental benefits;
- Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

If the contract includes both medical and dental coverage, those coverages will be considered separate Plans. The Medical/Pharmacy coverage will be coordinated with other Medical/Pharmacy Plans. In turn, the dental coverage will be coordinated with other dental Plans. The Plan described in this summary is the Emory University Traditional Dental Plan, the “Plan”.

**Plan Administrator** - Emory University, c/o Human Resource Department.

**Reasonable and Customary Charges** - This only applies to Out-of-Network claims. Only that part of a charge that is reasonable is covered. The reasonable charge for a service or supply is the lowest of the provider's usual charge for furnishing it, and the charge the Claims Administrator determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and the charge the Claims Administrator determines to be the prevailing charge level made for it in the geographic area where it is furnished.

In determining the reasonable charge for a service or supply, the complexity; the degree of skill needed; the type of specialty of the provider; the range of services or supplies provided by a facility; and the prevailing charge in other areas will be taken into consideration.

In some circumstances, the Claims Administrator may have an agreement with a provider (either directly, or indirectly through a third party) that sets the rate that will be paid for a service or supply. In these instances, in spite of the methodology described above, the reasonable charge is the rate established in such agreement.