



HUMAN
RESOURCES

Health Plan

Summary Plan Description

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

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

This health plan is partially funded by Vanderbilt University and administered by Aetna and Navitus Health Solutions.

SUMMARY OF HEALTH PLAN BENEFITS

Eligibility

All fully benefits-eligible or partially benefit-eligible faculty and staff as defined by the employer are eligible for immediate Health Care Plan coverage. In the case of an employee who acquires a spouse or child after becoming eligible for coverage, this family member is eligible on the date acquired.

Employees who were classified in a temporary position but otherwise met Health Plan coverage for 2016 and, in fact, were enrolled in Health Plan coverage in 2016 but would have not met coverage eligibility for 2017, are considered grandfathered for Health Plan coverage for the 2017 plan year or until employment termination.

Health Plan Options

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

- Aetna Plus
- Aetna Select
- Aetna HealthFund

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

Coverage Tiers

Vanderbilt offers a four-tiered rate structure:

1. Employee Coverage: Covers the employee only.
2. Employee and Spouse: Covers the employee and the employee's spouse.
3. Employee and Child(ren): Covers the employee and all eligible children.
4. Family Coverage: Covers the employee, the employee's spouse, and all eligible children.

See definition of eligible family members on page 7.

Salary-based Payroll Deductions for the Health Plan

The cost of medical coverage is based on the employee's annual base benefits rate (ABBR). For most employees, your ABBR is equal to your annual salary. There are salary bands that will determine monthly cost. These can be found in the Benefits Overview on the HR website.

Waiving Health Plan Coverage

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

Special Enrollment Provisions

If you waive coverage for yourself, your spouse or children because of other health insurance coverage, in the future you may be able to enroll yourself or your eligible family members in this Plan. You must follow the Family Status Change/Qualifying Life Event process within My VU Benefits within 30 days of the event that causes your other group insurance plan coverage to end, such as the last day of your spouse's employer-sponsored health coverage. In addition, if you have a new eligible family member as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your spouse and/or children, provided that you request enrollment within 30 days after the Family Status Change/Qualifying Life Event date by completing the Life Event process within My VU Benefits within 30 days of the event. A link to My VU Benefits can be found on the Vanderbilt HR homepage, under the Benefits tab. The University reserves the right to perform periodic eligibility audits that would require documentation to confirm an individual as your eligible family member. Copies of court documents or birth certificates are examples of acceptable documentation.

Effective Date of Coverage

Coverage is effective on the date an employee or eligible family member first becomes eligible for coverage, provided that application for coverage is made no later than 30 days after becoming eligible. The receipt of a membership or identification card from Aetna, or Navitus Health Solutions does not guarantee coverage or eligibility (see Eligibility).

Pre-Existing Conditions

There are no pre-existing condition clauses with any of the medical and pharmacy options offered under the Plan.

How to Enroll

You must enroll by completing the online benefits enrollment process to make your elections at the time you begin work at Vanderbilt by

logging in to the My VU Benefits website.

Changing Coverage

Plan options and coverage tiers may only be changed during Open Enrollment, which generally occurs each fall (contact the Office of Benefits Administration for exact dates) or in the event of a Family Status Change/Qualifying Life Event. Your health insurance option will carry over into each eligible Plan Year unless you make changes during Open Enrollment or in the occurrence of a Family Status Change/Qualifying Life Event. Flexible Spending Account elections do not carry over into the next Plan Year, if you choose to participate in Health Care FSA or Dependent Care FSA then you must re-enroll during Open Enrollment for each Plan Year you choose to have coverage.

If you experience a qualifying life event (see definition on page 7) during the plan year by completing the Family Status Change/Qualifying Life Event online process within My VU Benefits within 30 days of the qualifying life event that triggered the need for the change in coverage, such as the loss of your spouse's employer-sponsored health coverage, or the birth of a child (this is not intended to be an all-inclusive list). The effective date of any coverage change due to a qualifying event will be determined based on the qualified life event. You will be required to pay any missed payroll deductions caused by the effective date of your change.

Termination of Coverage

If a person ceases to be employed by Vanderbilt, individual coverage and coverage for his or her eligible spouse or children will terminate at midnight on the last day of the month in which the person terminates employment.

If a dependent is no longer eligible to be covered under the Plan, then coverage for the ineligible dependent will terminate at midnight on the date of the event that causes them to lose eligibility. Examples:

- A finalized Divorce will terminate the coverage of the employee's spouse at midnight on the day in which the divorce is signed by the judge and filed with the court. It is the participant's responsibility to notify Office of Benefits Administration of this change of status within 30 days by completing the online Family Status Change/Qualifying Life Event process in My VU Benefits.
- Coverage for an eligible child shall end at midnight on the last day of the month in which the child no longer qualifies as eligible due to their age. Refer to **Definition of Terms**, page 6, for age limit eligibility. It is the participant's responsibility to notify Office of Benefits Administration if the child is eligible for coverage beyond the age of 26 due to a disability. Notification must be made at least 30 days prior to the child's 26th birthday.

If payment is not made in full within 30 days of the due date, coverage for the employee and his or her spouse or children shall cease effective midnight of the last day of the month in which coverage was paid.

For certain qualifying events, arrangements can be made to continue coverage beyond the normal termination date. Your rights to continue group health plan coverage are described in the section entitled "Continuing Group Coverage – COBRA" in this booklet. If your Plan coverage terminates, the Plan Administrator can provide a certificate that documents your coverage for up to the previous 18 months.

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

Rescission of Health Coverage

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

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

Non-Assignment of Benefits

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

General Provisions

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

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

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

COST CONTAINMENT

This section gives a brief explanation of some cost containment strategies and additional features that are included in the Plan. It is very important that you read this section carefully and become familiar with each of the features because you will have to make important decisions regarding the health care you use. Refer to your option's Evidence of Coverage (EOC) or Summary Booklet, which can be found on the HR website, for a detailed description related to each of the sections below.

Selection of Provider – Physicians and Facilities

Vanderbilt offers three health plan options, administered by Aetna. All three options are preferred provider organizations (PPOs) and have three tiers with varying levels of coverage.

- Tier 1: Vanderbilt Health Affiliate Network (VHAN). For details, see www.vhan.com/members.
- Tier 2: Aetna "POS II" National network (In-network).
- Tier 3: Out-of-network providers may be used, but you will not have the advantage of the network discount. Also, out-of-network expenses have their own deductible and co-insurance limit. Other charges may apply if you seek care outside the network.

To learn more about the networks and check providers and facilities, visit the Aetna Physician Directory (DocFind) <http://www.aetna.com/docfind/custom/vanderbilt/>.

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

Deductibles, co-payments, co-insurance amounts, and out-of-pocket maximums in each of the Plan options are established by Vanderbilt University and are subject to change. To determine the current deductibles, co-payments, co-insurance, and out-of-pocket maximums, refer to your option's Evidence of Coverage (EOC) or Summary Booklet. In addition, a uniform glossary of health coverage and medical terms may be found on the HR website.

Prior Authorization

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

Plan Payment

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

Coordination of Benefits Provision

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

Maximum Benefit

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

Subrogation

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

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

Health Plan Exclusions and Limitations

Each health plan option contains its own list of exclusions and limitations for providers, tests, devices, procedures, and other aspects of medical and pharmacy coverage. It is your responsibility to review exclusions and limitations.

Applied Behavioral Analysis Therapy

Each health plan option includes Applied Behavioral Analysis (ABA) therapy for autism spectrum disorder.

Preventive Services

Eligible preventive services are covered under each of the available Plan options.

Prescription Drugs

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

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

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

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

Additional information about the prescription drug benefit program is available by calling the toll-free Navitus Health Solutions' Customer Care telephone number, 866.333.2757, or through their website <http://www.navitus.com>, or refer to the HR website.

CONTINUING YOUR COVERAGE

Continuation of Group Coverage while on Leave of Absence

If you take an approved leave of absence without pay, you may continue coverage under the plan at the same level from the time your approved leave begins. Coverage may be continued throughout the leave period by paying the required cost of coverage through direct bill payments.

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

Continuation Coverage — COBRA

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

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

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

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

4. Your spouse becomes eligible for Medicare.

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

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

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

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

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

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

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

1. Vanderbilt no longer provides group health coverage to any of its employees;
2. The premium for your continuation coverage is not paid on a timely basis;
3. You have or obtain group coverage under another plan, which is not subject to a pre-existing condition limitation or such limitation has been satisfied. However, if other group health coverage is obtained prior to the COBRA election, COBRA coverage may not be discontinued, even if the other coverage continues after the COBRA election;
4. You become eligible for Medicare. However, if Medicare is obtained prior to COBRA election, COBRA coverage may not be discontinued, even if the Medicare coverage continues after the COBRA election; or
5. You do not have to show that you are insurable to choose continuation coverage. However, under the law, you may be required to pay the entire premium for your continuation coverage plus an administrative fee. Once you elect COBRA coverage, you have up to 45 days to pay the first premium.

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

This law applies to the Group Health Care Plan for Vanderbilt University beginning on July 1, 1986 (under Section 10002(d) of COBRA). If you have any questions about this law, please contact the Plan Administrator, Office of Benefits Administration, PMB 407704, 2301 Vanderbilt Place, Nashville, TN 37240-7700 (615.343.4788). Also, if you have changed marital status, or you or your spouse have changed your address, please notify Benefits Administration Office at the above address.

DEFINITIONS OF TERMS

Eligible Family Members

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

will lose their coverage eligibility the first day of the month following the month in which they turn 18 years of age (age of majority).

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

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

Qualified Medical Child Support Order

For purposes of this section, a qualified medical support order is a medical child support order that creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to receive benefits payable with respect to a participant or beneficiary under a group health plan. A qualified medical support order is any judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under state law which:

1. relates to the provision of child support with respect to the child of a participant under a group health plan (including this Plan) or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to such benefit under such group health plan; or
2. enforces a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13623 of the Omnibus Budget Reconciliation Act of 1993) with respect to a group health plan, if such judgment, decree, or order (I) is issued by a court of competent jurisdiction or (II) is issued through an administrative process established under state law and has the force and effect of law under applicable state law.

An "alternate recipient" will mean any child of a participant who is recognized by a medical child support order as having a right to enrollment under a group health plan with respect to such participant.

Participants and beneficiaries may obtain, without charge, a copy of the Plan's qualified medical child support procedures from the Human Resources.

Qualifying Event

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

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

Summary of Benefits and Coverage and Uniform Glossary

The Patient Protection and Affordable Care Act (PPACA) created two new plan documents for participants: Summary of Benefits and Coverage (SBC) and a Uniform Glossary of Health Coverage and Medical Terms. A copy of Vanderbilt University's SBC can be found on the HR website.

Special Enrollment Rights under CHIPRA

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

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

If your child becomes eligible to receive a premium subsidy from the Child Health Insurance Program, you will be allowed under CHIPRA to disenroll (drop) your child from the Plan. You must request this coverage change within 60 days of this special-enrollment qualifying event by completing the online Family Status Change/Qualifying Life Event process on C2HR.

SUMMARY PLAN DESCRIPTION

Name of Plan Group Health Care for Vanderbilt University

Name of Plan Sponsor Vanderbilt University, PMB #407700, 2301 Vanderbilt Place, Nashville, Tennessee 37235

Employer Identification Number ("EIN") 62-0476822

Plan Number 513

Type of Plan and Plan Benefits

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

Type of Administration

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

Name of Plan Administrator/Privacy Officer/Privacy Contact Vanderbilt University, PMB #407700, 2301 Vanderbilt Place, Nashville, Tennessee 37235

Service of Legal Process

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

Eligibility to Participate in the Plan

Your coverage is effective on your hire date.

You may enroll for employee, employee plus spouse, employee plus child(ren), or family coverage. Coverage for your eligible family members becomes effective on the date you become eligible, provided you have enrolled for appropriate coverage, agree to make the required contributions, and you enroll them within 30 days from the date you first become eligible for family member coverage.

You may change coverage tiers by applying within 30 days after a qualifying life event (see definition on page 8).

Benefits

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

Cost

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

Plan Year

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

Filing Claims for Health Care Plan Benefits

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

Claims Decision Period

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

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

How to Appeal a Claim

Medical Appeals for hospital and physician services: If you do not agree with the denial of your claim, you have 180 days to file an appeal. The submission of an appeal does not guarantee coverage, but appeals should be made in writing to the claims administrator. You should state the reasons why you do not agree with the denial or partial denial and provide any supporting documentation. The

claims administrator will then review the information and provide a written decision within 60 days. If necessary, this period may be extended for an additional 60 days and you will receive written notice of this extension. Refer to the Evidence of Coverage or Summary booklet regarding the grievance or appeal procedures described therein for your health plan option. You may also contact the customer service department for Aetna at the number listed on your insurance membership card.

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

STATEMENT OF ERISA RIGHTS

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

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report. The Group Health Care Plan of Vanderbilt University summary annual reports are posted to <https://hr.vanderbilt.edu/benefits/sbc-eoc.php>.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse, or children if there is a loss of coverage under the Plan as a result of a qualify in life event. You or your eligible family members may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights. The Group Health Care Plan for Vanderbilt University (the Plan) does not have any pre-existing condition clauses. A certificate of creditable coverage will be provided to you free of charge when one or more of the following occurs: 1) You lose coverage under the Plan; 2) You become entitled to elect COBRA continuation coverage; 3) Your COBRA continuation coverage ceases 4) You request it before losing coverage or if you request it up to 24 months after losing coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution

Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Newborns and Mothers Protection Act of 1996

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

Mental Health Parity Act

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

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

Women's Health and Cancer Rights Act of 1998

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

Uniformed Services Employment and Reemployment Rights Act of 1994

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

Protected Health Information

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

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

Vanderbilt's *Notice of Privacy Practices* may be found at <http://hr.vanderbilt.edu/forms>

Equal Opportunity

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



**HUMAN
RESOURCES**

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