The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, for medical, call Aetna at **1-800-743-0910** or visit **www.Aetna.com**; for pharmacy call Capital Rx at 1-8833-599-0942 or visit www.cap-rx.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://hr.vanderbilt.edu/benefits/UniformGlossaryTerms.pdf or call 1-800-743-0910 request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$800 individual or $1,600 family for In-Network Aetna National Network; $2,400 individual or $4,800 family for Out of Network	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount, but a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No other specific deductibles.	
What is the out-of-pocket limit for this plan?	For in-network providers, $3,500 individual/ $7,000 family; for out-of-network providers $7,000 individual / $13,000 family; Pharmacy Plan has a separate OOP max, therefore pharmacy claims are not included in the Medical OOP max	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes, For a list of preferred in-network providers visit Provider Search Webpage call 1- 800-743-0910.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider / Pharmacy	Out-of-Network Provider/Pharmacy (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/office visit.	50% coinsurance after deductible	View plan booklet at http://hr.vanderbilt.edu//benefits/sbc-eoc.php
	Specialist visit	$50 copay/office visit	50% coinsurance after deductible	
	Preventive care/screening/ immunization	No charge	No charge	You may have to pay for services that aren't preventative. Ask your provider if the services needed are preventative. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work) or imaging.	10% coinsurance after deductible	50% coinsurance after deductible	View plan booklet at http://hr.vanderbilt.edu//benefits/sbc-eoc.php
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.cap-rx.com	Maintenance Generic	$1 copay/prescription (in-network pharmacy) $10 copay/prescription (mail order)	Not covered	Please refer to Capital Rx website for in-network pharmacies: www.cap-rx.com
	Level 1	$15 copay/prescription ($45 copay/prescription (mail order)	Not covered	Vanderbilt encourages members to use generics when available. If you, or your physician, choose a Capital Rx-formulary brand-name drug instead of the generic equivalent, you will pay the difference between the brand and the generic as well as the applicable copayment. Drugs not listed on Vanderbilt's formulary are not covered by the Plan.
	Level 2	30% coinsurance up to $150 (in-network pharmacy) 30% coinsurance up to $450 (mail order)	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider / Pharmacy	Out-of-Network Provider (You will pay the most)	
	Level 3	50% coinsurance up to $200 (in-network pharmacy) 50% coinsurance $600 min (mail order)	Not covered	View plan booklet at http://hr.vanderbilt.edu//benefits/sbc-eoc.php
	Specialty drugs	10% coinsurance up to $200 (at VUMC pharmacies only)	N/A	Only available for a 30-day supply at the Vanderbilt Outpatient Pharmacies.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 copay, then 10% coinsurance after deductible	$150 /copay then 50% coinsurance after deductible.	View plan booklet at http://hr.vanderbilt.edu//benefits/sbc-eoc.php
	Physician/surgeon fees	10% coinsurance after deductible	50% coinsurance after deductible	
If you need immediate medical attention	Emergency room care	$250 copay, then 10% after deductible	$250 copay, then 10% after deductible	View plan booklet at http://hr.vanderbilt.edu//benefits/sbc-eoc.php
	Emergency medical transportation	10% coinsurance after deductible	10% coinsurance after deductible	
	Urgent care	$50 copay/visit, then 10% coinsurance after deductible	$75 copay/visit, then 50% coinsurance after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	$150 copay then 10% coinsurance after deductible.	$150 copay then 50% coinsurance after deductible	View plan booklet at http://hr.vanderbilt.edu//benefits/sbc-eoc.php
	Physician/surgeon fees	10% coinsurance after deductible	50% coinsurance after deductible	View plan booklet at http://hr.vanderbilt.edu//benefits/sbc-eoc.php

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider / Pharmacy	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or services substance abuse	Outpatient services	$50 copay/visit	50% coinsurance after deductible	View plan booklet at http://hr.vanderbilt.edu//benefits/sbc-eoc.php
	Other Outpatient services	$150 copay then 10% coinsurance after deductible.	$150 copay then 50% coinsurance after deductible	
	Inpatient services	$150 copay then 10% coinsurance after deductible.	$150 copay then 50% coinsurance after deductible	
If you are pregnant	Prenatal Office visits	No charge	Not covered	Cost-sharing does not apply for in-network prenatal/postnatal preventative office visits, but depending on the types of services, coinsurance or a deductible may apply.
	Childbirth/delivery professional services	10% coinsurance after deductible	50% coinsurance after deductible	
	Childbirth/delivery facility services	$150 copay then 10% coinsurance after deductible.	$150 copay then 50% coinsurance after deductible.	
If you need help recovering or have other special health needs	Home health care	10% coinsurance after deductible.	50% coinsurance after deductible.	Home health care – 120 visit max per calendar year Physical Therapy, Occupational Therapy, & Speech Therapy, Skilled Nursing Care - 60 visit max per calendar year Chiropractor Services - 15 visit max per calendar year
	Rehabilitation services	10% coinsurance after deductible.	50% coinsurance after deductible.	
	Habilitation services	10% coinsurance after deductible.	50% coinsurance after deductible.	
	Skilled nursing care	10% coinsurance after deductible.	50% coinsurance after deductible.	
	Durable medical equipment	10% coinsurance after deductible.	50% coinsurance after deductible.	
	Hospice services	$150 copay then 10% coinsurance after deductible..	50% coinsurance after deductible.	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	N/A
	Children's glasses	Not covered	Not covered	N/A
	Children's dental check-up	Not covered	Not covered	N/A

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider / Non- Vanderbilt Pharmacy	Out-of-Network Provider (You will pay the most)	
Limits for Infertility Services - Comprehensive and Advanced Reproductive Technology (ART)	Limit per year for Comprehensive and ART medical services combined	$5,000 This limit is combined for in-network and out-of-network benefits	$5,000 This limit is combined for in-network and out-of-network benefits	N/A
	Limit per lifetime for Comprehensive and ART medical services combined	$10,000 - Combined for in-network and out-of-network benefits	$10,000 - Combined for in-network and out-of-network benefits	N/A
	Limit per lifetime for Comprehensive and ART medical services combined	$5,000	Not Covered	N/A
	Limit per lifetime for infertility medications.*	$10,000	Not Covered	N/A

* Infertility medications are provided by the pharmacy plan.

*For more information about limitations and exceptions, see plan or policy documents at http://hr.vanderbilt.edu//benefits/sbc-eoc.php

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental Care
- Hearing aids for adults
- Long Term Care
- Private Duty Nursing
- Routine eye care
- Routine Foot Care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery (limitations apply)
- Chiropractic Care (limitations apply)
- Hearing aids for children under 18
- Infertility Treatment (limitations apply)
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:
Tennessee Department of Commerce & Insurance
500 James Robertson Parkway
Davy Crockett Tower, 4th Floor
Nashville, TN 37243-0565
(615) 741-2241
https://www.tn.gov/commerce/consumer-services.html

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: For medical, call Aetna at **1-800-743-0910** or visit **www.Aetna.com;** for pharmacy call Capital Rx at 1-833-599-0942 or visit www.cap-rx.com.

Does this plan provide Minimum Essential Coverage? **Yes**.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **Yes**.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(Family Coverage)
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,600
Specialist copayment	$50
Hospital (facility) copayment	$150
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,600
Copayments	$200
Coinsurance	$1100
Pharmacy	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,900**

Managing Joe's type 2 Diabetes
(Family Coverage)
(a year of routine in-network care of a well- controlled condition)

The plan's overall deductible	$1600
Specialist copayment	$50
Primary copayment	$30
Other coinsurance	10%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$1600
Copayments	$50
Coinsurance	$60
Pharmacy	$150
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,420**

Mia's Simple Fracture
(Individual Coverage)
(in-network emergency room visit and follow up care)

The plan's overall deductible	$800
Specialist copayment	$50
Emergency Room copayment	$250
Emergency Room coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$800
Copayments	$300
Coinsurance	$80
Pharmacy	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,180**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: Total Rewards benefits@vanderbilt.edu or 615-343-4788.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.