

Schedule of benefits

If this is an ERISA plan, you may have certain rights under this plan. ERISA may not apply to a church or government group. Please contact the policyholder for additional information.

Prepared for:

Employer:	Vanderbilt University
Contract number:	ASC-0811338
Plan name:	Choice POS II CDHP Consumer Directed Health Plan
Schedule of benefits:	1A
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Third Party Administrative Services provided by Aetna Life Insurance Company

Schedule of benefits

This schedule of benefits (schedule) lists the **deductibles**, or **payment percentage**, if any apply to the **covered services** you receive under the plan. You should review this schedule to become aware of these and any limits that apply to these services.

How your cost share works

- The **deductibles** listed in the schedule below are the amounts that you pay for **covered services**.
 - For the **covered services** under your medical plan, you will be responsible for the dollar amount
- **Payment percentage** amounts, if any, listed in the schedule below are what the plan will pay for **covered services**.
- Sometimes your cost share shows a combination of your dollar amount that you will be responsible for and the **payment percentage** that your plan will pay.
- You are responsible to pay any **deductibles**, and remaining **payment percentage**, if they apply and before the plan will pay for any **covered services**.
- This plan doesn't cover every health care service. You pay the full amount of any health care service you get that is not a **covered service**.
- This plan has limits for some **covered services**. For example, these could be visit, day or dollar limits. They may be:
 - Combined limits between in-**network** and **out-of-network providers**
 - Separate limits for in-**network** and **out-of-network providers**
- Your cost share may vary if the **covered service** is preventive or not. Ask your **physician** or contact us if you have a question about what your cost share will be.

For examples of how cost share and **deductible** work, go to the *Using your Aetna benefits* section under Individuals & Families at <https://www.aetna.com/>

Important note:

Covered services are subject to the **deductible**, **maximum out-of-pocket**, limits, or **payment percentage** unless otherwise stated in this schedule.

Under this plan, you will:

1. Pay your **deductible**
2. Then pay any remaining after **deductible** up to the **maximum out-of-pocket**

How your deductible works

The **deductible** is the amount you pay for **covered services** each year before the plan starts to pay. This is in addition to any **payment percentage** you pay when you get **covered services** from an in-**network**, **out-of-network provider**. This schedule shows the **deductible** amounts that apply to your plan. Once you have met your **deductible**, we will start sharing the cost when you get **covered services**. You will continue to pay the **payment percentage**, if any, for **covered services** after you meet your **deductible**.

How your PCP or physician office visit cost share works

You will pay the **PCP** cost share when you get **covered services** from any **PCP**.

How your maximum out-of-pocket works

This schedule shows the **maximum out-of-pocket limits** that apply to your plan. Once you reach your **maximum out-of-pocket limit**, your plan will pay for **covered services** for the remainder of that year.

Contact us

We are here to answer questions. See the *Contact us* section in your booklet.

This schedule replaces any schedule of benefits previously in use. Keep it with your booklet.

Plan features

Deductible

You have to meet your **deductible** before this plan pays for benefits.

Deductible type	In-network	Out-of-network
Individual	\$2,000 per year	\$3,550 per year
Family	\$4,000 per year	\$7,100 per year

Deductible waiver

There is no in-network **deductible** for the following **covered services**:

- Preventive care
- Family planning services – female contraceptives

Maximum out-of-pocket limit

Includes the **deductible**.

Maximum out-of-pocket type	In-network	Out-of-network
Individual	\$4,500 per year	\$7,000 per year
Family	\$9,000 per year	\$13,000 per year

General coverage provisions

This section explains the **deductible**, **maximum out-of-pocket limit** and limitations listed in this schedule.

Deductible provisions

In-network **covered services** will apply only to the in-network **deductible**. Out-of-network **covered services** will apply only to the out-of-network **deductible**.

The **deductible** may not apply to some **covered services**. You still pay the **payment percentage**, if any, for these **covered services**.

Individual deductible

You pay for **covered services** each year before the plan begins to pay. After the amount paid for **covered services** reaches this individual **deductible**, this plan starts to pay for **covered services** for the rest of the year. The individual **deductible** applies to a person who is enrolled for self-only coverage with no dependent coverage.

Family deductible

You and your covered dependents pay for **covered services** each year before the plan begins to pay. After the amount paid for **covered services** reaches this family **deductible**, this plan starts to pay for **covered services** for the rest of the year. The family **deductible** applies to a person enrolled with one or more dependents.

Payment Percentage

This is the percentage of the bill you pay after you meet your **deductible**. This is in addition to any out-of-pocket costs you have to pay to meet your **deductible**, if you have one.

Maximum out-of-pocket limit

The **maximum out-of-pocket limit** is the most you will pay per year in **payment percentages** and **deductible**, if any, for **covered services**.

In-network **covered services** will apply only to the in-network **maximum out-of-pocket limit**. Out-of-network **covered services** will apply only to the out-of-network **maximum out-of-pocket limit**.

Individual maximum out-of-pocket limit

- This plan may have an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit**, each of you must meet your **maximum out-of-pocket limit** separately.
- After you or your covered dependents meet the individual **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the rest of the year for that person.

Family maximum out-of-pocket limit

After you or your covered dependents meet the family **maximum out-of-pocket limit**, this plan will pay 100% of the eligible charge for **covered services** that would apply toward the limit for the remainder of the year for all covered family members. The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members.

To satisfy this **maximum out-of-pocket limit** for the rest of the year, the following must happen:

- The family **maximum out-of-pocket limit** is met by a combination of family members
- No one person within a family will contribute more than the individual **maximum out-of-pocket limit** amount in a year

If the **maximum out-of-pocket limit** does not apply to a **covered service**, your cost share for that service will not count toward satisfying the **maximum out-of-pocket limit** amount.

Certain costs that you have do not apply toward the **maximum out-of-pocket limit**. These include:

- All costs for non-covered services which are identified in the booklet and the schedule
- Charges, expenses or costs in excess of the **recognized charge**
- Costs for non-emergency use of the emergency room
- Costs for non-urgent use of an urgent care **provider**

Limit provisions

Covered services will apply to the in-network and out-of-network limits.

Your financial responsibility and decisions regarding benefits

We base your financial responsibility for the cost of **covered services** on when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of **stays** that occur in more than one year. Decisions regarding when benefits are covered are subject to the terms and conditions of the booklet.

Covered services

Acupuncture

Description	In-network	Out-of-network
Acupuncture	80% per visit after deductible	40% per visit after deductible
Visit limit per year	10	10

Ambulance services

Description	In-network	Out-of-network
Emergency services	80% per trip after deductible	80% per trip after deductible
Non-emergency services	80% per trip after deductible	80% per trip after deductible

Applied behavior analysis

Description	In-network	Out-of-network
Applied behavior analysis	80% per visit after deductible	40% per visit after deductible

Autism spectrum disorder

Description	In-network	Out-of-network
Diagnosis and testing	80% per visit after deductible	40% per visit after deductible
Treatment	80% per visit after deductible	40% per visit after deductible
Occupational (OT), physical (PT) and speech (ST) therapy for autism spectrum disorder	80% per visit after deductible	40% per visit after deductible

Behavioral health

Mental health disorders treatment

Coverage provided is the same as for any other illness

Description	In-network	Out-of-network
Inpatient services-room and board including residential treatment facility	80% per admission after deductible	40% per admission after deductible

Description	In-network	Out-of-network
Outpatient office visit to a physician or behavioral health provider	80% per visit after deductible	40% per visit after deductible
Physician or behavioral health provider telemedicine consultation	80% per visit after deductible	40% per visit after deductible
Outpatient mental health disorders telemedicine cognitive therapy consultations by a physician or behavioral health provider	80% per visit after deductible	40% per visit after deductible

Description	In-network	Out-of-network
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program The cost share doesn't apply to in-network peer counseling support services after you meet your deductible	80% per visit after deductible	40% per visit after deductible

Substance related disorders treatment

Includes **detoxification**, rehabilitation and **residential treatment facility**

Coverage provided is the same as for any other illness

Description	In-network	Out-of-network
Inpatient services-room and board during a hospital stay	80% per admission after deductible	40% per admission after deductible

Description	In-network	Out-of-network
Outpatient office visit to a physician or behavioral health provider	80% per visit after deductible	40% per visit after deductible
Physician or behavioral health provider telemedicine consultation	80% per visit after deductible	40% per visit after deductible
Outpatient telemedicine cognitive therapy consultations by a physician or behavioral health provider	80% per visit after deductible	40% per visit after deductible

Description	In-network	Out-of-network
Other outpatient services including: • Behavioral health services in the home • Partial hospitalization treatment • Intensive outpatient program The cost share doesn't apply to in-network peer counseling support services after you meet your deductible	80% per visit after deductible	40% per visit after deductible

Clinical trials

Description	In-network	Out-of-network
Experimental or investigational therapies	80% per visit after deductible	40% per visit after deductible
Routine patient costs	80% per visit after deductible	40% per visit after deductible

Durable medical equipment (DME)

Description	In-network	Out-of-network
DME	80% per item after deductible	40% per item after deductible

Emergency services

Description	In-network	Out-of-network
Emergency room	80% per visit after deductible	Paid same as in-network

Non-emergency care in a hospital emergency room	Not covered	Not covered
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Emergency services important note:

- **Out-of-network providers** do not have a contract with us. The **provider** may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by the plan. If the **provider** bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the **provider**. Make sure the member ID is on the bill.
- In the case of a surprise bill from an out-of-network provider, where you had no control of their participation in your **covered services**, you will pay the same cost share you would have if the **covered services** were received from a **network provider**. The cost share will be based on the median contracted rate. Contact us immediately if you receive such a bill.

Foot orthotic devices (For diabetics only)

Description	In-network	Out-of-network
Orthotic devices	80% per item after deductible	40% per item after deductible

Habilitation therapy services

Physical (PT), occupational (OT) therapies

Description	In-network	Out-of-network
PT, OT therapies	80% per visit after deductible	40% per visit after deductible

Speech therapy (ST)

Description	In-network	Out-of-network
ST	80% per visit after deductible	40% per visit after deductible

Hearing aids

Description	In-network	Out-of-network
Hearing aids	80% per item after deductible	40% per item after deductible

Limit	\$1,000 per 3 years	\$1,000 per 3 years
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Hearing exams

Description	In-network	Out-of-network
Hearing exams	80% per visit after deductible	40% per visit after deductible
Visit limit	1 visit every year	1 visit every year

Home health care

A visit is a period of 4 hours or less

Description	In-network	Out-of-network
Home health care	80% per visit after deductible	40% per visit after deductible

Visit limit per year	120	120
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Home health care important note:

Intermittent visits are periodic and recurring visits that skilled nurses make to ensure your proper care. The intermittent requirement may be waived to allow for coverage for up to 12 hours with a daily maximum of 3 visits.

Hospice care

Description	In-network	Out-of-network
Inpatient services - room and board	80% after deductible	40% after deductible

Description	In-network	Out-of-network
Outpatient services	80% per visit after deductible	40% per visit after deductible

Limit per lifetime	unlimited	unlimited
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Hospice important note:

This includes part-time or infrequent nursing care by an R.N. or L.P.N. to care for you up to 8 hours a day. It also includes part-time or infrequent home health aide services to care for you up to 8 hours a day.

Hospital care

Description	In-network	Out-of-network
Inpatient services – room and board	80% after deductible	40% after deductible

Infertility services

Basic infertility

Description	In-network	Out-of-network
Treatment of basic infertility	80% per visit after deductible	40% per visit after deductible

Comprehensive infertility services

Description	In-network	Out-of-network
	50% per visit after deductible	40% per visit after deductible

Advanced reproductive technology (ART)

Description	In-network	Out-of-network
	50% per visit after deductible	40% per visit after deductible

Limits for Advanced reproductive technology (ART)

Description	In-network	Out-of-network
Limit per year for ART and Comprehensive 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
Limit per lifetime ART and Comprehensive services combined	\$10,000 Combined for in-network and out-of-network benefits	\$10,000 Combined for in-network and out-of-network benefits

Jaw joint disorder

Includes TMJ

Description	In-network	Out-of-network
Jaw joint disorder treatment	80% per visit after deductible	40% per visit after deductible

Maternity and related newborn care

Includes complications

Description	In-network	Out-of-network
Inpatient services – room and board	80% per admission after deductible	40% per admission after deductible
Services performed in physician or specialist office or a facility	80% per visit after deductible	40% per visit after deductible
Other services and supplies	80% after deductible	40% after deductible

Maternity and related newborn care important note:

Any cost share collected applies only to the delivery and postpartum care services provided by an OB, GYN or OB/GYN. Review the *Maternity* section of the certificate. It will give you more information about coverage for maternity care under this plan.

Nutritional support

Description	In-network	Out-of-network
Nutritional support	80% per visit after deductible	40% per visit after deductible

Obesity surgery

Description	In-network	Out-of-network
Inpatient services – room and board	80% per admission after deductible	40% per admission after deductible
Limit	1 procedure per year	1 procedure per year

Description	In-network	Out-of-network
Outpatient services	80% per visit after deductible	40% per visit after deductible
Limit	1 procedure per year	1 procedure per year

Oral and maxillofacial treatment (mouth, jaws and teeth)

Description	In-network	Out-of-network
Treatment of mouth, jaws and teeth	80% per visit after deductible	40% per visit after deductible

Outpatient surgery

Description	In-network	Out-of-network
At hospital outpatient department	80% per visit after deductible	40% per visit after deductible

Physician and specialist services

Physician services-general or family practitioner

Description	In-network	Out-of-network
Physician office hours (not-surgical, not preventive)	80% per visit after deductible	40% per visit after deductible
Physician surgical services	80% per visit after deductible	40% per visit after deductible

Description	In-network	Out-of-network
Physician telemedicine consultation	80% per visit after deductible	40% per visit after deductible

Description	In-network	Out-of-network
Physician visit during inpatient stay	80% per visit after deductible	40% per visit after deductible

Specialist

Description	In-network	Out-of-network
Specialist office hours (not-surgical, not preventive)	80% per visit after deductible	40% per visit after deductible
Specialist surgical services	80% per visit after deductible	40% per visit after deductible

Description	In-network	Out-of-network
Specialist telemedicine consultation	80% per visit after deductible	40% per visit after deductible

All other services not shown above

Description	In-network	Out-of-network
All other services	80% per visit after deductible	40% per visit after deductible

Preventive care

Description	In-network	Out-of-network
Preventive care services	100% per visit, no deductible applies	100% per visit, no deductible applies
Breast feeding counseling and support	100% per visit, no deductible applies	100% per visit, no deductible applies
Breast feeding counseling and support limit	6 visits in a group or individual setting Visits that exceed the limit are covered under the physician services office visit	6 visits in a group or individual setting Visits that exceed the limit are covered under the physician services office visit
Breast pump, accessories and supplies limit	Electric pump: 1 every 3 years Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump	Electric pump: 1 every 3 years Manual pump: 1 per pregnancy Pump supplies and accessories: 1 purchase per pregnancy if not eligible to purchase a new pump
Breast pump waiting period	Electric pump: 3 years to replace an existing electric pump	Electric pump: 3 years to replace an existing electric pump
Counseling for alcohol or drug misuse	100% per visit, no deductible applies	100% per visit, no deductible applies
Counseling for alcohol or drug misuse visit limit	5 visits/per year	5 visits/per year
Counseling for obesity, healthy diet	100% per visit, no deductible applies	100% per visit, no deductible applies
Counseling for obesity, healthy diet visit limit	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.

Counseling for sexually transmitted infection	100% per visit, no deductible applies	100% per visit, no deductible applies
Counseling for sexually transmitted infection visit limit	2 visits/per year	2 visits/per year
Counseling for tobacco cessation	100% per visit, no deductible applies	100% per visit, no deductible applies
Counseling for tobacco cessation visit limit	8 visits/per year	8 visits/per year
Family planning services (female contraception counseling)	100% per visit, no deductible applies	100% per visit, no deductible applies
Family planning services (female contraception counseling) limit	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting	Contraceptive counseling limited to 2 visits/12 months in a group or individual setting
Immunizations	100%, no deductible applies	100% per visit, no deductible applies
Immunizations limit	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician	Subject to any age limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician
Routine cancer screenings	100% per visit, no deductible applies	100% per visit, no deductible applies
Routine cancer screening limits	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your physician or see the <i>Contact us</i> section	Subject to any age, family history and frequency guidelines as set forth in the most current: Evidence-based items that have a rating of A or B in the current recommendations of the USPSTF The comprehensive guidelines supported by the Health Resources and Services Administration For more information contact your physician or see the <i>Contact us</i> section
Generic preventive care contraceptives (birth control)	100%	100%
Routine lung cancer screening	100% per visit, no deductible applies	100% per visit, no deductible applies
Routine lung cancer screening limit	1 screening every 12 per year Screenings that exceed this limit covered as outpatient diagnostic testing	1 screening every 12 per year Screenings that exceed this limit covered as outpatient diagnostic testing

Routine physical exam	100% per visit, no deductible applies	100% per visit, no deductible applies
Routine physical exam limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every year after that age, up to age 22; 1 exam every year after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration for children and adolescents Limited to 7 exams from age 0-1 year; 3 exams every 12 months age 1-2; 3 exams every 12 months age 2-3; and 1 exam every year after that age, up to age 22; 1 exam year months after age 22 High risk Human Papillomavirus (HPV) DNA testing for woman age 30 and older limited to 1 every 36 months
Well woman GYN exam	100% per visit, no deductible applies	100% per visit, no deductible applies
Well woman GYN exam limit	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

Prosthetic devices

Description	In-network	Out-of-network
Prosthetic devices	80% per item after deductible	40% per item after deductible

Reconstructive surgery and supplies

Including breast surgery

Description	In-network	Out-of-network
Surgery and supplies	80% per visit after deductible	40% per visit after deductible

Short-term rehabilitation services

Cardiac rehabilitation

Description	In-network	Out-of-network
Cardiac rehabilitation	80% per visit after deductible	40% per visit after deductible

Pulmonary rehabilitation

Description	In-network	Out-of-network
Pulmonary	80% per visit after deductible	40% per visit after deductible

Cognitive rehabilitation

Description	In-network	Out-of-network
Cognitive rehabilitation	80% per visit after deductible	40% per visit after deductible

Physical and occupational therapies

Description	In-network	Out-of-network
At the physician office	80% per visit after deductible	40% per visit after deductible

Speech therapy (ST)

Description	In-network	Out-of-network
At the office	80% per visit after deductible	40% per visit after deductible

Physical and occupational therapies

Description	In-network	Out-of-network
Visit limit per year	60	60

Speech therapy (ST)

Description	In-network	Out-of-network
Visit limit per year	60	60

Spinal manipulation

Description	In-network	Out-of-network
At the physician office	80% per visit after deductible	40% per visit after deductible

Visit limit per year	15	15
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Skilled nursing facility

Description	In-network	Out-of-network
Inpatient services - room and board	80% per admission after deductible	40% per admission after deductible
Other inpatient services and supplies	80% per admission after deductible	40% per admission after deductible

Day limit per year	60	60
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Tests, images and labs – outpatient**Diagnostic complex imaging services**

Description	In-network	Out-of-network
	80% per visit after deductible	40% per visit after deductible

Diagnostic lab work

Description	In-network	Out-of-network
	80% per visit after deductible	40% per visit after deductible

Diagnostic x-ray and other radiological services

Description	In-network	Out-of-network
	80% per visit after deductible	40% per visit after deductible

Therapies

Chemotherapy

Description	In-network	Out-of-network
Chemotherapy services	80% per visit after deductible	40% per visit after deductible

Gene-based, cellular and other innovative therapies (GCIT)

Description	In-network (GCIT-designated facility/provider)	Out-of-network (Including providers who are otherwise part of Aetna's network but are not GCIT-designated facilities/ providers)
Services and supplies	80% per visit after deductible	Not covered
Gene therapy products, prescription drugs	80% per visit after deductible	Not covered

Infusion therapy

Outpatient services

Description	In-network	Out-of-network
	80% per visit after deductible	40% per visit after deductible

Radiation therapy

Description	In-network	Out-of-network
Radiation therapy	80% per visit after deductible	40% per visit after deductible

Respiratory therapy

Description	In-network	Out-of-network
Respiratory therapy	80% per visit after deductible	40% per visit after deductible

Transplant services

Description	In-network (IOE facility)	Out-of-network (Includes providers who are otherwise part of Aetna's network but are non-IOE providers)
Inpatient services and supplies	80% per transplant after deductible	40% per transplant after deductible
Physician services	80% per visit after deductible	40% per visit after deductible

Urgent care services

At a freestanding facility or **provider** that is not a **hospital**

A separate urgent care cost share will apply for each visit to an urgent care facility or **provider**

Description	In-network	Out-of-network
Urgent care facility	80% per visit after deductible	40% per visit after deductible

Non-urgent use of an urgent care facility or provider	Not covered	Not covered
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Walk-in clinic

Not all preventive care services are available at a **walk-in clinic**. All services are available from a network **physician**.

Description	In-network	Out-of-network
Non-emergency services	80% per visit after deductible	100% per visit after deductible
Preventive immunizations	100% per visit, no deductible applies	100% per visit after deductible
Immunization limits	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician	Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician
Screening and counseling services	100% per visit, no deductible applies	100% per visit after deductible
Screening and counseling limits	See the <i>Preventive care services</i> section of the SOB	See the <i>Preventive care services</i> section of the SOB