VANDERBILT
Human Resources

Health Plan

Summary Plan Description

January 1, 2025

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 Capital Rx. The Aetna Choice CDHP & Aetna Select PPO plans are self-insured. The Aetna International health plan is a fully insured plan via Aetna.

SUMMARY OF HEALTH PLAN BENEFITS

Eligibility

All fully benefits-eligible or partially benefits-eligible faculty and staff as defined by Vanderbilt University (the "University") are eligible for immediate coverage under the Group Health Care Plan for Vanderbilt University (the "Plan"). In the case of an employee who acquires a spouse or child after becoming eligible for coverage, such family member is eligible on the date acquired.

Health Plan Options

The Plan includes a choice of three options:

- Aetna Choice (CDHP)
- Aetna Select (PPO)
- Aetna International (PPO)

All fully benefits-eligible faculty and staff (excluding J1T visa holders) are automatically enrolled for individual coverage under the default option (Aetna Choice (CDHP), 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 for other eligible family members, both the employee and his or her eligible family members must be enrolled in the same Plan option.

All J1T visa holders are automatically enrolled for individual coverage under the default option (Aetna International (PPO), 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 for other eligible family members, both the employee and his or her eligible family members must be enrolled in the same Plan option.

Partially benefits-eligible faculty and staff are not automatically enrolled in coverage under the Plan.

Coverage Tiers

The University 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 employee cost of medical coverage under Aetna Choice (CDHP) and Aetna Select (PPO) are 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 your monthly cost for coverage. These can be found in the Benefits Overview on the HR website. The employee cost of coverage under the Aetna International PPO plan is based on a percentage of the total premium. The University will provide you with information regarding your cost for coverage under these options.

How to Enroll

You must enroll for coverage for yourself and any eligible dependents by completing the online benefits enrollment process at the time you begin work at the University by logging into the My VU Benefits website. Once enrolled, your coverage will continue under the elected option and coverage tier unless you elect to change or waive your coverage during Open Enrollment each year. If you fail to complete Open Enrollment, your coverage will be defaulted into the Aetna Choice (CDHP) plan at your current coverage tier. (See "Waiving Health Plan Coverage" and "Changing Coverage" below.)

Waiving Health Plan Coverage

In the event that you are covered by another health plan, you may elect to waive coverage under the Plan. To waive coverage, newly hired employees must agree to the conditions of the Health Plan Waiver found within the online benefits enrollment tool within 30 days of their date of hire. Any eligible employee may waive health coverage for themselves and/or eligible family members, but to do so, you must agree to the conditions of the Health Plan Waiver found within the Open Enrollment online benefits enrollment tool during Open Enrollment.

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 if you experience a Family Status Change/Qualifying Life Event. 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 losing coverage under 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 newly acquired spouse and/or children, provided that you request enrollment within 30 days after the Family Status Change/Qualifying Life Event date by completing the Family Status Change/Qualifying 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 and 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 Capital Rx 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.

Changing Coverage

You may change your Plan option and/or coverage tier only (1) during Open Enrollment, which generally occurs each fall (contact Benefits Administration for exact dates), or (2) in the event of a Family Status Change/Qualifying Life Event (see **Definition of Terms**).

The University offers an "Active" Open Enrollment each year. "Active" Open Enrollment requires all eligible employees to log into My VU Benefits to select their health plan coverage for the upcoming calendar year. Eligible employees that are covered under the Plan at the time of Open Enrollment and who do not complete Open Enrollment will be defaulted into the Aetna Choice (CDHP) plan at their current coverage tier. J1T Visa employees that are covered under the Plan at the time of Open Enrollment and who do not complete Open Enrollment will be defaulted into the Aetna International plan at their current coverage tier. Coverage for eligible employees that have previously waived coverage and do not complete Open Enrollment will continue to be waived.

If you experience a Qualifying Life Event during the plan year you may change your Plan option and/or coverage tier 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; please see **Definition of Terms** for a complete list of Qualifying Life Events). The effective date of any coverage change due to a Qualifying Life Event will be determined based on the Qualifying Life Event and may be retroactive. You will be required to pay any premiums due for added coverage or difference in premiums resulting from a retroactive effective date of your change.

Termination of Coverage

If a person ceases to be employed by the University, individual coverage and any 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. For example:

- An employee's divorce will terminate the coverage of the employee's spouse at midnight on the day in which the final divorce decree is filed with the court. It is the employee's responsibility to notify the Plan of the Qualifying Life Event (divorce) within 30 days of such event through 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**, for age limit eligibility. It is the employee's responsibility to notify Benefits Administration if the child is eligible for coverage beyond the age of 26 due to a disability. Such notification must be made in writing at least 90 days prior to the child's 26th birthday, as there is an approval process conducted by Aetna. Your Benefit Representative can provide guidance on this process.

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

For certain Qualifying Life Events, coverage under the Plan may be continued beyond the normal termination date. Your right to continue group health plan coverage is described in the section entitled "Continuing Group Coverage – COBRA" in this document. If your Plan coverage terminates, the Plan Administrator can provide you a certificate that documents your coverage under the Plan for up to the previous 18 months.

Should the University opt to terminate the Plan, you will be provided written notice of such termination along with information regarding alternatives for coverage and procedures for obtaining any such coverage.

Rescission of Health Coverage

The Plan is limited by the Patient Protection and Affordable Care Act (PPACA) from retroactively terminating an enrollee's coverage. Under the PPACA, a "rescission" is a cancellation or discontinuance of health plan coverage that has retroactive effect. The Plan may rescind coverage retroactively if such coverage was obtained as a result of fraud or intentional misrepresentation. However, the Plan is required to give 30 days' prior written notice for rescission of coverage. An 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 also be retroactively terminated for nonpayment of employee required premiums or contributions toward the cost of coverage, which is not considered a rescission under the PPACA.

The Plan can terminate coverage prospectively (i) upon discovery during an eligibility audit that a covered dependent does not meet plan criteria for eligibility and there is no evidence of fraud or intentional misrepresentation, and (ii) when an employee no longer meets the eligibility requirements for the Plan. In such circumstances, coverage will end as of the end of the month in which it was determined that the employee or dependent does not meet the eligibility criteria.

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, at the option of the Plan, all or a portion of the benefits provided by the Plan may be paid directly to the person rendering such service, unless the participant requests otherwise in writing. Any payment made by the Plan in good faith pursuant to this provision shall fully discharge the Plan and the University to the extent of such payment.

General Provisions

The University has the exclusive right, power, and authority, in its sole and absolute discretion, to administer and interpret the Plan and other Plan documents. The University has all powers reasonably necessary to carry out its responsibilities under the Plan including, but not limited to, the sole and absolute discretionary authority to:

- Administer the Plan in accordance with its terms and to interpret Plan policies and procedures;
- Resolve and clarify inconsistencies, ambiguities, and omissions in the Plan document and among and between the Plan document and other related documents;
- Take all actions and make all decisions regarding questions of coverage, eligibility, and entitlement to benefits, and benefit amounts; and
- Process and approve or deny all claims for benefits.

The decision of the University on any disputes arising under the Plan, including, but not limited to, questions of construction, interpretation, and administration, shall be final, conclusive, and binding on all persons having an interest in or under the Plan. Any determination made by the University shall be given deference in the event the determination is subject to judicial review and shall be overturned by a court of law only if it is arbitrary and capricious.

The 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.

SCHEDULE OF BENEFITS

A complete description of the benefits available under each coverage option is contained in the Evidence of Coverage (EOC) or Summary Booklet specific to each option. The EOCs and/or Summary Booklets can be found on Vanderbilt's HR website: Benefit Plan Details (https://hr.vanderbilt.edu/benefits/sbc-eoc.php)

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 in light of these provisions. 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

The University offers three health plan options, each administered by Aetna.

The Aetna Choice (CDHP) and Aetna Select (PPO) have two tiers with varying levels of coverage:

- Tier 1: Aetna "POS II" National network (In-network)
- Tier 2: Out-of-network: Providers that are out-of-network 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) at http:/www.aetna.com/docfind/custom/vanderbilt/.

The Aetna International option for J1T employees which has three tiers offering varying levels of coverage:

- Outside U.S.
- Inside U.S. Preferred Benefits (In-Network)
- Inside U.S. Non-Preferred Benefits (Out-of-Network)

To learn more about the networks and check providers and facilities, visit Vanderbilt's HR website: Aetna International Health Plan (https://hr.vanderbilt.edu/benefits/internationalhealthplan.php).

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

Deductibles, co-payments, co-insurance amounts, and out-of-pocket maximums in each of the Plan options are established by the University and are subject to change. To determine the applicable 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, definitions of "deductibles", "co-payments", "co-insurance" and "out-of-pocket maximums", along with other terms used in this Plan may be found in the uniform glossary of health coverage and medical terms on the HR website.

Prior Authorization

Prior authorization (also called "precertification") may be required for certain services in certain options. Failure to follow the prior authorization procedure will result in benefits being reduced or denied. Please refer to your option's Evidence of Coverage (EOC) or Summary Booklet for an explanation of the precertification process.

Plan Payment

Participating providers (hospitals and physicians) within the network option you select 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 you or 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. Please refer to your option's Evidence of Coverage (EOC) or Summary Booklet for an explanation of the coordination of benefits under the Plan.

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 Plan to recover payments made by the Plan 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 relating to injuries caused by the accident. Please refer to your option's Evidence of Coverage (EOC) or Summary Booklet for an explanation of the subrogation provisions applicable to the Plan.

Health Plan Exclusions and Limitations

The Evidence of Coverage (EOC) for each 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 these exclusions and limitations.

Applied Behavioral Analysis Therapy

Each Plan option covers Applied Behavioral Analysis (ABA) therapy for autism spectrum disorder.

Preventive Services

Eligible preventive services are covered under each of the available Plan options. Please refer to your option's Evidence of Coverage (EOC) or Summary Booklet for a list of eligible preventive services.

Prescription Drugs

Capital Rx is the University's Pharmacy Benefits Manager. A separate membership identification card for this coverage will be mailed to individuals covered under Aetna Choice CDHP or Aetna Select PPO. Refer to the Capital Rx Summary Booklet and website for specific information regarding the preferred drug list (formulary) and network of participating pharmacies. The Capital Rx formulary for the University (the "Formulary") is a list of drugs selected by the Capital Rx Pharmacy and Therapeutics (P&T) Committee. Plan participants are not prohibited from receiving prescriptions for non-formulary drugs, but the Plan is not required to cover non-formulary drugs. In other words, if a prescription drug is not on the Formulary, it is not covered under the Plan and the participant is responsible for the full cost of the drug. For drugs on the Formulary, your cost is either a deductible, 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. Coverage for specialty drugs are available only when filled through one of the Vanderbilt Outpatient Pharmacies. Additionally, prescriptions filled at out-of-network pharmacies are not covered under the Plan, even if the prescription drug is on the Formulary.

Please refer to the Benefit Guide on the People Experience website to view the pharmacy benefits for each option (Aetna Choice CDHP or Aetna Select PPO) as the cost under each option is different. Additional information about the prescription drug benefit program is available by calling the toll-free Capital Rx Customer Care telephone number, (833) 599-0942, or through their website http://www.capitalrx.com.

Aetna administers the pharmacy benefit for the Aetna International Plan. Please visit the University's People Experience website for additional information: Aetna International Health Plan (https://hr.vanderbilt.edu/benefits/internationalhealthplan.php).

CONTINUING YOUR COVERAGE

Continuation of Group Coverage while on Leave of Absence

If you take an approved leave of absence without pay, you may continue coverage under the Plan at the same level of coverage in effect at 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 for coverage, 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 to work after approved FMLA leave has been exhausted or expires, the University may, under certain circumstances, require that the faculty or staff member reimburse the University for its share of the cost of coverage under the Plan paid by the University during such unpaid FMLA leave.

Continuation Coverage — COBRA

Introduction

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must register a qualifying event at My VU Benefits by visiting hr.vanderbilt.edu and navigating to the Benefits page.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. **You must notify Empyrean Billing Services, the Plan's**

COBRA administrator, by calling 833-874-1600 or via mail at PO Box 2617 Omaha, NE 68103-2617 within 60 days after the date the disability determination is issued, but in no case later than the end of initial 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. **You must notify Empyrean Billing Services, the Plan's COBRA administrator, by calling 833-874-1600, or via mail at PO Box 2617 Omaha, NE 68103-2617, within 60 days from the date of the second qualifying event.**

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.
For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Vanderbilt University
PMB 407704
2301 Vanderbilt Place
Nashville, TN 37240-7704
Telephone Number: (615) 343-4788

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, andstepchild or foster child is eligible under the Plan.
   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 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. 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. The Plan Administrator or designee must approve continuation of coverage for children over the age of 26 with a mental or physical disability.

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" means 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 People Experience department.

Qualifying Life Event

The birth or adoption of a child; obtaining legal guardianship or custody of a child; 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 program (TennCare), or CHIP program, the Plan will provide 60 days from the date of gain or loss of coverage for you to initiate a change through the Family Status Change/Qualifying Life Event process. For all other qualifying life events, you will have 30 days from the date of the qualifying life event to complete enrollment through the Family Status Change/Qualifying Life Event process.

If your Qualifying Life Event is audited by the People Experience department and it is discovered that you did not have an eligible qualifying life event to justify a mid-year election change through the enrollment provision of the Qualifying Life Event process, this will be considered

intentional misrepresentation or fraud and the Plan will revert your coverage back to the health coverage you had prior to the alleged Qualifying Life Event. Any ineligible health care or pharmacy claims paid by the Plan on your behalf because of such 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 and the Uniform Glossary 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 employees who are eligible for coverage under the Plan (but are not enrolled) to enroll for coverage if either:

- you or your child become eligible for premium assistance through Medicaid, Tennessee's CoverKids program, or other state child health plan, or
- you or your child's coverage under a Medicaid plan, Tennessee's CoverKids program, or other state child health plan terminates due to a loss of eligibility (as opposed to termination due to failure to pay premiums).

You must request coverage under this special enrollment right within 60 days of the date you or your child is determined to be eligible for assistance or such coverage is terminated by completing the online Family Status Change/Qualifying Life Event process through the My VU Benefits website.

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 Family Status Change/Qualifying Life Event process through My VU Benefits website.

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 Capital Rx for claims administration services. Aetna Choice (CDHP) and Aetna Select (PPO) are self-insured. Aetna International is a fully insured plan.

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 at Vanderbilt University, PMB #407700, 2301 Vanderbilt Place, Nashville, TN 37235. Service may be made on Aetna for the Aetna Choice (CDHP) and Aetna Select options at 151 Farmington Avenue, Hartford, CT 06156. Service may be made on Capital Rx at 228 Park Avenue South, Suite 87234, New York, NY 10003.

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 of Terms**).

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 (Evidence of Coverage and Summary Booklet) is incorporated in this Summary Plan Description by reference here.

Cost

The University and the employee share the cost of the Plan. The University's portion comes from the general assets of the institution. The amount of the employee's portion will be communicated to participants upon enrollment and 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 basis, 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.

How to Appeal a Claim

Medical Appeals

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

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 Capital Rx Customer Care telephone number, (833) 599-0942. The submission of an appeal does not guarantee coverage but appeals should be made in writing to Capital Rx. You should state the reasons why you do not agree with the denial or partial denial and provide any supporting documentation. The Capital Rx 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.

Appeals for pharmacy related to the Aetna International plan should be filed through Aetna, as it is the administrator of this Plan option. Please contact the customer service department for Aetna at the number listed on your insurance membership card.

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 Employee Benefits Security Administration. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and 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

You may continue health care coverage for yourself, spouse, or children if there is a loss of coverage under the Plan as a result of a qualifying 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 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 a certificate 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 Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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 went into effect for the Plan on January 1, 2010. The Mental Health Parity 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 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.

The University'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.

VANDERBILT
Human Resources

Mail: PMB #407704, 2301 Vanderbilt Place, Nashville, TN 37240-7704
In Person: 110 21st Avenue South, 10th floor, Nashville, TN 37203