



# **Welfare Benefit Plan**

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Plan Document and Summary Plan Description

# **VANDERBILT UNIVERSITY WELFARE BENEFIT PLAN**

## **Plan Document and Summary Plan Description January 1, 2017**

Effective as of January 1, 2017 Vanderbilt University hereby establishes the Vanderbilt University Welfare Benefit Plan ("Plan"). The Plan is established as an employee benefit plan within the meaning of Section 3(1) of the Employee Retirement Income Security Act (ERISA). This Plan document and Summary Plan Description explains the provisions of the Plan. You are urged to read this document carefully and to acquaint your family with its provisions.

The purpose of this Plan is to provide eligible employees of Vanderbilt University with certain welfare and fringe benefits under certain terms and conditions (the "Component Benefit Programs"). Certain benefits are fully-insured and provided through policies with insurance carriers. The cost of the Component Benefit Programs is paid either through contributions by Vanderbilt University, pre-tax or after-tax contributions by participants or a combination of both. The Component Benefit Programs are listed on Appendix A attached hereto.

Vanderbilt University intends that, for purposes of the Form 5500 annual reporting requirement, this document is considered a "wrap" plan and the terms of the underlying Component Benefit programs listed on Appendix A are hereby incorporated by reference. This document is not intended to give any substantive rights or benefits to employees that are not already provided under the terms of the applicable insurance policy and/or benefit plan document that governs each Component Benefit Program. Copies of such insurance policies and benefit plan documents are incorporated by reference herein and considered to be part of this Plan.

Generally, the terms and conditions under which you may be eligible for and receive the benefits are set forth in the terms of each applicable insurance policy and/or benefit plan document. This document does not replace the provisions of the insurance policy(ies) or benefit plan document(s). Every effort has been made to make this document as complete and accurate as possible. In the event of any difference between this document and one of the insurance policies or benefit plan documents, the terms of the policy or plan document will control.

If you have any questions about your benefits under the Plan, please contact the Human Resources Department.

### **ARTICLE I - BENEFITS**

The following Component Benefit Programs are provided by Vanderbilt University through the Plan:

- group medical benefits
- group dental benefits
- group vision benefits
- group life and AD&D benefits
- group disability benefits (short-term and long-term)
- group business travel benefits
- health flexible spending account benefit
- dependent care flexible spending account benefit

- wellness plan benefit
- employee assistance benefit
- education assistance benefit

## **ARTICLE II - ELIGIBILITY**

(A) **Eligibility and Participation:** The requirements for eligibility and participation with respect to any given Component Benefit Program, including any applicable enrollment procedures and when such coverage commences, are set forth in the applicable insurance policy or certificate or summary plan description for each Component Benefit Program offered through this Plan. Please contact the Human Resources Department for more information.

(B) **Qualified Medical Child Support Orders (Medical, dental, vision and health flexible spending account benefits only):** Notwithstanding any contrary provision in any group health insurance policy or any plan document, an eligible dependent child may include a child for whom an employee is required to provide coverage pursuant to a qualified medical child support order.

The Plan Administrator will adhere to the terms of any qualified medical support order that satisfies the requirements of this section and Section 609 of the Employee Retirement Income Security Act of 1974 ("ERISA"). For purposes of this section, a qualified medical support order is a medical child support order which 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 child support order is any judgment, decree, or order (including approval of a property settlement agreement) issued by a court of competent jurisdiction or through an administrative process established under state law which:

(i) Relates to the provision of child support with respect to the child of a participant under a group health 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

(ii) 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. For purposes of this section, an "alternate recipient" will mean any child of a participant who is recognized by a medical child support order as having a right to enrollment under a group health plan with respect to such participant.

Participants can obtain, without charge, a copy of the Plan's procedures regarding qualified medical child support orders from the Plan Administrator.

Payments under this Plan pursuant to a medical child support order described in this section in reimbursement for expenses paid by the alternate recipient or the alternate recipient's custodial parent or legal guardian will be made to the alternate recipient or the alternate recipient's custodial parent or legal guardian.

## **ARTICLE III - SOURCES OF CONTRIBUTIONS AND COST OF BENEFITS**

With respect to each underlying Component Benefit Program provided under the Plan, employees shall make contributions with respect to each benefit, if employee contributions are required, in the amounts specified and adjusted from time to time by Vanderbilt University. At least annually, eligible employees shall be provided information regarding any required contributions. Eligible employees may pay any required premiums for such benefits on a pre-tax basis through the Vanderbilt University Section 125 Cafeteria Plan or on an after-tax basis, as applicable.

## **ARTICLE IV - CLAIMS PROCEDURES**

The following claims procedures are applicable to claims filed under this Plan. The claims procedures for the insured benefits offered under this Plan are set forth in the insurance booklet or certificate provided by the insurance carrier. Should there be no claims procedure in your insurance booklet or certificate, the claims procedures of this document will govern. The claims procedures for all other benefits are set forth in the plan documents governing such benefits.

**(A) Submission of Claims.** Claims for benefits shall be made in the manner prescribed by the Plan Administrator.

**(B) Benefit Determination of Non-medical Claims:**

**(1) Timing of Notification of Benefit Determination.** If a claim is wholly or partially denied, the claimant shall be notified of the adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim, unless it is determined that special circumstances require an extension of time for processing the claim. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate that the special circumstances requiring an extension of time and the date by which the benefit determination is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing.

**(2) Manner and Content of Notification of Benefit Determination.** A claimant shall be provided with written notification of any adverse benefit determination. The notification shall set forth, in a manner calculated to be understood by the claimant, the following:

- (i) The specific reason or reasons for the adverse determination.
- (ii) Reference to the specific plan provision(s) on which the determination is based.
- (iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and
- (iv) A description of the review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 as amended ("ERISA") (where applicable), following an adverse benefit determination on review.

**(3) Appeals of Adverse Benefit Determinations.** Appeals of adverse benefit determinations may be submitted in accordance with the following procedures:

- (i) Claimants (or their authorized representatives) must appeal within 60 days following their receipt of a notification of an adverse benefit determination, and only one appeal is allowed.
- (ii) Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal.

(iii) Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

(iv) The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;

(v) No deference to the initial adverse benefit determination shall be afforded upon appeal.

(vi) The appeal shall be conducted by an individual who is neither the individual who made the underlying adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; and

(vii) Any medical or vocational expert(s) whose advice was obtained in connection with a claimant's adverse benefit determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination.

**(4) Timing of Notification of Benefit Determination on Review.** The claimant (or their authorized representative) shall be notified of the benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant's timely request for review, unless it is determined that special circumstances require an extension of time for processing the appeal. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the determination on review is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is timely filed, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as above due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

**(5) Manner and Content of Notification of Benefit Determination on Review.** A claimant shall be provided with written notification of the benefit determination on review. In the case of an adverse benefit determination on review, the notification shall set forth, in a manner calculated to be understood by the claimant, the following:

(i) The specific reason or reasons for the adverse determination.

(ii) Reference to the specific plan provision(s) on which the determination is based.

(iii) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; and

(iv) A statement of the claimant's right to bring an action under section 502(a) of ERISA (where applicable).

**(6) Definitions.**

(i) The term “adverse benefit determination” means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant’s or beneficiary’s eligibility to participate in a plan.

(ii) The term “relevant” means a document, record, or other information considered to be relevant to a claimant’s claim if such document, record, or other information:

- Was relied upon in making the benefit determination.
- Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination.
- Demonstrates compliance with administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants; or

**(C) Benefit Determinations for Medical Claims.**

**(1) Claims Procedures for a Claim Involving Urgent Care.**

(i) The plan administrator shall render a decision and notify the claimant on the initial receipt of a Claim Involving Urgent Care as soon as possible taking into account the medical exigencies, but no later than seventy-two (72) hours after receipt of the Claim Involving Urgent Care if all information necessary is included with the initial claim. For purposes of these claims procedures, a “Claim Involving Urgent Care” is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations (a) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, (b) in the opinion of a physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

(ii) If a Claim Involving Urgent Care requires additional information in order for the plan administrator to render a decision, the plan administrator must notify the claimant of the specific information necessary to complete the claim within twenty-four (24) hours of receipt of the Claim Involving Urgent Care. The plan administrator shall permit the claimant at least forty-eight (48) hours to provide the specified information. The plan administrator must render a decision on a Claim Involving Urgent Care that required additional information no later than the earlier of forty-eight (48) hours after receipt of the additional information or by the end of the time period the plan administrator gave the claimant to provide the additional information. In the event the Claim Involving Urgent Care is denied, the claim denial must include:

- (a) the specific reason or reasons for the adverse determination.
- (b) reference to the specific plan provisions on which the determination is based.
- (c) a description of any additional materials or information necessary for the claimant to perfect the claim.
- (d) an explanation of why such information is necessary.

- (e) a description of the plan's expedited review process for Claims Involving Urgent Care and applicable time limits on such review and a statement of the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination; and
- (f) in the event an internal rule, guideline, protocol, or similar criterion was relied upon in making the determination on the claim, either a copy of such rule or guideline or a statement that a copy of the rule or guideline, etc. will be provided to the claimant free of charge upon request, or if the determination was based on medical necessity, experimental or a similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination applying the terms of the plan to the claimant's medical circumstances, or a statement that such an explanation will be provided free of charge.

(iii) If a claimant fails to follow the Plan's claims procedures properly, the plan administrator must notify the claimant within twenty-four (24) hours of receipt of notice of the improperly filed claim of the proper procedures to be followed to file the claim. A claim is not filed properly when there is a communication by a claimant or an authorized representative of a claimant that is received by a person or organizational unit customarily responsible for handling benefit matters and it is a communication that names a specific claimant, a specific medical condition or symptom, and a specific treatment, service or product for which approval was requested.

## **(2) Claims Procedures for a Pre-Service Claim.**

(i) The plan administrator shall render a decision and notify the claimant on a Pre-Service Claim no later than fifteen (15) days after such claim is filed and within a reasonable period considering the medical circumstances. Such decision may be provided in writing or electronically. In the event the plan administrator denies a Pre-Service Claim, the denial must include the information in the adverse benefit determination below. In the event circumstances outside of the plan administrator's control require an extension of the period for rendering a decision and provided the plan administrator notifies the claimant of the need for the extension, the period for determining the Pre-Service Claim may be extended one time for up to fifteen (15) days. For purposes of these claim procedures, "Pre-Service Claim" means any claim for a benefit under a group health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

(ii) In the event additional information is needed to process the claim, the plan administrator shall notify the claimant of the additional information needed and request the fifteen (15) day extension for processing the claim for circumstances outside of the plan's control. The plan administrator shall permit the claimant at least forty-five (45) days to provide the specified information. When the additional information is received, the plan administrator shall decide the claim in no more than fifteen (15) days from the receipt of the additional information. The fifteen (15) day extension period for deciding the claim shall commence running upon the plan administrator's receipt of the additional information. In the event the plan administrator denies a Pre-Service Claim, the denial must include the information in the adverse benefit determination below.

(iii) If a claimant fails to follow the Plan's claims procedures properly, then the plan administrator shall notify the claimant of the failure to follow the plan's claims procedures properly and of the proper procedures to file within five (5) days of receipt of the communication from the claimant. This notice may be given orally to the claimant unless the claimant requests the notice be provided in writing.

**(3) Claims Procedures for a Post-Service Claim.** The plan administrator shall notify the claimant within a reasonable period of time and no later than thirty (30) days after receipt of the Post-Service Claim of the decision on the Post-Service Claim. Any adverse benefit determination on a Post-Service Claim shall include the information shown below. The initial period for determination on a Post-Service Claim may be extended one

time by the plan administrator for up to fifteen (15) days provided the plan administrator both determines that an extension is necessary due to matters beyond the control of the plan, and notifies the claimant prior to the expiration of the initial thirty (30) day period of the circumstances requiring the extension and the expected date by which the plan expects to render a decision. If such extension is necessary due to the need for additional information, the notice to the claimant must specifically describe the additional information needed and provide the claimant with at least forty-five (45) days in which the claimant may respond. In the event a claimant is notified of the need for additional information, the time period for processing the Post-Service Claim shall not begin to run again until the additional information is received from the claimant or his authorized representative. For purposes of these claims' procedures, "Post-Service Claim" means any claim for a benefit under a group health plan that is not a Pre-Service Claim.

#### **(4) Claims Procedures for a Concurrent Care Claim.**

(i) In the event the plan administrator determines to reduce or terminate a course of treatment or a series of treatments, the plan administrator must notify the affected participant or beneficiary of the intended termination or reduction (the adverse benefit determination) sufficiently in advance of the reduction or termination so that the participant or beneficiary may appeal the adverse benefit determination. The adverse benefit determination on a Concurrent Care Claim shall include the information specified below. Any decision on the appeal of the adverse benefit determination on the reduction or termination must be rendered before the reduction or termination of the care or course of treatment. For purposes of these claims procedures, "Concurrent Care Claim" means a claim that is reconsidered after an initial approval has been made and results in a reduction, termination, or extension of a benefit.

(ii) If a participant or beneficiary requests an extension of the course of treatment beyond the period or number of treatments, the claim will be decided as soon as possible, taking into account medical exigencies. The plan administrator will notify the participant or beneficiary of the outcome of the claim, whether adverse or not, within twenty-four hours after the receipt of the claim by the plan, provided that the claimant made the claim at least twenty-four hours prior to the expiration of the prescribed period of time or number of treatments.

**(5) Explanation of Denial of a Claim, other than a Claim Involving Urgent Care.** Explanation of a claim denial shall be sent to the claimant and shall set forth, in a manner calculated to be understood by the claimant, the following information:

- (i) The plan administrator's adverse determination.
- (ii) The specific reason or reasons for the adverse determination.
- (iii) Specific reference to the pertinent plan provisions on which the denial is based.
- (iv) A description of any additional materials or information necessary for the claimant to perfect the claim, and an explanation of why such information is necessary.
- (v) A description of the plan's review process for claims and applicable time limits on such review and a statement of the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination.
- (vi) In the event an internal rule, guideline, protocol or similar criterion was relied upon in making the determination, either a copy of such rule or guideline or a statement that a copy of the rule or guideline, etc. will be provided to the claimant free of charge upon request.
- (vii) In the event the adverse benefit determination is based on medical necessity or experimental treatment or a similar exclusion or limit, the claim denial must include either an explanation



of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such an explanation will be provided free of charge upon request.

#### **(6) Appeal for Denial of Claim for Medical Benefits.**

(i) *Claimant's Appeal Requirements and Rights:* If a claimant's claim for medical benefits is denied, either in whole or in part, the claimant shall have one hundred eighty (180) days from receipt of an adverse benefit determination on a claim for benefits to submit a written request for appeal to the plan administrator. If a claimant disagrees with the claim denial, the claimant must file a written request for appeal. A claimant should submit written comments, documents, records and all other information relating to the claim for benefits. A claimant may request reasonable access to and copies of all documents, records, and other information relevant to the claim. The claimant shall be provided this information free of charge. The review of the initial adverse determination will take into account all comments, documents, records and other information that is submitted, regardless of whether such information was submitted and considered in the initial determination of the claim. The claimant will also be provided a review that does not afford deference to the initial adverse determination to be conducted by someone who is neither the individual who made the initial determination nor the subordinate of such individual.

(ii) *Appeals Involving Medical Judgment in Whole or in Part:* If the appeal involves a determination based in whole or part on a medical judgment (including determinations with regard to whether a particular treatment or other item is experimental, investigational or not medically necessary or appropriate), a health care professional with the appropriate training and experience in the field of medicine at issue in the appeal will be appointed. The health care professional consulted will be an individual who is neither an individual who was consulted in connection with the initial determination that is the subject of the appeal nor the subordinate of any such individual. Upon request, the claimant will be provided with the identification of any medical or vocational experts whose advice was sought in connection with the appeal.

(iii) *First Level of Appeal for Denial of Claim for Medical Benefits.* All first level appeals for the denial of a claim for medical benefits shall be reviewed by the plan administrator as defined herein. If, after reviewing the appeal and any further information that the claimant submitted, the plan administrator denies the claim, either in whole or in part, a notice (which will be provided to the claimant in writing by mail or hand delivery, or through e-mail) will be provided to the claimant within a reasonable period of time, but not later than either fifteen (15) days for a Pre-Service Claim, thirty (30) days for a Post-Service Claim, and seventy-two (72) hours for a Claim involving Urgent Care, from the day the claimant's request for a review was received.

**(7) Second Level of Appeal for Denial of Claim for Medical Benefits.** If, after reviewing the first level of appeal and any further information that the claimant has submitted, the plan administrator denies the claim for medical benefits either in whole or in part, and the claimant disagrees with the denial, the denial must be appealed by requesting a review of the claim for medical benefits by the plan administrator. The plan administrator must receive a written request for an appeal within ninety (90) days of the date the claimant received notice that the claim for medical benefits was denied.

The remainder of the second level appeal for a denial of a claim for medical benefits will be handled as discussed above. The request for a second level appeal should be mailed to the plan administrator.

If, after reviewing the appeal and any further information that the claimant has submitted, the plan administrator denies the second level appeal, either in whole or in part, a notice (which will be provided to the claimant in writing by mail or hand delivery, or through e-mail) will be provided to the claimant within a reasonable period of time, but not later than either fifteen (15) days for a Pre-Service Claim or thirty (30) days for a Post-Service Claim, from the day the request for a review was received by the plan administrator.

The notice describing the decision shall include the information described above.

**(8) Independent Review of Medical Necessity Determinations or Coverage Rescissions.** If an appeal involves a medical necessity determination or a coverage rescission determination, a claimant may request an independent external review of his or her claim. Any such external review shall comply with applicable state or federal law and other rules and procedures for non-grandfathered plans as set forth in Department of Labor Regulation § 2590.715-2719.

### **ARTICLE V - TERMINATION OF COVERAGE**

To remain eligible for coverage under the Plan, you must remain an eligible employee actively working for Vanderbilt University. See the insurance carrier policy, booklet or certificate or the summary plan description for each Component Benefit Program for details concerning the termination of coverage rules. However, in certain circumstances, you or your dependents may be eligible for COBRA continuation coverage and/or a conversion policy, as explained in Article VI and Article VII.

### **ARTICLE VI - COBRA CONTINUATION COVERAGE** **(Group health benefits only)**

The provisions of this Article apply during any calendar year Vanderbilt University is subject to the federal law known as COBRA. To the extent COBRA is applicable to a Component Benefit Program and there are no provisions in the insurance policy, booklet or certificate or the summary plan description for such program, the provisions of this Article VI will apply. COBRA continuation coverage allows you and your dependents an opportunity to temporarily extend your health insurance coverage under the Plan at group rates in certain instances where coverage would otherwise end.

#### **Introduction**

This Article contains important information about your right to COBRA continuation coverage, which is a temporary extension of group health coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

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 in certain circumstances when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator.

#### **COBRA Continuation Coverage**

COBRA continuation coverage is a continuation of group health coverage when such coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this Article. 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 group health coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for such coverage.

If you are an employee, you will become a qualified beneficiary if you lose your group health coverage under the Plan because either one of the following qualifying events happens:

- your hours of employment are reduced, or

- your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your group health coverage under the Plan because any of the following qualifying events happens:

- 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 group health coverage under the Plan because any of the following qualifying events happens:

- 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 group health coverage under the Plan as a "dependent child."

### **When is COBRA 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. When the qualifying event is 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), the employer must notify the Plan Administrator of the qualifying event.

### **You Must Give Notice of Some Qualifying Events**

**For the 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 provide this notice to:**

**Benefit Express  
P.O. Box 189  
Arlington Heights, IL 60006  
877-837-5017**

## How is COBRA 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 beneficiaries 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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

***Disability extension of 18-month period of continuation coverage:*** If you or anyone in your family covered under group health benefit offered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of the COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60<sup>th</sup> day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. To qualify for the additional 11-month continuation period, you must provide the Plan Administrator with written notice of the determination of disability before the end of the initial 18-month continuation period and within 60 days after the date of the determination. If a final determination is made that the qualified beneficiary is no longer disabled, you must notify the Plan Administrator within 30 days of the final determination. In such a case, continuation coverage for the additional 11-month period for the disabled qualified beneficiary and the qualified beneficiaries who are his or her dependents will terminate as of the first day of the month beginning no more than 30 days after the date of the final determination, or on the date continuation coverage would otherwise terminate, if earlier.

***Second qualifying event extension of 18-month period of continuation coverage:*** If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible for group health coverage under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose group health coverage under the Plan had the first qualifying event not occurred. In no event may the total continuation period exceed 36 months from the date of the initial qualifying event.

## Cost of Continuation Coverage

Generally, the qualified beneficiary must pay the total cost of continuation coverage. This cost may be up to 102% of the cost of identical coverage for similarly situated participants. However, for disabled qualified beneficiaries who elect an additional 11 months of continuation coverage, the cost may be 150% of the cost of identical coverage for similarly situated participants for the additional 11-month period (and for any longer continuation period for which the disabled qualified beneficiary is eligible, as permitted by law). The 150% cost amount shall also apply to the disabled qualified beneficiary's dependents, as long as the disabled qualified beneficiary is in the coverage group receiving COBRA.

The initial premium must be paid within 45 days after the qualified beneficiary elects continuation coverage. Subsequent premiums must be paid monthly, as of the first day of the month, with a 30-day grace period for timely payment. However, no subsequent premium will be due within 45 days after the qualified beneficiary elects continuation coverage. Payment is considered made on the date on which it is sent to the plan.

## Termination of Continuation Coverage

Generally, continuation coverage terminates at the end of the initial 18- or 36-month continuation period or at the end of any additional 11- or 18-month continuation period for which the qualified beneficiary is entitled to elect continuation coverage. However, continuation coverage for a qualified beneficiary may end before the end of the initial or additional continuation period for any of the following reasons:

- (i) Coverage Terminated: Vanderbilt University no longer offers a group health plan to any of its employees;
- (ii) Unpaid Premium: The premium for continuation coverage is not timely paid;
- (iii) Other Coverage: The date on which a qualified beneficiary first becomes, after the date of the election of continuation coverage, covered under another group health plan. However, this provision does not apply during any time period the other group health plan contains any limitation or exclusion with regard to any pre-existing conditions, other than a limitation or exclusion which does not apply to the qualified beneficiary or is satisfied by the qualified beneficiary due to the Health Insurance Portability and Accountability Act;
- (iv) Medicare: The date on which a qualified beneficiary first becomes, after the date of the election of continuation coverage, entitled to Medicare (Part A or Part B); or
- (v) Cause: The date on which a qualified beneficiary's coverage is terminated for cause on the same basis that the plan terminates for cause the coverage of similarly-situated nonqualified beneficiaries (e.g., for fraud or misrepresentation in a claim for benefits).

## If You Have Questions

Questions concerning your Plan and your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

## Keep Your Plan Informed of Address Changes

To protect your family's rights, you should keep the Plan Administrator informed of 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

**Benefit Express**  
**P.O. Box 189**  
**Arlington Heights, IL 60006**  
**877-837-5017**

### **ARTICLE VII - CONVERSION PRIVILEGES**

When you are no longer eligible under the Plan (either as an active participant or as a qualified beneficiary receiving continuation coverage) you may be eligible to obtain an individual conversion policy for one or more of your insured benefits. The availability of this conversion coverage and the rules concerning your eligibility are set forth in the policy with each insurance carrier.

### **ARTICLE VIII - ADMINISTRATION**

(A) **Powers, Duties and Responsibilities of the Plan Administrator.** Vanderbilt University is the Plan Administrator and has the authority to control and manage the operation and administration of this Plan and the benefits offered hereunder, including the discretionary authority to make and enforce rules or regulations for the efficient administration of the Plan; to interpret the Plan; and to decide all questions concerning the Plan and the eligibility of any person to participate in the Component Benefit Programs offered hereunder.

The Plan Administrator may delegate any of its administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s), and expressly identifies the nature and scope of the delegated responsibility.

(B) **Power and Authority of Insurance Carriers.** With regard to the Component Benefit Programs that are fully insured, the insurer carrier is the named fiduciary and has the ultimate discretion and authority to determine all questions of eligibility for participation and eligibility for payment of benefits, to determine the amount and manner of the payment of benefits, to provide claims procedures and forms with regard to such benefits, and to otherwise construe and interpret the terms of the insurance policy governing such Component Benefit Program.

(C) **Records and Reports.** The Plan administrator shall keep a record of all actions taken and shall keep all other books of account, records and other data that may be necessary for proper administration of the Plan and shall be responsible for supplying all information and reports to governmental agencies or departments, employees, eligible dependents, beneficiaries, and others as required by law. The Plan Administrator shall make available to each employee such of his records under the Plan as pertain to him, for examination at reasonable times during normal business hours. The fiscal records of the Plan shall be maintained based on the Plan Year, provided that the policy years of any insurance policies or other coverage documents may be different than the Plan Year.

(D) **Reliance on Tables, Etc.** In administering the Plan, the Plan Administrator shall be entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions, and reports which are furnished by, or in accordance with the instructions of, any insurance carrier or by legal counsel, accountants, actuaries, consultants, experts, specialists, advisers, or other persons employed or engaged by the Plan Administrator.

(E) **Expenses of Administration.** All expenses incurred prior to the termination of the Plan that shall arise in connection with the administration of the Plan, including but not limited to administrative expenses and compensation and other expenses and charges of any legal counsel, accountants, actuaries, consultants, experts, specialists, advisers, or other persons employed or engaged by the Plan Administrator in connection with the administration of the Plan, shall be paid by Vanderbilt University.

## **ARTICLE IX - AMENDMENT AND TERMINATION**

(A) **Amendment of the Plan.** Vanderbilt University shall have the right at any time, and from time to time, to modify, alter or amend the Plan in whole or in part effective as of a specified date. Any amendment to the Plan shall be effective and documented in writing. No amendment shall have the effect of denying to any employee benefits which would provide coverage for periods prior to such amendment or denying benefits for events that occurred prior to such amendment.

(B) **Termination of the Plan.** Although Vanderbilt University intends to maintain the Plan indefinitely, Vanderbilt University shall have the right to terminate the Plan in whole or in part at any time, effective as of such date as Vanderbilt University may determine. However, no such termination shall have the effect of denying to any employee benefits which would provide coverage for periods prior to such termination or denying benefits for events that occurred prior to such termination.

(C) **No Vested Right to Benefits.** Notwithstanding anything in this Plan or in any insurance policy or plan document, no employee shall have any vested right to continued benefits under the Plan and any benefits or coverage may be altered or terminated at any time for periods after the amendment or termination of the Plan as provided in Paragraphs (A) and (B) above.

## **ARTICLE X – GENERAL PROVISIONS**

(A) **No Contract of Employment.** The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between any individual and Vanderbilt University to the effect that the individual will be employment for any specific period of time.

(B) **Insurance Contract Controls.** Insured benefits are provided solely pursuant to an insurance policy or contract between Vanderbilt University and the applicable insurance company. If the terms of this Plan conflict with the terms of such insurance policy or contract, the terms of the insurance policy or contract will control, unless superseded by applicable law.

(C) **Limitation of Rights.** Neither the establishment of this Plan nor any amendment thereof, nor the payment of any benefits, will be construed as giving to any employee or other person any legal or equitable right against Vanderbilt University, except as provided herein. Neither the establishment of this Plan nor any amendment thereof, nor the payment of benefits, nor any action taken with respect to this Plan shall confer upon any person the right to be continued in the employment of Vanderbilt University.

(D) **Headings.** The headings and subheadings of articles and sections are included solely for convenience of reference, and if there be any conflict between such headings and the text of the Plan, then the text of the Plan shall control.

(E) **Gender and Number.** Whenever any words are used herein in the masculine, feminine, or neutral gender, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

(F) **Severability of Provisions.** The provisions of this Plan are severable, and should any provisions be ruled illegal, unenforceable, or void, all other provisions not so ruled shall remain in full force and effect.

(G) **Entire Plan.** This Plan document and Summary Plan Description, including Appendix A attached hereto and the Coverage Documents identified in Appendix A, constitute the entire employee benefit plan for the eligible employees described herein. No modifications or alterations to this Plan shall be enforceable unless properly and validly made pursuant to the provisions of Article VIII and IX above.

(H) **Compliance with State and Federal mandates.** To the extent applicable, the Plan will provide benefits in accordance with the requirements of all applicable laws and as described in the insurance policy or certificate, including ERISA, FMLA, USERRA, COBRA, HIPAA, GINA, NMHPA, WHCRA, MHPAEA, HITECH, Michelle's Law and PPACA.

## **ARTICLE XI – ERISA STATEMENT OF RIGHTS**

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to:

### **(A) Receive Information About the Plan and its Benefits**

(i) Examine, without charge, at the Plan Administrator's office, and at other specified locations, all documents governing the Plan, including any insurance contracts, and if the Plan has 100 or more participants, 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.

(ii) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, any updated summary plan description and, if the Plan has 100 or more participants, a copy of the latest annual report (Form 5500 Series). The Plan Administrator may make a reasonable charge for the copies.

(iii) If there are more than 100 participants in the Plan, receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

### **(B) 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 the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently in the interest of you and other Plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

### **(C) Enforce Participant's 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 from the Plan and do not receive them within 30 days, you may file suit in 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 Plan 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 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 federal court. The court shall 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 the participant's claim is frivolous.

**(D) Assistance With Questions**

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, 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 the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., 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.

**ARTICLE XII – HIPAA PRIVACY STATEMENT**

**Group Health Benefits.** The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) requires, among other things, that certain group health plans include privacy provisions to ensure compliance with the privacy requirements of HIPAA (“Privacy Rule”). The following benefits offered under this Plan are subject to the Privacy Rule: group medical, dental and vision benefits; health flexible spending account, health reimbursement account, employee assistance program and wellness program.

**Fully Insured Health Benefits.** If the health plan is a fully insured health plan, which means that health benefits are provided solely through an insurance contract, as is the case with the group dental and vision benefits, the plan need not comply with the Privacy Rule as to these benefits if certain conditions are met. This is because, in the case of a fully insured health plan, the insurer is required to comply with the Privacy Rule and thereby ensure that your HIPAA privacy rights are protected.

The following conditions must be met for a fully insured health plan, such as a group dental or vision benefit, to be exempt from the requirement that it include the Privacy Rule as part of its plan documents:

- The plan sponsor must verify that the insurer of its health plan is HIPAA compliant by the applicable deadline, April 14, 2003 for most insurers.
- If the plan sponsor occasionally receives protected health information to assist a participant (or a participant's spouse or dependent) with a claim or an appeal when health benefits have been denied, the plan sponsor must ensure that the participant (or the participant's spouse, or dependent who is not a minor) authorizes the plan sponsor to receive such protected health information from the insurer.
- If the plan sponsor assists a participant in understanding the plan and the benefits provided under the plan and it is necessary for the plan sponsor to receive protected health information to assist in this manner, the plan sponsor must obtain authorization from the participant for its receipt of the protected health information.
- The plan sponsor receives protected health information only for the limited purpose (in addition to those listed above) of performing enrollment and disenrollment activities, and for the purpose of making payroll deductions, if applicable.
- The plan sponsor obtains summary health information from the insurer only for the limited purpose of obtaining premium bids, or for modifying, amending, or terminating the plan.

Vanderbilt University, as plan sponsor of this Plan, will verify or has verified that the insurers are HIPAA compliant by the applicable deadline. Additionally, with regard to the group dental and vision benefit, Vanderbilt University has adopted a policy of not receiving, disclosing, or using protected health information or summary health

information for any purpose other than for the limited purposes listed above, subject to authorization from the participant, or the participant's spouse or dependent, when appropriate.

For information regarding the HIPAA Privacy Rule and the insurer's compliance with the Privacy Rule, please contact the insurer. The information provided by the insurer will include definitional information, such as the definitions of "protected health information" and "summary health information," and also include information regarding how you, your spouse, or your dependent may authorize Vanderbilt University to obtain protected health information.

**Self-Funded Health Benefits.** The group medical, health flexible spending account benefit, health reimbursement account, employee assistance program and wellness program are considered "self-funded" health plans, meaning that benefits are paid from the plan sponsor's general assets and not through an insurance contract. Vanderbilt University, as the plan sponsor, is responsible for complying with the applicable provisions of the HIPAA Privacy Rule.

Members of Vanderbilt University's workforce have access to the individually identifiable health information of participants for administrative functions of these benefits. When this health information is provided to Vanderbilt University, it is Protected Health Information (PHI).

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict Vanderbilt University's ability to use and disclose PHI. The following HIPAA definition of PHI applies to this Plan:

**Protected Health Information.** Protected health information means information, including genetic information, that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or persons who have been deceased for 50 years or less.

Vanderbilt University shall have access to PHI only as permitted herein or as otherwise required or permitted by HIPAA.

(1) Provision of Protected Health Information to Plan Sponsor:

(A) Permitted Disclosure of Enrollment/Disenrollment Information. The Plan may disclose to the Plan Sponsor information on whether the individual is participating in the Plan or is enrolled in or has disenrolled from the Plan.

(B) Permitted Uses and Disclosure of Summary Health Information. The Plan may disclose Summary Health Information to the Plan Sponsor, provided that the Plan Sponsor requests the Summary Health Information for the purpose of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (2) modifying, amending, or terminating the Plan.

"Summary Health Information" means information (1) that summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a Health Plan; and (2) from which the information described at 42 C.F.R. § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 C.F.R. § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

(C) Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes. Unless otherwise permitted by law, and subject to the conditions of disclosure described in paragraph IV and obtaining written certification pursuant to paragraph VI, the Plan may disclose PHI to the Plan Sponsor, provided that the Plan Sponsor uses or discloses such PHI only for Plan administration purposes. "Plan administration purposes" means administration functions

performed by the Plan Sponsor on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor, and they do not include any employment-related functions.

Notwithstanding the provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner that is inconsistent with 45 C.F.R. § 164.504(f).

(D) Conditions of Disclosure for Plan Administration Purposes. Plan Sponsor agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Plan, Plan Sponsor shall:

- Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;
- Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI;
- Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosure provided for of which it becomes aware;
- Make available PHI to comply with HIPAA's right to access in accordance with 45 C.F.R. § 164.524;
- Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526;
- Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528;
- Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;
- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- Ensure that the adequate separation between Plan and Plan Sponsor (i.e., the "firewall"), required in 45 C.F.R. § 504(f)(2)(iii), is satisfied.

(E) Adequate Separation Between Plan and Plan Sponsor. The Plan Sponsor shall allow the Associate Vice Chancellor/Chief Human Resources Officer and/or the members Vanderbilt University's Office of Benefits Administration and/or the direct billing/COBRA department access to the PHI. No other persons shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use PHI to the extent necessary to perform the plan administration functions that the Plan Sponsor performs for the Plan. In the event that any of these specified employees does not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to the Plan Sponsor's employee discipline and termination procedures.

(F) Certification of Plan Sponsor. The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 C.F.R. § 164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in paragraph IV of this Section.

**ARTICLE XIII- BASIC INFORMATION ABOUT THE PLAN**

Name of Plan: Vanderbilt University Welfare Benefit Plan

Plan Sponsor: Vanderbilt University  
**PBM #407700**  
 2301 Vanderbilt Place  
 Nashville, TN 37235-7700  
 (615) 322-8330  
**EIN: 62-0476822**

Plan Number: 513

Plan Effective Date: January 1, 2017

Type of Plan: Group insurance plan providing health and welfare benefits.

Termination of Coverage: Coverage generally ends effective the last day of the month. Please see the insurance policy, booklet or certificate or the summary plan description (with regard to self-insured benefits) for each benefit for the termination of coverage provision for each plan. [However, coverage can be continued for an employee in certain situations such as during a medical leave of absence or a layoff. See the Human Resource Department for details.]

Type of Administration:

Fully Insured Plans: Administered by applicable insurance companies.  
 Self-insured Plans: Administered by third party administrators

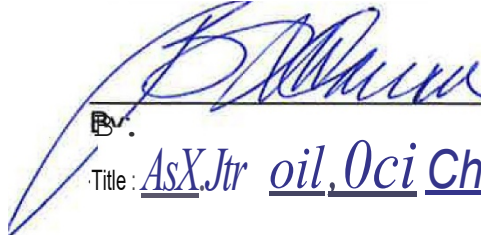
Plan Administrator: Vanderbilt University

Agent for Service of Legal Process: Vanderbilt University  
 PBM #407700  
 2301 Vanderbilt Place  
 Nashville, TN 37235-7700  
 (615) 322-8330

Plan Year: January 1 - December 31

IN WITNESS WHEREOF, Vanderbilt University by its duly authorized officer, has executed this Plan on this 11 c day of ovYcki, 2017.

**VANDERBILT UNIVERSITY**



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