VANDERBILT UNIVERSITY
HEALTH CARE FLEXIBLE SPENDING ACCOUNT PLAN
AND
SUMMARY PLAN DESCRIPTION

SECTION 1 - PURPOSE

The purpose of this Plan is to reimburse the Company's Eligible Employees for the cost of medical care incurred by the Company's Eligible Employees and their Dependents. Such reimbursements are funded solely by contributions of Eligible Employees. It is the Company's intent that this Plan qualify as an accident and health plan within the meaning of Section 105 of the Internal Revenue Code of 1986, as amended, and that the benefits payable under the Plan be eligible for exclusion from gross income under that section.

The Company intends that this program be a permanent program or arrangement for the exclusive benefit of its employees and their families. Nothing herein, however, shall prevent the Company from amending or terminating this Plan, provided such amendment or termination is permissible under applicable law and such amendment or termination does not affect a claimant's rights to benefits hereunder with respect to reimbursable expenses that have been incurred prior to the date Company action is taken to terminate the Plan or the effective date of such termination, whichever occurs last.

The exclusive purpose of this Plan is to provide the medical benefits described herein for covered employees and their family members. No benefits payable under this Plan shall be applied for any other purpose.

SECTION 2 - DEFINITIONS

2.1 "Benefits" means the amounts paid to Participants under the Plan as reimbursements for Qualifying Health Care Expenses paid or incurred by the Participant.

2.2 "Code" means the Internal Revenue Code of 1986, as amended.

2.3 "Company" means Vanderbilt University.

2.4 "Dependent" means:

a. a Participant's Spouse as defined in Section 2.13 herein;

b. a Participant's dependent as defined in Code § 152 (determined without regard to Code § 152(b)(1), (b)(2) or (d)(1)(B)); and

c. a Participant's child within the meaning of Code § 152(f)(1) who has not attained age 27 of as of the end of the Participant's taxable year. A Participant's "child" is an individual who is the son, daughter, stepson, or stepdaughter of the Participant, and includes both a legally adopted individual of the Participant and an individual who is lawfully placed with the Participant for adoption by the Participant. The term "child" also includes an "eligible foster child," defined as an individual who is placed with the employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

2.5 "Earned Income" means all income derived from wages, salaries, tips, self-employment and other employee compensation (such as disability benefits) but such term does not include any amounts received (i) under the Plan or any other health care expense reimbursement program under Code Section 105 or 106; (ii) as a pension or annuity; or (iii) as unemployment or workers' compensation.

2.6 "Fully Benefits Eligible Employee" means regular and term employees regularly scheduled to work 30 hours or more per week.

2.7 "Highly Compensated Employee" means any person who is a highly compensated employee as defined in Code § 414(q).

2.8 "Participant" means any employee of Vanderbilt University or a Related Employer who satisfies the eligibility requirements of Section 3 hereof.

2.9 "Plan" means this Vanderbilt University Health Flexible Spending Account Plan.

2.10 "Plan Administrator" means the person or persons designated to administer the Plan under Section 9 hereof.

2.11 "Plan Year" means the 12-month period beginning each January 1st and ending each December 31st.

2.12 "Qualifying Health Care Expense" means an expense incurred by a Participant, or by the Dependent of such Participant, for medical care as defined in Code § 213(d) (including, without limitation, amounts paid for hospital bills, doctor, vision and dental bills, and drugs), but only to the extent that the Participant or other person incurring the expense is not reimbursed or entitled to reimbursement for the expense through insurance or otherwise (other than under the Plan). "Qualifying Health Care Expense" does not include the following:

a. any expense incurred by a Participant who is covered under a high deductible health plan offered by the Company and has a Health Savings Account unless such expense is for or related to "permitted insurance" or "permitted coverage" as those terms are defined in Code § 223(c)(1)(B); or

b. any premium paid for health coverage under any plan maintained by the Company or any other employer or any expense incurred for qualified long-term care services as defined in Code § 7702B(c).

Notwithstanding anything in the Plan to the contrary, a Participant may not be reimbursed for the cost of any medicine or drug that is not "prescribed" within the meaning of Code § 106(f) or is not insulin. In addition, only medicine or drugs considered to be prescription drugs under Code § 106(f), including "over-the-counter" drugs obtained under prescription, shall be able to be purchased by debit and/or credit cards issued to be used in conjunction with the Plan. Any purchase must comply with the conditions set forth in Internal Revenue Service Notice 2010-59 (for "90 percent pharmacy" purchases) and Notice 2011-5 (for all other purchases), and any subsequent IRS guidance.

Qualifying Health Care Expenses shall be deemed to be incurred at the time the services to which the expenses related are rendered.

2.13 "Related Employers" means a controlled group of corporations (as defined in Code § 414(b)), trades or businesses (whether or not incorporated) which are under common control (as defined in Code § 414(c)) or an affiliated service group (as defined in Code § 414(m) or in Code § 414(o)). If the Company is a member of a related group, the term "Company" includes the related group members for purposes of crediting service, the definitions of Participant and Highly Compensated Employee, and for any other purpose required by the applicable Code section or by a Plan provision. However, the Company may permit an employee of a Related Employer to participate in the Plan only if the Related Employer executes a Participation Agreement for this Plan. If one or more of the Company's related group members become Participating Employers by executing a

Participation Agreement, the term "Company" includes the participating related group members for all purposes of the Plan, and "Plan Administrator" means the Company that is the signatory to the Execution Page of this Plan.

2.14 "Spouse" means the lawful spouse of a Participant as defined under applicable law but shall not include an individual legally separated from a Participant under a decree of legal separation.

SECTION 3 - ELIGIBILITY

3.1 Except as excluded under Section 3.2 hereof, if an individual is an employee of the Company or a Related Employer he or she is eligible to participate in the Plan if:

a. the employee is 18 years old or older;

b. the employee is a Fully Benefits Eligible Employee;

c. the employee has completed 90 days of employment; and

d. the Employee has completed, signed and submitted to the Employer an Enrollment Form.

3.2 The following individuals are not eligible to participate in the Plan:

a. any leased employee (including but not limited to those individuals defined as leased employees in Code § 414(n)) or an individual classified by the Employer as a contract worker or independent contractor for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll or is determined by the Internal Revenue Service or others to be a common-law employee of the Employer;

b. any individual who performs services for the Employer but who is paid by a third-party temporary or other external employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the Internal Revenue Service or others to be a common-law employee of the Employer;

c. any non-resident aliens who receive no U.S.-source income during the Plan Year; and

d. any self-employed individual (including a partner), or a person who owns (or is deemed to own) more than 2 percent of the outstanding stock of an S corporation.

3.3 An employee who meets the eligibility requirements under this Section 3 (an "Eligible Employee") on the effective date of this Plan shall become a Participant in the Plan as of the effective date, provided he or she has submitted any required election forms to the Plan Administrator. Otherwise, an Eligible Employee who elects to participate in this Plan will become a Participant on the first day of the month coinciding with or next following satisfaction of eligibility requirements. Former employees who are rehired within the same calendar year of their termination are not required to complete the ninety (90) day waiting period before re-enrolling in the Plan.

3.4 If a Participant ceases to be an Eligible Employee, all rights of such Participant and his or her Dependents to receive benefits for claims incurred after the termination date shall cease. Such Participant or Dependent will, however, retain the right to be reimbursed for claims incurred prior to the termination of employment if a claim for such reimbursement is submitted by April 15th of the calendar year following the year

in which the Participant ceases to be an Eligible Employee. For this purpose, a claim will be considered to be incurred when the services relating to such claim have been rendered.

3.5 After an employee ceases to be an Eligible Employee, participation in the Plan may be renewed upon the satisfaction of the eligibility requirements contained in this Section 3.

SECTION 4 - BENEFITS

The Company or its designee shall pay to each Participant such amounts as he or she has expended while a Participant for Qualifying Health Care Expenses for himself or herself and his or her Dependents up to the amount of reimbursement benefits elected by the Participant and subject to the limits described in Section 5, below. Qualifying Health Care Expenses that are paid by a Participant on an installment plan or similar agreement entered into between the Participant and a health care provider shall be reimbursed by the Plan only to the extent of amounts actually paid by the Participant consistent with the installment plan. Furthermore, payment of medical care claims must have some correlation with the actual provision of the medical services in order to be reimbursed by this Plan.

SECTION 5 - LIMITATION ON BENEFITS PROVIDED

5.1 No Participant shall be entitled to receive reimbursements under this Plan for any Plan Year in excess of the limit set forth in Code § 125(i). For this purpose, amounts received that are attributable to reimbursements due the Participant's Dependents shall be considered to have been received by the Participant. The amount of reimbursement benefits elected by the Participant shall be available to the Participant throughout the Plan Year, regardless of the amount contributed to the Plan by the Participant.

5.2 Reimbursement under this Plan shall be made only in the event, and to the extent, that reimbursement for amounts expended, or payment, for medical care is not provided for under any insurance policy or under any other plan of the Company or another employer or under any federal or state law. If there is such a policy, plan or law in effect providing for such reimbursement or payment in whole or in part, then, to the extent of the coverage under such policy, plan or law, the Company shall be relieved of any and all liability hereunder.

SECTION 6 - HEALTH CARE SPENDING ACCOUNT

6.1 **Establishment of Account**. The Company will cause to be established and maintained a Health Care Spending Account for each Plan Year with respect to each Participant who has elected to receive reimbursements of Qualifying Health Care Expenses incurred during the year. No Health Care Spending Account election shall automatically carry over to the following Plan Year. The Participant must re-enroll in the Health Care Spending Account each Plan Year during the Company's open enrollment period or within 30 days of a qualifying life event.

6.2 **Funding**. Benefits paid under the Plan are funded solely by Participant pre-tax salary deferrals. The Company will maintain these deferrals as general assets of the Company and pay these amounts out of the general assets of the Company at the time such benefits are to be paid. The total of Participant salary deferrals is subject to the limits set forth in Section 5.1 above. There will be no special fund or trust out of which benefits will be paid.

6.3 **Crediting of Account**. There shall be credited to a Participant's Health Care Spending Account for each Plan Year, as of the beginning of such Plan Year, an amount equal to the Participant's coverage amount for such Plan Year as elected by the Participant. Except as otherwise required by law, the amount credited for

each Plan Year to each such Health Care Spending Account shall be the property of the Company until paid out as a payment or reimbursement to the Participant.

6.4 **Debiting of Account**. A Participant's Health Care Spending Account for each Plan Year shall be debited from time to time in the amount of any payment to or for the benefit of the Participant for Qualifying Health Care Expenses incurred during such Plan Year.

6.5 **Grace Period.** The Company has elected to adopt the provisions of Internal Revenue Notice 2005-42 and Prop. Treas. Reg. § 1.125-1(e). The Plan allows for a grace period until March 15th following the end of the Plan Year. The grace period will apply to all Participants in the Plan. Expenses for Qualifying Health Care Expenses incurred during the grace period may be paid or reimbursed from the Plan from the Health Care Spending Account remaining unused at the end of the immediately preceding plan year. A Participant who has a balance in their Health Care Spending Account from the immediately preceding Plan Year, and who incurs Qualifying Health Care Expenses under the Plan during the grace period, may be paid or reimbursed for such expenses from their Health Care Spending Account as if the expenses had been incurred in the immediately preceding Plan Year. During the grace period, the Plan may not permit a Participant's Health Care Spending Account to be cashed-out or converted to any other taxable or nontaxable benefit. Amounts in a Participant's Health Care Spending Account may only be used to pay or reimburse Qualifying Health Care Expenses incurred with respect to the Plan. To the extent the balance in a Participant's Health Care Spending Account from the immediately preceding Plan Year exceeds the Qualifying Health Care Expenses incurred during any applicable grace period, such balance may not be carried forward to any subsequent period (including any subsequent plan year) and is forfeited. Qualifying Health Care Expenses incurred during the Plan Year and any applicable grace period must be submitted for payment or reimbursement by April 15th after the end of the grace period.

6.6 **Forfeiture of Account Balance.** The amount credited to a Participant's Health Care Spending Account for any Plan Year shall be used only to reimburse the Participant for Qualifying Health Care Expenses incurred during such Plan Year and any applicable grace period, and only if the Participant timely applies for reimbursement. If any balance remains in the Participant's Health Care Spending Account for a Plan Year after all reimbursements or payments due Participant for the Plan Year are made, such balance will not be carried over to reimburse the Participant for Qualifying Health Care Expenses incurred during a subsequent Plan Year, and will not be available to the Participant in any other form or manner. Such balance shall remain the property of the Company to any extent permitted by law, and the Participant shall forfeit all rights with respect to such balance.

6.7 **Effect of Health Reimbursement Arrangement ("HRA") – effective prior to March 16, 2023.** If a Participant of this Plan is also a Participant in the Health Reimbursement Account Plan during a Plan Year, reimbursement shall first be made from this Plan and only when benefits under this Plan are exhausted shall reimbursement be made under the Health Reimbursement Account Plan. Notwithstanding the foregoing, if a Participant is also a Participant in the Vanderbilt University Health Fund Account, reimbursement shall first be made from the Vanderbilt University Health Fund Account. When benefits under the Vanderbilt University Health Fund Account are exhausted, reimbursement shall be made from this Plan. The Health Reimbursement Account Plan terminated effective March 15, 2023. The Vanderbilt University Health Fund Account terminated effective December 31, 2018.

SECTION 7 - CLAIMS PROCEDURE

7.1 **Claims for Reimbursement**. A Participant who has elected to receive health care reimbursements for a Plan Year may apply to the Company, or the third-party administrator designated by the Company, for reimbursement of Qualifying Health Care Expenses incurred by the Participant while he or she

was a Participant during the Plan Year by submitting a statement in writing to the Company or its third-party administrator, in such form as the Company or third-party administrator may prescribe, setting forth:

a. the amount, date and nature of each expense with respect to which a benefit was received;

b. the name of the person, organization or entity to which the expense was paid;

c. the name of the person for whom the expense was incurred and, if such person is not the Participant requesting the benefit, the relationship of such person to the Participant;

d. the amount recovered or expected to be recovered, under any insurance arrangement or other plan, with respect to the expenses; and

e. a statement that the expense (or the portion thereof for which reimbursement is sought under the Plan) has not been reimbursed and is not reimbursable under any other health plan coverage.

This request application shall be accompanied by (i) a written statement from an independent third party stating that the expense has been incurred and the amount of the expense, and (ii) such other bills, invoices, receipts, or other statements or documents that the administrator may request. The application may be made before or after the Participant has paid such expense, but not before the Participant has incurred such expense. If the Health Care Spending Account is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), the Participant will be required to comply with substantiation procedures established by the Plan Administrator in accordance with Revenue Ruling 2003-43, Proposed Regulation § 1.125-6(d) or other IRS guidance.

7.2 **Reimbursement or Payment of Expenses**. The Plan Administrator shall reimburse the Participant from the Participant's Health Care Spending Account, at such time and in such manner as the Plan Administrator may prescribe. The Plan Administrator may, at its option, pay any such Qualifying Health Care Expenses directly to the person providing or supplying medical care in lieu of reimbursing the Participant. No reimbursement or payment shall at any time exceed the balance of the Participant's Health Care Spending Account for the Plan Year at the time of the reimbursement or payment, nor shall any reimbursement or payment be made if the claim submitted by the Participant is for an amount less than the minimum reimbursable amount established by the Plan Administrator. The amount of any Qualifying Health Care Expenses not reimbursed or paid because such amount is below the minimum reimbursable amount shall be carried over and reimbursed or paid only if and when the Participant's unreimbursed claims equal or exceed such minimum and the balance in the Participant's Health Care Spending Account permits such reimbursement or payment. Notwithstanding the preceding sentence, claims for expenses incurred during a Plan Year or any applicable grace period that are submitted for reimbursement after the last day of the Plan Year or any applicable grace period will be paid regardless of whether they equal or are below the minimum reimbursable amount, provided that they do not exceed the remaining balance of the Participant's Health Care Spending Account.

7.3 **Debit Card.** Each Participant will be provided with a Health Care Debit Card that may be used to pay for certain Covered Expenses directly from his or her Health Reimbursement Account subject to applicable Internal Revenue Code regulations and guidance. Use of the Health Care Debit Card is voluntary. Participants who decide not to use the Health Care Debit Card may be reimbursed for Covered Expenses by submitting a claim under Section 7.1 above.

7.4 **Limitation on Reimbursements or Payment with Respect to Certain Participants**. Notwithstanding any other provision of this Plan, the Plan Administrator may limit the amounts reimbursed or paid with respect to any Participant who is a Highly Compensated Employee to the extent that the Plan

Administrator deems such limitation to be advisable to assure compliance with any nondiscrimination provision of the Code. Such limitation may be imposed whether or not it results in a forfeiture under Section 6.6.

SECTION 8 - CLAIMS REVIEW PROCEDURE

8.1 Failure by the Company to respond to a claim within a reasonable time not to exceed 30 days after receipt of the claim by the Plan shall be deemed a denial. Within 60 days after denial of any claim for benefits under this Plan, the claimant may request in writing a review of the denial by the Plan Administrator. The Plan Administrator may delegate its duties under this Section 8 to a third party administrator.

8.2 A Participant shall have the right to a full and fair review of the claim. For this purpose, the claimant or authorized representative has the following rights:

a. to request a review upon written application to the Plan Administrator or its designated third party administrator within 60 days following receipt of a notification of an adverse benefit determination;

b. to 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;

c. to submit written comments, documents, records, and other information relating to the claim for benefits to the Plan Administrator or its designated third party administrator; and

d. to have a review that takes into account all comments, documents, records, and other information submitted by the claimant, without regard to whether such information was submitted or considered in the initial benefit determination.

8.3 A request for review of an adverse benefit determination shall be made within 60 days after notification of denial of the claim. The Plan Administrator or its designated third party administrator will notify the claimant of the Plan's benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant's request for review by the Plan, unless the Plan Administrator or its designated third party administrator determines that special circumstances require an extension of time for processing the claim. If the Plan Administrator or its designated third party administrator determines 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 Plan expects to render the determination on review.

8.4 The Plan Administrator or its designated third party administrator shall provide a claimant with written or electronic notification of a Plan's benefit determination on review. Any electronic notification shall comply with the standards imposed by 29 C.F.R. § 2520.104b-1(c)(1)(i), (iii) and (iv). In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant:

a. The specific reason or reasons for the adverse determination;

b. Reference to the specific plan provisions on which the benefit determination is based;

c. 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

d. A statement of the claimant's right to bring an action under § 502(a) of ERISA.

SECTION 9 - ADMINISTRATION

9.1 Vanderbilt University is hereby designated as the Plan Administrator to serve until resignation or removal by the Company's governing body and appointment of a successor by duly adopted resolution. The Plan Administrator shall have the authority to control and manage the operation and administration of the Plan, including the sole 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 Plan.

9.2 The Plan Administrator may appoint third party administrators to act for it under the Plan to the extent specified in the appointment. The Plan Administrator may engage agents to assist it and may engage legal counsel, including counsel to defend any action taken or omitted to be taken pursuant to the written opinions or certificates of any agent, counsel, or physician.

9.3 The Company shall retain the right, by action of its governing body or other designated party, in their sole and final discretion, to amend the Plan at any time and from time to time to any extent these persons may deem advisable or desirable, but in no event shall any amendment to the Plan result in discrimination in favor of a Participant who is a Highly Compensated Employee or key employee as defined in the Internal Revenue Code. A copy of the resolution of the party making such amendment shall be delivered to the Plan Administrator. This Plan shall be amended in a manner and effective as of the date set forth in such resolution, and the Participants and beneficiaries and all others having any interest under the Plan shall be bound thereby as of that effective date. Notwithstanding the foregoing, no amendment will affect the pre-tax benefits of the Participants and beneficiaries on a retroactive basis. Participants and beneficiaries shall be able to receive the benefits of the Plan unaffected until an amendment occurs.

9.4 The Company shall have the right by action of its governing body or other designated party, in its sole and final discretion, to terminate the Plan at any time. Upon such termination benefits shall cease. A copy of the resolution shall be delivered to the Plan Administrator and the Plan shall be terminated as of the date of termination specified in the resolution. The Company may delegate this authority to a committee appointed by its governing body. The Plan shall automatically terminate upon cessation of operations by the Company and all benefits cease unless a successor employer adopts and continues the Plan.

SECTION 10 - MISCELLANEOUS

10.1 All terms expressed herein shall be deemed to include the feminine and neutral genders and all references to the plural shall be deemed to include the singular and vice versa, all as proper construction shall dictate.

10.2 To the extent not pre-empted by applicable Federal law, questions concerning the proper interpretation of the terms of this agreement shall be determined in accordance with the law of the State of Tennessee, where the Company's principal business office is located.

10.3 The Plan Administrator shall keep a copy of this Plan document and Summary Plan Description and any other disclosure documents relating thereto that are in the public domain on file at its office where Participants may inspect them during the Company's regular business hours. Upon request, the Company shall provide a Participant or Dependent with copies of such documents. When the Plan Administrator provides such documents, the Plan Administrator may charge the requesting party a reasonable charge for photocopying these materials.

10.4 This document contains all of the operative provisions of this Plan. Any conflict between the provisions of this document and any other Company document purporting to explain the rights, benefits, or obligations of the parties hereunder shall be resolved in favor of this Plan document. In the event that a tribunal of competent jurisdiction shall determine in a final judgment or decree that one or more of the provisions of this Plan is invalid due to the provisions of applicable law, this Plan shall be interpreted as if the offending language had been stricken from its provisions and the remainder of the Plan document shall continue in full force and effect.

SECTION 11 - QUALIFIED MEDICAL CHILD SUPPORT ORDERS

11.1 The Plan Administrator will adhere to the terms of any qualified medical support order that satisfies the requirements of this Article XIV and Section 609 of the Employee Retirement Income Security Act of 1974 ("ERISA"). 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 (including this 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:

a. 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

b. 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 (including this 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 (including this Plan) with respect to such Participant.

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

SECTION 12 - CESSATION OF COVERAGE

12.1 In the event that a Participant ceases to be a Participant in this Plan for any reason during the Plan Year, the Participant's salary reduction agreement relating to this Plan shall terminate. Except as provided in Section 13, the Participant shall be entitled to reimbursement only for Qualifying Health Care Expenses incurred within the same Plan Year and before he or she ceased to be a Participant.

12.2 If and to the extent required by law (including, without limitation, Code §§ 105, 125 and 4980B and the regulations thereunder, as provided in Section 13), in the event that a Participant ceases to be an employee and undertakes to pay any required premiums to the Plan Administrator on a monthly basis (or within such other time limit as may be provided for by law), coverage under the Plan shall continue so long as such premiums are paid, but not beyond the end of the period for which such coverage is required by law. In addition, the former Participant shall be treated as a Participant under the Plan to such extent as is required by law, and shall be entitled to reimbursement for Qualifying Health Care Expenses incurred during such period of continued coverage, subject to Section 12.3 below.

12.3 Reimbursements shall be made for any Plan Year under this Section 12 only if the Participant applies for such reimbursement in accordance with Section 7 on or before April 15th following the close of the grace period following that Plan Year in accordance with the provisions of Section 6.5 (or, if such day falls on a Saturday, Sunday or holiday, the next following business day). In the event of the Participant's death, the Participant's Spouse (or, if none, the Participant's executor or administrator) may apply on the Participant's behalf for reimbursements. In the case of a Participant who terminates employment during the Plan Year, claims for reimbursement for expenses incurred prior to termination must be made by April 15th following his or her date of termination. No reimbursement under this section shall exceed the remaining balance, if any, in the Participant's Health Care Spending Account for the Plan Year in which the expenses were incurred.

SECTION 13 - CONTINUATION COVERAGE RIGHTS UNDER COBRA

13.1 Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Dependents, as applicable, whose coverage terminates because of a COBRA qualifying event (as who is a qualified beneficiary as defined under COBRA) shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had the day before the qualifying event for the periods prescribed by COBRA. Specifically, such individuals will be eligible for COBRA continuation coverage only if, under Section 6, they have a positive Health Care Spending Account balance at the time of a COBRA qualifying event (taking into account all claims submitted before the date of the qualifying event). Such individuals will be notified if they are eligible for COBRA continuation coverage. If COBRA is elected, it will be available only for the remainder of the Plan Year in which the qualifying event occurs; such COBRA coverage will cease at the end of the Plan Year and cannot be continued for the next Plan Year. Such continuation coverage shall be subject to all conditions and limitations under COBRA. Notwithstanding the foregoing, a qualified beneficiary (as defined under COBRA) who has COBRA coverage on the last day of a Plan Year may be entitled to reimbursement of Qualifying Health Care Expenses incurred during the grace period following that Plan Year in accordance with the provisions of Section 6.5.

Contributions for coverage under the Plan may be paid on a pre-tax basis for current Participants receiving taxable compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year) where COBRA coverage arises either (a) because the Participant ceases to be eligible because of a reduction of hours or (b) because the Participant's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (e.g. Participants who cease to be eligible because of retirement, termination of employment, or layoff), contributions for COBRA coverage for benefits under the Plan shall be paid on an after-tax basis (unless permitted otherwise by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year).

Federal law requires group health plans with more than 20 participants to offer COBRA continuation coverage to certain participants and beneficiaries who lose coverage due to certain qualifying events. If the Company is subject to and the Plan is covered by such federal law, it offers optional COBRA continuation coverage to you and/or your dependents if coverage of the eligible beneficiary would otherwise end due to one of the following events:

a. Termination of your employment for any reason except gross misconduct. Coverage may continue for you and your eligible dependents.

b. A reduction in hours worked by you. Coverage may continue for you and your eligible dependents.

c. Your death. Coverage may continue for your eligible dependents.

d. Divorce or legal separation from your spouse. Coverage may continue for that former spouse and your other eligible dependents.

e. You become entitled to Medicare. Coverage may continue for eligible dependents who are not entitled to Medicare.

f. Loss of eligibility of a covered dependent child. Coverage may continue for that dependent.

NOTE: To choose this COBRA continuation coverage, an individual must be a covered person under the Plan on the day before the qualifying event or be born to or adopted by you during the period of your COBRA continuation coverage.

These provisions provide for the continuation of the coverage you were receiving immediately before the qualifying event. You will not be allowed to change from this coverage once COBRA continuation coverage is elected except as provided below:

g. If you are relocating and your coverage includes a region-specific benefit package that will not service your health needs in the area to which you relocate, you will be allowed to change your COBRA continuation coverage. In such a case, you will be given, within a reasonable period after requesting a change in coverage, an opportunity to elect alternative coverage that the Company makes available to active employees. If the Company makes coverage available to similarly situated non-COBRA beneficiaries that can be extended in the area to which you are relocating, then that coverage is the alternative coverage that must be made available to you. The effective date of your alternative coverage will not be later than the date of your relocation, or, if later, the first day of the month following the month in which you request the alternative coverage. However, the Company is not required to make any other coverage available to you if the only coverage that it makes available to active employees is not available in the area to which you are relocating because all such coverage is region-specific and does not service individuals in that area.

h. If the Company makes an open enrollment period available to similarly situated active employees with respect to whom a qualifying event has not occurred, the same open enrollment period rights must be made available to each qualified beneficiary receiving COBRA continuation coverage. During any such open enrollment period you will be allowed to change your COBRA continuation coverage.

13.2 The taking of qualifying leave under the Family and Medical Leave Act ("FMLA") does not constitute a qualifying event. However, a qualifying event would occur if you are covered on the day before the first day of FMLA leave, you do not return to employment with the Company at the end of the FMLA leave and you would, in the absence of COBRA continuation coverage, lose coverage under the Plan. In such a case, the qualifying event would occur on the last day of your FMLA leave and your period of maximum coverage would be measured from that date. If, however, coverage under the Plan is lost at a later date and the Plan provides for an extension of coverage, then the maximum coverage period is measured from the date when your coverage is lost.

13.3 **You or other qualifying individual(s) have the responsibility to inform the Plan Administrator of a divorce, legal separation or a child losing dependent status under the Plan within 60 days of the qualifying event. Failure to provide this notification within 60 days will result in the loss of COBRA continuation coverage rights. You must provide such notice in writing to:**

Vanderbilt University
Human Resources
PMB: 407704
2301 Vanderbilt Place
Nashville, TN 37240-7704

The Company has the responsibility of notifying the Plan Administrator of your death, termination of employment, reduction in hours, or entitlement to Medicare within 30 days of the qualifying event. The Plan will notify you and other qualifying individual(s) of COBRA continuation coverage rights within 14 days of the notice described above. You and any other qualifying individuals will then have 60 days to elect COBRA continuation coverage. Failure to elect COBRA continuation coverage within 60 days after being notified by the Plan Administrator will result in loss of COBRA continuation coverage rights.

13.4 Once you and any other qualifying individuals elect COBRA continuation coverage and make the first premium payment as provided below, your COBRA continuation coverage will be effective retroactive to the date of your qualifying event. Any expenses incurred by you or a qualifying individual during the election period will be paid pursuant to the provisions of the Plan.

13.5 The maximum period of COBRA continuation coverage for individuals who qualify

a. due to termination of employment or reduction in hours worked is:

i. 18 months from the date of the qualifying event; or

ii. If a qualifying individual is disabled (as determined under the Social Security Act) at the time of your termination or reduction in hours or becomes disabled at any time during the first 60 days of COBRA continuation coverage, such continuation coverage for the qualifying individual and any non-disabled family members who are also entitled to COBRA continuation coverage may be extended to 29 months provided the qualifying individual or family member, if applicable, notifies the Plan Administrator within the 18-month COBRA continuation coverage period and within 60 days after receiving notification of disability determination. The Plan Administrator must also be notified of final determination that the qualifying individual is no longer disabled within 30 days of the date of the final determination.

b. due to any other described qualifying event is 36 months from the date of the qualifying event.

13.6 The maximum period for COBRA continuation of coverage for a child born to, adopted or placed for adoption with the covered employee is measured from the date of the parent's qualifying event.

13.7 If an individual experiences more than one qualifying event, the maximum period of coverage will be computed from the date of the earliest qualifying event, but will be extended to the full 36 months if required by the subsequent qualifying event.

13.8 If you are entitled to Medicare and your Spouse and dependent children would otherwise lose coverage because of a qualifying event which is either your termination of employment or reduction in hours, continuation coverage for your Spouse and dependent children will end on the later of (i) 36 months from the date you become entitled to Medicare or (ii) 18 months (or 29 months if there is a disability extension) after your termination of employment or reduction in hours.

13.9 The cost of COBRA continuation coverage is determined by the Company and paid by the qualifying individual. If the qualifying individual is not disabled, the applicable premium cannot exceed 102% of the plan's cost of providing coverage. The cost of coverage during a period of extended continuation coverage due to a disability cannot exceed 150% of the Plan's cost of coverage.

13.10 You and other qualified individual(s) must make the first payment within 45 days of notifying the Plan of selection of COBRA continuation coverage. Future payments can be made in monthly installments within 30 days of the due date unless the Company establishes a longer payment schedule. Rates and payment schedules are established by the Company and may change when necessary due to Plan modifications.

13.11 The cost of COBRA continuation coverage is computed from the date coverage would normally end due to the qualifying event.

13.12 If timely payment is made in an amount that is not significantly less than that amount required to be paid ($50.00 or 10% of the amount required to be paid, whichever is less), the Plan Administrator will notify you of the amount of the deficiency. You will have 30 days after the date the notice is provided to you to pay the deficiency. Failure to make the first payment within 45 days or any subsequent payment within 30 days of the established due date will result in the permanent cancellation of continuation coverage.

13.13 When COBRA Continuation Coverage Ends. COBRA Continuation of coverage ends on the earliest of:

a. The date the maximum COBRA continuation period expires.

b. The date the qualifying individual first becomes entitled to coverage under Medicare if such entitlement occurs after the date of the continuation of coverage election.

c. The last period for which payment was made when coverage is canceled due to non-payment of the required cost.

d. The date the Company no longer offers a health care reimbursement plan to any of its employees.

e. The date, after the date of the COBRA continuation of coverage election, the qualifying individual first becomes covered under any other health care reimbursement plan that does not exclude or limit coverage for a pre-existing condition the qualifying individual may have or when such limitation is satisfied due to application of prior creditable coverage as required under the Health Insurance Portability and Accountability Act (HIPAA).

f. When COBRA coverage has been extended up to 29 months due to disability, the date a final determination is made by the Social Security Administration that the qualified individual is no longer disabled.

13.14 In order to protect your 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. If you have any questions concerning your rights under COBRA, contact:

Vanderbilt University
Human Resources
PMB: 407704
2301 Vanderbilt Place
Nashville, TN 37240-7704
615-343-4788

SECTION 14 - MILITARY SERVICE

Notwithstanding any provisions of the Plan to the contrary, the rights of employees who leave employment to serve in the military will be governed by the Uniformed Services Employment and Reemployment Rights Act, 38 U.S.C. §§ 4301-4333.

SECTION 15 – HIPPA PRIVACY STATEMENT

15.1 **Employer's Access to PHI.** Members of the Employer's workforce have access to the individually identifiable health information of Participants for administrative functions of the Plan. When this health information is provided to the Employer, it is Protected Health Information (PHI). The Plan has also entered into a Business Associate Agreement with a third-party administrator ("TPA") under which the Plan has delegated to and the TPA has agreed to perform certain plan administration functions on behalf of the Plan. Under no circumstances will the Employer, or any employee of the Employer, have access to or receive any Protected Health Information regarding the Participants in the Plan (except as provided in Section 12.4 below and allowed under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")).

15.2 **Protected Health Information**. The TPA shall have access to the individually identifiable health information of Participants for administrative functions of the Plan as set forth in the Business Associate Agreement. When individually identifiable health information is provided from the Plan to the TPA, it is Protected Health Information (PHI). The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the TPA's ability to use and disclose PHI. Such use and disclosure is also governed by the terms of the Business Associate Agreement. The TPA shall have access to PHI from the Plan only as permitted under the Plan, the Business Associate Agreement or as otherwise required or permitted by HIPAA.

15.3 **PHI Definition**. "Protected health information" means 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 deceased.

15.4 **Provision of Protected Health Information to Employer**.

a. **Permitted Disclosure of Enrollment/Disenrollment Information**. The Plan may disclose to the Employer 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 Employer, provided that the Employer requests the Summary Health

Information for the purpose of 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.

15.5 **Provision of Protected Health Information to TPA.**

a. **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 Section 0(b), the Plan may disclose PHI to the Employer or the TPA, provided that the Employer or TPA uses or discloses such PHI only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Employer or the TPA on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related functions. Notwithstanding the provisions of this Plan to the contrary, in no event shall the Employer or TPA be permitted to use or disclose PHI in a manner that is inconsistent with 45 C.F.R. § 164.504(f).

b. **Conditions of Disclosure for Plan Administration Purposes**. The Employer 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, it shall:

i. not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;

ii. 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 Employer with respect to PHI;

iii. 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 Employer;

iv. 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;

v. make available PHI to comply with HIPAA's right to access in accordance with 45 C.F.R. § 164.524;

vi. make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526;

vii. make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528;

viii. 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;

ix. if feasible, return or destroy all PHI received from the Plan that the Employer 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

x. ensure that the adequate separation between the Plan and the Employer (i.e., the "firewall"), required in 45 C.F.R. § 504(f)(2)(iii), is satisfied.

c. **Adequate Separation between Plan and Employer**. The Employer 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 Employer 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 Employer for non-compliance pursuant to the Employer's employee discipline and termination procedures.

SECTION 16 - GENERAL INFORMATION

16.1 Plan Sponsor: Vanderbilt University.

16.2 Plan Sponsor's Federal Employer Identification Number is 62-0476822.

16.3 The Plan Administrator is Vanderbilt University. The Plan Administrator may engage agents to assist it and may engage legal counsel, including counsel to defend any action taken or omitted to be taken pursuant to the written opinions or certificates of any agent, counsel, or physician.

16.4 The agent for service of legal process is the Plan Administrator.

16.5 The Plan is funded by Employee salary deferrals of the Participants as allocated by the Participants.

16.6 The Plan was established effective as of July 1, 1984.

16.7 The Plan is restated effective January 1, 2024.

16.8 The Plan Year ends December 31st.

16.9 The Plan Number is 513.

IN WITNESS WHEREOF, Vanderbilt University, by its duly authorized officer, has executed this Plan on this 5th day of June, 2024.

VANDERBILT UNIVERSITY

Plan Sponsor

By: Chad D. Hooker
Its: Chief People Experience Officer