



Employee Assistance Program

Plan Document and Summary Plan Description

**VANDERBILT UNIVERSITY
WORK/LIFE CONNECTIONS - EMPLOYEE ASSISTANCE PLAN**

Plan document and Summary Plan Description

Restated January 1, 2017

ARTICLE I – INTRODUCTION

1.1 Effective as of January 1, 2017 Vanderbilt University restates the Vanderbilt University Work/Life Connections – Employee Assistance Plan (“Plan”). The Plan is 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 explain the provisions of the Plan. You are urged to read this document carefully and to acquaint your family with its provisions.

1.2 The purpose of the Plan is to provide employees and their spouses access to confidential and professional counseling for issues such as marital or family counseling, family psychological or psychiatric counseling, financial counseling, addiction counseling, behavioral counseling, substance abuse counseling and post-trauma counseling.

ARTICLE II - DEFINITIONS

2.1 “Employee” means any full-time or part-time employee of the Employer.

2.2 “Employer” shall mean Vanderbilt University.

2.3 “Participant” means an Employee of the Employer. The term “Participant” also includes the Spouse of any such eligible Employee.

2.4 “Spouse” means your lawful spouse as defined under applicable law, but shall not include an individual legally separated from an Employee under a decree of legal separation. The Employer may request such proof of dependent status as it deems necessary

ARTICLE III - ELIGIBILITY

3.1 **Eligibility.** All full-time and part-time Employees and their Spouses will be eligible for benefits under the Plan effective upon the Employee’s first date of employment with the Employer.

3.2 **Enrollment.** Eligible Employees and their Spouses are automatically enrolled in the Plan upon the Employee’s commencement of employment with the Employer.

3.3 **When Coverage Begins.** Coverage begins on the Employee’s first day of employment. If the Employee is not actively at work or in attendance on the date coverage would otherwise begin, coverage begins on the first day the Employee returns to work and assumes normal duties.

3.4 **Coverage During a Leave of Absence.** Coverage under the Plan will continue during any approved leave of absence, including family, medical, military, and other approved leaves.

3.5 **When Coverage ends.** Subject to continuation of coverage discussed in Article X, an Employee’s eligibility under the Plan will terminate upon the occurrence of the earliest of:

- (a) The last day of the month in which the Employee terminates employment with the Employer;
- (b) The date the Employee retires;
- (c) The date the Employees dies; or
- (d) The date the Employer terminates the Plan.

Eligibility of a Spouse under the Plan will terminate upon the occurrence of the earliest of:

- (a) The last day of the month in which the Employee terminates employment with the Employer;
- (b) The date the Employee retires;
- (c) The date the Employees dies;
- (d) The date the Spouse no longer meets the definition of a "Spouse" under the Plan;
or
- (d) The date the Employer terminates the Plan.

ARTICLE IV – PLAN BENEFITS

4.1 The Plan provides confidential and voluntary assessment, counseling, and referral services designed to help Employees and their Spouses resolve personal problems. The Plan provides short-term assistance through problem identification and short-term counseling by experienced, trained counselors.

4.2 If it is determined that additional expertise or more extensive treatment is needed, the Plan will provide the Participant with three (3) referrals to professionals or programs within the community who specialize in the area specific to the Participant's needs. The Participant is responsible for the cost of such referral services. Such referral services may be covered under the Vanderbilt University Health Plan. It is the Participant's responsibility to verify coverage under the Health Plan or pay for charges not paid or reimbursed by the Health Plan. The Plan does not cover and does not pay claims submitted by any health care provider or other third party that is not a participating provider or that provides services outside the scope of the Plan.

4.2 Participants may contact the Plan by calling 615-936-1327 to request information or schedule an appointment with a counselor. Counselors are available from 8am to 5pm Monday through Friday. Counseling sessions shall be scheduled at times mutually convenient to Counselor and the Participant. In the event of an emergency or crisis event after hours, Participants may contact the Plan and provide appropriate information to the answering service.

4.3 The benefits under this Plan will be provided to Participants at no charge. Costs associated with referrals to outside professionals or programs are not a benefit under the Plan; however, such costs may be covered under Vanderbilt University Health Plan.

4.4 The Plan's counseling services include problem assessment, short-term counseling and referrals to appropriate resources. Examples of personal problems the Plan can help with include:

- alcohol and other drug abuse;
- a breakdown in family or other relationships;
- a distressing living situation;
- interpersonal conflict on the job;
- the death of a family member or close friend;
- health problems;
- emotional or psychological distress;
- career concerns;
- legal problems;
- financial difficulties;
- retirement concerns; and
- work tardiness or absenteeism.

ARTICLE V - CONFIDENTIALITY

5.1 All interactions between a Participant and the Plan are strictly confidential and will not be noted in any official Employer record, clinical record or personnel file. Information from the Plan may be released only with a Participant's written permission, in response to state or federal statute or regulation, or from a court or other legal order. The law may require the release of specific information when the life or safety of a person is seriously threatened.

5.2 **Self-Referral.** If a Participant elects on his own to seek counseling assistance under the terms of the Plan, the Counselor will not inform the Employer or the appropriate authorities except in the following circumstances:

- a. If, in the professional opinion of the Counselor, the Participant is actively homicidal or suicidal;
- b. If, in the professional opinion of the Counselor, the Participant possibly poses a threat to the health and safety of patients, students, customers or co-workers, resulting from an emotional illness or substance use;
- c. In situations of child or domestic abuse;
- d. If there is suspected fraud or abuse; or
- e. Where the Participant signs a release of information.

In the event that a Participant who is receiving substance abuse counseling under this Plan is selected for random drug testing and tests positive, the Employer, in its discretion, may consider such substance abuse counseling as a mitigating factor in determining whether to terminate such Participant if the Participant or the Counselor, with the Participant's permission, has notified the Employer that the Participant is receiving substance abuse counseling prior to the random drug testing.

5.3 **Referral by a supervisor.** If an Employee contacts the Plan as the result of a supervisory requirement, the supervisor will be notified that the Employee kept the initial appointment and whether their participation is satisfactory or not satisfactory. Information will be requested from the supervisor to clarify the issues and expectations in order to best assist the Employee. However, no details regarding such counseling would be released to the supervisor unless the Employee executes a release allowing

the details of the counseling to be revealed to the supervisor and the Employer or one of the circumstances set forth in Section 5.2 above exists.

ARTICLE VI - ADMINISTRATION

The Employer shall have full responsibility and authority to interpret and administer the Plan, including the power to promulgate rules of Plan administration, the power to settle any disputes as to rights or benefits arising from the Plan, the power to appoint agents and delegate its duties, and the power to make any decisions or take any actions that the Employer, in its sole discretion, deems necessary or advisable to aid in the proper administration of the Plan. Actions and determinations by the Employer shall be final, binding and conclusive for all purposes of this Plan.

ARTICLE VII – AMENDMENT, SUSPENSION AND TERMINATION OF THE PLAN

7.1 **Plan Amendment.** The Employer shall retain the right, by action of its directors, in their sole and final discretion, to amend the Plan at any time and from time to time to any extent that the directors 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 Participant or Key Employee. A copy of the directors' resolution 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.

7.2 **Plan Termination.** The Employer shall have the right by action of its directors, in their 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 Plan shall automatically terminate upon cessation of operations by the Employer and all benefits cease unless a successor company adopts and continues the Plan.

ARTICLE VIII - FUNDING

No promises under this Plan shall be secured by any specific assets of the Employer, nor shall any assets of the Employer be designated as attributable or allocated to the satisfaction of such promises. The cost of benefits provided under the Plan shall be made from the Employer's general assets.

ARTICLE IX – RIGHTS OF PLAN PARTICIPANTS

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 shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

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.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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. If it should happen that plan fiduciaries misused the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security

Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ARTICLE X - CONTINUATION COVERAGE RIGHTS UNDER COBRA

10.1 Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant 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. Such individuals will be notified if they are eligible for COBRA continuation coverage. Such continuation coverage shall be subject to all conditions and limitations under COBRA.

Contributions for coverage under the Plan may be paid on a pre-tax basis for current Employees 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 Employee ceases to be eligible because of a reduction of hours or (b) because a Spouse 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 Employer 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.

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:

f. 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 Employer makes available to active employees. If the Employer 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 Employer 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.

g. If the Employer 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.

10.2 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 Employer 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.

10.3 You or other qualifying individual(s) have the responsibility to inform the Plan Administrator of a divorce or legal separation 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:

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

The Employer 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.

10.4 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.

10.5 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.

10.6 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.

10.7 If you are entitled to Medicare and your Spouse 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 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.

10.9 The cost of COBRA continuation coverage is determined by the Employer 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.

10.10 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 Employer establishes a longer payment schedule. Rates and payment schedules are established by the Employer and may change when necessary due to Plan modifications.

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

10.12 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.

10.13 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 Employer no longer offers an employee assistance 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 employee assistance 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.

10.14 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:

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

ARTICLE XI – CLAIMS PROCEDURES

11.1 Benefits under the Plan are provided to Participants at no cost and, therefore, no claims for benefits under the Plan is required. If a Participant believes they have been denied access to the Plan, he or she may file a written claim with the Plan.

11.2 Timing of Notification of Benefit Determination. If a claim is wholly or partially denied, the Participant shall be notified of the adverse benefit determination within a reasonable period of time, but not later than 30 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 Participant prior to the termination of the initial 30-day period. In no event shall such extension exceed a period of 30 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.

11.3 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.

11.4 Manner and Content of Notification of Benefit Determination. A Participant 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 Participant, the following:

- a. the specific reason or reasons for the adverse determination;
- b. reference to the specific plan/policy provisions on which the determination is based;
- c. a description of any additional material or information necessary for the Participant to perfect the claim and an explanation of why such material or information is necessary;
- d. a description of the review procedures and the time limits applicable to such procedures, including a statement of the Participant's right to bring a civil action under § 502(a) of ERISA (where applicable), following an adverse benefit determination on review; and
- e. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Participant upon request.

11.5 Appeals of Adverse Benefit Determination. Appeals of adverse benefit determinations may be submitted in accordance with the following procedures:

- a. Participants (or their authorized representatives) must submit an appeal within 180 days following their receipt of a notification of an adverse benefit determination, and only one appeal is allowed;
- b. Participants shall have the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;
- c. Participants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits;
- d. The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
- e. No deference to the initial adverse benefit determination shall be afforded upon appeal;
- f. 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
- g. Any medical or vocational expert(s) whose advice was obtained in connection with a Participant's adverse benefit determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination.

11.6 Timing of Notification of Benefit Determination on Review.

a. The Participant (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 Participant'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 Participant 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.

b. 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 Participant'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 Participant until the date on which the Participant responds to the request for additional information.

11.7 Manner and Content of Notification of Benefit Determination on Review. A Participant 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 Participant, the following:

- a. the specific reason or reasons for the adverse determination;
- b. reference to the specific plan/policy provisions on which the determination is based;
- c. a statement that the Participant 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 Participant's claim for benefits;
- d. a statement of the Participant's right to bring an action under § 502(a) of ERISA (where applicable); and
- e. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Participant upon request.

ARTICLE XII – MISCELLANEOUS PROVISIONS

12.1 **Employment rights.** Neither the establishment of the Plan nor the payment of any benefits under this Plan nor any action of the Employer, including its Board of Directors, in connection with this Plan shall be held or construed to confer upon any individual any legal right to remain an officer or an employee of the Employer.

12.2 **Counselors.** The Employer is not responsible for the advice rendered to an Participant by a counselor, nor is the Employer responsible for any action taken under the advice.

12.3 **Nonalienation.** No benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge, and any attempt to do so shall be void. No benefit under this Plan shall, prior to its receipt, be in any manner liable for or subject to the recipient's debts, contracts, liabilities, engagements, or torts.

12.4 **Binding effect.** This Plan shall inure to the benefit of, and be binding upon, the Employer and each Participant and upon the successors and assigns of the Employer and of each Participant.

12.5 **Governing law.** This Plan shall be governed by, and construed in accordance with, the laws of the State of Tennessee.

ARTICLE 12 HIPAA PRIVACY STATEMENT

13.1 **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")).

13.2 **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.

13.3 **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.

13.4 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.

13.5 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 13.5b(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 members of the Vanderbilt University 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.

ARTICLE XIV – GENERAL INFORMATION

14.1 Name and address of the Plan Sponsor:

Vanderbilt University
PMB #407700
2301 Vanderbilt Place
Nashville, TN 37240-7700
(615) 322-8303

14.2 Name and address of the Plan Administrator:

Vanderbilt University
PMB #407700
2301 Vanderbilt Place
Nashville, TN 37240-7700
(615) 322-8303

14.3 Name and address of the designated agent for service of legal process:

Vanderbilt University
PMB #407700
2301 Vanderbilt Place
Nashville, TN 37240-7700
(615) 322-8303

14.4 Employer Federal Identification Number: 62-0476822

14.5 Plan Number: 513

14.6 Restatement effective date: January 1, 2017

14.7 Plan Year: The Plan Year is the 12-month period beginning January 1 and ending December 31.

14.8 Type of Plan and Funding:

This Plan is a plan funded by the Employer from its general assets. It is intended to constitute a plan as described by the Employee Retirement Income Security Act of 1974 (ERISA).

14.9 Type of Administration:

Administration of the Plan, including claims processing, is performed by a third party administrator.

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising the Vanderbilt University Work/Life Connections – Employee Assistance Plan, Vanderbilt University has caused this Plan to be executed in its name and on its behalf, on March 21, 2016.

VANDERBILT UNIVERSITY

By: 

Title: Associate Vice Chancellor and
Chief Human Resources Officer