



**HUMAN
RESOURCES**

Section 125 Cafeteria Plan

Plan Document

**VANDERBILT UNIVERSITY
SECTION 125 CAFETERIA PLAN**

Effective January 1, 2017

SECTION 1 - PURPOSE

The purpose of this Plan is to make available to the Employer's eligible employees a choice among cash, and various pre-tax and after-tax benefits, as described in this Plan and elected by the Employer in the Adoption Agreement.

This Plan is intended to qualify under § 125 of the Internal Revenue Code of 1986, as amended, and is to be construed in accordance with the requirements of § 125 and regulations proposed and promulgated thereunder, as amended from time to time.

SECTION 2 - DEFINITIONS

2.1 **"Adoption Agreement"** means that Adoption Agreement executed by Employer by which the Employer adopts this Plan and agrees to be bound by its provisions.

2.2 **"Adverse benefit determination"** means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's or beneficiary's eligibility to participate in the Plan.

2.3 **"Allocation"** means the portion of the Participant's compensation which the Participant has committed to a particular benefit in the Election Form.

2.4 **"Carrier"** means one of the insurance companies, if any, which issued the Insurance Policies to the Employer or Employee to provide insurance benefits under this Plan. If a Preferred Provider Organization benefit is provided by this Plan, the term also includes the administrator of that benefit.

2.5 **"Code"** means the Internal Revenue Code of 1986, as amended from time to time. Reference to any section or subsection of the Code includes reference to any comparable or succeeding provisions of any legislation, which amends, supplements or replaces such section.

2.6 **"Compensation"** means a Participant's total salary or wages paid by the Employer and includable on the Participant's Form W-2 for federal income tax reporting purposes, including all bonuses, overtime, commissions, taxable benefits or otherwise.

2.7 **"Dependent"** means a Participant's dependent as defined in Code § 152.

2.8 **"Election Form"** means a written agreement by and between the Employer and the Participant entered into prior to each Period of Coverage in which the Participant agrees to a reduction in salary for the purposes of electing benefits under this Plan and which are therefore and thereafter considered Employer contributions.

2.9 **"Employee"** means any individual employed by an Employer and not excluded from participation in the Adoption Agreement.

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2.10 **“Employer”** means the entity identified in the Adoption Agreement as the Employer, and each Related Employer which adopts the Plan by executing the Adoption Agreement with the consent of the Employer identified in the Adoption Agreement, for the benefit of its eligible Employees or any successor organization of the Employer or any Related Employer which continues the Plan.

2.11 **“Health Care FSA”** means a health care flexible spending account as defined in Prop. Treas. Reg. § 1.125-5.

2.12 **“Health Savings Account”** or **“HSA”** means a health savings account established under Code § 223. Such arrangements are individual trusts or custodial accounts, each separately established and maintained by a Participant with a qualified trustee/custodian.

2.13 **“High Deductible Health Plan”** means a high deductible health plan offered by the Employer that is intended to qualify as a high deductible plan under Code § 223(c)(2), as described in materials provided separately by the Employer. Such high deductible health plan may or may not be the sole medical insurance plan eligible for pre-tax salary reduction funding under the Plan.

2.14 **“Highly Compensated Participant”** means a Participant who is treated as a Highly Compensated Participant or Individual within the meaning of Code §§ 105, 125, 129 or 414(q).

2.15 **“HSA Benefits”** has the meaning described in Section 5.2(f).

2.16 **“HSA-Eligible Individual”** means an individual who is eligible to contribute to an HSA under Code § 223 and who has coverage under a qualified high deductible health plan and who is not covered by any disqualifying non-high deductible health plan.

2.17 **“Insurance Policy”** means any of the insurance policies (or certificates or contracts) which are issued by a Carrier to the Employer or Employees.

2.18 **“Key Employee”** means a Participant who is a Key Employee within the meaning of Code § 416(i)(1).

2.19 **“Participant”** means any Employee who participates in the Plan in accordance with Section 3 hereof.

2.20 **“Period of Coverage”** means the period elected by the Employer in the Adoption Agreement during which a Participant’s coverage under a Qualified Benefit is effective.

2.21 **“Plan”** means this written “Vanderbilt University Section 125 Cafeteria Plan”, including the Adoption Agreement, together with any and all amendments and exhibits to such documents that are hereby incorporated by reference.

2.22 **“Plan Administrator”** means the Employer or such person or committee as named in the Adoption Agreement as the Plan Administrator to supervise the administration of the Plan.

2.23 **“Plan Entry Date”** means the day an Employee meets the eligibility requirements of the Plan, as specified in the Adoption Agreement, including the requirements of completing any required Election Form.

2.24 **“Plan Year”** means a 12 month period as shown in the Adoption Agreement, except for purposes of a short Plan Year which may be a period of less than 12 months as shown in the Adoption Agreement.

2.25 **“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 § 414(o)). If the Employer is a member of a related group, the term “Employer” includes the related group members for purposes of crediting service, the definitions of Employee, Highly Compensated Employee, and Compensation, and for any other purpose required by the applicable Code section or by a Plan provision. However, an Employer may permit an Employee to defer compensation under the Plan only if the Employer is a signatory to the execution page of the Adoption Agreement or to a Participation Agreement to the Employer’s Adoption Agreement. If one or more of the Employer’s related group members become Participating Employers by executing a Participation Agreement to the Employer’s Adoption Agreement, the term “Employer” includes the participating related group members for all purposes of the Plan, and “Plan Administrator” means the Employer that is the signatory to the execution page of the Adoption Agreement.

2.26 **“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 - PARTICIPATION

3.1 **Eligibility to Participate.** An Employee shall be eligible to participate in the Plan upon satisfaction of the eligibility requirements as specified in the Adoption Agreement. Such Employee shall enter the plan on the Plan Entry Date as specified in the Adoption Agreement. Eligibility for premium reimbursement benefits under this Plan shall also be subject to additional requirements, if any, specified in the insured plan document(s).

3.2 **Filing of Election Form.** The Plan Administrator shall furnish to each Employee an application to participate in the Plan, known as the “Election Form.” The Election Form must be completed by the Employee and filed with the Plan Administrator prior to the Employee’s applicable Entry Date. The Employee shall also furnish to the Plan Administrator such documents and information as may be requested by the Plan Administrator for the administration of the Plan. Upon executing and filing the Election Form, the Employee shall be deemed to have consented to be bound by all the provisions of this Plan and any and all amendments, and any determination made by the Plan Administrator with respect to the Participant’s rights under the Plan.

3.3 **Termination of Participation.** A Participant will cease to be a Participant as of the earlier of:

- (a) the date on which the Plan terminates;
- (b) the date on which Employee ceases to be an Employee eligible to participate;
- (c) at the end of any Plan Year if the Employee files with the Plan Administrator a written election not to participate in the Plan the following year; or
- (d) if elected in the Adoption Agreement, at the end of any Plan Year if the Employee fails to file with the Plan Administrator an Election Form for the following year. If this option is not elected in the Adoption Agreement, the Employee’s participation in the Plan shall continue in the following year on the same basis as the Employee elected in the previous year.

SECTION 4 -NONDISCRIMINATION

4.1 **Nondiscrimination Elections.** If and when the Plan Administrator determines that discrimination described under Code § 125 may occur, the Plan Administrator is authorized to modify the elections made by the Highly Compensated Participants or Key Employees to the extent necessary, in the Plan Administrator’s

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discretion, to avoid such discrimination. By executing and filing an Election Form, Highly Compensated Participants and Key Employees participating in the Plan expressly consent to such modifications as the Plan Administrator deems necessary or appropriate to avoid the possibility of discrimination.

4.2 Time of Recognition upon Determination of Discrimination. If the Plan is determined not to be qualified or to be discriminatory, any income deemed received under Code § 125 shall be taken into account in the tax year of the Employee, Highly Compensated Participant or Key Employee in which the Plan Year ends.

SECTION 5 - QUALIFIED BENEFITS

5.1 Qualified Benefits. The programs under which benefits are available to Employees under this Plan are set forth in the Employer's Adoption Agreement. Such benefits may include, among others, cash and reimbursement of employee required premiums for group insurance benefits and voluntary individual insurance benefits, reimbursement of qualifying dependent care and health care expenses, and pre-tax contributions to individual health savings accounts. All benefits offered under this Plan must meet the definition of "qualified benefits" contained in Code § 125(f). Effective for taxable years beginning after December 31, 2013, qualified benefits under this Plan shall not include any "qualified health plan" (as defined in § 1301(a) of the Patient Protection and Affordable Care Act) offered through an affordable insurance exchange or marketplace.

5.2 Description of optional benefits. While the election of one or more of the optional benefits may be made under this Plan, such benefits will be provided not by this Plan but by the plan documents governing such benefits. The types and amounts of benefits available under each option, the requirements for participating in such option, and the other terms and conditions of coverage and benefits under such option are as set forth from time to time in the plan documents for each benefit, and in the group insurance contracts and prepaid health plan contracts that constitute (or are incorporated by reference in) such plans. The benefit descriptions in such plans and contracts, as in effect from time to time, are hereby incorporated by reference into this Plan.

(a) **Group Medical Benefit Plans.** If the Employer elects in the Adoption Agreement to offer a group medical insurance plan, an eligible Participant may elect to defer, on a pre-tax basis, the required employee contribution from his or her Compensation to pay the Employee portion of the medical insurance premium. There shall be no reimbursement for group medical insurance premium expenses to the extent there is other reimbursement such as through other insurance, damages or otherwise. This Plan will pay, if applicable, at the Employee's election, the premiums due for medical insurance on behalf of the Employee directly to the self-insured trust or Carrier or will reimburse the Employee directly for premiums paid by the Employee. The group medical benefit plans are intended to comply with the provisions of Code Sections 105 and 106, and therefore will be deemed to be automatically amended to comply with all changes in law or regulations thereunder as of the effective date of each such change or regulation, unless the Employer elects to terminate the group medical insurance program following issuance of the new law or regulation.

(b) **Group Term Life Insurance Plan.** If the Employer elects in the Adoption Agreement to offer a group life insurance plan, an eligible Participant may elect to defer, on a pre-tax basis, the required employee contribution from his or her Compensation to pay the Employee portion of the premium for employee coverage under the group term life insurance plan. This Plan will pay, if applicable, at the Employee's election, the premiums due for group life insurance on behalf of the Employee directly to the Carrier or will reimburse the Employee directly for premiums paid by the Employee. The group life insurance program is intended to comply with the provisions of Code Section 79, and therefore will be deemed to be automatically amended to comply with all changes in law or regulations thereunder as of the effective date of each such change or regulation, unless the Employer elects to terminate the group life insurance program following issuance of the new law or regulation.

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(c) **Dependent Care Reimbursement Plan.** If the Employer elects in the Adoption Agreement to offer a dependent care reimbursement plan, an eligible Participant may elect to defer, on a pre-tax basis, an amount up to the annual maximum permitted under the separate dependent care reimbursement plan to pay for eligible dependent care expenses. To secure reimbursement for any dependent care expense, a Participant shall submit a receipted bill or unpaid bill as required in the dependent care reimbursement plan document. The dependent care reimbursement plan is intended to comply with the provisions of Code Section 129 and therefore will be deemed to be automatically amended to comply with all changes in law or regulations thereunder as of the effective date of each such change or regulation, unless the Employer elects to terminate the dependent care reimbursement program following issuance of the new law or regulation.

(d) **Group Disability Insurance Plan.** If the Employer elects in the Adoption Agreement to offer a group short term or long term disability insurance plan, an eligible Participant may elect to defer, on a pre-tax basis, the required employee contribution from his or her Compensation to pay the Employee portion of the group disability insurance premium. This Plan will pay, if applicable, at the Employee's election, the premiums due for group disability insurance on behalf of the Employee directly to the Carrier or will reimburse the Employee directly for premiums paid by the Employee. The group disability insurance program is intended to comply with the applicable provisions of the Internal Revenue Code, and therefore will be deemed to be automatically amended to comply with all changes in law or regulations thereunder as of the effective date of each such change or regulation, unless the Employer elects to terminate the group disability insurance program following issuance of the new law or regulation.

(e) **Health Care Expense Reimbursement Plan.** If the Employer elects in the Adoption Agreement to offer a health care expense reimbursement plan, an eligible Participant may elect to defer, on a pre-tax basis, an amount to pay for eligible medical expenses, up to the annual maximum permitted under the separate health care expense reimbursement plan, as set forth in the Election Form for the health care expense reimbursement plan. The maximum amount of reimbursements through a health care expense reimbursement plan for any Participant in any Plan Year shall not aggregate more than the Participant's Allocation to the health care expense reimbursement plan as set forth in the Participant's Election Form for the Plan Year. To secure reimbursement for a medical expense, a Participant shall submit from time to time a receipted bill or unpaid bill as required in the health care expense reimbursement plan document. The Plan will pay, if applicable, at the Employees' election, the medical expenses incurred on behalf of the Employee directly to the party owed or will reimburse the Employee directly for medical expenses incurred by the Employee. The health care expense reimbursement plan is intended to comply with the provisions of Code Sections 105 and 106, and therefore will be deemed to be automatically amended to comply with all changes in law or regulations thereunder as of the effective date of each such change or regulation, unless the Employer elects to terminate the health care expense reimbursement plan following issuance of the new law or regulation. For Plan Years beginning after December 31, 2012, a Participant may not elect for any Plan Year to have salary reduction contributions in regard to a health care expense reimbursement plan in excess of the limit set forth in Code Section 125(i) (the limit for 2016 is \$2,550).

(f) **Health Savings Account Benefits.** If the Employer elects in the Adoption Agreement to offer a Health Savings Account (HSA) benefit, an eligible Participant who is also eligible to contribute to an HSA under Code Section 223 may elect to make contributions on a pre-tax basis to an HSA account established by the Participant and maintained by an outside trustee/custodian to which the Employer can forward contributions to be deposited (this funding feature constitutes the HSA Benefit offered under this Plan). Such election can be increased, decreased or revoked prospectively by the Participant at any time during the Plan Year, effective no later than the first day of the calendar month following the date that the election change was filed.

(1) The annual amount contributed by a Participant to the HSA shall, in no event, exceed the lesser of (i) the maximum amount set forth in Code § 223 for HSA contributions applicable to the Participant's High Deductible Health Plan coverage option (i.e., single or family) for the calendar year in which

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the contribution is made; or (ii) the annual deductible under the High Deductible Health Plan coverage elected by the Participant.

(2) An additional catch-up Contribution may be made for Participants who are age 55 or older subject to the limit under Code § 223(b)(3).

(3) In addition, the maximum annual Contribution shall be: (i) reduced by any matching (or other) Employer contribution made on the Participant's behalf; and (ii) prorated for the number of months in which the Participant is an HSA-Eligible Individual.

(4) The tax treatment of the HSA (including contributions and distributions) is governed by Code § 223.

(5) Terms and conditions of coverage and benefits (e.g., eligible medical expenses, claims procedures, etc.) will be provided by and are set forth in the HSA, not this Plan. The terms and conditions of each Participant's HSA trust or custodial account are described in the HSA trust or custodial agreement provided by the applicable trustee/custodian to each electing Participant and are not a part of this Plan. The HSA is not an employer-sponsored employee benefit plan. It is a savings account that is established and maintained by an HSA trustee/custodian outside this Plan to be used primarily for reimbursement of "qualified eligible medical expenses" as set forth in Code § 223(d)(2). Even though this Plan may allow pre-tax salary reduction contributions and Employer contributions to an HSA, the HSA is not intended to be a benefit plan sponsored or maintained by the Employer.

(6) The Employer has no authority or control over the funds deposited in a HSA. However, the Employer may limit the number of HSA providers to whom it will forward contributions that the Employee makes via pre-tax salary reductions—such a list is not an endorsement of any particular HSA provider. The Plan Administrator will maintain records to keep track of HSA Contributions an Employee makes via pre-tax salary reductions, but it will not create a separate fund or otherwise segregate assets for this purpose.

(7) If the Employer elects a grace period as described in Section 5.8, then a Participant in a health care expense reimbursement plan during the immediately preceding Plan Year is not eligible to contribute to an HSA until the first day of the first month following the end of the grace period unless (1) the Participant has a zero balance in the Participant's health care expense reimbursement account as of the end of the Plan Year or (2) the Participant is making a qualified HSA distribution (as defined in Code § 106(e)) in an amount equal to the remaining balance in the health care expense reimbursement account as of the end of such Plan Year.

(g) **Voluntary Individual Insurance Benefits.** If the Employer elects in the Adoption Agreement to allow payment of premiums for voluntary individual insurance benefits, an eligible Participant may elect to defer, on a pre-tax basis, the required contribution from his or her Compensation to pay the premium for coverage under a voluntary individual insurance benefit. Such voluntary individual insurance benefits, if any, are not group benefits sponsored by the Employer and should not be viewed as endorsed by the Employer in any way. No contributions will be made by the Employer toward such individual benefits. The Employer's involvement with such benefits shall be limited to permitting insurers to publicize the benefit to employees, to collect premiums through payroll deductions and to remit such premiums to the applicable insurer. The Employer receives no consideration in the form of cash or otherwise in connection with such benefits, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions. Any such voluntary individual insurance benefit shall meet the requirements of a permitted benefit under Code § 125.

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5.3 Election of optional benefits in lieu of cash. A Participant may elect under this Plan to receive one or more of the optional benefits, to the extent available to the Participant under the applicable plans, in accordance with the procedures established by the Plan Administrator. If a Participant elects any such optional benefit under this Plan, the Participant's regular cash compensation will be reduced, and an amount equal to the reduction will be contributed by the Employer under the plan in question to cover the Participant's share of the cost of such benefit as determined by the Employer. The Employer may elect in the Adoption Agreement to treat an election by an Employee to participate in a group medical insurance plan as an election under this Plan to defer the employee cost of such coverage on a pre-tax basis.

5.4 Amendments to Available Benefit Programs. The Employer reserves the right at any time to increase or decrease or otherwise change or terminate the benefits available under this Plan, or the Carriers providing any benefits by amending the Adoption Agreement.

5.5 Maximum Benefit. The maximum benefits under this Plan are the maximum benefits specified in the Adoption Agreement, as modified by the Employer.

5.6 Prohibition of Deferred Compensation. If any balance remains in a Participant's health care expense reimbursement account or dependent care reimbursement account for a Plan Year after all reimbursements have been made for the Plan Year, then such balance shall not be carried over to reimburse the Participant for health care or dependent care expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance. All forfeitures under this Plan shall be used as follows: first, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements (i.e., providing health care expense reimbursement benefits) with respect to all Participants in excess of the contributions paid by such Participants through salary reductions; second, to reduce the cost of administering the health care expense or dependent care expense reimbursement program during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations. In addition, any health care expense or dependent care expense reimbursement payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the expense was incurred shall be forfeited and applied as described above.

5.7 Carryover of Unused Health Care Reimbursement Account Balances. Notwithstanding Section 5.6 hereof, the Employer may elect in the Adoption Agreement to allow Participants to carry over to a subsequent Plan Year up to \$500 of any unused balance in a health care expense reimbursement account. Any such carryover shall comply with IRS Notice 2013-71 and be subject to the maximum amount elected by the Employer in the Adoption Agreement (not to exceed the greater of \$500 or the balance remaining in the health care expense reimbursement account at the end of the Plan Year). If the Employer elects to adopt the carryover feature pursuant to this Section 5.7, the Employer may not also elect to adopt a grace period pursuant to Section 5.8 below.

5.8 Grace Period. Notwithstanding Section 5.6 hereof and subject to Section 5.7 above, the Employer may elect in the Adoption Agreement to adopt a grace period immediately following the end of each Plan Year during which unused benefits or contributions remaining at the end of the Plan Year may be paid or reimbursed to Participants for qualified benefit expenses incurred during the grace period. With respect to benefits offered under a health care expense reimbursement plan or dependent care reimbursement plan, expenses incurred during any such grace period may be reimbursed from unused contributions made with respect to that benefit as of the end of the immediately preceding Plan Year if the Participant applies for reimbursement of such expenses in accordance with the reasonable procedures prescribed by the Plan Administrator on or before ninety (90) days after the end of the grace period. Unused benefits or contributions relating to a particular benefit only may be used to pay or reimburse expenses incurred with respect to the same

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benefit. The reimbursement of expenses incurred during the grace period shall be made in accordance with IRS Notice 2005-42, Prop. Treas. Regs. § 1.125-1(e) and any subsequent guidance by the Internal Revenue Service with respect to such reimbursements. Subject to the provisions of Section 5.9 below, to the extent there remains any balance in a Participant's health care reimbursement account or dependent care reimbursement account, any such balance may not be carried forward to any subsequent Plan Year, cannot be cashed-out, and must be forfeited pursuant to Section 5.6 above. If the Employer elects to adopt a grace period pursuant to this Section 5.7, the Employer may not also elect to allow the carryover of unused health care expense reimbursement account balance pursuant to Section 5.7 above.

5.9 Grace Period Effect on HSA Contributions. If the Employer elects a grace period, then a Participant in the health care expense reimbursement plan (if any) during the immediately preceding Plan Year is not eligible to contribute to an HSA until the first day of the first month following the end of the grace period, unless (1) the Participant has a zero balance in the Participant's health care expense reimbursement account as of the end of the Plan Year or (2) the Participant is making a qualified HSA distribution (as defined in Code § 106(e)) in an amount equal to the remaining balance in the health care expense reimbursement account as of the end of such Plan Year.

SECTION 6 -ELECTION OF BENEFITS

6.1 Election of Benefit Coverage. Each Participant shall make an election of benefits from those available under this Plan. The Employee's election shall be made annually by executing and delivering to the Employer an Election Form prior to the Employee's initial Entry Date and thereafter, prior to the beginning of each Period of Coverage applicable to such benefit. The Election Form shall provide the benefits selected and the initial cost thereof. To the extent the Employee does not elect the maximum statutory benefits available under the Plan, a cash benefit shall be deemed to have been elected. An Election Form once filed shall be effective for such Period of Coverage until amended or revoked by the Employee in accordance with Sections 6.3 and 6.7.

6.2 Failure to Execute and Deliver an Election Form. If an eligible Employee fails to participate by failing to initially execute and file an Election Form with the Plan Administrator or fails to elect any available benefit, the Employee shall be deemed to have elected cash as a benefit. If an eligible Employee files an Election Form but fails to elect individual or family coverage for any benefit program, the Employee shall be deemed to have elected individual coverage. If at the end of a Period of Coverage an Employee fails to file with the Plan Administrator an Election Form for the following Period of Coverage prior to the start of the Period of Coverage (i) the Employee waives his or her right to participate in the Plan for the following Period of Coverage, or (ii) the Employee's participation in the Plan will continue in the following Period of Coverage on the same basis as the Employee elected in the previous Period of Coverage, as elected by the Employer in the Adoption Agreement.

6.3 Revocation or Change of Election During the Period of Coverage (Applies to all benefits other than HSA benefits – See Section 6.7 below or as noted).

(a) A Participant's Election Form and selection of benefits are irrevocable and cannot be changed during the Period of Coverage unless the change is due to and consistent with a change in status or as provided below. The Plan Administrator's decision regarding any change in election shall be final.

(b) A Participant may revoke an election in writing for the balance of the Period of Coverage and, if desired, file a new election in writing, if, under the facts and circumstances, (i) a change in status occurs, and (ii) the requested revocation and new election satisfies the consistency requirements in Section 6.4 below. Application for such change must be made no later than 30 days after the date of the actual event giving rise to the change in status. For this purpose, a change in status includes the following events:

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(1) Legal marital status. An event that changes a Participant's legal marital status, including marriage, death of Spouse, divorce, legal separation or annulment.

(2) Number of Dependents. An event that changes a Participant's number of Dependents, including birth, death, adoption or placement for adoption.

(3) Employment status. An event that changes the employment status of the Participant or the Participant's Spouse or Dependent, including termination or commencement of employment, a strike or lockout, a commencement or return from an unpaid leave of absence, and a change in worksite, as well as any other change in the individual's employment status that results in the individual becoming (or ceasing to be) eligible under a benefit plan of his or her employer.

(4) Requirements for unmarried Dependents. An event that causes a Dependent to satisfy or cease to satisfy the requirements for coverage on account of attainment of age, or any similar circumstance.

(5) Residence. A change in the place of residence of the Participant or his or her Spouse or Dependent that causes a loss of coverage.

(6) Other. Such other events that the Plan Administrator determines will permit the revocation of an election (and, if applicable, the filing of a new election) during a Plan Year under regulations and rulings of the Internal Revenue Service.

(c) If elected by the Employer in the Adoption Agreement, In the case of coverage under the group medical insurance plan, a Participant who elected to defer, on a pre-tax basis, the required employee contribution from his or her Compensation to pay the Employee portion of the group medical insurance premium under § 5.2(a) above may prospectively change his or her election with respect to such medical insurance, without regard to whether the Participant experienced a change in status event as described in Treas. Reg. § 1.125-4, as provided in IRS Notice 2014-55.

(d) In the case of coverage under a group medical insurance plan, a Participant may revoke an election in writing for the balance of the Period of Coverage and file a new election in writing that corresponds with the special enrollment rights provided in Code § 9801(f) (the Health Insurance Portability and Accountability Act of 1996), whether or not the change in election is permitted under Section 6.3(b) above.

(e) In the case of a judgment, decree or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order) that requires accident or health coverage for a Participant's child or for a foster child who is a Dependent of the Participant, a Participant may change his or her election (i) in order to provide coverage for the child under the health insurance plan if the order so requires, or (ii) in order to cancel coverage under the group medical insurance plan for the Participant's child if such order requires the Participant's Spouse or former Spouse or another individual to provide coverage for the child.

(f) In the case of coverage under a group medical insurance plan, a Participant may revoke an election in writing for the balance of the Period of Coverage and file a new election in writing in order to cancel or reduce such medical coverage for the Participant and/or for one or more covered Dependents of the Participant to the extent that such individual becomes entitled to coverage under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). In addition, if the Participant or any eligible Dependent who has been entitled to Medicare or Medicaid

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loses eligibility for such coverage, the Participant may file a new election in writing for the balance of the Period of Coverage to commence or increase coverage under the group medical insurance plan.

(g) If elected by the Employer in the Adoption Agreement, the Plan Administrator will, on a reasonable and consistent basis, automatically effectuate a prospective increase or decrease in affected Participants' elections for the balance of the Period of Coverage (except the health care expense reimbursement benefit) to reflect insignificant increases or decreases in the required contribution for the coverage elected. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including but not limited to the dollar amount or percentage of the cost change.

(h) The Plan Administrator may permit all Participants electing coverage under any of the benefits available to Employees under this Plan as set forth in the Employer's Adoption Agreement (except the health care expense reimbursement benefit) to revoke their elections for the balance of the Period of Coverage, provided that a similar coverage is elected for the balance of the Period of Coverage, if:

- (1) the Participant's share of the cost of such coverage significantly increases, or
- (2) such coverage ceases or is significantly curtailed.

(i) If a new benefit becomes available or an existing benefit is eliminated during the Period of Coverage, or if a similar change occurs under a plan of another employer, affected Participants may elect the new coverage (or may elect another option if a coverage has been eliminated), and make corresponding election changes regarding similar coverage, for the balance of the Period of Coverage.

(j) In the event that a Participant's Spouse or Dependent makes an election change under a plan maintained by his or her employer, the Plan Administrator may permit the Participant to revoke an election under the Plan and make a new election for the balance of the Period of Coverage that is on account of and corresponds with an election change made by the Participant's Spouse or Dependent, if:

- (1) the election change made by the Participant's Spouse or Dependent under his or her employer's plan satisfies the regulations and rulings under Code § 125; or
- (2) the period of coverage under the plan maintained by the employer of the Participant's Spouse or Dependent does not correspond with the Period of Coverage of this Plan.

(k) Any revocation and new election under this Section 6.3 shall be effective at such time as the Plan Administrator shall prescribe, unless otherwise required by law.

6.4 Consistency Rules.

(a) A Participant's requested revocation and new election will be consistent with a change in status if the election change is on account of and corresponds with a change in status that affects eligibility for coverage under a plan of the Employer or under a plan maintained by the employer of the Participant's Spouse or Dependent.

(b) Notwithstanding anything to the contrary in Section 6.4(a), in the case of the Participant's change in marital status (as set forth in Section 6.3(b)(1)) or in the case of a change in the employment status (as set forth in Section 6.3(b)(3)) of the Participant's Spouse or Dependent, a Participant may either increase or decrease the amount of the Participant's group medical coverage or the amount elected under the health care expense or dependent care expense reimbursement benefits as provided in the Adoption Agreement.

6.5 Coordination with the Family Medical Leave Act (FMLA).

(a) Notwithstanding any other provision of this Plan and any group medical insurance plan (including a health care expense reimbursement plan), if a Participant goes on a qualifying leave under the FMLA then, to the extent the Employer is subject to the FMLA, the Employer will continue to maintain the Participant's existing group medical benefits, health care expense reimbursement benefits, and HSA benefits on the same terms and conditions as if the Participant were still an active employee. That is, if the Participant elects to continue coverage while on leave, the Employer will continue to pay its share of any premiums or contributions, if any, to the respective plans. The Participant's share of premiums must be paid by the method normally used during any paid leave.

(b) In the event of non-paid FMLA leave, a Participant may elect to continue the Participant's existing group medical and health care expense reimbursement benefits during the leave. If the Participant elects to continue coverage while on FMLA leave, then the Participant may pay the Participant's share of any required premiums or contributions in one of the following manners, as elected by the Employer in the Adoption Agreement:

(1) **Pay-as-you-go Option:** The Participant may pay his share of the premiums the same as if the Participant were not on FMLA leave.

(2) **Catch-up Option:** The Employer and the Participant must agree in writing prior to the FMLA leave for the Employer to advance the premiums and that the Participant will repay the premiums amount upon his return from the leave. The Participant may make catch-up payments on a pre-tax or on an after-tax contribution basis. Furthermore, if a Participant fails to make the required premium payments under the "pay-as-you-go option" while on FMLA leave, the Employer may utilize the catch-up option to recoup the Participant's share of premium payments when the Participant returns from FMLA leave. If the Employer chooses to continue Plan coverage under these circumstances, the prior agreement of the Participant is not required.

(3) **Pre-pay Option:** The Participant may pre-pay all or a portion of his share of the premiums for the expected duration of the FMLA leave on a pre-tax basis out of pre-leave Compensation. To pre-pay in this manner, the Participant must make a special election to that effect prior to the date that such compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year). Alternatively, the Participant may pre-pay all or a portion of his share of the premiums on an after-tax basis.

These payment options are subject to the following requirements: (1) the pre-pay option may not be the only option; (2) the catch-up option may be the sole option but only if the catch-up option is the sole option the Employer offers to non-FMLA employees on a leave of absence; and (3) the Plan may not offer either the pre-pay option or the catch-up option without also offering the pay-as-you-go option if the Employer offers the pay-as-you-go option to non-FMLA employees on a leave of absence.

6.6 Automatic Termination of Election. Any election made under this Plan (including an election made through inaction under Section 6.2) shall automatically terminate on the date on which the Participant ceases to be a Participant in the Plan, although coverage or benefits under a benefit elected by the Employer in the Adoption Agreement may continue if and to the extent provided by such plan. In the event such a former Participant again becomes a Participant before the end of the same Plan Year, such Participant will be required to complete an Election Form for the balance of the Plan Year.

6.7 Election Modifications for HSA Benefits. As set forth in Section 5.2(f) and notwithstanding any other provision in this Plan, an election to make a contribution to an HSA can be increased, decreased or

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revoked at any time on a prospective basis. Such election changes shall be effective no later than the first day of the next calendar month following the date that the election change was filed. No other election changes can occur with regard to any other benefit under the Plan as a result of a change in an HSA election except as otherwise described in this Section 6.

6.8 Amendments by the Plan Administrator. If the Plan Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy for such year any nondiscrimination or other requirement imposed by the Code or any limitation on benefits provided to Key Employees, the Plan Administrator shall take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification of elections by Highly Compensated Employees (as defined by the Code for purposes of the nondiscrimination requirement in question) or Key Employees without the consent of such Employees.

SECTION 7 - ADMINISTRATION

7.1 Powers and Duties. The Plan Administrator shall have the power and duty to do all things necessary or convenient to effect the intent and purposes of this Plan which are not inconsistent with any of the provisions of this Plan, whether or not such powers and duties are specifically set forth in the Plan, including the delegation of any such duties to a third party administrator or a committee appointed by the board of directors of the Employer.

7.2 Rules and Regulations. The Plan Administrator may provide such rules and regulations as it deems necessary or desirable for the administration of the Plan and, from time to time, amend or supplement such rules and regulations.

7.3 Plan Construction. The Plan Administrator shall construe the Plan, which construction shall be final and binding on all Participants, their beneficiaries, heirs and assigns. For all purposes of interpreting, construing and implementing the terms and conditions of this Plan including, but not limited to, interpretation, implementation and decision-making under this section and under the claims procedure of this Plan, the Plan Administrator is and shall be specifically granted sole discretion in making decisions and determinations interpreting and implementing this Plan, and in the general operation of this Plan.

7.4 Inconsistencies. The Plan Administrator may correct any defect, supply any omission, or reconcile any inconsistency in the Plan in such a manner and to such extent as it shall deem expedient to carry the Plan into effect.

7.5 Questions. The Plan Administrator may determine answers to questions which may arise under the Plan including questions submitted by any Participant.

7.6 Notification of Employees of Available Benefits. The Plan Administrator shall provide Employees with reasonable notification of the benefits available under this Plan.

7.7 Delegation to Other Parties. 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, 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.

7.8 Benefit Payments. The Plan Administrator shall make any payment due under the Plan for the benefit of the Participant in such manner as the Plan Administrator determines appropriate in its sole discretion. Any payment of a benefit or installment paid in accordance with the provisions of this Plan shall be a complete discharge of any liability for the making of such payment under the provisions of the Plan. The Employer, Plan

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Administrator and agent or representative thereof shall be held harmless for authorizing and making such payment if such payment is made in good faith.

7.9 Plan Records. The Plan Administrator shall keep such records on Employees, Participants, former Employees, Highly Compensated Employees and the Plan as are necessary to show compliance with Code § 125 or for the administration of the Plan. The Plan Administrator will make available to each Participant any of the Plan's records as pertain to the Participant for examination at reasonable times during normal business hours.

7.10 Indemnification and Defense. The Employer agrees to indemnify and to defend to the fullest extent permitted by law any person or entity serving as the Plan Administrator or as agent or representative or consultant of the Plan Administrator against all liabilities, damages, costs and expenses (including attorneys' fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

SECTION 8 - CLAIM REVIEW AND APPEAL PROCEDURE

8.1 Filing claims. Claims for benefits under a qualified benefit plan shall be administered in accordance with the claims procedure set forth in the plan document and/or summary plan description for each benefit. A claim regarding the denial of a benefit under this Plan (such as the ability to pay for premiums on a pre-tax basis) due to an issue regarding an Employee's coverage under this Plan (i.e., such as a determination of (i) a change in status, (ii) a "significant" change in premiums charged, or (iii) eligibility and participation matters under the Plan) will be governed by the claims procedure under this Plan. The Plan Administrator will notify the claimant in writing within 90 days of the date the claim is submitted if the claim is denied. Such notification will set out the reasons the claim was denied, and further advise the claimant of what steps, if any, might be taken to validate the claim and the claimant's right to request an administrative review of the denial of the claim. A request for review may be made any time within the 60-day period after receipt by the claimant of a notice that the claim was denied. The claimant or its authorized representative will have the opportunity to review any important documents held by the Plan Administrator, and to submit comments and other supporting information. A determination on a request for review must be made by the Plan Administrator within 60 days of the date of the request for review.

SECTION 9 - AMENDMENT AND TERMINATION OF PLAN

9.1 Plan Amendment. The Employer shall retain the right, by action of its governing body, in its sole and final discretion, to amend the Plan at any time and from time to time to any extent that such governing body 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 Resolution of the governing body making such amendment shall be delivered to the Plan Administrator. The Employer may delegate this authority to a committee appointed by the governing body. This Plan shall be amended in such a manner 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 pretax 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.

9.2 Plan Termination. The Employer shall have the right by action of its governing body, 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 Employer may delegate this authority to a committee appointed by

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its governing body. The Plan shall automatically terminate upon cessation of operations by the Employer and all benefits cease unless a successor employer adopts and continues the Plan.

SECTION 10 - MISCELLANEOUS

10.1 Forms and Proofs. Each Participant or beneficiary eligible to receive any benefits under this Plan shall complete such claim forms and furnish such proof, receipts and releases as may be required by the Plan Administrator.

10.2 Exclusive Benefit. Irrespective of anything contained in this Plan, as now expressed or hereafter amended, it shall be impossible for any part of the funds of this Plan to be used for or devoted to any purposes not for the exclusive benefit of Participants or their beneficiaries at any time prior to the satisfaction of all rights and liabilities, fixed and contingent, with respect to Participants or their beneficiaries, either by operation, amendment, revocation or termination of the Plan. No part of the funds of this Plan shall be paid, distributed or made available to any Participant at any time, except as expressly provided by the Plan.

10.3 No Alienation of Benefits. No benefit or Participant account under the Plan shall be liable for any debt, liability, contract, engagement or tort of any Participant or beneficiary, nor be subject to anticipation, sale, assignment, transfer, encumbrance, pledge, charge, attachment, garnishment, execution or other voluntary or involuntary alienation or other legal or equitable process, nor be transferable by operation of law.

10.4 Qualified Medical Child Support Orders. The Plan Administrator may be required by law to recognize obligations incurred by Participants as a result of a medical child support order. The Plan Administrator must honor a "qualified medical child support order." A "qualified medical child support order" is defined as a decree or order issued by a court which creates or recognizes the existence of an alternate recipient's right to receive benefits for which a Participant or beneficiary is eligible under a group health plan. An "alternate recipient" is defined as any child of a Participant who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such Participant. The Plan Administrator shall establish a written procedure to determine the qualified status of medical child support orders and to administer the provisions of such benefits under such qualified orders.

10.5 Construction and Law Governing. Wherever necessary in this Plan and where the context will permit, the singular term and the related pronoun shall include the plural and either the masculine or the feminine. The Plan shall be construed, enforced and administered and the validity determined in accordance with Code § 125, where applicable, the Code (as amended), and the laws of the State elected in the Adoption Agreement. Should any provision be determined to be void by any court of competent jurisdiction, the Plan will continue to operate, and for purposes of the jurisdiction of that court only, will be deemed not to include the provision determined to be void.

10.6 Tax and Legal Effect. This Plan document, accompanying Adoption Agreement, and any related exhibits and attachments, are important legal instruments with significant legal and tax implications. It is understood and agreed that the Employer has read the Adoption Agreement, the Plan document and any attachments in their entirety, acknowledges that the Plan is suitable for its purposes, and accepts full responsibility for participation under the Plan.

10.7 Reliance on Employer. It is further understood and agreed that any instrument executed by the Employer, eligible Employee, Participant, Participant's Spouse or Dependent or beneficiary thereof, shall be received by, and may be relied upon without further investigation by, the Plan Administrator or third party administrator as conclusive evidence of any matter asserted therein or contained in the Plan and that the Plan Administrator and third party administrator shall be fully protected in taking, permitting or omitting any action on the basis thereof and shall incur no liability or responsibility for reliance thereon.


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10.8 **No Guarantee of Employment.** Nothing contained in this Plan shall be construed as a contract of employment between any Employee and the Employer, or as a right of any Employee to be continued in the employment of the Employer, or as a limitation of the right of the Employer to discharge any of its Employees, with or without cause.

10.9 **Qualified Military Service.** Notwithstanding any other provision of the Plan, the Plan will provide contributions, benefits and service credit with respect to qualified military service in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

IN WITNESS WHEREOF, the Employer has caused this Plan to be duly executed by its duly authorized officers by the execution of the Adoption Agreement attached hereto and made a part hereof.

VANDERBILT UNIVERSITY

By: 
Associate Vice Chancellor and Chief
Its: Human Resources Officer
Date: March 21, 2017