HEALTH CARE REIMBURSEMENT ACCOUNT PLAN
FOR EMPLOYEES OF THE UNIVERSITY OF VIRGINIA

Effective January 1, 2013
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HEALTH CARE REIMBURSEMENT ACCOUNT PLAN
FOR EMPLOYEES OF THE UNIVERSITY OF VIRGINIA

ARTICLE 1

PURPOSE AND ESTABLISHMENT

1.1 Purpose of Plan. The purpose of this Plan is to provide Employees with a choice between (a) reimbursement for Qualifying Health Care Expenses not reimbursed by any other plan and for which the Employee did not take a tax deduction and (b) cash compensation. The Plan is intended to qualify both as an accident and health care plan within the meaning of section 105(e) of the Code and that reimbursements paid under the Plan are eligible for exclusion from Participants' income under section 105(b) of the Code.

1.2 Plan Subject to Cafeteria Plan. This Plan shall be subject to the provisions of the Cafeteria Plan, except to the extent that such provisions are inconsistent with this Plan.

ARTICLE 2

DEFINITIONS

Wherever used herein, the following terms have the following meaning unless a different meaning is clearly required by the context and defined terms from the Plan description are incorporated in this document by reference, but only to the extent that such terms are not inconsistent with the following definitions.

2.1 Administrator means the Vice President of Human Resources, or if none, the Employer or such other person or committee as may be appointed from time to time by the University to supervise the administration of the Plan.

2.2 Board means the Rector and Visitors of the University of Virginia.

2.3 Cafeteria Plan means the University of Virginia Flexible Spending Account Plan established and maintained by the University, as amended from time to time.

2.4 COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.

2.5 Code means the Internal Revenue Code of 1986, as amended from time to time. Reference to any section of the Code shall include any provision successor thereto.

2.6 Dependent means (a) a Participant's spouse and (b) any person who is either (i) a Participant's child, stepchild, foster child, adopted child, or child placed with the Participant for adoption (without regard to student status, marital status, financial dependence or residency status with the Employee or any other person) who is under age 26; or (ii) a Participant's dependent (as defined in Code section 152, determined without regard to subsections (b)(1),
(b)(2), and (d)(1)(B) thereof, but subject to Code section 21(e)(5)), including but not limited to a blood or legal relative who received more than half of his or her financial support from the Participant.

2.7 **Effective Date** means January 1, 2013, the date that the Plan was amended and restated. The original Effective Date of the Plan is January 1, 1997.

2.8 **Eligible Employee** means any salaried Employee who works at least 20 hours per week, excluding Medical Center Employees.

2.9 **Employee** means any person employed by the Employer, rendering services to the Employer for remuneration, which is subject to federal income tax withholding and FICA taxes. Any person who is not on the payroll of the Employer shall not be an Employee for purposes of the Plan. The term Employee shall not include any person who is classified by the Employer as an independent contractor, temporary employee, leased employee, or contract employee (regardless of the person’s actual employment status under applicable law), any person whose employment is or becomes the subject matter of a collective bargaining agreement between employee representatives and the Employer unless such collective bargaining agreement expressly provides that such person is eligible for participation in the Plan, or self-employed individuals. The term also does not include a spouse or dependent of the Employee, unless they are also employed by the Employer.

2.10 **Employer** means the University of Virginia.

2.11 **HIPAA** means the Health Insurance Portability and Accountability Act of 1996, as it may be amended from time to time. The Plan is subject to the provisions relating to HIPAA set forth in Appendix A.

2.12 **Medical Center Employee** means any salaried employee of the University of Virginia Medical Center.

2.13 **Participant** means an Employee who satisfies the requirements of ARTICLE 3 of the Plan and who elects coverage under the Plan.

2.14 **Plan** means the Health Care Reimbursement Account Plan for Employees of the University of Virginia.

2.15 **Plan Year** means the 12-consecutive month period beginning on the first day of January of each year and ending on the last day of the immediately following December.

2.16 **Qualifying Health Care Expenses** shall have the meaning given to it in Section 5.5 of this Plan.

2.17 **Reimbursement Account** means an account established for recordkeeping purposes for designated contributions made by the Employer on behalf of the Participant for reimbursement of Qualifying Health Care Expenses.

2.18 **Termination** means the termination of a Participant’s employment as an Employee,
whether by reason of change in job classification, discharge, layoff, voluntary termination, disability, retirement, death, or otherwise.

2.19 **University** means the University of Virginia.

**ARTICLE 3**

**PARTICIPATION**

3.1 **Generally.** Each Eligible Employee will become a Participant in the Plan on the later of the first day of the month following the date of hire provided he makes a valid election for Health Care Reimbursement Account Benefits under the Cafeteria Plan.

In order to participate in the Plan, an Eligible Employee must, during the annual enrollment period of each preceding Plan Year or at such other time as determined by the Administrator, designate the coverage amount he desires under the Plan in the form designated by the Administrator. The Eligible Employee may designate from $240 to $2,500 for the Plan Year. The Employee's compensation shall be reduced pursuant to Article 5 of the Cafeteria Plan.

By becoming a Participant an Eligible Employee shall for all purposes be conclusively deemed to have assented to the provisions of the Plan and all amendments thereto.

3.2 **Prohibition Against Simultaneous Participation.** A Participant in the Plan may not at the same time participate in the Health Care Reimbursement Account Plan for Employees of the University of Virginia Medical Center.

3.3 **Termination of Participation.**

(a) A Participant's contributions to the Plan cease on the last day of the month that includes the Participant's Termination. However, a Participant who terminates coverage during a Plan Year may elect to continue to receive coverage under the Plan pursuant to COBRA after the date of Termination provided he or she continues to make contributions to the Plan after the date of Termination. Such contribution shall equal 102% of the amount of pay conversion dollars he or she would have allocated to the Plan had he or she remained an Employee throughout the Plan Year.

(b) A Participant who Terminates from the Plan and does not continue to make contributions for the remainder of the Plan Year (as described in paragraph 3.3(a) above) shall not receive coverage under the Plan for the remainder of such Plan Year. However, such Participant may submit eligible expenses incurred prior to Termination until April 30th of the year following the close of the Plan Year in which the Termination occurs.

(c) If contributions cease to be made as required under Section 3.1 with respect to any Participant, such Participant shall be deemed to have incurred a Termination as of the first date such required contributions are not made.

3.4 **Reinstatement of Former Participant.** In the event that a former Participant becomes a
Participant again within 30 days of the date on which he or she ceased participation and within the same Plan Year, the Participant’s elections in effect at the time of Termination shall be reinstated for the remaining portion of the Plan Year on the day his or her participation is reinstated.

In the event that a former Participant becomes a Participant again more than 30 days after the date on which he or she ceased participation, that Participant shall commence participation in the Plan upon the satisfaction of the requirements of Section 3.1. The Employee will need to submit a new enrollment form with the Administrator prior to participation.

3.5 Transfer to Another Division of the University.

(a) Transfer to Another Agency Controlled by the Board of Visitors. A Participant who transfers to another agency controlled by the Board will have his Participant account frozen as of the last pay period of his employment. At that time the Participant’s reimbursement account will be transferred to the dependent care reimbursement plan sponsored by such agency. The Participant will not be treated as if employed by a new employer, and as a result, all elections under this Plan must be maintained by the agency to which the Participant transfers.

(b) Transfer from Another Agency Controlled by the Board of Visitors. A Participant who transfers from another agency controlled by the Board will have his reimbursement account transferred from the dependent care reimbursement plan sponsored by such agency. The Participant will not be treated as if employed by a new employer, and as a result, all elections previously made under a plan of the agency must be maintained in this Plan.

ARTICLE 4

REVOCATION AND MODIFICATION OF ELECTED COVERAGE

4.1 Revocation and Modification. Once an election has been accepted by the Administrator in accordance with Section 3.1, a Participant may not modify or revoke his or her election for the remainder of the Plan Year except as permitted in the Cafeteria Plan.

4.2 Limitations on Elections of Highly Compensated Employees. The Administrator may reject elections of a “highly compensated individual” as that term is defined in section 105(h)(5) of the Code to prevent discrimination in favor of such individuals with respect to eligibility to participate or as to contributions and benefits in accordance with section 105(h) of the Code.

ARTICLE 5

BENEFITS

5.1 Generally. Each Participant will be entitled to receive for each Plan Year reimbursement of Qualifying Health Care Expenses up to the dollar amount of coverage elected by the Participant for that Plan Year. Such Participant will be entitled to receive for each Plan Year reimbursement of Qualifying Health Care Expenses incurred (a) during the Plan Year, and (b)
within the two and one-half month period following the end of the Plan Year (the “Grace Period”), provided, however, that in order to receive reimbursements incurred during these time periods, the Participant must be a Participant in the Plan when the Qualifying Health Care Expense is incurred and the Participant must apply for reimbursement on or before April 30th following the end of the Plan Year. Notwithstanding anything herein to the contrary, a Participant will not receive reimbursement from the Plan for expenses that are reimbursed by other medical plans or for which the Participant took a deduction on his or her income tax return.

A Participant may be reimbursed up to the full dollar amount of coverage the Participant has elected for a Plan Year, less any prior reimbursements for that Plan Year, regardless of the actual amount the Participant has contributed at the time he or she seeks reimbursement.

5.2 Forfeiture. If during the Plan Year and the Grace Period, a Participant incurs aggregate expenses qualifying for reimbursement less than the dollar amount of coverage he or she elects for the Plan Year under this Plan, any remaining amount in his or her Reimbursement Account after the end of the time period for submitting claims as set forth in Section 5.1 shall be forfeited. Any amount of coverage for a Plan Year unused due to the Participant’s failure to submit proper claims for reimbursements in conformity with procedures prescribed under this Plan shall also be forfeited. Subject to applicable law and regulations, forfeitures will be applied toward payment of Plan expenses and/or with the Employer.

5.3 Claims for Reimbursement. A Participant who has elected to receive a Qualifying Health Care Expense reimbursement for a Plan Year may apply to the Employer, or any persons authorized by the Employer, for reimbursement of Qualifying Health Care Expenses incurred by the Participant (or the spouse or Dependent of the Participant) during the Plan Year and the Grace Period, by submitting an application in writing to the Employer, or such authorized representative of the Employer, in such form as the Employer may prescribe, setting forth:

(a) the amount, date, and nature of the expense with respect to which a benefit is requested;

(b) the name of the person, organization, or entity to which the expense was or is to be paid;

(c) a written statement from an independent third party stating that the medical expense has been incurred and the amount of such expense;

(d) a written statement from the Participant that the medical expense has not been reimbursed or is not reimbursable under any other health plan coverage; and

(e) such other information as the Employer may from time to time require.

If the Plan offers a debit card, and the expense was paid for with such a debit card, the Participant must agree in writing before using the Plan’s card that they will only use the card for Qualifying Health Care Expenses, that the card will not be used for any Qualified Health Care Expense that has already been reimbursed, that they will not seek reimbursement from any other health plan, and that they will retain sufficient documentation for any expense paid with the debit card. This agreement must be reaffirmed each time the card is used and the card will be
automatically cancelled when the individual ceases to be a Participant. Further, the only situation where the card may be used will be limited to:

(i) physicians, dentists, vision care offices, hospitals, or other health care providers as identified by their merchant category code;

(ii) drug stores and pharmacies (as identified by their merchant category code) if 90% or more of the store’s gross receipts consist of items that are Qualified Health Care Expenses; and

(iii) other drug stores and pharmacies, non-health care merchants that have pharmacies and at mail order and web-based vendors that sell prescription drugs;

provided that the substantiation requirements outlined in IRS Notice 2011-5 are satisfied to the extent applicable to prescribed over-the-counter medicines or drugs. For all other providers and merchants, other than those described in (i), (ii) or (iii) above, debit cards may not be used to purchase over-the-counter medicines or drugs (whether or not prescribed).

Finally, the debit card must follow the correction procedures outlined in regulations promulgated under Section 125 of the Code for unsubstantiated medical expenses and the substantiation procedures for copayment matches, recurring medical expenses and real-time substantiation for providers described in (i), (ii) and (iii) above. If a debit card payment to a provider in (i), (ii) and (iii) above cannot be substantiated through a copayment match, recurring medical expense, or real-time substantiation, it must be treated as conditional pending substantiation through independent third-party information. No other charges other than those permitted for providers in (i), (ii) and (iii) above may be made to the debit card. If a Participant makes charges other than those permitted for providers in (i), (ii) or (iii), the Participant’s debit card may be suspended and other actions taken consistent with the correction procedures outlined in the regulations promulgated under Section 125.

5.4 Benefits Limited to Expenses Incurred During Plan Year and the Grace Period. The coverage elected for a Plan Year is only available to reimburse expenses which the Participant incurs during the Plan Year and the Grace Period. However, the Participant shall have until April 30th following the end of the Plan Year to submit claims for expenses incurred during the Plan Year and the Grace Period.

An expense is incurred during the Plan Year or the Grace Period if the services giving rise to the expense are performed during the Plan Year or the Grace Period. An expense shall not be deemed to be incurred during the Plan Year or the Grace Period merely because a Participant receives a bill for the expense during the Plan Year or the Grace Period or pays for the expense during the Plan Year or the Grace Period.

5.5 Qualifying Health Care Expenses.

(a) Standard Option. For Participants who have not elected to participate in a high deductible health plan meeting the requirements of Section 223(g)(2)(A) of the Code (an “HDHP”) and a health savings account as defined in Section 223(d) of the Code (an “HSA”) for a Plan Year, Qualifying Health Care Expenses shall include only amounts which are for
"medical care," within the meaning of section 213(d) of the Code, of the Participant or his or her Dependents. Qualifying Health Care Expenses are expenses for:

(i) deductibles and co-payments under the University of Virginia Health Care Plan or under accident and health insurance of the Participant or his or her Dependents;

(ii) dental care, including routine dental checkups, orthodontic work, and dentures;

(iii) prescription drugs;

(iv) eye care, including vision checkups, eyeglasses, and contact lenses;

(v) hearing care, including hearing examinations and hearing aids;

(vi) routine physical examinations;

(vii) any other medical care item which constitutes "medical care" within the meaning of section 213(d) of the Code, not including non-prescribed over-the-counter drugs.

(b) HSA-Compatible Limited Option. For Participants who have elected to participate in an HDHP and an HSA for a Plan Year, Qualifying Health Care Expenses shall include amounts described in Section 5.5(a), provided that such expenses are for vision or dental care as defined in Section 223(c) of the Code.

5.6 Refund of Duplicate Reimbursement. If a Participant receives a reimbursement under this Plan and reimbursement for the same expense is made under another plan, he or she will be required to refund the reimbursement to the Employer. The amount of the Participant's elected coverage under the Plan, to the extent of any such refund, shall be reinstated for the Plan Year in which the reimbursement was originally made.

5.7 Special Rules for COBRA Continuation Coverage. Notwithstanding any other provision of the Plan to the contrary, for the Plan Year in which the Qualifying Event (as defined in Section 4980B(f)(3) of the Code) occurs, the amount to be applied for the benefit of the Qualified Beneficiary (as defined in Section 4980B(g)(1) of the Code) for payment of Qualified Health Care Expenses shall be the amount so allocated for the Plan Year by the Participant, except that payments to a Participant under this Plan prior to the Qualifying Event shall be charged to the amount available to pay Qualified Health Care Expenses for such Plan Year with respect to both the Participant (or Qualified Beneficiary, if the Qualified Beneficiary ceases to be a Participant by reason of the Qualifying Event) and any Qualified Beneficiary whose right to continue to participate in this Plan derives from a relationship to such Participant. Furthermore, the period of COBRA Continuation Coverage shall be limited to the balance of the Coverage Period when the Qualifying Event occurs during any Plan Year and, finally, the ability to continue the Plan shall only be offered under COBRA if the amount of remaining available reimbursement for the Coverage Period exceeds the COBRA premium charged to the Qualified Beneficiary for the balance of the Plan Year.
ARTICLE 6

PLAN ADMINISTRATION

6.1 Plan Administrator. The administration of the terms and conditions of this Plan shall be the responsibility of the Administrator. The Administrator shall administer this Plan for the exclusive benefit of the Plan Participants and Dependents. In fulfilling its duties, the Administrator shall have those duties and obligations to carry out the terms and conditions of the Plan, including the powers necessary and appropriate to administer the Plan. The powers and authorities of the Administrator shall include, but shall not be limited to, the following:

(a) to make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of any claims procedures that may be required by applicable law;

(b) to interpret the Plan in its sole and complete discretion, its interpretation thereof in good faith to be final and conclusive on all persons claiming benefits under the Plan;

(c) to decide all questions concerning the Plan, the summary plan description, and all other Plan documents, and the eligibility of any Employee or any other person claiming entitlement to participate in the Plan, in its sole and complete discretion;

(d) to make factual findings and resolve ambiguities in connection with the interpretation of the Plan, the summary plan description, and all other Plan documents, in its sole and complete discretion;

(e) to appoint such agents, counsel, accountants, consultants, third party administrators and other persons as may be required to assist in the administration of the Plan;

(f) to allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such allocation, delegation, or designation to be by written instrument and in accordance with applicable requirements of law;

(g) to compromise, settle, or release claims or demands in favor of or against the Plan or the Administrator on such terms and conditions as the Administrator may deem desirable; and

(h) to adopt rules and regulations and make administrative decisions regarding the administration of the Plan, which rules, regulations, and administrative decisions may be amended, modified, or rescinded by action of the Administrator.

Notwithstanding anything herein to the contrary, benefits will be paid from the Plan only if the Administrator determines in its sole discretion that the applicant is entitled to them.

6.2 Examination of Records. The Administrator will make available to each Participant such of its records under the Plan as pertain to such Participant, for examination at reasonable times during normal business hours.

6.3 Nondiscriminatory Exercise of Authority. Whenever, in the administration of the Plan,
any discretionary action by the Administrator is required, the Administrator shall exercise its
authority in a nondiscriminatory manner so that all persons similarly situated will receive
substantially the same treatment.

6.4 Indemnification of Administrator. The Employer agrees to defend any civil action, to the
fullest extent permitted by law, against any Employee serving as the Administrator or as a
member of a committee designated as Administrator (including any Employee or former
Employee who formerly served as Administrator or as a member of such committee) against all
liabilities, damages, costs, and expenses (including attorney’s 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 and is in the scope of his or her
responsibility as Administrator.

ARTICLE 7

CLAIMS

7.1 Claims for Benefits.

   (a) Claims and Appeals Procedure. Plan benefits are administered in accordance with
a contract the Employer has entered into with a third party administrator. The applicable third
party administrator shall be responsible for deciding claims and the Administrator shall be the
named fiduciary with responsibility for deciding appeals of denied claims. Claims shall be made
in accordance with the claims and appeals procedures described in the contract or benefits
booklet provided by the third party administrator. If the contract or benefits booklet provided by
the third party administrator does not contain a claims and appeals procedure, claims and appeals
shall be made in accordance with this ARTICLE 7. Notwithstanding the foregoing, Section 7.4
shall apply to all claims and appeals of benefits.

   (b) Submission Deadline. All claims for reimbursement must be made by the
deadline set forth in Section 5.4. Claims for reimbursement submitted after such deadline will
not be considered.

   (c) Claims Denial. In the event a claim to all or any part of any benefit hereunder
shall be denied wholly or in part, the third party administrator shall provide to the claimant a
written notice setting forth:

       (i) the specific reason or reasons for the denial;

       (ii) specific references to the pertinent Plan provisions on which the denial is
            based;

       (iii) a description of any additional material or information necessary for the
            claimant to perfect the claim and why such material is necessary; and

       (iv) a description of the Plan’s review procedures and the time limits
            applicable to such procedures.
7.2 **Appeal of Denied Claims.**

(a) The claimant, or the claimant’s duly authorized representative, may appeal the denial of the claim by giving notice in writing to the entity or individual designated to receive appeals in the contract or benefits booklet provided by the third party administrator, within 60 days of receipt of the claim denial.

(b) The claimant, or the claimant’s duly authorized representative, may submit written comments, documents, records, and other information relating to the claim for benefits. Upon request and free of charge, the claimant shall have reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.

7.3 **Decision on Appeal of Denied Claims.**

(a) A decision on appeal will be made within 60 days after receipt of a request for review.

(b) The Administrator’s decision on review shall be written and, if the decision is a denial, shall include:

(i) the specific reason or reasons for the denial; and

(ii) specific references to the pertinent Plan provisions on which the denial is based.

7.4 **Legal Actions.** No legal action to recover benefits under the Plan may be filed after 12 months after the date of the Administrator’s decision on appeal.

**ARTICLE 8**

**AMENDMENT AND TERMINATION**

This Plan has been established with the intention of being maintained indefinitely. The Vice President of Human Resources (or his/her designee) shall have the sole right to alter, amend, or terminate this Plan in whole or in part at any time it determines to be appropriate. The Plan shall not be amended, altered, or terminated retroactively except to comply with applicable laws, including, without limitation, Code Section 125.

**ARTICLE 9**

**MISCELLANEOUS**

9.1 **Information to be Furnished.** Participants shall provide the Employer and Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.
9.2 **Limitation of Rights.** Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits will be construed as giving to any Participant or other person any legal or equitable right against the Employer or Administrator, except as expressly provided herein, and in no event will the terms of employment or service of any Participant be modified or in any way be affected hereby. Nothing in the Plan shall be interpreted as a waiver of the sovereign immunity of the Commonwealth of Virginia.

9.3 **Waiver of Provisions.** The waiver of any provisions of the Plan by the Administrator or the Employer on an occasion or occasions shall not be construed as authority, or as a binding precedent, for the waiver by the Administrator or the Employer respectively of the same provision on another occasion or of a different provision on the same or another occasion. Notwithstanding the preceding sentence, the Administrator and the Employer shall exercise any discretionary authority in a nondiscriminatory manner so that all persons similarly situated will receive substantially the same treatment.

9.4 **Communication to Employees.** The terms and conditions of this Plan shall be communicated to the Employees as soon as possible after adoption of the Plan. The Employees shall have such rights of enrollment as may be set forth herein.

9.5 **No Assignment of Rights.** The right of any Participant to receive any reimbursement or other benefit under this Plan shall not be assigned, pledged or alienated by the Participant, or levied upon or otherwise taken or attached by any creditor in any voluntary or involuntary proceeding, and any attempt to cause such right to be so subjected will not be recognized, except to the extent as may be required by law.

9.6 **No Guarantee of Tax Consequences.** Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of the Participant or a dependent under this Plan will be excludable from the Participant’s or dependent’s gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant or dependent.

9.7 **Provisions of Plan Binding On Participants.** Upon becoming a Participant, the Participant shall be bound then and thereafter by the terms of this Plan, including all amendments thereto.

9.8 **No Interest.** The Employer will not pay interest on any Participant’s designated contribution used to purchase coverage under this Plan.

9.9 **Severability.** If any provision of this Plan shall be held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof shall continue to be fully effective.

9.10 **Gender, Singular and Plural References.** References in this Plan to one gender shall include both genders, singular references shall include the plural, and plural references shall include the singular, unless the context clearly requires otherwise.
IN WITNESS WHEREOF, the University has caused this Plan to be executed in its name and behalf by the Vice President of Human Resources on this 23rd day of October, 2014.

UNIVERSITY OF VIRGINIA

By:

Title: Vice President of Human Resources
APPENDIX A – HIPAA PRIVACY & PROTECTED HEALTH INFORMATION

1. **Purpose.** Appendix A permits the Plan to disclose protected health information ("PHI"), as defined in HIPAA, to the Employer to the extent that such PHI is necessary for the Employer to carry out its administrative functions related to the Plan. This Appendix reflects the requirements set forth in 45 C.F.R. § 164.504(f) and the related regulations promulgated by the Department of Health and Human Services ("HHS").

2. **Disclosure to the Employer.** The Plan may disclose the PHI to the Employer that is necessary for the Employer to carry out the following administrative functions related to the Plan: quality assurance, claims and appeal processing, auditing, and monitoring. The Employer may use and disclose the PHI provided to it from the Plan only for the administrative purposes described in this Section.

3. **Limitations and Requirements Related to the Use and Disclosure of PHI.** The Employer agrees to the following limitations and requirements related to its use and disclosure of PHI received from the Plan:

   a. **Use and Further Disclosure.** The Employer shall not use or further disclose PHI other than as permitted or required by the Plan document or as required by all applicable law, including but not limited to HIPAA. When using or disclosing PHI or when requesting PHI from the Plan, the Employer shall make reasonable efforts to limit the PHI to the minimum amount necessary to accomplish the intended purpose of the use, disclosure, or request.

   b. **Agents and Subcontractors.** The Employer shall require any agents, including subcontractors, to whom it provides PHI received from the Plan to agree to the same restrictions and conditions that apply to the Employer with respect to such information.

   c. **Employment-Related Actions and Decisions.** Except as permitted by HIPAA and other applicable federal and state privacy laws, the Employer shall not use PHI for employment-related actions and decisions, or in connection with any other employee benefit plan of the Employer.

   d. **Reporting of Improper Use or Disclosure.** The Employer shall promptly report to the Plan any improper use or disclosure of PHI of which it becomes aware.

   e. **Adequate Protection.** The Employer shall provide adequate protection of PHI and separation between the Plan and the Employer by:

      i. ensuring that only University HR Benefits Specialists, Associates, and Assistants will have access to the PHI provided by the Plan:

      ii. restricting access to and use of PHI to only the Employees identified in Section 3(e)(i) above and only for the administrative functions performed by the Employer on behalf of the Plan that are described in Section 2 above;

      iii. requiring any agents of the Plan who receive PHI to abide by the Plan’s privacy rules; and
(iv) using the following procedure to resolve issues of noncompliance by the employees identified in Section 3(e)(i) above:

(A) Sanctions for Non-Compliance.

(1) Discipline. The Employer has a zero tolerance policy regarding the improper use or disclosure of PHI by any Employee. Any Employee who violates HIPAA or the Plan’s privacy rules will be subject to sanctions, which may include verbal counseling, write-ups, suspension, and/or termination. An Employee is an employee-at-will and employment may be terminated at any time, with or without cause or notice.

(2) Discretion of the Privacy Officer. The Employer does not guarantee that one form of discipline will necessarily precede another. Further, the Employer, acting through the Plan’s Privacy Officer, reserves the right, at all times, to take whatever disciplinary action it deems appropriate, up to and including termination. Prior notification and progressive discipline are not prerequisites for termination or other disciplinary action.

(B) Exemptions.

(1) Whistleblower. No violation may be considered to have been committed if an Employee discloses PHI with a good faith belief that the Plan has engaged in conduct that is unlawful or unethical, or that potentially endangers one or more Employees, their dependents, or the public and the disclosure is to (a) a health oversight agency or public health authority authorized by law to investigate or otherwise oversee the relevant conduct or conditions of the Plan; or (b) an attorney retained by or on behalf of the Employee for the purpose of determining legal options with regard to whether the Plan has engaged in conduct that is unlawful or improper.

(2) Victims of a Crime. No violation can be considered to have been committed where an Employee, who is the victim of a criminal act, discloses PHI to a law enforcement official, provided that (a) the PHI disclosed is about the suspected perpetrator of the criminal act; and (b) the PHI is limited to the information listed in 45 C.F.R. § 164.512(f)(2)(i).

(C) Documentation. All sanctions that are applied will be documented and any related records will be retained for six years in accordance with Policy XX (Documentation and Records Retention) of the Plan’s Privacy Policies and Procedures.

(f) Return or Destruction of PHI. If feasible, the Employer shall return or destroy all PHI received from the Plan that the Employer maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If such return or destruction is not feasible, the Employer shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(g) Participant Rights. The Employer shall provide Participants with the following rights:

(i) the right to access to their PHI in accordance with 45 C.F.R. § 164.524;
(ii) the right to amend their PHI upon request (or the Employer will explain to
the Participant in writing why the requested amendment was denied) and incorporate any such
amendment into a Participant’s PHI in accordance with 45 C.F.R. § 164.526; and

(iii) the right to an accounting of all disclosures of their PHI in accordance
with 45 C.F.R. § 164.528.

(b) Cooperation with HHS. The Employer shall make its books, records, and internal
practices relating to the use and disclosure of PHI received from the Plan available to HHS for
verification of the Plan’s compliance with HIPAA.

4. Certification. The Plan will disclose PHI to the Employer only upon receipt of
Certification by the Employer that the Plan documents have been amended in accordance with 45
C.F.R. § 164.504(f), and that the Employer shall protect the PHI as described in Section 3 herein.

5. Security Standards Requirement. To comply with the HIPAA Security Regulations, the
Employer must:

(a) implement administrative, physical, and technical safeguards that reasonably and
appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it
creates, receives, maintains, or transmits on behalf of the Plan;

(b) ensure that the adequate separation required by 45 C.F.R. § 164.504(f)(2)(iii) is
supported by reasonable and appropriate security measures;

(c) ensure that any agent, including a subcontractor, to whom it provides this
information agrees to implement reasonable and appropriate security measures to protect the
information; and

(d) report to the Plan any security incident of which it becomes aware.

6. Amendment. Notwithstanding any other provision of the Plan, this Appendix A may be
amended in any way and at any time by the Plan’s Privacy Officer.