UNIVERSITY OF VIRGINIA MEDICAL CENTER

FLEXIBLE SPENDING ACCOUNT PLAN

AMENDED AND RESTATED

Effective January 1, 2014

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UNIVERSITY OF VIRGINIA MEDICAL CENTER
FLEXIBLE SPENDING ACCOUNT PLAN

ARTICLE 1

PURPOSE AND ESTABLISHMENT

1.1 Purpose of Plan. The purpose of this Plan is to provide Employees of the Employer with a choice between cash and benefits under the welfare benefit plans maintained by the Employer.

1.2 Cafeteria Plan Status. This Plan is intended to qualify as a "cafeteria plan" under section 125 of the Code, and is to be interpreted in a manner consistent with the requirements of section 125 of the Code.

ARTICLE 2

DEFINITIONS

Wherever used herein, the following terms have the following meanings 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 other such person or committee as may be appointed from time to time by the Employer to supervise the administration of the Plan.

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

2.3 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.

2.4 Dental Plan means the dental plan offered by the Employer to Eligible Employees.

2.5 Dependent Care Reimbursement Account Plan means the University of Virginia Medical Center Dependent Care Account Plan, as it may be amended from time to time.

2.6 Effective Date means January 1, 2014, the date that the Plan was amended and restated. The original Effective Date of the Plan is January 1, 1997.

2.7 Eligible Employee means any salaried Employee who works at least 20 hours per week. Notwithstanding the foregoing, for the purpose of Schedule A only, Eligible Employee also means non-salaried Employees who worked an average of 30 or more hours each week during their measurement period.

2.8 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.

2.9 Employer means the University of Virginia Medical Center.

2.10 Flex Dollars means those amounts that are granted to eligible Participants for the purpose of purchasing benefits under Section 5.1 in an amount determined each year at the discretion of the Employer.

2.11 FMLA means the Family and Medical Leave Act of 1993, as it may be amended from time to time.

2.12 Health Care Plan means the health care plan(s) made available to Eligible Employees.

2.13 Health Savings Account or HSA means a health savings account established under section 223 of the Code. Such arrangements are individual trusts or custodial accounts, each separately established and maintained by an Eligible Employee with a qualified trustee/custodian. Although an HSA may be funded by compensation reduction amounts and employer contributions, if any, under this Plan, the HSA is not an Employer-sponsored benefit.

2.14 Health Care Reimbursement Account Plan means the Health Care Reimbursement Account Plan for Employees of the University of Virginia Medical Center, as it may be amended from time to time.

2.15 Health Insurance Marketplace means an organization set up by a state or the federal government to facilitate the purchase of health insurance in each state in accordance with Patient Protection and Affordable Care Act of 2010.

2.16 Key Employee means any person who is a key employee as defined in section 416(i)(1) of the Code.

2.17 Medical Center means the University of Virginia Medical Center.

2.18 Participant means an Eligible Employee who satisfies the requirements of Article 3 of the Plan.

2.19 Participant Account means the account established for a Participant and maintained by the Employer for recordkeeping purposes.

2.20 Plan means the University of Virginia Medical Center Flexible Spending Account Plan as set forth herein, together with any and all amendments and supplements hereto.

2.21 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.

2.22 Qualified Health Plan means an insurance plan that is certified by the Health Insurance Marketplace and meets certain minimum standards of coverage required by the Patient Protection and Affordable Care Act of 2010.

2.23 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.

2.24 Vision Plan means the vision plan offered by the Employer to Eligible Employees.

ARTICLE 3

ELIGIBILITY AND PARTICIPATION

3.1 Generally. An Eligible Employee shall become a Participant in the Plan upon (a) having completed an on-line enrollment election and a compensation reduction agreement, if applicable, in such form as approved by the Administrator, or (b) if an enrollment election and compensation reduction agreement are not submitted, when benefits are deemed to have been elected pursuant to Section 5.6. Benefit elections will be effective as of the date specified in the benefit option.

3.2 Prohibition Against Simultaneous Participation. A Participant of this Plan may not at the same time participate in the Flexible Spending Account Plan of the University of Virginia.

3.3 Participation During FMLA. A Participant who is absent from work due to FMLA leave shall have the right to continue to participate in this Plan. The Participant's right to maintain coverage while on a leave of absence described in this Section 3.3 is conditioned on the Employee's (a) continuing to have an employment relationship with the Employer, and (b) making the required contributions.

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 former 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. The preceding sentence does not apply to participation in an HSA. Rehired former Participants must affirmatively elect to participate in the HSA upon rehire.

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 former Participant shall commence participation in the Plan upon the satisfaction of the requirements of Section 3.1. The former Participant will need to file a new enrollment form and compensation reduction agreement with the Administrator prior to participation.

3.5 Termination of Participation. A Participant shall cease to participate in the Plan on the earliest of:

(a) the date that the Plan is terminated under ARTICLE 8;

(b) the end of the month that includes the date of a Participant's Termination;

(c) the end of the month that includes the date the Participant ceases to be an Eligible Employee; or

(d) the date that all required contributions with respect to the Participant's elections under the optional benefits described in Sections 5.1(a)-(c) and (e) and 5.2(a)-(f) are no longer being made.

ARTICLE 4

FLEX DOLLARS, ALLOCATIONS, AND CONTRIBUTIONS

4.1 Calculation of Flex Dollars. Each Participant eligible to participate in the Plan pursuant to Section 3.1 shall have Flex Dollars credited to his behalf in an amount determined each Plan Year by the Employer.

4.2 Participant Benefit Cost Reduction. Each Participant shall be entitled to select from among the benefit options provided in ARTICLE 5. To the extent available, a Participant may utilize the Flex Dollars credited on his behalf to pay for such benefits listed in Section 5.1. To the extent that a Participant selects options in an amount in excess of the Flex Dollars allocated on his behalf for each Plan Year, the difference will be required to he paid by the Participant through compensation reduction, as provided in Section 4.3. In addition, to the extent a Participant elects benefits offered in the optional benefits listed in Section 5.2, the Participant will be required to pay for such benefits through compensation reduction, as provided in Section 4.3.

4.3 Compensation Reduction. A Participant's compensation shall be reduced on a pre-tax basis by an amount of contributions which the Participant elects (or is deemed to have elected pursuant to Section 5.6) for such Plan Year under this Plan.

ARTICLE 5

BENEFITS ELECTION

5.1 Benefit Options Using Flex Dollars. Each Participant may elect to receive the following optional benefits in accordance with the procedure described in Section 5.4(a):

(a) Health Care Plan;

(b) Dental Plan;

(c) Vision Plan;

(d) Cash; and

(e) effective on and after January 1, 2014, Health Savings Account, but only if the Participant meets the eligibility requirements to participate in an HSA as described in Schedule A.

If a Participant elects an optional benefit described under Section 5.1(a), (b), (c), or (e), then the Flex Dollars allocated on behalf of such Participant shall be reduced, and an amount equal to the reduction will be contributed by the Employer under each respective optional benefit to cover the Participant's share of the cost of such benefit as determined by the Employer.

5.2 Benefit Options Using Compensation Reduction. Each Participant may elect to receive his full compensation for any Plan Year in cash or to have a portion of it applied by the Employer toward the cost of one or more of the following optional benefits in accordance with the procedure described in Section 5.4(b):

(a) Health Care Plan;

(b) Dental Plan;

(c) Vision Plan;

(d) Dependent Care Reimbursement Account Plan;

(e) Health Care Reimbursement Account Plan; and

(f) effective on and after January 1, 2014, Health Savings Account, but only if the Participant meets the eligibility requirements to participate in an HSA as described in Schedule A.

If a Participant elects an optional benefit described under this Section 5.2, then the Participant's compensation shall be reduced, and an amount equal to the reduction will be credited by the Employer to a reimbursement account in accordance with the Dependent Care Reimbursement Account Plan or the Health Care Reimbursement Account Plan or will be contributed by the Employer under each respective optional benefit to cover the Participant's share of the cost of such benefit as determined by the Employer, as the case may be. Amounts credited to a reimbursement account shall be subject to forfeiture in accordance with the terms of the Dependent Care Reimbursement Account Plan and the Health Care Reimbursement Account Plan.

5.3 Description of Benefits. While the election to receive benefits under one or more of the optional benefits described in Sections 5.1 and 5.2 may be made under this Plan, the benefits will be provided not by this Plan but by the Dependent Care Reimbursement Account Plan, the Health Care Plan, Dental Plan, Vision Plan, the Health Care Reimbursement Account Plan, or Health Savings Account, as applicable. The types and amounts of benefits available under each option described in Section 5.1(a)-(c) and Section 5.2(a)-(e), the requirements for participating in

each benefit option, and the other terms and conditions of coverage and benefits under each option are as set forth from time to time in the Dependent Care Reimbursement Account Plan, the Health Care Plan, the Dental Plan, the Vision Plan, and the Health Care Reimbursement Plan. The benefit descriptions in such plans (including any contracts incorporated by reference), as in effect from time to time, are hereby incorporated by reference into this Plan. The types and amounts of benefits available under the Health Savings Account described in Sections 5.1(e) and 5.2(f), the requirements for participating, and the other terms and conditions of coverage and benefits under the HSA are as set forth in Schedule A.

5.4 Election Procedure.

(a) Benefit Options Listed in Section 5.1. Approximately 60 (or fewer) days prior to the commencement of each Plan Year, the Administrator shall make elections available to each Participant and to each other Employee who is expected to become a Participant at the beginning of the Plan Year. The elections shall be effective as of the first day of the Plan Year. Each Participant who desires one or more optional benefit coverages described in Section 5.1 for the Plan Year shall so specify and shall agree to a reduction in the Flex Dollars credited on his behalf. The amount of the reduction in the Participant's compensation for the Plan Year for each optional benefit described in Section 5.1 shall be equal to the amount that the Participant's share of the cost of such optional benefit exceeds such Participant's Flex Dollars available for the Plan Year, and shall be adjusted automatically in the event of a change in such cost. The amount of the reduction in the Participant's compensation for the Plan Year for each optional benefit described in Section 5.1(e) shall be the amount elected by the Participant, subject to the limitations of the HSA. The election(s) must be completed in the form and manner determined by the Administrator on or before such date as the Administrator shall specify, which date shall be no later than the beginning of the first pay period for which the Participant's Flex Dollar reduction agreement will apply.

(b) Benefit Options Listed in Section 5.2. Approximately 60 (or fewer) days prior to the commencement of each Plan Year, the Administrator shall make elections available to each Participant and to each other Employee who is expected to become a Participant at the beginning of the Plan Year. The elections shall be effective as of the first day of the Plan Year. Each Participant who desires one or more optional benefit coverages described in Section 5.2 for the Plan Year shall so specify and shall agree to a reduction in compensation. The amount of the reduction in the Participant's compensation for the Plan Year for each optional benefit described in Section 5.2 shall be equal to the amount of the Participant's share of the cost of such optional benefit and shall be adjusted automatically in the event of a change in such cost. The amount of the reduction in the Participant's compensation for the Plan Year for each optional benefit described in Section 5.2(d)**Error! Reference source not found.**, 5.2(e), and 5.2(f) shall be the amount elected by the Participant, subject to the limitations of the Dependent Care Reimbursement Account Plan, the Health Care Reimbursement Account Plan, and the HSA, respectively. The election(s) must be completed in the form and manner determined by the Administrator on or before such date as the Administrator shall specify, which date shall be no later than the beginning of the first pay period for which the Participant's compensation reduction agreement will apply.

5.5 New Participants. As soon as practicable before an Employee becomes a Participant under Section 3.1 and 3.3, the Administrator shall provide the election and compensation reduction agreements described in Section 5.4 to the Employee. A Participant Account will be established for each new Participant. If the Employee desires one or more optional benefits described in Sections 5.1 or 5.2 for the balance of the Plan Year, he or she shall so specify and shall agree to a reduction in compensation as provided in Section 5.4. The election must be completed in the form and manner determined by the Administrator on or before such date as the Administrator shall specify, which date shall be no later than the beginning of the first pay period for which the Participant's compensation reduction agreements will apply.

5.6 Failure to Elect. If a Participant fails to elect on or before the specified due date upon his or her initial eligibility, such Participant shall be deemed to have elected to receive his full compensation in cash. After his or her initial enrollment, a Participant failing to submit a new election relating to the Health Care Plan, Dental Plan, and/or Vision Plan on or before the specified due date for any subsequent Plan Year shall be deemed to have made the same election as was in effect as to such optional benefits just prior to the preceding Plan Year. The Participant shall also be deemed to have agreed to a reduction in his compensation for the subsequent Plan Year equal to the Participant's share of the cost from time to time during such Plan Year of each such optional benefit he is deemed to have elected for such Plan Year. A Participant failing to return a completed election form to the Administrator relating to the Dependent Care Reimbursement Account Plan, Health Care Reimbursement Account Plan, and/or HSA on or before the specified due date for any subsequent Plan Year shall be deemed to have elected cash compensation in lieu of such optional benefits, regardless of the election in effect during the preceding Plan Year.

5.7 Changes by Administrator. If the Administrator determines, before or during any Plan Year, that the Plan or any benefit option under the Plan may fail to satisfy for such Plan Year any nondiscrimination requirement imposed by the Code or any limitation of benefits provided to Key Employees, the Administrator shall impose a *pro rata* reduction on the benefit elections of all Employees who are considered to be highly compensated under section 125(e) of the Code or Key Employees sufficient to assure compliance with any such requirement or limitation.

5.8 Irrevocability of Election by Participant During the Plan Year. Once an election has been accepted by the Administrator with respect to the benefit options listed in Sections 5.1 and 5.2 or an election has been deemed to have been made pursuant to Section 5.6, a Participant may not modify or revoke his or her election for the remainder of the Plan Year except where modification or revocation is necessitated by and is consistent with a change described in this Section 5.8 and not otherwise prohibited under this Section 5.8. A modification or revocation of a benefit election is consistent with such a change only if the election change is on account of, and corresponds with, the event precipitating the change, as determined by the Administrator in light of rules and regulations promulgated by the Department of the Treasury. The Participant must change his or her election within 60 days of the event that caused the change. Any such modification or revocation of an election shall be effective on the first of the month following the date the election is filed. However, if such election is on account of the birth, adoption, or placement for adoption of a Participant's dependent, an election shall be effective retroactive to the date of the birth, adoption, or placement for adoption of such dependent, with respect to group health coverage only.

This Section 5.8 does not apply to elections for contributions made to an HSA.

(a) Rules Applicable to the Health Care Plan, Dental Plan, Vision Plan, Dependent Care Reimbursement Account Plan, and Health Care Reimbursement Account Plan. The following rules apply to the benefits described in Sections 5.1(a)-(c) and 5.2(a)-(e).

(i) Change in Status. The following events shall constitute a change in status:

(1) events that change a Participant's legal marital status, including marriage, death of spouse, and divorce;

(2) events that change a Participant's number of dependents, including birth, adoption, placement for adoption, and death of a dependent;

(3) events that change the employment status of the Participant, the Participant's spouse, or the Participant's dependent, including a termination or commencement of employment; a strike or lockout; a commencement of, or return from, an unpaid leave of absence; and a change in worksite. In addition, if the eligibility conditions of the Plan to which the Participant, the Participant's spouse, or the Participant's dependent are subject are contingent on the individual's employment status and there is a change in that employment status that causes the individual to become eligible or ineligible under the Plan, then the change will constitute a change in employment status for purposes of this Section 5.8(a)(i)(3); and

(4) an event that causes a dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, or any similar circumstance.

(b) Rules Applicable to the Health Care Plan, Dental Plan, Vision Plan, and Dependent Care Reimbursement Account Plan. The following rules apply to the benefits described in Sections 5.1(a)-(c) and 5.2(a)-(e).

(i) Significant Cost Changes. If the cost of coverage under any benefit option described under Sections 5.1(a)-(c) and 5.2(a)-(e) should change significantly, the following shall apply:

(1) Automatic Changes. If the cost of a benefit option increases (or decreases) during a Plan Year, the Administrator may, on a reasonable and consistent basis, automatically prospectively increase (or decrease) affected election forms and/or compensation reduction agreements.

(2) Significant Cost Changes. If the cost of a specific benefit option significantly increases (or decreases) during a Plan Year, Participants may make a corresponding prospective increase (or decrease) in their election forms and/or compensation reduction agreements. In the case of a significant increase in cost, Participants may revoke their elections, and, in

lieu thereof, either elect to receive on a prospective basis, coverage under another benefit option providing similar coverage, or drop coverage if no other benefit option providing similar coverage (i.e., coverage for the same category of benefits for the same individuals) is available. In the case of a significant decrease in cost, Participants may commence participation in the benefit option with a decrease in cost, whether or not the Participant had previously elected coverage under the Plan. For this purpose, a cost increase or decrease refers to an increase or decrease in the amount of compensation reductions required under the Plan, whether that increase or decrease results from an action taken by the Participant or from an action taken by the Employer.

(3) Dependent Care Reimbursement Account Plan. In the case of the Dependent Care Spending Account Plan, the Participant may modify his or her benefit election, as appropriate, only if a cost change is imposed by a dependent care provider who is not a relative of the Participant.

(ii) Significant Coverage Changes. If the coverage under any benefit option under Sections 5.1(a)-(c) and 5.2(a)-(e) should change significantly, the following shall apply:

(1) Significant Curtailment Without Loss of Coverage. If a Participant, or a Participant's spouse or dependent who had been participating in the Plan and receiving coverage has a significant curtailment of that coverage during the Plan Year that is not a loss of coverage as described in Section 5.8(b)(ii)(2) (e.g., a significant increase in any deductible, copay, or out-of-pocket cost sharing limit), the Participant may revoke his or her election for that coverage, and, in lieu thereof, elect to receive on a prospective basis coverage under another benefit option providing similar coverage. Coverage is significantly curtailed only if there is an overall reduction in coverage provided so as to constitute reduced coverage generally (e.g., the loss of one particular physician in a network does not constitute a significant curtailment).

(2) Significant Curtailment With Loss of Coverage. If a Participant, or a Participant's spouse or dependent who had been participating in the Plan and receiving coverage has a significant curtailment of that coverage during the Plan Year that is a loss of coverage during the Plan Year, the Participant may revoke his or her election under the Plan, and, in lieu thereof, elect either to receive on a prospective basis coverage under another benefit option providing similar coverage or to drop coverage if no similar benefit option is available. For purposes of this paragraph (b)(ii)(2), a loss of coverage means a complete loss of coverage under the benefit option or other coverage option (including the elimination of a benefit option or an HMO ceasing to be available in the area where the Participant resides). In addition, the Employer shall, in its discretion, treat the following as a loss of coverage:

(A) a substantial decrease in the medical care providers available under the option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the physicians participating in a preferred provider network or an HMO);

(B) a reduction in the benefits for a specific type of medical condition or treatment with respect to which the Participant, the Participant's spouse, or the Participant's dependent is currently in a course of treatment; or

(C) any other similar fundamental loss of coverage.

(3) Addition or Improvement of Benefit Option. If the Employer adds a new benefit option or other coverage option, or if coverage under an existing benefit option or other coverage option is significantly improved during the Plan Year, Participants (whether or not they have previously made an election under the Plan or have previously elected the benefit option) may revoke their election under the Plan and, in lieu thereof, make an election on a prospective basis for coverage under the new or improved benefit option.

(iii) Change in Coverage Under Another Plan. The Participant may make a prospective election change that is on account of, and corresponds with, a change made under another employer plan (including a plan of the Employer or of another employer) if:

(1) the other plan permits participants to make an election change that would be permitted under paragraphs (a), (b), or (c) of this Section 5.8, or

(2) if the plan year of the other plan is different from the Plan Year of the Plan.

(c) Rules Applicable to the Health Care Plan, Dental Plan, Vision Plan, and the Health Care Reimbursement Account Plan. The following rules apply only to the benefits described in Sections 5.1(a)-(c) and 5.2(a)-(c), and (e) unless otherwise noted.

(i) Exception for COBRA. A Participant may elect to increase payments under this Plan in order to pay for continuation coverage if the Participant, or Participant's spouse or dependent becomes eligible for continuation coverage under the Health Care Plan, Dental Plan and/or Vision Plan, as provided in section 4980B of the Code.

(ii) Special Enrollment Rights. A Participant may revoke a benefit election and file a new election with respect to the Health Care Plan if both the revocation and the new election are on account of and consistent with, a special enrollment right in section 9801(f) of the Code, whether or not the change in election would be permitted under paragraph (a) above. These enrollment rights were added by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and permit mid-year enrollment for employees and dependents in certain circumstances.

(iii) Judgment, Decree, or Order. A Participant may revoke a benefit election and make a corresponding new benefit election if a judgment, decree, or order resulting from a divorce, or change in legal custody (including a qualified medical child support order as defined in section 609 of ERISA):

(1) requires the Participant to provide accident or health coverage for the Participant's child or a foster child who is the Participant's dependent, or

(2) requires the Participant's spouse, or other individual to provide coverage for the child and such coverage is, in fact, provided.

(iv) Entitlement to Medicare or Medicaid. If a Participant, Participant's spouse, or Participant's dependent who is enrolled in the Health Care Plan becomes enrolled 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), the Participant may make a prospective election change to cancel or reduce coverage of the Participant, the Participant's spouse, or the Participant's dependent under the Health Care Plan. In addition, if a Participant, Participant's spouse, or Participant's dependent who has been entitled to such coverage under Medicare or Medicaid loses eligibility for such coverage, the Participant may make a prospective election to commence or increase coverage of the Participant, the Participant's spouse or the Participant's dependent under the Health Care Plan.

(v) Loss of Coverage Under Other Group Health Coverage. If the Participant, the Participant's spouse, or the Participant's dependent loses coverage under any group health coverage sponsored by a governmental or educational institution, the Participant may make a prospective election to add coverage under the Plan for the Participant, the Participant's spouse, or the Participant's dependent. This paragraph (v) shall not apply to the Health Care Reimbursement Account Plan.

(d) Rules Applicable to the Health Care Plan. The following rules apply to the benefits described in Sections 5.1(a) and 5.2(a).

(i) Revocation due to a Reduction in Hours of Service. A Participant may revoke an election that is on account of, and corresponds with, a change in the Participant's hours of service if:

(1) the Participant has been in an employment status under which the Participant was reasonably expected to average at least 30 hours of service per week, and there is a change in that Participant's status so that the Participant will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the Participant ceasing to be eligible under the Health Care Plan; and

(2) the revocation of the election of coverage under the Health Care Plan corresponds to the intended enrollment of the Participant and any related individuals who cease coverage due to the revocation in another plan that

provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

(ii) Revocation due to Enrollment in a Qualified Health Plan. A Participant may revoke an election and enroll in a Qualified Health Plan if:

(1) the Participant is eligible for a special enrollment right to enroll in a Qualified Health Plan through a Health Insurance Marketplace pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the Participant seeks to enroll in a Qualified Health Plan through a Health Insurance Marketplace during the Health Insurance Marketplace's annual open enrollment period; and

(2) the revocation of the election of coverage under the Health Care Plan corresponds to the intended enrollment of the Participant and any related individuals who cease coverage due to the revocation in a Qualified Health Plan through a Health Insurance Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

(e) Dependent. For purposes of this Section 5.8, the term dependent shall have the meaning given to it in the Component Plan for which an election revocation, or modification is requested.

5.9 Automatic Termination of Election. Elections made under this Plan (or deemed to be made under Section 5.6) shall automatically terminate on the date on which the Participant ceases to be a Participant in the Plan, although coverage of benefits under the Dependent Care Reimbursement Account Plan, the Health Care Plan, and the Health Care Reimbursement Account Plan may continue if and to the extent provided by such plans.

5.10 Transfer to or from Another Agency Controlled by the Board of Visitors.

(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 health care reimbursement plan and/or dependent care reimbursement plan, as the case may be, 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) Transfers From Another Agency Controlled by the Board of Visitors. A Participant who transfers from another agency controlled by the Board will have his reimbursement accounts transferred from the Health Care Reimbursement Account Plan and/or the Dependent Care Reimbursement Account Plan, as the case may be, 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 by this Plan.

5.11 Maximum Employer Contributions. The maximum amount of Employer contributions under the Plan for any Participant shall be the sum of (a) the maximum amounts which the Participant may receive in the form of dependent care assistance under the Dependent Care Reimbursement Account Plan and as health care reimbursements under the Health Care Reimbursement Account Plan, as set forth in such plans, and (b) the cost from time to time of the most expensive benefits available to the Participant under the Health Care Plan (including the portion of such costs payable with Employer contributions).

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 the foregoing, any claim which arises under the Dependent Care Reimbursement Account Plan, any Health Care Plan or Health Care Reimbursement Account Plan, shall not be subject to review under this Plan, and the Administrator's authority under Section 6.1 shall not extend to any matter as to which an administrator under any such other plan is empowered to make determinations under such plan.

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 settlements 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 in the scope of his or her responsibilities as Administrator.

ARTICLE 7

CLAIMS

7.1 Claims Under the Plan. All claims brought by a Participant under this Plan, including, but not limited to, claims regarding eligibility or election changes under the Plan, shall be made in writing to the Administrator. The decisions of the Administrator on any matter within its authority shall be final and binding on all parties, including without limitation, the Employer and Participants.

7.2 Claims Under an Optional Benefit. Any claim which arises with respect to benefits under any of the optional benefits in Sections 5.1 and 5.2 shall not be subject to review under this Plan, but shall be subject to the claims procedures set forth under such plan. The Administrator's authority under Section 7.1 shall not extend to any matter as to which an administrator under any such other plan is empowered to make under such plan. The Administrator has no authority with respect to any HSA established by a Participant.

7.3 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. Upon termination or discontinuance of the Plan, all elections under this Plan shall terminate.

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 Medical Center has caused this Plan to be executed in its name and behalf by its Vice President of Human Resources on this 23 day of October, 2014.

UNIVERSITY OF VIRGINIA MEDICAL CENTER

By: _____

Title: Vice President of Human Resources

SCHEDULE A
Health Savings Account

Effective on an after January 1, 2014, the Employer maintains a high-deductible health plan (HDHP) for the benefit of its Eligible Employees as described under section 223(c)(2) of the Code. The Employer reserves the right, but is not required, to make a discretionary contribution in accordance with Section A-2 below to a Health Savings Account (HSA) for all Eligible Employees who are enrolled in the HDHP and elect to participate in the HSA. The HSA is owned by the Eligible Employee. The HSA is not an ERISA-covered plan and is not sponsored by the Employer.

A-1 Eligibility. To participate in the HSA, an Eligible Employee: (1) must be covered under the Employer's HDHP; (2) cannot be claimed as another person's tax dependent; (3) cannot be entitled to Medicare benefits; and (4) cannot have any health coverage other than HDHP coverage except for certain types of permitted insurance or coverage (e.g., HSA-Compatible (Limited) FSA).

A-2 Employer Contributions. Employer contributions, if any, shall be made to the custodian of the HSA designated by the Employer in an amount determined by the Employer, in its sole discretion. The amount of Employer contributions, if any, shall be communicated to Participants on an annual basis. The Employer contributions, if any, will be made at the time determined by the Employer, in its sole discretion.

A-3 Participant Contributions. A Participant may make additional HSA contributions as long as the total Employer and Participant contributions made to the HSA (or any other HSA owned by the Participant) do not exceed the maximum annual contributions limit as designated and indexed annually by the Internal Revenue Service. An election to make a Participant Contribution to an HSA can be increased, decreased or revoked at any time on a prospective basis. Such election changes shall be effective no less frequently than monthly. No benefit election changes can occur as a result of a change in HSA election except as otherwise described in Article 5 of the Plan. For example, a Participant generally would not be able to terminate an election under the Health Care Expense Account Plan in order to be eligible for the HSA, unless one of the exceptions described in Section 5.8 of the Plan occurred.

A-4 Coordination with Health Care Reimbursement Account Plan. A Participant may not elect benefits under both a HSA and the Standard Option offered under the Health Care Reimbursement Account Plan.

A-5 Trust/Custodial Agreement. HSA benefits under this Plan consist solely of the ability to make contributions to the HSA on a pre-tax or after-tax basis via the Participant's Compensation Reduction Agreement. 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 trust/custodial 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 the reimbursement of "qualified eligible medical expenses" as set forth in section 223(d)(2) of the Code. While the Employer may choose one or more trustees/custodians who are permissible recipients of Employer and Participant contributions, the Employer has no authority or control over the funds deposited in a HSA. Even though this Plan may allow contributions to an HSA through compensation reduction agreement, the HSA is not intended to be an ERISA benefit plan sponsored or maintained by the Employer in accordance with DOL guidance set forth in Field Assistance Bulletins (FABs) 2004-1 and 2006-2.

FIRST AMENDMENT
TO THE
THE UNIVERSITY OF VIRGINIA MEDICAL CENTER
FLEXIBLE SPENDING ACCOUNT PLAN

(As Amended and Restated January 1, 2014)

W I T N E S S E T H

WHEREAS, The University of Virginia Medical Center Flexible Spending Account Plan (the "Plan") was established effective January 1, 1997 by the University of Virginia Medical Center (the "Medical Center");

WHEREAS, the Plan was amended and restated effective January 1, 2014;

WHEREAS, the Medical Center wishes to amend the Plan to modify election rules under the Plan to allow 30 days to make changes after a qualifying event and to automatically carry over previous elections under the reimbursement accounts unless the participant elects otherwise; and

WHEREAS, Article 8 permits the Vice President of Human Resources to amend the Plan at any time;

NOW, THEREFORE, in accordance with the foregoing, the Plan is hereby amended as follows effective January 1, 2019, unless otherwise stated:

1. The fifth sentence of Subsection 5.4(b) is hereby amended to read as follows:

> "The amount of the reduction in the Participant's compensation for the Plan Year for each optional benefit described in Section 5.2(d), 5.2(e), and 5.2(f) shall be the amount elected by the Participant, subject to the limitations of the Dependent Care Reimbursement Account Plan, the Health Care Reimbursement Account Plan, and the HSA, respectively."

2. Effective January 1, 2017, Section 5.6 is hereby amended in its entirety to read as follows:

> "5.6 Failure to Elect. If a Participant fails to elect on or before the specified due date upon his or her initial eligibility, such Participant shall be deemed to have elected to receive his full compensation in cash. After his or her initial enrollment, a Participant failing to submit a completed election form to the Plan Administrator relating to the optional benefits in Section 5.1 (a) – (f) on or before the specified due date for any subsequent Plan Year shall be deemed to have made the same election as was in effect for each such optional benefit for the preceding Plan Year. The

Participant shall also be deemed to have agreed to a reduction in his compensation for the subsequent Plan Year equal to the Participant's share of the cost from time to time during such Plan Year of each such optional benefit he is deemed to have elected for such Plan Year."

3. The third sentence of the first paragraph of Section 5.8 is hereby amended to read as follows:

"The Participant must change his or her election within 30 days of the event that caused the change."

IN WITNESS WHEREOF, the undersigned being an authorized officer of the Medical Center has caused this Amendment to be executed on behalf of the Medical Center this 6th day of August, 2019.

UNIVERSITY OF VIRGINIA MEDICAL CENTER

By: _____
Vice President of Human Resources

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

Effective January 1, 2019

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FOR EMPLOYEES OF THE UNIVERSITY OF VIRGINIA MEDICAL CENTER

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 Medical Center 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 Medical Center Flexible Spending Account Plan established and maintained by the Medical Center, 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, 2019, 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.

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 Medical Center.

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 means 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 Medical Center.

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, upon initial eligibility and during any subsequent annual enrollment period 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 an annual amount from $240 up to the limit in effect under Code section 125(i)(1), as may be adjusted for inflation under Code section 125(i)(2). The Employee's compensation shall be reduced pursuant to Article 5 of the Cafeteria Plan. Effective January 1, 2017, if a Participant fails to submit a completed election on or before the specified annual enrollment period due date for a subsequent Plan Year, then such Participant shall be deemed to have made the same election as was in effect for the preceding Plan Year.

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.

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 remain 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(c)(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 Medical Center 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 Medical Center has caused this Plan to be executed in its name and behalf by the Vice President of Human Resources on this 6th day of August, 2019.

UNIVERSITY OF VIRGINIA MEDICAL CENTER

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 Medical Center 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.

(h) 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.

DEPENDENT CARE REIMBURSEMENT ACCOUNT PLAN

FOR EMPLOYEES OF

THE UNIVERSITY OF VIRGINIA MEDICAL CENTER

Effective January 1, 2019

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DEPENDENT CARE REIMBURSEMENT ACCOUNT PLAN FOR EMPLOYEES OF THE UNIVERSITY OF VIRGINIA MEDICAL CENTER

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 Dependent Care Expenses for which the Employee did not take a tax credit and (b) cash compensation. The Plan is intended to qualify as a dependent care reimbursement plan within the meaning of section 129 of the Code wherein reimbursements paid under the Plan are eligible for exclusion from Participants' income under section 129(a) 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 Medical Center 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 Medical Center Flexible Spending Account Plan established and maintained by the Medical Center, as amended from time to time.

2.4 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.

2.5 Compensation means the remuneration directly paid to an Employee by the Employer which is subject to withholding for federal income tax purposes for the Plan Year.

2.6 Earned Income means an individual's wages, pay, tips and other employee compensation, plus the amount of the individual's net earnings from self-employment for the taxable year, but shall not include pensions or annuities, amounts to which Section 871(a) of the Code applies (relating to income of a nonresident alien individual not connected with a United States business) or amounts paid or incurred by an individual's company for dependent care assistance to an

employee; provided, however, that in the case of a Participant's who is a student or physically or mentally incapable of self-care, such spouse shall be deemed for each month during which such spouse is a full-time student at an educational institution, or is incapable of self-care, to be gainfully employed and to have earned income of not less than (a) $250, if there is one Qualifying Individual with respect to the Participant for the taxable year or (b) $500, if there are two or more Qualifying Individuals for the taxable year.

2.7 Effective Date means January 1, 2019, 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.

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 Medical Center.

2.11 Full-Time Student means an individual who, during each of at least five months during the Participant's taxable year, is enrolled at an educational organization described in section 170(b)(1)(A)(ii) of the Code. The individual must enroll for the number of course hours considered to constitute full-time study, and may not attend exclusively at night.

2.12 Medical Center means 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 Dependent Care Reimbursement Account Plan for Employees of the University of Virginia Medical Center.

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 Dependent Care Expenses shall have the meaning given to it in Section 5.5 of this Plan.

2.17 Qualifying Individual means (a) the Participant's child, grandchild, brother or sister who is under age 13, who lives with the Participant for more than one-half of the year and who does not provide more than one-half of his own support for the year, (b) a disabled spouse who lives

with the Participant for more than one-half of the year, and (c) a disabled relative or household member who is principally dependent on the Participant for support, who lives with the Participant for more than one-half of the year and who does not have gross income in excess of the exemption amount specified in Section 151(d) of the Code. A Qualifying Individual cannot include a domestic partner, civil union member, or the dependents of either unless they are also a dependent under Section 152 of the Code who meets the requirements above.

Notwithstanding the foregoing, in the case of a divorced or separated parent, a Qualifying Individual who is a child shall, as provided in Section 21(e)(5) of the Code, be treated as a Qualifying Individual of the custodial parent (within the meaning of Section 152(e) of the Code) and shall not be treated as a Qualifying Individual with respect to the non-custodial parent.

2.18 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 Dependent Care Expenses.

2.19 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.

2.20 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 (a) first day of the month following the date of hire provided he makes a valid election for Dependent Care Reimbursement Account Benefits under the Cafeteria Plan.

In order to participate in the Plan, an Eligible Employee must, upon initial enrollment and during any subsequent annual enrollment period 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 $5,000 annually (or $2,500 annually if the Participant is married and files a separate return) of coverage; provided however, that each Participant's coverage under this Plan shall be limited to the lesser of (a) the Participant's Earned Income for the Plan Year, and (b) the Participant's spouse's Earned Income for the Plan Year. The Employee's compensation shall be reduced pursuant to Article 5 of the Cafeteria Plan. Effective January 1, 2017, if a Participant fails to submit a completed election form to the Plan Administrator on or before the specified annual enrollment period due date for a subsequent Plan Year, after having elected benefits for the preceding year, then such Participant shall be deemed to have made the same election as was in effect for the preceding Plan Year.

If the Participant's spouse is a Qualifying Individual or is a Full-Time Student, the spouse will be deemed to have Earned Income for purposes of this Section 3.1 for each month during the Plan Year in which the spouse is a Full-Time Student or a Qualifying Individual, equal to either (a) $200, if there is only one Qualifying Individual with respect to the Participant, (b) $400, if there

is more than one Qualifying Individual with respect to the Participant, or (c) such other dollar amounts as may be permitted under section 21(d) of the Code, which are incorporated herein by reference.

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 Dependent Care Reimbursement Account Plan for Employees of the University of Virginia.

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. A 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.

(b) 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 "highly compensated employees" as that term is defined in section 414(q) of the Code to prevent either:

(i) discrimination in favor of such employees with respect to eligibility to participate or as to contributions and benefits in accordance with sections 129(d)(2) and (3) of the Code; or

(ii) the average benefits provided to employees who are not highly compensated employees from being less than 55% of the average benefits of the highly compensated employees under all the plans of the Medical Center in accordance with section 129(d)(8) of the Code.

ARTICLE 5

BENEFITS

5.1 Generally. Each Participant will be entitled to receive for each Plan Year reimbursement of Qualifying Dependent Care Expenses that he or she incurs during the Plan Year 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 Dependent 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 for allowable expenses incurred during these time periods, the Participant must be a Participant in the Plan when the Qualifying Dependent 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 for which he or she took a dependent care tax credit on his or her income tax return. In no event shall the sum of the reimbursements made to the Participant under this Plan and the amount of dependent care tax credit taken by the Participant exceed $5,000 ($2,500 in the case of married individuals filing separate returns) for any Plan Year.

During the Plan Year, a Participant may be reimbursed up to the full dollar amount of coverage the Participant has accrued in his or her Reimbursement Account to that date, less any prior reimbursements for that Plan Year. If the Participant's expenses exceed the accrued amount to date, the Participant will receive additional reimbursement checks as the Participant accrues additional funds in his or her Reimbursement Account.

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 remain with the Employer.

5.3 Claims for Reimbursement. A Participant who has elected to receive a Qualifying Dependent Care Expense reimbursement for a Plan Year may apply to the Employer, or any persons authorized by the Employer, for reimbursement of Qualifying Dependent Care Expenses incurred by 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:

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

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

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

(iv) a written statement from the Participant that the dependent care expense has not been reimbursed or is not reimbursable from another source; and

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

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 Dependent Care Expenses. Qualifying Dependent Care Expenses shall include only amounts paid which constitute "employment-related expenses" within the meaning of section 21 of the Code. Specifically, the Participant must incur Qualifying Dependent Care Expenses for the care of a Qualifying Individual, and for related household services, which enable the Participant to be gainfully employed. Qualifying Dependent Care Expenses shall be limited to the Participant's payment for services rendered, (a) in the Participant's home; or (b)

outside of the Participant's home only if such services are provided for the care of a Qualifying Individual who is under age 13, or who is age 13 or older and who regularly spends at least eight hours a day in the Participant's home, provided that services rendered in a Dependent Care Center as defined in section 21 of the Code must satisfy the requirements of section 21 of the Code and the regulations thereunder.

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, the Participant 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 Report to Participants On or Before January 31 of Each Year. On or before each January 31, the Administrator shall furnish to each Participant (or former Participant) who has elected dependent care assistance under this Plan for the prior calendar year, a written statement showing the amount of such assistance paid or payable with respect to Qualifying Dependent Care Expenses incurred by the Participant (or former Participant) during such year. If the amount of such Qualifying Dependent Care Expenses is not yet known to the Administrator by January 31, the written statement shall show the amount of dependent care assistance elected by the Participant (or former Participant) for such year. Nothing contained in this Section 5.8 shall preclude the Administrator from furnishing during the Plan Year, in its discretion and as it deems necessary or appropriate, periodic written statements to each Participant (or former Participant) showing the amount of such assistance paid or payable with respect to Qualifying Dependent Care Expenses incurred by the Participant (or former Participant) as of the date of such periodic statement.

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:

(i) 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;

(ii) 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;

(iii) 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;

(iv) 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;

(v) 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;

(vi) 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;

(vii) 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

(viii) 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

PLAN 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 Medical Center has caused this Plan to be executed in its name and behalf by its Vice President of Human Resource on this 6th day of August, 2019.

UNIVERSITY OF VIRGINIA MEDICAL CENTER

By: _____

Title: Vice President of Human Resources