# UNIVERSITY OF VIRGINIA

# FLEXIBLE SPENDING ACCOUNT PLAN

AMENDED AND RESTATED

Effective January 1, 2014

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# UNIVERSITY OF VIRGINIA
# 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 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, excluding Medical Center Employees. Notwithstanding the foregoing, for the purpose of Schedule A only, Eligible Employee also means a non-salaried Employee who worked an average of 30 or more hours each week during the measurement period, excluding Medical Center Employees.

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.

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

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

2.12 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.

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

2.14 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.

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

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

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

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

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

2.20 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.

2.21 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.

2.22 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.

2.23 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 5.5. 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 Medical Center.

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 component Plans described in Sections 5.1(a)-(f) are no longer being made.

## ARTICLE 4

## COMPENSATION REDUCTION

A Participant's compensation shall be reduced on a pre-tax basis by the amount necessary to pay for the benefits that the Participant elects (or is deemed to have elected pursuant to Section 5.5) for the plan year under the benefit options offered in Section 5.1. The Participant's Participant Account shall be credited in an amount equal to the pre-tax amount so deferred under this ARTICLE 4.

## ARTICLE 5

## BENEFITS ELECTION

5.1 Benefit Options. 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:

(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.

5.2 Description of Benefits. While the election to receive benefits under one or more of the optional benefits described in Section 5.1 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)-(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 Section 5.1(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.

5.3 Election Procedure. 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 compensation. 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 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 5.1(d), 5.1(e), and 5.1(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.

5.4 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 5.3 to the Employee. A Participant Account will be established for each new Participant. If the Employee desires one or more optional benefits described in 5.1 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 5.3. 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.

5.5 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 described in Section 5.1(a), 5.1(b) and Section 5.1(c) 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 described in Section 5.1(d), 5.1(e), and/or 5.1(f) 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.

5.6 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.

5.7 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 Section 5.1(a)-(e) or an election has been deemed to have been made pursuant to Section 5.5, 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 5.7 and not otherwise prohibited under this Section 5.7. 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 5.7 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 Section 5.1(a), (b), (c), (d) and (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 5.7(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), 5.1(b), 5.1(c) and (d).

(i) Significant Cost Changes. If the cost of coverage under any benefit option described under Sections 5.1(a), 5.1(b), 5.1(c), or 5.1(d) of the Plan 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), 5.1(b), 5.1(c), and 5.1(d) of the Plan 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 paragraph (b)(ii)(2) of this Section (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 5.7, 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), 5.1(b), 5.1(c), and 5.1(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 Section **Error! Reference source not found.**.

(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 U.S. 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 5.7, the term dependent shall have the meaning given to it in the Component Plan for which an election revocation, or modification is requested.

5.8 Automatic Termination of Election. Elections made under this Plan (or deemed to be made under Section 5.5) 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 Component Plans.

5.9 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.

5.10 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 Section 5.1 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 University 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

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 benefitelection 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 5.7 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.