VANDERBILT
People, Culture
and Belonging

Section 125 Cafeteria Plan

Summary Plan Description

VANDERBILT UNIVERSITY
SECTION 125 CAFETERIA PLAN

Restated effective January 1, 2026

SUMMARY PLAN DESCRIPTION

This is your summary plan description ("SPD") for the Vanderbilt University Section 125 Plan (the "Plan"). This SPD is a description, in summary form, of the provisions of the Plan, including the Adoption Agreement signed by Vanderbilt University, and various component plans thereunder. This document and other descriptive materials provided to you by the Employer are written in a manner that is intended to be easily understandable and to summarize the benefits available to you under the Plan. The Plan and the Adoption Agreement contain more detailed information about plan benefits. Every effort has been made to ensure that this SPD, the Plan and the Adoption Agreement contain a consistent description of the Plan benefits; however, if there is any conflict or inconsistency between these materials, the provisions of the Plan and Adoption Agreement prevail.

Vanderbilt University reserves the right to change, amend or terminate the Plan and any of the component plans at any time and for any reason. Also, please keep in mind that the Plan, any changes to it, or any payments to you under its terms, does not constitute a contract of employment with Vanderbilt University and does not give you the right to be retained in the employment of Vanderbilt University. No one speaking on behalf of the Plan or Vanderbilt University can alter the written terms of the Plan. You and your beneficiaries may obtain copies of the Plan, the Adoption Agreement, the component plans and related documents or examine these documents by contacting the Plan Administrator.

ARTICLE 1 - ADMINISTRATIVE INFORMATION

1.1 Plan Sponsor: Vanderbilt University (the "Employer").

1.2 The Employer's Federal Employer Identification Number is 62-0476822.

1.3 The purpose of this Plan is to allow Participants to pay for certain qualified benefits offered by the Employer on a pre-tax basis.

1.4 The Plan Administrator is Vanderbilt University**.** The Plan Administrator may appoint additional third party administrators to act for it under the Plan to the extent specified in the appointment. The Plan Administrator may engage agents to assist it and may engage legal counsel, including counsel to defend any action taken or omitted to be taken pursuant to the written opinions or certificates of any agent, counsel, or physician.

1.5 The agent for service of legal process is Vanderbilt University, PMB #407700, 2301 Vanderbilt Place, Nashville, Tennessee 37240-7700.

1.6 The Plan is funded by salary deferrals of the Participants and Employer contributions.

1.7 The Plan is restated effective January 1, 2026.

1.8 The Plan Year is the twelve month period beginning January 1st and ending December 31st. The Plan Number used by the Employer to identify the Plan is 501.

ARTICLE 2 - ELIGIBLE EMPLOYEES

2.1 If you are an employee of the Employer you are eligible to participate in the Plan if you are a Fully Benefits-Eligible Employee or a Partially Benefits-Eligible Employee (as defined by the Employer).

2.2 Notwithstanding Section 2.1 above, The following individuals are not eligible to participate in the Plan:

a. any leased employee (including but not limited to those individuals defined as leased employees in Code § 414(n)) or an individual classified by the Employer as a contract worker or independent contractor for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll or is determined by the Internal Revenue Service or others to be a common-law employee of the Employer;

b. any individual who performs services for the Employer but who is paid by a third-party temporary or other external employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the Internal Revenue Service or others to be a common-law employee of the Employer;

c. any non-resident aliens who receive no U.S.-source income during the Plan Year; and

d. any self-employed individual (including a partner), or a person who owns (or is deemed to own) more than 2 percent of the outstanding stock of an S corporation.

2.3 Your eligibility for premium reimbursement benefits under this Plan may also be subject to additional requirements as specified in the applicable component plan document(s). Please see the Plan Administrator for more details.

2.4 If you are an eligible employee and elect to participate in this Plan, you will become a Participant in the Plan on your first day of employment if you have completed any required election form(s).

ARTICLE 3– YOUR CAFETERIA PLAN BENEFITS

You may elect to defer a portion of compensation paid to you by the Employer to pay the cost of coverage for the component plans offered. The various benefit options available under the Plan will be described to you in information materials distributed prior to each enrollment period.

All employee salary deferrals are withheld on a pre-tax and pre-Social Security basis. The benefits available are more fully described in the plan documents governing each benefit plan. A copy of these plan documents is available from the Plan Administrator.

If you elect coverage under the component benefits offered by the Employer, you will be deemed to have elected to defer income under this Plan to pay your portion of the cost of such coverage on a pre-tax basis.

ARTICLE 4 – CONTRIBUTIONS TO THE PLAN

4.1 You are required to make contributions to this plan to receive benefits from the Plan. The Plan Administrator will provide you with information regarding the cost of coverage under the component plans.

ARTICLE 5 - ELECTION OF BENEFITS

5.1 **Election of Benefit Coverage**. You will make an election of benefits from those available under this Plan as set forth in Article 3 above. Your election will be made annually by executing and delivering to the Employer an election form prior to your entry date and, thereafter, prior to the beginning of each Plan Year. The Plan Administrator will provide you information regarding the cost of each benefit. To the extent you do not elect the maximum statutory benefits available under the Plan, you will be deemed to have elected to receive your compensation with no deductions for payment of benefits. Once submitted to the Employer, your election will be effective until amended or revoked by you, as permitted under the Plan. Upon enrollment the Employer will inform you whether it will treat an election by an Employee to participate in certain benefits available under the Plan as an election under this Plan to defer the employee cost of such benefit(s) on a pre-tax basis.

5.2 **Failure to Execute and Deliver an Election Form**. If you are eligible to participate in the Plan but fail to initially execute and file an election form with the Plan Administrator or fail to elect any available benefit, you will be deemed to have elected to receive your compensation with no deductions for payment of benefits. If you are a Participant in the Plan but fail to make an election as to a benefit on or before the due date specified by the Plan Administrator for any subsequent Plan Year, your tier election for health coverage will stay the same, and be defaulted into the Aetna Choice (CDHP) plan. Other benefit elections except the Health Care Flexible Spending Account Plan, Health Savings Account and the Dependent Day Care Flexible Spending Account Plan will continue in the following year on the same basis as the Employee elected in the previous year. With respect to the Health Care Flexible Spending Account Plan, Health Savings Account and the Dependent Day Care Flexible Spending Account Plan, failure to make an election will be deemed to be an election to not participate in such benefits for the following Plan Year. Additionally, if you failed to file an election via My VU Benefits or fail to make an election as to the Spousal Fee relating to coverage under the Health Insurance Plan, you will be charged the Spousal Fee for the subsequent Plan Year.

5.3 **Revocation or Change of Election During the Plan Year**.

a. Your election of benefits is irrevocable and cannot be changed, excludes Health Savings Account (as you can change your election anytime via My VU Benefits) during the Plan Year unless the change is due to and consistent with a change in status or as provided below. The Plan Administrator's decision regarding any change in election shall be final.

b. You may revoke an election in writing for the balance of the Plan Year and, if desired, file a new election in writing, if, under the facts and circumstances, (1) a change in status occurs, and (2) the requested revocation and new election satisfies the consistency requirements in Section 5.4 below. Application for such change must be made no later than 30 days after the date of the actual event giving rise to the change in status. For this purpose, a change in status includes the following events:

i. Legal marital status. An event that changes your legal marital status, including marriage, death of spouse, divorce, legal separation or annulment. "Spouse" means your lawful spouse as defined by the Internal Revenue Service in Revenue Ruling 2013-17.

ii. Number of dependents. An event that changes the number of your dependents (as defined in Internal Revenue Code § 152), including birth, death, adoption or placement for adoption. The Employer may request such proof of dependent status as it deems necessary.

iii. Employment status. An event that changes your employment status or the employment status of your Spouse or dependent, including termination or commencement of employment, a strike or lockout, a commencement or return from an unpaid leave of absence, and a change in worksite, as well as any other change in the individual's employment status that results in the individual becoming (or ceasing to

be) eligible under a benefit plan of the Employer.

iv. Requirements for unmarried dependents. An event that causes a dependent to satisfy or cease to satisfy the requirements for coverage on account of attainment of age, or any similar circumstance.

v. Residence. A change in your place of residence or the place of residence of your Spouse or dependent that causes a loss of coverage.

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

c. In the case of coverage under a group health plan, you may revoke an election in writing for the balance of the Plan Year and file a new election in writing that corresponds with the special enrollment rights provided in Internal Revenue Code § 9801(f) (the Health Insurance Portability and Accountability Act of 1996), whether or not the change in election is permitted under Section 5.3(b) above.

d. In the case of a judgment, decree or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order) that requires accident or health coverage for your child or for a foster child who is your dependent, you may change your election (1) in order to provide coverage for the child under the group health insurance plan if the order so requires, or (2) in order to cancel coverage under the health insurance plan for your child if such order requires your Spouse or former Spouse or another individual to provide coverage for the child.

e. In the case of coverage under a group health plan, you may revoke an election in writing for the balance of the Plan Year and file a new election in writing in order to cancel or reduce such medical coverage for yourself and/or for one or more of your covered dependents to the extent that you become entitled to coverage under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under § 1928 of the Social Security Act (the program for distribution of pediatric vaccines). In addition, if you or any eligible dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, you may file a new election in writing for the balance of the Plan Year to commence or increase coverage under the group health plan.

f. The Plan Administrator may permit all Participants electing coverage under any of the benefits available to Employees under this Plan, except for elections relating to a health care expense reimbursement benefit, to revoke their elections for the balance of the Plan Year, provided that a similar coverage is elected for the balance of the Plan Year, if:

i. the Participant's share of the cost of such coverage significantly increases, or

ii. such coverage ceases or is significantly curtailed.

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

(i) In the event that your Spouse or dependent makes an election change under a plan maintained by his or her employer, the Plan Administrator may permit you to revoke

an election under the Plan and make a new election for the balance of the Plan Year that is on account of and corresponds with an election change made by your Spouse or dependent, if:

(ii) the election change made by your Spouse or dependent under his or her employer's plan satisfies the regulations and rulings under Internal Revenue Code § 125; or

(iii) the period of coverage under the plan maintained by the employer of your Spouse or dependent does not correspond with the Plan Year of this Plan.

i. Any revocation and new election under this Section 5.3 shall be effective at such time as the Plan Administrator shall prescribe, unless otherwise required by law.

5.4 **Consistency Rules**.

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

b. Notwithstanding anything to the contrary in Section 5.4(a), in the case of the Participant's change in marital status (as set forth in Section 5.3(b)(i)) or in the case of a change in the employment status (as set forth in Section 5.3(b)(iii)) of the Participant's Spouse or dependent, a Participant may either increase or decrease the amount of the Participant's group medical coverage or the amount elected under the health care or dependent care reimbursement plan.

5.5 **Automatic Termination of Election**. Any election made under this Plan (including an election made through inaction under Section 5.2) shall automatically terminate on the date on which you cease to be a Participant in the Plan, although coverage or benefits may continue if and to the extent provided by such plan.

5.6 **Amendments by the Plan Administrator**. If the Plan Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy for such year any nondiscrimination or other requirement imposed by the Internal Revenue Code or any limitation on benefits provided to “key employees”, the Plan Administrator shall take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification of elections by ‘highly compensated employees” (as defined by the Internal Revenue Code for purposes of the nondiscrimination requirement in question) or “key employees” without the consent of such employees.

5.9 **Coordination with the Family Medical Leave Act (FMLA)**. Notwithstanding any other provision of this Plan and any group health plan, to the extent the Employer is subject to FMLA, a Participant who is on approved FMLA leave has the following options unless the Employer continues the Participant’s regular compensation during the leave of absence:

a. Election revocation - reinstatement. A Participant taking FMLA leave may revoke an existing election under the Plan and elect reinstatement in the Plan under the same terms as the prior election upon returning to employment.

b. Continued coverage during FMLA leave. A Participant may elect to continue coverage under any benefit offered under this Plan during FMLA leave.

c. Premium payments. With respect to a Participant who continues Plan coverage during paid FMLA leave, the Participant's share of premiums must be paid by the method normally used during any paid leave. A Participant may pay his or her share of premiums with after-tax dollars to pay the portion of any premium due for continued coverage during unpaid FMLA leave:

The Employer must continue to pay the portion of the cost of the coverage the Employer was paying prior to the FMLA leave. However, the Employer need not continue the health coverage for a Participant who does not make the required premium payments.

ARTICLE 6 - CLAIM REVIEW AND APPEAL PROCEDURE

6.1 **Filing Claims**. Claims for benefits under one of the component plans above shall be administered in accordance with the claims procedure set forth in the plan document and/or summary plan description for each benefit. If you are denied a benefit under this Plan (such as the ability to pay for premiums on a pre-tax basis) due to an issue regarding your coverage under this Plan (i.e., such as a determination of (i) a change in status, (ii) a 'significant" change in premiums charged, or (iii) eligibility and participation matters under the Plan document), the claims procedure under this Plan will apply. You will be notified in writing by the Plan Administrator within 90 days of the date you submitted your claim if the claim is denied. Such notification will set out the reasons your claim was denied, and further advise you of what steps, if any, you might take to validate the claim. It will further advise you of your right to request an administrative review of the denial of the claim. You may request a review any time within the 60-day period after you have received notice that the claim was denied. You or your authorized representative will have the opportunity to review any important documents held by the Plan Administrator, and to submit comments and other supporting information. In most cases, a decision will be reached within 60 days of the date of your request for review.

ARTICLE 7 - PLAN ADMINISTRATION

7.1 **Administrator**. The Employer is hereby designated as the Plan Administrator to serve until resignation or removal by the Employer's governing body and appointment of a successor by a duly adopted resolution. The Plan Administrator may appoint third party administrators to act for it under the Plan to the extent specified in the appointment. The Plan Administrator shall have the authority to control and manage the operation and administration of the Plan, including the discretionary authority to make and enforce rules or regulations for the efficient administration of the Plan; to interpret the Plan; and to decide all questions concerning the Plan and eligibility of any person to participate in the Plan.

7.2 **Plan Amendment**. The Employer shall retain the right, by action of its governing body, in its sole and final discretion, to amend the Plan at any time and from time to time to any extent that such governing body may deem advisable or desirable, but in no event shall any amendment to the Plan result in discrimination in favor of a Participant who is a Highly Compensated Participant or Key Employee. A copy of the Resolution of the governing body making such amendment shall be delivered to the Employer. This Plan shall be amended in a manner and effective as of the date set forth in such resolution, and the Participants and beneficiaries and all others having any interest under the Plan shall be bound thereby as of that effective date. Notwithstanding

the foregoing, no amendment will affect the pre-tax benefits of the Participants and beneficiaries on a retroactive basis. Participants and beneficiaries shall be able to receive the benefits of the Plan unaffected until an amendment occurs.

7.3 **Plan Termination**. The Employer shall have the right by action of its governing body, in its sole and final discretion, to terminate the Plan at any time. Upon such termination benefits shall cease. A copy of the resolution shall be delivered to the Employer and the Plan. Participation of any related employers shall be terminated as of the date of termination specified in the resolution. The Plan will automatically terminate upon cessation of operations by the Employer and all benefits cease unless a successor employer adopts and continues the Plan.

ARTICLE 8 - WHEN YOUR BENEFITS END

Your benefits end when: (i) you are no longer an employee or no longer meet the eligibility requirements of the Plan; (ii) your employment with the Employer terminates or you retire, or (iii) the Plan is terminated, modified, amended or changed to end such coverage.

ARTICLE 9 - QUALIFIED MEDICAL CHILD SUPPORT ORDERS

9.1 The Plan Administrator will adhere to the terms of any qualified medical support order that satisfies the requirements of this Article and § 609 of the Employee Retirement Income Security Act of 1974 ("ERISA"). For purposes of this section, a qualified medical support order is a medical child support order which creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to receive benefits payable with respect to a Participant or beneficiary under a group health plan. A qualified medical child support order is any judgment, decree or order (including approval of a property settlement agreement) issued by a court of competent jurisdiction or through an administrative process established under state law which:

a. Relates to the provision of child support with respect to the child of a participant under a group health plan or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to such benefit under such group health plan; or

b. Enforces a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13623 of the Omnibus Budget Reconciliation Act of 1993) with respect to a group health plan, if such judgment, decree, or order (i) is issued by a court of competent jurisdiction or (ii) is issued through an administrative process established under state law and has the force and effect of law under applicable state law. For purposes of this section, an "alternate recipient" will mean any child of a participant who is recognized by a medical child support order as having a right to enrollment under a group health plan with respect to such participant.

9.2 Participants and beneficiaries may obtain, without charge, a copy of the Plan's qualified medical child support procedures from the Plan Administrator.

ARTICLE 10 - MILITARY SERVICE

10.1 Notwithstanding any provisions of the Plan to the contrary, the rights of employees who leave employment to serve in the military will be governed by the Uniformed Services Employment and Reemployment Rights Act.