VANDERBILT UNIVERSITY POSTDOCTORAL TRAINEE BENEFIT PROGRAM

SUMMARY PLAN DESCRIPTION

August 1, 2017

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INTRODUCTION

VANDERBILT UNIVERSITY POSTDOCTORAL TRAINEE BENEFIT PROGRAM (the "Company") established the VANDERBILT UNIVERSITY POSTDOCTORAL TRAINEE BENEFIT PROGRAM (the "Plan") effective August 1, 2017.

Although the purpose of this document is to summarize the more significant provisions of the Plan, the Plan document will prevail in the event of any inconsistency.

OTHER SUMMARY PLAN DESCRIPTIONS

This Plan incorporates the terms of all welfare benefit plans subject to ERISA sponsored by VANDERBILT UNIVERSITY POSTDOCTORAL TRAINEE BENEFIT PROGRAM or any affiliate who has adopted the Plan (contact your Plan Administrator if you are unsure which welfare benefits plans are subject to ERISA).

You should receive separate Summary Plan Descriptions from each of the welfare benefit plans described above. In the separate Summary Plan Descriptions you should find information about eligibility, benefits and employee/employer contributions for each of the separate welfare benefit plans. You are eligible to participate in this Plan if you are eligible to participate in one of the welfare benefit plans described above. In addition, in general, all benefits of this Plan are provided by the welfare benefit plans described above.

This Summary Plan Description incorporates the terms of the other Summary Plan Descriptions for each of the welfare benefit plans described above.

You can find a summary of the eligibility requirements and the employer/employee contributions for the welfare benefit plans mentioned above in the "WELFARE BENEFIT PLAN CHART ADDENDUM" at the end of the document.

CLAIMS

Refunds/Indemnification

You must immediately repay any excess payments/reimbursements. You must reimburse the Company for any liability the Company may incur for making such payments, including but not limited to, failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If you fail to timely repay an excess amount and/or make adequate indemnification, the Plan Administrator may: (i) to the extent permitted by applicable law, offset your salary or wages, and/or (ii) offset other benefits payable under this Plan.

Third Party Recovery

If you are paid benefits from another welfare benefit plan the Plan may be entitled to reimbursement. In particular, the plan may be entitled to reimbursement for benefits which are related to medical expenses that are also payable under Workers' Compensation, any statute, any

uninsured or underinsured motorist program, any no fault or school insurance program, any other insurance policy or any other plan of benefits, or when related medical expenses that arise through an act or omission of another person are paid by a third party, whether through legal action, settlement or for any other reason.

By participating in the Plan you and your covered dependents consent and agree that a constructive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party. In accordance, you and your covered dependents agree to cooperate with the Plan in reimbursing it for Plan costs and expenses. If you or your covered dependents have any reason to believe that the Plan may be entitled to recovery from any third party, you must notify the Plan. And, at that time, you (and your attorney, if applicable) must sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses arising from circumstances that entitle the Participant or covered dependent to any payment, amount or recovery from a third party.

You and your covered dependent consent and agree that you will not assign your rights to settlement or recovery against a third person or party to any other party, including your attorneys, without the Plan's consent. As such, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Plan.

Claim Procedures - In General

This section applies for any claim for benefits under a welfare benefit plan that is covered by ERISA unless the welfare benefit plan has a claims procedure that is compliant with ERISA section 503. If the welfare benefit plan has a claims procedure that is compliant with ERISA section 503, the claims procedure of the welfare benefit plan will apply. In general, this means that if the claims procedure of the welfare benefit plan has timeframes and procedures that are at least as favorable to you or more favorable than the deadlines provided below, the claims procedure of the welfare benefit plan will apply. In the case of a group health plan, any procedures for obtaining prior approval as a prerequisite for obtaining a benefit, such as preauthorization procedures or utilization review procedures are described in the relevant SPD for that plan and incorporated herein.

You or any other person entitled to benefits from the welfare benefit plan (a "Claimant") may apply for such benefits by completing and filing a claim with the applicable welfare benefit plan provider in accordance with the provider's claim filing guidelines. In general, claims must be filed in writing (except urgent care claims, which may be made orally) with the applicable welfare benefit plan provider. Any claim that does not relate to a specific benefit under the plan (for example, a general eligibility claim or a dispute involving a mid-year election change) must be filed with the welfare benefit plan's plan administrator. Any claim must include all information and evidence that the welfare benefit plan provider or plan administrator (the "Claim Reviewer") deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. If a claim is received, but there is not enough information to process the claim, you will be given an opportunity to provide the missing information.

A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" under these rules, unless it is determined that your inquiry is an attempt to file a claim.

If you want to bring a claim for benefits under the Plan, you may designate an authorized representative to act on your behalf so long as you provide written notice of such designation to the applicable provider identifying such authorized representative. In the case of a claim for medical benefits involving urgent care, a health care professional who has knowledge of your medical condition may act as your authorized representative with or without prior notice.

Timing of Notice of Claim

The Claim Reviewer will notify the Claimant of any benefit determination within a reasonable period of time but not later than the timeframe specified below depending on the type of claim.

Group Health Plan Claims

Group health plan claims may involve urgent care, concurrent care claims, pre-service care claims or post-service claims. Each has different time-frames that may apply and is described below.

Urgent Care. The Claim Reviewer will notify the Claimant of the benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the plan, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable. In the case of such a failure, the Claim Reviewer will notify the Claimant as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Claim Reviewer will notify the Claimant of the determination as soon as possible, but in no case later than 48 hours after the earlier of (A) the plan's receipt of the specified information, or (B) the end of the period afforded the Claimant to provide the specified additional information.

Concurrent care (a group health plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments). The welfare benefit plan will notify a Claimant of any reduction or termination of a course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. Any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care that will be decided as soon as possible, taking into account the medical exigencies, and the Claim Reviewer will notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of

the claim by the plan, provided that any such claim is made to the plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Pre-service claims. The Claim Reviewer will notify the Claimant of the plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the plan. This period may be extended one time by the plan for up to 15 days, provided that the Claim Reviewer both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the Claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Claim Reviewer expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Post-service claims. The Claim Reviewer will notify the Claimant, of an adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the plan for up to 15 days, provided that the Claim Reviewer both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Disability Claims

In the case of a claim for disability benefits, the Claim Reviewer will notify the Claimant, of the plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the plan. This period may be extended by the plan for up to 30 days, provided that the Claim Reviewer both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the Claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If, prior to the end of the first 30-day extension period, the administrator determines that, due to matters beyond the control of the plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Claim Reviewer notifies the Claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the plan expects to render a decision. The notice of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the Claimant will be afforded at least 45 days within which to provide the specified information.

Other Claims

The Claim Reviewer will notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim. This period may be extended one time by the Plan for up to 90 days, provided that the Claim Reviewer both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial review period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Content of Notice of Denied Claim

If a claim is wholly or partially denied, the Claim Reviewer will provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (4) an explanation of the steps that the Claimant must take if he wishes to appeal the denial including a statement that the Claimant may bring a civil action under ERISA.

In addition to the above information, if it is a group health plan or a plan providing disability benefits, the following information must be included with the notice described above:

(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or

(B) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

In addition, in the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims must be included with the notice described above and may be provided to the Claimant orally within the time frame described above, provided that a written or electronic notification is furnished to the Claimant not later than 3 days after the oral notification.

Appeal of Denied Claim

If a Claimant wishes to appeal the denial of a claim, he must file an appeal with the Claim Reviewer on or before the 180th day (or the 60th day in the case of a claim other than a group health plan benefit or a disability benefit) after he receives the Claim Reviewer's notice that the claim has been wholly or partially denied. The appeal will identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant will be provided, upon request and free of charge, documents and other information relevant to his claim. An appeal

may also include any comments, statements or documents that the Claimant may desire to provide. The Claim Reviewer will consider the merits of the Claimant's presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Claim Reviewer may deem relevant. The Claimant will lose the right to appeal if the appeal is not timely made.

In considering the appeal of a group health plan benefit or a disability benefit, the Claim Reviewer will:

(1) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(2) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(3) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(4) Provide that the health care professional engaged for purposes of a consultation under Subsection (2) will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

(5) In addition, in the case of a claim involving urgent care, provide for an expedited review process pursuant to which (A) a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the Claimant; and (B) all necessary information, including the plan's benefit determination on review, will be transmitted between the plan and the Claimant by telephone, facsimile, or other available similarly expeditious method.

Notice of Denied Appeal Review

If a claim is wholly or partially denied, the Claim Reviewer will provide the Claimant with a notice identifying all the information identified above, plus a discussion of the decision and available external claims processes and information regarding how to initiate an appeal.

Except as provided below for group health urgent care, pre-service and post-service claims, the Claim Reviewer will notify the Claimant of the Plan's benefit determination on

review within 60 days after receipt by the Plan of the Claimant's request for review of an adverse benefit determination (45 days in the case of a claim involving disability benefits). If the Claim Reviewer determines that an extension of time for processing is required, written notice of the extension will be furnished to the Claimant prior to the termination of the initial 60-day period (45 days in the case of a claim involving disability benefits). In no event will such extension exceed a period of 60 days from the end of the initial period (45 days in the case of a claim involving disability benefits). The extension notice will indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the determination on review.

Urgent care claims. In the case of a claim involving urgent care, the Claim Reviewer will notify the Claimant of the plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request for review of an adverse benefit determination by the plan.

Pre-service claims. In the case of a pre-service claim, the Claim Reviewer will notify the Claimant, of the plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Such notification will be provided not later than 30 days after receipt by the plan of the Claimant's request for review of an adverse benefit determination.

Post-service claims. The Claim Reviewer will notify the Claimant of the plan's benefit determination on review within a reasonable period of time. Such notification will be provided not later than 60 days after receipt by the plan of the Claimant's request for review of an adverse benefit determination.

CONTINUATION RIGHTS

Military Service

If you serve in the United States Armed Forces and must miss work as a result of such service, you may be eligible to continue to receive benefits with respect to any qualified military service.

COBRA

Under Federal law, you, your spouse, and your dependents may be entitled to COBRA continuation coverage in certain circumstances. Please see the "COBRA NOTICE" that is attached to the end of this Summary Plan Description for important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The COBRA NOTICE generally explains COBRA continuation coverage and when it may become available to you. The Plan Administrator will inform you of these rights, if any, when you terminate employment.

FMLA

If you go on unpaid leave that qualifies as family leave under the Family and Medical Leave Act you may be able to continue receiving benefits.

YOUR RIGHTS UNDER ERISA

As a participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). This federal law provides that you have the right to:

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

In addition, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining your benefits or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the

Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

MISCELLANEOUS

Qualified Medical Child Support Orders

In certain circumstances you may be able to enroll a child in the Plan if the Plan receives a Qualified Medical Child Support Order (QMCSO). You may obtain a copy of the QMCSO procedures from the Plan Administrator, free of charge.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. If you or your dependents become ineligible for Medicaid or a state child health program (CHIP) or become eligible for premium assistance under Medicaid or a state child health program (CHIP), you must request enrollment within 60 days. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for: All stages of reconstruction of the breast on which the mastectomy was performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; Prostheses; and Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your Plan Administrator at the number provided at the end of this Summary Plan Description.

Newborns' And Mothers' Health Protection

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Loss of Benefit

You may lose all or part of any payment due to you if we cannot locate you when your benefit becomes payable to you.

You may not alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which you may expect to receive, contingently or otherwise, under the Plan, except that you may designate a Beneficiary.

Amendment and Termination

The Company may amend, terminate or merge the Plan at any time.

Administrator Discretion

The Plan Administrator has the authority to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities in the Plan and to supply omissions to the Plan. Any construction, interpretation or application of the Plan by the Plan Administrator is final, conclusive and binding.

Taxation

The Company intends that all benefits provided under the Plan will not be taxable to you under federal tax law. However, the Company does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan. You should consult with your professional tax advisor to determine the tax consequences of your participation in this Plan.

Privacy

The Plan is required under federal law to take sufficient steps to protect any individually identifiable health information to the extent that such information must be kept confidential. The Plan Administrator will provide you with more information about the Plan's privacy practices.

ADMINISTRATIVE INFORMATION

1. The Plan Sponsor and Plan Administrator is VANDERBILT UNIVERSITY POSTDOCTORAL TRAINEE BENEFIT PROGRAM.

   Its address is 2301 Vanderbilt Place, Nashville, TN 37235.

   Its telephone number is 949-583-2925.

   Its Employer Identification Number is 62-0476822.

2. The Plan is a welfare benefit plan which has been designated by the sponsor as its plan number is 505.

3. The Plan's designated agent for service of legal process is the chief officer of the entity named in number 1. Any legal papers should be delivered to him or her at the address listed in number 1. However, service may also be made upon the Plan Administrator.

4. The Company's fiscal year ends on September 30th and the plan year ends on July 31st.

Addendum

Refund of Premium Contributions - For fully insured Component Benefit Programs, the plan will comply with (DOL) Department of Labor guidance regarding refunds (e.g., dividends, demutualization, experience adjustments, and/or medical loss ratio rebates (MLR)) of insurance premiums. To the extent that the Company receives rebates determined to be plan assets to the extent amounts are attributable to insurance premiums paid by Participants, the rebates will (a) be distributed within 90 days of receipt to the Participants covered by the policy to which the rebate relates under a reasonable, fair, and objective allocation method or (b) if distributing the rebates would not be cost-effective because the amounts are small or would give rise to tax consequences to the Participants, the rebates may be used to pay future Participant premiums or for benefit enhancements which benefit the Participants covered by the policy to which the rebate relates. Such determination will be made by the Plan Administrator, acting in its fiduciary capacity, after weighing the cost to the Plan and the competing interest of participants. Any rebates attributable to insurance premiums paid by the Company shall be retained by the Company.

COBRA NOTICE

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

Your hours of employment are reduced, or

Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

Your spouse dies;

Your spouse's hours of employment are reduced;

Your spouse's employment ends for any reason other than his or her gross misconduct;

Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

The parent-employee dies;

The parent-employee's hours of employment are reduced;

The parent-employee's employment ends for any reason other than his or her gross misconduct;

The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);

The parents become divorced or legally separated; or

The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

The end of employment or reduction of hours of employment; Death of the employee; The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Company at 2301 Vanderbilt Place, Nashville, TN 37235. The Company's telephone number is 949-583-2925.

How is COBRA Continuation Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Administrator
2301 Vanderbilt Place
Nashville, TN 37235
949-583-2925.

WELFARE BENEFIT PLAN CHART APPENDIX

Welfare Benefit Plan Name	**Eligibility and Employer/Employee Contributions**
PPO Medical	Eligibility: Immediately; Contributions: Employer and Employee contribute toward the plan
PPO Dental	Eligibility: Immediately; Contributions: Employer and Employee contribute toward the plan
HMO Dental	Eligibility: Immediately; Contributions: Employer and Employee contribute toward the plan
Life	Eligibility: Immediately; Contributions: Employer and Employee contribute toward the plan
LTD	Eligibility: Immediately; Contributions: Employer and Employee contribute toward the plan

V-3.00

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

VANDERBILT UNIVERSITY POSTDOCTORAL TRAINEE BENEFIT PROGRAM

QUALIFIED MEDICAL CHILD SUPPORT ORDER PROCEDURES

What is a Qualified Medical Child Support Order (QMCSO)?

A “QMCSO” is a medical child support order (from a court or administrative agency) that creates or recognizes the right of an “alternate recipient” to receive benefits for which a participant or beneficiary is eligible under a group health plan. It is recognized by the group health plan as “qualified” because it includes information and meets other requirements.

Who can be an “alternate recipient”?

Any child of a participant in a group health plan who is recognized under a medical child support order as having a right to enrollment under the plan with respect to such participant is an alternate recipient.

What information must a medical child support order contain to be a “qualified” order?

A medical child support order must contain the following information in order to be qualified:

* The name and last known mailing address of the participant and each alternate recipient, except that the order may substitute the name and mailing address of a State or local official for the mailing address of any alternate recipient;

* A reasonable description of the type of health coverage to be provided to each alternate recipient (or the manner in which such coverage is to be determined);

* The period to which the order applies; and

* An order may not require a plan to provide any type or form of benefit, or any option, not otherwise provided under the plan, except to the extent necessary to meet the requirements of certain State laws.

A "National Medical Support Notice" can also be a qualified medical support notice.

PROCEDURES

Upon receiving a medical child support order the Plan Administrator will:

1. Determine if the document is a National Medical Support Notice or a judgment order or decree from a court or administrative process.

2. Notify the participant, each alternate recipient and the issuing court or agency in the case of a National Medical Support Notice of the receipt of the order and provide a copy of these procedures.

3. Review the employment status of the affected employee/parent and review the Plan provisions to determine which, if any, group health plan benefits are available to the alternate recipient.

4. Determine if the document is a qualified medical support order.

5. Notify the participant and the alternate recipient whether the document is a qualified medical support order within a reasonable time after receipt of the order (not to exceed 40 days in the case of a National Medical Support Notice).

V-3.00