The Vanguard Group, Inc.
Benefit Plan
2018

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General Plan Information

This document serves as the Summary Plan Description (SPD) for The Vanguard Group, Inc. Benefit Plan (the "Plan") and, together with the Plan booklets (Plan booklets are available on CrewNet), serves as the Plan Document for the Plan. This SPD contains important information regarding the benefits provided by The Vanguard Group, Inc. to eligible crew members under the Plan.

This SPD reflects the Plan as amended and restated effective January 1, 2018. This SPD describes the basic features of these benefits and how they operate. As used in this SPD, "Vanguard" refers to The Vanguard Group, Inc., Vanguard Marketing Corporation, Vanguard Advisers, Inc., Vanguard Fiduciary Trust Company, and Vanguard National Trust Company, and "crew member" refers to their employees, respectively.

General Requirements for Eligibility

"Crew member" means any individual who: (a) performs services for Vanguard; (b) is treated as an employee for purposes of income and employment taxes by Vanguard; and (c) is on the U.S. payroll of Vanguard.

Generally, the Plan only covers and/or provides benefits to crew members, as defined above. Additional eligibility requirements (e.g. scheduled to work at least 30 hours a week or at least 37.5 hours per week or requirements to have a certain number of years of service) may apply for certain benefits under the Plan. Crew members who are classified as interns or as seasonal crew are not eligible for any benefits under the Plan and/or described in this SPD. Contingent workers are not crew members and are not eligible for any benefits under the Plan and/or described in this SPD. Contingent workers perform services for Vanguard: (i) as independent contractors, (ii) as workers performing services on behalf of a consulting firm or other service provider, (iii) pursuant to an arrangement with a third party outsourcing, leasing, or staffing organization, or (iv) as workers performing services to Vanguard on behalf of an independent organization with expertise in specific functions, including functions peripheral to the core business of Vanguard. If a person who is a contingent worker is subsequently determined to be a common law employee of Vanguard by a governmental agency, a court or by Vanguard, such person still will not be eligible for coverage under the Plan.

Organization of this SPD

This SPD document is separated into seven sections. Section I addresses benefits for which Vanguard pays the full cost. Section II describes health care and other benefits that you can elect and also that you contribute towards the cost of coverage under Section 125 of the Internal Revenue Code of 1986, as amended (the "Code"). Section III describes the Health Savings Account which is a separate tax favored funding vehicle that is not part of the Plan, but is part of the Code Section 125 arrangement. Section IV describes domestic partner coverage under the various benefits offered under the Plan. Section V describes other benefits offered by Vanguard, such as the wellness program, and Section VI describes the Severance Plan. The remaining Sections explain the Plan's claims and appeals process and other administrative details. Please see Section VIII about your rights to receive information about your Plan and benefits.

In cases where a particular benefit has an automatic and optional component, such as life insurance/AD&D and long-term disability, the benefit is described under Section II.

Applicable Tax Code Provisions, including Code Section 125

It is the intent of Vanguard that certain benefits provided under the Plan be excludable from taxable income of participating covered crew members under the applicable sections of the Code, including but not limited to sections 79, 105, 106 and 125. Moreover, the Plan is intended to qualify as a cafeteria plan under section 125 of the Code and this SPD is intended to satisfy the writing requirements of Department of Treasury Regulation section 1.125-1(c).

SPD describes ERISA and Non-ERISA governed benefits

Benefits subject to ERISA that are not Code section 125 benefits are described in this SPD for the purpose of satisfying the written instrument requirements of ERISA section 402 and shall not be considered part of the Code section 125 arrangement that is part of the Plan. Similarly, benefits that are Code section 125 benefits and are not subject to ERISA are described in this SPD solely for the purpose of satisfying the written instrument requirements of Code section 125, and shall not be considered subject to ERISA. Any benefits described in this SPD that are not subject to either Code section 125 or ERISA are included in this SPD solely as an administrative convenience to Vanguard, and shall not be considered as part of the Code section 125 cafeteria arrangement that is part of this Plan, or subject to ERISA.

Health Savings Account not part of Plan, but is part of Code Section 125

The Health Savings Account (the HSA) is a tax favored funding vehicle that is not subject to ERISA and is not part of the Plan, but is part of the Code section 125 cafeteria arrangement. The HSA is not sponsored or endorsed by Vanguard. The HSA is described in this SPD because it is part of the Code section 125 cafeteria arrangement.

Claims Procedures

Please be aware that if you have a claim or appeal for benefits under the Plan (other than Severance Plan), Section VII – Claims and Appeals Procedures for Plan Benefits, explains the requirements and timing deadlines applicable to all claims and appeals. Claims and appeals for benefits under the Severance Plan are covered in Section VI.

Please Note

Neither this SPD, nor any of the benefit programs described herein, is to be considered an employment contract or a limit on Vanguard's right to terminate the employment of any crew member.

This SPD describes the health and welfare benefit plans provided by Vanguard to eligible crew members and serves as the summary plan description required for benefits covered by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Every effort has been made to report correct information.

Some of the benefits described in this SPD have Plan booklets that are available on CrewNet. In the event of any differences between this SPD and the Plan booklets regarding the benefits covered or provided under the Plan (e.g. covered services, exclusions, pre-certification requirements, etc.), the Plan booklets will control. In contrast, this SPD will control the rules for crew member and dependent eligibility for coverage, as well as the enrollment and election rules, including Code Section 125 rules; provided, however, that in the event of any differences between this SPD and the Plan booklets for fully insured benefits, the Plan booklets, which are certificates of insurance coverage and/or insurance policies, must also govern rules for crew member and dependent eligibility for coverage. The fully insured benefits provided under the Plan are: (i) business travel accident insurance; (ii) life insurance, including accidental death and dismemberment, spousal life and dependent life insurance benefits; (iii) vision; and (iv) long-term disability. All other benefits

described in this SPD and provided under the Plan are self-insured and paid out of Vanguard's general assets.

Vanguard has the right to amend, modify or terminate any and all benefits provided under the Plan at any time. No consent of any participant or beneficiary is required for Vanguard to exercise its right to do so.

This SPD (along with the Plan booklets) is provided electronically to crew members through Vanguard's internal CrewNet site or through CrewNet External (https://crewnet.vanguard.com). You may request a paper copy of the SPD or any part thereof free of charge by calling Vanguard Crew Central™ at 844-VG1-CREW (844-841-2739) or extension 1CREW.

Whom To Call…

If you have questions about benefits or coverage under any of the programs described in this SPD, please call the following phone numbers and access the following websites. You can also find additional information on Vanguard's internal CrewNet site or through CrewNet External (https://crewnet.vanguard.com).

Benefit Program	Whom To Call	Website Address
Adoption and Surrogacy Assistance	Vanguard Crew Central 844-VG1-CREW (844-841-2739) or extension 1CREW	https://crewnet.vanguard.com
Best Doctors	Best Doctors 866-904-0910	www.bestdoctors.com
Business Travel Accident	Vanguard Crew Central 844-VG1-CREW (844-841-2739) or extension 1CREW	https://crewnet.vanguard.com
COBRA Administrator	WageWorks 888-251-6982	
Crew Assistance Program	Carebridge 800-437-0911	www.myliferesource.com access code R6C39
Dental	Delta Dental 800-471-1282	www.deltadentalins.com/vanguard
Education Assistance Programs (Academic Assistance Plan, Dependent Scholarship Program, Student Loan Repayment Assistance Program)	EdAssist 855-729-5960	www.tamsonline.org/vanguard (Academic Assistance Plan and Dependent Scholarship Program) www.tamsonline.org/vanguardloanrepay (Student Loan Repayment Program)
Flexible Spending Accounts (Health Care and Dependent Day Care)	Aetna 800-938-0512	www.payflex.com
Health Advocate	Health Advocate 855-424-9400	www.healthadvocate.com/vanguard
Health Savings Account	HealthEquity 866-346-5800	http://learn.healthequity.com/vanguard/has
Legal Services	Hyatt Legal Plans 800-821-6400	www.legalplans.com Click **Learn More: Info Site** under the Members section, and type "GetLaw" as the access code.
Life Insurance and AD&D	Minnesota Life 866-293-6047	www.lifebenefits.com
Long-Term Disability	Cigna 800-36-CIGNA(24462)	www.cigna.com
Medical	Aetna 800-938-0512	www.aetna.com

On-site health clinic	CrewCare 800-992-6911 or extension 1WELL	https://mypremisehealth.com/MyChart
Prescription Drug	CVS Caremark 866-559-6903	www.caremark.com
Purchased Paid Time Off	Vanguard Crew Central 844-VG1-CREW (844-841-2739) or extension 1CREW	https://crewnet.vanguard.com
RedBrick Health Corporation	RedBrick Health 844-724-3948	https://vanguard.redbrickhealth.com
Short-Term Disability	Sedgwick 800-495-2310	www.claimlookup.com/vanguard
Telemedicine	Teladoc 855-TELADOC(835-2362)	http://www.teladoc.com/Aetna
Vision	VSP 800-877-7195	http://vanguard.vspforme.com
Wellness	Vanguard Crew Central 844-VG1-CREW (844-841-2739) or extension 1CREW	https://crewnet.vanguard.com

Section I – Automatic Benefits

A. Short-Term Disability

Introduction

Vanguard provides Short-Term Disability (STD) income replacement benefits to eligible crew members who are unable to work because of a qualifying illness or injury. The Plan Administrator has delegated day-to-day benefits administration, including determination of eligibility for, the amount of, and duration of STD benefits, to Sedgwick CMS ("Sedgwick"), a third-party disability management company (also called the External TPA). See Section II.E for an explanation of Long-Term Disability (LTD) benefits.

While this benefit is not subject to ERISA, Vanguard has established a formal claims determination and appeal process and delegated its responsibilities for this claims determination and appeal process to the External TPA for STD benefits.

Eligibility

All active full-time crew member (scheduled to work at least 37.5 hours per week) or an active part-time crew member (scheduled to work at least 30 hours per week) immediately before becoming ill or being injured, as set forth in the Vanguard Short-Term Disability Policy (the "Policy") in Plan booklet A, are eligible to receive STD coverage. Crew members scheduled to work less than 30 hours per week are not eligible for coverage under this benefit under the Plan. For the definition of eligible crew member, please see General Plan Information at the front of this SPD.

Your eligibility for STD benefits begins on your first day of employment as an active full-time crew member (scheduled to work at least 37.5 hours per week) or an active part-time crew member (scheduled to work at least 30 hours per week).

Cost of Coverage

Vanguard pays the full cost of your STD coverage under the Plan.

Benefit Amount

Eligible crew members may qualify for STD benefits when the same or a related illness or injury prevents the crew member from being at work for more than the Elimination Period, as defined in the *Definitions* section of the Policy in Plan booklet A. The maximum payable STD period per approved qualifying illness or injury is 180 calendar days. After 180 calendar days, crew members may be eligible for LTD benefits. Please refer to the LTD benefits section in the SPD (Section II.E) for details.

Two consecutive periods of disability due to the same or related cause or condition and separated by a period of not more than 30 days will be considered as one disability benefit period. Periods of disability for different conditions separated by at least one day of full-time active work shall be considered a different disability benefit period (claim), subject to a new Elimination Period.

STD benefits are based on employment status (i.e. full-time or part-time); "Salary", "Level", and "Years of Service" are based on the date you become disabled for each approved "Period of Disability". These terms are defined in the *Definitions* section of the Policy in Plan booklet A. STD benefits, if approved by the External TPA, may be paid for a total duration of up to 180 days for each disability, according to the schedule below. The External TPA determines the amount of STD benefits as well as the period of paid STD benefits.

Grade Level	**Years of Service**	**Weeks at Full Salary***	**Weeks at 66⅔% Salary***
•Individual Contributor 1–5 •Specialist 1 •Manager 1 •Sales Professional 1 •Sales Manager 1	Less than 10 years	0-13 weeks	14-26 weeks
	More than or equal to 10 years	26 weeks	0 weeks
•Specialist 2 and above •Manager 2 and above •Sales Professional 2 and above •Sales Manager 2 and above	Any years of service	26 weeks	0 weeks

*up to the actual approved disability duration

Exclusions

STD income benefits will not be paid for the following:

- Disability that begins after Vanguard or the crew member gives notice of the crew member's termination of employment for any reason;
- Disability that begins during a temporary layoff due to lack of work;
- Disability caused by working conditions or an accident at the workplace (Worker's Compensation benefits may be available for such a disability);
- Day of disability after the crew member's retirement from Vanguard under the terms of Vanguard's retiree program;
- Day of absence from work due to disability during which the crew member performed any work for remuneration or profit;
- Disability caused by elective cosmetic surgery to improve appearance, except for cosmetic surgery required due to an illness or injury;
- Day of absence during which the crew member is not in compliance with this policy (e.g. crew member is not under the care of a licensed physician as defined by applicable state law and this policy);
- Day of disability that occurred before the crew member notified his/her next level of management of the disability unless Vanguard determines the delay was due to a reasonable cause; and
- Day of disability resulting from illness or injury sustained during, or as a result of, committing a crime.

Termination of Benefits

Approved STD benefits will continue until the earliest of the following:

- The date on which the crew member is no longer disabled (as determined by the External TPA);
- The date the crew member reaches the maximum benefit period payable under the STD Policy;
- The date on which the crew member fails to provide required proof of disability;
- The date on which the crew member fails to comply with any of the requirements under the Policy, including a refusal to allow an independent medical examination;
- The date that the crew member dies; or
- The date on which the crew member begins a leave of absence other than a disability absence.
- The date on which the crew member's employment terminates.

Termination of Coverage

A crew member's coverage terminates under this program at the earliest of the following:

- The date on which the crew member's employment terminates;
- The premium due date if Vanguard fails to pay the required premium to the insurer other than on account of an inadvertent error
- The date the crew member is no longer eligible for STD benefits; or
- The date this program terminates.

For More Information

Plan booklet A is the Vanguard Short-Term Disability Policy and is available on CrewNet. This SPD together with Plan booklet A serve as the full Plan Document for Short Term Disability benefits. If you have any questions, please call Crew Central at 844-VG1-CREW (844-841-2739) or extension 1CREW.

B. Business Travel Accident Insurance

Introduction

This Business Travel Accident Insurance benefit program pays a benefit if you die or become dismembered as a result of an accident while traveling on company business. This benefit is subject to ERISA.

Eligibility

All active full-time crew member (scheduled to work at least 37.5 hours per week) or an active part-time crew member (scheduled to work at least 30 hours per week) at the time a business travel accident occurs, are eligible for Business Travel Accident coverage. Crew members scheduled to work less than 30 hours per week are not eligible for coverage under this benefit under the Plan. For the definition of eligible crew member, please see General Plan Information at the front of this SPD.

Cost of Coverage

Vanguard pays the full cost of your Business Travel Accident Insurance benefits.

Benefit Amount

You are eligible for a benefit up to five (5) times your Direct Pay.

Your 2018 Direct Pay is your annual base salary as of September 30, 2017, plus your 2016 Partnership Plan distribution paid in June 2017, plus any performance bonuses paid between May 1, 2016 and April 30, 2017 (if applicable).

Regardless of your pay, you will not get less than $100,000 of benefit or more than the maximum benefit amount of $500,000 subject to the limits below. Benefits will be paid to you (or your beneficiary for loss of life) if you suffer any of the losses described below:

For Loss of…*	**Benefit is…**
Life	5 times your Direct Pay
Both hands or both Feet	5 times your Direct Pay
Sight of both eyes	5 times your Direct Pay
One hand and one foot	5 times your Direct Pay
One hand and the sight of one eye	5 times your Direct Pay
One foot and the sight of one eye	5 times your Direct Pay
Speech and hearing in both ears	5 times your Direct Pay
One hand or one foot	2.5 times your Direct Pay
Sight of one eye	2.5 times your Direct Pay
Speech or hearing in both ears	2.5 times your Direct pay
Thumb and index finger of same hand	1.25 times your Direct Pay

* Loss of hand or foot means complete severance through or above the wrist or ankle joint. Loss of sight of an eye means total loss of the entire sight in that eye that cannot be recovered. Loss of hearing in ear means total loss of the entire ability to hear in that ear that cannot be recovered. Loss of speech means total loss of the entire ability to speak that cannot be recovered. Loss of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits.

Exclusions

This benefit program does not cover loss caused by or resulting from any one or more of the following:

- Intentionally self-inflicted injuries - suicide or any attempt - while sane or insane or through auto-eroticism;
- Declared or undeclared war or any act thereof;
- Stroke or cerebrovascular accident or event, cardiovascular accident or event, myocardial infarction or health attack, coronary thrombosis, or aneurysm;
- Medical or surgical treatment of sickness, disease, mental incapacity or bodily infirmity whether the loss results directly or indirectly from the treatment;
- Sickness, disease, mental incapacity or bodily infirmity whether the loss results directly or indirectly from any of these;
- Infections of any kind, regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an other than bacterial infection occurring as a consequence of an accidental cut or wound and in the absence of any underlying sickness, disease or condition including but limited to diabetes;
- Riding as a pilot or crew member in any vehicle or device for aerial navigation;
- Riding in any aircraft owned, operated or leased by or on behalf of Vanguard;
- While under the influence of drugs or intoxicants while operating any vehicle or conveyance;
- While under the influence of any narcotic, unless taken under advice of and as specified by a physician; and
- Your commission of or attempt to commit a felony.

Termination of Coverage

A crew member's coverage will terminate on the earliest of:

- The date this program terminates,
- The premium due date if Vanguard fails to pay the required premium to the insurer other than on account of an inadvertent error,
- The date the crew member is no longer eligible for the benefit; or
- The date on which the crew member's employment terminates.

For More Information

Please call Crew Central at 844-VG1-CREW (844-841-2739) or extension 1CREW to answer any questions about your Business Travel Accident coverage.

Section II – Elective Benefits

A. Introduction

The Plan allows you to create a personal benefits portfolio from a menu of health care, certain other tax favored benefits (such as crew member life insurance), after-tax benefits, and taxable cash, each as permitted to be offered under a Code Section 125 plan that fits the needs of you and your family. You can choose benefit coverage from the following benefit programs:

Health Benefits
- Medical including Prescription Drug
- Dental
- Vision

Life Insurance and Accidental Death & Dismemberment (AD&D)
- Crew Member Life and AD&D
- Spousal Life (elective, but not part of the Code Section 125 plan)
- Dependent Life (elective, but not part of the Code Section 125 plan)

Flexible Spending Accounts
- Health Care Flexible Spending Account
- Dependent Day Care Flexible Spending Account

Long-Term Disability (LTD)

Legal Services

Purchased Paid Time Off

Eligibility

All active full-time crew member (scheduled to work at least 37.5 hours per week) or a part-time crew member (scheduled to work at least 30 hours per week), are eligible to participate in the elective benefits described in this Section II of the SPD as of the first day of active employment. Crew members scheduled to work less than 30 hours per week are not eligible to participate in the Plan and thus are not eligible to elect benefits under this Section II of the SPD. For the definition of eligible crew member, please see General Plan Information at the front of this SPD.

New Hire Enrollment

You may elect your benefits using the online HR system (Workday) or any other procedure approved by the Plan Administrator. If you fail to make an affirmative election for the benefits described in this Section II within 30 days of your hire date, default elections will be made on your behalf and you will automatically receive:

- Crew member only (single) medical coverage, including prescription drug coverage (Aetna HealthFund $1250 Deductible Option).
- Life and AD&D coverage each equal to 2 times your Direct Pay (please see definition of Direct Pay under Section I.B. for Business Travel Accident Insurance).
- LTD coverage with premium deductions to be made on a pre-tax basis.

All other elective benefits described in this Section II of the SPD will be automatically waived and your coverage will be irrevocable for the year (unless you incur a permitted election change, explained below).

Your enrollment form will list your biweekly contribution for each benefit option and coverage level. The enrollment form will indicate if your biweekly contribution will be deducted from your paycheck on a pre-tax or after-tax basis.

Annual Open Enrollment

Each year, you will have the opportunity to choose your elective benefits for the following calendar year. You will be able to elect your benefits using the online HR system (Workday) or any other procedure approved by the Plan Administrator. With four exceptions (listed below), your benefit elections for the current calendar year and dependent coverage elections are "evergreen." So if you fail to make an affirmative election during annual open enrollment, your current benefit elections and dependent coverage elections will automatically carryover into the following calendar year (also a Plan Year).

Flexible Spending Account elections are NOT evergreen elections. You will need to make a new election each year to participate in the Health Care Flexible Spending Account and the Dependent Day Care Flexible Spending Account. In addition, purchased PTO and legal services elections are also not evergreen elections.

Health Savings Account (HSA) elections (see Section III for more information) also are not evergreen elections and you will need to make a new election each year to make your own payroll contributions to the HSA.

Your enrollment form will list your biweekly contribution for each benefit option and coverage level. The enrollment form will also indicate if your biweekly contribution will be deducted from your paycheck on a pre-tax or after-tax basis.

Your coverage is irrevocable (unless you incur a permitted election change, as explained below).

Note: You, your spouse, your domestic partner, and your eligible dependents will not be entitled to coverage under any of the benefits in this Section II unless you have made a valid election (which includes the default/evergreen elections noted above) and have made any required crew member payroll contributions, except as may otherwise be permitted by applicable law, and Plan terms as determined by the Plan Administrator.

You may not choose different options within the same benefit for your dependents. For example, if the crew member is enrolling an eligible dependent (spouse, domestic partner or child) for coverage under a medical option (e.g. the HDHP) including prescription coverage, the eligible dependent must be enrolled in the same option (HDHP) as the crew member.

Vanguard paid credits: You receive Vanguard paid credits, which are applied towards the cost of the Basic Life and Long-Term Disability coverage.

Enrollment Changes

You may change your health care and other Code Section 125 covered benefit elections during the annual open enrollment period.

During the year, you cannot stop, start, increase, or decrease your level of your elected health care and other Code Section 125 covered benefits unless you have a permitted election change event, as described below. If you experience a permitted election change event, you may be allowed to change your benefit election for the balance of the Plan Year after the change, provided your election change is on account of and consistent with the change in status that affects eligibility, and is permitted under Code Section 125 and under the terms of the Plan.

The following life events are among those that may be treated as a permitted election change event ("Event"):

- A change in status which includes:
    1. A change in your legal marital status;
    2. A change in the number of your eligible dependents;
    3. Termination or commencement of employment, by you, your spouse, or your eligible dependent;
    4. A change in work hours or employment status for you, your spouse or your eligible dependent (such as commencement of or return from unpaid leave) that results in a change in eligibility for you, your spouse or your eligible dependent for benefits under this Plan or another plan;
    5. Your dependent satisfies or ceases to satisfy the eligibility requirement for a particular benefit; and
    6. A change in place of residence or work for you, your spouse or your eligible dependent that affects benefits coverage;
- You, your spouse or your eligible dependent become entitled to a special enrollment right under a group health plan;
- A change in coverage attributable to your spouse's or your eligible dependent's employment;
- A significant increase or decrease in the cost of coverage of a Vanguard plan;
- A significant increase in the cost of your spouse's or eligible dependent's plan;
- You, your spouse or eligible dependent becomes enrolled under Medicare or Medicaid;
- You, your spouse or eligible dependent cease to satisfy the eligibility requirements under Medicaid or a state Children's Health Insurance Program (CHIP);
- You, your spouse or eligible dependent become eligible for a premium assistance plan under Medicaid or CHIP;
- A qualified judgment, decree or order requires health coverage for a dependent child; and
- A change in your Health Savings Account (HSA) contribution amount.

(Please refer to Section II.B for Special Enrollment Rights and Section IV for eligible domestic partner status changes.)

Any change to the benefit elections must be on account of and consistent with the underlying Event. For example, if you are married and covering your spouse under the Plan and your spouse obtained a new job with his/her own coverage, it would be a consistent benefit election change to drop coverage under the Plan and be covered under your spouse's plan. In that event, you will be asked to certify that you will be added to your spouse's plan.

If you want to change your benefit elections during the year because you experience an Event, you must submit the benefits change via the online HR system (Workday) within 30 days of such Event. There are two exceptions related to this general rule: If you or your eligible dependents lose coverage under Medicaid or CHIP, you have 60 days after the termination of coverage to change your benefit elections; if you or your eligible dependent becomes eligible for

Medicaid or CHIP, you have 60 days after eligibility is determined to make a change to your benefit elections.

In most cases, the effective date of your permitted election change will be the date of the Event. However, if your dependent no longer meets the eligibility requirements, as described in Section II.B, the effective date of your permitted election change will be the date of the Event or the date Crew Central is notified, whichever is later: provided that you notify Crew Central within 30 days (or if applicable, 60 days) of such Event. If you do not notify Crew Central on a timely basis; you must wait until the next annual open enrollment period to change your elections.

Once your dependent child(ren) reaches age 26 and no longer meets the eligibility requirements of the Plan, their coverage will end at midnight on the last day of the month in which they turn 26.

During your benefits change, you will have an opportunity to review and print your benefit elections. **It is extremely important that you make sure your elected coverages and costs are accurate. To access your complete elections and your total cost and credits, view your Benefit Elections from the Benefits tab within Workday (please see CrewNet for the job aid to view your Benefit Elections). If you find any errors, contact Crew Central immediately. If you fail to report any errors within 14 business days following an Event or before the end of the plan year following the annual open enrollment period (e.g. December 31, 2017 for 2018 benefits coverage), you will be unable to make any changes to your health care and other Code Section 125 covered benefit choices until the next open enrollment period or unless you have another Event as described above.**

You must provide acceptable proof of your Event and documents that supports the change you are requesting to make to your benefit elections within 30 days of the date you submit the benefit election change via the online HR System (Workday). Otherwise, you will have to wait until the next annual open enrollment period to make any benefit election changes.

The Plan Administrator will determine whether a requested change is on account of and consistent with a permitted election change and thus permitted under the terms of the Plan. The ability to make an election change may vary by benefit. For example, special limits apply with respect to benefits under Legal Services and to Purchased Paid Time Off, as described in Sections II.F and II.G.

Generally, any contribution change related to your new benefits election will be deducted from the first paycheck following the payroll period in which the change is effective. In other words, new hires will not see any deductions for their benefits elections until the first full pay after the date of hire, and crew with a permitted election change will not see any deductions for their change in benefits election (if applicable) until the first full pay after the event date. Furthermore, deductions are not prorated by day, but assessed per pay period. Any status changes elected after December 15 in a particular calendar year may not be funded in that same year depending upon Vanguard's payroll processing schedule. You should consider this if you are participating in a Flexible Spending Account.

If you have a question concerning the permitted election change rules, please call Crew Central at 844-VG1-CREW (844-841-2739) or extension 1CREW.

B. Health Benefits

Introduction

The Plan offers comprehensive health benefits including medical, prescription drug, dental, and vision benefits (collectively referred to as "Health Benefits"). These Health Benefits are subject to ERISA.

Eligibility

If you meet the eligibility requirements set forth in Section II.A, you are eligible to elect these benefits as of your first day of employment.

Your Dependents

You may enroll your eligible dependents for Health Benefits at the same time you enroll yourself. Your eligible dependents include the following:

- Your legally married spouse.
- Your eligible domestic partner. As used here and throughout this SPD, the words "domestic partner" means any individual who meets the eligibility requirements as defined by the Plan in Section IV of this SPD.
- Any child(ren) under age 26:
  - Natural children, legally adopted children (including a child who you are legally obligated to support in anticipation of adopting such child, even if the adoption is not yet final), foster children, and stepchildren.
  - Any child for whom you are required to provide medical coverage under a Qualified Medical Child Support Order (QMCSO). A QMCSO is any judgment, decree, or order (including a settlement agreement or administrative notice), issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process under state law that has the force and effect of law in that state, which creates or recognizes the existence of the right of a child to, or assigns to such child the right to, receive benefits for which a participant is eligible under the plan, and which the Plan Administrator determines meets the requirements of ERISA. The effective date of coverage for the child shall be the date specified in the QMCSO, or if none, the date of the QMCSO. (You or your beneficiary may request a copy of Vanguard's QMCSO Procedures from the Plan Administrator without charge.)
- Any child(ren) age 26 and older who remains continuously mentally or physically disabled and primarily dependent upon you for support. A dependent child who meets the above eligibility requirements will continue to be eligible until the day he or she reaches the limiting age, unless he or she is disabled as described above. Application for continued coverage for a disabled child must be made within 31 days of the child's 26th birthday. Proof may be required to support the continuation of the disability. Coverage will stop at the earlier of: the end of the child's disability, failure to give proof that the disability continues, failure to have any required examination, or the end of the child's status as your dependent.

Note: No person may be covered as a dependent of more than one crew member.

Cost of Coverage

Your crew member contributions toward the cost of Health Benefits will be deducted from your paycheck before Federal, Medical and Social Security taxes, and in some cases state taxes, are taken out. This is referred to throughout this section as "pre-tax" money. The amount of these contributions will be provided in the annual enrollment materials and is subject to change. In

addition to your share of premiums, you may also be required to pay a co-pay, deductible or co-insurance at the time services are provided. The amount of the co-pays, deductibles or co-insurance for each benefit will be provided in the annual enrollment materials as well as in the Plan booklets and is subject to change.

(Please see Section IV for domestic partner levels of coverage.)

Coverage Category Options

You may elect one of the following coverage categories:

Crew member only
Crew member and spouse/domestic partner (DP)
Crew member and spouse/DP and one child
Crew member and spouse/DP and two children
Crew member and spouse/DP and three children
Crew member and spouse/DP and four or more children
Crew member and one child
Crew member and two children
Crew member and three children
Crew member and four or more children
Waive coverage

Provider Networks

The Health Benefits are administered by third-party administrators who have contracted with health care providers and pharmacies to provide treatment at negotiated rates and/or discounts. Coverage for services provided by network providers may differ from those provided by non-network providers. Please refer to the provider directories for each benefit for that third party administrator's list of network providers. Directories are located on each third party administrator' website:

Dental	www.deltadentalins.com/vanguard
Medical	www.aetna.com
Prescription Drug (included with your medical coverage)	www.caremark.com
Vision	http://vanguard.vspforme.com

If you would like a hard copy of the provider directory, please contact the third party administrator for the specific benefit. While the provider directories are believed to be accurate as of the print date, they are subject to change without notice. Participating providers are independent contractors in private practice and are not employees or agents of the third party administrators or of their affiliates.

The availability of any particular provider cannot be guaranteed for referred or in-network benefits, and provider network composition is subject to change without notice. In addition, not every provider listed in the directories may be accepting new patients. Although the third-party administrators may have identified providers who were not accepting patients as known at the time the directory was created, the status of a provider's practice may have changed. For the most current information, you should call the third party administrator's number on the back of your ID card for that benefit.

Special Enrollment Rights

You may enroll yourself and your dependents in the Plan during the first 30 days after you become eligible, or during the annual open enrollment period. If you do not enroll during either of these enrollment periods, and if you have declined enrollment for yourself or your dependents (including your spouse) because of other medical insurance coverage, you may subsequently be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. However, if you have declined enrollment for yourself or your dependents (including your spouse) because of medical coverage under Medicaid or CHIP, you have 60 days after the termination of that coverage to request enrollment for yourself or your dependents.

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.

In addition, if you or your dependent becomes eligible for Medicaid or CHIP, you have 60 days after eligibility is determined to notify Crew Central if you want to make a change to your benefit elections.

Once you have requested a change to your benefit elections, you must provide acceptable proof of your change in status and submit the benefit election changes within 30 days of the event. Otherwise, you will have to wait until the next annual open enrollment period to make any changes.

If you experience an event that triggers special enrollment rights (dependent loses coverage under other plan, marriage, birth, adoption or placement for adoption) you may change both the level of your coverage (for example, from crew member only to crew member plus spouse) and the benefit option (for example, from the high deductible health plan to the Aetna HealthFund). Such changes must generally be requested within 30 days after the occurrence of the triggering event.

In the event of a special enrollment right due to marriage, birth, adoption, or placement for adoption, coverage is retroactive to the date of the event, provided that you request enrollment of your dependent within 30 days of the event. The paycheck following the payroll period in which Vanguard is notified and documentation is received will reflect the change in the cost of your benefits.

(Please refer to Section II.A for Enrollment Changes and Section IV for Special Enrollment Rights regarding domestic partners)

Termination of Coverage

Termination of your medical and prescription, dental, and/or vision coverage (and that of a spouse, domestic partner, or dependent) for a particular health benefit under the Plan occurs at the earliest of the following:

- The date on which the crew member's employment terminates;
- The Plan or the offered benefit terminates;
- The date the crew member is no longer eligible for the benefit; or
- The date the crew member fails to make any required contribution at the end of the period for which a contribution was required.

However, those covered may be eligible for COBRA coverage as described in Section II.B.6.

1. Medical and Prescription Drug Benefits

Eligibility

Vanguard offers medical benefits to all crew members who meet the eligibility requirements in Section II.A and their dependents who meet the eligibility requirements in Section II.B and Section IV. Medical benefits include telemedicine and prescription drug benefits.

Medical Coverage

The medical benefits are self-insured benefits that are administered by Aetna. This means that Vanguard's costs for these benefits include the amount of actual claims paid plus administrative and network access fees paid to Aetna. The Plan booklets for each medical benefit option are located on CrewNet. These Plan booklets, describe the benefit provisions, including all benefits, limitations, exclusions, and cost-sharing provisions for the Plan's medical benefits. Aetna uses these Plan booklets to make determinations on claims for benefits under the Plan. In the event of any differences between this SPD and the Plan booklets regarding the medical benefits covered under the Plan (e.g. covered services, exclusions, pre-certification requirements, etc.), the Plan booklets will control. In contrast, this SPD will control the rules for crew member and dependent eligibility for coverage, as well as the enrollment and election rules, including the Code Section 125 rules.

Crew members may choose from the following medical benefit options:

Aetna HealthFund

1. $950/ $1900 deductible option
2. $1250/ $2500 deductible option

The Aetna HealthFund allows you to choose providers from the Aetna network without requiring you to designate a primary care physician or to obtain a referral. If you go to an out-of-network provider, those expenses are covered at a lower percentage, based on "reasonable and customary" (R&C) fees. This consumer-directed health option is designed to give you more control over how you use your medical coverage. Preventive care is covered 100%. For nonpreventive care, there is a deductible obligation in addition to coinsurance obligations, but these costs may be offset by your Health Reimbursement Arrangement (HRA) funded by Vanguard. Aetna refers to your HRA as the Aetna HealthFund. The offset amount will vary depending on the amount you have accumulated in your HRA. Unused amounts in your HRA will be carried over into the next calendar year, assuming you elect one of the two Aetna HealthFund options for the following year.

Any unused balance may be converted into a retiree health fund for eligible retirees, upon request. If you leave Vanguard and you do not elect COBRA, your HRA balance will be forfeited.

Please see Plan booklets B and D for details on the Aetna HealthFund $950/$1900. This SPD together with Plan booklets B and D serve as the full Plan Document for the Aetna HealthFund $950/$1900. Please see Plan booklets C and D for details on the Aetna HealthFund $1250/$2500. This SPD together with Plan booklets C and D serve as the full Plan Document for the Aetna HealthFund $1250/$2500. The Plan booklets are available on CrewNet. If you have any questions, call Crew Central at 844-VG1-CREW (844-841-2739) or extension 1CREW.

High Deductible Health Plan (HDHP)

The HDHP covers preventive care at 100% like the Aetna HealthFund but has a higher deductible and greater coinsurance obligation for nonpreventive care than the Aetna HealthFund. However,

unlike the Aetna HealthFund, the costs of your nonpreventive prescriptions will be applied toward your deductible and out of pocket limit in the HDHP. This medical benefit option allows you to choose providers from the Aetna network without requiring you to designate a primary care physician or to obtain a referral. If you go to an out-of-network provider, those expenses are covered at a lower percentage, based on R&C fees. This consumer-directed health option increases your control over how you use your medical coverage and includes a health savings account (HSA) to help offset the deductible and has unique tax advantages. If you are eligible to make or receive contributions to a HSA, HealthEquity will establish an HSA for you. Vanguard will make a onetime annual contribution to your HSA at HealthEquity on your behalf and you may elect to contribute to your HSA through payroll deductions. You are not taxed on contributions to your HSA, account earnings, or on distributions from the HSA as long as the distributions are used for qualified health care expenses. In addition, you may contribute to your HSA by submitting a contribution directly to HealthEquity. Unused balances will be carried over from year to year and are yours even if you leave Vanguard.

Please see Plan booklets E and F for details on the HDHP. This SPD together with the Plan booklets available on CrewNet serve as the full Plan Document for the High Deductible Health Plan. Please see Section III in this SPD for details on the HSA. The HSA is not subject to ERISA and is not sponsored by Vanguard. If you have any questions, call Crew Central at 844-VG1-CREW (844-841-2739) or extension 1CREW.

Telemedicine

Those who are enrolled in a Vanguard medical plan have access to Teladoc. With Teladoc, you have access to U.S. board-certified doctors and pediatricians over the phone or via online video 24 hours a day, 7 days a week. Teladoc physicians can diagnose and recommend treatment for a number of non-emergency medical issues, such as colds and flu, sore throat, allergies, and ear infections.

Prescription Drug Coverage

Each of the three medical benefit options described above provide prescription drug benefits through CVS Caremark to crew members who meet the eligibility requirements in Section II.A and their dependents who meet the eligibility requirements in Sections II.B and IV.

Your prescription drug coverage will vary based on the medical option that you choose, as the prescription coverages are different for the Aetna HealthFund and HDHP. However, regardless of which medical option you choose, Vanguard will pay 100% of the cost of select generic preventive medications that help improve certain chronic conditions. Under the prescription benefit, if you are enrolled in the Aetna HealthFund, you will be responsible for a copay when purchasing generic drugs. When purchasing brand-name drugs you will be responsible to pay a percentage of the cost of the medicine, referred to as coinsurance. There is a separate out of pocket maximum from your medical option for prescription costs. Once you meet the prescription maximum, copays or coinsurance will not be required for the remainder of the plan year.

Under the HDHP, the coverage will be based on whether a drug is considered to be supporting preventive care or not. Additionally, under the HDHP, nonpreventive prescription drug cost will count toward the medical deductible and out-of-pocket totals. There is not a separate out of pocket maximum for prescription costs.

You should use the retail pharmacy for your immediate drug needs and for short-term medications (i.e., 30-day supplies). CVS Caremark will allow three 30-day refills of long-term maintenance medications at a retail pharmacy. After you have met the three refills, you are required to use either of the following options—both of which have the same co-pay.

- Use the mail service program to have a 90-day supply of medication delivered to your home.
- Have the 90-day prescription filled at a CVS/pharmacy.

For More Information

Please see Plan booklet G for details on the prescription drug coverage. Plan booklet G can be found on CrewNet. This SPD together with Plan booklet G serve as the full Plan Document for Prescription Drug coverage. If you have any questions, call Crew Central at 844-VG1-CREW (844-841-2739) or extension 1CREW.

NOTE: If you decide to waive medical coverage, you will also waive prescription drug coverage.

2. Dental Benefits

Eligibility

Vanguard offers dental benefits to all crew members who meet the eligibility requirements in Section II.A and their dependents who meet the eligibility requirements in Section II.B or Section IV, regardless of whether they elect or waive medical including prescription coverage. Dental coverage is not automatic; you must elect it.

Dental Coverage

There are two dental benefit options provided through Delta Dental – Standard and Enhanced. The options differ in the dental services that are covered as well as the percentage of established charges that are paid.

The following table highlights the options and what they each cover:

	Standard	**Enhanced**
Annual deductibles (individual/family)	$25/$50	$25/$50
Preventive (exams, cleanings, x-rays, sealants, periodontal maintenance)	100% (no deductible)	100% (no deductible)
Basic Restorative (fillings, posterior composites, emergency palliative treatment)	50%	80%
Endodontics, periodontics, and oral surgery (root canals and gum treatment	50%	80%
Other restorative (recementation of inlay, crown, or bridge)	50%	50%
Major restorative (crowns, inlay, onlays; bridges, dentures and implants)	None	50%
Orthodontia	None	50% (lifetime limit of $3,000 per individual)
Annual limit (Annual limit can increase. Refer to Preventive Incentive below.)	$500 per individual	$2,000 per individual (excluding orthodontia)

Delta Dental's Network

The dental benefit is administered by Delta Dental with three tiers of dentists from which to choose:

- PPO participating dentist: Choose a PPO dentist for the greatest savings. PPO dentists have agreed to accept a discounted fee and cannot charge more for the service than Delta Dental has negotiated to pay.
- Premier participating dentist: Choose a Premier dentist for some savings. Premier dentist have agreed to accept a discounted fee – although not as large of a discount as PPO dentists – and cannot charge more for the service than Delta Dental has negotiated to pay.

- Out-of-network or non-participating dentist: You may also visit a provider that is not in Delta Dental's network, but your costs will be the highest with this option. The reimbursement amount for non-participating dentists is calculated using Delta Dental's Premier network amount, and then limited to the applicable percentage outlined in the summary chart above.
  Out-of-network or non-participating dentists may:
  - "Balance bill" you up to their full fees. In other words, they can charge the difference between Delta Dental's Premier allowed amount and their actual fee.
  - Require you to pay for services out-of-pocket and submit a claim form to Delta Dental for reimbursement.

To find out if your current provider is in Delta Dental's network, go to www.deltadentalins.com/vanguard and click the link under "Finding a Delta Dental dentist". Once there, you will be able to search by dentists in your area in the Premier or PPO networks. You can also find out by calling Delta Dental at 800-471-1282 or by asking your dentist in which Delta Dental plan he or she participates.

The Preventive Incentive

To encourage preventive cleanings, each individual covered under the Plan who has at least one preventive cleaning and exam in a calendar year will have an increased annual limit for dental services the following calendar year; the limit will rise from $500 to $600 for those enrolled in the Standard plan and from $2,000 to $2,250 for those enrolled in the Enhanced Plan. After two consecutive years of preventive cleanings, you will receive another increase of $100 for the Standard plan or $250 for the Enhanced plan, up to a maximum annual limit of $700 and $2,500, respectively.

For More Information

Plan booklet H is the summary of coverage booklet for the Standard option and Plan booklet I is the summary of coverage booklet for the Enhanced option. This SPD together with Plan booklets H and I, available on CrewNet, serve as the full Plan Document for the Dental benefits. If you have any questions, call Crew Central at 844-VG1-CREW (844-841-2739) or extension 1CREW.

3. Vision Benefits

Eligibility

Vanguard offers vision benefits through VSP to all crew members who meet the eligibility requirements in Section II.A and their dependents who meet the eligibility requirements in Section II.B or Section IV, regardless of whether they elect or waive medical including prescription coverage. Vision coverage is not automatic; you must elect it.

Vision Coverage

The vision benefit covers the cost of two pairs of corrective glasses, two pairs of contact lenses, or one pair of each. All services and supplies must be furnished or prescribed by a licensed ophthalmologist, optometrist, physician, or an optician.

Vision benefits under the Plan are fully insured.

Refer to the chart below for high-level coverage information.

	In-network coverage	**Out-of-network reimbursement****
Exam*	Covered in full	$45
Single-vision lenses	Covered in full	$30
Bifocals	Covered in full	$50
Trifocals	Covered in full	$65
Frames	Up to $130 for any frame of your choice or $150 for featured frame brands	$70
Evaluation/fitting for contacts	Covered in full	$200 **Note:** This amount covers reimbursement for the evaluation, fitting, **and** contacts.
Contacts	Covered in full up to $200	

*Contact lens evaluations and fittings are not considered part of a regular exam.
**All out-of-network reimbursements are paid up to the listed amount, or the cost of the service or product provided if less that the listed amount (e.g., if an out-of-network vision exam is $30, then reimbursement is $30 and not the full $45).

For More Information

Plan booklet J is the summary of coverage booklet for vision. This SPD together with Plan booklet J, available on CrewNet, serve as the full Plan Document for Vision Benefits. If you have any questions, call Crew Central at 844-VG1-CREW (844-841-2739) or extension 1CREW.

4. Coordination of Benefits

The Health Benefits provided under the Plan are intended to help you pay for those costs that you or your dependents incur for necessary medical, prescription, dental, and vision services and supplies.

Sometimes individuals may be covered by more than one "group plan" and total benefits may exceed the actual expenses. If full payments were made by all plans involved, the cost of medical care would increase unnecessarily for everyone. Accordingly, under this Coordination of Benefits (COB) provision, health benefits payable by the Plan are coordinated with benefits payable under another group plan or Medicare or Medicaid so that the total benefit received by the individual does not exceed the allowable expense.

Other group plans subject to the Plan's COB provision are group benefit plans that provide health coverage (including medical, dental, prescription or vision coverage) on an insured or uninsured basis. Examples of other group plans include health plans made available by an employer other than Vanguard and health plans made available through an educational institution. Other group plans also include no-fault, uninsured, and underinsured motorist insurance required by law, or heath care benefits paid through settlement of a lawsuit. Any individual health insurance policy you may have is not subject to the COB provision.

To obtain all the benefits for which you are eligible, claims should be filed with each of your sources of coverage. In general, the secondary payer pays the difference between what the primary plan paid and what the secondary payer would have paid if they were the primary payer. The maximum amount payable by our Plan is limited to the amount that would be paid if there were no other plan involved. When our Plan is the secondary payer, Plan benefits will be reduced by any amount payable by the primary plan.

See the following Plan booklets for the coordination of benefit provision for the following plans: Plan booklet D for the Aetna HealthFund plans; Plan booklet F for the HDHP, Plan booklet G for the prescription plan; Plan booklet H for the Standard Dental plan; Plan booklet I for the Enhanced Dental plan; or Plan booklet J for the Vision plan.

Which Plan Pays?

Except with respect to Medicare and Medicaid as described below, the primary payer will be determined in accordance with the following rules:

- ***Plans Without COB Provision***
  If the other group plan does not include a provision to coordinate benefits, it will be the primary payer.

- ***Plans Covering Employees***
  Any other group plan, or this Plan, that covers an individual as an employee is primary over plans that cover the individual in any other capacity, including as a COBRA coverage recipient.

- ***Plans Covering Dependents***
  Any other group plan, or this Plan, that covers an individual in a capacity other than as a dependent is primary over plans that cover the individual as a dependent.

- ***Plans Covering Same Dependent***
  The "birthday rule" will determine which of two parents' health care plans the primary payer is for a dependent child in cases where both parents are enrolled in group plans and the other group plan has a birthday rule, except when the parents are divorced (see below). The birthday rule makes the plan of the parent with the earlier birth date (month and day only) the primary payer for health care services the child receives. If the other plan does not have a birthday rule, the plan of the male parent is primary, except when the parents are divorced (see below).

- ***Divorce or Legal Separation***
  Unless otherwise required by a court order, the primary payer of benefits for a dependent child whose parents are divorced or legally separated is determined as follows:

  - The plan covering the parent with custody of the child is primary.
  - If the parent with custody of the child has remarried, the stepparent's plan is primary over the plan of the parent without custody.
  - The birthday and gender rules apply where the parents have joint custody.

  A court decree may determine the primary plan. You should advise Vanguard of any court decree.

- ***Responsibility Not Determined***
  When the determination cannot be made under the above rules, then the plan that has covered the individual for the longest period of time will be the primary plan.

- ***Continuation Coverage***
  The plan that covers an active employee (or dependent of such employee) or retiree is primary over a plan that provides coverage under a right of continuation under federal or state law.

Coordination with Medicare and Medicaid

The Plan, or other group plan, will generally be primary over Medicare for those services that would otherwise have been provided by Medicare where:

- You are an active employee, age 65 or older, and are entitled to Medicare benefits.
- If required by law, a disabled individual (under age 65) is covered under the Plan by reason of his/her spouse's or parents current employment and is entitled to Medicare benefits.
- A dependent, which is covered under the Plan, is also entitled to Medicare (other than because of disability) and has not waived his/her right to Plan benefits.
- You or your dependent is entitled to Medicare benefits solely on the basis of having end-stage renal disease. (The Plan pays as primary during the first 30 months of Medicare coverage.)

The Plan, or other group plan, will generally be primary over Medicaid for those services that would otherwise have been provided by Medicaid.

(Please refer to Section IV for domestic partner eligibility.)

Plan's Rights

The Plan retains the right to release or obtain, without consent of, or notice to any person, any information that is deemed necessary in order to apply the COB provision of the Plan. Any individual claiming benefits under the Plan is required to furnish any written information requested by the Plan to implement the COB provision. The Plan retains the right to recover any amount of payments made that should not have been made under the COB provision from the person it paid or from the person for whom it has paid or any other group plan to which the Plan was secondary.

5. Coverage During Certain Leaves

If you have met the eligibility requirements in Section II.A, and are on an approved leave of absence, you are also eligible to elect benefits described in this Section II.

For clarification, approved leave of absences include, but may not be limited to:

- Short-Term Disability Leave
- Family and Medical Leave
- Long-Term Disability Leave
- Personal Leave
- Uniformed Services Leave
- Workers' Compensation Leave
- Parental Leave
- Paid Family Care Leave

Family and Medical Leave and Other Leaves of Absence

If you go on an approved leave of absence, including a leave that qualifies under the Family and Medical Leave Act of 1993 (FMLA), coverage for you and your dependents will continue in accordance with Vanguard's leave policies, including its Family and Medical Leave Act Policy. Please refer to these policies on CrewNet. If you have any questions, call Crew Central at 844-VG1-CREW (844-841-2739) or extension 1CREW.

If you are on a paid leave of absence, your payroll deductions for elected benefits will continue.

If you continue coverage during an unpaid leave, additional payroll deductions will occur when you return to work to make up all missed contributions while on the unpaid leave of absence.

If you choose to waive your coverage during your unpaid leave, you may re-enroll in the Plan when you return to work. Your coverage will start again on the first day you return to work.

Uniformed Services Leave

If you take uniformed services leave, whether for active duty or for training, your health coverage will continue in accordance with Vanguard's Uniformed Services Leave Policy. In accordance with the Uniformed Services Employment and Reemployment Rights Act (USERRA), as amended by the Veterans Benefits Improvement Act of 2004, coverage will continue for up to 24 months of uniformed services leave as long as you continue to pay your portion of the cost, provided that your total leave, when added to any prior periods of uniformed services leave from Vanguard, does not exceed five years (with certain exceptions). Upon expiration of any entitlement to continuation of coverage due to uniformed services leave, you may have a right to further continued coverage under COBRA. As permitted by federal law, however, any additional right you may have to continuation coverage under USERRA, as amended by the Veterans Benefits Improvement Act of 2004, shall run concurrently with and be satisfied by your continuation of coverage under COBRA. Please refer to Vanguard's Uniformed Services Leave Policy on CrewNet for more details on continuing health coverage during uniformed services leave. If you have any questions, call Crew Central at 844-VG1-CREW (844-841-2739) or extension 1CREW.

COBRA Continuation Coverage after your Leave Ends

If you do not return to work at the end of your leave of absence, you may be entitled to purchase COBRA continuation coverage as described in Section II.B.6 of this SPD.

6. Continuing Coverage under COBRA

The right to purchase a temporary extension of health coverage was created by the Consolidated Omnibus Budget Reconciliation Act of 1985, a federal law commonly known as COBRA. COBRA requires that this Plan offer crew members and their eligible dependents the opportunity to purchase such continuation coverage in certain instances where coverage under the plan would otherwise end. The following generally explains COBRA continuation coverage, when it may become available to you and your eligible dependents, and what you need to do to protect your right to receive it. **Both you and your spouse should take the time to read this carefully and keep it with your records.**

For purposes of this section, the phrase "group health plan" includes medical with prescription drug, dental, vision, the Crew Assistance Program, the Best Doctors program, wellness services offered through RedBrick and CrewCare, as well as coverage under a health care flexible spending account.

You May Have Other Options Available To You When You Lose Group Health Coverage

You may be eligible to buy an individual plan through the Health Insurance Marketplace ("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 group health plan coverage, which would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are described later in the document under the "Who is Covered?" section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You and your eligible dependents could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event.

Continuation coverage is the same group health plan coverage that the Plan provides to other participants and beneficiaries who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants and beneficiaries covered under the Plan, including open enrollment and special enrollment rights. Under the Plan, however, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Generally, you and your spouse or domestic partner will receive an initial notice describing COBRA rules and responsibilities within 90 days after you first become eligible under the group health plan.

Who Is Covered As A Qualified Beneficiary?

If you are a crew member covered by a group health plan, you are a qualified beneficiary, and have the right to choose continuation coverage for yourself, if you lose your group health coverage for any of the following qualifying events:

- The termination of your employment (except for gross misconduct);
- A reduction in your hours of employment to less than 30 hours per week; or

If you are the spouse or domestic partner of a crew member covered by a group health plan, you are a qualified beneficiary, and have the right to choose continuation coverage for yourself, if you lose group health coverage under the plan for any of the following qualifying events:

- Your spouse/domestic partner dies;
- Your spouse's/domestic partner's hours of employment are reduced to less than 30 hours per week;
- Your spouse's/domestic partner's employment ends for any reason other than his or her gross misconduct;
- Your spouse/domestic partner becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse/domestic partner.

A dependent child of a crew member covered by a group health plan is also a qualified beneficiary, and has the right to continuation coverage, if group health coverage under the plan is lost for any of the following qualifying events:

- The parent-crew member dies;
- The parent-crew member's hours of employment are reduced to less than 30 hours per week;
- The parent-crew member's employment ends for any reason other than his or her gross misconduct;
- The parent-crew member becomes entitled to Medicare benefits (under Part A, Part B or both);
- The parents become divorced or legally separated; or
- The child ceases to meet eligibility requirements for coverage under the plan as a "dependent child."

(Please refer to Section IV of the document for information on domestic partner COBRA eligibility.)

A child born to, or placed for adoption with, the covered person during a period of continuation coverage is also a qualified beneficiary. In accordance with the terms of the group health plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification and proof to Crew Central of the birth or adoption. If the covered person fails to notify Crew Central and submit proof in a timely fashion (in accordance with the terms of the group health plan), the covered person will NOT be offered the option to elect COBRA coverage for the child.

Separate elections. Each qualified beneficiary has an independent election right for COBRA coverage. For example, if there is a choice among types of coverage under the Plan, each of you who are a qualified beneficiary eligible for continuation of coverage is entitled to make a separate election among the types of coverage. Thus, a spouse/domestic partner or dependent child is entitled to elect continuation of coverage even if the covered crew member does not make that

election. Thus, you, your spouse/domestic partner, and/or your dependent children (where applicable) would each, as a qualified beneficiary, have the option to elect continuation coverage as described below. Notwithstanding these independent election rights, you may elect continuation coverage on behalf of your spouse/domestic partner, and parents may elect continuation coverage on behalf of their children.

Your Duties Under The Law

Under the law, the crew member or a family member has the responsibility to inform the COBRA Administrator of a divorce, legal separation, or a child losing dependent status under the group health plan. This notice must be provided within 60 days from the later of (1) the date of the event or (2) the date on which coverage would end under the plan because of the event. *If the crew member or a family member fails to provide this notice to the COBRA Administrator during this 60-day notice period, any family member who loses coverage will NOT be offered the option to elect COBRA continuation coverage.* When the COBRA Administrator is notified that one of these events has happened, the COBRA Administrator will notify you that you have the right to elect continuation coverage. Any individual who is either a crew member covered under the group health plan, a qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of you or a qualified beneficiary may provide the notice.

In order to protect your family's rights, you should keep the COBRA Administrator informed of any changes in the addresses of family members. You should also keep a copy for your records, of any notice you send to the COBRA Administrator.

Vanguard's Duties Under The Law

Vanguard has the responsibility to notify the COBRA Administrator of the employee's death, termination of employment (other than for gross misconduct) or reduction in hours, or Medicare entitlement. Notice must be given to the COBRA Administrator within 30 days of the event. When the COBRA Administrator is notified that one of these events has occurred, the COBRA Administrator will notify you that you have the right to elect continuation coverage.

Electing COBRA Continuation Coverage

Under the law, you must elect continuation coverage within 60 days from the date you would lose coverage because of one of the events described above or, if later, 60 days after the COBRA Administrator sends you notice of your right to elect continuation coverage. **If you do not elect continuation coverage within the time period described above, you will lose your right to elect continuation coverage.** If you elect continuation coverage, Vanguard is required to give you coverage that, as of the time coverage is being provided, is identical to the coverage provided under the group health plan to similarly situated crew members or family members. This means that if the coverage for similarly situated crew members or family members is modified, your coverage will be modified. "Similarly situated" refers to a current crew member or dependent who has not had a Qualifying Event.

In considering whether to elect continuation coverage, you should take into account that a failure to continue group health plan coverage will affect your future rights under federal law. You should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Duration of Coverage

Continuation coverage is a temporary continuation of coverage. The chart below outlines the maximum coverage periods based on the initial termination reason:

Reason For Termination Under Plan	Period
Voluntary termination of crew member	18 months
Involuntary termination of crew member (except for gross misconduct)	18 months
Reduction in work hours for crew member to less than 30 hours per week	18 months
Death of crew member	36 months
Divorce, legal separation, or termination of domestic partnership	36 months
Dependent child no longer qualifies as a dependent under the group health plan	36 months

There are circumstances under which continuation coverage may be extended. When the qualifying event is the end of employment or reduction of the crew member's hours of employment, and the crew member became entitled to Medicare benefits less than 18 months before the qualifying event, continuation coverage for qualified beneficiaries other than the crew member lasts until 36 months after the date of Medicare entitlement. For example, if a crew member becomes entitled to Medicare 8 months before the date on which his or her employment terminates, continuation coverage for the crew member's spouse/domestic partner and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

If your family experiences another qualifying event while receiving 18 months of continuation coverage (in accordance with the chart above), your spouse/domestic partner and dependent children can get 18 additional months of continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the COBRA Administrator. The extension may be available to the spouse/domestic partner and dependent children receiving continuation coverage if the crew member dies or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse/domestic partner or dependent child to lose coverage under the plan had the first qualifying event not occurred.

Special rules for disability. The 18 months may be extended to 29 months if the crew member or covered family member is determined by the Social Security Administration to be disabled (for Social Security disability purposes) at any time during the first 60 days of continuation coverage. This 11-month extension is available to all family members who are Qualified Beneficiaries due to termination or reduction in hours of employment, even those who are not disabled. To benefit from the extension the crew member or a family member must inform the COBRA Administrator of a determination by the Social Security Administration and that the crew member or covered family member was disabled during the 60-day period after the crew member's termination of employment or reduction in hours, within 60 days of such determination and before the end of the original 18-month continuation coverage period. If, during continued coverage, the Social Security Administration determines that the crew member or family member is no longer disabled, the individual must inform the COBRA Administrator of this predetermination within 30 days of the date it is made. If another Qualifying Event occurs within the 29-month continuation period, then the continuation coverage period is 36 months after the termination of employment or reduction in hours for the family members other than the crew member.

Early Termination of Continued Coverage

The law provides that your continuation coverage may be cut short prior to the expiration of the 18-, 29-, or 36-month period for any of the following five reasons:

- Vanguard no longer provides group health coverage to any of its crew members;
- The premium for continuation coverage is not paid on time (within the applicable grace period);
- The qualified beneficiary becomes covered - after the date COBRA is elected - under another group health plan (whether or not as an employee) or the Marketplace;
- The qualified beneficiary becomes entitled to Medicare benefits after the date COBRA is elected; or
- Coverage has been extended for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

Continuation coverage under COBRA is provided subject to your eligibility for coverage under the group health plan; Vanguard reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

Premium Payments

You do not have to show that you are insurable to choose COBRA continuation coverage. However, under the law, you may be required to pay up to 102 percent of the entire premium for your continuation coverage. If your coverage is extended from 18 to 29 months for disability, you may be required to pay 150 percent of the premium beginning with the 19th month of continuation coverage. The cost of group health coverage periodically changes. If you elect continuation coverage, the COBRA Administrator will notify you of any changes in the cost.

The initial payment for continuation coverage is due 45 days from the date of your election. If you do not make your first payment for continuation coverage in full no later than 45 days from the date of your election, you will lose all continuation coverage rights under the Plan.

After you make your initial payment, you will be required to make periodic payments for each subsequent coverage period. Periodic payments are made on a monthly basis, with payment due on the first day of the month. If you make a periodic payment on or before the first day of the month, your coverage under the Plan will continue for that month without any break. The Plan will not, however, send periodic notices of payments due for these coverage periods.

Although periodic payments are due on the first day of the month, you will be given a grace period of 30 days after the first day of the month to make your periodic payment. Your continuation coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that month. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for a particular month, you will lose all rights to continuation coverage under the Plan.

COBRA and Family and Medical Leave Act (FMLA) Leave

An FMLA leave does not make you eligible for COBRA coverage. However, whether or not you continue health coverage during an FMLA leave, you may be eligible for COBRA as of the earliest of the following events:

- When you inform Vanguard that you are not returning at the end of the leave;
- The end of the leave, assuming you do not return; and
- When the FMLA leave entitlement ends.

For purposes of an FMLA leave, you will be eligible for COBRA, as described above, only if:

- You or your dependent is covered by the Plan on the day before the leave commences (or becomes covered during the FMLA leave); and
- You do not return to employment at the end of the FMLA leave; and
- You or your dependent loses coverage under the Plan before the end of what would be the maximum COBRA continuation period.

For More Information

Additional information about COBRA can be obtained by calling WageWorks at 888-251-6982 or Crew Central at 844-VG1-CREW (844-841-2739) or extension 1CREW. If you have changed your marital status, if you or your spouse/domestic partner has changed addresses, or if a dependent ceases to be a dependent eligible for coverage under the terms of the plan, you are responsible for promptly notifying WageWorks or Crew Central.

For more information about your rights under ERISA, including COBRA 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 the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of regional and district EBSA offices are available through the EBSA website.

7. Other Non-COBRA Continuation of Coverage

If you elected health benefits, including prescription drug, dental and vision benefits, (and are currently covered under these benefits) at the time of either of the two events described below, your coverage will continue for up to 12 months subject to certain conditions, as described below:

Reason for Continuation Coverage	Eligible for Coverage	Maximum Coverage Period
Qualify for benefits under the Long-Term Disability program	Crew member and covered dependents	12 months from crew member's Long-Term Disability effective date
Death of a Crew Member	Covered dependents	12 months from the date of crew member's death

After 12 months, this coverage will end, and you and/or your dependents may elect to continue coverage under COBRA for up to 36 months.

In the event of long term disability, the disabled crew member must pay any contributions required for such coverage and these contributions will be deducted from his or her long term disability benefits. The cost of coverage will be determined using rates that apply to actively employed crew members. Failure to pay required contributions will result in the termination of coverage. In the event of death, Vanguard will continue the coverage for the surviving covered dependents at no charge for up to 12 months.

C. Life Insurance and Accidental Death and Dismemberment

Introduction

Vanguard provides eligible crew members with automatic life insurance and automatic accidental death and dismemberment (AD&D) insurance. This automatic coverage is paid for entirely by Vanguard. You may also purchase additional life and AD&D insurance under the Plan. Life insurance and AD&D insurance are subject to ERISA.

Eligibility

Vanguard offers life insurance and AD&D insurance to all crew members who meet the eligibility requirements in Section II.A.

1. Crew Member Life and AD&D Insurance

Vanguard provides you with life insurance coverage equal to two times your Direct Pay, as well as an equal amount of AD&D coverage, for "free"—this means that your credits will equal the price of this coverage. You also have the option to elect a flat $50,000 coverage option instead of a multiple of your Direct Pay. If you elect this option, you will not be subject to imputed income taxes (see below in the Basic Life Coverage Options table). If your credits exceed the cost of your Basic Life coverage, you may use them to purchase other benefits.

Additionally, you may purchase supplemental life insurance to increase this coverage to between one and up to seven times your Direct Pay in addition to the basic life options you already receive (see below in the Supplemental Life Coverage Options table).

Your 2018 Direct Pay is your annual base salary as of September 30, 2017, plus your 2016 Partnership Plan distribution paid in June 2017, plus any performance bonuses paid between May 1, 2016 and April 30, 2017 (if applicable).

Your AD&D coverage amount will mirror your life insurance coverage amount, but you will not pay for any additional AD&D coverage.

Basic Life Coverage Options	**Credits/Costs**
$50,000 2 times your Direct Pay	Credits equal 2 times your pay for both options.
Supplemental Life Coverage Options	**Cost**
1 times your Direct Pay 2 times your Direct Pay 3 times your Direct Pay 4 times your Direct Pay 5 times your Direct Pay 6 times your Direct Pay 7 times your Direct Pay	Costs are based on coverage amount and age and are calculated on your online enrollment form. See below for supplemental life rates.

Evidence of Insurability

You do not need to provide evidence of insurability (EOI) for basic life insurance. However, you must satisfy EOI requirements if you elect an amount of supplemental life insurance over $500,000 for the first time or are considered a "late entrant" to the Plan. You will be notified by Vanguard's third-party life insurance company, if EOI is required. You must complete the EOI form within 30 days of notification from Minnesota Life. The EOI form must be approved by Minnesota Life before the elected amount is effective. If the EOI is not completed within 30 days, you will be assigned the maximum amount of coverage permitted without EOI approval.

Cost of Coverage

Your costs for the basic and supplemental life insurance options that you are eligible for are shown on your online enrollment form. The maximum for basic life insurance is $1 million. The maximum for supplemental life insurance coverage is the lesser of seven times your Direct Pay or $1.5 million. Therefore, the maximum for basic and supplemental life insurance coverage is the lesser of nine times your Direct Pay or $2.5 million. Costs for supplemental life insurance will be based on your age as of December 31 of the Plan Year for which you are enrolling. The table below shows the rate per $1,000 of coverage for each age bracket for the Plan Year. Your online enrollment form will calculate the cost of supplemental life insurance for you. You pay the full cost of supplemental life insurance on a pre-tax basis.

Age as of December 31 of the plan year	**Cost for Supplemental Life Per $1,000 of Coverage Per Pay**
Under 25	$ 0.013
25 to 29	$0.016
30 to 34	$0.018
35 to 39	$0.023
40 to 44	$0.033
45 to 49	$0.066
50 to 54	$0.106
55 to 59	$0.175
60 to 64	$0.273
65 to 69	$0.457
70 or older	$0.951

Imputed Income Information

Under current tax regulations, if your group life insurance coverage exceeds $50,000, the federal government taxes the value of the employer's cost of providing that excess coverage as "imputed income," with the amount of the "income" set by an IRS formula. The following table shows how much taxable income per $1,000 of coverage above $50,000 will be reflected on your year-end Form W-2 Wage and Tax statement as imputed income.

W-2 Life Insurance Imputed Income:

Age as of December 31 of the plan year	**Taxable Income Per $1,000 Of Coverage Per Year (Over $50,000)**
Under 25	$0.60
25 to 29	$0.72
30 to 34	$0.96
35 to 39	$1.08
40 to 44	$1.20
45 to 49	$1.80
50 to 54	$2.76
55 to 59	$5.16
60 to 64	$7.92
65 to 69	$15.24
70 or older	$24.72

Important Life Insurance Considerations

During open enrollment each year, you can increase your previous supplemental life election by **one** times your Direct Pay, up to the limit of seven times your Direct Pay or $1.5 million. You may also reduce your previous election without restrictions at open enrollment.

If you are on a leave of absence, any election increase to basic life and/or supplemental life insurance will not go into effect until you return to work.

Beneficiaries

The beneficiaries you choose will apply for both basic and supplemental life insurance as well as your AD&D coverage.

Any amount of insurance under a coverage for which there is no beneficiary at your death will be payable to the first of the following: (a) your lawful spouse, if living, otherwise: (b) your natural or legally adopted child (children) in equal shares, if living, otherwise; (c) your parents in equal shares, if living, otherwise; (d) your brothers and sisters in equal shares, if living, otherwise; (e) the personal representative of your estate.

In addition, upon reaching age 75, your basic life and supplemental life insurance amounts will be reduced by 35%; and 50% at age 80.

2. Spousal/Domestic Partner Life Insurance

Under the Plan, you can purchase life insurance for your spouse/domestic partner up to the following limits:

Spouse/Domestic Partner Life Coverage Options
$10,000
$20,000
$40,000
$60,000
$80,000
$100,000
Waive coverage

Evidence of Insurability

You will be notified by Minnesota Life if EOI is required. You must complete Minnesota Life's EOI within 30 days. You will be notified if your new coverage has been approved or denied. The EOI form must be approved by Minnesota Life before the elected amount is effective. If the EOI is not completed within 30 days, you will be assigned the maximum amount of coverage permitted without EOI approval.

If you and your spouse/domestic partner are both crew members, you must both waive spousal life insurance because you are each eligible for your own life insurance coverage.

(Please refer to Section IV for domestic partner eligibility.)

Cost of Coverage

You pay the full cost of your spousal/domestic partner life insurance on an after-tax basis.

Beneficiary

You are automatically the beneficiary for your spousal/domestic partner life insurance election.

3. Dependent Child Life Insurance

Under the Plan, you can purchase life insurance for your dependent child(ren) up to age 26, as follows:

Dependent Child Life Coverage Options
$2,500 per child covered
$5,000 per child covered
$10,000 per child covered
Waive coverage

If both you and your spouse/domestic partner are Vanguard crew members, only one of you may elect dependent child life insurance.

Dependent children will **not** be eligible if they are:

- In the armed forces of any country.
- Eligible as a crew member under the Vanguard health plan.

(Please refer to Section IV for eligibility pertaining to children of a domestic partner.)

Cost of Coverage

You pay the full cost of your dependent child life insurance on an after-tax basis.

Beneficiary

You are automatically the beneficiary for your dependent child life insurance election.

For More Information

Plan booklet K is the Minnesota Life Insurance booklet and is available on CrewNet. This SPD together with Plan booklet K serve as the full Plan Document for life insurance benefits. If you have any questions, call Crew Central at 844-VG1-CREW (844-841-2739) or extension 1CREW.

D. Flexible Spending Accounts

Introduction

Flexible spending accounts (FSA) offer you an opportunity to pay for your eligible out-of-pocket health care and dependent day care expenses with money that is deducted from your paycheck before Federal, Medicare, and Social Security taxes, and in some cases state taxes, are taken out. This is referred to throughout this section as "pre-tax" money.

Throughout this section, reference is made to the Plan Year. The Plan Year runs from January 1 through December 31.

There are two types of flexible spending accounts available under the Plan:

- The Health Care Flexible Spending Account (Health Care FSA) which is subject to ERISA; and
- The Dependent Day Care Flexible Spending Account (Dependent Day Care FSA) which is not subject to ERISA.

Eligibility

If you meet the eligibility requirements in Section II.A, you may participate in these accounts.

How the Accounts Work

- These accounts are governed by Section 125 of the Code. See Section II.A for a description of permitted election change events ("Events").
- During the annual open enrollment period or at the time of an Event, estimate your eligible expenses and elect how much money you want to contribute to each account for that Plan Year.
- Your annual contribution election will automatically be deducted from your paycheck equally across 26 pay periods in the Plan Year and credited to an account in your name. Your FSA account is merely a recordkeeping account; it is not funded by Vanguard (all reimbursements are paid from the payroll contributions made by crew members), and your FSA account does not accumulate interest.
- The payroll deductions will stop at the end of the Plan Year, or earlier if you stop participating due to an Event.
- After you incur an eligible expense, you can be reimbursed with pre-tax money from your FSA.
- You must make a new election for each Plan Year during open enrollment to participate in the FSA.

You can check on the status of your account throughout the year by viewing the PayFlex website (www.payflex.com), Aetna Navigator website (www.aetna.com), or by calling Aetna's customer service department at 800-938-0512.

Enrollment

Participation in these accounts is optional. You may enroll in one of the FSAs or both. If you do not enroll when you are first eligible, you will have to wait until the next annual open enrollment period unless you incur an Event. See Section II.A for a description of permitted election change events---also called Events in this SPD.

Once you enroll in an FSA, you must participate in your selected FSA for the entire Plan Year, unless:

- You have an Event that permits you to stop making contributions to the FSA.
- Your employment terminates and you do not elect COBRA for your Health Care FSA.

If you stop contributing to your FSA during the year due to an Event that permits you to stop FSA contributions, including termination of employment from Vanguard, you are no longer considered a participant in those accounts as of the effective date of such Event and your coverage in the FSA will terminate. Eligible expenses incurred prior to the effective date your coverage ended may still be covered as described below.

1. The Health Care Flexible Spending Account

Eligible Dependents

You may use Health Care FSA to pay eligible expenses for the following individuals (regardless of whether they are covered by the Vanguard health plan):

- Yourself;
- Your legally married spouse or domestic partner for which you claim as a pre-tax dependent for health coverage purposes (Please refer to Section IV for discussion on qualified domestic partners);
- Your dependent children; and
- Anyone else you can claim as a dependent for income tax purposes for the Plan Year, including a child(ren) of a qualified domestic partner (Please refer to Section IV for a discussion on qualified domestic partners).

Annual Maximum

For 2018, you may elect to contribute up to $2,650 in your Health Care FSA. The IRS imposes a limit on the amount you may contribute into your Health Care FSA. The limit is indexed for cost-of-living adjustments periodically.

FSA and Your Health Plan Election

If you elect to participate in the Health Care FSA, you will qualify for either a general purpose Health Care FSA or a limited Health Care FSA, depending on the type of health coverage you elect. Please refer to the section on the limited Health Care FSA to read about the impact of your health coverage decision (and/or that of your spouse) on the type of Health Care FSA coverage you may want to elect.

General Purpose Health Care FSA

In most cases, if you elect the Aetna HealthFund or waive medical coverage, you will elect a general purpose Health Care FSA. Reimbursement can be made from this type of FSA for any eligible expense you incur, after your Aetna HealthFund has been exhausted (if applicable). The HealthFund account of your medical plan functions as a Health Reimbursement Arrangement (HRA) and will be used first to pay out-of-pocket eligible expenses even if you have a remaining balance in your FSA from the prior year during the grace period. However, you may receive reimbursement from your FSA for dental, prescription and vision expenses before your HRA is depleted.

Examples of eligible expenses include:

- Deductibles, co-payments and other out-of-pocket costs for medical, prescription, dental, or vision expenses not covered by the Plan;
- Over-the-counter medicines, such as allergy medicine, cold medicine, and pain reliever provided such medicines are prescribed by a doctor; and
- Certain over-the-counter expenses that do not require a prescription, such as bandages, contact lens solution, and family planning items.

Limited Health Care FSA

If you elect the Aetna High-Deductible Health Plan (HDHP) and wish to contribute to a Health Savings Account (HSA), and participate in a Health Care FSA, please keep in mind that IRS rules state that a general purpose Health Care FSA is considered disqualifying health coverage and will prevent you from being eligible to make HSA contributions. This rule applies whether the individual is the participant in the general purpose FSA, or simply someone whose expenses can be reimbursed (please refer to the Eligible Dependents section to read about whose expenses can be reimbursed from the Health Care FSA). If you decide to enroll in the limited Health Care FSA you will still be eligible to make HSA contributions.

If you are a participant in the Aetna HealthFund but your spouse is a participant in a high deductible health plan and wishes to contribute to an HSA (whether at Vanguard or elsewhere), please keep in mind that your spouse will be ineligible to contribute to an HSA if you enroll in a general purpose Health Care FSA. In this instance, the general purpose FSA is considered disqualifying coverage for your spouse. If you decide to stay enrolled in the general purpose FSA then your spouse may not make HSA contributions. If you decide to instead enroll in the limited Health Care FSA, your spouse will be eligible for HSA contributions.

The limited Health Care FSA works differently than a general purpose Health Care FSA. Under a limited Health Care FSA, you cannot receive reimbursement for medical and nonpreventive prescription drug expenses until you meet the plan deductible.

Prior to meeting your HDHP deductible, your limited health care FSA can be used to reimburse the following expenses at any time (list is not exhaustive):

- Co-payments and other out-of-pocket costs for dental and vision care not covered by the Plan;
- Co-payments and other out-of-pocket costs for preventive prescription expenses; and
- Over-the-counter preventive medicine prescribed by a doctor.

After you have satisfied your HDHP deductible, your limited health care FSA can be used to reimburse all eligible health care expenses, including the following:

- Co-payments and other out-of-pocket costs for medical, dental, vision and nonpreventive prescription expenses not covered by the Plan; and
- All eligible over-the-counter expenses beyond just those for dental, vision, and preventive care.

Eligible Expenses

A complete list of eligible expenses can be found on PayFlex website (www.payflex.com). You may also use IRS Publication 502 (Medical and Dental Expenses) under the headings of "What Medical Expenses Are Includible?" and "What Expenses Are Not Includible", but only as a guide. Publication 502 is meant only to help taxpayers understand what, of their medical expenses, may be considered as tax deductions, not what is considered an eligible expense under a Health Care FSA. There are even some items that are listed as deductible as medical care but that are not considered as eligible expenses under a Health Care FSA (e.g. health insurance premiums, long-term care premiums).

Reimbursement From Your Account

As stated above, only eligible health care (medical, dental and vision) expenses you incur during the Plan Year and during the carryover period are eligible for reimbursement during the time in which you are a participant in the Health Care FSA. However, if you were not a participant in the Plan as of December 31st of the Plan Year, you are not eligible for the carryover period even if you had funds remaining in your account when your participation in the Plan terminated. Expenses are treated as having been incurred when the medical care that gives rise to the medical expenses is provided, and not when you are formally billed or charged for, or pay for the medical care (except orthodontia expenses, see below).

NOTE: If you cease participation during the Plan Year, any health care expenses you incur in that Plan Year after you cease participation will not be eligible for reimbursement.

Generally, there are three ways to access the funds in your Health Care FSA:

- Autopay Processing
- FSA Debit Card
- Filing a Paper Claim

Autopay Processing

If you are enrolled in the Aetna HealthFund and/or Delta Dental and have elected the Health Care FSA, your medical and/or dental claims will be processed through Autopay processing and any FSA-eligible claims will receive reimbursement via direct deposit to the primary bank account in which your paycheck is deposited. You will automatically be enrolled in the Autopay processing at the beginning of each Plan Year, but you may opt out if you would like to control when you receive reimbursement from your FSA. If you opt out of Autopay processing, you will be required to submit paper claims.

Autopay processing is not available for:

- Limited Health Care FSA claims
- Orthodontia claims
- Vision claims

Reimbursement requests for the claims above must be submitted on a paper claim form; please see 'Filing a Paper Claim' below for more information.

FSA Debit Card
You will receive a debit card to pay for prescription drug expenses if you are enrolled in the general purpose Health Care FSA. The debit card can be used at many pharmacies for prescription drug copays or coinsurance and eligible over-the-counter expenses. All limited Health Care FSA claims must be submitted on a paper claim form; please see 'Filing a Paper Claim' below for more information.

Filing a Paper Claim
For claims not covered under the Autopay processing feature or the FSA debit card, you must file a paper claim for reimbursement. After you have incurred an eligible expense, complete a reimbursement claim form and send it to PayFlex with copies of the applicable receipts or explanation of benefits (EOB). The documentation should outline that the expense has been incurred, the date the expense was incurred, and the amount of such expense. You will be reimbursed up to the full amount elected for the Plan Year. A reimbursement form can be downloaded from CrewNet or PayFlex website.

Orthodontia Expenses

Orthodontia claims submitted for FSA reimbursement will be processed based on the date of payment for such services (as opposed to the date the services are incurred). This permits the reimbursement of certain advance payments for orthodontic treatments up to your annual contribution election, even if the services have not been provided at the time of the advanced payment.

Autopay processing is not available for orthodontia claims. All reimbursement requests for orthodontia claims must be submitted on a paper claim form.

Qualified Reservist Distribution

The Heroes Earnings Assistance and Relief Tax (HEART) Act of 2008 permits optional distributions of unused amounts in Health Care FSAs to military reservists who are called to active duty for 180 days or more. This optional distribution was adopted for the 2011 plan year and can be utilized for your 2011 Health Care FSA balance or any future year's balance. The amount you have available for a Qualified Reservist Distribution (QRD) is the amount you have contributed this plan year to your Health Care FSA minus any reimbursements you have already received during the year.

You may request a QRD on or after the date of your call to active duty and before the last day of the Plan's grace period, March 15. Once you request a QRD, your participation in the FSA will cease and the right to submit FSA claims will terminate. The amount of your QRD is included in your gross income and wages and is subject to employment taxes for the year in which you receive the distribution.

If you would like to request a QRD, please complete the form on CrewNet. If you have any questions, call Crew Central at 844-VG1-CREW (844-841-2739) or extension 1CREW.

If You Have a Leftover Balance

Starting in 2018, the Plan permits you to carryover up to $500 of unused Health Care FSA funds into the next Plan Year for the full Plan Year (not just two and half months). Accordingly, up to $500 contributed to a FSA in a given Plan Year, that remains unused at the end of the Plan Year, can be used for eligible expenses incurred by December 31 of the following year. Any unused

funds over $500 contributed in the current Plan Year will be forfeited. The carryover amount from the current Plan Year does not count toward the annual maximum in the next Plan Year.

For example, if you have $500 of unused Health Care FSA funds at the end of 2019, you can carryover this $500 into 2020 and use this carryover balance for eligible expenses incurred during 2020. This $500 carried over from 2019 does not count toward the annual Health Care FSA maximum in 2020. Please note that if you have $750 of unused Health Care FSA funds at the end of 2019, you can only carryover $500 of the $750 into 2020 and you will forfeit $250.

The Plan also permits a run-out period during which proof necessary to substantiate a claim for eligible Health Care FSA expenses incurred for the prior Plan Year may be submitted. The run-out period to submit claims ends on May 31 of the year following the Plan Year in which the eligible expenses must be incurred.

For example, if you end the 2018 year with $750 of unused Health Care FSA balance, you have until May 31, 2019 to submit claims for reimbursement for eligible expenses you incurred in 2018. If you do not have any additional 2018 eligible expenses or if you do not submit your 2018 eligible expenses by May 31, 2019, you will forfeit $250 of your 2018 unused Health Care FSA balance on May 31st and carryover the remaining $500 into 2019. You will then be able to use the $500 for 2019 eligible expenses. This $500 carried over into 2019 must then be used for 2019 eligible expenses. However, you still have the run-out period so if you end the 2019 Plan Year with $500 of unused Health Care FSA balance you have until May 31, 2020 to submit your claims for 2019 eligible expenses.

In order to take advantage of the carryover period and run-out period, you must be:

- A participant in the Plan with Health Care FSA coverage that is in effect on the last day of the Plan Year to which the carryover period relates (e.g., December 31, 2018 to carry over up to $500 of unused 2018 Health Care FSA contributions into 2019); or
- A qualified beneficiary who has COBRA coverage under the Health Care FSA on the last day of the Plan Year to which the carryover period relates (e.g., December 31, 2018 to carry over up to $500 of unused 2018 Health Care FSA contributions into 2019).

As required under Internal Revenue Service regulations, a "use it or lose it" rule applies. Any contributions remaining in the Health Care FSA at the close of the Plan Year (if in excess of $500) or at the end of the following Plan Year (if $500 or less and being carried over), and for which necessary proof is not submitted by the end of the run-out period, will be forfeited and will not be available to you as a refund.

If You Leave Vanguard or Cease Participation

If you are no longer participating in the FSA because you have left Vanguard or waived coverage because of an Event that permitted you to stop FSA contributions during the Plan Year, you may still be reimbursed for expenses as long as they are incurred after you enrolled in the FSA for the Plan Year and prior to the date you terminated participation in the FSA. You may submit claims for reimbursement for expenses incurred before your participation stopped until May 31 following the end of the Plan Year in which your coverage was terminated.

You may continue to submit paper claim reimbursements to PayFlex. Only the expenses that are incurred while you were an active participant in the Plan will be eligible for reimbursement from the account.

If You Die

If you die, your surviving dependents may be reimbursed for expenses incurred during your period of participation during the Plan Year until your date of death. Your surviving dependents may submit claims for reimbursement for expenses incurred before your participation stopped until May 31 following the end of the Plan Year in which you died.

COBRA

Certain Health Care FSA participants may be eligible for COBRA continuation coverage if they have a positive Health Care FSA balance at the time of the "qualifying event" (taking into account all claims submitted prior to the qualifying event date). Crew Central will notify you of your COBRA rights, if any, under the Health Care FSA. However, even if COBRA coverage is elected for the Health Care FSA, COBRA coverage for the Health Care FSA will end at the end of the year in which the qualifying event occurred and cannot be elected for the next calendar year. See the COBRA section of this SPD for more information on COBRA continuation coverage.

2. The Dependent Day Care Flexible Spending Account

Eligible Dependents

The Dependent Day Care FSA can be used to pay eligible expenses for the care of the following dependents:

- Children or other dependents under the age of 13;
- A spouse who is physically or mentally incapable of self-care; or
- Any other dependent (regardless of age) who lives with you and is physically or mentally incapable of self-care, such as an elderly parent.

Generally, the care must be provided for someone who qualifies as your dependent for Federal income tax purposes. Also, qualified dependents age 13 or older must live with you (i.e., spend at least eight hours a day in your home).

Annual Maximum

Each Plan Year, you may deposit up to $5,000 in your Dependent Day Care FSA, subject to certain limits described below.

Federal law requires that the amount excluded from your gross income for deposit in a Dependent Day Care FSA cannot exceed the lesser of:

- $5,000 ($2,500 if you are married and filing separate federal income tax returns);
- Your annual income; or
- Your spouse's annual income.

If your spouse is (1) a full-time student for at least five months during the year or (2) physically and/or mentally handicapped, there is a special rule to determine his or her annual income. To calculate the income, determine your spouse's actual taxable income (if any) earned each month that he or she is a full-time student or disabled. Then, for each month, compare this amount to either $200 (if you claim expenses for one dependent) or $400 (if you claim expenses for two or more dependents). The amount you use to determine your spouse's annual income is the greater of the actual earned income and these assumed monthly income amounts of either $200 or $400.

If your spouse also participates in a Dependent Day Care FSA at his/her employer, each of you can deposit up to $2,500 in an account (if you file separately) or up to $5,000 combined in both accounts (if you file jointly). **By making an election under the Plan, you are representing to Vanguard that your contributions to your Dependent Day Care FSA are not expected to exceed the federal legal limits.**

If you are married and filing separate federal income tax returns, the $2,500 limit described above will not apply if you are (1) legally separated or (2) your spouse did not reside with you for the last six (6) months of the calendar year, you maintained a household that was your dependent's primary residence for more than six (6) months during the year, and you paid more than half of the expenses of that household.

To comply with Internal Revenue Service regulations, the Plan will be tested to ensure it meets nondiscrimination rules. If the Plan does not pass the test, certain highly compensated crew members may not be able to contribute up to the full annual contribution amount on a pre-tax basis. You will be notified if this affects you.

Eligible Expenses

You can use the Dependent Day Care FSA to pay for dependent day care expenses so that you and your spouse can work or look for work. You can also use the account to pay for dependent day care if your spouse attends school full-time for at least five months of the year or if your spouse is disabled. Eligible expenses include:

- A qualified child care or adult day care center (must meet all state and local regulations if it provides care for more than six individuals);
- A housekeeper whose duties include dependent day care;
- Preschool tuition;
- Before and after-school programs;
- Summer day camps (not for educational or overnight purposes);
- A relative who cares for your dependents (the relative cannot be your dependent for Federal income tax purposes or your child under the age of 19); and
- A person who cares for an eligible child or an elderly or disabled dependent in your home.

A complete list of eligible expenses can be found on the PayFlex FSA website (www.payflex.com) and in IRS Publication 503 found at IRS.gov.

Dependent Day Care Subsidy Program

Vanguard may provide a subsidy to help pay for your dependent day care expenses. To be eligible to participate in the Dependent Day Care Subsidy Program, crew members must have an annual household income below $75,900 for 2018 and elect the Dependent Day Care FSA Subsidy option during enrollment. For those eligible crew members who enroll in the Dependent Day Care Subsidy Program, Vanguard "matches" the crew member's contribution (as a percent of the crew member's dependent day care contribution election). The percentage "match" is 30%, up to an annual maximum of $1,500.

For example, if a crew member's gross household income is $34,000, and the crew member's contribution election is $3,000, Vanguard's subsidy would be $900 ($3,000 x 30%), and set the crew member's pre-tax contribution election at $2,100 (or $3,000 - $900). Then the total amount reimbursable from the plan is $3,000 ($900 from Vanguard and $2,100 from the crew member).

Please refer to CrewNet for more details about the Dependent Day Care Subsidy Program. In addition, you may contact Crew Central at 844-VG1-CREW (844-841-2739) or extension 1CREW to answer any questions you may have about the Dependent Day Care FSA.

Reimbursement From Your Account

The expenses that can be reimbursed through the account are only for dependent care expenses incurred during the Plan Year and grace period as long as you remain an eligible participant in the Dependent Day Care FSA. Expenses are treated as having been incurred when the care that gives rise to the expense is provided, and not when you are formally billed or charged for, or pay for the care.

NOTE: If you cease participation during the Plan Year based on a permitted election change, any dependent day care expenses you incur in that Plan Year after you cease participation will not be eligible for reimbursement.

Filing a Paper Claim

After you have incurred an eligible expense, complete a reimbursement claim form and send it to PayFlex with documentation (such as a bill) from the provider stating that the expense has been incurred, the dates that the expense occurred and the amount of such expense. The statement must include the provider tax ID or Social Security number, address and signature; the dependent's name; and an itemized bill with the dates on which the provider cared for your dependent. A reimbursement form can be downloaded from CrewNet or PayFlex website.

If you file a claim for more than the balance to date in your Dependent Day Care FSA, you will be reimbursed only up to the amount in your Dependent Day Care FSA. When additional funds are deducted from your pay, they will be posted to your Dependent Day Care FSA and you will be reimbursed for any outstanding expense.

Dependent Day Care FSA vs. Tax Credit

The current tax laws provide two means of saving on dependent day care expenses: dependent day care assistance plans (such as the Dependent Day Care FSA) and the federal dependent day care tax credit. The tax credit applies to the same expenses that are eligible for reimbursement through the Account. You can take a tax credit on your federal income tax return from 20% to 30% of your eligible dependent day care expenses, depending on your adjusted gross income. The amount of the credit offsets your tax liability dollar for dollar. The expenses covered by the credit are limited to a maximum of $3,000 for one dependent and $6,000 for more than one dependent. The credit equals a percentage of your dependent day care expenses up to the maximum limit on expenses.

You can use either the Dependent Day Care FSA or the tax credit – but not both – for the same expenses. More specifically, if you use the Dependent Day Care FSA for $5,000 of expenses for one child, you can save taxes on the full $5,000, but you eliminate your ability to use the tax credit since amounts reimbursed under the Dependent Day Care FSA reduces, dollar-for-dollar, the amount of the available tax credit. If, on the other hand, you are reimbursed $1,400 through the Dependent Day Care FSA for expenses for one child, you can only apply up to $1,000 to the tax credit.

Because you will not be able to take advantage of the tax credit for amounts reimbursed through your Dependent Day Care FSA, you may wish to consider which of the two methods will save you more in tax dollars. Your individual tax situation will determine which approach is better for you. Generally, the Dependent Day Care FSA provides a greater tax savings for people whose marginal tax rate is above 15% of adjusted gross income. You may want to consult a tax adviser for help in

determining whether the Dependent Day Care FSA is more advantageous than the tax credit, as individual circumstances must be considered. You may also refer to IRS Publication 503, available by request from the IRS by calling 800–829-3676.

If You Have a Leftover Balance

Under the Plan, a grace period of two-and-one-half months is permitted to cover eligible expenses incurred in the following Plan Year. Accordingly, any money contributed to a Dependent Day Care FSA in a given year must be used for eligible expenses incurred by March 15 of the following year.

The Plan also permits a run-out period during which proof necessary to substantiate a claim may be submitted. The run-out period for substantiation ends on May 31 of the year following the Plan Year in which the contributions are made.

In order to take advantage of the grace period and the run-out period, you must be a participant in the Plan with Dependent Day Care FSA coverage that is in effect on the last day of the Plan Year to which the grace period relates (e.g. December 31, 2018 to be able to use 2018 Dependent Day Care FSA contributions for eligible expenses incurred by March 15, 2019).

As required under Internal Revenue Service regulations, a "use it or lose it" rule applies. Any contributions remaining in the Dependent Day Care FSA at the close of the grace period, and for which necessary substantiation is not submitted by the end of the run-out period, will be forfeited and will not be available to you as a refund; so it is important for you to estimate your expenses carefully.

If You Leave Vanguard or Cease Participation

If you are no longer participating in the FSA because you have left Vanguard or waived coverage because of a permitted election change, you may still be reimbursed for expenses as long as they are incurred after you enrolled in the FSA for the Plan Year and prior to the date you terminated participation in the FSA. You may submit claims for reimbursement until May 31 following the end of the Plan Year in which your coverage was terminated.

You may continue to submit paper claim reimbursements to PayFlex. Only the expenses that are incurred while you were an active participant in the Plan will be eligible for reimbursement from the account.

If You Die

If you die, your surviving dependents may be reimbursed for expenses incurred during your period of participation during the Plan Year until your date of death. Your surviving dependents may submit claims for reimbursement until May 31 following the end of the Plan Year in which you died.

Leave of Absence

Generally, the dependent daycare expenses that are incurred during the period of a paid or unpaid leave of absence are not eligible for reimbursement. Crew members can elect to increase or decrease their annual dependent day care pledge at the commencement or termination of an unpaid leave of absence, as stated in Section II.A (Enrollment Changes).

E. Long-Term Disability

Introduction

The Long-Term Disability (LTD) benefit provides financial protection to eligible crew members by paying a portion of your base pay if you are unable to work because of an injury or illness that qualifies as a long term disability. The Plan Administrator has delegated day to day benefits administration, including determination of eligibility for, the amount of, and duration of LTD benefits to Cigna (also called the External TPA). See Section I.A for an explanation of Short-Term Disability (STD) benefits.

LTD is fully insured by the External TPA and is subject to ERISA. The Plan Administrator has also delegated its fiduciary responsibility for the ERISA claims determination and appeal process to the External TPA for LTD benefits. Accordingly, the External TPA is the named fiduciary for claims appeal purposes under ERISA.

Eligibility

Vanguard offers LTD income benefits to all crew members who meet the eligibility requirements in Section II.A. Your coverage will begin on your first day of employment as a crew member who meets these eligibility requirements.

Cost of Coverage

Vanguard pays the full cost of your LTD coverage under the Plan. You will receive an allotment of Vanguard paid credits, which will equal the cost of the LTD coverage. You choose whether the premium is paid for on a pre-tax or after-tax basis. This can have important tax consequences:

- If you choose to pay for LTD premiums with pre-tax dollars (as you do for your medical, dental, and vision benefits; supplemental life insurance; and flexible spending accounts), and you ever become disabled, your LTD income benefits will be subject to federal, and if applicable, also state and local income tax.

- If you choose to pay for LTD premiums with after-tax dollars, you will be paying more than if you choose to pay with pre-tax dollars. But if you subsequently become disabled, any LTD income benefits you receive will be exempt from federal income taxes, and if applicable, possibly state and local income taxes.

LTD coverage is mandatory for all crew members: You cannot waive coverage. You may only choose whether you pay for this coverage with pre- or after tax dollars. Whether you decide to pay for coverage with pre- or after-tax dollars will depend on your personal circumstances, including your age and your financial situation.

Benefit Amount

Eligible crew members who have been disabled for more than the Elimination Period, as defined in the LTD Booklet/Certificate, due to a qualifying illness or injury may qualify for LTD benefits. The amount crew members who qualify for LTD receive is based on the "Covered Earnings" as defined in the LTD Booklet/Certificate in effect just prior to the date the long term disability begins. In some cases, crew members can receive disability payments even if they work while they are disabled. The gross LTD benefit will replace 66⅔% of pre-disability "Covered Earnings" as defined in the LTD Booklet/Certificate, but not more than the "Maximum Monthly Benefit" of $15,000.

Note that this gross LTD benefit may be reduced by other income benefits. See the LTD Booklet/Certificate in the Plan booklet for more details.

Enrollment

LTD benefits are based on employment status (i.e. full-time or part-time), your "Covered Earnings", and whether or not you meet the definition of "Disabled" as determined by the External TPA, Cigna. All of these terms as well as others relating to the LTD benefit are defined in the Long Term Disability Booklet/Certificate which can be found in Plan booklet L.

Maximum Benefit Period

Your age on date disability begins	**Your maximum benefit period** ends on either: the SSNRA* or the date listed below, whichever is later.
Age 61 or under	Your 65th birthday or the date the 60th Monthly Benefit is payable, if later.
Age 62	The date the 60th Monthly Benefit is payable.
Age 63	The date the 60th Monthly Benefit is payable.
Age 64	The date the 60th Monthly Benefit is payable.
Age 65	The date the 12th Monthly Benefit is payable.
Age 66	The date the 12th Monthly Benefit is payable.
Age 67	The date the 12th Monthly Benefit is payable.
Age 68	The date the 12th Monthly Benefit is payable.
Age 69 or older	The date the 12th Monthly Benefit is payable.

*SSNRA means the Social Security Normal Retirement Age in effect under the Social Security Act on the Policy Effective Date.

Disabilities Not Covered By the Plan - Exclusions

The Plan does not cover any disabilities caused by, contributed to by, or resulting from:

- Suicide, attempted suicide, or self-inflicted injury while sane or insane.
- War or any act of war, whether or not declared.
- Active participation in a riot.
- Commission of a felony.
- The revocation, restriction or non-renewal of your license, permit or certification necessary to perform the duties of your occupation unless due solely to Injury or Sickness otherwise covered by the Policy.

In addition, the Plan will not cover disability due to incarceration in a penal or corrections institution.

Termination of Benefits

Refer to the "Termination of Disability Benefits" section of Plan booklet L on when LTD benefits end.

Termination of Coverage

A crew member's coverage for LTD benefits will terminate on the earliest of the following dates:

- The date the Plan or the LTD benefits under the Plan terminates;
- The date the crew member is no longer eligible for LTD benefits;
- The date the crew member's employment with Vanguard terminates; or

- The date Vanguard stops paying the required premium.

LTD coverage may be continued while the crew member is on an approved leave of absence. Coverage during an approved leave may continue until the earlier of the date Vanguard stops paying the required premium **or** the date the leave ends.

Termination of coverage will not affect a covered disability that began before the date of termination.

For More Information

Plan booklet L is the Cigna LTD Booklet/Certificate and is available on CrewNet. This SPD together with Plan booklet L serve as the full Plan Document for LTD benefits. If you have any questions, call Crew Central at 844-VG1-CREW (844-841-2739) or extension 1CREW.

F. Legal Services

Introduction

Hyatt Legal Plans, Inc. ("Hyatt") has been selected to provide legal plan benefits. The services will be provided through a panel of participating law firms. Lawyers in this network are called Plan Attorneys. The actual provisions of the Legal Plan are set forth in a written document maintained by Vanguard (Plan booklet M). All statements made in this SPD (other than determinations of crew member eligibility to participate) are subject to the provisions and terms of Plan Booklet M (which control in the event of conflict with this SPD). This benefit is not subject to ERISA.

Eligibility

Crew members who meet the eligibility requirements in Section II.A may enroll in the Legal Plan. If you enroll in the Legal Plan, you and your eligible dependents will be eligible to receive covered Legal Services. Eligible dependents include your spouse and your child(ren) up to age 26.

(Please refer to Section IV of the document for domestic partner eligibility.)

Enrollment

An eligible crew member may choose to join or drop out of the Legal Plan at the annual open enrollment period. If you become an eligible crew member after the annual open enrollment period, you can elect to participate in the Legal Plan by completing your enrollment election within 30 days of employment. You will not be permitted to change your election to participate (or not to participate) in the Legal Plan for any reason during the Plan Year, even in cases of unpaid leave, unless you cease to be an eligible crew member. The Legal Plan has a minimum participation period of one Plan Year (starting with January 1st and ending December 31st) of the current plan year. For newly eligible crew members enrolling after January 1st, the minimum participation period will end December 31st of the first Plan Year for which they enrolled.

When Coverage Begins

Generally, Legal Plan coverage becomes effective on the first day of the first month of the Plan year in which Vanguard offers the Legal Plan (typically January 1), for the elections you made during the previous open enrollment period. For new hires, coverage begins on your date of hire.

When Coverage Ends

Your ability to receive legal services under the Legal Plan ends if you are no longer an eligible crew member or on January 1st if you chose not to enroll during the annual open enrollment period. If you become ineligible to participate in the Legal Plan for any reason, including termination of employment, the Legal Plan will cover the legal fees for those covered services that were opened and pending during the period you were enrolled in the Legal Plan. In order for services to be covered, you or your eligible dependents must have obtained a Case Number (assigned by Hyatt), retained an attorney and the attorney must begin work on the legal matter while you are an eligible member of the Legal Plan. Of course, no new matters may be started after you become ineligible.

Administration and Funding

The Legal Plan is provided for and administered through a contract with Hyatt Legal Plans, Inc. Hyatt makes all determinations regarding attorneys' fees and what constitutes covered services. All contributions collected from crew members electing this coverage are paid to Hyatt Legal Plans, Inc.

Cost of Coverage

You pay the cost of the Legal Plan through **after-tax** payroll deductions.

How to Get Legal Services

To use the Legal Plan, visit www.legalplans.com or call Hyatt Legal Plans' Client Service Center at 800-821-6400. Be prepared to give your Crew ID or Membership Number (sent to you in early January if you elect the Legal Plan at open enrollment). If you are the spouse or an eligible dependent of a participating crew member, you will need the Crew ID or Membership Number of the participating crew member through whom you are eligible.

If you use Hyatt's web site at www.legalplans.com, click "**Login to See Your Coverage"** under the Members section. You will need to provide the last four digits of your Membership Number and home zip code, when prompted.

If you call the Client Service Center, the Client Service Representative who answers your call will:

- Verify your eligibility for services;
- Make an initial determination of whether and to what extent your case is covered (the Plan Attorney will make the final determination of coverage);
- Give you a Case Number that is similar to a claim number (you will need a new Case Number for each new case you have);
- Give you the contact information of the Plan Attorney most convenient to you; and
- Answer any questions you have about your Legal Plan services.

Then call the Plan Attorney and identify yourself as a participating crew member referred to them by Hyatt Legal Plans. You should request an appointment for a consultation. You should be prepared to give them your Case Number, the name of the legal plan you belong to and the type of legal matter you are calling about. If you wish, you may choose an out-of-network attorney. In a few areas, where there are no Participating Law Firms, you will be asked to select your own attorney. In both circumstances, Hyatt Legal Plans will reimburse you for these non-Plan attorneys' fees based on a set fee schedule.

You **must** call Hyatt Legal Plans or register on their website (www.legalplans.com) prior to using the services of any attorney.

Plan Confidentiality, Ethics, and Independent Judgment

Your use of the Legal Plan and the legal services provided to you are confidential. The Plan Attorney will maintain strict confidentiality of the traditional lawyer-client relationship. Vanguard will know nothing about your legal problems or the services you use under the Legal Plan. Hyatt administrators will have access only to limited statistical information needed for administration of the Legal Plan. No one will interfere with your Plan Attorney's independent exercise of professional judgment when representing you.

All attorneys' services provided under the Legal Plan are subject to ethical rules for lawyers. The Plan Attorney's obligations are exclusively to you, and the Plan Attorney's relationship is exclusively with you. Hyatt Legal Plans, Inc., or the law firm providing services under the Legal Plan, is responsible for all services provided by their attorneys. **The Legal Plan has no liability for the conduct of any Plan Attorney or other attorney you select who provides services to you.**

Plan Attorneys will refuse to provide services if the matter is clearly without merit, frivolous or for the purpose of harassing another person.

If you have a complaint about the legal services you have received or the conduct of Plan Attorney, call Hyatt Legal Plans at 800-821-6400. Your complaint will be reviewed and you will receive a response within two business days of your call.

Exclusions

Excluded services are those legal services that are not provided under the plan. No services, not even a consultation, can be provided for the following matters:

- Employment-related matters, including Vanguard or statutory benefits
- Matters involving Vanguard, MetLife® and affiliates, and Plan Attorneys
- Matters in which there is a conflict of interest between the crew member and the crew member's spouse or dependents in which case services are excluded for the spouse and dependents
- Appeals and class actions
- Farm matters, business and investment matters, matters involving property held for investment or rental, or issues when the covered crew member is the landlord
- Patent, trademark and copyright matters
- Costs or fines
- Frivolous or unethical matters
- Matters for which an attorney-client relationship exists prior to the crew member becoming eligible for Legal Plan benefits.

If You Leave Vanguard

As long as the crew member opens a case before the legal coverage period ends or they terminate employment, Hyatt will see the case to completion. This is at no extra cost to the crew member after coverage ends or they terminate. They will not, however, be able to open any new cases. If the crew member wishes to continue their legal services coverage after termination, they have 30 days to contact Hyatt. Hyatt will then send a packet and they will have another 30 days to enroll. The cost of the extension, for 30 months of coverage, is $16.50 per month for a total of $495 to be paid up-front.

For More Information

Plan booklet M is the summary of coverage for legal services and is available on CrewNet. If you have any questions, call Crew Central at 844-VG1-CREW (844-841-2739) or extension 1CREW.

G. Purchased Paid Time Off

Introduction

In addition to Vanguard's standard paid time off entitlement, crew members may elect to purchase additional paid time off (PTO) under the Plan. This benefit is not subject to ERISA.

Eligibility

Crew members who meet the eligibility requirements in Section II.A may elect to purchase PTO at Open Enrollment in increments of 7.5 hours, but not more than one additional workweek per year. If you are eligible to purchase PTO, the number of hours you may purchase is based on the hours you are scheduled to work on January 1 of the plan year you are making elections for at the time your Open Enrollment is initiated in the online HR system (Workday). The cost is based on your salary as of September 30th of the year in which you make your election. For example, at Open Enrollment for the 2018 Plan Year, if you are scheduled to work 30 hours per week beginning January 1, 2018, you would be able to purchase up to 30 hours of PTO. The cost would be based on your salary as of September 30, 2017.

Enrollment

If you are interested in this option, you must elect it during the annual open enrollment period. Newly hired crew members are not eligible in their year of hire.

Cost of Coverage

For each hour you purchase, an amount equivalent to one hour of your salary as of September 30th of the prior year will be spread over the Plan Year and deducted from your first 24 biweekly paychecks on a pre-tax basis for the current Plan Year.

You are not permitted to change your purchased vacation election for any reason during a Plan Year, except in the case of an employment status change where the crew member is no longer benefits eligible (such as a reduction of hours less than 30 hours per week). If contributions are missed due to an unpaid leave of absence, additional payroll deductions will occur when you return to work.

Reimbursement

You must use your standard PTO before you can use your purchased PTO. You may not carry over your purchased PTO to the following Plan Year; however, you may be reimbursed for the days you did not use. If you do not request to use all of your purchased PTO, you will be automatically reimbursed in December for any unscheduled days, and no further action is needed. IRS regulations do not allow Vanguard to reimburse after December 31 of the year for which the PTO was purchased.

Section III - Health Savings Account

Introduction

A Health Savings Account (HSA) is a special account owned by an individual and used to reimburse the account owner for current or future qualified health care expenses. You may contribute to the HSA on a pre-tax basis and receive tax-free earnings on accumulated funds. Any distributions from the HSA for qualified medical, prescription, dental and vision expenses are tax-free. All qualified health care expenses are defined by the IRS (see Publication 502 on www.irs.gov). The HSA is not subject to ERISA and is not endorsed by Vanguard.

Eligibility

If you meet the eligibility requirements in Section II.A and are enrolled in the High-Deductible Health Plan (HDHP) a Health Savings Account (HSA) will automatically be established with HealthEquity.

Your HSA eligibility is determined on a monthly basis. You are only eligible to make or receive contributions to an HSA if you are enrolled in an HDHP by the 1st day of the month and you do not have other disqualifying health coverage. In general, disqualifying coverage means that you or your spouse cannot have coverage that pays for any of your medical expenses before your HDHP deductible is met (except for certain limited preventive care expenses).

Eligible Dependents

You can use the HSA to pay for qualified health care expenses for the following individuals, regardless of whether they are covered by the Plan:

- Yourself;
- Your legally married spouse (if he/she is not enrolled in a general purpose health care FSA with his/her employer);
- Your domestic partner claimed as your pre-tax dependent for health coverage purposes (Please refer to Section IV for discussion on qualified domestic partners);
- Your dependent children; and
- Anyone else you can claim as a dependent for income tax purposes for the Plan Year.

Note: If you are covering a domestic partner on an after-tax basis, you are eligible to contribute up to the family annual maximum to an HSA. You may use assets in your HSA for your domestic partner's health care expenses but, generally, such a distribution is taxable and subject to an additional 20% excise tax if you are under age 65. Your domestic partner, if covered by the HDHP, may also establish his or her own HSA, if he or she meets the eligibility requirements.

Enrollment

When you enroll into the HDHP, HealthEquity will send you a Welcome Kit, which includes a Visa® Health Account debit card to be used to pay for qualified medical expenses. The HealthEquity HSA is initially set up as a cash account and may be maintained as such, but if you are interested in investing, you may elect from a variety of Vanguard mutual funds.

Annual Contributions

You can make contributions to your HSA with HealthEquity via payroll deduction or directly by personal check or bank transfer. Vanguard will make a contribution to your HSA with HealthEquity. These contributions will begin during the 1st month of eligibility.

Contribution limits are indexed each year by the IRS. For 2018, the maximum annual HSA contribution is $3,450 for individual HDHP coverage and $6,900 for family HDHP coverage. Crew members who reach age 55 by the last day of the plan year, can contribute an additional $1,000 to an HSA for that year under the catch-up provision.

You are responsible for keeping track of all contributions for the year to ensure that you do not exceed the annual maximum contribution. Please be aware that if you notify Vanguard of your ineligibility to make HSA contributions or have already contributed the maximum annual amount to your HSA by the time an employer contribution (described above) is to be made, Vanguard will not make a contribution to your account.

Vanguard's contribution of $600 for individual coverage or $1,200 for family coverage counts toward your annual maximum contribution. In addition, you and your spouse/domestic partner (covered under the HDHP) may qualify for additional employer contributions to your HSA by participating in the Health Smart Rewards wellness program. Any dollars earned in the Health Smart Rewards wellness program are deposited into your HSA at certain thresholds throughout the year.

If you enroll in the HDHP after January 1 of a plan year, you are not eligible to make a full contribution to your HSA unless you stay enrolled in the HDHP for the following Plan Year through December 31. If so, you can make the full contribution, up to the IRS maximum, for the current Plan Year. Otherwise, you are limited to one-twelfth the annual maximum contribution amount for each month you are HSA-eligible. Remember, in order to be HSA eligible, you must be enrolled in the HDHP by the 1st day of the month. If you enroll in an HDHP after the 1st day of the month, you will not be HSA eligible until the 1st day of the following month. If you contribute more than what you are permitted based on the number of months you are HSA- eligible, any excess contributions will become taxable and subject to an additional 20% penalty tax.

You may contribute to your HSA until the deadline for filing taxes of the following calendar year. However, if you are contributing to the HSA through payroll deductions, HSA contributions that will apply to the 2018 limit will cease after the 26th pay of 2018. If you elect to make contributions via payroll deduction for 2019, they will begin the first pay in January whether you have satisfied the 2018 contribution limit or not.

Mid-Year Plan Elections/Changes

Some life events allow you to change your medical plan elections. If you enroll in the HDHP during a life event and are eligible to make contributions to an HSA, you can also set up bi-weekly HSA payroll deductions at that time. (Please see Section II.A for Enrollment Changes.)

You may change your HSA payroll contribution amount at any time by submitting a request to change your HSA election. Your change will take effect the first of the month following the month in which the change was made. In order to have a change go into effect for the current plan year, changes must be requested by the end of November of the current plan year. You will be capped at the maximum annual contribution for your coverage level.

Distributions

Unlike a flexible spending account, there is no deadline for submitting claims for reimbursement. In the event of an audit, you will be required to produce receipts for any medical expenses for which you have been reimbursed.

Distributions from your HSA for qualified medical, prescription, dental and vision expenses are tax- free. Qualified health care expenses are those that the IRS would view as qualified for the medical and dental expenses deduction for tax purposes. Any money taken out of your HSA for anything other than qualified expenses is taxable. If you take a distribution for anything other than eligible expenses, such distribution should be included in your taxable income when you file your tax return for the year of the distribution and, if you are under the age of 65, a 20% penalty will be assessed on the claimed amount.

Beneficiaries

Any person can be named as your beneficiary for your HSA. If you designate your spouse as your HSA beneficiary upon your death, the account will be transferred to your spouse's name and will remain an HSA with all tax benefits intact. If you designate your HSA to a non-spouse beneficiary, the HSA funds will be liquidated and the beneficiary will be responsible to pay taxes on the balance.

Beneficiaries are not established during the online enrollment process and are separate from your life insurance beneficiary. Once your enrollment is complete, HealthEquity will mail you a welcome kit with the beneficiary form included. You will need to return the completed form by mail or fax to HealthEquity.

You can change your HSA beneficiary at any time.

If You Leave Vanguard

The contributions that you have made to the HSA are yours – you take them with you if you leave Vanguard or retire. You may continue to use your HSA funds to pay for medical expenses for yourself, your spouse and any tax dependents.

After you leave Vanguard, additional contributions cannot be made to the HSA unless you are covered by an HDHP. HDHP coverage can be continued through COBRA, but Vanguard will not make any employer contributions to the HSA. However, the funds can continue to be distributed from your HSA.

You may use the HSA to reimburse yourself for eligible health care expenses, and some insurance premiums, such as long-term care policies, COBRA premiums, health insurance premiums if on unemployment compensation, and Medicare Parts A, B, and D.

For More Information

Additional information on HSAs is available on CrewNet or the U.S. Department of the Treasury website, http://www.treasury.gov/resource-center/faqs/Taxes/Pages/Health-Savings-Accounts.aspx. If you have any questions, call Crew Central at 844-VG1-CREW (844-841-2739) or extension 1CREW.

Section IV - Domestic Partners

Introduction

A crew member who meets the eligibility requirements in Section II.A may elect health benefits through the Plan for his or her eligible domestic partner and the domestic partner's child(ren). The tax implications of such benefits will depend upon whether the domestic partner qualifies as a tax dependent for health coverage purposes within Section 105(b) of the Code. Clarification on the eligibility for covering a domestic partner and their child(ren) is provided below.

Domestic partners (and, where applicable, the domestic partner's children) may be covered under the following benefits:

Group health plans

- Medical including Prescription Drug
- Dental
- Vision
- Best Doctors
- Crew Assistance Program (CAP)
- RedBrick

Flexible Spending Accounts (only covers Domestic Partners and their children claimed on a crew member's tax return)

- Health Care Flexible Spending Account
- Dependent Day Care Flexible Spending Account

Spousal/Domestic Partner Life Insurance

Legal Services

Health Advocate

Eligibility

The benefits listed above are offered to same- or opposite-sex domestic partners who meet the eligibility criteria listed below. Crew members must complete and submit Vanguard's *Affidavit of Domestic Partnership* ("Affidavit"), which is available on CrewNet. In order to be considered under the plan as an eligible domestic partnership, so that the crew member may elect benefits for their domestic partner, both the crew member and the domestic partner must certify that:

- We have been living in a committed and exclusive relationship, have continually resided in the same primary residence for a period of at least six months, and intend to continue to reside together permanently;
- We are each other's sole domestic partner and intend for our domestic partnership to be permanent;
- We are jointly responsible for each other's common welfare and financial obligations, or the non-crew member domestic partner is chiefly dependent upon the crew member for care and financial assistance;
- Neither of us is married (either legally or by common-law) to anyone else, a domestic partner of anyone else, or legally separated from anyone else;
- We are 18 years of age or older;

- We do not have a blood relationship that would bar marriage under the laws of the State in which we reside, (or if applicable, were married) and we have otherwise satisfied all other marriage requirements imposed by such State;
- We are not in this relationship solely for purposes of obtaining benefits; and
- We have provided the documentation requested by HR (listed on the Affidavit) supporting our domestic partnership.

If an individual is an eligible domestic partner, the crew member may elect to provide health benefits for any child(ren) of the crew member's eligible domestic partner who is under the age of 26, even if coverage is not elected for the eligible domestic partner.

Note: You may not choose different options within the same benefit for the domestic partner. For example, if the crew member is enrolling the domestic partner in a medical plan including prescription coverage, the domestic partner must be enrolled in the same plan as the crew member.

Affidavit of Domestic Partnership

The crew member and the domestic partner will be required to sign Vanguard's Affidavit. In support of your Affidavit, you and your domestic partner must submit certain documents to provide verification of your economic interdependency.

The entire record of evidence presented with Vanguard's Affidavit will be considered in deciding whether an individual is an eligible domestic partner.

Covering Your Domestic Partner as a Pre-Tax Dependent

An eligible domestic partner of the crew member will qualify as a tax dependent for health coverage purposes within the meaning of Section 105(b) of the Code to the extent they:

- Have resided in the same primary residence as the crew member and is a member of the crew member's household;
- Rely upon the crew member for the entire coverage period for over one-half of their support;
- Are not "qualified children" (as described in section 152(c) of the Code) of any other taxpayer for the entire coverage period; and
- Are not an ineligible individual under section 152(b) meaning they are not a dependent of a Code 152(b) dependent, a married dependent filing a joint return, or someone who is not a citizen or national of the US, or a resident of the US.

Covering Your Domestic Partner's Child

Generally, if a crew member covers their domestic partner's child(ren) under the Plan, the cost of such coverage is paid on an after-tax basis. However, coverage can be paid on a pre-tax basis if the domestic partner's child(ren) is considered the crew member's dependent for federal income tax purposes and if the conditions of a tax dependent required by Section 152(d) of the Code, are met. While this situation is not common, if the domestic partner's child(ren) meet the definition of a tax dependent, any premiums paid during the year for the domestic partner's child(ren) will be treated as pre-tax contributions to the Plan.

Cost of Coverage

The crew member will be responsible to pay for domestic partner coverage through biweekly payroll deductions.

If you cover a domestic partner, typically the cost of such coverage is paid by you on an after-tax basis through payroll withholding. In addition, imputed income will be added to the crew member's biweekly pay equal to the value of coverage minus the after-tax amount the crew member pays for domestic partner coverage.

If, however, you establish to the satisfaction of Crew Central that your domestic partner and/or your domestic partner's child(ren) for whom you seek coverage are your dependents within the meaning of Sections 105(b) and 152 of the Code, respectively, any amounts paid by you for coverage for such dependents will be treated as pre-tax contributions to the Plan.

To claim dependent status for your domestic partner or any child(ren) of your domestic partner, you must sign the Affidavit in the presence of a notary public and provide the Affidavit and supporting documentation to Crew Central. Failure to provide the Crew Central with the Affidavit and supporting documentation could result in loss of coverage.

Special Enrollment Rights

If you cover your domestic partner and/or his or her children under the Plan and you are paying the cost of such coverage on an after-tax basis, you may elect or terminate coverage for such individual at any time during the Plan Year. If you cover your domestic partner and/or his or her child(ren) under the Plan and, because such individual(s) are your dependents within the meaning of Sections 105(b) and 152 of the Code, you may elect or terminate coverage for such individuals only if you or they experience a permitted election change (as described in Section II.A of this SPD).

Coordination with Medicare and Medicaid

The Plan, or other group plan, will generally be primary over Medicare for domestic partners for those services that would otherwise have been provided by Medicare where:

- Your domestic partner is entitled to Medicare on the basis of disability and covered by the Plan (as your dependent).
- Your domestic partner is entitled to Medicare benefits solely on the basis of having end-stage renal disease. (The Plan pays as primary during the first 30 months of Medicare coverage.)

The Plan, or other group plan, will generally be secondary to Medicare for domestic partners where:

- Your domestic partner is entitled to Medicare on the basis of their age and covered by the Plan (as your dependent).

The Plan, or other group plan, will generally be primary over Medicaid for those services that would otherwise have been provided by Medicaid.

Termination of Domestic Partner Benefits

A crew member may remove a domestic partner from his or her benefits coverage by submitting a status change with appropriate documentation. Reasons coverage may end include:

- The domestic partner has obtained coverage elsewhere.
- The domestic partner relationship ends.
- The domestic partner no longer meets the eligibility requirements.
- The crew member is no longer benefits eligible.
- The crew member terminates employment at Vanguard.
- The crew member dies.

Domestic Partners and COBRA

Generally, domestic partners are not qualified beneficiaries and, therefore, domestic partners have no independent right to elect continuation coverage. However, to the extent that a crew member has elected domestic partner coverage before a qualifying event that is the crew member's termination of employment (other than for gross misconduct) or reduction of hours to less than 30 hours per week, the crew member who is a qualified beneficiary shall have the ability to elect continuation of domestic partner coverage after the qualifying event.

For More Information

Additional information on domestic partner coverage is available on CrewNet. If you have any questions, call Crew Central at 844-VG1-CREW (844-841-2739) or extension 1CREW.

Section V – Optional Benefits

A. Academic Assistance Plan

Introduction

The Vanguard Academic Assistance Plan ("Academic Assistance") was established to assist in furthering the education of crew members and improving their skills. Academic Assistance provides reimbursement for tuition and books to eligible crew members enrolled in eligible programs at accredited institutions. Academic Assistance exists solely for the benefit of crew members. This benefit is not subject to ERISA.

Eligibility

All active full-time crew member (scheduled to work 37.5 or more hours per week) are eligible to participate in Academic Assistance. Crew members scheduled to work less than 37.5 hours per week are not eligible for coverage under this benefit under the Plan. For the definition of eligible crew member, please see the General Plan Information at the front of this SPD.

Eligible Programs

Programs eligible for reimbursement under Academic Assistance include:

- Undergraduate programs, listed on our field of study list, taken at an accredited institution and lead to an Associate's or Bachelor's degree. Approved fields of study can be found on CrewNet.
- Graduate degree programs:
    1. Master of Business Administration (MBA) at an accredited institution.
    2. Master of Science in Information Technology (MSIT), Master of Science in Information Systems (MSIS), Master of Science in Information Science (MSIS), or Master of Science in Data Analytics (MSDA) at an accredited institution, even if they are not job-related.
    3. All other graduate degrees must be related to the crew member's current job and lead to a Master's degree from an accredited institution. A graduate-level program is job-related if it maintains or improves the skills necessary in the crew member's current job or it is required by Vanguard (or applicable law or regulations) as a condition for the crew member to retain his or her position or compensation level. All approved graduate degree programs are contingent on the crew member remaining in a comparable position/department while pursuing the degree. Failure to remain in a comparable position or department through the final reimbursement could result in the termination of the Academic Assistance benefit.

Reimbursable Expenses

Reimbursement is limited to tuition and book expenses associated with courses as part of an Eligible Program (as defined above) as well as certain credit-based exams that provide credit towards such Eligible Programs ("Eligible Exams") under the Plan.

Each crew member can receive up to $9,000 reimbursement per calendar year for Eligible Programs and/or Eligible Exams completed in such a calendar year. The calendar year in which the course ends will determine the calendar year to which the reimbursement applies. For example, if a crew member completes a course on October 17, 2017 and requests reimbursement for the course on January 9, 2018, the reimbursement will count towards the 2017 calendar year, not the 2018

calendar year when the reimbursement is paid under the Plan. Taxation will be based on the calendar year in which the reimbursement is paid. Using the example above, the 2018 reimbursement for the course completed in 2017, will be taxable (or excluded from taxable income) in the 2018 calendar year.

Crew must submit final grade and receipt documents within six months following the end of the course or seven days after receiving their final grades, whichever is later.

In order to receive reimbursement, the crew member must have been employed with Vanguard full-time prior to the start of any course for which they are seeking reimbursement. If the crew member is on a paid or unpaid leave of absence at the time of expected reimbursement, the crew member will not receive reimbursement until after they return to work. If a crew member is receiving financial assistance from other sources (e.g. grants, financial aid), he or she will only be eligible for reimbursement under Academic Assistance if and to the extent his or her eligible expenses exceed the amount of such financial assistance.

The term "financial assistance" includes scholarships, fellowships, grants, tuition waivers, or any other form of public or private financial assistance that effectively reduces the financial obligation incurred by the crew member in connection with his or her education. However, a student loan is not considered financial assistance.

Amount of Reimbursement

Subject to the overall cap described above, the amount of reimbursement that a crew member receives for each Eligible Course depends on the grade received in the course, as shown below:

Grade	**Reimbursement (tuition and books)**
A or B	100%
C+, C or "Pass" in a pass/fail course	50%
C – or below, or "fail" in a pass/fail course	None

For Pass/Fail courses, letter grade equivalencies cannot be submitted to receive full reimbursement. Reimbursement is based on the grade as listed on the official school transcript.

A crew member will be fully reimbursed for eligible expenses, regardless of the grade earned in the Eligible Course, if the course is taken at the direction of Vanguard or Vanguard determines, in its sole discretion, that Vanguard's business requirements make it necessary for the crew member to discontinue the course. Please be aware that shipping and handling on books; taxes on books; expenses relating to travel, meals, lodging, parking, software programs, or supplies; or other fees are not covered by Academic Assistance.

Tax Treatment

It is intended that amounts reimbursed under Academic Assistance be excludable from the gross income of eligible crew members to the extent permitted by sections 127 and 132 of the Code. However, Academic Assistance reimbursements are not limited to amounts that are excludable from income under section 127 or 132 of the Code.

Whether an amount reimbursed under Academic Assistance is taxable to the crew member depends on the nature of the Eligible Program and the federal and state tax rules in effect at the time reimbursement is made.

- Undergraduate, MSIT, MSIS, and MSDA courses. Under current tax law, the first $5,250 in reimbursed expenses per calendar year for undergraduate courses and non-job-related courses that are part of an MSIT, MSIS, or MSDA program are not subject to federal income or employment taxes. Reimbursements may be subject to state income tax (see "State tax" below for more information). Any amount in excess of $5,250 will be treated as ordinary income for federal and state income tax purposes.
- Graduate courses. Reimbursed expenses for job-related graduate courses are not subject to federal income or employment taxes. Reimbursements may be subject to state income tax (see "State tax" below for more information).

State Tax

Reimbursements may be subject to state (and if applicable, local) income tax depending on the state and locality in which a crew member works and lives. Crew members who reside in other states should contact their state tax agency or consult with their tax advisor to determine whether their reimbursements will be subject to state income tax.

Source of Reimbursement

All reimbursements are paid solely from Vanguard's general assets. Vanguard does not maintain any trust or special fund for reimbursing crew members.

Exclusions

Medical and other doctoral programs, law degrees, post-baccalaureate programs, professional designation programs, regulatory licensing, job-related certificate programs, courses required prior to admission into a graduate program that are not taken as part of an undergraduate degree of study, and academic review courses (such as those given in preparation for the GMAT) are not covered under Academic Assistance. In addition, expenses for any course that instructs the crew member in any sport, game, or hobby are not covered under Academic Assistance. Job-related certificate programs are not covered under Academic Assistance, but may be covered by the crew member's department. Crew members interested in pursuing such certificate programs should contact their supervisors for additional details. Shipping and handling on books, taxes on books, and other fees are not covered under Academic Assistance. In addition, any expense relating to travel, meals, lodging, parking, software programs, supplies or other aspects of the degree program are not covered.

Using Vanguard Information for Course Work

Crew members may use nonproprietary and non-confidential information to which they have access through their departments and job functions. Crew members may not request such information from any other department or crew member. Crew members may not use confidential or proprietary information in any circumstance. When submitting a course for approval, crew members will acknowledge they have read and understand this policy.

If You Leave Vanguard

If a crew member resigns or if the crew member is discharged by Vanguard before the eligible reimbursement has been paid, the crew member is not eligible to receive reimbursement under Academic Assistance.

For all courses other than those under an undergraduate program, certain repayment conditions apply to any reimbursements received. As part of the Academic Assistance application process, crew members enrolling in graduate-level programs must sign a Graduate Degree Participation Agreement acknowledging the repayment requirements. Even if the terms of the Academic Assistance benefit change, crew members will be required to repay reimbursements in accordance with the terms of the Graduate Degree Participation Agreement in place at the time of each request for reimbursement.

Crew members terminating for any reason are required to reimburse Vanguard as follows:

Degree Level Program	**Repayment Requirement**
Undergraduate	None
Graduate (except MSIT, MSIS, and MSDA)	100% of assistance paid within 12 months of termination
MSIT, MSIS, and MSDA	100% of assistance paid within 12 months of termination 50% of assistance paid between 13-24 months of termination

B. Adoption Assistance Plan

Introduction

The Adoption Assistance Plan provides financial assistance to eligible crew members seeking to adopt a child. This Plan is intended to qualify as an adoption assistance program under the meaning of section 137 of the Code. This benefit is not subject to ERISA.

Eligibility

All active full-time crew member (scheduled to work 37.5 or more hours per week) are eligible for coverage under this benefit under the Plan. Crew members scheduled to work less than 37.5 hours per week are not eligible for coverage under this benefit under the Plan. For the definition of eligible crew member, please see the General Plan Information at the front of this SPD.

Reimbursable Eligible Expenses

Reimbursement is limited to eligible expenses as defined below. The maximum amount of reimbursement available per adoption is the maximum adoption tax credit under the Code for the calendar year, without regard to lower maximums that may apply or limit the amount excludable from federal taxable income on an individual taxpayer basis due to adjusted gross income. The maximum reimbursement per adoption is $13,810 for adoptions finalized in 2018.

Eligible expenses can include but are not limited to the following reasonable and necessary expenses directly related to the legal adoption of an eligible child:

- Adoption fees;
- Court costs;
- Attorney fees;
- Counseling expenses;
- Uninsured maternity expenses of the birth mother;
- Traveling expenses (including amounts expended for meals and lodging while away from home); and
- Other expenses that are directly related to the legal adoption of an eligible child.

An eligible child means an individual who is not a relative of an eligible crew member or domestic partner (please refer to Section IV for details) and who:

- Has not attained age eighteen (18); or
- Is physically or mentally incapable of caring for oneself.

Exclusions

Eligible reimbursement expenses do not include expenses that are:

- Paid, reimbursed, or excused under any other plan or program;
- Incurred in violation of any state or federal law or in carrying out any surrogate parenting arrangement;
- Incurred with respect to the adoption of a child of the eligible crew member's spouse (i.e. a step-child);
- Incurred prior to the date the crew member becomes an eligible full time crew member (as defined above) for purposes of the Adoption Assistance Plan ;
- Incurred with respect to the adoption of an eligible child who is not a U.S. citizen or resident until and unless the adoption is finalized; or
- Incurred with respect to the adoption of embryos.

Exclusions from Taxable Income

The reimbursement amount you receive under this Adoption Assistance Plan will be excludable from federal tax unless your taxable income exceeds a certain dollar amount set by the IRS. Other taxes may apply, such as state taxes, which will vary by state. For 2018, if your federal modified adjusted gross income (MAGI) exceeds $207,140, the dollar amount of the adoption assistance reimbursement you can exclude from your federal taxable income will begin to phase out, and once your MAGI reaches $247,140 or more, none of these reimbursements you receive will be excludable from taxable income.

Reimbursement Procedures

A claim for reimbursement must be submitted prior to the end of the Plan Year following the Plan Year which includes the later of (1) the date the adoption becomes final or; (2) the expense is incurred. You must also be an eligible full time crew member on the date the adoption becomes final, submit your claim for reimbursement while you are employed as an eligible full time crew member, and be employed as an eligible full time crew member on the date the Adoption Assistance reimbursement is paid. You may request reimbursement by completing the Adoption or Surrogacy Assistance Reimbursement Form located on CrewNet and submitting a case to Crew Central (along with documents reflecting proof of adoption and substantiation of expenses).

C. Best Doctors

Introduction

Best Doctors is a confidential program that allows crew members and their families access to medical advice from nationally recognized doctors. The program can be used to obtain advice on anything from minor surgery to serious issues like cancer and heart disease. With Best Doctors, crew members can have an expert doctors review their diagnosis and treatment plan to make sure it is right for them. This benefit is subject to ERISA.

Eligibility

All active crew members, and spouses, domestic partners, dependent children, parents and parents-in-law of crew members, are eligible for coverage under this benefit. For the definition of eligible crew member, please see the General Plan Information at the front of this SPD.

Participation

Eligible individuals may use Best Doctors through self-referral. Any crew member and their eligible dependents seeking to participate in Best Doctors should call Best Doctors at 866-904-0910.

Cost of Coverage

Vanguard pays the full cost of your Best Doctors benefit. There is no charge for using this benefit.

How the Benefit Works

Contact Best Doctors in order to take advantage of these four services to help you and your family make the right medical decisions:

1. **In-Depth Medical Review** - Best Doctors is like getting a second opinion, only through a process called InterConsultation™. Best Doctors will collect all records, images and test samples and leading doctors will review those along with the diagnosis and/or treatment plan and provide their detailed recommendation.
2. **Critical Care Support** - Best Doctors can get an expert involved when a medical event that requires emergency treatment, intensive care, or an extended hospital stay occurs. The expert will work with the local medical team to get the best care.
3. **Ask the Expert** – Get answers to basic questions about a diagnosis, treatment options and health conditions from an expert by calling Best Doctors. They will discuss concerns and will work with the most appropriate specialists. Best Doctors will also help determine what questions for you to ask.
4. **Find a Doctor** – Best Doctors can help find a local doctor or specialist, approved by a health plan, using a database of more than 53,000 medical experts in over 450 specialties and subspecialties worldwide.

Termination of Coverage

Termination of the eligibility to use Best Doctors occurs at the earliest of the following events:

- The date on which the crew member's employment terminates;
- The date this Plan terminates;
- The date the crew member is no longer eligible for the benefit; or

- The premium due date if Vanguard fails to pay the required premium to Best Doctors other than on account of an inadvertent error.

However, those covered may be eligible for COBRA coverage as described in Section II.B.6.

D. CrewCare

Introduction

CrewCare is a health clinic and physical therapy facility located on the Pennsylvania, North Carolina, and Arizona campuses. This benefit is subject to ERISA.

The daily operations of CrewCare are managed by an outside company, Premise Health. Premise Health is the industry's largest independent provider of workforce health management programs and clinics and has been in the onsite health care business for more than 30 years.

CrewCare is staffed by medical professionals, including nurse practitioners, physical therapists, health coaches, and nutritionists. Services offered include, but are not limited to:

- Assessment and treatment of minor illnesses and injuries;
- Counseling and support for chronic conditions;
- Immunizations and injections, such as allergy injections;
- Laboratory services;
- Nutritional counseling;
- Personal health coaching;
- Physical therapy;
- Preventive care;
- Referral management and coordinated care with primary physicians, specialists, and other Vanguard health management vendors;
- Screenings (such as blood pressure and cholesterol) and diagnostic tests;
- Life management counseling (PA location only); and
- Prescription concierge service through CVS/pharmacy in Frazer, PA (PA location only).

Eligibility

All crew members are eligible to use CrewCare. Dependents of crew members (spouse, children, stepchildren, etc.) are not eligible for coverage under this benefit under the Plan. For the definition of eligible crew member, please see the General Plan Information at the front of this SPD.

Costs of Services

Vanguard pays the cost of maintaining the on-site clinics and offering this benefit to eligible crew members. However, there is a fee if eligible crew members choose to use Crew Care. The cost for a visit to CrewCare will be based on your medical option and payments will be made through payroll deduction. If you would prefer not to have payment for your visit deducted from your paycheck, you may pay for your appointment with a credit card. CrewCare cannot accept cash or checks. Below are the costs of CrewCare visits based on your medical option.

Medical Plan	**Payment**
Aetna HealthFund	• With funds remaining in your HealthFund: $10 will be deducted from your account • With no funds remaining in your HealthFund: $10
High-Deductible Health Plan (HDHP)*	• $35 before deductible • $7 after deductible
Crew members not enrolled in a Vanguard medical option	• $35

*Per laws governing the HDHP: If you are enrolled in the HDHP, you have to pay the fair market value of any health care visit until you reach your deductible. For the Wellness Center, this amount is $35. After you reach your deductible, you'll pay 20% coinsurance of the fair market value ($7).

Preventive care: All in-network preventive services (immunizations, well visits, etc.) are covered 100% with no deductible, coinsurance or copay.

Nonpreventive care: These services (sick visits, etc.) are subject to copays, deductibles and coinsurance depending on the medical option you elected.

Other Costs

An additional charge may apply to services rendered by outside providers or considered non-preventive. Some examples include:

- Processing of blood work by Quest Diagnostics for laboratory tests.
- Immunizations not associated with Vanguard initiated business travel.

Participation

Eligible crew members may voluntarily use CrewCare.

How the Plan Works

You may request services at CrewCare using the secure patient portal at https://mypremisehealth.com/MyChart.

Termination of Coverage

Termination of the eligibility to use CrewCare occurs at the earliest of the following events:

- The date on which the crew member's employment terminates;
- The date this Plan terminates;
- The date the crew member is no longer eligible for the benefit; or
- The premium due date if Vanguard fails to pay the required premium to Premise Health other than on account of an inadvertent error.

However, those covered may be eligible for COBRA coverage as described in Section II.B.6.

E. Crew Assistance Program

Introduction

Vanguard contracts the professional services of Carebridge to provide eligible crew members with the Crew Assistance Program (CAP) recognizing that a healthy crew member is the heart of a strong, healthy organization. This benefit is subject to ERISA.

Eligibility

All active crew members, and the spouses, domestic partners, dependent children and children of domestic partners of such crew members, are eligible for coverage under this benefit under the Plan. For the definition of eligible crew member, please see the General Plan Information at the front of this SPD.

Cost of Coverage

Vanguard pays the full cost of CAP. There is no charge for using this benefit.

Participation

Through self-referral crew members (and the spouses, dependent children, domestic partners or a child of domestic partners) may use CAP for help with concerns such as:

- Alcohol and drug abuse
- Depression and anxiety
- Difficult emotional problems
- Family/parenting problems
- Financial pressures
- Grief and loss
- Legal concerns
- Marital and relationship issues
- Stress management
- Spousal/child/parent abuse
- Troubling personal matters
- Work relationships

In addition, a crew member who violates Vanguard's Drug- and Alcohol-Free Environment Policy, or whose emotional state is negatively affecting job performance, may be directed to CAP as a condition of continued employment at Vanguard. Admission to CAP will not insulate a crew member from other disciplinary action resulting from any other Vanguard policy violation that may occur subsequent to CAP enrollment. Any crew member seeking to participate in CAP should either contact Carebridge directly by calling 800-437-0911, or contact the Crew Relations Representative for his or her department for information.

Crew members and their dependents have access to Carebridge's website, www.myliferesource.com. The site offers self-help articles and multimedia resources related to relationships, life concerns, wellness and work. The site also offers the ability to research child care, elder care, college planning, financial and legal advice, parenting, and adoption.

How the Benefit Works

Carebridge involves the use of professional counselors – external to Vanguard – that provide a resource for assistance with personal, family, alcohol, or drug concerns. The individual will be evaluated by a Carebridge counselor and, if appropriate, will be offered counseling up to four sessions per year. Carebridge CAP sessions are provided at no cost to the crew member, spouse, dependent child, domestic partner, or a child of a domestic partner. In most cases, issues can be resolved within CAP. However, if longer-term treatment is necessary, the CAP professional will refer the individual to an appropriate resource.

Confidentiality

Your Carebridge CAP assistance is confidential and conforms to HIPAA requirements. Participation in the program or in treatment is not disclosed to anyone at Vanguard without the participant's written permission except in the following situations:

- By court order;
- Imminent threat of harm to self or others; or
- Situations of abuse (such as child or elder abuse).

Note: If participation in CAP is required as a condition of employment, management will be given no information beyond the fact that the crew member is participating as required.

Termination of Coverage

Termination of your coverage (and that of a spouse, dependent child, domestic partner, or a child of the domestic partner) under the Carebridge CAP benefit occurs at the earliest of the following events:

- The date on which the crew member's employment terminates;
- The date this Plan terminates;
- The date the crew member is no longer eligible for the benefit; or
- The premium due date if Vanguard fails to pay the required premium to Carebridge other than on account of an inadvertent error.

However, those covered may be eligible for COBRA coverage as described in Section II.B.6.

F. Dependent Scholarship Program

Introduction

The Dependent Scholarship Program (the "Program") provides a financial benefit to eligible crew members to use towards the cost of their eligible dependents' post-secondary education expenses. This benefit is not subject to ERISA.

Eligibility

A crew member is eligible to participate in the Program if he or she is an active full-time crew member (scheduled to work 37.5 or more hours per week) and has completed two years of service, measured from your hire date, or rehire date if you have been rehired by Vanguard. Crew members scheduled to work less than 30 hours per week are not eligible for this Program. For the definition of eligible crew member, please see the General Plan Information at the front of this SPD

Benefit Amount

Eligible crew members can receive an annual Vanguard-paid scholarship award of up to $1,000 per academic year to use toward an eligible dependent child's post-secondary education expenses. The Program benefit has a lifetime cap of $4,000 for each eligible dependent child. Requests for scholarship awards must be submitted within 6 months after the end of the second semester.

Eligible Dependent Child

In order for your dependent child to be eligible to qualify as a eligible dependent child under the Program, the dependent child must be: (1) age 25 or younger by the date the crew member first submits a Dependent Scholarship Application with EdAssist; and (2) considered a full-time (at least 12 credits completed per semester) undergraduate student at an accredited two-or four-year college or university or considered a full-time student at a technical/trade school.

Tax Treatment

Program scholarship awards are considered taxable to crew members and will be reported on the crew members' Form W-2.

Source of Scholarship Award

All Program scholarship awards are paid solely from Vanguard's general assets. Vanguard does not maintain any trust or special fund for the Program scholarship award.

Exclusions

A dependent child over the age of 25 is not eligible to qualify as an eligible dependent child under the Program. In addition, any dependent child enrolled in a graduate program, professional designation program, certificate program or enrolled as a part-time undergraduate student is not eligible to qualify as a dependent child under the Program.

G. Health Advocate

Introduction

Health Advocate, Inc. is a healthcare advocacy and assistance company and helps employer plan participants navigate the healthcare system. This benefit is not subject to ERISA.

Eligibility

All active crew members, and spouses, domestic partners, dependent children, parents, and parents-in-law of crew members, are eligible to participate in this benefit under the Plan. For the definition of eligible crew member, please see the General Plan Information at the front of this SPD.

Participation

Crew members and their eligible dependents may access Health Advocate by calling 855-424-9400 or by emailing them at: answers@HealthAdvocate.com.

Cost of Coverage

Vanguard pays the full cost of your Health Advocate benefit. There is no charge for using this benefit.

How the Benefit Works

Health Advocate's Core Health Advocacy program is a free and confidential service that centers around a team of Personal Health Advocates (PHAs) who help handle any health care and insurance-related issues you and your family encounter. PHAs will assist you and your family with clinical and administrative issues involving your medical, hospital, dental, pharmacy and other health care needs.

When you call Health Advocate you will be assigned your own PHA, typically a Registered Nurse, who is supported by a team of medical directors and benefits specialists. This highly personalized assistance program offers a number of services to include:

- Resolve insurance claims and billing issues
- Find the right doctors
- Schedule appointments
- Clarify insurance coverage
- Assist with elder care issues
- Obtain cost estimates for procedures
- Assist in the transfer of medical records

Health Advocate follows careful protocols and complies with all government privacy standards so that you may rest assured your medical and personal information will remain strictly confidential.

Termination of Coverage

Your eligibility to participate in Health Advocate's Core Health Advocacy program ends when your employment with Vanguard terminates.

H. RedBrick

Introduction

RedBrick is a lifestyle management company that partners with organizations such as Vanguard to offer certain wellness benefits. This includes, but is not limited to, the Compass health assessment and telephonic health coaching.

Eligibility

All active crew members are eligible to use RedBrick, even if they are not covered by a Vanguard medical option. Spouses or domestic partners covered by a Vanguard medical option are also eligible to use RedBrick. Dependent children are not eligible for coverage under this benefit under the Plan. For the definition of eligible crew member, please see the General Plan Information at the front of this SPD.

Participation

Active crew members and their covered spouses or domestic partners may voluntarily participate in all RedBrick programs.

Cost of Coverage

Vanguard pays the full cost of your RedBrick benefit. There is no charge for using this benefit.

How the Program Works

Active crew members and their covered spouses or domestic partners seeking to use the RedBrick resources may log on to the RedBrick website at https://vanguard.redbrickhealth.com or call the RedBrick Help Line 1-844-724-3948.

Termination of Coverage

Termination of your eligibility to use RedBrick occurs at the earliest of the following events:

- The date on which the crew member's employment terminates;
- The date this Plan terminates;
- The date the crew member is no longer eligible for the benefit; or
- The premium due date if Vanguard fails to pay the required premium to Redbrick other than on account of an inadvertent error.

However, those covered may be eligible for COBRA coverage as described in Section II.B.6.

I. Health Smart Rewards Wellness Program

Introduction

Vanguard's Health Smart Rewards wellness program provides opportunities for eligible crew members and their covered spouses or domestic partners to improve their physical well-being. The Health Smart Rewards wellness program includes, but is not limited to, the Compass health assessment, biometric screening, prevention education, and informational programs for which you could earn Health Smart Rewards dollars. This benefit is subject to ERISA.

Eligibility

All active crew members are eligible to participate in the Health Smart Rewards wellness program, even if they are not covered by a Vanguard medical option. Spouses or Domestic Partners covered by a Vanguard medical option are also eligible to participate and earn reward dollars. Dependent children are not eligible for coverage under this benefit under the Plan. For the definition of eligible crew member, please see the General Plan Information at the front of this SPD.

Participation

Active crew members and their covered spouses or domestic partners may voluntarily participate in the Health Smart Rewards wellness program.

Cost of Coverage

Vanguard subsidizes some of the costs of the Health Smart Rewards wellness program, but fees are required for some of the programs. The cost, if any, of each program will be determined at the time the program is offered. Information on the cost will be available on CrewNet.

Health Smart Rewards Dollars

Your Health Smart Rewards dollars are deposited into your health fund account (health reimbursement arrangement for Aetna HealthFund participants, or health savings account for HDHP participants) and can be used to help pay for future medical expenses. If you are not covered by one of Vanguard's medical options, your rewards will be in the form of a gift card. Any Health Smart Reward dollars received on a gift card are taxable.

How the Program Works

To earn Health Smart Rewards dollars, you must complete your biometric screening (except the tobacco-free measure) by September 30 of the calendar year. You must also report whether you are tobacco free and complete your Compass health assessment (these 3 requirements together are called the "Participation Requirements") by November 30 before you can start earning any reward dollars.

Contact Crew Central at 844-VG1-CREW or extension 1CREW if it is medically inadvisable or unreasonably difficult for you to complete one or more of the Participation Requirements as Vanguard may waive one or more of the Participation Requirements and give you the opportunity to earn Health Smart Rewards dollars by completing qualifying healthy activities.

View CrewNet or call Crew Central at 844-VG1-CREW (844-841-2739) or extension 1CREW for more details, including the requirements necessary to earn reward dollars as well as the list of qualifying healthy activities. Some qualifying health activities do require registration.

If you or your covered spouse or domestic partner cannot meet a biometric target or participate in a healthy activity, you may be able to earn the same reward dollars by different means. Contact Crew Central, and a benefits specialist will work with you (and, if you wish, your doctor) to find other reasonable alternatives that are right for you in light of your health status and also to determine whether a waiver may be appropriate in your situation.

Termination of Coverage

Your eligibility to participate in Vanguard's wellness programs ends when your employment with Vanguard terminates. Termination of your eligibility to participate in the Health Smart Rewards wellness program occurs at the earliest of the following events:

- The date on which the crew member's employment terminates;
- The date this Plan terminates;
- The date the crew member is no longer eligible for the benefit; or
- The premium due date if Vanguard fails to pay the required premium to Redbrick other than on account of an inadvertent error.

J. Student Loan Repayment Assistance Program

Introduction

Vanguard established the Student Loan Repayment Assistance Program (the "Repayment Program") to help ease the burden of crew members who have student loans that have accumulated as a result of past education expenses, as well as to assist in the overall financial well-being of crew members. The Repayment Program provides payment directly to the student loan servicer for those eligible crew members who have graduated from an accredited degree program in the past five years. The Repayment Program provides assistance only for crew member student loans. This benefit is not subject to ERISA.

Eligibility

A crew member is eligible to participate in the Repayment Program if he or she: (i) is an active full-time crew member (scheduled to work 37.5 or more hours per week); (ii) has graduated from an accredited undergraduate or graduate degree program; and (iii) the graduation date is no more than five years prior to the date the crew member first submits an application with EdAssist. Crew members scheduled to work less than 37.5 hours per week are not eligible for coverage under this benefit under the Plan. For the definition of eligible crew member, please see the General Plan Information at the front of this SPD.

Benefit Amount

Eligible crew members can receive Vanguard-paid student loan repayments up to $100 per month, not to exceed $1,200 per calendar year, in the form of a payment made directly to the student loan servicer on behalf of the crew member, provided that their student loan is an Eligible Student Loan (defined below) and is not in deferred or default status. The Repayment Program has a lifetime cap of $7,200, assuming the Eligible Student Loan has not been fully repaid before reaching the $7,200 lifetime cap.

Eligible crew members already enrolled in the Academic Assistance Plan, or those who wish to enroll in the Academic Assistance Plan, are eligible to participate in the Repayment Program however, the maximum annual benefit cap for both programs is $9,000. This means that if crew members wish to take advantage of the maximum annual student repayment benefit of $1,200, crew will be eligible for up to an annual reimbursement amount of $7,800 under the Academic Assistance Plan. Remember that Academic Assistance Plan reimbursements generally are not taxable. In contrast Vanguard paid student loan repayments are taxable.

Eligible crew members are required to make their regular, required monthly payment toward the Eligible Student Loan as required by the terms of the student loan. Vanguard paid loan repayments made under the Program will be in addition to the crew members' required monthly payments and are intended to help reduce the principal amount of the Eligible Student Loan as well as interest due. Any late fees or penalties incurred by the eligible crew member due to missed or late payments are the sole responsibility of the crew member.

Eligible Student Loans

In order for a student loan to be eligible for repayment under the Repayment Program (an "Eligible Student Loan"), it must be considered a United States (US) Education Loan (listed below), must have been borrowed by the crew member as the crew member's own student loan, must be used to pay expenses for an accredited undergraduate or graduate degree program (but see exclusions below) and cannot be in deferred or default status.

US Education Loans eligible for repayment under the Program include:

- Federal Perkins Loans
- Private Student Loans
- Subsidized Stafford Loans (FFELP/Direct)
- Unsubsidized Stafford Loans (FFELP/Direct)
- Health Professional Loans
- Grad PLUS Loans (FFELP/Direct)
- Student Consolidation Loans
- Student Refinance Loans
- State Loans

Tax Treatment

Payments made on behalf of eligible crew members to the student loan servicer are considered taxable to crew members.

Source of Vanguard Paid Loan Repayments

All Vanguard-paid loan repayments are paid solely from Vanguard's general assets. Vanguard does not maintain any trust or special fund for the Repayment Program.

Exclusions

Loans taken for professional designation programs, regulatory licensing, job-related certificate programs, courses required prior to admission into a graduate program that are not taken as part of an undergraduate degree of study, academic review courses (such as those given in preparation for the GMAT), home equity loans and retirement plan loans (used to repay education expenses), loans not in the crew member's name and Direct Parent PLUS Loans are not eligible for repayment under the Repayment Program. Other expenses such as late fees, installment plan and/or deferred payment fees are not eligible for repayment under the Repayment Program.

If You Leave Vanguard

If a crew member resigns or if the crew member is discharged by Vanguard before the monthly loan repayment has been made to the loan servicer, the crew member will not be eligible for any future monthly loan repayments under the Repayment Program. In addition, crew members must repay to Vanguard 100% of any amounts paid by Vanguard to the student loan servicer during the 12 months prior to the crew member's termination date.

K. Surrogacy Assistance Program

Introduction

The Surrogacy Assistance Program provides financial assistance to eligible crew members using a surrogate. This benefit is not subject to ERISA.

Eligibility

All active full-time crew member (scheduled to work 37.5 or more hours per week) are eligible for coverage under this benefit under the Plan. Crew members scheduled to work less than 37.5 hours per week are not eligible for coverage under this benefit under the Program. For the definition of eligible crew member, please see the General Plan Information at the front of this SPD.

Reimbursable Eligible Expenses

Reimbursement is limited to eligible expenses as defined below. The maximum amount of reimbursement available for a surrogacy is the same maximum reimbursement amount under the Adoption Assistance Plan. The maximum reimbursement per surrogacy in 2018 is $13,810.

Eligible expenses can include but are not limited to the following reasonable and necessary expenses directly related to the surrogacy costs to bear a newborn child:

- Surrogacy agency fees;
- Compensation to the surrogate;
- Medical claims associated with the pregnancy of the surrogate and delivery of the child;
- Attorney fees;
- Counseling expenses
- Traveling expenses associated with the surrogacy (including amounts expended for meals and lodging while away from home); and
- Other expenses that are directly related to, and for the principal purpose of, an eligible surrogacy.

Exclusions

Eligible reimbursement expenses do not include expenses that are:

- Paid, reimbursed, or excused under any other plan or program;
- Incurred in violation of any state or federal law or in carrying out any surrogate parenting arrangement;
- Non-medical related expenses for the eligible surrogate (e.g. clothing, food, transportation to doctor's appointments); or
- Incurred prior to the date the crew member becomes an eligible full time crew member (as defined above) for purposes of the Surrogacy Assistance Program

Tax Treatment

The reimbursement amount you receive under this Surrogacy Assistance Plan will be considered taxable income to crew members and will be subject to State, Federal, Social Security, Medicare, and Federal Unemployment Taxes at the time of payment.

Reimbursement Procedures

A claim for reimbursement must be submitted prior to the end of the Plan Year following the Plan Year which includes the later of:

(1) the date of the birth of the child or;
(2) the expense is incurred.

You must also be an eligible full time crew member on the date the baby is born, submit your claim for reimbursement while you are employed as an eligible full time crew member, and be employed as an eligible full time crew member on the date the Surrogacy reimbursement is paid to you. You may request reimbursement by completing the Adoption or Surrogacy Assistance Reimbursement Form located on CrewNet and submitting a case to Crew Central (along with documents reflecting proof of custody and substantiation of expenses).

Section VI – Severance Plan

Purpose

The Severance Plan has been established for the benefit of eligible U.S. crew members of The Vanguard Group, Inc. and participating subsidiaries (The Vanguard Group, Inc. and its participating subsidiaries are referred to as "Vanguard"). The purpose of the Severance Plan is to define when Vanguard may, in its sole discretion, provide severance pay to certain crew members who are involuntarily terminated from employment. The legal rights and obligations of any crew member having an interest in the Severance Plan are determined solely by the provisions of The Vanguard Group, Inc. Severance Plan (the "Severance Plan"), as interpreted by the Plan Administrator. The Severance Plan is subject to ERISA.

Please remember this is a summary of the Severance Plan. It is not the plan document itself. Your rights under the Severance Plan are governed exclusively by the Severance Plan document. If there is any conflict between this SPD and the Severance Plan document, the Severance Plan document is the final authority and will govern in all cases.

Eligibility

All regular crew members, full-time or part-time, who are (i) actively employed by Vanguard (or on an approved leave of absence), (ii) employees for income and employment tax withholding purposes, (iii) have completed a Year of Service, and (iv) on the U.S. payroll, are eligible for coverage under the Severance Plan.

Crew members who are classified as interns or as seasonal crew are not eligible for benefits under the Severance Plan. Contingent workers are not eligible for coverage under this benefit under the Severance Plan. Contingent workers are not crew members and are not eligible for any benefits under the Severance Plan. Contingent workers perform services for Vanguard: (i) as independent contractors, (ii) as workers performing services on behalf of a consulting firm or other service provider, (iii) pursuant to an arrangement with a third party outsourcing, leasing, or staffing organization, or (iv) as workers performing services to Vanguard on behalf of an independent organization with expertise in specific functions, including functions peripheral to the core business of Vanguard. If a person who is a contingent worker is subsequently determined to be a common law employee of Vanguard by a governmental agency, a court or by Vanguard, such person still will not be eligible for coverage under the Severance Plan.

Cost of Coverage

Vanguard pays the full cost of the Severance Plan.

Eligible Termination

An eligible crew member (as described above) must meet all of the following requirements to be eligible for severance benefits under the Severance Plan:

1. He or she is involuntarily terminated, but see below for types of involuntary terminations that are not eligible for severance.
2. He or she signs (and does not revoke) a waiver and release of all claims, agrees in writing to other provisions that may be required, such as confidentiality, non-solicitation, non-competition and non-disparagement provisions, and returns all Vanguard owned property.
3. He or she meets any other eligibility provisions that may be required as a condition of receiving severance benefits.

A crew member who voluntarily resigns or who fails to return from an approved leave of absence (including leaves of absence for medical reasons) is not eligible for severance benefits.

A crew member whose employment is terminated under the following circumstances, is **not** eligible for severance benefits:

1. Termination for disciplinary reasons such as insubordination, misconduct, or violation of Vanguard policies or rules.
2. Before or after the termination of employment, it is determined that the crew member violated any: (i) terms or conditions of employment or (ii) Vanguard policies or rules.
3. Termination for willful failure to improve performance despite communication(s) from the crew member's manager or Crew Relations regarding the performance improvements needed.
4. Death, or termination after experiencing a physical or mental condition that started while employed and entitles the crew member to short term or long term disability benefits under a Vanguard plan or a government provided program (such as social security or workers compensation).
5. The crew member is offered employment by another Vanguard affiliate (U.S. or non-U.S.) or transfers employment to another Vanguard affiliate (U.S. or non-U.S.).
6. The crew member is eligible to receive severance or other separation benefits under any other agreement with Vanguard.

Severance Plan Benefits

An eligible crew member who: (i) has incurred an eligible termination of employment, (ii) Crew Relations has, in its sole discretion, determined is eligible for severance benefits, (iii) has signed a waiver and release of all claims, agreed in writing to other provisions that may be required, such as confidentiality, non-solicitation, non-competition and non-disparagement provisions, and returned all Vanguard owned property, and (iv) satisfied any other eligibility conditions that may apply, will be considered a Qualifying Crew Member. Absent a different determination by Crew Relations, Qualifying Crew Members will receive the standard package of severance benefits described below. Crew Relations may determine, in its sole discretion, to provide severance benefits in a greater or lesser amount (including no severance benefits) than the standard package of severance benefits:

1. Two Weeks Advance Notice, or Pay in lieu of Notice:

Two weeks advance notice of termination of employment, or weekly base pay in lieu of some or all of such notice. Unlike all other severance benefits under the Severance Plan, a Qualifying Crew Member does not need to sign a release to receive this advance notice/pay.

2. Severance Pay = cash payment based on completed Years of Service:

Severance Pay equal to one week of weekly base pay for each completed Year of Service.

A Year of Service is a full twelve months of service without rounding. Service starts on a Qualifying Crew Member's most recent date of hire by Vanguard and ends on the last day of employment. If the Qualifying Crew Member previously terminated and has been rehired by Vanguard, any prior period of Vanguard service will be added to the most current period. The starting date is shown on CrewNet as the hire date, or for rehires, the continuous service date on Workday.

Weekly base pay is the weekly rate of base salary in effect immediately prior to termination of employment, excluding all extra pay such as performance and other incentive bonuses, partnership, overtime pay, commissions or other allowances.

Severance Pay may be reduced by (i) severance pay previously paid under the Severance Plan, (ii) amounts the crew member owes to Vanguard, (iii) amounts paid by Vanguard (or payable by the crew member) under all federal, state and local tax or other applicable laws, and (iv) amounts any crew member is entitled in connection with any statute, regulation or agreement that relates to notice, severance or separation benefits (including but not limited to the Worker Adjustment and Retraining Notification Act and any state or local statute concerning notice, severance or separation benefits).

Severance Pay will be paid to a Qualifying Crew Member in a lump sum as soon as practical after such Qualifying Crew Member satisfies all the conditions under the Severance Plan for such payment (e.g. signing the release of claims, etc.). Crew Relations may in its sole discretion decide to instead pay such Severance Pay in regular payroll installments over a period not longer than 24 months from the date of termination.

3. Subsidy or Cash for COBRA:

If a Qualifying Crew Member who is covered by a Vanguard health and/or dental benefit plan at termination of employment timely elects to continue such medical and/or dental coverage under COBRA, Vanguard will cover the cost of the full COBRA premium for three months for such Qualifying Crew Member and any covered dependents. (See the Benefit Plan SPD for more information on electing COBRA.) Alternatively, Crew Relations may in its sole discretion decide to instead pay the cost of such COBRA premiums to the Qualifying Crew Member in a taxable cash lump sum (even if he or she did not elect COBRA), without any gross up for taxes. Any cash will be paid at the same time as Severance Pay (described in 2 above).

4. Outplacement Services:

Qualifying Crew Members will also receive outplacement services for up to a 3-month period following termination of employment. Crew Relations will determine, in its sole discretion, the specific outplacement program. The outplacement agency will contact Qualifying Crew Members with information about these services.

If a Qualifying Crew Member dies before receiving all of the severance payments payable under the Severance Plan, any remaining cash payments will be paid in a lump sum to the Qualifying Crew Member's beneficiary as determined by the Vanguard group life insurance plan.

Reservation of Discretion

While the Severance Plan provides the standard eligibility provisions that apply as well as the standard types and amounts of severance benefits payable under the Severance Plan, both the Plan Administrator and Crew Relations retain the sole discretion to add to or waive Severance Plan eligibility provisions at any time for any reason. Under the Severance Plan, both the Plan Administrator and Crew Relations have the right (a) to establish additional eligibility requirements and conditions, (b) to determine that a terminated crew member who meets the eligibility criteria spelled out above is nonetheless not eligible, (c) to determine that a terminated crew member who does not meet the eligibility criteria, nonetheless is eligible, and (d) subject to certain guardrails set forth by ERISA and the Code, to award severance benefits to a terminated crew member in a greater or lesser amount (including no severance benefits at all), in a different manner, or based on different specific circumstances, than provided for in the Severance Plan.

ERISA Claims Procedure for the Severance Plan Only

First Level Claim. A terminated crew member does not need to apply for benefits under the Severance Plan. However, if the terminated crew member (the "Claimant") (or his or her authorized representative) wishes to file a claim for benefits, the claim must be in writing and filed with the Plan Administrator (or its delegate) at the address provided below, and must be received by the Plan Administrator (or its delegate) within ninety (90) days after the effective date of employment termination, or, if benefits have started, within ninety (90) days of any reduction or cessation of benefits.

Decision Timeline for First Level Appeal. If the Plan Administrator (or its delegate) denies a claim in whole or in part, the Plan Administrator (or its delegate) will provide notice to the Claimant, in writing, within 90 days after the claim is filed, unless the Plan Administrator (or its delegate) determines that additional time is needed. If additional time is needed, the Plan Administrator (or its delegate) will give the Claimant written notice of the need for additional time prior to the end of the first 90-day period. The extension may not go beyond 90 days from the end of the first 90 day period and the notice must explain the special circumstances requiring more time as well as the date the Plan Administrator (or its delegate) expects to make the benefit decision.

Notice of Denial of First Level Appeal. The written notice of a denial of a claim shall provide the Claimant the following information:

1. the specific reason or reasons for the denial;
2. the specific Severance Plan provisions on which the denial is based;
3. any additional material or information necessary for the Claimant to perfect the claim and an explanation as to why such information is necessary; and
4. an explanation of the Severance Plan's claims procedure and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal.

Appeal of Adverse Benefit Determinations. If the first level of appeal is denied, the Claimant (or his or her duly authorized representative) may request the Plan Administrator (or its delegate) to conduct a full and fair review of the claim and its denial. Such request must be sent in writing to the Plan Administrator (or its delegate) at the address provided below and such request must be sent within 60 days after receiving notice that the claim for benefits has been denied. The Claimant (or his or her duly authorized representative) may:

1. request a review upon written notice to the Plan Administrator (or its delegate) within 60 days after receipt of a notice of the denial of a claim for benefits;
2. submit written comments, documents, records, and other information relating to the claim for benefits; and
3. examine the Severance Plan and obtain, upon request and without charge, copies of all documents, records, and other information relevant to the Claimant's claim for benefits.

Decision Timeline for Appeal of Adverse Determination. The Plan Administrator (or its delegate) will provide a decision on the review not later than 60 days after receipt of a request for review, unless the Plan Administrator (or its delegate) determines that additional time is needed. If additional time is needed, the Plan Administrator (or its delegate) will give the Claimant written notice of the need for additional time prior to the termination of the first 60-day period. The extension may not go beyond 60 days from the end of the first 60 day period and the notice must explain the special circumstances requiring more time for the decision as well as the date the Plan Administrator (or its delegate) expects to make the decision on review.

Notice of Denial of Review. The written determination of the Plan Administrator (or its delegate) shall provide the Claimant the following information:

1. the specific reason or reasons for the decision;
2. the specific Severance Plan provisions on which the decision is based;
3. the Claimant's right to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits; and
4. a statement of the Claimant's right to bring a civil action under section 502(a) of ERISA.

Claimants Must Follow Claims Procedure. No person may bring an action for any alleged wrongful denial of Severance Plan benefits in a court of law unless these claims procedures are exhausted and a final determination is made by the Plan Administrator (or its delegate). If the Claimant or other interested person challenges a decision of the Plan Administrator (or its delegate), a review by the court of law will be limited to the facts, evidence and issues presented to the Plan Administrator (or its delegate) during the claims procedure set forth above. Facts and evidence that become known to the Claimant or other interested person after having exhausted the claims procedure must be brought to the attention of the Plan Administrator (or its delegate) for reconsideration of the claims determination. Issues not raised with the Plan Administrator (or its delegate) will be deemed waived.

Time Limit For Legal Action. Any suit or legal action brought by a Claimant under the Severance Plan must be brought by the Claimant no later than one year following the final determination by the Plan Administrator (or its delegate) regarding the claim for benefits under these claims procedures. The one-year statute of limitations on suits for benefits applies in any forum where a Claimant brings such suit or legal action. If a civil action is not filed within this one year period, the Claimant's benefit claim is deemed permanently waived and abandoned.

Address for Claims and Appeals to Plan Administrator.
The Vanguard Group, Inc.
Benefits Committee
P.O. Box 876
Valley Forge, PA 19482

The Vanguard Group, Inc. Benefits Committee has delegated its authority to review and decide appeals under the Severance Plan to the Severance Appeals Committee. Claims and appeals should still be addressed to the Plan Administer and sent to the address listed above. The Plan Administrator will forward all correspondence to the Severance Appeals Committee.

ERISA Rights Statement. As a participant in the Severance Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Severance Plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- 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 Severance 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.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Severance Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Severance Plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other Severance 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 a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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 materials 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 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. If it should happen that the Severance Plan fiduciaries misuse the Severance 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.

Assistance with Your Questions

If you have any questions about your Severance Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, 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 NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

Other General ERISA Information

1. **Plan Name**: The Vanguard Group, Inc. Severance Plan (also part of The Vanguard Group, Inc. Benefit Plan).

2. **Plan Number**: 506 (the same plan number as The Vanguard Group, Inc. Benefit Plan).

3. **Employer/Plan Sponsor:**
The Vanguard Group, Inc.

Vanguard Marketing Corporation
Vanguard Advisors, Inc.
Vanguard Fiduciary Trust Company
Vanguard National Trust Company

4. **Employer Identification Number:** 23-1945930

5. **Type of Plan**: Employee Welfare Benefit – Severance Pay Plan

6. **Plan Administrator**:
The Vanguard Group, Inc.
Benefits Committee
P.O. Box 876
Valley Forge, PA 19482

7. **Agent for Service of Legal Process:**
The Vanguard Group, Inc.
100 Vanguard Boulevard
Malvern, PA 19355

Service of Process may also be made on the Plan Administrator.

8. **Sources of Contribution**: The Severance Plan is unfunded and all benefits are paid from the general assets of Vanguard.

9. **Type of Administration**: The Severance Plan is administered by the Plan Administrator.

10. **Plan Year:** January 1 through December 31.

Other Legal Notices and Disclaimers.
While the summary plan description for The Vanguard Group, Inc. Benefit Plan (the "Benefit Plan SPD") also serves as a plan document for the other benefits described within the Benefit Plan SPD, there is a separate plan document for the Severance Plan. You have the right to request a paper copy of the Severance Plan document (reasonable fees may be charged for copying costs) by sending a written request to the Plan Administrator at the address provided above for the Plan Administrator.

Vanguard reserves the right, in its sole discretion, to amend, change, suspend or terminate the Severance Plan at any time and for any reason. Vanguard does not have any obligation to --- and nothing contained in this summary or in this SPD or the Severance Plan shall be construed as creating an express or implied obligation or promise on the part of Vanguard to---maintain or continue to offer the Severance Plan. Eligibility for severance, including the receipt of severance benefits, does not constitute a promise or right of continued employment or render any person a crew member or employee of Vanguard.

Section VII – Claims and Appeals Procedures for Plan Benefits

Under DOL regulations, participants are entitled to full and fair view of any claims for benefits made under the Plan. This section explains the Plan's claims and appeal procedures and explains how to file claims for Plan benefits, when you will be notified of benefit decisions, and how to appeal any decisions that deny Plan benefits (also called adverse benefit decisions).

Please note that certain deadlines for submitting a claim or appeal apply - each is described below (except Severance Plan claims and appeals procedures are described in Section VI).

Definitions

The following terms are used throughout this Section and, where capitalized, have the specific meanings given below.

- **Adverse Benefit Determination** – a denial, reduction, termination of or failure to provide or make payment (in whole or in part) for benefits (including a service or supply) under the Plan. An Adverse Benefit Determination also includes the rescission of coverage.
- **Appeal** – a written request to the Claims Fiduciary to reconsider a denial of benefits (such denial also called an Adverse Benefit Determination).
- **Claim** – any request for a Plan benefit(s) made in accordance with these claim procedures. A request for benefits that is not made in accordance with these claims procedures will not be treated as a Claim under these procedures.
- **Claimant** – you, your eligible dependents, or your designated beneficiary (as applicable) once a request is made for a Plan benefit(s) in accordance with these claim procedures.
- **Claims Processor** – the party responsible for processing claims. A Claims Processor does not have discretionary authority to interpret the Plan or to make discretionary benefit decisions. When a Claims Processor determines that a benefit is not payable under the Plan, any appeals of Adverse Benefit Determinations would be reviewed by the Claims Fiduciary. The Claims Processor may vary depending on the benefit under review.
- **Claims Fiduciary** – the party who is the fiduciary responsible for making decisions regarding Claims and Appeals and the party with discretionary authority to interpret the Plan to make benefit decisions. The Claims Fiduciary may vary depending on the benefit under review.
- **Day** – when mentioned in these claims procedures, the term indicates calendar day.
- **Final Internal Adverse Benefit Determination** – an Adverse Benefit Determination that has been upheld by a Claims Fiduciary after completing the internal appeals process (or an Adverse Benefit Determination after the internal appeals process has been exhausted).
- **Final External Adverse Benefit Determination** – An Independent Review Organization (IRO) decision regarding a Claim after completing an external review.
- **Independent Review Organization (IRO)** – an entity that conducts independent external reviews of Adverse Benefits Determinations and Final Internal Adverse Benefit Determinations.
- **Authorized Representative** – this individual may act on behalf of a Claimant with respect to a Claim or Appeal under these procedures. However, no person (including a treating health care professional) will be recognized as an Authorized Representative until the Plan receives an Appointment of Authorized Representative form signed by the Claimant, except that for Urgent Care Claims, the Plan shall, even in the absence of a signed

Appointment of Authorized Representative form, recognize a health care professional with knowledge of the Claimant's medical condition (e.g. the treating physician) as the Claimant's Authorized Representative unless the Claimant provides specific written direction otherwise.

Benefits Claims and Appeals Procedures

Plan benefits (except Severance Plan benefits) are subject to the claims and appeals procedures in this Section of the SPD. However, particular benefits described in this SPD may have claims procedure information in addition to what is described below, and would be provided in the applicable Plan booklet to this SPD (or other materials provided by the Claims Fiduciary). This additional claims procedure information (if any) is in addition to, and does not override, the claims procedure information described in this SPD. Please note that the claims and appeals procedures for the Severance Plan are located in Section VI of this SPD.

Some of the benefits described in this SPD are not subject to ERISA, thus the specific claims and appeals procedures and deadlines required by ERISA do not apply to these benefits.

Filing a Claim

If you wish to file a Claim, you must complete a written Claim on the proper form and submit it to the Claims Fiduciary or Claims Processor, as applicable, responsible for reviewing the Claim if it is not already submitted on your behalf by your provider. (See below for the list of Claims Fiduciaries and Claims Processors.) Claims must be filed by the deadline stated in the procedures described below for the particular benefit under which the Claim is being filed. You can obtain the necessary claim forms on CrewNet. If you have any questions, call Crew Central at 844-VG1-CREW (844-841-2739) or extension 1CREW.

Most Claims relate to specific benefits under the Plan. Any other Claim that does not relate to a specific benefit under the Plan (for example, a general eligibility claim) must be filed with Crew Central. Please see the sections below to find the party you should file your Claims with and where you can find a copy of the claims procedures for the particular benefit you are claiming.

A request for prior approval of a benefit or service where prior approval is not required is not a Claim under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid is not a Claim under these rules.

The claims and appeals procedures for the benefits offered under the Plan are grouped according to the claims and appeals procedures applicable to the benefits:

(1) Group health benefits subject to ERISA (medical with prescription drug, dental, vision, Crew Assistance Program, health care FSA, Best Doctors, CrewCare and wellness plans);

Please note that the procedures for a group health benefit Claim depend upon the particular type of Claim. The types of Claims that you generally may bring under group health benefits are:

- ***Pre-Service Claim*** – Is a type of claim for a particular benefit that is conditioned upon you receiving prior approval in advance of receiving the benefit. A Pre-Service Claim must contain, at a minimum, the name of the individual for whom benefits are being claimed, a specific medical condition or symptom, and a specific treatment, service, or product for

which approval is being requested. You will be notified if you have failed to follow the procedures for filing a Pre-Service Claim as soon as possible, but not later than 5 days (24 hours in the case of an Urgent Care Claim) following the failed attempt.

- ***Post-Service Claim*** – Is a type of claim for payment for a particular benefit or for a particular service after the benefit or service has been provided. Claims relating to health care FSAs, Crew Assistance Program, Best Doctors and wellness will always be treated as Post-Service Claims. A Post-Service Claim must contain the information requested on a Claim form provided by the applicable provider.

- ***Urgent Care Claim*** – Is a type of claim for benefits or services involving a sudden and urgent need for such benefits or services. A Claim will be considered to involve urgent care if the Claims Fiduciary or a physician with knowledge of your condition determines that the application of the claims procedures for non-urgent Claims (1) could seriously jeopardize your life or your health, or your ability to regain maximum function or (2) in your physician's opinion, would subject you to severe pain that cannot adequately be managed without the care or treatment that is the subject of the Claim.

- ***Concurrent Care Claim*** – Is a type of claim relating to the continuation/reduction of an ongoing course of treatment.

(2) Long-term disability and other non-health benefits subject to ERISA (accidental death & dismemberment, business travel accident and life insurance plans);

(3) Short-term disability, not subject to ERISA; and

(4) Other benefits not subject to ERISA (academic assistance, adoption assistance, dependent care FSA, dependent scholarship, HSA, legal services, purchased PTO, student loan repayment assistance and surrogacy assistance benefits).

If Your Claim Is Denied

If your Claim for an ERISA benefit is denied in full or in part (otherwise referred to as an Adverse Benefit Determination), ERISA requires the Claims Fiduciary to provide you with written notice of the denial (except that a denied Urgent Care Claim will be provided orally) to include:

- Sufficient information to identify the Claim to include: the date of service, the health care provider, and the claim amount (if applicable);

- A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

- The specific reasons for the denial;

- The specific Plan provisions on which the denial is based;

- A request for any additional information needed from the Claimant to reconsider the claim and the reason this information is needed;

- A description of any internal rule, guideline, protocol, or other similar criterion relied upon in making the determination (if the denial is based on an internal rule, guideline, protocol, or other similar criterion) or a statement that a copy of such rule, guideline, protocol, or other criterion will be provided to you free of charge at your request, if applicable;

- An explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances (if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit) or a statement that a copy of such explanation will be provided to you free of charge at your request, if applicable; and

- An explanation of the Plan's appeal procedures, including the time limits applicable for such procedures

If your Claim for a non-ERISA benefit is denied, you will receive notice, either written or electronically, from the Claims Processor.

Appealing a Denial

If you receive an Adverse Benefit Determination on your initial Claim (including a decision to discontinue or reduce benefits relating to an ongoing course of treatment), you may appeal the denial by filing a written request (or an oral request in the case of an Urgent Care Claim) with the appropriate Claims Fiduciary. **The standard appeal process described below, and in the applicable Plan booklets, must be exhausted before you can pursue the Claim in court.**

If you decide to appeal a denied Claim for benefits, under the Plan you are entitled to a "full and fair review" that must include the following:

- An opportunity for you to submit written comments, documents, records, and other information relating to your Claim for benefits (regardless of whether such information was considered in your initial Claim) to the Claims Fiduciary for review and consideration;

- Access to review the Claim file, including having access to, and copies of, all documents, records and other information that are relevant to your Claim as well as any new or additional evidence the Claims Fiduciary considers, relies upon or generates by the Plan in connection with the Claim, free of charge; and

- New or additional rationale for the denial of the Claim at the internal claims appeal stage, free of charge, and the Claimant shall have no less than 45 days to respond to such new evidence or rationale, except with respect to Appeals of Urgent Care Claims (in which event the Claimant will be provided no less than two days to respond to the new evidence or rationale

With regard to group health plan and long term disability Claims; you are entitled to additional rights (in addition to the above criteria) as part of a "full and fair review" of your Appeal:

- A review that has no bearing on denial of the initial Claim, and is conducted by an individual who is neither the individual who issued the first denial nor the subordinate of

that person, and measures are taken to ensure the independence and impartiality of the persons involved in making the decision;

- If the whole or part of the Appeal is based on a medical judgment, the individual reviewing the Appeal shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

- Identify any expert whose advice was obtained on behalf of the Plan regarding the appeal regardless of whether the advice was relied upon in making the benefit determination;

- An expedited review process, in the case of an Urgent Care Claim, and allow for the Appeal to be requested orally or in writing and maintain that all necessary information relating to the Appeal shall be transmitted between you and the Plan by telephone, fax, or other similar expeditions method.

You (or your Authorized Representative) can appeal and request a claim review. (Please see the applicable deadlines for the Claim you wish to have reviewed under the "Time Deadlines for Claims and Appeals Procedures" chart below) You must file your Appeal in writing with the appropriate Claims Fiduciary responsible for reviewing the Claim. (Please see the "Time Deadlines for Claims and Appeals Procedures" chart below for the appropriate Claims Fiduciary) In some cases, the Claims Fiduciary may be Vanguard in which case you must file your written Appeal with Crew Central. If you are unsure who the Claims Fiduciary is, you may contact Crew Central. Your Appeal must state the specific reasons that you believe entitle you to benefits, or to greater or different benefits.

Notice of Appeal Determination

In general, the Claims Fiduciary must notify you of its decision with respect to your Appeal within a reasonable amount of time, but not to exceed 60 days, from the receipt of your request for review. Please see the "Time Deadlines for Claims and Appeals Procedures" chart below for specific details on the response time for your Appeal.

Denial of Appeal

If your Appeal is denied in full or in part, you will be notified in writing of the Claims Fiduciary's final and binding decision. This notice of denial will include:

- Sufficient information to identify the Claim to include: the date of service, the health care provider, and the claim amount (if applicable);

- A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

- The specific reason or reasons for the denial. In addition, if the denial is based on new or additional rationale you submitted, the rationale for the denial must be included or sent to you as soon as possible and sufficiently in advance of the date on which the notice of the final benefit denial is required to be provided to give you a reasonable opportunity to respond prior to that date;

- Specific references to the pertinent Plan provisions on which the decision is based;

- Reasonable access to, upon request and free of charge, copies of all documents, records and other information relevant to the Claim for benefits. A document, record, or other information shall be considered relevant to your Claim if the item was relied upon in making the benefit determination; and was submitted, considered, or generated in the course of making the benefit determination without regard if it was relied upon in making the determination;

- A description of any internal rule, guideline, protocol, or other similar criterion relied upon in making the determination (if the denial is based on an internal rule, guideline, protocol, or other similar criterion) or a statement that a copy of such rule, guideline, protocol, or other criterion will be provided to you free of charge at your request, if applicable;

- An explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances (if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit) or a statement that a copy of such explanation will be provided to you free of charge at your request, if applicable; and

- A statement of your right to bring a civil action in Federal court under Section 502 of ERISA, if applicable. In the case of a medical or prescription Claim for benefits, if you have completed the standard appeal process (outlined above) you may request an "External Review". An External Review is a review of an Adverse Benefit Determination by an (IRO). You must complete all levels of the standard appeal process before the request can be made.

To request an External Review, you need to submit the "Request for External Review Form" to Aetna (for medical) or CVS Caremark (prescription), as applicable, within 123 days of the date you received the Adverse Benefit Determination. This process is voluntary and you are not required to undertake it before pursuing legal action. If you do not file for voluntary External Review, the Plan will not find that you failed to exhaust your administrative remedies because of that decision.

If you would like more information on how to request an External Review or how the process works, please see Plan booklet D for details on the Aetna HealthFund plans, Plan booklet F for details on the HDHP plan, or Plan booklet G for details on the CVS Caremark plan.

If you feel your right to a benefit that is subject to ERISA has been improperly denied please see the "Your Rights Under ERISA" section for information on legal action you can take if after you have completed the standard appeals process.

ACA Compliance

Please note that notwithstanding anything else in this SPD, the Plan will comply with the applicable requirements of the Affordable Care Act (unless the group health benefit in question is an "excepted benefit" to which the Affordable Care Act does not apply). This means that Claimants shall have the following rights:

- Review of Claim File - The right to review the Claim file, including access to and copies of documents, records and other information relevant to the Claim at issue;

- Opportunity to Present Evidence and Testimony - The opportunity to present evidence and testimony as part of the Appeals process. The terms "evidence" and "testimony" shall be interpreted in accordance with DOL guidance;

- Disclosure of New Rationale and Opportunity to Respond - Be advised if the Claims Fiduciary considers, relies upon, or generates additional evidence in connection with the Claim, or is considering a new or additional rationale for the denial of the Claim at the internal claims appeal stage, free of charge, and shall give the Claimant no less than 45 days to respond to such new evidence or rationale, except with respect to Appeals of Urgent Care Claims (in which event the Claimant will be provided no less than two days to respond to the new evidence or rationale);

- No Conflict of Interest - To the extent Plan personnel are involved in the claims process, the Claims Fiduciary will not consider, in connection with any decisions matters with respect to an individual involved, directly or indirectly, with the evaluation or determination of the claims or appeals of any Claimant, whether or not such individual is likely to support the denial of benefits to a Claimant;

- External Review – An External Review for Final Adverse Benefit Determinations involving (1) medical judgment (excluding those involving only contractual or legal interpretation without any medical judgment) as determined by the IRO, or (2) rescission of coverage (i.e. a retroactive termination of coverage, whether or not the rescission has any effect on any particular benefit at the time). If the Claim is an Urgent Care Claim or involves an ongoing course of treatment, Claimants may process with expedited External review at the same time as the internal appeals process. External Review is not available for Final Adverse Benefit Determinations involving a failure to meet the Plan's eligibility requirements.

Claimants Must Follow Claims Procedure

No person may bring an action for any alleged wrongful denial of Plan benefits in a court of law unless these claims procedures are exhausted and a final determination is made by the Plan Administrator (or its delegate).

If the Claimant or other interested person challenges a decision of the Plan Administrator (or its delegate), a review by the court of law will be limited to the facts, evidence and issues presented to the Plan Administrator (or its delegate) during the claims procedure set forth above. Facts and evidence that become known to the Claimant or other interested person after having exhausted the claims procedure must be brought to the attention of the Plan Administrator (or its delegate) for reconsideration of the claims determination. Issues not raised with the Plan Administrator (or its delegate) will be deemed waived.

Time Limit For Legal Action

Any suit or legal action brought by a Claimant under the Plan must be brought by the Claimant no later than one year (unless specified elsewhere in a Plan booklet; the dental benefits and LTD benefits have a three year time limit for legal action) following the final determination by the Plan Administrator (or its delegate) regarding the claim for benefits under these claims procedures. The one-year statute of limitations on suits for benefits applies in any forum where a Claimant brings such suit or legal action. If a civil action is not filed within this one year period, the Claimant's benefit claim is deemed permanently waived and abandoned.

Please note: You do not have to request and complete External Review (applicable for medical and prescription drug Claims only) before bringing a legal action. However, if you complete the External Review and receive a Final External Adverse Benefit Determination, you may still bring legal action against the Plan, Plan Administrator, Claims Fiduciary or any other person with respect to a medical or prescription drug Claim.

If you feel your right to a benefit that is subject to ERISA has been improperly denied please see the "Your Rights Under ERISA" section for information on legal action you can take if after you have completed the standard appeals process.

Governing Law and Jurisdiction and Venue

The Plan will be governed by ERISA and to the extent not preempted by ERISA, by the laws of the Commonwealth of Pennsylvania. Exclusive jurisdiction and venue of all disputes arising out of and relating to the Plan, matters of Plan interpretation or factual determinations made by the Plan Administrator or its delegates is in any court of appropriate jurisdiction in the Commonwealth of Pennsylvania.

Claims and Appeal Procedure Time Deadlines

It is important to know what type of Claim you have because the claims and appeal procedures and deadlines vary depending on the type of Claim involved. All of the deadlines for each type of benefit Claim are summarized in the chart below.

(1) Group health benefit claims subject to ERISA

The applicable Claims Fiduciary for the group health benefits as well as the location of their claims procedures are listed below:

<table>
<tr><th colspan="3">Claims for the following benefits: Medical, Prescription, Dental, Vision, Health Care FSA, Best Doctors, CrewCare, Crew Assistance Program and Wellness Program</th></tr>
<tr><td rowspan="9">Deadline for Claimant to file a Claim (if deadline is not specified here, please contact the applicable Claims Fiduciary, listed below)</td><td>Medical</td><td>90 days after the date you receive services</td></tr>
<tr><td>Prescription</td><td>For a claim that requires prior-authorization, there is no deadline; For a post-service request claim, you have 365 days after the date you receive services</td></tr>
<tr><td>Dental</td><td>Within 12 months after the date you receive services</td></tr>
<tr><td>Vision</td><td>Within 365 days after the date you receive services</td></tr>
<tr><td>Crew Assistance Program</td><td>90 days after the date you receive services</td></tr>
<tr><td>Health Care FSA</td><td>By May 31st of the following tax year</td></tr>
<tr><td>Best Doctors</td><td>Within 6 months after the date you receive services</td></tr>
<tr><td>CrewCare</td><td>90 days after the date you receive services</td></tr>
<tr><td>Health Smart Rewards Wellness Program</td><td>Within 60 days of the HRA Incentive deposit date/gift card issue date or HSA Incentive deposit date, as applicable (schedule of dates are on CrewNet). You must timely apply for the wellness benefits to bring a claim. Please see the Healthy Smart Rewards section in this SPD for such deadlines).</td></tr>
</table>

TYPES OF GROUP HEALTH CLAIMS				
Responsible Party		**Urgent Care Claim**	**Pre-Service Claim**	**Post-Service Claim**
Claimant	**Claimants must submit an initial Claim within the applicable statute of limitations period as described above in the "Time Limit for Legal Action" section. If a Claimant fails to submit the Claim within such time period, the Claim may be time-barred.**			
Claims Fiduciary	**Deadline for Claims Fiduciary to approve or deny Claim**	**As soon as possible**, but not later than **72 hours** after receiving the initial Claim, if it was proper and complete. OR **As soon as possible**, but not later than **24 hours** in the case of a Concurrent Care Claim if you request to extend the treatment at least 24 hours before it would otherwise end.	**A reasonable period**, but not more than **15 days** after receiving the initial Claim. OR In the case of a Concurrent Care Claim, you will be notified in advance of any reduction or termination of treatment so you may Appeal the decision.	Claims Fiduciary is not required to notify you of a Claim approval for Post-Service Claims. If your Claim is denied, you must be notified within **a reasonable period**, but not more than **30 days** after receiving the initial Claim.
Claims Fiduciary	**Extension of deadline for Claims Fiduciary to approve or deny Claim** **Claims Fiduciary must provide notice to Claimant of extension before the first time limit expires to approve or deny Claim**	No extension permitted.	One **15-day extension** of the first time limit for the Claims Fiduciary to review the claim for "matters beyond the control of the plan" with notice to the Claimant. In the case of a Concurrent Care Claim, the same time frames apply.	
Claims Fiduciary	**If Claim submission is incomplete, Claims Fiduciary may give Claimant opportunity to provide**	N/A	If an incomplete Claim is filed by the Claimant, the Claims Fiduciary may deny the Claim or notify the Claimant of the incomplete Claim. Claimant must be given at least **45 days** to provide missing information as specified in the notice. The time for the approval or denial is put on hold from the date the notice of incomplete submission is sent to	

	additional information		the Claimant until the date the Claimant responds with additional information. The Claims Fiduciary has **15 days** from the date in which they received the missing information to approve or deny the Claim.	
Claimant	**Deadline to submit an Appeal following a denial**	**180 days** after receiving notice of initial decision.		
Claims Fiduciary	**Deadline for Claims Fiduciary to approve or deny the Appeal and notify Claimant of decision for Prescription (administrative claims only), Dental, Vision, Crew Assistance Program, Wellness Program, and Health Care FSA claims** **<u>*THIS ONLY APPLIES FOR BENEFITS THAT PROVIDE ONE LEVEL OF APPEAL*</u>**	For benefits that only provide one level of Appeal, the Claims Fiduciary must notify the Claimant of their decision on the Appeal **as soon as possible**, but not later than **72 hours** after receiving the Appeal**.** If the Appeal is denied, your Appeal rights are exhausted.	For benefits that only provide one level of Appeal, the Claims Fiduciary must notify the Claimant of their decision on the Appeal no later than **30 days** after receiving the Appeal. If the Appeal is denied, your Appeal rights for are exhausted. In the case of Concurrent Care, the Claims Fiduciary must notify Claimant of their decision **before treatment ends or is reduced** when the plan's decision is to reduce or terminate the concurrent care early.	For benefits that provide one level of Appeal, the Claims Fiduciary must notify the Claimant of their decision on the Appeal within a reasonable period of time but no later than **60 days** after receiving the Appeal. If the Appeal is denied, your Appeal rights are exhausted.
Claims Fiduciary	**Deadline for Claims Fiduciary to approve or deny Appeal and notify Claimant of decision for Medical, Prescription (for all other claims besides administrative claims), and Wellness claims**	N/A (please see External Review below for further review)	For benefits that provide two levels of Appeal, the Claims Fiduciary must notify the Claimant of their decision on the **first and second level of Appeal** no later than **15 days** after receiving the Appeal. *for deadline to submit second level	For benefits that provide two levels of Appeal, the Claims Fiduciary must notify the Claimant of their decision **on their first and second level of Appeal** within a reasonable period of time but no later than **30 days** after receiving the Appeal.

	<u>*ONLY FOR BENEFITS THAT PROVIDE TWO LEVELS OF APPEAL*</u>		appeal, see immediately below.	*for deadline to submit second level appeal, see immediately below.
Claimant	**Deadline to submit a second level Appeal following a denial of a level one Appeal**	**60 days** after receiving notice of the level one Appeal denial		
Claimant	**Deadline to request External Review—available** ***For Medical and Prescription benefits only***	**Four months** after receiving Final Internal Adverse Benefit Determination. An Urgent Care Claim may qualify for expedited External Review. Please see below.		
Claimant	**Deadline for correcting the External Review request (if Claimant sent incomplete request)**	Claims Fiduciary must permit the Claimant to complete the request within the **four-month filing period** or, if later, **48 hours** after notification.		
IRO	**Deadline to provide notice of preliminary External Review eligibility**	**Six business days** after receiving the request for External Review.		
IRO	**Deadline to provide notice of External Review decision**	**45 days** after Independent Review Organization's (IRO) receipt of a qualifying request for External Review.		
IRO	**Deadline to provide notice of preliminary <u>expedited</u> External Review eligibility**	**Immediately** upon receipt of a qualifying request for an expedited External Review.		
IRO	**Deadline to provide notice of <u>expedited</u> External Review decision**	**72 hours** after reviewer's receipt of a qualifying request for expedited External Review.		

Claims Fiduciary – Group Health Benefits

The applicable Claims Fiduciary for the group health benefits as well as the location of their claims procedures are listed below:

Benefit	Claims Fiduciary	Where to File Your Claim	Specific Location of Claims and Appeals Procedures
Medical	Aetna	Aetna Life Insurance Company P.O. Box 981106 El Paso, TX 79998-1106 1-800-938-0512	HealthFund plans: Plan booklet D HDHP plan: Plan booklet F
Prescription	CVS Caremark	Call 1-866-559-6903 to inquire	Plan booklet G
Dental	Delta Dental	Delta Dental P.O. Box 2105 Mechanicsburg, PA 17055-6999 1-800-471-1282	Plan booklets H & I
Vision	VSP	VSP PO Box 385018 Birmingham, AL 35238-5018	Plan booklet J
Crew Assistance Program	Carebridge	Contact Crew Central at 844-VG1-CREW (844-841-2739) or extension 1CREW	Contact Carebridge for claims and appeals procedures
Health Care Flexible Spending Account (FSA)	Aetna	PayFlex Systems USA, Inc. PO Box 4000 Richmond, KY 40476-4000 Fax: 1-888-238-3539	The Health Care FSA claim form can be found on CrewNet
Best Doctors	Vanguard Crew Central	Contact Crew Central at 844-VG1-CREW (844-841-2739) or extension 1CREW	Contact Crew Central for claims and appeals procedures
CrewCare	Vanguard Crew Central	Contact Crew Central at 844-VG1-CREW (844-841-2739) or extension 1CREW	Contact Crew Central for claims and appeals procedures
Health Smart Rewards Wellness Program	Vanguard Crew Central	Contact Crew Central at 844-VG1-CREW (844-841-2739) or extension 1CREW	Contact Crew Central for a claim form

(2) <u>Long-term disability and other non-health benefit claims subject to ERISA</u>

Benefit	Disability Claims under the Long-Term Disability (LTD) Plan	Other Non-Health Benefit Claims: Accidental Death & Dismemberment (AD&D), Business Travel Accident and Life Insurance	
Deadline to file a Claim (if deadline is not specified here, please contact the applicable Claims Fiduciary, listed below)	Within **31 days** after a covered disability occurs or begins or **as soon as reasonably possible**	**AD&D**	
		Business Travel Accident	

		Life Insurance
Deadline for Claims Fiduciary to approve or deny Claim	**A reasonable period**, but not more than **45 days**, unless notice of extension of deadline provided	**A reasonable period**, but not more than **90 days**, unless notice of extension of deadline provided
Extension of deadline for Claims Fiduciary to approve or deny Claim **Claims Fiduciary must provide notice to Claimant of extension before the time limit expires to approve or deny Claim**	Up to **two 30-day extensions** for "matters beyond the control of the plan" are permitted with notice to the Claimant before the initial 45-day deadline or first 30-day deadline expires to approve or deny Claim	**One 90-day extension** for "special circumstances" is permitted with notice to the Claimant before initial 90-day time limit expires to approve or deny Claim
If Claim submission is incomplete, plan may give Claimant opportunity to provide additional information	If incomplete Claim is filed by Claimant, the Claims Fiduciary may deny the Claim or notify the Claimant of the incomplete Claim (Claimant must be given at least **45 days** to provide missing information as specified in the notice). The time for the approval or denial is put on hold from the date the extension notice is sent until the date the Claimant responds with additional information.	**N/A**
Deadline for Claimant to submit an Appeal following a denial	**180 days** after receiving notice of initial decision	**60 days** after receiving notice of initial decision
Deadline for Claims Fiduciary to review Appeal from Claimant	**A reasonable period**, but not more than **45 days**	**A reasonable period**, but not more than **60 days**
Extension of deadline for Claims Fiduciary to review Appeal	**One 45-day extension** for "special circumstances" is permitted with notice to the Claimant	**One 60-day extension** for "special circumstances" is permitted with notice to the Claimant
How many levels of Appeal does the Plan permit for these benefits?	**1 level of Appeal**	**1 level of Appeal**

Claims Fiduciary – Non-health Benefits

The applicable Claims Fiduciary for the long-term disability and other non-health benefits as well as the location of their claims procedures are listed below:

Benefit	Claims Fiduciary	Where to File Your Claim	Specific Location of Claims and Appeals Procedures
Accidental Death & Dismemberment	Minnesota Life Insurance Company	Minnesota Life Insurance Company 400 Robert Street North St. Paul, MN 55101-2098	Plan booklet K

		1-866-293-6047	
Business Travel Accident Insurance	American International Companies	American International Companies Accident and Health Claims Division PO Box 15701 Wilmington, DE 19850-5701 Vanguard Crew Central 1-844-VG1-CREW (844-841-2739)	Contact Crew Central for claims and appeals procedures
Life Insurance	Minnesota Life Insurance Company	Minnesota Life Insurance Company 400 Robert Street North St. Paul, MN 55101-2098 1-866-293-6047	Contact Minnesota Life for claims and appeals procedures
Long-Term Disability	Life Insurance Company of North America (CIGNA)	CIGNA 1601 Chestnut Street Philadelphia, PA 19192-2235 1-800-36-CIGNA	Plan booklet L

(3) Short-Term Disability Benefit Claims (Not Subject to ERISA)

The time deadlines, Claims Processor, and the location of the claims procedures for the short-term disability benefit are listed below:

Deadline to file a Claim	Within **30 days** from the date your claimed disability began
Deadline for Claims Processor to approve or deny claim	**A reasonable period**, but not more than **45 days**
Deadline for Claims Processor to approve or deny Claim **Claims Processor must provide notice to Claimant of extension before the time limit expires to approve or deny Claim** **If Claim submission is incomplete, plan may give Claimant opportunity to provide additional information**	Up to **two 30-day extensions** for "matters beyond the control of the plan" are permitted with notice to the Claimant before time limit expires to approve or deny Claim If incomplete Claim is filed by the Claimant, the plan may deny the Claim or notify the Claimant of the incomplete Claim (Claimant must be given at least **45 days** to provide missing information as specified in the notice). The time for the approval or denial is put on hold from the date the extension notice is sent until the date the Claimant responds with additional information.
Deadline for Claimant to submit an Appeal following a denial	**60 days** after receiving notice of initial decision
Deadline for Claims Processor to review Appeal from Claimant	**A reasonable period**, but not more than **45 days**
Extension of deadline for Claims Processor to review Appeal	**One 45-day extension** for "special circumstances" is permitted with notice to the Claimant.
How many levels of Appeal does the plan permit?	1 level of Appeal

Claims Processor

Benefit	Claims Processor	Where to File Your Claim	Specific Location of Claims and Appeals Procedures
Short-Term Disability	Sedgwick	Sedgwick P.O. Box 14648 Lexington, KY 40512 1-800-495-2310 **AND** Contact Crew Central at 844-VG1-CREW (844-841-2739) or extension 1CREW	Plan booklet A

(4) Other benefits not subject to ERISA

For questions related to any of the following benefits (not subject to ERISA), please refer to the corresponding contact/vendor:

Benefit	Contact/Vendor
Academic Assistance	EdAssist 855-729-5960
Adoption Assistance	Vanguard Crew Central 844-VG1-CREW (844-841-2739) or extension 1CREW
Dependent Care Flexible Spending Account (FSA)	Aetna Life Insurance Company PayFlex Systems USA, Inc. PO Box 4000 Richmond, KY 40476-4000 Fax: 1-888-238-3539 PayFlexDirect.com
Dependent Scholarship	EdAssist 855-729-5960
Health Savings Account (HSA)	Health Equity 888-354-0697
Legal Services	Hyatt Legal Plans 800-821-6400
Purchased PTO	Vanguard Crew Central 844-VG1-CREW (844-841-2739) or extension 1CREW
Student Loan Repayment Assistance	EdAssist 855-729-5960
Surrogacy Assistance	Vanguard Crew Central 844-VG1-CREW (844-841-2739) or extension 1CREW

Section VIII – Administrative Information

A. Subrogation and Reimbursement Rights

The Plan reserves the right to be subrogated to any and all claims of or on behalf of a participating crew member or covered spouse or dependent ("Covered Person") against a third party that involves recovery of amounts paid or payable under the terms of the Plan. Acceptance of benefits under the Plan establishes an equitable lien by agreement by the Plan over any proceeds received by a Covered Person with respect to a benefit claim made under the Plan in the form of a judgment, settlement, payment or compensation (regardless of fault, negligence or wrongdoing) from (1) a third party, (2) a liability insurer for a third party, or (3) any other source (including but not limited to any form of uninsured or underinsured motorist coverage, any medical payments, no-fault or school insurance coverage, or any other form of insurance coverage) ("Recovery") to the extent paid (or payable) by the Plan for the claim at issue.

Please consult the Plan booklet applicable to the medical option you have selected. If the booklet has Summary of Coverage (SOC) language, (e.g. it mentions a Subrogation and Right of Recovery Provision), the policy in the booklet will govern. If the booklet has no mention of SOC language, the policy outlined here will apply.

If a Covered Person receives any Recovery, the Covered Person must repay the Plan in full for any such benefits which have been paid or which will in the future have to be paid under the Plan for expenses already incurred or which are reasonably foreseeable at the time of said recovery. Reimbursement to the Plan will be without reduction, set-off or abatement for attorney's fees or costs incurred by the Covered Person in collecting payment (whether by judgment, settlement, payment or compensation) for the claim at issue. The Plan may require a Covered Person as a precondition to benefit payments to both sign a reimbursement agreement and to agree, in writing, to assist the Plan to secure the Plan's right to reimbursement of payment from a third party.

The Plan has the right to be paid first from any recovery described above and any and all related monies paid (or payable) to, or for the benefit of a Covered Person, to the extent of the benefits paid or payable by the Plan, whether or not the Covered Person has been made whole for injuries received. The Plan's right to recover will apply regardless of the manner in which the recovery is structured or worded (e.g., the recovery may seek to limit the Plan's reimbursement by stating that amounts paid do not represent medical expenses). The Plan's recovery will not be reduced by attorney's fees.

Covered Persons have an obligation and duty to reimburse the Plan for any amounts that should be paid to the Plan pursuant to these subrogation and reimbursement rights. Covered Persons are considered to give the Plan a first lien on any and all amounts to which the Plan is entitled. If the Plan does not receive payment of any such amounts, it may take legal action against the Covered Person, offset the amount of any future claim payment under the Plan to the Covered Person by the amounts that are owed or discontinue benefits under the Plan.

B. Amendment and Termination

Vanguard reserves the right, in its sole discretion, to amend, change, suspend or terminate the Plan or any of its component benefit programs, plans and/or options at any time by action of its Board of Directors or such other officers as may be authorized from time to time by the Board. Additionally, The Vanguard Group, Inc. Benefits Committee has authority to make any amendment to the Plan.

C. ERISA Information

Vanguard provides employee benefit plans for eligible crew members in accordance with the Employee Retirement Income Security Act of 1974, as amended (ERISA), a federal law relating to the funding and administration of employee benefit plans.

Plan Sponsor

The Vanguard Group, Inc.

The Plan benefits described in this summary apply to crew members of:
The Vanguard Group, Inc.
Vanguard Marketing Corp.
Vanguard Advisers, Inc.
Vanguard Fiduciary Trust Co.
Vanguard National Trust Co.

Address
100 Vanguard Boulevard
Malvern, PA 19355
610-669-1000

Employer Identification Number

Vanguard's Employer Identification Number (EIN) is 23-1945930

Plan Administrator

The Plan Administrator for the Plan is:

The Vanguard Group, Inc.
Benefits Committee
P.O. Box 876
Valley Forge, PA 19482

Questions can also be directed to Crew Central at 844-VG1-CREW (844-841-2739) or extension 1CREW.

The Plan Administrator is responsible for making sure that the Plan operates according to the terms of ERISA and the appropriate documents, contracts, or other agreements. In this respect, the Plan Administrator is the sole judge of the application and interpretation of the Plan provisions, and has the discretionary authority to construe the provisions of the Plan, to resolve disputed issues of fact, and to make determinations regarding eligibility for benefits. The Plan Administrator also has the authority to delegate certain of its powers and duties to a third party and has delegated certain administrative functions under the Plan to insurance companies and third party administrators. The Plan Administrator has also delegated its fiduciary authority to determine and decide claims for benefits as well as any appeals of such claims for benefits to certain of its third party administrators (including insurance companies). As the Plan Administrator's delegate, each of these third party administrators has the authority to make decisions under the Plan relating to benefit claims.

The decisions of the Plan Administrator (or its delegate) in all matters relating to the Plan (including, but not limited to, eligibility for benefits, Plan interpretations, and disputed issues of fact) will be final and binding on all parties and generally will not be overturned by a court of law.

In addition, the Plan Administrator has designated Crew Central to be responsible for the day-to-day administration of the benefit plans described in this SPD. Crew Central can answer benefit-related questions or help you with the processing of claims. Crew Central is located at the address listed below. Any inquiries should be made to:

The Vanguard Group, Inc.
Crew Central, Mailport M20
P.O. Box 876
Valley Forge, PA 19482

Questions can also be directed to Crew Central at 844-VG1-CREW (844-841-2739) or extension 1CREW.

Agent for Service of Legal Process

If you feel you must take legal action for any reason regarding your benefits, legal action can be served on the Plan Sponsor in care of:

The Vanguard Group, Inc.
100 Vanguard Boulevard
Malvern, PA 19355

Questions can also be directed to Crew Central at 844-VG1-CREW (844-841-2739) or extension 1CREW.

Service of legal process may also be made on the Plan Administrator.

Plan Name

The Vanguard Group, Inc. Benefit Plan

Plan Number

506

Plan Type

The Plan includes medical, dental, vision, prescription drug, life insurance, disability, accidental death and dismemberment insurance, legal services, purchased paid time off, health care and dependent day care flexible spending accounts, academic assistance, adoption assistance, crew assistance, severance, and wellness benefits provided by Vanguard to eligible crew members.

Plan Funding

Vanguard's benefits are funded through contributions made by Vanguard, and in some cases, by crew members. Cost will vary depending on the benefit.

Plan Year

The Plan Year is January 1 - December 31.

D. Your Rights Under ERISA

As a participant in certain of the benefits described in this SPD, you are entitled to certain rights and protections under ERISA.

ERISA provides that all participants in a plan covered by ERISA shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, 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 SPD. 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 Group Health Plan Coverage

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 SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your 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, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare 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, which are described in this SPD.

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 administrator. If you have a claim for benefits that 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 domestic relations order or 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.

Assistance with Your Questions

If you have any questions about your 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 (EBSA), 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.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the EBSA toll-free phone number at 866-444-EBSA (3272), or by visiting the EBSA web site at www.dol.gov/ebsa.

E. HIPAA Privacy Notice

This section describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability and Accountability Act of 1996 and the Health Information Technology for Economic and Clinical Health Act and the related regulations (collectively, "HIPAA") impose numerous requirements on employer group health plans concerning the use and disclosure of individual health information. This information, known as protected health information (referred to in this notice as "health information"), includes virtually all individually identifiable health information held by a group health plan — whether received in writing, in an electronic medium, or as an oral communication.

This notice describes the privacy practices that the Plan will follow in order to comply with the requirements of HIPAA with respect to the following benefits:

- Medical
- Prescription Drug
- Dental
- Vision
- Health Care Flexible Spending Account
- Crew Assistance Program
- Wellness Program

This notice does not apply to health information collected or maintained by Vanguard on behalf of the non-health employee benefits that it sponsors, including disability benefits, life insurance, accident death and dismemberment insurance, and worker's compensation insurance.

The Plan may share health information with each other to carry out treatment, payment, or health care operations. The medical, prescription, and dental benefits are self-insured plans. These plans are collectively referred to as the “Plan” in this notice, unless specified otherwise. **It is important to note that Vanguard does not routinely have access to your individual health information. We use third party administrators, such as Aetna, to perform the daily administrative functions of our plans.** It is Vanguard’s policy to train the limited number of crew members who have access to Plan personal health information in the manner necessary and appropriate to permit them to carry out their plan functions in compliance with HIPAA.

The Plan’s Duties with Respect to Health Information About You

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan’s legal duties and privacy practices with respect to your health information. It is important to note that these rules apply to Vanguard’s benefit plans, referred to as the Plan, and not to Vanguard as an employer. If you participate in an insured plan option (such as the VSP Vision Plan), you will receive a notice directly from the insurer regarding its privacy practices.

How the Plan May Use or Disclose Your Health Information

The HIPAA privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- **Health care operations** include activities by the Plan (and in limited circumstances other plans or providers) such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business planning and development. *For example, the Plan may use summary information about crew member claims to review the effectiveness of wellness programs.*

- **Treatment** includes providing, coordinating, or managing health care by one or more doctors or other health care providers. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. *For example, the Plan, through our third party administrators, may share health information about you with physicians who are treating you. Or, the Plan, through its third party administrators, may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.*

- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations and provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing; as well as "behind the scenes" plan functions such as risk adjustment, collection, or reinsurance. *For example, the Plan, through our third party administrators, may share information about your coverage or the expenses you have incurred with another health plan in order to coordinate payment of benefits.*

The Plan may disclose your health information to third parties that assist the Plan in its operations. For example, the Plan may share your health information with its business associates if the business associate is responsible for paying medical claims for the Plan. The Plan's business associates have the same obligation to keep your health information confidential as the Plan does. The Plan must require its business associates to ensure that your health information is protected from unauthorized use or disclosure.

The amount of health information used, disclosed or requested will be limited to the "minimum necessary" to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses protected health information for underwriting purposes, the Plan will not use or disclose protected health information that is your genetic information for such purposes.

Other Allowable Uses or Disclosures of Your Health Information

In certain cases, your health information can be disclosed **without** authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information describing your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You will generally be given the chance to agree or object to these disclosures (although exceptions may be made, for example if you are not present or if you are incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan is also allowed to use or disclose your health information **without** your written authorization for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with such laws.
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (including disclosures to the target of the threat); this includes disclosures to assist law enforcement officials in identifying or apprehending an individual because the individual has made a statement admitting participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody.
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects.
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you will be notified of the Plan's disclosure if informing you will not put you at further risk).
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request, or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information).
Law enforcement purposes	Disclosures to law enforcement officials required by law or pursuant to legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosure about a death that may have resulted from criminal conduct; and disclosure to provide evidence of criminal conduct on the Plan's premises.
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties.
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death.
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, and subject to certain assurances and representations by researchers regarding necessity of using your health information and treatment of the information during a research project.

Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws.
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates.
HHS investigations	Disclosures of your health information to the Department of Health and Human Services (HHS) to investigate or determine the Plan's compliance with the HIPAA privacy rule.

How the Plan May Share Your Health Information with Vanguard

The Plan, or its third party administrator, may disclose your health information without your written authorization to Vanguard for plan administration purposes. Vanguard may need your health information to administer benefits under the Plan. Vanguard agrees not to use or disclose your health information other than as permitted or required by the Plan documents or by law.

Here are some examples of additional information that may be shared between the Plan and Vanguard, as allowed under the HIPAA rules:

- The Plan, or its third party administrator, may disclose "summary health information" to Vanguard, as the Plan sponsor, if requested, for purposes of obtaining premium bids to provide coverage under the Plan, or for modifying, amending, or terminating the Plan. (Summary health information is information that summarizes crew member claims information, but from which names and other identifying information has been removed.)
- The Plan, or its third party administrator, may disclose to Vanguard information on whether an individual is participating in the Plan.

Note that the Plan is prohibited from using or disclosing your genetic information for underwriting purposes.

Vanguard cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Vanguard from a source other than the Plan (e.g., you or your health care provider) for purposes such as administering its family and medical leave policy, fulfilling its obligations under the Americans with Disabilities Act, or administering its workers' compensation program, is *not* protected under HIPAA's privacy rules (although the privacy of this type of information may be protected under other federal or state laws).

Most uses or disclosures of psychotherapy notes (where applicable), uses and disclosures of your health information for marketing purposes and disclosures that constitute the sale of your health information require an authorization. Other uses and disclosures will be made only with your written authorization. You may revoke your authorization as allowed under the HIPAA rules. However, you cannot revoke your authorization if the Plan has taken action relying on it. In other words, you cannot revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use or disclosure of your unsecured health information as required by law.

Your Individual Rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. All requests made pursuant to these rights must be made in writing. To exercise any of these rights, you may first call Crew Central at 844-VG1-CREW (844-841-2739) or extension 1CREW for instructions. Or you may submit the request in writing to the following address:

The Vanguard Human Resources Department
Attention: HIPAA Privacy Official
Mailport M22
P.O. Box 876
Valley Forge, PA 19482

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. And if the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you are notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid in full out of pocket for the item or service.

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations. If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; records relating to enrollment, payment, or claims adjudication; case or medical management record systems maintained by a plan or its third party administrators; or a group of records the Plan uses to make decisions about individuals. However, you do **not** have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or

administrative proceedings. In addition, the Plan may deny your right to access, although in certain circumstances you may request a review of the denial.
If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible onsite), the Plan will provide you with:

- The access or copies you requested;
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint; or
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information. The Plan may also charge reasonable fees for copies or postage. If the Plan does not maintain the health information but knows where it is maintained, you will be informed of where to direct your request.

You may request an electronic copy of your health information if it is maintained in an electronic health record. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. Any charge that is assessed to you for these copies, if any, must be reasonable and based on the Plan's cost.

Right to amend your health information that is inaccurate or incomplete
With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set to the extent that it is inaccurate or incomplete. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will:

- Make the amendment as requested;
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint; or
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

Right to receive an accounting of disclosures of your health information
You have the right to a list of certain disclosures the Plan has made of your health information. This is often referred to as an "accounting of disclosures." You generally may receive an accounting of disclosures that were required by law, that were made in connection with public health activities, or that were made in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on these types of disclosures of your health information going back for six years from the date of your request.

You do **not** have a right to receive an accounting of any disclosures made:

- For treatment, payment, or health care operations;
- To you about your own health information;
- Incidental to other permitted or required disclosures;
- Where authorization was provided;
- To family members or friends involved in your care (where disclosure is permitted without authorization);
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances; or
- As part of a "limited data set" (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or a law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You will be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request
You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agree to receive this notice electronically may request a paper copy at any time.

Right to Breach Notification
You have the right to, and will receive, notification if a breach of your unsecured health information requiring notification occurs.

Changes to the Information in This Notice

The Plan must abide by the terms of the privacy notice currently in effect. However, the Plan reserves the right to change the terms of its privacy policies as described in this notice at any time, and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If the Plan materially changes any of its privacy practices covered by this notice, it will revise this notice, and provide you with the revised notice within 60 days of the revision (or within such other time frame required under the regulations), or if the Plan posts the notice on its website it shall: (1) prominently post the material change or the revised Notice on its website by the effective date of the material change to the notice; and (2) provide the revised notice, or information about the material change and how to obtain the revised notice during the next annual enrollment or at the beginning of the plan year if there is no annual enrollment process. In addition, copies of the revised notice will be made available to you upon your written request, and any revised Notice will also be available on CrewNet.

Complaints

If you believe your privacy rights have been violated or the Plan has not followed its legal obligations under HIPAA, you may complain to the Plan's Privacy Officer or with Office for Civil Rights of the United States Department of Health and Human Services. You will not be retaliated against for filing a complaint. If you have any questions about filing a complaint, you may call Crew Central at 844-VG1-CREW (844-841-2739) or extension 1CREW. All complaints must be made in writing and sent to the following address:

The Vanguard Human Resources Department
Attention: HIPAA Privacy Official
Mailport M22
P.O. Box 876
Valley Forge, PA 19482

Contact

For more information on the Plan's privacy policies or your rights under HIPAA, call Crew Central at 844-VG1-CREW (844-841-2739) or extension 1CREW.

F. Notice Under Woman's Health and Cancer Act of 1998

If you have had or going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). Federal law requires group health insurance to provide coverage for the following services to an individual receiving plan benefits in connection with a mastectomy; thus the health plans offered by Vanguard will provide coverage for those services in accordance with this law. The required mastectomy coverage includes:

- 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 at all stages of the mastectomy, including lymphedema.

The benefits for these services will be provided in a manner determined in consultation with the attending physician and patient. These reconstructive benefits are subject to annual Plan deductibles and coinsurance provisions like other medical and surgical benefits covered under your medical plan.

G. Notice Under the Newborn and Mothers Act

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 for up to 48 hours (or 96 hours) as applicable.

H. Notice of Creditable Coverage

Important Notice from Vanguard about Creditable Prescription Drug Coverage and Medicare

The purpose of this notice is to advise you that the prescription drug coverage under The Vanguard Group, Inc. Benefit Plan (the "Plan") is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in year 2018. As such, the Plan's prescription drug coverage constitutes "creditable coverage."

Why is This Important?
This notice is important because it proves that you have creditable coverage. Because our prescription coverage is creditable coverage, you may be protected from having to pay a penalty if you subsequently lose or drop this coverage. This protection applies as long as you do not have a break of 63 days or more between the time creditable coverage under the Plan ends and your Medicare Part D prescription plan coverage begins.

Notice of Creditable Coverage
Please read this notice carefully. This notice has important information about your current Vanguard medical plan (including prescription drug coverage) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan if you become covered by Medicare in 2018. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current Plan coverage and Medicare's prescription drug coverage:

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

Vanguard has determined that the prescription drug coverage administered by CVS Caremark is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered creditable coverage. Because your existing coverage is creditable coverage, you can keep this coverage and you will not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, (for example, you leave employer coverage) you will be eligible for a two month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Vanguard coverage will not be affected. You may coordinate the Vanguard medical plan (including prescription) with a Medicare prescription drug plan. If you decide to enroll in a Medicare prescription drug plan and drop your Vanguard medical plan (including prescription), be aware that you and your dependents may not be able to get your Vanguard coverage back during the current plan year, unless you have a change in status as described in the Plan. However, provided you remain eligible, you may enroll back in Vanguard's medical plan (including prescription) during the next open enrollment period under the Plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Vanguard and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium will go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You will have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next October to join.

For More Information About This Notice
For more information about this notice or your current prescription drug coverage or to request a copy of this notice, contact Crew Central by calling 844-VG1-CREW (844-841-2739) or extension 1CREW. A copy of this notice will also be posted on CrewNet.

Note: You may receive this notice at other times in the future – such as before the next period you can enroll in Medicare prescription drug coverage or if this Vanguard coverage changes.

For More Information About Your Options Under Medicare Prescription Drug Coverage
More detailed information about Medicare plans that offer prescription drug coverage is contained in the *Medicare & You* handbook. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here are additional resources for information about Medicare prescription drug plans:

- Visit Medicare's website at www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of the *Medicare & You* handbook for their telephone number) for personalized help
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call 800-772-1213 (TTY 800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you were required to pay a higher premium (a penalty).

I. Notice Regarding Vanguard's Health Smart Rewards Wellness Program

Vanguard's Health Smart Rewards wellness program is a voluntary wellness program administered by RedBrick and is available to all active crew members and their covered spouses or domestic partners. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the Health Smart Rewards wellness program, you will be asked to complete a biometric screening, which will include a blood test for non-HDL cholesterol and glucose level, as well as measurements of body mass index (BMI) and blood pressure. You will also be asked to complete a voluntary health assessment (HA) that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease) and to report your tobacco usage. You are not required to complete the biometric screening, HA, or report your tobacco usage.

However, active crew members and their covered spouses or domestic partners who choose to participate in the Health Smart Rewards wellness program can earn up to $500 each year. See CrewNet for more detail regarding how you can earn these rewards.

Although you are not required to complete the biometric screening, HA, or report your tobacco usage, you must timely complete each of these three program requirements to be eligible to earn the other $400 remaining reward dollars.

If you do not reach the $500 maximum reward after completing the biometric screening, HA, and tobacco usage reporting, you can still earn remaining rewards by completing qualifying healthy activities such as RedBrick Track, RedBrick Journeys, Fit 2 Thrive, Next-Steps Consult, 50 ShipShape visits, CrewCare health coaching program, RedBrick phone coaching program, and preventive care screenings. See CrewNet for more detail regarding these activities.

If you or your covered spouse or domestic partner cannot meet a biometric screening target or participate in a healthy activity, you may be entitled to a reasonable accommodation or you may be able to earn the same reward by different means. Contact Crew Central at 844-VG1-CREW or extension 1CREW, and a benefits specialist will work with you (and, if you wish, your doctor) to find a reasonable accommodation or other reasonable alternatives that are right for you in light of your health status, and also to determine whether a waiver may be appropriate in your situation.

The results from your biometric screening and the information from your HA will be used to provide you with information to help you understand your current health and potential risks and may also be used to offer you services through the Health Smart Rewards wellness program, such as RedBrick Track, RedBrick Journeys, Fit 2 Thrive, Next-Steps Consult, 50 ShipShape visits, CrewCare health coaching program, RedBrick phone coaching program, and preventive care screenings. You also are encouraged to share your results or concerns with your own doctor.

Protections from disclosure of medical information
We are required by law to maintain the privacy and security of your personally identifiable health information. Although the Health Smart Rewards wellness program and Vanguard may use aggregate information it collects to design a program based on identified health risks in the

workplace, the Health Smart Rewards wellness program will never disclose any of your personal information either publicly or to Vanguard, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the Health Smart Rewards wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the Health Smart Rewards wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the Health Smart Rewards wellness program or receiving Health Smart Rewards dollars. Anyone who receives your information for purposes of providing you services as part of the Health Smart Rewards wellness program will abide by the same confidentiality requirements. The only individuals who would receive your personally identifiable health information are RedBrick health coaches, consumer support personnel, and biometric screeners, in order to provide you with services under the Health Smart Rewards wellness program.

In addition, all medical information obtained through the Health Smart Rewards wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the Health Smart Rewards wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the Health Smart Rewards wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the Health Smart Rewards wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice or about protections against discrimination and retaliation, please contact Crew Central at 844-VG1-CREW or extension 1CREW.