WAKE FOREST
UNIVERSITY

# Retiree Welfare Benefit Program Summary Plan Description

**July 2024**

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# Introduction

Wake Forest University ("Wake Forest" or the "University") maintains the Wake Forest University Retiree Welfare Benefit Program (the "Plan") to provide certain welfare benefits to its eligible former employees.

This Summary Plan Description ("SPD") summarizes the provisions of the Plan and includes information about:

- Eligibility and Enrollment
- Benefit Credits and Payment
- Claims and Appeals
- Plan Administration
- Your ERISA Rights

This SPD is not intended to provide any rights to benefits that are not described in the Plan. The terms of the Plan may change in the future. You should carefully review the benefits-related communications periodically by the University for changes to the terms of the Plan and the information in this SPD.

References to "you" and "your" in this document refer to former employees of the University (and its participating affiliates) who are eligible to participate in the Plan, unless the reference indicates otherwise.

References to your "Employer" in this document refer to Wake Forest University or, if you were an employee of a participating affiliate of the University, your former employer.

The information in this SPD is effective as of July 1, 2024. The SPD is only a *summary* of the key provisions of the Plan. If there is a conflict between the legal Plan document and this SPD, the legal Plan document will control.

Wake Forest reserves the right to amend, modify, suspend, or terminate the Plan (or any underlying benefit program) in whole or in part, at any time and for any reason.

If you have any questions about this SPD, contact Human Resources at (336) 758-4700 or email ***askHR@wfu.edu***.

# Benefit Programs

The following benefit programs are provided under the Plan:

**Health Reimbursement Arrangement ("HRA")**
**Death Benefit**

This document includes information applicable to the retiree health and welfare benefits offered by Wake Forest that are subject to the Employee Retirement Income Security Act ("ERISA").

Information about other retiree benefits that are not subject to ERISA is available on the Human Resources ***website***, or you can contact Human Resources for more information.

## Benefit Program Information

| Benefit Program | Contact | Contact Information |
|---|---|---|
| **Health Reimbursement Arrangement (HRA)** | Via Benefits | (844) 570-2795<br>***https://my.viabenefits.com/wfu*** |
| **Death Benefit** | Wake Forest Human Resources | (336) 758-6233<br>***retiree@wfu.edu***<br>***Retiree Death Benefit Policy*** |

The HRA is a group health plan. The Retiree Death Benefit is a group death benefit plan.

For information about eligibility and for answers to general benefits questions regarding the benefit programs, contact Human Resources at (336) 758-4700 or email ***AskHR@wfu.edu***.

## Plan Information

| | |
|---|---|
| **Plan Name** | **Wake Forest University Retiree Welfare Benefit Program** |
| **Plan Sponsor** | Wake Forest University<br>1834 Wake Forest Road<br>Winston-Salem, NC 27109 |
| **Employer ID Number** | 56-0532138 |
| **Plan Administrator** | Wake Forest University<br>1834 Wake Forest Road<br>Winston-Salem, NC 27109<br>(336) 758-7415 |
| **Agent for Service of Legal Process** | Wake Forest University<br>Attn: Legal Department<br>1834 Wake Forest Road<br>Winston-Salem, NC 27109<br>(336) 758-7415 |
| **Plan Number** | [516] |
| **Plan Year** | January 1 – December 31 |

The Plan is an "employee welfare benefit plan" under ERISA.

The Plan is funded by employer general assets. Wake Forest is not required to maintain any fund or segregate any amount for purposes of funding the Plan or any benefit program, or for the benefit of any person under the Plan. No person has any claim against, right to, or security or other interest in, any fund, account, or asset of Wake Forest or its affiliates from which any payment under the Plan may be made.

The Plan Administrator has the full discretionary authority to interpret the Plan in accordance with its terms and the applicable provisions of ERISA, and to resolve all claims and disputes under the Plan. The Plan Administrator may delegate some or all of its authority to any other person, in its sole discretion, and references to the Plan Administrator in this SPD include its delegates.

# Eligibility

## Coverage for Retirees

### HRA Retiree Eligibility

You are eligible to participate in the HRA if you meet all the following requirements:

- as of the date your employment with your Employer ended, you were:
  - at least age 62 and had completed at least 10 years of service; or
  - at least age 65 and had completed at least 5 years of service;
- you maintained WFU medical coverage until you were Medicare eligible;
- you are currently age 65 or older;
- you are eligible for Medicare; and
- you are enrolled in medical coverage purchased through ***Via Benefits*** (or you have been continuously enrolled in an individual Medigap plan with AARP since January 1, 2016).

### Retiree Death Benefit Eligibility

You are eligible to participate in the Retiree Death Benefit if, as of the date your employment with your Employer ended, you were:

- classified by the Employer as a "benefits-eligible" employee; and
- at least age 62 and had completed at least 10 years of service, or at least age 65 and had completed at least 5 years of service.

## Coverage for Your Dependents

### HRA Dependent Eligibility

Generally, the following dependents are eligible for coverage under the HRA:

- Your spouse who is age 65 or older and is eligible to receive Medicare, or
- Your domestic partner who was enrolled in the HRA as of June 30, 2016.

To be eligible for coverage under the HRA, your dependent must have maintained WFU medical coverage until Medicare eligible and must be enrolled in medical coverage

purchased through ***Via Benefits*** (or have been continuously enrolled in an individual Medigap plan with AARP since January 1, 2016).

**Retiree Death Benefit**

Dependents are not eligible for coverage under the Retiree Death Benefit.

**General Requirements for Dependent Coverage under the Plan**

You may be required to provide evidence regarding your dependent's eligibility for Plan benefits. Wake Forest reserves the right to request evidence of your dependents' eligibility.

You must notify Wake Forest when a dependent no longer meets a benefit program's eligibility requirements. Your dependent's coverage will end when they cease to be eligible according to the terms of the Plan, even if you fail to give notice to the University.

Enrolling ineligible dependents, falsifying information regarding your dependent's eligibility, or failing to notify Wake Forest of a covered dependent's loss of eligibility may result in retroactive termination of the ineligible dependent's benefits and other enforcement action. You may be required to repay any amounts paid out from the Plan on behalf of your ineligible dependent.

# Enrollment

## Plan Enrollment

### HRA Enrollment

If you are eligible to participate in the HRA, you will become a participant in the HRA on the date you become enrolled in medical coverage purchased through ***Via Benefits***.

If you are not yet eligible to receive Medicare, but your spouse is age 65 or older and is eligible for Medicare, you will become a participant in the HRA (with an HRA account established in your name) on the date your spouse enrolls in medical coverage purchased through ***Via Benefits***.

**Rehires.** If you are enrolled in the HRA and are later rehired by Wake Forest or affiliated Employer, your participation in the HRA will be paused during your employment. You will not be eligible to receive reimbursement of expenses incurred while you are an employee of the University or affiliate.

### Retiree Death Benefit Enrollment

You will become a participant in the Retiree Death Benefit in accordance with the rules and procedures established by the Plan Administrator. Please refer to the ***Retiree Death Benefit policy*** for more information.

## Termination of Coverage

Your enrollment in a benefit program will terminate on the date that you cease to be eligible for the benefit program.

Dependent coverage under a benefit program will generally terminate on the date that your enrollment ends or, if earlier, the date the dependent is no longer eligible for coverage under the benefit program (or, if earlier, the date you fail to provide proof that your dependent is eligible for coverage).

(See the next section for information about termination of HRA coverage.)

Your (and your dependent's) coverage under the Plan will terminate if Wake Forest terminates the Plan or benefit program or if you submit false claims or otherwise violate the terms of the Plan.

## Termination of HRA Coverage

Your coverage under the HRA will terminate as of the earliest of:

- The date of your death.
- The date you are no longer eligible for Medicare.
- The last day of the month in which you cease to be enrolled in medical coverage purchased through Via Benefits.

Eligible expenses incurred after your participation in the HRA ends are not eligible for reimbursement. You may submit claims for reimbursement for eligible expenses incurred on or before the date your participation in the HRA ends, as long as the claims are submitted no later than six months after your participation in the HRA ends.

**HRA Coverage Upon Your Death**

If you die without an eligible spouse or domestic partner, your HRA account will be forfeited as of your date of death. However, your estate or representatives may submit claims for eligible expenses incurred prior to your death as long as such claims are submitted no later than six months after your death.

If you die with an eligible spouse or domestic partner who is age 65 or older and is enrolled in medical coverage purchased through Via Benefits, the surviving dependent will become a participant in the HRA, and your HRA account will continue in the name of the surviving dependent and for the surviving dependent's benefit. The surviving dependent will receive benefit credits and may submit claims for reimbursement of health care expenses. When the surviving dependent dies, any amounts remaining in the HRA account will be forfeited.

# HRA Benefit Credits

As a participant in the HRA, you will receive benefit credits to your HRA account. The timing and amount of the benefit credit varies and will be an amount determined by the University and communicated to you, typically prior to the start of the Plan year. HRA benefit credits are prorated for participants who enroll mid-year.

Your HRA benefit credits can be used to reimburse your (and your eligible dependent's) premiums for medical coverage purchased through ***Via Benefits*** and premiums for Medicare Part B coverage. You may submit claims for reimbursement of your Medicare Part B coverage in accordance with the procedures established by the Plan Administrator. If your claim for reimbursement is approved, you will be paid as soon as reasonably possible.

If there are any amounts remaining in your HRA account at the end of the Plan year, those amounts will carry over to the next Plan year.

Please note that your HRA account is a bookkeeping account on the Employer's records; it is not funded and does bear interest or accrue earnings. All benefits under the Plan are paid entirely from the Employer's general assets. In addition, the law does not allow you to make contributions to your HRA account.

# Claims and Appeal Procedures

This section provides instructions and information to file claims under the Plan and to appeal claims that have been denied. Claims may be subject to different procedures for each of the benefit programs, as described below.

The Plan Administrator has the full discretion and authority to determine all claims under the Plan unless such discretion and authority is delegated to a claims administrator. Any action or determination made by the authorized claims administrator during the claims and appeals process is final, conclusive, and binding.

## Eligibility Claims

Claims that relate solely to determining whether you or your dependents are eligible to participate under the Plan or relate to your enrollment in the Plan, and that do not involve a claim for benefits under the Plan, must be filed in writing with the Plan Administrator. The Plan Administrator decides claims for eligibility under the Plan. The Plan Administrator's decisions regarding eligibility under the Plan are final and binding on all persons and cannot be appealed.

## Benefit Claims

Each benefit program under the Plan has a designated claims administrator to process and review your claims for benefits.

Plan participants and beneficiaries must follow the procedures established by the claims administrator. You must submit a claim for benefits within the time period described in these procedures.

**Authorized Representatives**

Plan participants and beneficiaries may exercise their rights under the Plan directly or through an authorized representative. If you choose to exercise your rights through an

authorized representative, you must submit a written statement to the applicable claims administrator designating the individual who is authorized to act on your behalf with respect to a claim for benefits. You may have only one authorized representative at a time with respect to a claim. An assignment or attempted assignment of your benefits does not constitute a designation of an authorized representative. A designation of an authorized representative must be clearly stated in a form acceptable to the claims administrator. In certain circumstances, an authorized representative may be required to produce evidence of their authority to act on your behalf and the Plan may require you to execute a form relating to such representative's authority before that person will be given access to your information or allowed to take any action for you.

For purposes of these claims and appeals procedures, "you" refers to the claimant and includes the claimant's authorized representative, when applicable.

Claims and appeals must be timely submitted within the time frames described below.

## Initial Benefit Claims

Claims for Plan benefits must be made on a form provided for that purpose, or in any other manner specified in writing, by the Plan Administrator or designated claims administrator (each, as applicable, the "claims administrator").

The period of time within which a benefit determination is required to be made will begin at the time a claim is filed in accordance with the procedures of the Plan, without regard to whether all the information necessary to make the benefit determination accompanies the filing. For purposes of these claims and appeals procedures, electronic notification from a claims administrator serves as written notification in accordance with applicable Department of Labor regulations.

### Retiree Death Benefit Claims

The following procedures apply to claims for benefits under the Retiree Death Benefit.

The claims administrator will review your claim and inform you in writing of its decision within a reasonable period of time, but not later than 90 days after the claims administrator receives the claim. If the claims administrator determines that special circumstances require an extension of time for processing the claim, the 90-day period

may be extended by up to an additional 90 days (for a total of 180 days). The claims administrator will provide you with written notice of the extension prior to the end of the initial 90-day period. The notice will describe the special circumstances requiring an extension of time and the date by which the claims administrator expects to render its decision.

**HRA Benefit Claims**

The following procedures apply to claims for benefits under the HRA.

The claims administrator will notify you of the denial of a claim within 30 days after receiving the claim. This 30-day period may be extended by up to 15 days if the claims administrator determines that an extension is necessary to process your claim due to matters beyond the control of the claims administrator. If an extension is necessary, you will be notified before the end of the initial 30-day period of the reasons for the delay and when the claims administrator expects to make a decision.

If more time is needed because additional information is necessary to process your claim, the claims administrator will send you a notice specifying the information required and you will have 45 days to provide the information. If the period of time is extended due to your failure to submit information necessary to decide your claim, the period for processing your claim will be tolled (*i.e.*, suspended) from the date on which the notification of extension is sent to you until the date the claims administrator receives the additional information.

## Notification of Adverse Benefit Determination

If the Plan denies your claim, in whole or in part, it will provide you with written notification of the adverse benefit determination. The notification will contain the following information:

- the specific reason or reasons for the adverse benefit determination;
- reference to the specific Plan provisions on which the determination is based;
- a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;

- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol or criterion, or a statement that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and that a copy of such rule, guideline, protocol, or criterion will be provided free of charge to you upon request; and
- a description of the Plan's appeal procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

## Benefit Claim Appeals

If your claim for benefits is denied, in whole or in part, you must follow the administrative procedures for an appeal and exhaust such administrative procedures prior to seeking any other form of relief.

**To appeal an adverse benefit determination, you must file the appeal no later than 60 days (180 days for HRA benefit claims) after the date you are notified of the claim denial.** If your appeal is not timely filed, your claim will be deemed permanently waived and abandoned, and you will be precluded from reasserting it under these procedures or in a court or any other venue. Your appeal must be made in writing and may include written comments, documents, records, and other information relating to the claim for benefits, and these comments, documents, records, and other information will be taken into account without regard as to whether they were submitted or considered in the initial benefit determination.

You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. A document, record, or other information is relevant to a claim for benefits if the document, record, or information:

- was relied upon in making the adverse benefit determination;
- was submitted, considered, or generated in the course of making the benefit determination, without regard to whether the document, record, or information was relied upon in making the adverse benefit determination;

- demonstrates compliance with the administrative processes and safeguards that ensure and verify that benefit claim determinations are made in accordance with governing Plan documents and that, where appropriate, the Plan provisions have been applied consistently; or
- constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for your diagnosis, without regard to whether such advice or statement was relied upon in making the adverse benefit determination.

The review of an HRA claim will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

You will be notified of the Plan's benefit determination on review within a reasonable period of time, and not later than 60 days after the Plan's receipt of your request for review of an adverse benefit determination. If the claims administrator determines that an extension of time for processing the appeal is necessary, written notice of the extension will be provided to you prior to the end of the 60-day period, and the extension will not exceed 60 days from the end of the initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the claims administrator expects to render the determination on review.

**Notification of Benefit Determination on Review**

The claims administrator will provide you with written notification of the Plan's benefit determination on review. In the case of an adverse benefit determination, the notification will include:

- the specific reason or reasons for the adverse benefit determination;
- reference to the specific Plan provisions on which the determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;

- a description of any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures;
- if your claim is for benefits under the HRA, the specific rule, guideline, protocol, or criterion, or a statement that such rule, guideline, protocol, or criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or criterion will be provided to you free of charge upon request (if applicable); and
- a statement of your right to bring an action under Section 502(a) of ERISA.
- if your claim is for benefits under the HRA, the following statement: "You and your plan may have other voluntary dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

## Limitations on Claims and Legal Action

Except to the extent provided under the applicable Program Documents, a claim will not be considered for payment by the Plan more than one year after the occurrence of the circumstances giving rise to the claim.

The Plan's internal claims and appeal procedures must be utilized and fully exhausted before you may bring a legal action against Wake Forest, the Plan Administrator, the claims administrator, or the Plan. The exhaustion requirement applies to all types of claims under the Plan, including: (i) claims for benefits under the Plan, (ii) enforcement of your rights under the terms of the Plan, and (iii) clarification of your rights to future benefits under the terms of the Plan.

No legal or equitable action relating to a claim for benefits may be commenced later than one year after you receive a final notice of the benefit determination under internal review. No other legal or equitable action involving the Plan may be commenced later than two years from the time the person bringing an action knew, or had reason to know, of the circumstances giving rise to the action.

If a shorter statute of limitations applies under the Program Document or applicable law, this provision will enforce such statute of limitations.

In any action brought by a participant, beneficiary, or any other person against the Plan, its fiduciaries, its administrators, or Wake Forest University, the legal fees of the Plan, its fiduciaries, its administrators, and Wake Forest University will be paid by the person bringing the action, unless the court specifically finds that there was a reasonable basis for the action.

# Miscellaneous

## Plan Expenses

All Plan expenses are paid by Wake Forest University unless paid by the Plan.

## Amendment and Termination of the Plan

Wake Forest may amend or terminate the Plan and any benefit program at any time for any reason. Wake Forest also may replace the arrangement through which benefits are paid under the Plan. The benefits under the Plan are not vested benefits and in no event is any person vested in any rights or benefits under the Plan.

## Conditions of Receiving Benefits

By participating in the Plan, you agree to the terms and conditions of the Plan. Some benefit programs may require you to take additional action before you are entitled to receive Plan benefits.

## Plan Documents Control

The SPD is not intended as a substitute for the Plan, any benefit program, or other benefit provided by Wake Forest. The Plan documents control in all cases and on all questions. You have the right to read and copy (subject to any duplication charge) the formal Plan documents at any time upon request to the Plan Administrator.

## Plan Administration Decision Final and Binding

All decisions of the Plan Administrator (or its authorized delegate, such as a claims administrator) will be conclusive and binding upon all persons having or claiming to have any interest or right under the Plan.

## Keep Your Plan Informed of Address Changes

It is important that you keep the Plan Administrator informed of any changes in your contact information, including your mailing address and email address and the addresses of your dependents. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

## Anti-Assignment

Except as otherwise expressly set forth in the applicable Program Document, any benefit, right, or interest available to you or a covered dependent under the Plan, any right you or a covered dependent may have to receive payments under the Plan, and any payment to be made under the Plan to you (or on behalf of you or a covered dependent) cannot be assigned or transferred in any way (voluntarily or involuntarily). Any decision to pay a provider directly in no way reflects or creates any rights of a provider to benefits, reimbursements, or payments of any kind under the Plan or benefit programs.

## Right of Recovery/Overpayments

The Plan has the right to recover benefits it has paid to any person that were in excess of the benefit that should have been paid. If the Plan provides a benefit or payment that exceeds the amount that should have been paid, the Plan Administrator may: require that the overpayment be returned when requested, reduce future benefit payments by the amount of the overpayment, or recover the overpayment by any other legally permitted means.

## HIPAA Privacy Rights

The HRA is subject to the privacy rules of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). To receive a copy of the Plan's notice regarding compliance with HIPAA's privacy rules, or if you have any questions about HIPAA, please contact the Plan Administrator.

## COBRA

Your eligible dependent may be able to elect to temporarily continue coverage under certain Plan benefits, beyond the date that their coverage would otherwise end, under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). Information about continuing coverage under the Plan will be provided to you by the Plan Administrator when applicable.

## Tax Effects

The University and the Plan Administrator make no representations or warranties as to whether benefits paid under the Plan will be treated as excludable from gross income for federal or state income tax purposes.

# Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants are 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 work sites and union halls), all Plan documents, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report ("Form 5500 Series") and updated 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 your eligible 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, 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 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.

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 federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in court after following and exhausting the Plan's claims procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a 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 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, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 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.