Health and Welfare Benefit Plan Summary Plan Description

January 2025

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Introduction

Wake Forest University maintains the Wake Forest University Health and Welfare Benefit Plan (the "Plan") to provide certain health and welfare benefits to eligible employees of the University and their eligible dependents. The Plan is comprised of the Plan document, which includes the applicable contracts, benefit booklets, policies, and agreements ("Program Documents") provided by the Plan's insurance carriers and third-party benefit administrators, and the Health Care Flexible Spending Account component of the Wake Forest University Flexible Spending Account Plan.

This document, together with the benefit program summaries, certificates of coverage, and benefits booklets for each benefit program, constitute the Summary Plan Description ("SPD") for the Plan. This document includes information about:

- Eligibility and Enrollment
- Premiums and Contributions
- COBRA Continuation Coverage
- Claims and Appeals
- Administrative Information
- Your ERISA Rights

Details and information regarding benefits and covered services are described in the applicable benefit program summary, benefits booklet, or certificate of coverage for each benefit program. This document is not intended to provide any substantive rights to benefits not described in the Program Documents.

The terms of the Plan may change in the future. You should carefully review the benefits-related communications issued periodically and the annual Benefits Guidebook issued during open enrollment for changes to the terms of the Plan.

References to "you" and "your" in this document refer to current and former employees of the University and its 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 are an employee of an affiliate of the University, your employer.

The information in this document is effective as of January 1, 2024. The SPD is for informational purposes and is not intended as an offer of employment or to establish the terms and conditions of employment in any way. The SPD is only a *summary* of the key provisions of the Plan. Please see Program Documents for details about the Plan benefits, which are available at: ***https://hr.wfu.edu***.

If there is a conflict between the legal Plan documents and this SPD, the legal Plan documents 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:

Medical, Prescription Drug, and Behavioral Health
Dental
Vision
Health Care Flexible Spending Account
Term Life and AD&D Insurance
Whole Life Insurance
Long-Term Disability
Legal Services
Business Travel Accident Insurance
Employee Assistance Program
Separation Pay Policy

This document includes information applicable to the health and welfare benefits offered by Wake Forest that are subject to the Employee Retirement Income Security Act ("ERISA"). Information about these welfare benefits is provided in the following sections.

Wake Forest also offers other benefits that are not subject to ERISA, such as a dependent care flexible spending account (FSA), health savings account, short-term disability, and education benefits. Refer to the annual Benefits Guidebook and the University Policy Library for information about these other Wake Forest welfare benefits.

Benefit Program Information

Benefit Program	Contact	Contact Information and Program Documents
Medical Plan (including Behavioral Health and Prescription Drug)	Aetna	(855) 586-6961 *www.aetna.com* **Program Documents** a. *Aetna Whole Health - High/Low Plan* b. *Aetna Choice POS II – High/Low Plan* **Schedule of Benefits** a. *Aetna Whole Health - High Plan* b. *Aetna Whole Health - Low Plan* c. *Aetna Choice POS II - High Plan* d. *Aetna Choice POS II - Low Plan*
Dental Plan	MetLife	(800) 942-0854 *www.metlife.com/mybenefits* *Low Plan Summary* *High Plan Summary*
Vision Plan	Superior Vision by MetLife	(800) 507-3800 *www.superiorvision.com* *Vision Plan Benefit Summary*
Health Care FSA	McGriff Insurance Services	(800) 930-2417 *www.mcgriff.com* *Health Care FSA Plan Summary*
Long-Term Disability	New York Life	(800) 732-1603 *www.newyorklife.com/group-benefit-solutions* *Long-Term Disability Policy*
Term Life Insurance	New York Life	(866) 799-2725 *www.newyorklife.com/group-benefit-solutions* *Life Insurance Policy*

Benefit Program	Contact	Contact Information and Program Documents
Whole Life Insurance	Unum	(800) 635-5597 ***www.unum.com*** ***Whole Life Summary***
Accidental Death & Dismemberment Insurance (AD&D)	New York Life	(866) 799-2725 ***www.newyorklife.com/group-benefit-solutions*** ***AD&D Policy***
Long-Term Care Insurance	Genworth	(800) 416-3624 ***www.genworth.com/wake*** ***LTC Program Information***
Legal Plan	ARAG Services	(800) 247-4184 ***www.araglegal.com*** ***Low Plan Policy*** ***High Plan Policy***
Business Travel Accident Insurance	Wake Forest University Financial Services	(336) 758-4197
Separation Pay Policy	Wake Forest Human Resources	(336) 758-4700 AskHR@wfu.edu ***Separation Pay Policy***
Employee Assistance Program (EAP)	Wake Forest Baptist Medical Center	(336) 716-5493 ***Employee Assistance Program Information*** ***HELPS***

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

Benefit Program Funding and Administration

An insurance company is responsible for paying the claims for the following benefit programs, pursuant to a group insurance contract:

Vision Plan	National Guardian Life Insurance Company (administered by Superior Vision Services, Inc.)
Long-Term Disability Plan Term Life Insurance AD&D Insurance	Life Insurance Company of North America (New York Life)
Whole Life Insurance	Unum Life Insurance Company of America
Long-Term Care Insurance	Genworth Life Insurance Company
Business Travel Accident Insurance	Federal Insurance Company (Chubb)
Legal Plan	ARAG Insurance Company

Wake Forest is responsible for paying benefits from its general assets for the following benefit programs, which are administered pursuant to contracts with the following entities:

Medical Plan	Aetna Life Insurance Company (*Medical, Behavioral Health, and Prescription Drug)*
Dental Plan	Metropolitan Life Insurance Company
Health Care FSA	McGriff Insurance Services
EAP	Wake Forest Baptist Medical Center

Plan Information

Plan Name	**Wake Forest University Health and Welfare Benefit Plan**

Plan Sponsor	Wake Forest University 1834 Wake Forest Road Winston-Salem, NC 27109
Employer ID Number	56-0532138
Plan Administrator	Wake Forest University 1834 Wake Forest Road Winston-Salem, NC 27109 (336) 758-7400
Agent for Service of Legal Process	Wake Forest University Attn: Legal Department 1834 Wake Forest Road Winston-Salem, NC 27109 (336) 758-6100
Plan Number	501
Plan Year	January 1 – December 31

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

The Medical Plan, Dental Plan, Vision Plan, Health Care Flexible Spending Account, and Employee Assistance Program are group health plans.

The Long-Term Disability Plan is a group disability plan.

Term Life Insurance and Whole Life Insurance are group death benefit plans.

Accidental Death and Dismemberment Insurance and Business Travel Accident Insurance are group accident plans.

The Long-Term Care Plan is a group long-term care plan.

The Legal Plan is a pre-paid legal services plan.

The Separation Pay policy is a severance pay arrangement.

The Plan is funded by insurance contracts and the 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 and each benefit program 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

Your eligibility to enroll in the Plan is based on your employment classification and the requirements of each benefit program. Generally, full-time and part-time with benefits faculty and staff of the University or Reynolda House are eligible to participate in the Plan beginning on the first day of the month coinciding with or following their date of hire.

Full-time and part-time with benefits status is based on the annual budgeted hours for your primary position listed in Workday, as follows:

	Full-Time Requirements	Part-Time Requirements
Faculty	1,096 – 1,462 hours	1,000 – 1,095 hours
Staff and Post Docs	1,560 – 2,080 hours	1,000 – 1,559 hours
Reynolda House Staff	1,560 – 1,820 hours	1,000 – 1,559 hours

Any additional eligibility requirements that may apply to benefit programs are described in the applicable Program Documents.

You will be eligible to enroll in certain Medical Plan coverage options if Wake Forest determines that you are a "full-time" employee for purposes of the Affordable Care Act ("ACA"). Wake Forest will notify you if you are eligible to enroll in the Medical Plan under the ACA. ACA eligibility is determined in accordance with rules established by the Plan Administrator. For more information on ACA eligibility, contact Human Resources.

Coverage for Your Dependents

Your dependents' eligibility for Plan coverage varies depending on the benefit program. Generally, the following dependents are eligible for coverage under the Plan:

- Your spouse.

- Your children who are younger than age 26. This includes biological children, stepchildren, adopted children, foster children, and any children for whom you are financially responsible for providing Plan coverage under a court order.
- Your children, regardless of age, who are incapable of self-sustaining employment and who are dependent upon you or other care providers for lifetime care and supervision because of a disabling condition occurring before they reach age 26 and who were covered under the applicable benefit program when they reached 26.
- Any children who are under your legal guardianship or who are in your custody under an interim court order of adoption or who are placed with you for interim order vesting temporary care.

You may be required to provide evidence regarding your dependents' eligibility for Plan benefits. Wake Forest reserves the right to request, at reasonable intervals, 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 could result in retroactive termination of the ineligible dependent's benefits and in legal/disciplinary action for you, up to and including termination of employment. You may be required to repay any amounts paid out from the Plan on behalf of your ineligible dependent.

Your dependents are not eligible for coverage under Long-Term Disability Insurance or Business Travel Accident Insurance.

Please review the applicable Program Documents for additional information about dependent eligibility.

Enrollment

You cannot enroll in the Plan at any time. The Plan provides specific times during which you can enroll in the benefits available under the Plan. Enrollment in the Plan is permitted:

- when you first become eligible for coverage under the Plan,
- during the annual open enrollment period, and
- when you experience a qualifying life event.

Enrolling in the Plan for the First Time

When you first become an eligible employee under the Plan, you must complete the initial enrollment process no later than **30 calendar days** following your date of hire as an eligible employee. If you become an eligible employee after your date of hire, you must complete the initial enrollment process no later than 30 calendar days following the date you become an eligible employee.

If you enroll in the Plan within this 30-day period, your coverage will be effective as of the first day of the month coinciding with or following your date of hire. If you do not enroll in benefits under the Plan within this 30-day period, your next opportunity to enroll will be during the next open enrollment period or upon a qualifying life event (described below).

You will be automatically enrolled in the Long-Term Disability Plan, Basic Term Life Insurance, AD&D Insurance, Business Travel Accident Insurance, and the EAP. Wake Forest pays the cost of coverage for these benefit programs.

Annual Open Enrollment

You will have an opportunity each year to enroll in Plan benefits or change or revoke your coverage elections for you and your eligible dependents. You will receive information and instructions for completing the annual enrollment process.

Your coverage election will take effect on January 1 following the annual enrollment period and will remain in effect until the following December 31 (unless you change it upon a qualifying life event).

Unless otherwise stated in the Plan's annual enrollment materials, if you do not submit an election during annual enrollment, your prior year enrollment elections will renew for the following Plan year, except for the Health Care FSA. You must re-enroll the Health Care FSA each year, or your election for the following Plan year will be $0.

Changing Your Enrollment During the Year

If you experience a qualifying life event, you may elect to add or drop eligible dependents and/or add or drop coverage under the Plan. You must submit your new election no later than **30 calendar days** following the date of the qualifying life event. **Any change to your coverage must be consistent with the qualifying life event as determined by the Plan Administrator**. You must provide the information the Plan Administrator requests to verify the occurrence of the life event and to verify your dependents, if applicable. Your change in coverage will typically take effect retroactive to the date of the event (or the date you lost other coverage, if applicable).

You may change your Plan coverage elections upon the following qualifying life events:

Change in your Marital Status. This includes your marriage, divorce, legal separation, annulment, or death of a spouse.

Change in your Number of Dependents. This includes the birth, adoption, placement for adoption, or death.

Change in your, your Spouse's, or your Dependent's Employment Status. This includes the termination or commencement of employment, a strike or lockout, or commencement of or return from an unpaid leave of absence.

Dependent Satisfies or Ceases to Satisfy the Plan Eligibility Requirements. This includes reaching the dependent age limit or any similar circumstance.

Change in your Spouse's or Dependent's Residency. This includes a change in your spouse's or dependent's residence that results in a change in their coverage.

Loss of Plan Benefit. If a benefit option is no longer offered under the Plan, or the coverage is significantly reduced (for example, a hospital health system is no longer covered as a network provider).

Changes Permitted Under Other Plans. If your spouse or dependent is covered under a plan that has a different enrollment period than this Plan.

You may change your Medical Plan, Dental Plan, and Vision Plan coverage upon the following qualifying life events:

Receipt of a Qualified Medical Support Order. This includes a judgment, decree, or order (including approval of a property settlement) resulting from a divorce, legal separation, annulment, or change in legal custody that requires accident or health coverage for your child (including a foster child who is your dependent).

Change in Medicare or Medicaid Enrollment. This includes your, your spouse's or your dependent's enrollment in or loss of coverage under Medicare or Medicaid.

Loss of Certain Other Coverage. This includes loss of coverage under the Indian Health Service, a state health benefits risk pool, or foreign government health plan.

Change in Eligibility for MarketPlace Coverage

Loss of Medicaid or CHIP Coverage. You may elect to add coverage for yourself and eligible dependents within **60 calendar days** after you lose, or become eligible for, coverage under Medicaid or the Children's Health Insurance Plan ("CHIP").

Newly Acquired Dependent. You may elect to add Medical Plan coverage for yourself and eligible dependents within **60 calendar days** after the birth of a child.

Changes to your coverage elections are subject to the terms of the applicable benefit program. Please review the applicable Program Document for additional information about changing your coverage elections.

Coverage While on Leave of Absence

Your coverage under the Plan will continue while you are on an approved leave of absence to the extent permitted under the applicable benefit program. For more information about your Plan coverage during an approved leave of absence, contact Human Resources/Benefits.

If you are on an approved **paid leave of absence**, your premiums and contributions for any continued coverage will be made through payroll deduction.

If you are on an approved **unpaid leave of absence**, you may be required to pay your premiums and contributions for any continued coverage during or after your leave.

Coverage Following a Termination of Employment

Your coverage under the Medical Plan (including Prescription Drug and Behavioral Health), Dental Plan, and Vision Plan will end on the last day of the month in which you terminate from employment. Coverage for all other Benefits Programs under the Plan generally will end upon your termination date. However, you may be able to elect to temporarily continue coverage under certain benefit programs for yourself and your eligible dependents as required under the Consolidated Omnibus Budget Reconciliation Act ("COBRA"). For more information about coverage after termination of employment and COBRA coverage continuation, see ***COBRA Continuation Coverage*** section of this SPD and the applicable Program Document. Other benefit programs may permit you to convert or port your coverage.

Coverage Upon Rehire

If your employment with Wake Forest ends and you are rehired by Wake Forest as an eligible employee within 30 calendar days after your employment ended, your Plan coverage in effect on your termination date will be automatically reinstated.

However, if you are rehired more than 30 calendar days after your employment ended, your coverage will not be automatically reinstated. If you are rehired as an eligible employee, you may re-enroll in Plan coverage within 30 calendar days after your date of rehire.

If you are rehired as an employee who is eligible for Medical Plan coverage under the Affordable Care Act, your coverage will be determined under those rules. For more information on ACA eligibility, contact Human Resources.

Coverage Upon Your Death

Your coverage under the Plan generally will end on your date of death. Your eligible dependents may be able to elect to temporarily continue coverage under certain Plan benefits under COBRA. For more information about coverage after your death and COBRA coverage continuation, see ***COBRA Continuation Coverage*** section of this SPD and the applicable Program Document. Your eligible dependents may submit claims for expenses or benefits incurred prior to your death.

Termination of Coverage for Other Reasons

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

Your dependent's enrollment in a benefit program will generally terminate on the date that your enrollment ends or, if earlier, the date dependent is no longer eligible for coverage under the benefit program.

Plan coverage will also terminate if:

- You fail to pay your share of the premium (as applicable) or employee contribution,
- Wake Forest terminates the Plan or benefit program,
- The Plan or any benefit program is no longer offered to your class of employees,
- You submit false claims or otherwise violate the terms of the Plan, or
- You fail to provide proof that your dependent is eligible for coverage.

Premiums and Contributions

The amount you pay for coverage under a Plan benefit (*i.e.*, premiums) is based on the coverage you elect. Please review the annual Benefits Guidebook for information about benefit program premiums and contributions. A schedule of required premiums/contributions is available from Human Resources.

Long-Term Disability, **Basic Term Life Insurance**, **AD&D Insurance**, **Business Travel Accident Insurance**, **Separation Pay,** and **EAP** benefits are provided automatically at no cost to you. Wake Forest pays the cost of coverage for these Plan benefits.

The premiums you pay toward the cost of your Plan benefit coverage are deducted on a:

- ***Pre-tax*** basis for any Medical Plan, Dental Plan, and Vision Plan coverage you elect, as well as any contributions you choose to make to the Health Care FSA.
- ***After-tax*** basis for any Voluntary Life Insurance, AD&D Insurance, Long-Term Care Insurance, and Legal Plan coverage you elect.

Pre-tax premiums are deducted from your pay *before* your taxes are calculated, so they reduce your taxable income. After-tax premiums are deducted from your pay after your taxes are calculated, so they have no impact on your taxable income. Determination of whether premium deductions are pre-tax or after-tax will be done in accordance with state and federal regulations and may change as regulations change. *Note:* The payment of certain life insurance premiums may be imputed to you as taxable income.

COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act ("COBRA") allows you the opportunity to purchase continued group health plan coverage in certain instances where coverage under the Plan would otherwise end.

The COBRA rules apply to the:

- Medical Plan
- Dental Plan
- Vision Plan
- Employee Assistance Program (EAP)
- Health Care FSA

Special COBRA rules apply to the Health Care FSA. COBRA is available for your Health Care FSA only if the amount remaining in your FSA exceeds the amount you have been reimbursed from your FSA on the date of the qualifying event.

The Medical Plan, Dental Plan, Vision Plan, Health Care FSA, and EAP are each considered separate group health plans for purposes of COBRA. The following COBRA rules will apply unless the applicable benefit program specifies terms of continuation coverage. See the applicable Program Document for more information.

Right to Elect COBRA Continuation Coverage

Generally, you, your spouse, and your dependent children can elect COBRA continuation coverage if coverage would otherwise end because of a "qualifying event." An individual with a right to continue Plan coverage under COBRA is a "qualified beneficiary." Your civil union partner is eligible for COBRA as a qualified beneficiary if your partner is your legal spouse.

You can elect COBRA continuation coverage if your coverage would otherwise end because of any of the following qualifying events:

- termination of your employment (for reasons other than your gross misconduct)

- change of your employment status due to a reduction in hours

Your spouse can elect COBRA continuation coverage if your spouse's coverage would otherwise end because of any of the following qualifying events:

- termination of your employment (for reasons other than your gross misconduct)
- change of your employment status due to a reduction in hours (including a leave of absence)
- your death
- your divorce or legal separation
- your entitlement to Medicare

Your dependent children can elect COBRA continuation coverage if their coverage would otherwise end because of any of the following qualifying events:

- termination of your employment (for reasons other than your gross misconduct)
- change of your employment status due to a reduction in hours (including a leave of absence)
- your death
- your divorce or legal separation
- your entitlement to Medicare
- failure to qualify as an eligible dependent

Notices

The Plan Administrator (or the Plan Administrator's delegate) will notify you if you become entitled to elect to continue Plan coverage under COBRA. **However, you and your family must notify the Plan Administrator within 60 days of your divorce or legal separation or when a child no longer qualifies as a covered dependent under the Benefit Program.** You must provide notice of these events in writing to the Plan Administrator. Failure by you or your family to timely provide proper notice will result in ineligibility for you and your spouse and dependent children to continue or extend Plan coverage, as applicable.

Election Period

You will have at least 60 days to elect whether to continue coverage under the Plan, beginning no later than the date your coverage would otherwise terminate due to a

qualifying event. The Plan Administrator must receive your written election within 60 days from the later of:

- the date your Plan coverage would otherwise terminate due to a qualifying event, or
- the date the Plan Administrator notifies you of your continuation rights because of a qualifying event.

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

Oral communication regarding COBRA coverage is not acceptable as a COBRA election and will not preserve your COBRA rights.

Length of COBRA Continuation Coverage

COBRA coverage is a temporary continuation of coverage. COBRA coverage can continue for up to 18 months if the qualifying event is your employment termination or the reduction in your work hours. In some cases, a qualifying event may permit your spouse and your dependent children to elect continued coverage for up to 36 months. If, during the first 18-month period of COBRA coverage, a second qualifying event occurs that would permit your spouse and dependent children to elect coverage for up to 36 months, your spouse and dependent children may then elect to continue coverage for an additional 18-month period, for a maximum of 36 months after the original qualifying event. Notice of the second qualifying event must be properly given to the Plan Administrator within 60 days of the occurrence of such event, along with any required documentation. See the *Notices* section above for a discussion of the required notice procedures.

For example, suppose you stop working for Wake Forest and you, your spouse, and your dependent children elect continued coverage. Coverage would normally continue for 18 months. However, during that 18-month period, you and your spouse divorce. Upon proper written notice to the Plan Administrator within 60 days of the divorce, your spouse and children may elect continued coverage for an additional 18-month period, for a maximum total period of 36 months from the time your employment ended.

In providing the notice of a second qualifying event, you must follow the procedures specified by the Plan Administrator. Failure to follow the procedures or failure to provide the notice in writing to the Plan Administrator during the 60-day notice period will result in a loss of entitlement to COBRA continuation coverage for the second qualifying event extension.

Note: Medicare entitlement that occurs after termination of employment generally will not cause an extension of COBRA by 18 months. If your employment ends or your work hours are reduced within 18 months after your entitlement to Medicare, your spouse and dependent children may continue coverage for up to 36 months from the date you become entitled to Medicare. However, if your employment ends or your work hours are reduced more than 18 months after your entitlement to Medicare, your spouse and dependent children may continue coverage for up to 18 months from the date your employment ended or your work hours were reduced.

COBRA continuation with respect to the Health Care FSA will not extend beyond the end of the Plan year in which the qualifying event occurred.

Type of Coverage. If you are eligible for COBRA continuation coverage, you may elect to continue the coverage under the Plan that was in force immediately before the qualifying event. Your coverage will be the same as the coverage that is provided to similarly situated individuals who have not experienced a qualifying event. You will not be required to give evidence of good health in order to continue coverage. In addition, during an annual enrollment period, you will have the same rights to choose among coverage options (with respect to the benefits for which you have previously elected to continue coverage) as the rights that are available to similarly situated individuals who have not experienced a qualifying event. For these purposes, the Medical Plan, Dental Plan, Vision Plan and EAP are considered separate plans.

Cost of Continued Coverage

You must pay the full cost of continued coverage, plus 2% to cover administrative costs. If you decide to continue coverage after the date your coverage would otherwise terminate, the Plan Administrator must receive your payment for your retroactive coverage within 45 days from the date of your election. At that time, you may have to pay for the following:

- coverage during the 60-day election period, and
- coverage during the 45-day payment period following that date.

After that, regular monthly payments for coverage will be due on or before the first day of each month. Payment must be received no later than 30 days after the first day of the month for which the premium is owed.

Individuals with a disability determination and their family members with extended coverage must pay 102% of the full cost of their continuation coverage for the first 18 months. After 18 months, the required payments will increase from 102% to 150% of the full cost of coverage if the individual with a disability determination is covered.

COBRA Coverage in the Event of Disability

If the Social Security Administration determines, within 60 days of the date that COBRA continuation coverage began, that you, your covered spouse, or your covered dependent is/are disabled, you and your dependents who are entitled to COBRA continuation coverage can request an extension of the maximum coverage period from 18 to 29 months. To obtain this extended coverage, the Plan Administrator must be notified of the Social Security Administration's disability determination within 60 days of the determination and prior to the end of the initial 18-month period. You must provide this notice in writing to the Plan Administrator. The notice must contain a description of the qualifying event, the date of occurrence of the event, and the names of all dependents whose coverage may be affected by the occurrence of such event. You are required to include with your notice a copy of the determination letter from the Social Security Administration. Failure by you or your family to timely provide such notice will result in ineligibility to obtain extended coverage.

If the Social Security Administration later determines that the individual is no longer disabled, you must notify the Plan Administrator within 30 days of the determination. Termination of COBRA coverage for this reason will occur as of the first day of the month beginning more than 30 days after the date of the final determination.

Continuation Coverage for Newly Acquired Dependent Children

If, while your coverage is being continued under COBRA, a child is born to or placed for adoption with you, you may elect coverage for the newly acquired dependent child under the same provisions in effect for similarly situated active employees if you:

- notify the Plan Administrator of the birth or adoption of the child within 30 days of the birth or adoption; and
- pay the required premium.

You must provide notice of the birth or adoption, and any other documentation the Plan Administrator may require, in writing to the Plan Administrator. Failure to timely provide proper notice will result in ineligibility to obtain COBRA coverage for the newly acquired dependent.

If a second qualifying event occurs for a newly acquired dependent child that is added to coverage during the period of COBRA continuation coverage, the child may be eligible for coverage for up to 36 months from the date of the original qualifying event.

Termination of Continued Coverage

Continued coverage for any covered person will be terminated and cannot be reinstated if:

- the maximum coverage period (18, 29, or 36 months) is reached,
- payment is not received on a timely basis,
- the person becomes covered by another group plan, but only if that plan does not limit or exclude coverage for any preexisting condition of the person,
- the person becomes entitled to Medicare, or
- the Plan is terminated.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

Other Options Besides COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a

"special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at ***www.healthcare.gov***.

Claims and Appeal Procedures

This section provides instructions and information you will need to file claims under the Plan and to appeal claims that have been denied. Claims are subject to different procedures for each of the benefit programs.

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 relating 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. Please see the Benefit Program Information section of this document or the applicable Program Documents for the claims administrator's contact information.

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 Representative

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.

In the case of a claim involving urgent care (please see the *Urgent Care Claims* section below for a definition of "urgent care"), a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative. A "health care professional" means a physician or other health care professional who is licensed, accredited, or certified to perform specified health services, consistent with state law.

The following claims and appeals procedures apply to benefit programs whose Program Documents (i) do not specify claims or appeals procedures or (ii) do not include claims or appeals procedures that comply with ERISA. 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 set out by the Plan.

Initial 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.

Non-Group Health Plan Claims

The following procedures apply to claims for benefits under benefit programs that are not group health plans. See ***Benefit Program Information*** for information on which benefit programs are group health plans.

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.

Special Rule for Disability Claims

If your claim is a disability claim, the claims administrator will review the claim and inform you in writing of its decision within a reasonable period of time, but not later than 45 days after the claims administrator receives the claim. This 45-day period may be extended by up to an additional 30 days. If, prior to the end of the first 30-day extension period, the claims administrator determines that, due to matters beyond the control of the claims administrator, a decision cannot be rendered within the first 30-day extension period, the period for making the determination may be extended by up to an additional 30 days (for a total of 105 days). The claims administrator will provide you with written notice of the extension prior to the end of the applicable notice period. The notice will describe the circumstances requiring the extension and the date a decision is expected, an explanation of the standards on which entitlement to benefits is based, any unresolved issues that prevent the claims administrator from rendering a decision on the claim, and the additional information required to resolve the issues. You will be given at least 45 days to provide the specified information.

Group Health Plan Claims

The following procedures apply to claims for benefits under benefit programs that are group health plans. See ***Benefit Program Information*** for information on which benefit programs are group health plans.

Urgent Care Claims

An urgent care claim is a type of pre-service claim (described below) under the Medical, Dental, or Vision Plan where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your health condition, could cause severe pain that cannot be adequately managed without the requested care or treatment. The claims administrator, in consultation with a physician who knows your medical condition, will determine whether a claim involves urgent care.

- The claims administrator will notify you of its approval or denial of an urgent care claim as soon as possible, taking into account the medical circumstances, but no later than 72 hours after receiving the claim. To expedite the processing of an urgent care claim, the claims administrator's determination may be oral, but a written or electronic confirmation will follow within three days.

- If sufficient information is not provided to determine whether, or to what extent, benefits are covered or payable, you will be notified as soon as possible, but no later than 24 hours following receipt of your claim, of the specific information necessary to complete the claim. You will have a reasonable amount of time, but not less than 48 hours, to provide the specified information. After you provide the requested information, the claims administrator will notify you of its approval or denial of the claim as soon as possible and within 48 hours. If you do not provide the requested information within 48 hours of when it is requested, your urgent care claim will be denied.

- If you fail to follow the claims administrator's procedures for filing an urgent care claim, you will be notified within 24 hours after receipt of your claim of the proper procedures to be followed in filing an urgent care claim. This only applies to a communication from you that is received by a person or organizational unit

customarily responsible for handling benefit matters and that names a specific individual, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested. Notice of an improperly filed urgent care claim may be provided orally or, if you request, in writing.

Pre-Service Claims

A pre-service claim is a group health plan claim for pre-authorization or precertification before receiving care other than urgent care. For example, the Plan may require pre-authorization before receiving non-urgent hospitalization or elective surgery.

- The claims administrator will notify you of the denial of a pre-service claim within 15 days after receiving the claim. This 15-day period may be extended up to an additional 15 days if 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 15-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 pre-service 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.

- If you fail to follow the claims administrator's procedures for filing a pre-service claim, you will be notified within five days after receipt of your claim of the proper procedures to be followed in filing a pre-service claim. This only applies to a communication from you that is received by a person or organizational unit customarily responsible for handling benefit matters and that names a specific individual, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested. Notice of an improperly filed pre-service claim may be provided orally or, if you request, in writing.

Post-Service Claims

A post-service claim is a claim for payment of group health plan benefits after the service has been received or the expense incurred. For example, a claim submitted after a doctor's office visit is a post-service claim. A claim for reimbursement from the Health Care FSA is a post-service claim.

- The claims administrator will notify you of the denial of a post-service 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 post-service 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.

Concurrent Care Claims

Concurrent care claims are claims under the Medical, Dental, or Vision Plan to extend an ongoing course of treatment that was previously approved for a specific period of time or number of treatments. For example, a request to extend a hospital admission to five days when it was initially authorized for three days would be a concurrent care claim. Concurrent care claims also include claims where previously approved treatments are reduced or terminated under the terms of the Plan.

- If you request an extension of ongoing treatment in an urgent care situation, the claims administrator will notify you of the approval of denial of a concurrent care claim as soon as possible, taking into account the medical circumstances, but no later than 24 hours following receipt of the claim if your claim is made at least 24 hours before the end of the previously approved treatment. If your request for

extended treatment is not made within 24 hours before the end of the previously approved treatment period, the claims administrator will follow the urgent care time frames for approval or denial.

- If you request an extension of ongoing treatment in a non-urgent care situation, your request will be considered a new claim and will be reviewed within the pre-service or post-service time frames, whichever applies.
- If an ongoing course of treatment will be reduced or terminated, the claims administrator will notify you sufficiently in advance to give you an opportunity to appeal before the reduction or termination takes effect.

Notification of Adverse Benefit Determination

Benefit determinations are based only on whether benefits are available under the Plan for the proposed treatment or procedure. 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; 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.

Additional information for group health plan claim notifications. If your claim is for benefits under a benefit program that is a group health plan, the written notification will also include:

- 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

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

Additional information for Medical Plan claim notifications. If your claim is for benefits under the Medical Plan, the adverse benefit determination will also include: (i) information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount (if applicable)); (ii) description of the availability, upon request, of the diagnosis and treatment codes associated with the claim involved, including their respective meanings; (iii) the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim; (iv) a description of the applicable external review procedures, the time limits applicable to such procedures, and how to initiate an external review; and (v) contact information for any applicable office of health insurance consumer assistance or ombudsperson established to assist individuals with the internal claims and appeals and external review process.

Additional information for urgent care claim notifications. In the case of any adverse benefit determination concerning a claim involving urgent care, the notification of benefit determination will include a description of the expedited review process applicable to the claim. Also, in the case of an adverse benefit determination concerning a claim involving urgent care, the information set out in this section may be provided to you orally within the time frames in the section above, entitled "Urgent Care Claims," provided that a written notification that meets all the requirements of this section is furnished to you not later than three days after the oral notification.

Additional information for disability claim notifications. The written notification for a disability claim will also include:

- a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views presented by you to the applicable health care professionals treating you and vocational professionals who evaluated you; (B) the

view of the medical or vocational expert whose advice was obtained on behalf of the Plan in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination made by the Social Security Administration regarding your disability status that is presented by you to the claims administrator;

- if the denial is based on a medical necessity or experimental treatment, or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- either the specific internal rules, guidelines, protocols, standards, or other similar criteria relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria do not exist; and
- 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.

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 benefit claims under a group health plan and disability 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. In the case of denial of an

urgent care claim, you may submit an appeal orally or in writing and all necessary information may be transmitted by telephone, facsimile, or other available similarly expeditious method.

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.

Appeals of group health plan claims and disability claims. The review of a group health plan claim or disability 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. In deciding an appeal of any adverse benefit determination that is based on medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, medically necessary, or appropriate, the fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The Plan will identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit

determination, without regard to whether the advice was relied upon in making the adverse benefit determination. Any health care professional that is engaged for purposes of a consultation for deciding an appeal of an adverse benefit determination that involves medical judgment will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination, nor the subordinate of such individual.

Appeal of disability claims. Before the claims administrator can issue an adverse benefit determination on review of a disability claim, you will be provided, free of charge, with any new or additional evidence considered, relied upon or generated by the Plan in connection with your appeal as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal, so that you shall have a reasonable opportunity to respond prior to that date. In addition, if the denial of your appeal is based on a new or additional rationale, the claims administrator will provide you, free of charge, with the new or additional rationale as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on appeal, so that you shall have a reasonable opportunity to respond prior to that date.

Group Health Plan Claims

Urgent Care Claims. For an appeal of an urgent care claim, you will be notified of the benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an adverse benefit determination by the Plan.

Pre-Service and Concurrent Care Claims. For an appeal of a pre-service or concurrent care claim, you will be notified of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances, and not later than 30 days after receipt by the Plan of your request for review of an adverse benefit determination.

Post-Service Claims. For an appeal of a post-service claim, 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.

Non-Group Health Plan Claims

Disability Claims. For an appeal of a disability claim, you will be notified of the Plan's benefit determination on review within a reasonable period of time, and not later than 45 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 45-day period, and the extension will not exceed 45 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.

All Other Benefit Claims. For all other benefit claims appeals, 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; and

- a statement of your right to bring an action under Section 502(a) of ERISA.

Additional information for group health plan claim notifications. If your claim is for benefits under a benefit program that is a group health plan, the written notification will also include:

- 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 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 the adverse benefit determination is based on medical necessity or an experimental treatment, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- 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."

Additional information for disability claim notifications. Written notification of determination of a disability claim appeal will also include:

- a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (A) the views presented by you to the applicable health care professionals treating you and vocational professionals who evaluated you; (B) the view of medical or vocational expert whose advice was obtained on behalf of the Plan in connection with your appeal, without regard to whether the advice was relied upon in making the benefit determination; and (C) a disability determination made by the Social Security Administration regarding your disability status that is presented by you to the claims administrator;
- if the denial is based on a medical necessity or experimental treatment, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the

determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

- either the specific internal rules, guidelines, protocols, standards, or other similar criteria relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria do not exist.

Additional information for Medical Plan claim notifications. If your claim is for benefits under the Medical Plan, the adverse benefit determination will also include: (i) information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount (if applicable); (ii) description of the availability, upon request, of the diagnosis and treatment codes associated with the claim involved, including their respective meanings; (iii) the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim and a discussion of the decision; (iv) a description of the applicable external review procedures, the time limits applicable to such procedures, and how to initiate an external review; and (v) contact information for any applicable office of health insurance consumer assistance or ombudsperson established to assist individuals with the internal claims and appeals and external review process.

External Review (for Medical Plan Claims only)

If the appeal of your claim for benefits under the Medical Plan is denied, you may request to participate in the external review program. You may request an external review of the adverse benefit determination by written request to the Plan Administrator. **You must submit your request for external review no later than four months from the date you received the adverse benefit determination.**

External review may be available if your claim involves a rescission of Medical Plan coverage or involves medical judgment (*e.g.*, if the determination is based on medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or a determination that a particular treatment is experimental or investigational).

Your claim is not eligible for external review if: (i) you were not covered under the Medical Plan at the time the health care product or service was requested or, (ii) in the case of

retrospective review, you were not covered under the Medical Plan at the time the health care product or service was provided.

This external review program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge to you after exhausting the Plan's claims and appeals procedures, or if the claims administrator or the Plan Administrator fails to timely respond to your appeal.

External review of your claim will be performed by an independent review organization that is qualified to decide whether the requested service or procedure is a qualified expense under the Plan. Neither you nor the claims administrator will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision.

Preliminary Review

Within five business days following the date the claim administrator receives your external review request, the claims administrator will complete a preliminary review of the request to determine whether:

- you are, or were, covered under the Medical Plan at the time the health care product or service was requested or, in the case of a retrospective review, you were covered under the Medical Plan at the time the health care product or service was provided;
- the denial involves either medical judgment or a rescission of coverage;
- you have exhausted the Plan's internal appeals process, unless you are not required to exhaust the internal appeals process under the law (please see below for additional information about the requirements to exhaust the Plan's internal appeals process); and
- you have provided all the information and documents required to process an external review.

You will be notified within one business day after the claims administrator completes the preliminary review if your request is eligible for external review, or if further information or documents are needed. You will have the remainder of the four-month period described

above (or 48 hours following receipt of the notice, if later) to perfect your request for external review.

If your claim is not eligible for external review, the claims administrator will outline the reasons your claim is ineligible in the notice and will provide contact information for the U.S. Department of Labor's Employee Benefits Security Administration.

Referral to Independent Review Organization

If your claim is eligible for external review, the claims administrator will assign the matter to an independent review organization ("IRO"). You may submit additional information in writing to the IRO within 10 business days of the IRO's notification that it has been assigned the request for external review.

When your request for external review is assigned to an IRO, the IRO will review all of the information and documents timely received. To the extent additional information or documents are available and the IRO considers them appropriate, the IRO may also consider the following in reaching its decision:

- Your medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the claims administrator, you, and your treating provider;
- The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;
- Any applicable clinical review criteria developed and used by the claims administrator, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

- The opinion of the IRO's clinical reviewer or reviewers after considering the information described above, to the extent the information or documents are available and the clinical reviewer or reviewers consider them appropriate.

The IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.

Notification of IRO Decision

The IRO will provide you and the claims administrator with written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The notice of the final external review decision will include the following information:

- A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
- The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;
- A statement that the determination is binding, except to the extent that other remedies may be available under state or federal law;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman that may be available to assist you.

Reversal of Decision

Upon receipt of a notice of a final external review decision reversing a claim denial or appeal denial, the claims administrator shall provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Request for Expedited External Review

You may make a request for an expedited external review with the claims administrator at the time you receive either of the following:

- A claim denial that involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize life or health or would jeopardize the ability to regain maximum function, provided that you have already filed a request for an expedited internal appeal, or
- An appeal denial that involves a medical condition for which the time frame for completion of a standard external review would seriously jeopardize life or health or would jeopardize the ability to regain maximum function, or if the appeal denial concerns an admission, availability of care, continued stay, or health care product or service for which you received emergency services, but you have not been discharged from a facility.

The IRO will provide notice of the final external review decision as soon as possible, but no more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not provided in writing, within 48 hours after the date of providing the notice, written confirmation of the decision shall be provided.

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, except that a claim for benefits under the Separation Pay policy must be filed within 180 days after you receive a final notice of the benefit determination. 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, the shorter statute of limitations will apply.

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, except as may be otherwise expressly provided in the Program Documents.

Acts of Third Parties (Subrogation and Reimbursement)

Whenever someone else (including your own insurer under an automobile or other policy) is legally responsible or agrees to compensate you for an illness or injury suffered by you or any of your dependents covered by the Plan, you must reimburse the Plan (or applicable benefit program) for any benefits paid by the Plan relating to that illness or injury, up to the full amount of the compensation received from the other party (regardless of how that compensation may be characterized). The required reimbursement will not be reduced to reflect any costs or attorneys' fees incurred in obtaining the compensation unless separately agreed to, in writing, by the Plan Administrator.

Coordination of Benefits

Coordination of benefits applies when you have coverage under more than one group program. The purpose of coordination of benefits is to ensure that you receive the coverage to which you are entitled under the Plan. It is your obligation to notify the claims administrator of the existence of such other group coverages.

The claims administrator has the right in administering the coordination of benefits to:

- pay any other organization an amount that it determines to be warranted if payments that should have been made by the claims administrator have been made by such other organization under any other group program.
- recover any overpayment which the claims administrator may have made to you, any provider, insurance company, person, or other organization.

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.

Separation Pay Benefits. Receipt of benefits under the Separation Pay policy is expressly conditioned upon an eligible employee's execution of a release agreement and waiver of claims against the University (as required by the University in its discretion) within the time period required by the University. In no event will an employee have the discretion to determine the year of payment of separation pay.

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.

No Guarantee of Employment

Nothing in the Plan gives you the right to remain employed by the University or affects the University's right to terminate your employment any time with or without cause.

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.

Qualified Medical Child Support Order

If a Qualified Medical Child Support Order ("QMCSO") is issued for your child, your child will be eligible for enrollment in the benefit programs under the Plan as required by the order. You must notify the Plan Administrator and enroll that child (and yourself if you are not enrolled) in the Plan within 30 days of the date that the QMCSO is issued.

A QMCSO is a judgment, decree, order (including approval of a settlement agreement), a National Medical Support Notice (completed in accordance with the Child Support Performance and Incentive Act of 1998), or administrative notice that is issued pursuant to a state domestic relations law (including a community property law) or an administrative process, and that provides for child support or health benefit coverage for a child under a group health plan, and satisfies all of the following requirements:

- The order recognizes or creates a child's right to receive group health benefits for which you are eligible,

- The order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address,
- The order includes a description of the coverage to be provided, or the manner in which the type of coverage is to be determined, and
- The order states the period to which it applies.

A QMCSO will not require the Plan to provide any type or form of benefit or coverage not otherwise provided under the Plan, except a QMCSO may require that the Plan comply with state laws regarding child health care coverage.

Any payment of benefits in reimbursement for covered expenses paid by the child or the child's custodial parent or legal guardian will be made to the child, the child's custodial parent or legal guardian, or to the state official whose name and address have been substituted for the name and address of the child.

At your request, the Plan Administrator will furnish procedures that describe the process to follow when entering a QMCSO, free of charge. Contact Human Resources at (336) 758-4700 or ***AskHR@wfu.edu*** to request a copy of the Plan's QMCSO procedures.

HIPAA Privacy Rights

The Medical Plan, Dental Plan, Vision Plan, Health Care FSA, and Employee Assistance Program are 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.

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.

Internal Revenue Code Section 409A

It is intended that this Plan be excepted or exempt from Section 409A of the Internal Revenue Code of 1986, as amended ("Section 409A"), including, without limitation, the exception for short-term deferrals and welfare benefits, and this Plan will be construed and administered in a manner consistent with this intent. To the extent applicable, each amount to be paid under the Plan is a separate identified payment for purposes of Section 409A. If any amount or benefit under the Plan is determined to be "deferred compensation" within the meaning of Section 409A, then the terms of this Plan are intended to comply with Section 409A and will be interpreted accordingly. The Plan will be reformed in the manner necessary to achieve compliance with Section 409A. Under no circumstances will Wake Forest or any of its affiliates be responsible for any taxes, penalties, interest, or other losses or expenses that you may incur in connection with Section 409A.

Important Legal Notices About the Plan

Newborns' and Mothers' Health Protection Act

Federal law generally prohibits group health plans from restricting benefits for hospital lengths of stay in connection with childbirth for the birthing parent or newborn child to less than:

- 48 hours following a vaginal delivery, and
- 96 hours following a cesarean section.

However, federal law does not generally prohibit the birthing parent's or newborn's attending provider, after consulting with the mother, from discharging the birthing parent or newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). For individuals

receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which a mastectomy has been performed
- Surgery and reconstruction of the other breast to create a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedemas

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the Plan.

Rights and Protections Against Surprise Medical Bills

You are protected from balance billing (sometimes called "surprise billing") in certain situations. Group health plans and health insurance issuers generally may not, under federal law, charge more than the in-network cost-sharing amount for emergency care services or treatment by an out-of-network provider at an in-network hospital or ambulatory surgical center ("in-network facilities").

When you see a doctor or other health care provider, you may owe certain cost-sharing amounts, such as a copayment, coinsurance, and/or deductible. You may owe other costs or have to pay the entire bill if you see a provider or visit a health care facility that is not in the Plan's network (out-of-network providers or facilities).

Out-of-network providers may be permitted to bill you for the difference between what the Plan covers and the full amount charged for a service by the provider or facility. This is called "balance billing." Sometimes you may receive an unexpected balance bill, also called "surprise billing," when you cannot control who is involved in your care (for example, when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider).

You are protected from balance billing for:

- **Emergency services**. If you receive emergency services from an out-of-network provider or facility, you cannot be balanced billed for these services. The most the provider or facility may bill you is the Plan's in-network cost-sharing amount (such

as copayments and coinsurance). This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balanced billed for such post-stabilization services. Contact the Plan Administrator for further details.

- **Certain services provided by an out-of-network provider at an in-network facility**. When you get services from an in-network facility, certain providers at the facility may be out-of-network. In these cases, the most that providers may bill you is the Plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistance surgeon, hospitalist, or intensivist services.

  If you get other types of services at these in-network facilities, out-of-network providers cannot balance bill you, unless you give written consent and give up your protections not to be balanced billed. They may not ask you to give up your protections not to be balance billed.

You are never required to give up your protections from balance billing. You are not required to accept out-of-network care. You can choose a provider or facility in the Plan's network.

When balance billing is not allowed, you are only responsible for paying your share of the in-network cost under the Plan. The out-of-network provider may not bill you for amounts above your in-network cost-sharing amount under the Plan. Any cost-sharing amount you pay for emergency services or out-of-network services will count toward your in-network deductibles and out-of-pocket maximums.

The Plan covers emergency services without requiring you to get prior authorization and covers emergency services by out-of-network providers.

If you think you have been wrongly billed, you may contact the HHS No Surprises helpdesk at 1-800-985-3059. For more information about your rights under federal law, visit ***www.cms.gov/nosurprises/consumers***.

For More Information

If you have any questions concerning your rights to coverage, you should contact the Plan Administrator.

For more information about your rights under ERISA, COBRA, HIPAA, and other laws affecting group health plans, contact 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's website.)

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 yourself, spouse, or 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.