

The University of Pennsylvania Health and Welfare Program

Summary Plan Description

As of July 1, 2005

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SECTION 1

Introduction to Your Benefits

Introduction

Your University of Pennsylvania benefit programs are designed to assist you in achieving financial security. They provide for certain kinds of expenses, such as medical and dental expenses and insurance on your life and those of your dependents.

Penn's benefits can provide real value to you and your family. However, to get the most out of them, you need to understand how the benefits work, when you can receive benefits, and what steps you must follow. This book can help.

This is your summary plan description ("SPD") for The University of Pennsylvania Health and Welfare Program (the "Program") which includes Medical, Dental, Vision, Group Life Insurance, Dependent Life Insurance, Pre-Tax Expense Accounts and Long-Term Disability Plans. In addition, this document includes a brief description of the Long Term Care insurance available to you. The SPD is a description, in summary form, of the provisions of the Program and the various "Plans" thereunder.

Important Notes on the Plan Summaries

This document and the booklets, certificates and other descriptive material provided to you by the University and the various benefit providers are written in a manner that is intended to be easily understandable and to summarize the benefits available to you under the Program. There may be other materials (such as an insurance policy or other contractual agreement with a health care or other service provider) that contain more detailed information about Program benefits. Every effort has been made to ensure that all of these materials contain a consistent description of the Program's benefits. However, if there is any conflict or inconsistency between these materials, it is the Plan Administrator's responsibility to interpret the conflicting provisions and determine what benefits will be provided under the Program. The University reserves the right to change, amend or terminate the Program and any of the component Plans at any time and for any reason. Also, please keep in mind that the Program, any changes to it, or any payments to you under its terms, does not constitute a contract of employment with the University and does not give you the right to be retained in the employment of the University. No one speaking on behalf of the Program or the University can alter the terms of the Program. You and your beneficiaries may obtain copies of the Program, the component Plans and related documents or examine these documents by contacting the Plan Administrator at the number and address set forth in Section 7 below.

The provisions of applicable collective bargaining agreements govern the health and welfare benefits of employees in collective bargaining units.

The PennChoice Benefits Options

PennChoice includes your options for medical, dental, vision, group life and dependent life insurance, health care and dependent care pre-tax expense accounts and long term care insurance. For purposes of this summary, medical coverage includes mental health and substance abuse and prescription drug coverage.

PennChoice offers some unique opportunities. Through PennChoice you can:

- Choose the level of coverage that best meets your needs.
- Convert part of your pay into pre-tax benefit contributions and save federal income, Social Security, and Medicare taxes on these contributions to purchase certain benefits under the Program.

- Pay for certain uninsured health care and dependent care expenses through the Pre-Tax Expense Accounts.

You will be asked to make decisions about your benefits once a year. That means you need to evaluate your needs, learn about your options, and choose benefit levels that will protect you (and, in some cases your eligible family members) for a full year (the University of Pennsylvania's plan year is a fiscal year and runs from July 1 thru June 30).

The University has partnered with ADP Benefit Services (ADP), for the administration of all of your health and welfare benefits. ADP operates the Penn Benefits Center, located at ADP's Salt Lake City, Utah location. The Penn Benefits Center is fully staffed with representatives who have a comprehensive knowledge of PennChoice and access to modern technology and regular training and who are dedicated to providing service to you. You will need to contact the Penn Benefits Center, at 1-888-PENNBEN (1-888-736-6236), for most of your inquiries related to PennChoice. Throughout the SPD, you will be referred to either the Penn Benefits Center at ADP, or when applicable, the University's Benefits Office, in the Human Resources Department located at 3401 Walnut Street, Philadelphia, Pennsylvania.

Eligibility for Coverage

Employees Eligible for Coverage

Your eligibility for participation is based on your employment status. You are an eligible employee if you are in one of the following employment categories:

- Regular Full-time Staff (weekly and monthly paid) working 35 or more hours per week for 12 months of the year.
- Full-time Faculty in a benefits eligible title (the University's Benefits Office will verify Faculty Appointments and benefits eligibility).
- Limited Service Staff (weekly and monthly paid) scheduled to work at least 35 hours a week for nine months of the year.
- Regular Part-time Staff (weekly and monthly paid) who work 17½ to 28 hours per week in accordance with the 'Part-time' policy.
- Part-time Faculty in a benefits eligible title (the University's Benefits Office will verify Faculty Appointments and benefit eligibility).
- Full-time Visiting Faculty.

Note: Other members of faculty and staff not listed here may be eligible for benefits. In addition, if an employee is covered by a collective bargaining agreement, the provisions of the applicable collective bargaining agreement will describe the extent to which the employee is eligible for Program benefits.

Dependents Eligible for Coverage

Your dependents may also be enrolled for the Medical, Dental, Vision and Dependent Life Insurance plans. Eligible dependents include:

- your spouse (including a spouse of a common law marriage) or same-sex domestic partner

- You must complete certification forms and return them to the Benefits Office when enrolling your common law spouse or same-sex domestic partner.
- your or your spouse's unmarried child who resides in your household for more than one-half of the year (temporary absences due to special circumstances, including absences due to illness, education, business, vacation or military service are not treated as absences) and receives more than one-half of his or her support and maintenance from you
 - up to June 30 of the plan year (the 12-month period ending each June 30) in which your child reaches age 19 (age 23 if enrolled as a full-time student generally in an accredited secondary school, college or university);
 - beyond the limiting age described above if the child is incapable of self-support because of a mental or physical condition that existed prior to age 19, and who was eligible for coverage as a dependent prior to age 19;
 - certain health plan options allow coverage for dependents beyond age 19.

Call the Penn Benefits Center if you have any questions about your child's eligibility.

- your same-sex domestic partner's unmarried child subject to the same age, student status and disability rules described above, provided the child resides in your household for more than one-half of the year (temporary absences due to special circumstances, including absences due to illness, education, business, vacation or military service are not treated as absences) and receives more than one-half of his or her support and maintenance from your same-sex domestic partner.

Note: In the case of a child who receives over one-half of his or her support during the calendar year from his or her parents (i) who are divorced or legally separated under a decree of divorce or separate maintenance, (ii) who are separated under a written separation agreement, or (iii) who live apart at all times during the last six months of the year, and where such child is in the custody of one or both parents for more than one-half of the year, such child will be considered the dependent of both parents, regardless of the child's place of residence or the amount of support provided by either parent. Contact your tax advisor or refer to IRS Publication 502 for more information.

"Children" includes biological children, stepchildren, children placed with you for adoption, legally adopted children, the biological or adopted children of a same-sex domestic partner, and children for whom you are the legal guardian. Note: In the case of legal guardianship, there may be restrictions on the types of coverage available for the child.

A *spouse* is an individual who is participating with you in a legally recognized marriage under applicable state law.

A *spouse of a common-law marriage* is an individual who is participating with you in a legally recognized common law marriage under applicable state law. (See glossary for definition of common law marriage.) Also you are required to complete the University's Common-Law Marriage Affidavit and supply the appropriate documentation listed on the affidavit.

A *same-sex domestic partner* is an individual participating with you in a same-sex domestic partnership that is registered with the University's Benefits Office. You are required to complete the University's Affidavit of Domestic Partnership, and supply the appropriate documentation listed on the certification.

A *biological* child is a child born to you for whom you provide financial support and are the, or one of the, legally designated parent(s).

You may be required to certify that any biological, step or adopted child between the ages of 19 and 23 who you claim as a dependent continues to qualify for coverage as an eligible dependent. You may be required to submit documentation, such as:

- a full-time roster from an accredited college or university
- or*
- verification of a disability for unmarried, over-age, handicapped children (based on the disability and plan, the verification may be required once or twice a year. Refer to the carrier's plan booklets.)

If your dependent is enrolling as a full-time student in the middle of a plan year, go to www.upenn.edu/u@penn (click on "Health benefits - view, enroll, change", under Benefits) or contact the Penn Benefits Center at 1-888-PENNBEN (1-888-736-6236).

The determination of whether a child is dependent on you or your same-sex domestic partner for support and maintenance shall be determined by the Plan Administrator in accordance with section 152 of the Internal Revenue Code and the regulations thereunder.

If both you and your spouse/same-sex domestic partner are benefit eligible employees of the University and eligible to participate in the Program:

- Medical and dental benefits - you both may enroll as individuals, but only one of you may cover your children.
- Dependent Life Insurance - only one of you may cover your children.

Dependents in full-time active military service are not eligible for coverage under PennChoice.

Enrolling in the Plans: Initial Eligibility

You must enroll via the University of Pennsylvania enrollment website at www.upenn.edu/u@penn (click on "Health benefits - view, enroll, change", under Benefits)" within 30 days of the date you and/or your dependent(s) become eligible to make elections through PennChoice. You will need your Penn Net ID and password to enroll.

When Coverage Begins -- All Benefits Except the Dependent Care Pre-Tax Expense Account

If your first day of employment is on the first through the fifteenth of the month, then you are eligible for benefits on the first of the following month. If your first day of employment is on the sixteenth through the thirty-first of the month, then you are eligible for benefits on the first of the month following thirty days of employment. The following matrix provides you with examples of hire dates, eligibility and deadlines for enrolling:

If Your Hire Date is:	Your Benefits Begin:	Your Deadline to enroll is:
11/2	12/1	12/31
11/16	1/1	1/31

Note: Post-Doctoral employees and Visiting Faculty are eligible for benefits as of their date of hire.

Note: Part-time faculty and staff are eligible for coverage under the Health Care Pre-Tax Expense Account following two years of employment.

When Coverage Begins -- The Dependent Care Pre-Tax Expense Account

With respect to the Dependent Care Pre-Tax Expense Account, you are eligible for coverage as of the first payroll period following one year of employment and the attainment of age 21.

If You Do Not Enroll

The University automatically sets your coverage levels if you do not log on to the online enrollment system to enroll within the required time frame; that is, within 30 days of becoming eligible, or, when applicable, by the open enrollment deadline. These coverage levels are called *default coverage* and are applied as follows:

- Full-time faculty and staff who are newly eligible for coverage and do not enroll online within 30 days will not participate in Medical, Dental, Vision, Supplemental Life, Dependent Life or Pre-Tax Expense Accounts. You will be defaulted to Basic Life and AD&D Insurance, if you are actively at work on your coverage effective date.
- Part-time faculty and staff who are newly eligible for coverage and do not enroll online within 30 days will not participate in Medical, Vision, Optional Life, or Pre-Tax Expense Accounts. You will be defaulted to no coverage.
- Post-doctoral employees and Visiting Faculty who are newly eligible for coverage and do not enroll online within 30 days will be defaulted to single medical coverage under the Keystone Health Plan East HMO plan.
- Visiting Faculty who are newly eligible for coverage and do not enroll online within 30 days will be defaulted to no medical coverage.

This coverage will remain in effect until the end of the plan year, unless you experience a qualifying life change event that allows you to change your benefits. Otherwise, you may not add coverage until the next annual open enrollment period for the following plan year.

If you do not enroll your eligible dependents for medical coverage as part of your PennChoice enrollment or for dental coverage within 30 days of attaining eligibility, you must wait until the next annual open enrollment before you can enroll your dependents unless they experience a qualifying life change event or have a special enrollment right, as described below.

Annual Choices

On an annual basis, PennChoice allows you to choose the benefit coverages that best meet your needs. You make your choices during the annual open enrollment period for the plan year that follows (July 1 through June 30). Your choices remain in effect for the full plan year and may only be changed if you have a qualifying change in status, as described in "Changing Your Benefits During the Year", below. Generally, changes to your contributions begin in June. Contributions to Pre-Tax Expense Accounts begin with the first pay period in July.

You select your coverage from a list of options provided by the University, as described below. The options provide varying levels of benefit protection. They also have different costs. You can choose an option that reflects the level of coverage that you need as well as how much you want to spend for coverage.

Available Options

Specific coverage options available to each employment category are listed below.

Full-time Faculty (Benefits Eligible), Regular Full-time Staff, and Limited Service Staff*		
Plan	Your PennChoice Options	Funding
Medical, Mental Health and Substance Abuse and Prescription Drug	You can choose from among the available Medical plans or waive coverage. You can choose employee, employee + one, or employee + two or more coverage. Medical plans generally include Mental Health and Substance Abuse Coverage and Prescription Drug Coverage.	You and the University share the cost of coverage.
Dental	You can choose from among the available Dental plans or waive coverage. You can choose employee, employee + one, or employee + two or more coverage.	You and the University share the cost of coverage.
Vision	You can elect coverage under the Vision Care plan or waive coverage. You can choose employee, employee + one, or employee + two or more coverage.	You pay the full cost of coverage.
Basic Life and AD&D Insurance	You automatically receive Basic Life Insurance coverage equal to one times your annual base salary not to exceed \$300,000 and AD&D Insurance coverage equal to two times your annual base salary, up to a maximum benefit of \$125,000. If your salary is over \$50,000, you have the option of limiting your Basic Life Insurance to \$50,000 (amounts over \$50,000, up to \$300,000, result in imputed income to you; see "Taxes on Your Coverage" under Life Insurance, below, for more information). If your basic and supplemental equal \$500,000 or above, you are required to submit Evidence of Insurability to the carrier.	The University pays the full premium for Basic Life Insurance and AD&D Insurance.
Supplemental Life Insurance	You can elect optional Supplemental Life Insurance coverage of up to 5 times your annual base salary in increments of one-half of your base salary. Total combined Basic and Supplemental Insurance cannot exceed \$1,000,000.	You pay the full premium for any Supplemental Life Insurance you elect.
Dependent Life Insurance	You can elect optional Dependent Life Insurance coverage for your spouse/same-sex domestic partner and/or eligible dependent children who are 30 days or older. The maximum is \$5,000 per child,	You pay the full premium for any Dependent Life Insurance you elect.

Full-time Faculty (Benefits Eligible), Regular Full-time Staff, and Limited Service Staff*		
Plan	Your PennChoice Options	Funding
	\$10,000 for a spouse or domestic partner.	
Health Care Pre-Tax Expense Account	You can contribute up to \$4,000 for the plan year to an account to reimburse yourself for eligible health care expenses.	You pay the full cost of contributing to this account.
Dependent Care Pre-Tax Expense Account	You can contribute up to \$5,000 for the plan year to reimburse yourself for eligible dependent care expenses (you must be 21 years of age and have completed one year of service to be eligible to participate). Individuals classified as highly compensated (according to IRS rules, W-2 earnings of \$95,000 and above) may contribute up to \$3,500.	You pay the full cost of contributing to this account.
Long-Term Disability	You automatically receive LTD coverage equal to 60% of your base salary at the onset of disability, up to \$7,500 per month, minus income from other sources (see "Long-Term Disability (LTD) Benefits").	The University pays the full cost of coverage.
Long-Term Care	You can choose from among daily benefit amounts ranging from \$125 to \$175 per day for long-term care services and supplies. You can also elect non-forfeiture protection that assures benefits even if you stop paying premiums.	You pay the full cost of coverage.

**Note: The provisions of applicable collective bargaining agreements govern the Health and Welfare benefits of employees in collective bargaining units.*

Note: Benefits that are dependent on your "base salary" do not take into account pay received for services performed for CPUP.

Part-time Faculty (Benefits Eligible) and Regular Part-time Staff		
Plan	Your PennChoice Options	Funding
Medical, Mental Health and Substance Abuse and Prescription Drug	You can choose from among the available Medical plans or waive coverage. You can choose employee, employee + one, or employee + two or more coverage. Medical plans include Mental Health and Substance Abuse Coverage and Prescription Drug Coverage.	You pay the full cost of coverage.
Vision	You can elect coverage under the Vision Care plan or waive coverage. You can choose employee, employee + one, or employee + two or more coverage.	You pay the full cost of coverage.
Optional Life and AD&D Insurance	You can elect Optional Life Insurance equal to two times your annual base salary (in increments of one-half of your base salary) or waive coverage. If you elect optional coverage, you automatically receive AD&D Insurance coverage equal to two times your annual base salary, up to a maximum benefit of \$125,000.	You pay the full premium for Optional Life Insurance.

Health Care Pre-Tax Expense Account	You can contribute up to \$1,000 for the plan year to an account to reimburse yourself for eligible health care expenses. You are eligible to participate after two years of continuous service.	You pay the full cost of contributing to this account.
Dependent Care Pre-Tax Expense Account	You can contribute up to \$5,000 for the plan year to an account to reimburse yourself for eligible dependent care expenses. You must be age 21 and have one year of continuous service to be eligible.	You pay the full cost of contributing to this account.
Long-Term Care	You can choose from among daily benefit amounts ranging from \$125 to \$175 per day for long-term care services and supplies. You can also elect non-forfeiture protection that assures benefits even if you stop paying premiums.	You pay the full cost of coverage.

Note: Benefits that are dependent on your "base salary" do not take into account pay received for services performed for CPUP.

Full-time Visiting Faculty		
Plan	Your PennChoice Options	Funding
Medical, Mental Health and Substance Abuse and Prescription Drug	You can choose from among the available Medical plans or waive coverage. You can choose employee, employee + one, or employee + two or more coverage. Medical plans include Mental Health and Substance Abuse Coverage and Prescription Drug Coverage.	You pay the full cost of coverage.
Note: You may receive other benefits if explicitly provided in the Provost Staff Conference Minutes.		

If You Do Not Enroll During Open Enrollment

If you were previously enrolled under PennChoice and do not make a change online during open enrollment or within 30 days of a qualifying life change event, your default coverage, including participation in the Pre-Tax Expense Accounts, will remain at the same coverage levels and options in which you were enrolled for the prior plan year (although the University reserves the right to replace coverage options that are no longer available with similar coverage options currently available). You will be responsible for any contributions associated with this default coverage.

Changing Your Benefits During the Year

You can make changes outside of open enrollment only if you have a qualifying change in status. Generally, changes must be on account of and correspond with the change in status.

For the purposes of the University's plans, a qualifying change in status includes:

- Marriage, divorce or legal separation when allowed under state law in the state in which you reside
- Establishment and verification by the University's Benefits Office of a same-sex domestic partnership or termination of a same-sex domestic partnership
- Birth or adoption of a child or placement of a child for adoption, gaining a step-child, becoming legal guardian of a child, birth of the child of your same-sex domestic partner

- Death of your child or your spouse's/same-sex domestic partner's child
- A child's change in dependent status due to age, or return to or end of full-time student status
- Loss of a dependent's dependent status under the Plan
- Qualification of a Medical Child Support Order
- Your or your spouse's/same-sex domestic partner's or dependent's gain or loss of other coverage as a result of a change in employment status or work schedule (including beginning or end of a leave of absence)
- Change in coverage under a non-Penn sponsored plan due to (1) a change in status under that plan or (2) a differing election period (these events will not allow a change under the Health Care Pre-Tax Expense Account)
- Change in your dependent care provider
- Change in the cost of dependent care, if the provider is not your relative
- Change in your employment status resulting in a change in eligibility (e.g., change from full-time to part-time)
- Termination of employer contributions to your spouse's/same-sex domestic partner's plan (this will not allow a change under the Health Care Pre-Tax Expense Account)
- Change in your or a dependent's residence
- Expiration of non-Penn sponsored COBRA coverage for yourself or a dependent
- Eligibility for Medicaid

Note: To be eligible to change your benefits following a qualifying life change event, you must report the event online via the University of Pennsylvania enrollment website at www.upenn.edu/u@penn (click on “Health benefits - view, enroll, change”, under Benefits) or call the Penn Benefits Center at 1-888-PENNBEN (1-888-736-6236), and submit any necessary forms and documentation (as applicable) within 30 days after the event. The Plan Administrator reserves the right to determine whether you have experienced an event that would permit an election change and whether your requested election change is consistent with such event.

Caution: You may not make an election to change the contributions being made to a Health Care Pre-Tax Expense Account if that election would cause the anticipated amount allocated to the Account to be less than the amount of expenses already reimbursed from the Account for the plan year.

Remember that you may only make changes that are consistent with the change in your family status. Your new benefit elections will take effect on the date of the event, if the event is birth, adoption or placement for adoption, or on the first of the following month for all other events.

Special Enrollment Rights

If you decline enrollment for yourself or your dependents (including your spouse) because of other

health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

A newborn child, an adopted child, or a child placed with you for adoption is automatically covered for the first 31 days of life, the date the child was adopted, or the date the child was placed for adoption. To continue coverage for a newborn beyond 31 days, you must enroll online within 30 days of the birth. To continue coverage for an adopted child or a child placed with you for adoption beyond 30 days, you must enroll online within 30 days of the adoption or placement.

In addition, if you have a new dependent as a result of marriage, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage.

To request special enrollment or obtain more information, go to www.upenn.edu/u@penn (click on "Health benefits - view, enroll, change", under Benefits) or contact the Penn Benefits Center at 1-888-PENNBEN (1-888-736-6236).

When Participation Ends

Your participation in the PennChoice plans ends when you are no longer eligible to participate. The date your coverage ends depends on the date you leave or become ineligible under the terms of each plan. Other chapters in this book provide more detailed information on when coverage ends under each particular plan.

If your staff position has been discontinued or transformed, under the current Position Discontinuation and Staff Transition (PDST) Policy (#628), your Medical, Dental, Vision and Health Care Pre-Tax Expense Account benefits continue through the last day of the month following the month in which your pay continuation period ends (or the end of such month if the pay continuation period ends prior to the 16th day of such month), subject to your payment of the required contributions toward such coverage. You may continue Long Term Care coverage by making premium payments directly to the insurance company. All other benefits under PennChoice (i.e., Life Insurance (basic and supplemental), Long-Term Disability and the Dependent Care Pre-Tax Expense Account) cease at the beginning of the severance period.

Notwithstanding the foregoing, the University may, in its sole discretion, cause your (or your dependents') coverage under the Plan to terminate if you or your dependent provides false information or makes misrepresentations in connection with a claim for benefits; permits an unauthorized person to use a membership or other identification card for the purpose of wrongfully obtaining benefits; obtains or attempts to obtain benefits by means of false, misleading or fraudulent information, acts or omissions; fails to make any copayment, supplemental charge, or other amount due with respect to a benefit; behaves in a manner disruptive, unruly, abusive, or uncooperative to the extent that the Plan is unable to provide benefits to him or her; or threatens the life or well-being of personnel administering the Plan or of providers of services or benefits.

Your Contributions

Your contributions for medical, dental and vision benefits, and the pre-tax expense accounts, are made with pre-tax dollars.* That is, they are deducted from your pay *before* any federal income tax, FICA (Social Security) tax and Medicare Insurance tax are withheld. Pre-tax contributions lower the amount

of your taxable income and, therefore, lower the taxes you pay. There are exceptions to the pre-tax status of your contributions for a same-sex domestic partner and a partner's child(ren) who are not your dependents for federal income tax purposes, as noted below.

Your contributions towards Supplemental/Optional Life Insurance, Dependent Life Insurance and Long-Term Care Insurance are made with after-tax contributions. That is, they are deducted from your pay *after* federal income tax, FICA (Social Security) tax and Medicare Insurance tax are withheld.

All contributions are taken from your paycheck one month prior to the month in which your coverage is effective, with the exception of the Pre-Tax Expense Accounts, which are deducted in the current month.

Coverage costs may be revised from time to time.

** Note that post-doctoral employees and Visiting Faculty pay for their medical coverage with after-tax dollars and are deducted in the current month.*

Contributions for Your Same-Sex Domestic Partner and Your Partner's Dependent Child(ren)

The amount of your contribution to provide health benefits for a same-sex domestic partner and children of a same-sex domestic partner will be the same as for a spouse and his or her children. However, the Internal Revenue Code treats spouses and children through marriage differently with respect to health benefits. The cost of coverage for a spouse and stepchildren is automatically exempt from taxes, but for a person who is not a spouse or a stepchild through marriage, a payment for health benefit coverage is not exempt from tax unless the person is a "dependent" as defined in the Internal Revenue Code.

If your same-sex domestic partner and his or her children are your dependents for tax purposes under section 152 of the Internal Revenue Code, you may provide the University with an "Affidavit of Tax Qualified Dependents" to that effect to gain the benefit of tax-favored benefit coverage. If your same-sex domestic partner and his or her children are *not* your dependents for tax purposes, the payments for coverage under the University's benefit programs will be deducted from your salary on a pre-tax basis and then the total **value** of the coverage provided on behalf of your same-sex domestic partner and his or her children under the University's benefit programs will be considered taxable income to you. You will not actually receive additional income in your paycheck, but the University will withhold city, state and federal taxes on this additional "imputed" amount and it will be reported on your Form W-2 for the year. The value of the coverage provided to your same-sex domestic partner and his or her children will be based on the cost of the coverage under the University's benefit program, as determined by the University. If your same-sex domestic partner and his or her children qualify as dependents for tax purposes, the cost of coverage under the University's benefit programs will be deducted from your pay on a pre-tax basis and no additional income will be imputed to you.

Definition of "Dependent" for Tax Purposes

Under the definition in section 152 of the Internal Revenue Code, your same-sex domestic partner is a dependent if:

1. Your domestic partner is a member of your household, and has his or her principal place of residence in your home.

AND

2. You furnish over half of your same-sex domestic partner's support for the year. In making this calculation, the amount you contribute towards your same-sex domestic partner's support must be compared with the amounts received for support of your same-sex domestic partner from all other sources, including any amounts supplied by him, or her and including earnings.

AND

3. For the current year, no other taxpayer can claim your domestic partner as a “qualifying child” for federal income tax purposes.

If you elect to have the eligible children of your same-sex domestic partner covered by the University's benefit programs, the same rules on dependency apply. The value of coverage will be taxable to you unless the children are your dependent(s). So, if the children do not have their principal place of residence in your home and receive over half of their support from you (or if someone else can claim the children as a “qualifying child” for tax purposes), the children are not your tax qualified dependents and the value of coverage under the University's benefit programs will be taxable to you.

We suggest that you consult a tax advisor to determine whether you may claim your same-sex domestic partner and/or his or her children as dependents for tax purposes, before you certify that they are dependents.

If Domestic Partner And His/Her Children Are Not Your Dependents For Tax Purposes		
Who is Covered	Premium Paid by Employee (Pre-Tax Contribution)	Imputed Income
Employee and partner	Employee contribution for family coverage	Cost to the Plan of single coverage
Employee, partner and employee's dependent child(ren)	Employee contribution for family coverage	Cost to the Plan of single coverage
Employee, partner and partner's dependent child(ren)	Employee contribution for family coverage	Cost to the Plan of family coverage
Employee, partner, employee's dependent child(ren) and partner's dependent child(ren)	Employee contribution for family coverage	Cost to the Plan of family coverage

SECTION 2

Health Care Benefits

Introduction to Your Medical, Dental, and Vision Benefits

Your health care benefits provide financial assistance for medical, dental and vision expenses you incur during the year, and protect you against the high cost of care if you have a serious illness or injury. For both medical and dental care, you may choose a plan that is right for you and your family. Penn's plans are designed to meet the diversified needs of faculty and staff by offering various kinds of protection within a range of costs.

To get the most out of your health care plans, you need to know what benefits are provided under each plan, which services are covered, what you have to do to enroll, and how to apply for benefits. For details about what medical and dental benefits are provided, refer to your health plan booklet.

You can find enrollment, eligibility, and contribution information under Section 1: Introduction to Your Benefits. (See "Enrolling in the Plans: Initial Eligibility", "Your PennChoice Options, Long-Term Disability Coverage, and Funding", and "Your Contributions".)

About the Medical Plans:

Currently, you can choose between a number of different kinds of medical protection:

- You can choose insurance that covers additional benefits under a Preferred Provider Organization (PPO). This type of plan offers preferred and non-preferred provider coverage. It pays for some preventive care as well as eligible expenses when you are ill. In general, you pay less out of pocket when you use preferred providers because you do not have any deductibles or co-insurance. You pay a co-pay for physician's office visits and most other medical services are covered in full. Benefits under the non-preferred provider portion of the Plan are traditional insurance benefits. When you use non-preferred providers, the Plan reimburses you (or the physician or hospital) for eligible expenses you incur. (Payments are based on the rates that have been negotiated with preferred providers.) If a non-preferred provider is used, the Plan's payments are subject to deductibles, co-insurance and out-of-pocket maximums. This plan does not require referrals for care.
- You can join a Health Maintenance Organization (HMO). This type of plan is a managed care plan. Your care is coordinated through a primary care physician. HMOs pay for preventive care and eligible expenses when you are ill. You pay co-pays for physician's office visits - most other medical services are paid in full. In general, you must receive medical services from care providers (physicians, hospitals, etc.) that are part of the HMO network and must have referrals from your primary care physician in order for most specialist services to be paid by the HMO. You pay the cost of services obtained through providers who do not participate in the HMO and for services rendered without a referral from your primary care physician. There are exceptions to these general guidelines. You should refer to the Plan literature of the HMOs for more information about these exceptions.
- You can also join a Point of Service Plan (POS). A POS plan is a managed care plan with a network of providers and the option to get self-referred care and care outside of the network. The Plan pays for preventive care and eligible expenses when you are ill. You can receive low cost care by using the network and obtaining referrals from your network primary care physician. If you receive care without a referral or from a non-network provider you pay more out of your pocket and some services are subject to deductibles, co-insurance and out-of-pocket maximums.

Within each of these categories you can choose the specific Plan that meets your needs for medical care and protection against high health care costs.

For any Plan that provides services through a network of providers, provider lists are furnished automatically, without charge, as a separate document.

IMPORTANT NOTES:

- **Please keep in mind that the University may change the available coverage options (for example, adding, dropping or replacing coverage options) at any time and for any reason.**
- **The medical plans offered DO NOT guarantee that all covered services will be available through preferred or in-network providers. If a preferred or in-network provider is not available and you utilize a non-preferred or out-of-network provider, the expense will be processed as an out-of-network expense in accordance with the terms of the Plan.**
- **You should also note that in-network providers might refer you to providers who are outside the network. Anytime you use an out-of-network provider, your services will be processed accordingly (non-preferred or self-referred). You should always verify whether or not the provider is in-network by calling the number on the back of your ID card.**

The Preferred Provider Organization (PPO)

PENNCare/Personal Choice is a Preferred Provider Organization (PPO) Plan administered by Independence Blue Cross, which provides insurance against high out-of-pocket medical expenses plus preventive care. You have lower out-of-pocket costs when you use preferred providers.

PENNCare/Personal Choice has three parts: coverage through PENNCare Preferred Providers, coverage through Personal Choice Preferred Providers, and coverage through Non-Preferred Providers.

- PENNCare Preferred Providers are physicians, hospitals and other care providers who are part of the PENNCare provider network. You do *not* have to choose a primary care physician or obtain referrals. When you use PENNCare Preferred Providers, you do not have to meet a deductible for covered services. The Plan pays:
 - 100% of Usual, Customary and Reasonable (UCR) for covered services (after applicable co-payments).
 - Please note that to receive this level of coverage, your provider must participate in both the PENNCare and Personal Choice networks. If you use a PENNCare provider who chooses not to participate in the Personal Choice network, coverage will be provided at the Out-of-Network (Self-Referred) level.
- Personal Choice Preferred Providers are physicians, hospitals and other care providers who are part of the Independence Blue Cross Personal Choice provider network. You do *not* have to choose a primary care physician or obtain referrals. When you use Personal Choice Preferred Providers, many services are covered at 100% with no deductible while other services are subject to deductibles, co-insurance, and out-of-pocket maximums. The Plan pays:
 - 100% of UCR for physician office visits, outpatient X-Rays and labs (provider must be in-network), emergency care, pediatric immunizations, maternity care, and outpatient mental health visits (after applicable co-payments).
 - 80% of UCR for other covered services (after deductible).

- Non-Preferred Providers are physicians, hospitals and other care providers who are *not* part of the PENNCare or Personal Choice provider networks. Non-Preferred Provider benefits are comprehensive insurance benefits through Blue Cross/Blue Shield. There are deductibles, co-insurance and out-of-pocket limits. You or the provider must file a claim for payment of benefits. The Plan pays:
 - 100% of UCR for emergency accident/medical care (after applicable co-payments).
 - 70% of negotiated rate for all other services, subject to deductibles, co-insurance and out-of-pocket maximums.

You are responsible for any non-preferred provider charges in excess of the amount paid by the Plan.

Important Notes:

- Emergency visits are covered at 100%. If you are admitted to the hospital, your in-patient charges will be processed based on whether the facility is in-network or out-of-network.
- If services are rendered at a “free-standing facility”, you **must contact Member Services** to confirm whether or not the facility is in-network.

Maximum Lifetime Benefits

The maximum lifetime benefit for non-preferred providers is \$1,500,000 per individual. It is unlimited for PENNCare providers and Personal Choice Preferred Providers.

IMPORTANT: This is only a brief description of the PENNCare/Person/Choice Plan. Please refer to your booklet for further information about this coverage.

The Managed Care (Point of Service) Plan

The Point of Service (POS) plan is a managed care plan. Penn currently offers two POS options: *UPHS Point of Service* and *AmeriHealth Point of Service*. The POS design includes a feature that allows you to obtain care without a referral from your primary care physician or from non-network providers. There are two types of benefits under the POS option: Referred Care and Self-Referred Care. Referred Care is care coordinated through your primary care physician – or managed care – within the UPHS/Keystone or AmeriHealth provider networks. Self-Referred Care is any care you receive without a referral from your primary care physician, or from providers who are not part of a provider network. POS pays for preventive care and care when you are ill. The POS plan has three parts:

- When using referred care through the UPHS Provider Network, you must receive care from or be referred from your primary care physician (PCP). You do not have to meet a deductible, and you pay the lowest co-payments. The Plan pays:
 - 100% of UCR for covered services (after applicable co-payments).
 - Please note that to receive this level of coverage, your provider must participate in both the UPHS and Keystone networks. If you use a UPHS provider who chooses not to participate in the Keystone network, coverage will be provided at the Out-of-Network (Self-Referred) level.

- When using referred care through the Provider Network, you must receive care from or be referred from your primary care physician (PCP). You do not have to meet a deductible, and you pay low co-payments. The Plan pays:
 - 100% of UCR for covered services (after applicable co-payments).
- Self-referred care is any care you receive without a referral from your primary care physician or from a provider who does not participate in the provider networks. When you self-refer, your benefit coverage works like an indemnity plan. There are deductibles, co-insurance and out-of-pocket limits. You must file a claim to receive benefits. You pay:
 - 100% of UCR for emergency accident/medical care (after applicable co-payments).
 - 80% of UCR for all other services, subject to deductibles, co-insurance and out-of-pocket maximums.

Important Notes:

- Emergency visits are covered at 100%. If you are admitted to the hospital, your in-patient charges will be processed based on whether the facility is in-network or out-of-network.
- If services are rendered at a “free-standing facility”, you **must contact Member Services** to confirm whether or not the facility is in-network.

Maximum Lifetime Benefits

There is no maximum lifetime benefit for referred care (care referred or provided by a network primary care physician). The maximum lifetime benefit for non-referred/out-of-network care is \$1,000,000 per individual.

IMPORTANT: This is only a brief description of the Point of Service Plans. Please refer to your booklet for further information about this coverage.

Health Maintenance Organizations (HMO's)

HMOs are managed care plans. Penn offers the following HMOs: *Aetna HMO, Keystone Health Plan East and AmeriHealth HMO*. HMOs pay for preventive care and care when you are ill. All care is coordinated through your primary care physician (PCP). This means care must either be provided or referred by your PCP for the HMO to cover the services. Care obtained without a referral or from out-of-network providers is not covered (exceptions are made for emergency care). There are no deductibles and you pay a low co-payment for physicians' office visits and other services. The Plan pays 100% for covered services (after applicable co-payments).

Maximum Lifetime Benefits

There are no maximum lifetime benefits for Referred Care (care referred or provided by an Aetna or Keystone network primary care physician). The Aetna HMO plan has a \$500,000 maximum lifetime benefit for out-of-network services.

IMPORTANT: This is only a brief description of the HMO Plans. Please refer to your booklet for further information about this coverage.

Emergency Care Information for HMO and POS Subscribers

Please be aware of the following stipulations on emergency care if you need to seek emergency care:

- If you are unable to contact your Primary Care Physician within the allowed time under your HMO, call the Emergency Number on your HMO subscriber card.
- An out-of-area emergency must be urgent care and is subject to plan review.
- Aetna HMO members: Hospitals must call the HMO for admission notification within 24 hours of admission.
- Keystone Health Plan East HMO and POS members: Hospitals must call the HMO for admission notification within 48 hours of admission.

If you do not follow these procedures, you may not receive any plan benefits in connection with the emergency treatment.

Pre-existing Conditions and Maternity Hospital Stays

Pre-existing Conditions - Penn's Medical Plans cover pre-existing conditions from the date coverage becomes effective for you or your dependents.

Hospital Stays for Maternity- Penn's Medical Plans allow for a minimum stay of 48 hours after the vaginal delivery of a newborn and 96 hours after a cesarean section, in accordance with federal laws. Providers are not required to obtain authorization from Penn or the Medical Plans for prescribing a length of stay not in excess of these periods.

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

Women's Health and Cancer Rights Act Notice

The Women's Health and Cancer Rights Act of 1998 requires the Plan to cover the following medical services in connection with coverage for a mastectomy:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce symmetrical appearance; and
- prostheses and physical complications in all stages of mastectomy, including lymphedemas.

These services shall be provided in a manner determined in consultation with the attending physician and the patient. Coverage for these medical services are subject to all applicable deductibles and coinsurance amounts.

Prescription Drug Coverage

Under all Medical Plan options prescription drug coverage is provided through Caremark Prescription Services. Under the Caremark plan, you pay discounted prices for prescription drugs when you use participating providers and show your Caremark card to the pharmacist at the time of purchase.

The major pharmacy chains and many local pharmacies participate in the Caremark network. You may obtain up to a 34-day supply at a retail pharmacy. If you use your Caremark ID card at a participating pharmacy, you pay 10% of the discounted price for generic drugs (\$5 minimum co-insurance) and 30% of the discounted price for brand name drugs (\$15 minimum co-insurance) at the time of purchase.

If you do not use your Caremark ID card at a participating pharmacy or if you fill your prescription at a non-participating pharmacy, you pay the full cost of the prescription at the time of purchase and file a claim form with Caremark to be reimbursed. There will be a 5% surcharge above the normal co-insurance, so you will be reimbursed at 85% for a generic drug and 65% for a brand name drug.

Mail Order Program: Caremark offers mail order services for long-term maintenance prescriptions. You may obtain up to a three-month supply through this program. When you use the mail order services, you pay 10% of the discounted price for generic drugs (\$10 minimum co-insurance for a 3-month supply) and 30% of the discounted price for brand name drugs (\$30 minimum co-insurance for a 3-month supply). Note that if you use the mail order program to purchase a brand name drug for which there is no generic equivalent, you pay only 10% of the cost instead of the normal 30%.

Please note: Union members generally do not participate in the University's prescription plan. They participate in a Union sponsored plan and prescription cards are issued through the Union.

Please refer to your New Member material for further information about this coverage.

Mental Health and Substance Abuse Benefits

Under all Medical Plan options, your mental health and substance abuse coverage is provided through Penn Behavioral Health who is the administrator for these benefits. Penn Behavioral Health has arranged for provider networks to provide you with mental health and substance abuse benefits. There are two Point of Service (“POS”) options and a Preferred Provider Organization (“PPO”) option that are offered as Penn Behavioral Health provider networks. The two POS options are the UPHS Point of Service option and the AmeriHealth Point of Service option. The PPO option is called the PENNCare/Personal Choice PPO. The POS options and the PPO option each provide covered mental health and substance abuse services in-network from preferred providers and out-of-network from non-preferred providers. These options allow you to use any qualified provider, but your out-of-pocket expense will be less when you choose to utilize preferred providers under the POS options or the PPO option. You should refer to the Benefits Explanation for Mental Health and Substance Abuse Services provided by Penn Behavioral Health which has been provided to you separately for additional information concerning your mental health and substance abuse benefits including a description and schedule of mental health and substance abuse services which are covered under all Medical Plan options, additional information on provider networks, exclusions and limitations for mental health and substance abuse services, claims procedures, managed care and cost management services. Please contact Penn Behavioral Health as follows if you have any questions concerning your mental health and substance abuse benefits:

Penn Behavioral Health
3535 Market Street, 4th Floor

The Dental Assistance Plans

The Dental Assistance Plan you choose determines the services that are covered, the expenses and amounts of those expenses you will pay and your costs. It also affects how and where you receive dental services and the procedure for obtaining benefits.

You currently have a choice between two Dental Assistance Plans:

- **The Penn Faculty Practice (PFP) Plan** provides services through the University's Dental Care Centers. The Plan pays all or most of the cost of many dental services as long as they are received through a Dental Care Center. You can contact the Penn Benefits Center for office locations.
- The **MetLife Preferred Dentist Program (MetLife PDP)** offers the option of selecting a dentist of your choice or one from a network of preferred providers. When you use a MetLife preferred provider dentist, you pay a percentage of the negotiated fee and therefore, pay less out-of-pocket. When you use a non-preferred dentist, the Plan will reimburse you a percentage of the reasonable and customary charge for services.

You choose the Plan that will best meet your needs for dental care and fit your budget.

IMPORTANT: Please keep in mind that the University may change the available coverage options (for example, add, drop or replace a coverage options) at any time and for any reason.

Comparing Benefits and Services

The following chart compares benefits and services of both the Penn Faculty Practice Plan and the MetLife Preferred Dentist Program. You may also obtain additional information from the Plan booklets issued by the Penn Faculty Practice Plan and MetLife or visit the Penn Faculty Plan Practice Web site at: www.pfp.dental.upenn.edu and the MetLife Web site at: www.metlife.com/dental.

Service	Penn Faculty Practice (PFP) Plan*	MetLife PDP **	
		Preferred Provider	Non-Preferred Provider
Diagnostic Care (exams, x-rays)	100%***	100%***	100% of R&C
Preventive (cleanings)	100%	100%	100% of R&C Limited to 2 visits per plan year (7/1 – 6/30)
Restorative (fillings)	100%	90%	90% of R&C
Oral Surgery (extractions)	100%	100%	100% of R&C
Endodontics (root canal therapy)	80%	80%	80% of R&C

Periodontics (gum disorders)	80%	80%	80% of R&C
Prosthodontics (bridges, dentures)	60%	50%	50% of R&C
Crowns and restorations	60%	50%	50% of R&C
Implants	50% (\$1,000 annual maximum)	Not covered	Not covered
Orthodontics	60% ****	50%	50% of R&C
(for children under age 19)		\$1,000 lifetime maximum per child	
Annual Maximum (plan year)	\$3,000 per person	\$1,500 per person	

**In the PFP Plan, if you receive dental treatment anywhere other than a PFP Plan office, no benefits will be paid except in an emergency that occurs outside of the Philadelphia area (outside a 50-mile radius of a PFP Plan office). Reimbursement will be at the PFP Plan coverage level, based on PFP network fees.*

***Benefits at a MetLife PDP provider are based on the fee negotiated by MetLife with the provider. Non-preferred provider benefits are based on the Plan's reasonable and customary limits (R&C). Non-preferred dentist are not required to accept the Plan's R&C as payment in full, so you may be required to pay any charges in excess of the payment made by the Plan.*

****Percentages shown represent the percentage of the negotiated rate that will be paid by the Plan. Amounts in excess of the stated percentage must be paid by you. PFP providers and MetLife preferred providers have agreed to accept the negotiated rate as payment in full and will not bill you for amounts in excess of the negotiated rate.*

*****For the PFP Plan, there is a 12-month waiting period for orthodontic services for dependents age 5 or older. For more detailed information, you may go to the PFP website at www.dental.upenn.edu/patients.*

Predetermination of Benefits

Your dentist can submit a treatment plan for review any time the charges for treatment will exceed \$300. This enables you and your dentist to learn in advance what treatments are covered and at what amounts.

Changing Plans in the Middle of Treatment

If you change from one Dental Assistance Plan to the other during the annual enrollment period, certain treatments that have already begun under the first plan will continue to be covered by that plan. However, if you change plans during the annual enrollment period and have a dependent receiving orthodontia treatment whose banding began prior to the start of the new plan year, neither plan will provide coverage for the remaining expenses.

Vision Care Plan

The OptiChoice Vision Care Program allows you to obtain care from a network of providers at a reduced cost, or go to a non-network provider and receive a predetermined reimbursement.

Benefits and Services

The following chart outlines the benefits and services offered by the OptiChoice Vision Care Program. You may obtain additional information from the Plan booklets issued by Clarity Vision.

OptiChoice Vision Care Plan			
Service	Frequency	In-Network	Out-of-Network (program reimbursement)
Eye exam	Once every 12 months	100%	\$32
Glasses	Once every 12 months in lieu of contact lenses		
Frames		100% up to \$60 retail value	\$24
Lenses		100%	\$24 single vision \$36 bifocal \$46 trifocal \$72 aphakic/lenticular
Contact Lenses Evaluation and Fitting	Once every 12 months	100%	\$20 daily wear \$30 extended wear
Contact Lenses	Once every 12 months in lieu of glasses		
Standard		100%	\$48
Specialty (unlimited boxes)		100% up to \$75 retail value	\$48
Disposable (unlimited boxes)		100% up to \$75 retail value	\$75
Additional Discounts*	Unlimited		
Lens options (tints, coatings)		10% discount	Not applicable
Vision care supplies (contact lens solution)		10% discount	Not applicable
Additional eyewear**		Discounted prices	Not applicable

**These discounts are only available at the point of purchase.*

***After receiving reimbursement for eyeglasses or contacts during the benefit period, you can buy additional pairs from OptiChoice providers at discounted prices.*

Coordination of Benefits

The medical, dental, vision, and prescription plans contain a coordination of benefits provision. This means that an individual is covered so that the total benefits paid by the Penn Plan will not cause the total benefits received under all plans to be more than the benefits that would have been paid by this Plan had this Plan been the primary plan.

How Plans Coordinate with Each Other

When an individual is covered by two plans, one of the plans is considered primary, and the other is secondary. The primary plan pays its benefits without regard to the other plan(s). The secondary plan then may pay benefits according to its provisions. Those benefits may be reduced, based on the benefits paid by the primary plan.

How Primary and Secondary are Determined

The following rules apply in most cases. Please refer to your booklet for the rules that apply to your plan. A plan without a coordination of benefits provision is always primary. If all the plans an individual is covered by have a coordination of benefits provision, then one of the plans must be considered primary. Here is how the Plans determine the primary plan:

1. The plan covering the patient directly, rather than as a dependent, is primary. The other plan is secondary.
2. Except as provided in the next paragraph, if a child is covered under both the parents' plans, the parent whose birth date comes first during the calendar year carries the primary plan. If both parents have the same birth date, the plan that covered the parent for the longer period is primary. If the other plan does not have a birthday rule, then the other plan is primary.

If the parents are separated or divorced or at the termination of a domestic partnership, the plans pay in this order:

- A. If a court decree has established financial responsibility for the child's health care expenses, the plan of the parent with this responsibility;
 - B. The plan of the parent with custody of the child;
 - C. The plan of the step-parent married to the parent or the plan of the domestic partner in the domestic relationship with the parent with custody of the child;
 - D. The plan of the parent without custody of the child.
3. If the employee or spouse is either laid off or retired, the plan covering the other person (as an active employee) is primary.
 4. Expenses incurred for the treatment of injury arising out of the maintenance or use of a motor vehicle shall be eligible for coverage only to the extent that such benefits are in excess of, and not in duplication of, benefits paid or payable:

- A. under a plan or policy of motor vehicle insurance, provided that non-duplication as contained herein is not prohibited by law or;
 - B. through a program or other arrangement of qualified or certified self-insurance.
5. If none of the above applies, the plan covering the patient the longest is primary.

When the PennChoice Plan is secondary, its payments shall be reduced to account for the benefits paid from the primary plan. The PennChoice Plan will not pay any secondary benefits if the benefits you received under the primary plan were equal to or greater than the benefits you would have received under this Plan if this Plan had been primary.

Special Situations Affecting Your Medical, Dental and Vision Benefits

If You Take a Leave of Absence

The following paragraphs set forth the general rules regarding how typical paid and unpaid leaves of absence affect your benefits. To learn how these rules apply in special circumstances (such as receipt of worker's compensation or sabbaticals), you should go to the University's website at www.hr.upenn.edu/ and refer to the policy manual.

Unpaid Leave of Absence

If you are approved to take an unpaid leave of absence during the plan year for any reason other than disability, including Family and Medical Leave, you can choose to continue your medical, dental, and/or vision coverage for up to 24 months while you are on leave, or waive the benefit until you return to active status.

If you elect to continue your medical, dental, and/or vision coverage you must make contributions at the appropriate level – at the active employee rate for a period of Family and Medical Leave and at 100% of the cost of coverage for any other type of approved leave.

You will receive a bill each month with instructions for submitting payment. The University's health and welfare administrator, ADP, handles billing and premium collection. Your premium payments will be on an after-tax basis.

If you are a faculty member, your coverage during a period of unpaid leave of absence is provided in accordance with the University's leave policies and procedures.

Paid Leave of Absence

If you take a paid leave of absence for any reason other than disability, including Family and Medical Leave, your medical, dental, and/or vision coverages, including your contributions, continue as though you were in active employment status.

Note: If you are on Family and Medical Leave, your leave may be paid, unpaid or a combination of paid and unpaid depending on your accumulated time balances. (Refer to the University's Family and Medical Leave Policy.)

If you choose to waive any coverage during the leave of absence (whether paid or unpaid), you must re-enroll within 30 days of the date on which you return to active status. In addition, if the open enrollment

period occurs while you are on leave and you want to change your medical, dental and/or vision coverage elections, you may make any coverage changes for the next fiscal year while on leave.

Disability Leave of Absence

See "If You Become Disabled " below for details.

When Coverage Ends

If your employment with the University ends or you become ineligible for coverage, medical, dental, and vision coverage for you and your dependents will end as follows:

- If either event occurs on or before the 15th day of the month, your coverage will continue until the end of that month.
- If either event occurs after the 15th day of the month, your coverage will continue through the end of the month following the month in which your employment terminates or you become ineligible for coverage.

If your dependent child becomes ineligible because of age or graduation, coverage ends on the last day of the plan year (June 30) after the child becomes ineligible.

If your dependent child becomes ineligible because of voluntarily dropping out of school, coverage ends on the last day of the month in which he/she was a full time student. You must record the event using the online enrollment system at www.upenn.edu/u@penn (click on "Health benefits - view, enroll, change", under Benefits) within 30 days of the event.

If your dependent (spouse/same-sex domestic partner or child) becomes ineligible for any other reason (such as divorce, termination of your partnership or if your child marries) his/her medical, dental, and vision coverage under any option ends on the last day of the month in which the dependent loses eligibility.

If coverage ends for a qualifying reason, you or your dependent can continue coverage through COBRA continuation at your own expense. (See "Your Right to Continue Coverage – COBRA", below.) You are not eligible for COBRA if your employment is terminated for gross misconduct.

Extension of Benefits

If medical coverage ends while you or a dependent is hospitalized, you may be eligible for continued coverage until the individual is discharged. Similarly, if dental coverage ends, you or your dependent may be eligible to receive benefits for certain types of dental services, provided treatment had begun before coverage ended. You should contact your provider's member services department for additional information (phone numbers are located in Section 9: Carrier Directory) about when coverage may continue in these or similar situations.

If You Become Disabled

If you qualify for Long-Term Disability (LTD) benefits, your medical and dental coverages may continue under the University's Retiree Health Plan. If you are an HMO participant, the University currently pays the full cost of coverage for you and your dependents while you are receiving LTD benefits. If you are in any other type of medical plan that is sponsored by the University, you and the University currently share the cost of coverage, with the University paying the higher amount. The

University currently pays the full amount of dental coverage. **IMPORTANT: Please keep in mind that the University reserves the right to change this cost-sharing structure in the future or to eliminate coverage entirely.**

If You Retire

If you retire and have not met the eligibility requirements described below, medical and dental coverage for you and your dependents will end. However, you may be eligible to continue them through COBRA as described under "Your Right to Continue Coverage – COBRA", below.

If you retire and you meet the age and service requirements shown below, you and certain of your dependents may be eligible for medical and dental coverage under the University's Retiree Health Plan.

Age at retirement	Years of continuous full-time service
Age 62 and older	10
Between age 55 and 61	15

IMPORTANT: All determinations as to your eligibility for retiree health coverage will be made in accordance with the University's Retiree Health Plan.

If You Are Re-employed

If you are retired, age 65 or older, eligible for retiree health benefits and return to work at Penn in a position eligible for health benefits, your coverage under the Retiree Health Plan will cease and you will again be eligible for coverage under one of the active Medical Plans. You will be required to contribute to your coverage under the same guidelines as an active employee with the same job title.

Your Right to Continue Coverage - COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) provides you and your dependents the right to continue medical, dental, and vision coverage and participation in the health care pre-tax expense account (collectively referred to as "health coverage") if health coverage for you or your dependents is lost as a result of a "qualifying event" (as described in the chart below). In that case, you and/or your dependents will be offered continuation of health coverage for up to the length of time indicated in the chart below.

Continuation of benefits under COBRA does not apply to coverage provided for same-sex domestic partners and their children. The University, however, permits continuation of health benefits for same-sex domestic partners and their children on the same basis as COBRA.

Participants who elect to continue coverage have the right to add dependents to their coverage under the same terms applicable to active employees, e.g. open enrollment and qualifying life change events. Children born to, adopted by or placed with a qualified beneficiary during the COBRA period qualify for coverage under COBRA for the remainder of the qualified beneficiary's COBRA period.

COBRA Qualifying Event:	COBRA Maximum Coverage Duration [Note: Actual duration of COBRA coverage may be shorter, as described in greater detail below. Also, for the Health Care Pre-Tax Expense Account, coverage ends as of the last day of the plan year in which the qualifying event occurs.]
Termination of employment (for any reason other than gross misconduct or disability)	18 months (employee and covered dependents); may be extended to 29 months if a qualified beneficiary is disabled*
Reduction in the employee's hours worked	18 months (employee and covered dependents) ; may be extended to 29 months if a qualified beneficiary is disabled*
Death of the employee	36 months (covered dependents)
Divorce or legal separation or termination of a same-sex domestic partnership	36 months (spouse/former spouse/same-sex domestic partner and covered dependent children)
Dependent child ceases to qualify as a dependent	36 months (whether the employee is active or retired)

*To be eligible for the 11-month extension, the disabled qualified beneficiary must be determined to have been disabled at any time during the first 60 days of COBRA coverage and written notice of such determination must be provided to ADP within 60 days of the date of the determination and before the original 18-month COBRA period expires. The 11-month disability extension does not apply to domestic partners or their children.

The University contracts with ADP to handle COBRA administration, billing, and premium collection. An application for continued benefits under COBRA must be returned directly to ADP at the address listed in Section 9: Carrier Directory. You and/or your dependents may elect to continue coverage under the health plans in which you and/or they were enrolled at the time the qualifying event occurred. You may change your medical insurance to another plan only if you are in an HMO or POS plan and are moving to an area not serviced by the HMO or POS. In that case, you may elect to change to PENNCare/Personal Choice.

Each month, you, your spouse/same-sex domestic partner or your child(ren) will receive a bill for the full premium with instructions for submitting payment. The cost of the coverage will be 102% of the applicable premium for any period of continued coverage, or 150% of the premium for the 19th through the 29th month of coverage if COBRA is extended due to disability. The first premium must be paid within 45 days of the individual's election to continue coverage, and must cover the number of full months from the date the coverage was lost until the date the first premium for coverage under COBRA is received. Subsequent premiums are due on the first of each month for that month, subject to a 30-day grace period. In most cases, medical, dental, and/or vision coverage begins from the first day after the day your coverage would otherwise have been terminated to prevent a lapse in coverage.

If you elect to continue coverage following a termination of employment or a reduction in hours and, during the 18-month period of continuation coverage, a second event occurs that would have caused your dependents to lose coverage under the Plan (if they had not lost coverage already), they may be

given the opportunity to extend the period of continuation coverage to a total of 36 months. You or your dependent must notify ADP in writing at the address listed in Section 9: Carrier Directory, of the occurrence of the second event. In addition, if you (the covered employee) become entitled to Medicare benefits and during the subsequent 18-month period lose coverage due to a termination of employment (for reasons other than gross misconduct) or a reduction in hours of employment, all qualified beneficiaries other than you will be entitled to a maximum of 36 months of coverage from the date of Medicare entitlement.

Coverage will end before the maximum duration period for any of the following reasons:

- Failure to pay the applicable premium by the due date.
- Anyone who has made an election to receive COBRA coverage and who later becomes covered under any other group health plan that does not contain any exclusions or limitations with respect to a pre-existing condition of the individual, other than a pre-existing condition or exclusion that does not apply to or is satisfied by the individual under applicable federal law.
- Anyone who has made an election to receive COBRA coverage and who later becomes entitled to Medicare benefits.
- The individual is no longer disabled during the 11-month extension of benefits for disability.
- The University ceases to provide health benefits to any employee.

Continuation Coverage During Military Service

Employees and dependents who lose health coverage due to the employee's military leave of absence under the Uniformed Services Employment and Reemployment Rights Act of 1994 may elect to continue coverage for up to 24 months (18 months if continuation coverage is elected prior to December 10, 2004). Any individual who elects to continue such coverage will be required to make the same premium payments as a COBRA participant.

Conversion of Medical Coverage

When medical coverage ends through COBRA, the individuals covered under COBRA benefits are generally eligible to convert their coverage to an individual policy then offered through the insurer. Coverage conversion is available through all plans with the exception of PENNCare and UPHS POS. (Conversion is available for a Plan 100 participant; however, you convert to another plan *similar* to Plan 100.) If you have elected continued benefits under COBRA or COBRA comparable benefits, conversion to an individual policy is available only if medical coverage ends as a result of the expiration of the maximum period of coverage under COBRA or COBRA comparable benefits.

Conversion is available only if coverage is not available through another employer-sponsored medical plan.

The insurance company determines what type of individual conversion policy is available. Note that the conversion policy may offer different benefits than those provided under the University's plans. No medical examination is required to convert coverage. However, you must make written application and pay the first premium within 30 days after coverage under your University-sponsored plan ends. Premium rates will be based on the fee schedules established by the individual plan.

Dental coverage cannot be converted to an individual policy.

Neither Vision Plan coverage nor Health Care Pre-Tax Expense Account coverage can be converted to an individual policy.

Where You Can Learn More

Section 7 of this SPD contains administrative information including how to file a claim and plan numbers. You can also contact plan carriers directly to obtain more information. Section 9 lists telephone numbers and addresses for PennChoice medical, dental and prescription drug carriers.

You can also contact The Penn Benefits Center at 1-888-PENNBEN (888-736-6236).

SECTION 3

Group Life Insurance

Introduction to Your Group Life Insurance

The Life Insurance Plan provides life, accident, and special disability insurance coverage. Most participants are eligible to elect from a number of different levels of protection. Certain job classifications may be eligible for a fixed amount of life insurance only, and are not eligible for all types of protection. See "Your PennChoice Options and Funding" under Section 1: Introduction to Your Benefits or contact the Penn Benefits Center for more information.

The Life Insurance Plan includes several types of protection:

- Basic, Supplemental and Optional Life Insurance which pay benefits to your beneficiary if you die
- Accelerated Death Benefits which permit you to receive part of your life insurance benefits if you have a terminal illness
- Accidental Death and Dismemberment Insurance (AD&D) which pays benefits to your beneficiaries if you die in an accident or pays benefits to you if you lose your sight or limbs due to an accident (details covered in AD&D section)
- Dependent Life Insurance which pays benefits to you if your covered spouse/same-sex domestic partner or dependent child(ren) die.

For the purposes of this plan, pay means your "benefits base salary". Benefits base salary is the salary paid to you for your primary appointment at the University, including any pretax contributions made under this Plan, but excluding any bonus or overtime payments. If you are a faculty member with a full-time administrative appointment, benefits base salary means your annual salary paid for your primary appointment, including any pretax contributions made under this Plan, plus compensation paid for any administrative appointments. Your benefits base salary is determined prior to open enrollment (typically in March) and remains in effect for the entire upcoming plan year. **Note: Benefits base salary does not take into account pay received for services performed for CPUP.**

Enrollment and Beneficiary Designation

When you enroll for coverage you complete an enrollment form and name a beneficiary to receive benefits in case of your death. You may name anyone as your beneficiary and can change your beneficiary at any time. All you need to do is complete a new beneficiary designation form and return it to Aetna Life Insurance Company, P. O. Box 14547, Lexington, KY 40512-4547. You do not need the consent of your beneficiary to do so. Your new beneficiary designation will take effect on the date you return your signed form to the Penn Benefits Center. Remember to keep a record of your current beneficiary. See "Payment of Benefits", below for how benefits are paid if you do not name a beneficiary. (You cannot name the University of Pennsylvania as a beneficiary.)

IMPORTANT: In general, your beneficiary designation remains in effect until changed by you and does not change automatically as a result of marriage or divorce.

Life Insurance

<ul style="list-style-type: none"> • Full-time Faculty in benefits eligible title <li style="text-align: center;"><i>or</i> • Regular Full-time or Limited Service Staff. <p><i>Note: The provisions of applicable collective bargaining agreements govern the Health and Welfare benefits of employees in collective bargaining units.</i></p>	<ul style="list-style-type: none"> • Basic Life Insurance: <ul style="list-style-type: none"> – One times your benefits base salary rounded up to the next higher \$100, not to exceed \$300,000, is provided at no cost to you. – If your benefits base salary is more than \$50,000, you can choose to limit your Basic Life Insurance coverage to \$50,000 in order to avoid paying imputed income tax. (See "Taxes on Your Coverage", below for more information on imputed income.) • Supplemental Life Insurance: <ul style="list-style-type: none"> – You can elect up to an additional four times your benefits base salary, rounded up to the next higher \$100, at your own cost. – During each open enrollment (or if you have a qualifying life change event) you can increase your coverage in increments of one-half times your benefits base salary, up to one multiple of salary, not to exceed 5 times your benefits base salary. • Basic and Supplemental Life Insurance combined cannot exceed \$1,000,000. <i>If your basic and supplemental total more than \$500,000, you must provide satisfactory evidence of insurability to the insurance company.</i>
<ul style="list-style-type: none"> • Part-time Faculty in a benefits eligible title <li style="text-align: center;"><i>or</i> • Regular Part-time Staff. 	<ul style="list-style-type: none"> • Optional Life Insurance: <ul style="list-style-type: none"> – You can elect two times your benefits base salary, rounded up to the next highest \$100, at your own cost.
<ul style="list-style-type: none"> • Full-time Visiting Faculty 	<ul style="list-style-type: none"> • Life Insurance coverage of \$10,000 if indicated in the Provost Staff Conference minutes.

The insurance rates you pay for Life Insurance coverage are reflected in your customized new hire guide or in open enrollment guide.

Payment of Benefits

The full amount of your Life Insurance is paid to your beneficiary if you die. If you do not have a designated beneficiary at the time of your death or your beneficiaries pre-decease you, benefits will be paid as follows to those who survive you:

- your spouse, if any;
- if there is no spouse, in equal shares to your children;

- if there is no spouse or child, to your parents, equally or to the survivor;
- if there is no spouse, child or parent, in equal shares to your brothers and sisters; or
- if none of the above survives, to your executors or administrators.

Accelerated Death Benefits

This feature permits you to request payment of your Life Insurance if you have a terminal illness with a life expectancy of 12 months or less. Your spouse, assignee, or irrevocable beneficiary, if any, must consent to payment. The benefit paid to your beneficiary upon your death will be reduced by the full amount of the living benefit.

Taxes on Your Coverage

Under current law, if you have employer-paid life insurance over \$50,000, you must pay income taxes on the value of the coverage over \$50,000. The value of the coverage is called imputed income. Therefore, if you have Basic Life Insurance over \$50,000, you will pay Federal Withholding Tax, Social Security Tax (FICA), Medicare Insurance tax and Philadelphia City Wage Tax (if applicable) on the value of the life insurance in excess of \$50,000. Applicable taxes are deducted based on your pay frequency (weekly or monthly).

Your imputed income is determined by age-related rates set by the federal government similar to premium rates. The rates are for each \$1,000 of coverage per month. Since the value of Basic Life Insurance **over** \$50,000 is taxable, you should multiply the amount in excess of \$50,000 by the applicable IRS rate per \$1,000 of coverage, multiplied by 12 months to determine your imputed income for the year. The table below shows the imputed IRS rates used to calculate imputed income for amounts of life insurance benefits in excess of \$50,000. The rate used is based on your age as of the end of the calendar year in which you were covered.

For example, a 49-year-old employee with \$150,000 of Basic Life Insurance would have \$100,000 subject to imputed income (\$150,000 minus \$50,000). This will result in an additional \$180 in income on his or her federal income tax return (\$100,000 divided by 1,000, multiplied by .15 (from the table below), then multiplied by 12 months). Assuming a combined federal, FICA, state and local income tax rate of 40%, the result is \$72 in additional taxes for the year. As you can see, the overall impact of the additional coverage is small in relation to the protection this coverage provides.

Imputed income is reported as part of your taxable income on your year-end Form W-2. FICA, Medicare and applicable city taxes on imputed income are withheld from each paycheck.

Age	Rate per \$1,000 per month
Under 25	\$.05
25 – 29	\$.06
30 – 34	\$.08
35 – 39	\$.09
40 – 44	\$.10
45 – 49	\$.15
50 – 54	\$.23
55 – 59	\$.43
60 – 64	\$.66
65 – 69	\$1.27
70 +	\$2.06

Accidental Death and Dismemberment Insurance (AD&D)

If you have Life Insurance, you also have AD&D Insurance. The University provides this coverage at no cost to you. AD&D Insurance pays benefits if you die or have other losses directly caused by an accident. The benefit that is payable is up to two times your annual benefits base salary at the time of the accident. The maximum benefit for AD&D is \$125,000.

Schedule of AD&D Benefits

The full amount of your AD&D Insurance will be paid to your beneficiary if your death is directly caused by an accident. These benefits are in addition to any Life Insurance benefits.

In addition, AD&D Insurance covers some losses that are a direct result of accidental bodily injuries you may receive while covered. The following are the benefits payable under the AD&D Plan:

Accidental Loss	Total Accident Insurance Coverage Payable*
Loss of life	Two times annual benefits base salary
Loss of two feet, two hands, or sight in both eyes; <i>or</i> Loss of a combination of one foot, one hand or sight in one eye	Two times annual benefits base salary
Loss of one hand, one foot, or sight in one eye	One times annual benefits base salary

**To a maximum of \$125,000.*

For benefits to be payable, death or the loss suffered must be the direct result of the accidental injury, and from no other cause (i.e., self-inflicted). Coverage is provided for the loss of a hand, foot, or sight

that occurs within 90 days of the accident. The loss of a hand or foot means that it is completely severed at or above the wrist or ankle joint. Loss of eyesight means the complete and permanent loss of sight.

Exclusions

AD&D benefits are not paid for losses due to:

- a disease or illness of any kind, physical or mental infirmity, or medical treatment of these; ptomaine or bacterial infection, except infection as a result of an accidental cut or wound; or
- suicide; or
- an injury or a sickness that is intentionally self-inflicted; or
- war declared or not declared; any act incident to war; service in any military of any country while the country is engaged in war; or police duty as a member of any military or naval organization; or
- taking part in, or as a result of taking part in, the commission of a felony

Payment of Benefits

If living, you are automatically the beneficiary of AD&D benefits. Otherwise, benefits will be paid as under your life insurance.

Dependent Life Insurance

Full-time faculty in a benefits eligible title and regular full-time or limited service staff can elect to purchase Dependent Life Insurance coverage for your spouse/same-sex domestic partner and eligible children who are at least 30 days old, but less than 19 years old (up to 23 if a full-time student), under the Dependent Life Insurance program. Regular part-time staff, part-time faculty in benefits eligible title and visiting faculty are not eligible for Dependent Life Insurance.

Any dependent who is institutionalized and/or disabled on the date he/she would otherwise become eligible for coverage will not become covered until the date he/she is no longer institutionalized and/or disabled.

Coverage Options

When you make your Dependent Life Insurance elections, you will have the following choices:

Option	Coverage Amount	
	Spouse/Partner	Child
1	No coverage	No coverage
2	\$10,000	No coverage
3	No coverage	\$5,000 per child

4	\$10,000	\$5,000 per child
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Payment of Benefits

You are automatically the beneficiary of Dependent Life Insurance. If you and your child die, the benefit will be paid to your surviving spouse. If you do not have a surviving spouse, benefits will be paid to your estate.

Tax Status

Your contributions towards Life Insurance and Dependent Life Insurance are made with after-tax contributions. That is, they are deducted from your pay after federal income tax, FICA (Social Security) tax and Medicare Insurance tax are withheld.

Special Situations Affecting Your Group Life Insurance

If Your Employment Ends

The following table illustrates what happens to Life Insurance, AD&D Insurance, and Dependent Life Insurance if your employment with the University ends:

If you:	Life Insurance	AD&D Insurance	Dependent Life Insurance
Die	Paid to your beneficiary.	Paid to your beneficiary if death is caused by an accident.	Coverage stops.
Terminate employment for any reason other than death or retirement	Coverage stops. You can convert coverage to an individual policy. If you die within 31 days of the date coverage ends, your life insurance benefits will be paid to your beneficiary.	Coverage stops.	Coverage stops. Your dependents can elect to convert coverage to an individual policy. However, if a dependent dies within 31 days of the date coverage ends, benefits will be paid.
Become disabled	Basic Insurance continues while you are receiving LTD benefits if you have been covered for 6 months. Coverage continues until the date you are no longer disabled. You may continue Supplemental Insurance at the same age-based rates in effect prior to your becoming disabled.	Coverage stops.	Coverage stops. You have the option to convert to an individual policy.

If You Stop Making Contributions

If you are still actively employed but stop making the required contributions, your life insurance coverage will stop as of the end of the pay period when you last made contributions.

If You Take a Leave of Absence

The following paragraphs set forth the general rules regarding how typical paid and unpaid leaves of absence affect your benefits. To learn how these rules apply in special circumstances (such as receipt of worker's compensation or sabbaticals), you should go to the University's website at <http://www.hr.upenn.edu/> and refer to the policy manual.

Unpaid Leave of Absence

If you choose to continue your life insurance coverage while on an unpaid leave of absence, you will receive a bill, each month, for the full premium with instructions for submitting payment. The University contracts with ADP to handle billing and premium collection. Your premium payments will be on an after-tax basis and coverage may continue for the lesser of the length of your approved leave or up to 24 months.

If you choose to waive coverage during this period, any life insurance you have will end on the first of the month after your leave begins. Your benefits will be reinstated when you return from leave, provided you re-enroll within 30 days of the date in which you return to active status.

If the open enrollment period occurs while you are on leave and you want to change your life insurance elections, you may make any coverage changes for the next fiscal year while on leave.

Paid Leave of Absence

If you take a paid leave of absence, your life insurance coverage and premium payments remain the same as if you were in active status for the lesser of the length of your approved leave or up to 24 months. If the open enrollment period occurs while you are on leave and you want to change your coverage elections, you may make any coverage changes for the next fiscal year.

Note: If you are on a leave that is an approved Family and Medical Leave, your Basic Life Insurance continues to the end of the sixth month following the start of the leave or, if longer, the period required by the state in which you reside. If you have Supplemental or Optional Life Insurance, you must pay for coverage during the unpaid portion of your absence with after-tax dollars.

If You Retire

If you retire and have not met the eligibility requirements described below, life insurance coverage for you and your dependents will end. However, you may be able to convert your life insurance coverage and dependent life insurance coverage (but not AD&D coverage) to individual policy(ies).

If you retire and you meet the age and service requirements shown below, you may receive life insurance coverage under the University's Retiree Health Plan. All other coverages will end. However, you may be able to convert your life insurance coverage and dependent life insurance coverage (but not AD&D coverage) to individual policy(ies).

Age at retirement	Years of continuous full-time service
Age 62 and older	10
Between age 55 and 61	15

IMPORTANT: All determinations as to your eligibility for retiree life insurance coverage will be made in accordance with the University's Retiree Health Plan.

If You Are Re-employed

If you are retired, age 65 or older, eligible for retiree medical benefits and return to work at Penn in a position eligible for medical benefits, your coverage under the Retiree Health Plan will cease and you will again be eligible for coverage under one of the active Medical Plans. You will be required to contribute to your coverage under the same guidelines as an active employee with the same job title.

If the Plan Ends or Your Eligibility Ends

Your coverage ends immediately if the Plan and/or the life insurance group contract is discontinued, or if the Plan is amended to discontinue eligibility to the category of employees under which you are covered, or, if you cease to be a member of an eligible group.

Converting Coverage

If you retire, leave the University for any reason, or become ineligible for coverage, you may convert your life insurance coverage (but not your AD&D coverage) to an individual policy that is equal to or less than the amount of your coverage prior to retirement. Your converted policy as a retiree combined with the University-provided coverage of \$2,000 cannot exceed the amount of your coverage prior to retirement. If you become re-employed by the University and are again eligible for coverage under the group policy, your conversion policy will terminate.

You must apply for conversion to an individual policy within 31 days of your retirement or termination date. You can receive a conversion application by contacting the Penn Benefits Center at 1-888-PENNBEN (1-888-736-6236) and pressing Option #2.

How to File a Claim

In the event of death, a claim must be filed with Aetna Group Insurance, the University's life insurance carrier. The person filing the life insurance claim should contact the Penn Benefits Center at 1-888-PENNBEN (1-888-736-6236) and press Option #2. This will transfer the caller to an Aetna representative who will explain the details for processing the claim.

If your covered dependent (spouse/same-sex domestic partner or child) dies, you should contact the Penn Benefits Center and press Option #2 as soon as possible. An Aetna representative will help you with the necessary forms and documents needed for processing the claim. You will be asked to provide the insurance company with a certified copy of the death certificate. Additional proof of death or loss may also be required for all claims. Once proof acceptable to the insurance company is received, benefits will be paid as soon as possible.

If a claim is filed under the AD&D Insurance, a written claim must be filed within 20 days after the date of loss with Aetna. In addition, proof of death, disability or loss must also be provided within 90 days.

Claim Payments

Except as otherwise permitted by a third-party insurer or the Plan Administrator, life insurance benefits generally will be paid to you in a lump sum.

Situations Affecting Plan Benefits

Although your Life Insurance benefits are designed to provide life and accident insurance, any of the following situations could affect your benefits:

- If you or your beneficiary do not file a claim or furnish proof of loss to the Penn Benefits Center, insurance payments will be delayed until you or your beneficiary furnish such information.
- If you or a dependent (spouse/same-sex domestic partner, dependent child) are no longer eligible for the Plan, your coverage will end, regardless of the Dependent Life Insurance option, or any premiums paid in error. Dependent coverage ends for your dependent on the date he/she ceases to be an eligible dependent.
- If you fail to make any timely payment of any required contributions, your coverage will end (Supplemental, Optional, and/or Dependent Life Insurance).

You can convert your life insurance coverage to an individual policy within 31 days of the date coverage ends for any reason. You can receive a conversion application by contacting the claims administrator.

Assignment of Coverage

This assignment will be irrevocable unless the assignee releases you from the agreement. You may be able to assign to someone else all rights, interest, and ownership of your insurance coverage under the employee Life and AD&D plans subject to Plan Administrator's and/or the insurance carrier's approval and consent.

Where You Can Learn More

Basic Life Insurance benefits are paid by the University, and administered and fully insured by Aetna. Supplemental and Optional Life Insurance, AD&D Insurance and Dependent Life Insurance paid for by you and are insured and administered by Aetna. For more information, contact:

Aetna Life Insurance Company
Life Conversion Unit
151 Farmington Avenue
Hartford, CT 06165-1992

Or Call:

The Penn Benefits Center
1-888-PENNBEN (1-888-736-6236) and press Option #2

SECTION 4

Pre-Tax Expense Accounts

Introduction to Your Pre-Tax Expense Accounts

The Pre-Tax Expense Accounts let you pay certain expenses with pre-tax dollars. There are two accounts:

- The Health Care Pre-Tax Expense Account - to help pay for uninsured medical and dental expenses
and
- The Dependent Care Pre-Tax Expense Account - to help pay for dependent care expenses that are necessary for you (and your spouse, if you are married) to work.

The Advantages of These Accounts

When you use the Pre-Tax Expense Accounts, you set aside dollars from your gross pay before any taxes are withheld. The government taxes only your reduced income amount so you pay lower taxes each paycheck. The dollars you have elected to set aside are held for you in a special account(s) until you submit claims for reimbursement. When you have paid for an eligible expense, you can reimburse yourself with the Pre-Tax dollars in your account(s).

Eligibility and Participation

Full-time benefits-eligible faculty and regular full-time and limited service staff are eligible to participate in the Health Care Pre-Tax Expense Account upon hire (up to \$4,000 per year) and the Dependent Care Pre-Tax Expense Account after 1 year of continuous service and attaining age 21 (up to \$5,000 per year).

Regular part-time staff and part-time faculty in a benefits eligible job title are eligible to participate in the Health Care Pre-Tax Expense Account after 2 years of continuous service (up to \$1,000 per year) and the Dependent Care Pre-Tax Expense Account after 1 year of continuous service and attaining age 21 (up to \$5,000 per year).

Your participation is voluntary. You decide whether to participate in either or both accounts when you first become eligible for them and again at each open enrollment.

Your Contribution Decision

You decide how much you want to contribute for the plan year during the annual enrollment period - or if you are newly eligible or have a qualifying change in status, within 30 days of eligibility or the qualifying event. Your contributions are set aside from your pay, and held for you in your account. When you have an eligible expense, you file a request for reimbursement.

Important Government Restrictions

Because of the tax advantages offered through the Pre-Tax Expense Accounts, the federal government places important restrictions on their funding and use.

- You decide how much to contribute for each plan year. Only expenses incurred during the plan year in which you participate are eligible. Contributions for expenses you incur before your participation begins, or after it ends, cannot be reimbursed from your account.
- Once you make your decision, it may only be changed if you have a qualifying change in status. If you choose to decrease your election as a result of a change in status and you have already received

reimbursements from your Health Care Pre-Tax Expense Account, you must reduce your election by an amount equal to or greater than the amount of your reimbursement(s).

- Any money left in your account for which there are no eligible expenses is forfeited at the end of the grace period (90 days after the end of the plan year).

Even if you lose some money at the end of the plan year, it is possible (depending on the amount of money you forfeit) to save more on your taxes than you are losing from your account. For example, suppose you forfeit \$100 at the end of the plan year. If your tax savings during the year are greater than \$100, it is still to your advantage to have used the account.

The Health Care Pre-Tax Expense Account

You can use the Health Care Pre-Tax Expense Account for eligible expenses incurred by you, by your spouse, or by any dependent with respect to whom you are entitled to claim a deduction on your federal income tax return (or would be entitled to claim a deduction but for the dependent's gross income). These dependents are not required to be enrolled in your medical plan in order to qualify.

Your Contributions to the Health Care Pre-Tax Expense Account

The amount you contribute to the Health Care Pre-Tax Expense Account should be based on how much you anticipate spending during the plan year for eligible expenses.

- There is no minimum contribution.
- The maximum contribution for full-time benefits-eligible faculty and regular full-time and limited service staff is \$4,000 for the plan year.
- The maximum contribution for regular part-time staff and part-time faculty in a benefits eligible job title is \$1,000 for the plan year (you are eligible to contribute after 2 years of continuous service).

If you and your spouse are both Penn employees and participating in a Health Care Pre-Tax Expense Account, you each have a \$4,000 (or \$1,000 if you are part-time) individual maximum.

Eligible Expenses

In general, your Health Care Pre-Tax Expense Account can be used for expenses that the Internal Revenue Service would consider deductible for federal income tax purposes, although there are some exceptions. You can only use the account for expenses not covered by your health plan. The following list provides some examples:

- medical, dental, vision and prescription drug plan deductibles, co-payments and coinsurance amounts
- vision expenses, including eyeglasses, contact lenses, and office visits as well as the cost of a guide dog for the blind and special education devices for the blind, such as a special typewriter
- confinement in a facility primarily for screening tests and physical therapy or hydrotherapy
- general physical exams
- cosmetic surgery due to birth defects, disease or trauma

- chiropractic treatments
- physical therapy
- services for chromosome or fertility studies
- treatment (other than surgery) of corns, bunions, calluses, foot structural disorders, etc.
- immunizations
- well-baby care
- bandages, support hose or other pressure garments
- charges in excess of the usual and customary rate or usual and prevailing charge for covered expenses
- acupuncture for pain relief as performed by a licensed practitioner
- syringes, needles and injections
- vitamins and mineral supplements prescribed for treatment of illness
- transportation expenses to receive medical care, including fares for public transportation and actual out-of-pocket car expenses, such as gas and oil (in lieu of out-of-pocket expenses, a standard mileage rate of \$.15 per mile may be used)
- expenses not paid by Penn's medical, dental or vision plans, or not paid in full by the Program (such as orthodontia and durable medical equipment)
- hearing expenses, including hearing aids, special instructions or training for the deaf (such as lip reading), the cost of acquiring and training a dog for the deaf, and special telephone and audio display equipment for the deaf
- individual psychiatric or psychological counseling one-on-one or within a group
- miscellaneous expenses, including birth control pills, installation and monthly rental charges for fluoride treatment to home water when recommended by a dentist, a stop-smoking program, a weight-loss program prescribed by a physician to treat a specific illness, and hypnosis for treatment of an illness
- non-prescription (over-the-counter) medicines and drugs that are used for medical care (these are eligible expenses only if incurred on or after September 3, 2003 – the types of medicines and drugs that are eligible is subject to change by the University from time to time)
- "halfway house" care to help individuals adjust from life in a mental hospital to community living
- tutoring by a licensed school or therapist for a child with a severe learning disability, and special schooling for the handicapped

- fees paid to a medical information plan maintaining an individual's medical information by computer
- special car controls for the handicapped

Reimbursement may also be made for all or part of certain capital expenditures that are made primarily for health care reasons. For example, an air conditioner installed in the home for a person with severe allergies may qualify for partial reimbursement. Another example might be the installation of an exercise swimming pool to aid in the recovery of a stroke victim.

The federal government publishes a booklet (Publication 502) listing the expenses that may be eligible for reimbursement through the Health Care Pre-Tax Expense Account. You can request a copy from your local Internal Revenue Service Office listed under U.S. Government Offices in your telephone book or go to the web at www.irs.gov/forms_pubs/index.html. The local Philadelphia phone number is 215-574-9900.

Note: Publication 502 should be used for general reference purposes only. Notwithstanding what the publication says, premiums for health insurance and certain long-term care expenses are NOT eligible for reimbursement. Also, as noted above, expenses for non-prescription medicines and drugs are now eligible for reimbursement, although such expenses are not deductible for income tax purposes.

Ineligible Expenses

Here are some examples of expenses that are *not* eligible for reimbursement through the Health Care Pre-Tax Expense Account:

- premiums paid to employer-sponsored health, dental, vision, prescription drug or contact lens insurance coverage incurred by you or your dependents
- premiums paid for long-term care insurance coverage and certain other long term care expenses
- premiums for private insurance (not provided by an employer) and for medical care included in the tuition fee of a college or university when billed separately
- marriage or family counseling
- salary of a licensed practical nurse (LPN) incurred in connection with the care of a normal and healthy newborn even when such care may be required due to the death of the mother in childbirth
- funeral and burial expenses
- household and domestic help even when recommended by a qualified physician due to an employee's or dependent's inability to perform physical housework
- custodial care in an institution
- costs of sending a child with behavioral and/or learning problems to a special school for benefits the child may receive from the course of study and disciplinary methods
- health club dues, YMCA dues, steam bath, etc.

- social activities, such as dance lessons or classes (even when recommended by a qualified physician for general health improvement)
- membership fees or costs associated with weight-loss for general health and well-being purposes
- maternity clothes, diaper service, etc.
- cosmetics, toiletries, toothpaste, etc.
- the segment of automobile insurance premiums providing medical coverage for persons injured through an accident involving an employee's car
- the segment of life insurance premiums paid for loss of earnings or for accidental loss of life, limb, sight, etc.
- vacation or travel taken for general health purposes, a change in environment, improvement of morale, etc., or taken to relieve physical or mental discomfort not related to a particular disease or physical defect
- transportation expenses to and from work, even though a physical condition may require special means of transportation
- non-prescription medicines and drugs (these expenses are eligible if incurred on or after September 3, 2003)
- non-prescription items (such as vitamins) that are merely beneficial for your or your dependent's general health
- elective cosmetic surgery, face lifts, facial hair removal by electrolysis, liposuction, etc.
- cosmetic dental work
- confinement in a nursing home for illness or injury
- medical or dental expenses provided to an individual(s) who is not your tax dependent, or your pets.

If the expense is paid by a health care plan it is *not* eligible for reimbursement. For example, suppose your spouse has an expense covered by the medical plan where he or she works, your Health Care Pre-Tax Expense Account could only be used to reimburse you for amounts not paid by that medical plan, such as deductible and coinsurance amounts.

Once an expense is claimed through the expense account, it *cannot* be used as a tax deduction when you file your federal income taxes. It can be claimed on one or the other, but not on both.

Submitting Claims

When you have an eligible health care expense, you first pay the expense. Then you submit a request for reimbursement to the third party administrator, ADP, for any amount you paid out-of-pocket. The Plan rules for submitting a request are as follows:

- The expense must have been *incurred* during the plan year - that is, between July 1 and June 30 - and not before your participation began or after your participation ended. Expenses are considered to be incurred on the day the service is provided, not when you are billed or when it is paid.
- Your request form must be accompanied by documentation showing the nature of the item or service, the date expense was incurred, the amount paid for the item or service and proof that you paid for the item or service.
- If your expense is eligible under the University's medical plan, or any other plan(s) covering you or the family member who incurred the expense, you must first file a claim under that plan(s). When claims are submitted to your insurance plan(s), you receive an "Explanation of Benefits" (EOB). This is a statement showing how your benefits were calculated and the out-of-pocket amount you are responsible for paying. You must attach all EOBs you receive to your request for reimbursement from the Health Care Pre-Tax Expense Account.
- The minimum amount of any aggregate claims that may be reimbursed at any one time is \$50.
- The maximum amount reimbursable under the Plan for expenses incurred in a plan year is an amount equal to the total of your contributions for that plan year, not in excess of \$4,000 per year (\$1,000 if you are part-time).
- Requests are processed twice a month.
- After the close of the plan year, you have three months (until September 30) to submit requests for expenses incurred during the prior plan year. This three-month period, called the grace period, is only for processing reimbursements. The expenses for which you are reimbursed must have been incurred during the plan year ending on the prior June 30.
- When you submit a claim for reimbursement, you must provide all required supporting documentation and certify on the claim form that the expense is an eligible expense.
- If your request for reimbursement is denied for any reason, you have certain rights as a plan participant. These rights are described in the section entitled "Administrative Information".

When Participation Ends

Your participation in the Health Care Pre-Tax Expense Account ends if your job status changes to one that is ineligible or if your employment with the University ends for any reason. Your contributions end with your final paycheck.

You may continue to submit requests for reimbursements after you leave through the end of the three-month grace period after the end of the plan year. Your reimbursement is determined as follows:

- You may be reimbursed for expenses incurred prior to your termination date, up to the amount you elected to contribute, less any previous reimbursements.
- You can continue to make contributions under COBRA and be reimbursed for expenses incurred during the remainder of plan year, before or after your termination date, up to the amount you elected to contribute.

Contributions made in a prior plan year (prior to July 1) may not be used to reimburse expenses incurred in a subsequent plan year (on or after July 1).

Note: During Open Enrollment, you must actively elect to discontinue your participation for the new plan year. If you do not, your election will automatically continue for the same annual amount during the new plan year.

The Dependent Care Pre-Tax Expense Account

If you have “qualifying individuals” (as described below) who need daily care while you work, you can pay for that care with pre-tax dollars through the Dependent Care Pre-Tax Expense Account.

Your Dependent Care Pre-Tax Expense Account Contribution

The amount you contribute to the Dependent Care Pre-Tax Expense Account should be based on how much you anticipate spending during the plan year for eligible expenses.

- There is no minimum contribution.
- The maximum contribution is \$5,000 for both the plan year (eligible to contribute after 1 year of continuous service and attaining age 21). However, the amount of reimbursement you are permitted to exclude from your federal taxable income may be less than \$5,000, as described in the next section. In addition, the Plan Administrator has the right to limit the contribution that can be made by "highly compensated employees" in order to help the Plan pass a statutory nondiscrimination test that prohibits a disproportionate amount of benefits to be paid on behalf of highly compensated employees. This right has been exercised in the past. If you are affected by this limit you will be notified. Individuals classified as highly compensated (according to IRS rules, W-2 earnings of \$95,000 and above) may contribute up to \$3,500.

Maximum Tax-Free Reimbursement

Generally, amounts reimbursed from your Account are tax-free to you. However, federal law provides that the amount excluded from your gross income cannot exceed the lesser of:

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

If your spouse is (1) a full-time student for at least five months during the year or (2) physically and/or mentally handicapped, there is a special rule to determine his or her annual income. To calculate the income, determine your spouse's actual taxable income (if any) earned each month that he or she is a full-time student or disabled. Then, for each month, compare this amount to either \$250 (if you claim expenses for one dependent) or \$500 (if you claim expenses for two or more dependents). The amount you use to determine your spouse's annual income is the greater of the actual earned income or these assumed monthly income amounts of either \$250 or \$500. By making an election under the Plan to contribute to a Dependent Care Spending Account, you are representing to the Company that your contributions to the Account are not expected to exceed these limits.

If you are married and filing separate federal income tax returns, the \$2,500 limit described above will not apply if you are (1) legally separated or (2) your spouse did not reside with you for the last six

months of the calendar year, you maintained a household that was your dependent's primary residence for more than six months during the year and you paid more than half of the expenses of that household.

If your child is enrolled at the Penn Children's Center, the amount you can receive from the Dependent Care Pre-Tax Expense Account tax-free is reduced by the subsidy that the University provides to the Center. The University subsidy is the difference between the rate charged to you and the rate charged to center users who are not University employees or faculty members plus any additional direct subsidy or fee reduction provided by the University to you. If you have questions about whether you are credited with a subsidy or the amount of the subsidy, please contact the University Benefits Office.

The \$5,000 maximum limit is a household limit if you are married filing a joint federal income tax return. Therefore, if both you and your spouse participate in a dependent care assistance plan (through PennChoice or through another employer), your combined maximum tax-free benefit is \$5,000 in a calendar year.

By making an election to contribute to a Dependent Care Pre-Tax Expense Account, you are representing to the University that your contributions to the account are not *expected* to exceed the applicable tax-free reimbursement limit.

Some Special Timing Considerations

Your contributions to the Dependent Care Pre-Tax Expense Account are subject to some special timing considerations. All PennChoice plans are administered on a plan year that begins each July 1 and ends each June 30. However, the federal income tax reimbursement limits for the Dependent Care Pre-Tax Expense Account (as described above) are based on a calendar year.

You should plan carefully when you calculate your annual contribution. For example, if you first contribute to the plan during the first half of the calendar year (January 1 through June 30), and your contributions are more than \$2,500 for such period, you should make certain that your contributions for the second half of the calendar year (July 1 through December 31) are less than \$5,000 so that your contributions for the calendar year do not exceed \$5,000.

Eligible Expenses

You can use the Dependent Care Pre-Tax Expense Account to reimburse yourself for eligible expenses directly related to the "well-being and protection" of a "qualifying individual" (defined below) if those expenses are necessary for you to work. If you are married, your spouse must also be employed (or seeking employment), enrolled as a full-time student, or disabled for your expenses to qualify. Expenses incurred while you are not working (e.g., sick day, vacation, etc.) do not qualify for reimbursement.

For the purposes of this plan, a qualifying individual includes:

- your child, grandchild, brother or sister who is under age 13, who resides in your household for more than one-half of the year and who does not provide more than one-half of his or her own support for the year (if you are divorced or separated, certain qualifications and special custody/support rules may apply);
- a disabled spouse who resides in your household for more than one-half of the year; and
- a disabled relative or household member who is principally dependent on you for support, who resides in your household for more than one-half of the year and who does not have gross income in

excess of a specified amount (\$3,200 for 2005). For this purpose, gross income includes Social Security benefits, pension benefits, wages, interest and dividend income, etc.

Note: A disabled dependent must spend at least eight hours a day in your home. A disabled dependent who is confined to an institution for care would not qualify.

Eligible dependent care expenses include:

- services provided to care for eligible dependents while you are at work, as long as the provider submits a tax ID or social security number
- household services, if attributable to the care of your dependent
- the services of a day care center (if the center provides care for more than six individuals, other than residents, it must comply with all applicable state and local laws)
- care for a disabled dependent provided outside your home as long as the dependent is a child under age 13 or is in your home for at least eight hours a day
- certain education expenses—for example, the cost of nursery school, including lunches—if your child is not yet in the first grade. (Note: Kindergarten expense reimbursement requests will be approved to the extent that the request shows that a portion of a kindergarten expense was primarily for the care (and not the education) of a dependent child. Reimbursement requests marked simply as "kindergarten" expenses will not be approved.)
- expenses for care provided in your home, as long as the care is not provided by someone you or your spouse claims as a dependent on your federal income tax return, or your child who is under age 19 (even if you no longer claim that child as a dependent)

To make sure your situation and the type of care being provided meets IRS requirements, refer to IRS Form 2441 and IRS Publication 503, "Child and Dependent Care Expenses." In addition, you should know that if you use a dependent care provider inside your home you may be considered the employer of that individual and may be responsible for withholding and paying employment taxes. For more information, refer to IRS Publication 926, "Employment Taxes for Household Employees." These forms and publications are available on the IRS' website (www.irs.gov), and also should be available at your local post office or public library.

Ineligible Expenses

Here are some examples of expenses that are not eligible for reimbursement through the Dependent Care Pre-Tax Expense Account:

- non-employment related care, such as babysitting fees during non-working hours or expenses incurred on days when you (or your spouse) are not working due to vacation or illness
- transportation expenses
- convalescent or nursing home expenses for a parent or disabled spouse
- overnight camp expenses

- educational expenses for a child in the first grade or above
- dependent care expenses that enable you or your spouse to do volunteer work

Comparing the Dependent Care Pre-Tax Expense Account and Tax Credit

A federal tax credit is available for the same dependent care expenses that can be reimbursed through the dependent care pre-tax expense account. The tax credit is an alternative to the account. As a general rule, the higher your gross family income, the less valuable the tax credit becomes to you. Whether it is better for you to contribute to an expense account or take advantage of the tax credit depends on your individual circumstances. ***Note that the tax credit and the federal tax rates have changed for years beginning in 2003. These changes may cause the tax credit to be more advantageous to you in 2003 and later years even if the expense account was more advantageous to you in prior years.*** Here is approximately how they compare:

- The tax credit allows you to subtract a part of your expenses directly from the federal income taxes you owe. With the expense account you reduce your taxable income by the amount of your contributions. This, in turn, reduces the total taxes you owe. The tax advantage of the expense account depends on you being able to exclude any reimbursement from your gross income for tax purposes (see above). In general, you can exclude up to \$5,000, unless you are married filing a separate income tax return, in which case you can exclude only \$2,500.
- The expenses you can apply toward the tax credit are limited to \$3,000 if you have one dependent and \$6,000 if you have more than one. With the expense account, your IRS filing status, rather than the number of dependents you have, determines the amount of reimbursement that you can exclude from your gross income.
- As a *very* general guideline, if your household income is \$39,000 or more, the expense account is more advantageous than the tax credit. ***This determination depends on a number of factors. You should consult a personal tax advisor before making your election.***
- You may use both the dependent tax credit and the expense account in one year, but not for the same expenses. Moreover, your contributions to the account lower, dollar for dollar, the amount you may apply toward the tax credit.
- If you contribute \$5,000 to an expense account and you have two or more dependents, you may use the tax credit for dependent care expenses in excess of \$5,000 (subject to the \$6,000 limit).

Another tax credit available under current tax law is the earned income credit. This credit also reduces dollar-for-dollar the federal tax you have to pay, but is calculated somewhat differently from the child care credit described above. The credit is available to individuals with a child who is under age 19 (under age 24 if a student) or who is totally and permanently disabled. The credit does not depend on the amount you pay in child care expenses. The earned income credit has no effect on the amount you can contribute under the expense account, and the earned income credit cannot be claimed for any individual for whom you claim the child care credit described above. The use of the account will result in a reduction in your taxable income and may thus qualify you for the earned income credit where you would not otherwise have qualified. If this credit applies, the use of the expense account may be advantageous to you even if your household income is less than the \$39,000 guideline mentioned above. ***Again, you should consult a professional tax advisor to determine whether the pre-tax expense account makes sense for you.***

Submitting Claims

When you have an eligible expense for dependent day care, you pay the expense first and then submit a request for reimbursement to ADP for any amount you paid out-of-pocket. The following are the procedures for submitting a claim:

- The expense must have been *incurred* during the plan year - that is, between July 1 and June 30 - and not before your participation began. An expense is considered to be incurred on the day the service is provided.
- The federal government requires you to report the taxpayer identification number of your care provider on your claim form. If the care provider is an individual, the individual's Social Security number is the taxpayer identification number.
- Your request form must be accompanied by documentation showing the date of service, and that you paid for the service.
- Requests are processed weekly.
- If you do not have enough money in your account to cover the full amount of your reimbursement request, you will receive only as much as you have in your account. The balance of your request will be held until another contribution is made. You will then receive another reimbursement check to make up the difference.
- The minimum amount of any aggregate claims that may be reimbursed at any one time is \$50.
- The maximum amount reimbursable under the Plan for expenses incurred in a plan year is an amount equal to the total of your contributions for that plan year.
- After the close of the plan year, you have three months – until September 30 – to submit requests for expenses incurred during the plan year. This three-month period is called the grace period. Keep in mind, this period is only for processing of reimbursements. The expenses for which you are reimbursed must have been incurred during the plan year.
- When you submit a claim for reimbursement, you must certify on the claim form that the expense is an eligible expense. ADP is entitled to rely on this certification for all purposes.
- If your request for reimbursement is denied for any reason, you have certain rights as a plan participant. These rights are described in the administrative chapter of this book.

When Participation Ends

Your participation in the Dependent Care Pre-Tax Expense Account ends if your job status changes and makes you ineligible or if your employment with the University ends for any reason. Your contributions end with your final paycheck.

You may continue to submit requests for reimbursements after you leave through the end of the three-month grace period. You may be reimbursed for expenses incurred through the end of the plan year, up to the balance in your account at the time you stopped participating.

Contributions made in a prior plan year (prior to July 1) may not be used to reimburse expenses incurred in a subsequent plan year (after July 1).

Note: During Open Enrollment, you must actively elect to discontinue your participation for the new plan year. If you do not, your election will automatically continue for the same amount during the new plan year.

Special Situations Affecting Your Pre-Tax Expense Accounts

If You Take a Leave of Absence

The following paragraphs set forth the general rules regarding how typical paid and unpaid leaves of absence affect your benefits. To learn how these rules apply in special circumstances (such as receipt of worker's compensation or sabbaticals), you should go to the University's website at <http://www.hr.upenn.edu/> and refer to the policy manual.

Unpaid Leave of Absence

If you take an unpaid leave of absence during the plan year for any reason, your contributions to your Pre-Tax Expense Accounts are suspended during your leave. You may continue to submit requests for reimbursement while on leave for eligible expenses incurred during the plan year, up to the balance in your account as of your last paycheck. Or, you are eligible to submit requests for eligible expenses incurred prior to your leave, subject to specific Pre-Tax Expense Account rules on reimbursement. If the plan year ends while you are on leave, you can re-enroll in an Expense Account upon your return to active status.

To recommence participation following the leave, you must re-enroll within 30 days of the date on which you return to active status. You can restart your contributions at the prior contribution level so that your contribution for the year will be less than you originally elected or you can restart contributions at an increased level so that your contributions for the year will equal the amount that you originally elected. You may also make any other appropriate election to change your contributions on account of a qualifying change in status. (See "Changing Your Benefits During the Year" in Section 1: Introduction To Your Benefits.)

Note: Under COBRA, you are eligible to continue making contributions to your Health Care Pre-Tax Expense Account. If you elect to continue to make contributions, you may be reimbursed for eligible expenses incurred during the plan year just as if you were in active employment status.

Paid Leave of Absence

If you take a paid leave of absence during the plan year for any reason, your contributions to your Pre-Tax Expense Accounts will continue as if you were actively employed, unless you make an appropriate election to change your contributions during the open enrollment period for an upcoming plan year or you make an appropriate election to change your contributions on account of a qualifying change in status. (See "Changing Your Benefits During the Year" in Section 1: Introduction To Your Benefits.)

Note: If you are on Family and Medical Leave, your leave may be paid, unpaid or a combination of paid and unpaid depending on your accumulated time-off balances. (Refer to the University's Family and Medical Leave Policy.)

If You Become Disabled

Please see "Other Benefits During Disability" in Section 6: Long-Term Disability.

In the Event of Your Death

In the event of your death, your beneficiaries may continue to request reimbursement for expenses that would have been eligible had you lived through the end of the plan year, not to exceed the balance in your account. The full amount you designated to contribute would be available for expenses incurred prior to death. Your beneficiaries may submit requests for reimbursement through the end of the three-month grace period.

Where You Can Learn More

ADP administers the Flexible Spending Accounts. For more information on Flexible Spending Accounts, contact ADP at 888-PENNBEN (888-736-6236). If you have a Flexible Spending Account, submit claims for reimbursement to the following address:

ADP FSA Services
P.O. Box 1853
Alpharetta, GA 30023-1853
888-PENNBEN (888-736-6236)

SECTION 5

Long-Term Care

Introduction to Long-Term Care

According to the U.S. Department of Health and Human Services, one out of every four Americans who lives to retire will some day enter a nursing home. This statistic is compelling because this type of care can cost thousands of dollars each year and neither Medicare nor most employer-provided medical plans cover these expenses. That is why Long-Term Care Insurance can be valuable to your future financial planning. However, whether it makes sense for you to purchase Long-Term Care Insurance at this stage in your life depends on a variety of factors. You should consult with a professional financial advisor before purchasing coverage.

Eligibility and Enrollment

Full-time and part-time benefits-eligible faculty, regular full-time and part-time staff, and limited service staff are eligible for Long-Term Care Insurance. You may also enroll the following family members, whether or not you choose coverage for yourself:

- your spouse or same-sex domestic partner
- your parents and/or parents-in-law
- your grandparents and/or grandparents-in-law
- your same-sex domestic partner's parents or grandparents.

If you enroll, your coverage begins on the first day of the month following your enrollment. If you enroll an eligible family member – or if you are a retiree – you must provide satisfactory evidence of insurability to the insurance company before coverage can become effective.

Long-Term Care Insurance is fully administered by CNA Insurance. CNA must receive your application within 30 days of your eligibility date. Otherwise, you can enroll during subsequent annual open enrollment periods. Please note that if you do not enroll within your initial eligibility period, you must provide Evidence of Insurability to CNA.

Cost

You pay the full cost of Long-Term Care Insurance. Rates are based on the option elected and the age of the covered individual when coverage begins. You can obtain current rates from CNA Insurance Company by calling 1-800-528-4582.

Your Long-Term Care Options

Each Long-Term Care option offered through Penn provides coverage for the same services and supplies.

The options vary in the maximum daily benefits they pay – \$125, \$150 or \$175 a day. In addition, one of the options includes a non-forfeiture of benefits provision. This feature assures a reduced level of benefits – even if you stop paying premiums. The options may also include inflation protection, which automatically increases benefits.

Covered Long-Term Care Services

The Long-Term Care Plan offers benefit coverage in a range of settings. These include:

- nursing home care

- home health care
- adult day care
- care in an assisted living facility
- community based care

An Overview of Long-Term Care Benefits

Here is an overview of the benefits Long-Term Care Insurance provides:

When Benefits Begin	When a covered individual can no longer perform two or more of the following activities of daily living: <ul style="list-style-type: none"> • bathing • dressing • toileting • transferring • continence • eating due to a loss of functional capacity or severe cognitive impairment.
Benefit Options	Daily maximum benefit options of \$125, \$150 and \$175.
Benefit Waiting Period	90 days.
Inflation Protection	Opportunity to purchase additional amounts of coverage available every three to five years.
Non-Forfeiture Protection	At the end of three years of coverage, you may cease to make contributions and retain a reduced Lifetime Maximum Benefit.
Waiver of Premium	Premium payments are waived after 90 days of benefits while a covered individual continues to receive benefits.
Lifetime Maximum	Lifetime maximum benefit for nursing home care equal to the annualized daily maximum benefit times five.
Institutional Care	Skilled nursing home, intermediate care or custodial facility, assisted living facility and hospice care are paid at 100% up to the daily maximum.
Community Based Care	Home health care, adult day care, adult foster care, home hospice care are paid at 50% of the daily maximum.
Informal Care	Paid at 25% of the daily maximum for up to 30 days in a calendar year.
Caregiver/Respite	Paid at 100% of the daily maximum benefit for up to 21 days in a calendar year.

Bed Reservation Benefit	Up to 21 days.
Alternate Plan of Care	Under an Alternate Plan, payment may be made for caregiver services and/or modifications to the home.

Claiming Benefits

All claims should be submitted to the insurance company.

Maximum Lifetime Benefits

Lifetime maximum benefit is equal to a factor of 1825 (365 days per year times 5 years) times the daily maximum benefit selected, or at least five years of benefits. The lifetime benefit will exceed 5 years if lesser amounts of benefits are paid daily.

Tax Status

Your contributions for Long-Term Care Insurance are made with after-tax contributions. That is, they are deducted from your pay after federal income tax, FICA (Social Security) tax and Medicare Insurance tax are withheld.

If Your Employment Terminates

This coverage is portable, which means that if you should leave your employment at Penn, you can continue coverage by making premium payments directly to the insurance company.

Termination of Coverage

Long-Term Care Plan coverage stops on the date you stop making any required contributions or the date after you exceed your maximum benefit.

Where You Can Learn More

Long-Term Care Insurance is insured and administered through CNA Insurance. For more information about Long-Term Care Insurance contact CNA Insurance at 800-528-4582.

Claims can be submitted to:

CNA Insurance
Group Long-Term Care Insurance
P.O. Box 593925
Orlando, FL 32859-9987
1-800-528-4582

SECTION 6

Long-Term Disability

Introduction to Your Long-Term Disability (LTD) Benefits

Long-Term Disability (LTD) benefits can become payable if you are disabled as described below due to an illness or injury and are unable to continue working.

Eligibility

You are eligible for LTD coverage on your date of hire if you are a full-time faculty or staff member of the University.

Cost

The University pays the full cost of LTD benefits. Therefore, any LTD benefits you receive from the Plan will be subject to applicable federal, state and local taxes.

Enrollment

There is nothing you need to do to enroll for LTD coverage. Your coverage begins automatically.

Plan Benefits

LTD benefits are payable after:

- Aetna (which is the Claims Administrator for purposes of LTD benefits) determines that you have incurred a qualifying disability

and

- the six-month “elimination period” has passed from the date you first became disabled.

The term “disability” or “disabled” means, for conditions occurring or reoccurring on or after July 1, 2005:

First 24 Months. For the first 24-month period following completion of the six-month elimination period, “disability” or “disabled” means your inability to perform the material duties of your own occupation, solely because of disease or injury, as determined by Aetna. This includes situations where you may be able to work but are unable to earn more than 80% of your pre-disability earnings performing the material duties of your own occupation, solely because of disease or injury.

After 24 Months. For periods after the completion of the 24-month period described above, “disability” or “disabled” means your inability to engage in any reasonable occupation appropriate to you by reason of education, training and experience, solely because of a disease or injury as determined by Aetna. This includes situations where you may be able to work but are unable to earn more than 80% of your pre-disability earnings performing the material duties of any occupation appropriate to you by reason of education, training and experience. For purposes of applying this requirement, determinations of whether an occupation is reasonable and appropriate for you, by reason of your education, training and experience, shall be made by Aetna (and, where necessary, Aetna’s vocational experts) in accordance with Aetna’s non-discriminatory policies and procedures.

The LTD benefits provided under the Plan – in combination with income from other sources – pays 60% of your “benefits base” at the onset of disability, up to a maximum benefit of \$7,500 per month. For this purpose, your “benefits base” is your monthly base salary and excludes all extra compensation,

such as bonuses, overtime, incentive compensation, summer teaching or research salaries, amounts earned for teaching responsibilities for executive education courses at The Wharton School, and evening school or College of General Studies salaries, but includes any additional salary paid to a faculty member for performing services as an administrator so long as the administrative appointment is for a period of not less than 12 months. **Note: “Benefits base” does not include pay received for services performed for CPUP.**

If you receive “income from other sources”, your LTD benefits will be reduced by those amounts. If you receive a lump sum from these sources, this lump sum amount will be deductible from your future LTD benefits. Further, if you are eligible for, but fail to apply for benefits or waive participation under Social Security, Railroad Retirement, Workers' Compensation programs or the Occupational Diseases Act, your LTD benefits will be reduced by the amount of what would normally be awarded under such programs.

“Income from other sources” includes disability or retirement benefits paid by Social Security (including dependents’ benefits), Workers' Compensation, other government plans, unemployment, monthly disability payments from a pension plan, or any settlement or damage award received from the University that is attributable to earnings related to the disability. It also includes 50% of income from part-time or rehabilitative employment and income from any other employer.

“Income from other sources” does not include:

- cost of living increases from any income from other sources which become effective while you are disabled and eligible to receive payments (this exception does not apply to any increases in earnings if you work while disabled)
- amounts you receive:
 - for reimbursement of hospital, medical or surgical expenses
 - which represent reasonable attorney's fees incurred in connection with the claim for income from other sources
 - from a tax deferred annuity plan (TDA), non-qualified deferred compensation plan, individual retirement account (IRA), keogh (HR-10) plan, or a retirement plan under a professional service corporation with respect to principals or shareholders
 - benefits from any individual disability insurance policy.

Duration of LTD Benefits

LTD benefits begin **after** six months of continuous disability. These first six months are considered to be an "elimination period." To qualify for LTD benefits, you must be under the regular care of a physician and provide satisfactory evidence of continuing disability.

LTD benefits end upon one of the following events:

- You stop being disabled, as determined by Aetna. This includes situations where you are disabled because you meet the “own occupation” definition of disability for the first 24 months, but stop being disabled because you do not meet the “any occupation” definition of disability after the first 24 months.

- You reach a particular age. If the disability occurs on or before your 60th birthday, LTD benefits continue for the period of your disability, but not beyond the end of the month in which you reach age 65. If the disability occurs after your 60th birthday, LTD benefits continue until the earlier of the date your disability ends, or a total of 60 monthly LTD payments have been made.
- Your death.
- You fail to furnish proof, as required by Aetna, of your continued disability.

Recurrence of a Disability

LTD benefits will be restored if you return to active employment following a period of disability absence if you suffer a recurrence of the disability, as determined by Aetna, within 90 days after returning to active employment.

Return to Work Benefits

LTD benefits are designed to encourage you to return to work during your disability. If you work on a part-time basis or in rehabilitative employment, only 50% of the income you earn will be used to reduce your LTD benefits.

Exclusions

There is no LTD coverage for disabilities caused or contributed to by:

- service in the Armed Forces or Merchant Marine of the United States or any other country
- warfare
- willful participation in any criminal act
- intentionally self-inflicted or self-incurred injury not resulting from other medical or mental conditions; or
- use of drugs or narcotics or any other chemical substance or compound contrary to law.

In addition, LTD benefits will not be paid during the six-month elimination period, after the end of the maximum benefit period based on age, or if you are not under the regular care of a physician.

Other Benefits During Disability

While you are receiving LTD benefits, certain other Plan benefits may be continued (provided that you otherwise satisfy the conditions and requirements for receiving such benefits):

Medical Benefits	Medical coverage continues while you are receiving LTD benefits. You and the University share the cost. The University currently pays up to the HMO premium. If the option you have elected costs more than the HMO premium, you pay the difference. Employees approved prior to July 1, 1998, do not pay any premium for their medical benefits.
Dental Benefits	Dental coverage continues while you are receiving LTD benefits.

	The University currently pays the full cost.
Vision Benefits	Vision coverage continues while you are receiving LTD benefits. You pay the full cost.
Life Insurance	Basic Life Insurance continues while you are receiving LTD benefits. . If you were also enrolled in supplemental life insurance, you may continue this benefit at the same age-based rates in effect prior to your disability.
Accidental Death and Dismemberment Insurance	Coverage stops.
Dependent Life Insurance	Coverage stops. You have the option to convert to an individual policy.
Health Care Pre-Tax Expense Account	Your contributions end with your final paycheck from the University, as an active employee. You may continue to submit requests for reimbursement while disabled through the end of the grace period. Your requests must be for eligible expenses incurred and paid for during your active employment, not to exceed your account election. You can elect to continue coverage through COBRA until the end of the plan year. (See "Your Right to Continue Coverage – COBRA" under Section 2: Health Care Benefits.)
Dependent Care Pre-Tax Expense Account	Your contributions end with your final paycheck from the University, as an active employee. You may continue to submit requests for reimbursement while disabled through the end of the grace period. You may be reimbursed for expenses incurred up to the time you terminated, up to the balance in your account at the time you stopped participating.
Long-Term Care Insurance	Coverage continues if you continue to pay the required premiums directly to the insurance company.
Tax Deferred Retirement Plan	Certain "basic" University contributions will continue under the University's Tax Deferred Retirement Plan ("TDR Plan") during a period of disability regardless of whether you are contributing to the TDR Plan. Other "matching" University contributions may continue if you continue to contribute to the TDR Plan during a period of disability.
Educational Benefits	Benefits currently continue as they were in effect at the time you became disabled.

IMPORTANT: Please note that these benefits are neither permanent nor guaranteed. The University may make changes to these benefits (for example, eliminating certain benefits entirely

or changing the cost-sharing amounts to increase the amounts paid by disabled employees) at any time and for any reason.

Claiming Benefits

You or a family member should contact Aetna at 800-488-2386 to report your disability and begin your application process. Aetna generally will not start the claims process until you have been absent from work for three months. LTD benefits cannot begin until the forms and necessary proof of disability have been submitted to and approved by Aetna. Claims for LTD benefits must be submitted no later than 120 days after the end of the six-month elimination period. Otherwise, no LTD benefits will be paid.

To apply for LTD benefits, you will need to submit any and all documentation showing that:

- you became disabled while covered under the Plan from a condition which the Plan does not exclude;
- you are and have been under the regular care of a physician; and
- you satisfy the definition of disability as described above.

You will also be asked to submit documentation for the following:

- authorization to obtain information;
- any other sources of income you are or may become entitled to receive;
- authorization to obtain Social Security award or denial information; and
- work history and education questionnaire.

When you file a claim you will agree to permit Aetna to consult with your physician and to review any related medical records. Aetna may also require that a physician of its choice, at its own expense, examine you.

Involuntary Applications for Standing Faculty

An application for LTD benefits may be forwarded to Aetna by a dean or director who believes that a member of the Standing Faculty may be eligible to receive LTD benefits even though the individual has chosen, after counseling, not to apply for LTD benefits.

Termination of Coverage

LTD coverage stops on the date:

- you are no longer eligible as described above;
- you are no longer actively at work at the University for any reason; or
- you terminate your employment with the University for any reason.

LTD coverage cannot be continued or converted to individual coverage.

Where You Can Learn More

LTD benefits are self-funded, but administered by Aetna. You can contact Aetna to learn more about your LTD benefits at:

Aetna Disability Service Center
P.O. Box 14553
Lexington, KY 40512
1-800-488-2386

SECTION 7

Administrative Information

Introduction to Administrative Information

This information applies to the PennChoice Medical, Dental, Vision, Group Life and AD&D Insurance, Long-Term Disability and the Pre-Tax Expense Accounts. In particular, it describes your rights as a plan participant, the procedure to appeal a claim denial, and administrative information to assist you with questions, complaints or problems concerning a University benefit plan.

If you have any questions concerning your benefits, you can call or write:

The Penn Benefits Center
P.O. Box 26745
Salt Lake City, UT 84126-0745
1-888-PENNBEN
1-888-736-6236

Plan Sponsor and Administrator

The University sponsors The University of Pennsylvania Health and Welfare Program.

The Plan Administrator for The University of Pennsylvania Health and Welfare Program is:

Dr. John J. Heuer
Vice President for Human Resources
The University of Pennsylvania
3401 Walnut Street, Suite 538A
Philadelphia, PA 19104-6228
(215) 898-6884

The University sponsors and administers each of the Plans described in this booklet except to the extent that it has entered into a contract with an insurer or other organization to provide benefits. In that case the insurer or other organization assists the University in certain areas of plan administration, such as processing claims for benefits and paying plan benefits.

If you have any questions about your benefits, contact the Penn Benefits Center first. If the Penn Benefits Center cannot immediately answer your question, someone will get back to you with the answer or the name of the person, department or agency that can provide you with the information you need.

Plan Identification

When dealing with or referring to the benefit plans for claims appeals or other correspondence, you will receive help more quickly if you identify them fully and accurately.

To identify a plan correspondence with the federal government, you need to use the University's Employer Identification Number (EIN), which is assigned by the Internal Revenue Service. Penn's EIN is 23-1352685. You also need to know the Plan's official name and number, which is The University of Pennsylvania Health and Welfare Program, plan identification number is 503.

Plan Year

The records for each plan are maintained on a twelve-month basis. The plan year is the same as the University's fiscal year: it begins on July 1 and ends on June 30.

Agent for Service of Legal Process

The agent on whom legal process for a lawsuit should be served is:

Dr. John J. Heuer
Vice President for Human Resources
The University of Pennsylvania
3401 Walnut Street, Suite 538A
Philadelphia, PA 19104-6228
(215) 898-6884

Not a Contract of Employment

No provisions of any of your benefit plans are considered a contract of employment between you and the University, nor does your participation in any plan provide any guarantee of continued employment. The University's rights with regard to disciplinary action and termination of any employee, if necessary, are in no manner changed by any provision of any plan.

Plan Continuation

The University (acting through the Vice President of Human Resources) reserves the right to amend, suspend, change or terminate the Plan (or any portion of the Plan) at any time and for any reasons. This means that any benefit provided through the Plan or any portion of the Plan may be discontinued in its entirety, modified to provide higher or lower levels of covered benefits, modified to provide higher or lower levels of cost to the University or covered employees. If the Plan (or any portion of the Plan) is terminated or amended in a material fashion, you will be promptly notified if you are affected by the termination or amendment. In no event will any termination of the Plan (or any portion of the Plan) or any amendment to the Plan adversely affect the payment of benefits to which you already were entitled under the terms of the Plan immediately prior to the amendment or termination.

Plan Funding

Benefits under certain Plans described in this booklet are paid or provided by the University from the University's general assets; benefits under other Plans are insured and provided under insurance contracts or HMO agreements. See Section 9: Carrier Directory, for more information.

Your Rights as a Plan Participant

As a participant in The University of Pennsylvania Health and Welfare Program, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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 employee benefit 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 materials from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a Federal court. If it should happen that the Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and

legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator through the Penn Benefits Center. 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 Ave NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Authority of Plan Administrator

In general, the Plan Administrator is the sole judge of the application and interpretation of the Program, and has the discretionary authority to construe the provisions of the Program, to resolve disputed issues of fact, and to make determinations regarding eligibility for benefits. However, the Plan Administrator has the authority to delegate certain of its powers and duties to a third party. The Plan Administrator has delegated certain administrative functions under the Program to various service providers. As the Plan Administrator's delegate, these service providers have the authority to make decisions under the Program relating to benefit claims, including determinations as to the medical necessity of any service or supply.

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

Decisions on Medical Care

Medical benefits provide solely for the payment of certain health care expenses. All decisions regarding health care are the sole responsibility of each covered individual in consultation with the health care providers selected by the individual. The Plan contains rules for determining the percentage of allowable health care expenses that will be reimbursed and whether particular treatments or health care expenses are eligible for reimbursement. The covered individual in accordance with the Plan's claims procedure may dispute any decision with respect to the level of health care reimbursement, or the coverage of a particular health care expense. Each covered individual may use any source of care for health treatment and health coverage as selected by such individual, and neither the Plan nor the University shall have any obligation for the cost or legal liability for the outcome of such care, or as a result of a decision by a covered individual not to seek or obtain such care, other than liability under the Program for the payment of benefits.

Qualified Medical Child Support Order ("QMCSO")

A QMCSO is a court order giving a child who otherwise might not be eligible for coverage under the Plan, a right to such coverage. Normally, the court in connection with a divorce or separation, issues such an order. Before the Plan Administrator complies with a QMCSO, it must determine that the court order meets the requirements of applicable law pertaining to QMCSOs. You will be notified, if the Plan Administrator receives a court order relating to you and of the procedure used by the Plan Administrator

to determine whether the order is a QMCSO. Participants and beneficiaries may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Privacy of Health Information

Effective April 14, 2003, the receipt, use and disclosure of protected health information is governed by regulations issued under the Health Insurance Portability and Accountability Act (commonly referred to as "HIPAA"). In accordance with these regulations, the Plan Administrator, certain employees working with, and on behalf of, the Plan and the Plan's business associates may receive, use and disclose protected health information in order to carry out the payment, treatment and health care operations under of the Plan. These entities and individuals may use protected health information for such purposes without your authorization. If your protected health information is used or disclosed for any other purpose (other than as specifically required or authorized under HIPAA), the Plan must first obtain your written authorization for such use or disclosure.

Third Party Recovery/Subrogation

If your injury or illness was caused by the action or inaction of another person or party, that person or party may be responsible for your hospital or medical bills. Automobile accident injuries or personal injury suffered on another's property are examples.

Since collecting payments for these expenses from the third party may take a long time, the Program will provide the appropriate benefits and then seek repayment from any settlement you may receive. You (and your authorized representative or attorney) may be asked to sign a form which acknowledges the Program's right to be reimbursed and verifies that you will help the Program secure its rights to reimbursement or recovery. If you bring a liability claim against a third party, benefits payable under the Program must be included in the claim. When the claim is resolved, you must reimburse the Program for the cost of the benefits provided. The Program will have first priority in any recovery regardless of the manner in which the recovery is structured or worded and regardless of whether you have been "made whole" by the settlement. The Program's reimbursement will not be reduced by attorney's fees, unless agreed to by the Program. Any so-called "fund doctrine" or "common fund doctrine" or "attorney's fund doctrine" shall not defeat the right of the Program to recover under this section without paying attorney's fees or costs. Further, the Program will not recognize any attempt to apply the "collateral source" rule or the "common fund" rule as legal theories intended to prevent or limit the Program's recovery from any payment you may receive from a third party.

You are legally obligated to avoid doing anything that would prejudice the Program's rights of reimbursement. However, the Program shall be entitled to recover in accordance with these rules, even if you do not sign or return its forms. Your failure to cooperate may result in your disqualification from receipt of further benefits from the Program. In addition, the Program may offset any future benefits otherwise payable.

This provision does not apply to an individual insurance policy covering you or your dependents for which you or your dependent paid the premium.

Recoupment

The Program has the right to recover any mistaken payment, overpayment or any payment that is made to any individual who was not eligible for that payment. The Program, or its designee, may withhold or offset future benefit payments, sue to recover such amounts, or may use any other lawful remedy to recoup any such amounts.

Benefit Payments to Third Parties

The Plan Administrator may elect to pay benefits directly to a health care provider unless the payment has already been made by the covered person. Where the health care provider rendering services does not have an agreement with the Plan to the contrary, the Plan Administrator may, at its election, pay benefits directly to the covered person. In the event the covered individual is deceased, benefits may be paid at the Plan Administrator's option to the covered person's estate, spouse, the participant through whom the individual is covered, or the covered person's closest relative as determined by the Plan Administrator.

No Assignment of Benefits

You cannot assign, pledge, encumber or otherwise alienate any legal or beneficial interest in benefits under the Plan, and any attempt to do so will be void. The payment of benefits directly to a health care provider, if any, shall be done as a convenience to the covered person and shall not constitute an assignment of benefits under the Plan.

Claims Information

This section gives you information about filing claims and what to do if a claim is denied. To receive benefits from many of the Plans, you must file a claim. The following provides information on filing claims in each of the Plans. For addresses and phone numbers please refer to Section 9: Carrier Directory. In most cases addresses are also listed on the claim form.

A request for benefits is a "claim" subject to these procedures only if it is filed by you or your authorized representative in accordance with the Plan's claim filing guidelines. In general, claims must be filed in writing (except urgent care claims, which may be made orally) with the applicable provider identified in the Carrier Directory. Any claim that does not relate to a specific benefit under the Plan (for example, a general eligibility claim or a dispute involving a mid-year election change) must be filed with the Plan Administrator at the address set forth under "Plan Sponsor and Administrator" above. A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" under these rules, unless it is determined that your inquiry is an attempt to file a claim. If a claim is received, but there is not enough information to process the claim, you will be given an opportunity to provide the missing information.

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

Medical Plans

- ***PENNCare/Personal Choice***

When you use Preferred Providers you do not file any claims. When you use Non-Preferred Blue Cross and Blue Shield Providers, the provider is responsible for filing your claim with Blue Cross/Blue Shield. When you use nonparticipating providers, you must file a claim form with Blue Cross/Blue Shield.

- ***UPHS Point of Service and AmeriHealth Point of Service***

When you receive Referred Care, you do not have to file a claim. When you receive Self-Referred Care, you must file a Point of Service claim form with Keystone Health Systems, Inc. or AmeriHealth (as applicable). You may obtain a claim form from the University's Benefits Office, or by visiting the Human Resources website at www.hr.upenn.edu. Complete the form according to the instructions printed on the form and mail it and any documentation noted on the form to the address on the form.

- ***Aetna HMO, Keystone Health Plan East HMO and AmeriHealth HMO.***

You do not have to file claims when you participate in an HMO. If you receive emergency care outside of the HMO network, you may be required to provide a written explanation regarding the nature of the emergency to the HMO carrier.

Note: Aetna provides limited reimbursement after a \$1,000 deductible in some cases for non-referred care and care provided outside of the network. You can file a claim for reimbursement by obtaining a claim form from Aetna.

- ***Mental Health and Substance Abuse Benefits***

Please follow the claims procedures set forth in the Benefits Explanation provided to you by Penn Behavioral Health.

Dental Plans

- ***Penn Faculty Practice Plan (PFPP)***

You do not have to file any claims.

- ***MetLife Preferred Dentist Program (MetLife PDP)***

Your dentist will complete the MetLife PDP Claim form and mail it to MetLife. You may obtain a claim form from the University's Benefits Office or from MetLife directly at 1-800-942-0854, and they will fax or mail them to you. Or claim forms may be obtained from their Web site: www.metlife.com/dental. You should take this form with you when you visit your dentist.

Vision Plan through OptiChoice/Clarity Vision

- When you use OptiChoice preferred providers, you do not have to file any claims. When you use non-preferred providers, you must file a claim form. You may obtain a claim form from the Penn Benefits Center, or by visiting the Human Resources website at www.hr.upenn.edu. Complete the form according to the instructions on the form and mail it with any documentation noted to the address on the form.

Prescription Drug Coverage through Caremark Health Systems, Inc.

- When you use participating pharmacies and show your Caremark card or purchase your prescriptions through the mail, you do not have to file any claims. When you use non-participating pharmacies or a participating pharmacy and do not show your Caremark card, you must file a claim form. You may obtain a claim form from the Penn Benefits Center, or Caremark directly. Complete the form according to the instructions on the form and mail it with any documentation noted to the address on the form. (Union members must see Shop Steward regarding their Prescription Plan.)

Group Life Insurance

- ***Basic, Supplemental, and Optional Life:*** Upon your death, your beneficiary should contact the Penn Benefits Center at 1-888-PENNBEN (1-888-736-6236) and press Option #2. This will transfer your beneficiary directly to an Aetna Customer Service Representative who will provide instructions on filing a death claim.
- ***Dependent Life:*** Upon your dependent's death, you should contact the Penn Benefits Center at 1-888-PENNBEN (1-888-736-6236) and press Option #2. This will transfer you directly to an Aetna Customer Service Representative who will provide instructions on filing a death claim.
- ***Accidental Death and Dismemberment:*** In the event of an accidental death or dismemberment, you or your beneficiary should contact the Penn Benefits Center at 1-888-PENNBEN (1-888-736-6236) and press Option #2. This will transfer you or your beneficiary directly to an Aetna Customer Service Representative who will provide instructions on filing a claim.

Pre-Tax Expense Accounts

- ***Health Care:*** Complete and sign a Health Care Pre-Tax Expense Account Request for Reimbursement form and return it to ADP with your explanation of benefits (EOB), proof of payment and any other information specified on the form.
- ***Dependent Care:*** Complete, sign and return a Dependent Care Pre-Tax Expense Account Reimbursement Form to ADP with your original itemized bill, your proof of payment and any other information specified on the form.

Long-Term Care

- To file a claim, the individual must contact CNA Insurance Company at 1-800-528-4582.

Long-Term Disability

- Once Aetna is notified of the request for Long-Term Disability (LTD) benefits, Aetna forwards claim processing information to the individual.

- The application process for LTD benefits should begin after an eligible individual who is expected to remain disabled for at least 12 months has been off from work for 3 months. Aetna generally will make a decision on a completed application within 60 days before the end of the elimination period. (The elimination period begins when the eligible individual first become disabled and ends after 6 months of disability.)
- Claims for LTD benefits must be submitted but no later than 120 days after the end of the 6-month elimination period. Otherwise, no benefits will be paid.

General Claim Provisions

For purposes of description of claim denials below, the entity with the authority to review and evaluate initial claim for benefits (such as an insurance company) shall be referred to below as the "Claims Administrator." The entity with the authority to make determinations relative to appeals of denied claims shall be referred to below as the "Appeals Administrator."

If Your Claim for Non-Health Benefits is Denied (Group Life Insurance, Long Term Disability, Dependent Care Pre-Tax Expense Account and Long Term Care)

Time Periods for Responding to Initial Claims

If you bring a claim for benefits under any of the Plans, the Claims Administrator will respond to you within 90 days (45 days for a claim involving disability benefits) after receipt of the claim. For claims other than claims involving disability benefits, if the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 90-day period that the Claims Administrator needs up to an additional 90 days to review your claim. In the case of a claim involving disability benefits, the Claims Administrator will notify you within the initial 45-day period that the Claims Administrator needs up to an additional 30 days to review your claim. If the Claims Administrator determines that additional time is necessary to review your claim for disability benefits, the Claims Administrator may notify you of an additional 30-day extension.

Notice and Information Contained in Notice Denying Initial Claim

If the Claims Administrator denies your claim (in whole or in part), the Claims Administrator will provide you with written notice of the denial. This notice will include the following:

- Reason for the Denial - the specific reason or reasons for the denial;
- Reference to Plan Provisions - reference to the specific Plan provisions on which the denial is based;
- Description of Additional Material - a description of any additional material or information necessary for you to perfect your claim and an explanation as to why such information is necessary;
- Description of Any Internal Rules - in the case of any claim involving disability benefits, a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the determination and that a copy of such rule will be provided to you free of charge at your request; and

- Description of Claims Appeals Procedures - a description of the Plan's appeals procedures and the time limits applicable for such procedures (such description will include a statement that you are eligible to bring a civil action in Federal court under Section 502 of ERISA to appeal any adverse decision on appeal).

Appealing a Denied Claim for Benefits

If your initial claim for benefits is denied by the Claims Administrator, you may appeal the denial by filing a written request with the Appeals Administrator within 60 days (180 days in the case of a claim involving disability benefits) after you receive the notice denying your initial claim for benefits. If you decide to appeal a denied claim for benefits, you will be able to submit written comments, documents, records, and other information relating to your claim for benefits (regardless of whether such information was considered in your initial claim for benefits) to the Appeals Administrator for review and consideration. You will also be entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to your appeal.

Time Periods for Responding to Appealed Claims

If you appeal a denied claim for benefits, the Appeals Administrator will respond to you within 60 days (45 days in the case of a claim involving disability benefits) after receipt of the claim. If the Appeals Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Appeals Administrator will notify you within the initial 60-day period (45 days in the case of a claim involving disability benefits) that the Appeals Administrator needs up to an additional 60 days (45 days in the case of a claim involving disability benefits) to review your claim.

Notice and Information Contained in Notice Denying Appeal

If the Appeals Administrator denies your claim (in whole or in part), the Appeals Administrator will provide you with written notice of the denial. This notice will include the following:

- Reason for the Denial - the specific reason or reasons for the denial;
- Reference to Plan Provisions - reference to the specific Plan provisions on which the denial is based;
- Statement of Entitlement to Documents - a statement that you are entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to your claim and/or appeal for benefits;
- Description of Any Internal Rules - in the case of a claim involving disability benefits, a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the appeal determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to you free of charge at your request; and
- Statement of Right to Bring Action - a statement that you are entitled to bring a civil action in Federal court under Section 502 of ERISA to pursue your claim for benefits.

The decision of the Appeals Administrator shall be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law. If you challenge the decision of the Appeals Administrator, a review by a court of law will be limited to the facts, evidence and issues presented during the claims

procedure set forth above. The appeal process described herein must be exhausted before you can pursue the claim in federal court. Facts and evidence that become known to you after having exhausted the appeals procedure may be submitted for reconsideration of the appeal in accordance with the time limits established above. Issues not raised during the appeal will be deemed waived.

If Your Claim for Health Benefits is Denied (Medical, Dental, Vision, Prescription and Health Care Pre-Tax Expense Account)

Types of Health Claims

There are several different types of claims that you may bring under the Plan. The Plan's procedures for evaluating claims (for example, the time limits for responding to claims and appeals) depends upon the particular type of claim. The types of claims that you generally may bring under the Plan are as follows:

- **Pre-Service Claim** - A "pre-service claim" is a claim for a particular benefit under the Plan that is conditioned upon you receiving prior approval in advance of receiving the benefit. A pre-service claim must contain, at a minimum, the name of the individual for whom benefits are being claimed, a specific medical condition or symptom, and a specific treatment, service or product for which approval is being requested.
- **Post-Service Claim** - A "post-service claim" is a claim for payment for a particular benefit or for a particular service after the benefit or service has been provided. A post-service claim must contain the information requested on a claim form provided by the applicable provider.

Note: Claims for dental, vision, prescription and health care pre-tax expense account benefits will always be "post-service claims" under these rules.

- **Urgent Care Claim** - An "urgent care claim" is a claim for benefits or services involving a sudden and urgent need for such benefits or services. A claim will be considered to involve urgent care if the Claims Administrator or a physician with knowledge of your condition determines that the application of the claims review procedures for non-urgent claims (i) could seriously jeopardize your life or your health, or your ability to regain maximum function, or (ii) in your physician's opinion, would subject you to severe pain that cannot adequately be managed without the care or treatment that is the subject of the claim.
- **Concurrent Care Review Claim** - A "concurrent care review claim" is a claim relating to the continuation/reduction of an ongoing course of treatment.

Time Periods for Responding to Initial Claims

If you bring a claim for benefits under one of the Plans, the Claims Administrator will respond to your claim within the following time periods:

- **Pre-Service Claim** - In the case of a pre-service claim, the Claims Administrator shall respond to you within 15 days after receipt of the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 15-day period that the Claims Administrator needs up to an additional 15 days to review your claim. If such an extension is because you failed to provide the information necessary to evaluate your claim, the notice of extension will describe the information that you need to provide

to the Claims Administrator. You will have no less than 45 days from the date you receive the notice to provide the requested information.

- **Post-Service Claim** - In the case of a post-service claim, the Claims Administrator shall respond to you within 30 days after receipt of the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 30-day period that the Claims Administrator needs up to an additional 15 days to review your claim. If such an extension is necessary because you failed to provide the information necessary to evaluate your claim, the notice of extension will describe the information that you need to provide to the Claims Administrator. You will have no less than 45 days from the date you receive the notice to provide the requested information.
- **Urgent Care Claim** - In the case of an urgent care claim, the Claims Administrator shall respond to you within 72 hours after receipt of the claim. If the Claims Administrator determines that it needs additional information to review your claim, the Claims Administrator will notify you within 24 hours after receipt of the claim and provide you with a description of the additional information that it needs to evaluate your claim. You will have no less than 48 hours from the time you receive this notice to provide the requested information. Once you provide the requested information, the Claims Administrator will evaluate your claim within 48 hours after the earlier of the Claims Administrator's receipt of the requested information, or the end of the extension period given to you to provide the requested information. There is a special time period for responding to a request to extend an ongoing course of treatment if the request is an urgent care claim. For these types of claims, the Claims Administrator must respond to you within 24 hours after receipt of the claim by the Plan (provided, that you make the claim at least 24 hours prior to the expiration of the ongoing course of treatment).
- **Concurrent Care Review Claim** - If the Plan has already approved an ongoing course of treatment for you and contemplates reducing or terminating the treatment, the Claims Administrator will notify you sufficiently in advance of the reduction or termination of treatment to allow you to appeal the Claims Administrator's decision and obtain a determination on review before the treatment is reduced or terminated.

Notice and Information Contained in Notice Denying Initial Claim

If the Claims Administrator denies your claim (in whole or in part), the Claims Administrator will provide you with written notice of the denial (although initial notice of a denied urgent care claim may be provided to you orally). This notice will include the following:

- **Reason for the Denial** - the specific reason or reasons for the denial;
- **Reference to Plan Provisions** - reference to the specific Plan provisions on which the denial is based;
- **Description of Additional Material** - a description of any additional material or information necessary for you to perfect your claim and an explanation as to why such information is necessary;
- **Description of Any Internal Rules** - a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to you free of charge at your request; and

- Description of Claims Appeals Procedures - a description of the Plan's appeals procedures and the time limits applicable for such procedures (such description will include a statement that you are eligible to bring a civil action in Federal court under Section 502 of ERISA to appeal any adverse decision on appeal and a description of any expedited review process for urgent care claims).

Appealing a Denied Claim for Benefits

If your initial claim for benefits is denied by the Claims Administrator, you may appeal the denial by filing a written request (or an oral request in the case of an urgent care claim) with the Appeals Administrator within 180 days after you receive the notice denying your initial claim for benefits. If you decide to appeal a denied claim for benefits, you will be able to submit written comments, documents, records, and other information relating to your claim for benefits (regardless of whether such information was considered in your initial claim for benefits) to the Appeals Administrator for review and consideration. You will also be entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to your appeal.

Time Periods for Responding to Appealed Claims

If you appeal a denied claim for benefits, the Appeals Administrator will respond to your claim within the following time periods:

- Pre-Service Claim - In the case of an appeal of a denied pre-service claim, the Appeals Administrator shall respond to you within 30 days after receipt of the appeal.
- Post-Service Claim - In the case of an appeal of a denied post-service claim, the Appeals Administrator shall respond to you within 60 days after receipt of the appeal.
- Urgent Care Claim - In the case of an appeal of a denied urgent care claim, the Appeals Administrator shall respond to you within 72 hours after receipt of the appeal.
- Concurrent Care Review Claim - In the case of an appeal of a denied concurrent care review claim, the Appeals Administrator shall respond to you before the concurrent or ongoing treatment in question is reduced or terminated.

Notice and Information Contained in Notice Denying Appeal

If the Appeals Administrator denies your claim (in whole or in part), the Appeals Administrator will provide you with written notice of the denial (although initial notice of a denied urgent care claim may be provided to you orally or via facsimile or other similarly expeditious means of communication). This notice will include the following:

- Reason for the Denial - the specific reason or reasons for the denial;
- Reference to Plan Provisions - reference to the specific Plan provisions on which the denial is based;
- Statement of Entitlement to Documents - a statement that you are entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to your claim and/or appeal for benefits;

- Description of Any Internal Rules - a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the appeal determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to you free of charge at your request; and
- Statement of Right to Bring Action - a statement that you are entitled to bring a civil action in Federal court under Section 502 of ERISA to pursue your claim for benefits.

The decision of the Appeals Administrator shall be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law. If you challenge the decision of the Appeals Administrator, a review by a court of law will be limited to the facts, evidence and issues presented during the claims procedure set forth above. The appeal process described herein must be exhausted before you can pursue the claim in Federal court. Facts and evidence that become known to you after having exhausted the appeals procedure may be submitted for reconsideration of the appeal in accordance with the time limits established above. Issues not raised during the appeal will be deemed waived.

If the time limitations set forth have not been exceeded, no person may bring an action in a court of law unless the claims review procedure is exhausted and a final determination has been made. If you, your dependent, your beneficiary, or another interested person challenges the decision, a review by a court of law will be limited to the facts, evidence and issues presented during the claims procedure set forth above. Facts and evidence that become known to you, your dependent, your beneficiary, or another interested person after having exhausted the appeals procedure may be submitted for reconsideration of the appeal in accordance with the time limits established above. Issues not raised during the initial appeal will be deemed waived.

SECTION 8

Glossary

Glossary

Beneficiary: The person(s) or organization you choose to receive insurance benefits from a plan if you die. A trust can also be named a beneficiary.

Coinsurance: After you meet the deductible, your medical and/or dental plan pays a specified percentage of the usual customary and reasonable (UCR) charges for covered services. You pay the remaining charges, called coinsurance.

Common Law Marriage: A marriage legally recognized under applicable State law for which you and your spouse have signed the *University's Common Law Marriage Affidavit* and supplied the required documentation attesting to the following:

- You exchanged words with your spouse in the present tense for the purpose of indicating your mutual consent to form a permanent and exclusive marital relationship at common law of husband to wife and you have been living together and holding yourselves out as husband and wife since that time;
- You and your spouse are not legally married to any other individual, and, if previously married, you and/or your spouse, as applicable, obtained a legal divorce or annulment or the former spouse is deceased;
- You and your spouse were mentally competent to enter into a contract according to the laws of the State in which you resided at the time you entered into the common law marriage;
- You and your spouse were 18 years of age or older and old enough to enter into marriage according to the laws of the State in which you resided at the time you entered into the common law marriage;
- You and your spouse do not have a blood relationship that would bar marriage under applicable laws of the State in which you resided at the time you entered into the common law marriage; and
- You and your spouse did not enter into this relationship solely for purposes of obtaining benefits.

Co-payment/Copay: A flat per-service charge for services, such as doctor visits.

Deductible: The dollar amount you must pay each year before your medical and/or dental plan begins to pay benefits for certain covered expenses. The deductible amount depends upon the Plan you select.

Health Maintenance Organization (HMO): A health care plan which provides medical services through a network of physicians, hospitals and other health care providers. Care is coordinated through a primary care physician. Benefits are provided for preventive care and for care due to illness. Benefits are not available for services performed by a provider that is not a part of the HMO network. (Exceptions may be made for emergency care.) The Keystone Health Plan East and Aetna Plans are HMO plans.

Indemnity Plan: A traditional group insurance plan which reimburses enrolled employees for all or part of the expense of covered medical or dental treatment, typically after meeting a deductible. The plan gives you freedom to choose your physicians and other care providers. Plan 100 is an indemnity plan.

Out-of-Pocket Maximum: The most you have to pay out of your own pocket during the benefit year in coinsurance after you meet your deductible as long as you use providers who accept your plan's UCR. Once you reach the out-of-pocket maximum, the Plan pays 100% of UCR. If you use providers who do

not accept your plan's UCR, your actual out-of-pocket maximum may be greater than the maximum stated by the Plan because expenses that exceed the plan's UCR do not count toward the Plan's out-of-pocket maximum. Out-of-pocket maximums stated by plans are based on your use of providers that accept the Plan's UCR.

Point of Service Plan (POS): A managed care plan with a network of providers that provides reduced benefits for services received outside of the network or without a referral from your primary care physician. Care received outside the network or without a referral is subject to a deductible and coinsurance. Covered benefits obtained through a network provider with a referral from your primary care physician are generally covered in full with a small copayment for care. The UPHS Plan is a point of service plan.

UCR or R&C: UCR or R&C refers to usual, customary and reasonable fees physicians, dentists or health care facilities in the same geographical area charge for similar services. When a plan says it pays 100% of UCR or R&C, it means it pays 100% of the usual, customary and reasonable fees for that service in a given geographical area. It does not necessarily mean the Plan pays 100% of the charge for a service. If the provider is obligated, due to his/her affiliation with the Plan, to accept the Plan's UCR or R&C as payment in full, then you will not have to pay the provider anything in addition to the payment made by the Plan. However, if the provider is not affiliated with the Plan and therefore not obligated to accept the UCR or R&C, you may have to pay any charges in excess of the payment made by the Plan.

SECTION 9

Carrier Directory

Carrier Directory

PennChoice Plan	Send Claims to (Claims Administrator):	Important Numbers (Customer Service and Emergency)	Send Appeals to (Appeals Administrator):
Prescription Drug			
<p>Caremark Prescription Drug Plan</p> <p>(Self-insured by the University and administered through Caremark Prescription Services, Inc.)</p> <p>Group/Policy #: PENRX</p>	<p>Caremark Prescription Services, Inc. P.O. Box 686005 San Antonio, TX 78268-6005</p> <p>Caremark Mail Service P.O. Box 407009 Ft. Lauderdale, FL 33340-7009</p>	<p>Customer Service: 800-378-0802</p>	<p>First Level Appeals:</p> <p>Caremark Prescription Services P.O. Box 686005 San Antonio, TX 78268-6005</p> <p>Caremark Mail Service P.O. Box 407009 Ft. Lauderdale, FL 33340-7009</p> <p>Second Level Appeals: University of Pennsylvania Benefits Office 3401 Walnut Street, Suite 527A Philadelphia, PA 19104-6228</p>
Medical			
<p>PENNCare/ Personal Choice</p> <p>(Self-insured by the University and administered through Independence Blue Cross and PA Blue Shield)</p> <p>Group/Policy #: 33204</p> <p>COBRA 33209</p>	<p><i>Preferred Providers:</i> Not Applicable</p> <p><i>Non-Preferred Providers:</i> PA Blue Shield P.O. Box 890016 Camp Hill, PA 17089-0016</p>	<p>Customer Service: 215-241-2990</p> <p>If you are calling from outside the 215 area code, call 1-800-841-1992</p> <p>For inpatient admission, pre-certification is required except for maternity or emergency admissions.</p> <p>Call 1-800-TO-ADMIT for pre-certification.</p>	<p>Member Appeals Department PO Box 41820 Philadelphia, PA 19101-1820 1-888-671-5276</p>

PennChoice Plan	Send Claims to (Claims Administrator):	Important Numbers (Customer Service and Emergency)	Send Appeals to (Appeals Administrator):
<p>UPHS POS (Self-insured by the University and administered through Keystone Health Systems, Inc. and Independence Blue Cross)</p> <p>Group/Policy #: 200061</p> <p>COBRA 200083 PA 250062 NJ</p>	<p><i>Referred Care:</i> Not Applicable</p> <p><i>Self-Referred Care:</i> P.O. Box 41574 Philadelphia, PA 19101-1574</p>	<p>Customer Service: 215-567-3550</p> <p>If you are calling from outside the 215 area code, call 1-800-253-3854</p> <p>Call PCP and HMO within 48 hours of emergency care. For an emergency out of the area, go to the nearest hospital. Contact Primary Physician within 48 hours. Hospital must call 1-800-227-3116.</p> <p>Sick Care out of the area: 1-800-810-BLUE.</p>	<p>Member Appeals Department PO Box 41820 Philadelphia, PA 19101-1820 1-888-671-5276</p>
<p>Keystone Health Plan East HMO (Self-insured by the University and administered through Keystone Health Plan East)</p> <p>Group/Policy #: 902794</p> <p>COBRA 900251</p>	<p>N/A</p>	<p>Member Services: 215-241-CARE (215-241-2273)</p> <p>If you are calling from outside the 215 area code, call 1-800-227-3114</p> <p>Call Primary Physician and HMO within 48 hours of emergency care. For an emergency out of the area go to the nearest hospital. Contact Primary Physician within 48 hours. Hospital must call 1-800-227-3116.</p> <p>Sick Care out of the area: 1-800-810-BLUE.</p>	<p>Member Appeals Department PO Box 41820 Philadelphia, PA 19101-1820 1-888-671-5276</p>
<p>Aetna HMO (Self Insured and administered</p>	<p>Aetna HMO Solutions Dept.</p>	<p>Customer Service:</p>	<p>Aetna HMO Solutions Dept.</p>

PennChoice Plan	Send Claims to (Claims Administrator):	Important Numbers (Customer Service and Emergency)	Send Appeals to (Appeals Administrator):
through Aetna) PA/DE/NJ Group/Policy #: 0416 PA/DE/NY 0416-603 NJ	P.O. Box 1125 Blue Bell, PA 19422	1-800-323-9930 Call both Primary Physician and Aetna (1-800-541-3149) within 24 hours of emergency care. For an emergency out of the area, go to the nearest hospital. Contact Primary Physician within 24 hours. Hospital must call 1-800-245-1206.	P.O. Box 1125 Blue Bell, PA 19422
UPHS POS AmeriHealth Group/Policy #: 200061	Claims Servicing Center P. O. Box 7458 Philadelphia, PA 19101-7458	Customer Service: 215-567-3550 If you are calling from outside the 215 area code, call 1-800-253-3854 Call PCP and HMO within 48 hours of emergency care. For an emergency out of the area, go to the nearest hospital. Contact Primary Physician within 48 hours. Hospital must call 1-800-227-3116. Sick Care out of the area: 1-800-227-3116.	Member Appeals Department PO Box 41820 Philadelphia, PA 19101-1820 1-888-671-5276
AmeriHealth HMO <u>www.ibx.com</u> Group Policy #: 418752	N/A	1-215-241-CARE (1-215-241-2273) Customer Service: 215-567-3550 If you are calling from outside the 215 area code, call 1-800-253-3854	Member Appeals Department PO Box 41820 Philadelphia, PA 19101-1820 1-888-671-5276

PennChoice Plan	Send Claims to (Claims Administrator):	Important Numbers (Customer Service and Emergency)	Send Appeals to (Appeals Administrator):
		<p>Call PCP and HMO within 48 hours of emergency care. For an emergency out of the area, go to the nearest hospital. Contact Primary Physician within 48 hours. Hospital must call 1-800-227-3116.</p> <p>Sick Care out of the area: 1-800-227-3116.</p>	
Mental Health and Substance Abuse Benefits			
<p>Penn Behavioral Health (Self-insured by the University and administered by Penn Behavioral Health)</p>	<p>Penn Behavioral Health Claims Department 3535 Market Street, 4th Floor Philadelphia, PA 19104</p>	<p>1-888-321-4433 www.pennbehavioralhealth.org . Complaint Process: Member Services PENN Behavioral Health 3535 Market Street, 4th Floor Philadelphia, PA 19104</p>	<p>Member Appeals Department PENN Behavioral health 3535 Market Street, 4th Floor Philadelphia, PA 19104</p>
Vision			
<p>OptiChoice (Insured and administered through PA Blue Shield) Group/Policy #: 700061</p>	<p>PA Blue Shield P.O. Box 890500 Camp Hill, PA 17089-0500</p>	<p>Customer Service: 1-800-541-2039</p>	<p>PA Blue Shield P.O. Box 890500 Camp Hill, PA 17089-0500</p>
Dental			
<p>Penn Faculty Practice Plan (Self-insured and administered through PFPP)</p>	<p>N/A</p>	<p>Customer Service: 215-573-8844 Evenings and weekends: Call</p>	<p>Penn Faculty Practice 220 South 40th Street Philadelphia, PA 19104-6387</p>

PennChoice Plan	Send Claims to (Claims Administrator):	Important Numbers (Customer Service and Emergency)	Send Appeals to (Appeals Administrator):
		any Dental Care Network office for instructions on how to reach the resident on call. Or, call the emergency answering service at 215-952-8029. If outside a 50-mile radius of any office, use any dentist for emergency treatment.	
MetLife Preferred Dentist Program (Self insured and administered through MetLife) Group/Policy #: 300187	<i>In-network:</i> Not Applicable <i>Out-of-network:</i> MetLife Dental Claims P.O. Box 981282 El Paso, TX 79998-1282	Customer Service: 1-800-942-0854	MetLife Dental Claims P.O. Box 981282 El Paso, TX 79998-1282

Long Term Disability			
Long Term Disability Self-Insured, but administered by Aetna.	Aetna Disability Service Center P.O. Box 14553 Lexington, KY 401512	Customer Service: 1-800-488-2386	Aetna, Inc. Aetna Disability Service Center P.O. Box 14553 Lexington, KY 40512
Long Term Care			
Long Term Care Insurance (Insured and administered by CNA) Group/Policy #: 9731TQ	CNA CNA Plaza Chicago, IL 60685	Customer Service: 1-800-528-4582	CNA CNA Plaza Chicago, IL 60685
Life Insurance			
Life, AD&D, Dependent Life (Insured and administered through Aetna) Group/Policy #: 811718	Aetna Life Insurance Company 151 Farmington Avenue Hartford, CT 06156-1992	Customer Service: 212-490-9000 Or 1-888-PENNBEN (1-888-736-6236), press Option #2	Aetna Life Insurance Company 151 Farmington Avenue Hartford, CT 06156-1992
Pre-Tax Expense Accounts			
Health Care and Dependent Care Pre-Tax Expense Accounts (Self-insured by the University and administered by ADP)	ADP FSA Services P.O. Box 1853 Alpharetta, GA 30023-1853	Customer Service: 888-PENNBEN (888-736-6236) Option 2	University of Pennsylvania Benefits Office 3401 Walnut Street, Suite 527A Philadelphia, PA 19104-6228