

SUMMARY PLAN DESCRIPTION

FOR THE

UNIVERSITY OF PENNSYLVANIA

RETIREE HEALTH PLAN

Note: This booklet is only a summary of certain portions of the Plan. Only the Plan itself can give any person a right to benefits and this is not the Plan. This booklet does not describe all the provisions of the Plan and is not a substitute for the Plan. If you want to determine your rights under the Plan, ask to see a copy of the Plan. If anything in this booklet conflicts with the Plan, the Plan will be followed. Nobody speaking on behalf of the Plan or the Plan sponsor can alter the terms of the Plan.

As of January 1, 2006

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INTRODUCTION

The University of Pennsylvania Retiree Health Plan (the "Plan") provides benefits for eligible retirees (and their eligible dependents) of the University of Pennsylvania (the "University") and any participating subsidiaries or affiliates. However, employees of the Hospital of the University of Pennsylvania are not eligible to participate in the Plan.

One of the many requirements of the Employee Retirement Income Security Act of 1974 (ERISA), a federal law applying to employee benefit plans, is that employers must supply employees with a description of the various benefit plans it maintains. Such information must be included in a summary plan description ("SPD") for each plan. This document, together with any booklets or other descriptive material you receive from the University, insurance companies, and health maintenance organizations ("HMOs"), constitute the SPD for the Plan. This SPD describes the Plan as in effect as of January 1, 2006.

Because benefits from the Plan will be of importance to you and your eligible dependents, you should retain this SPD as a part of your permanent records, but please be advised that it is only a summary. The SPD is shorter and less technical than the underlying legal documents which establish the Plan. As such, the SPD may not describe every situation that may affect every covered retiree or dependent. The SPD is not meant to alter the Plan or any legal instrument related to the Plan's creation, operation, funding or benefit payment obligations. **IMPORTANT: If there is any conflict or inconsistency between the SPD and the documents constituting the Plan, or with respect to any provision that is not discussed in the SPD, the documents constituting the Plan will control.** You and your beneficiaries may obtain copies of the Plan and its related documents or examine these documents by contacting the "Plan Administrator" (the individual responsible for administering the Plan) at the number and address set forth in the "Additional Information" section of the SPD.

The Plan, 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 or its subsidiaries or affiliates.

The University reserves the right to modify, amend, or terminate any or all of the benefits under the Plan at any time and for any reason.

ELIGIBILITY TO PARTICIPATE

This section of the SPD describes the eligibility requirements that a retiree must satisfy to participate in the Plan. In addition to the following rules regarding age and service, you must also have been eligible for medical coverage prior to retirement.

- **Eligibility Rules for Existing Retirees:** This summary generally describes the retiree benefits that are available to eligible retirees on or after January 1, 2006. If you were receiving retiree benefits before January 1, 2006, you will continue to receive these benefits on and after January 1, 2006, but these retiree benefits will be subject to the provisions described in this summary.
- **Eligibility Rules for New Retirees:** The University recently changed the Plan's eligibility requirements. However, the University wants to provide a grace period to employees who were closer to retirement. As such, employees who retire before January 1, 2009, will be subject to the

Plan's existing eligibility rules. Employees who retire on or after January 1, 2009 will be subject to the new eligibility rules.

- **Eligibility Rules for Employees Retiring Before January 1, 2009:** If you retire before January 1, 2009 and (1) after reaching age 62 with 10 or more years of service, or (2) after reaching age 55 with 15 or more years of service, you will be eligible to participate in the Plan upon your retirement. Service must be full-time and continuous
- **Eligibility Rules for Employees Retiring On or After January 1, 2009:** If you retire on or after January 1, 2009, you are eligible to participate in the Plan upon your retirement if you satisfy the "Rule of 75" (that is, the sum of your age and service totals at least 75). The Rule of 75 also has minimum age and service requirements. You must be at least age 55 with 15 or more years of service or you must be at least age 62 with 10 or more years of service. Service must be full-time and continuous. The Rule of 75 applies to all other retiree benefits including tuition, life insurance, dental and vision plans. The following examples illustrate the Rule of 75 requirements for some hypothetical employees who retire under the new eligibility rules:
 - Jerry is age 55 and has 20 years of service. Jerry would be eligible for benefits under the Plan because the total of his age and service is 75 and he satisfies the minimum age and service requirements.
 - Helen is age 62 and has 14 years of service. Helen would be eligible for benefits under the Plan because the total of her age and service is 76 and she satisfies the minimum age and service requirements.
 - Bob is age 55 and has 17 years of service. Bob would not be eligible for benefits under the Plan because the total of his age and service – 72 – is less than 75. This is true even though Bob satisfies the minimum age and service requirements.
 - MaryAnn is age 70 and has 8 years of service. MaryAnn would not be eligible for benefits under the Plan because she does not satisfy the minimum age and service requirements. This is true even though the total of MaryAnn's age and service – 78 – exceeds 75.

Important: Please note that these examples are intended only to illustrate the Plan's new eligibility requirements. Your eligibility for Plan benefits will be determined at the time you retire under the terms of the Plan as in effect at that time.

Special Eligibility Rule for FIAP Employees: If you retire pursuant to the University's Faculty Income Allowance Plan (FIAP), you are eligible to participate in the Retiree Health Plan.

- **Eligibility Rules for Dependents:** Any "eligible dependent" (as defined below) who was receiving benefits before January 1, 2006 can continue to receive these benefits on or after January 1, 2006, but these benefits will be subject to the provisions described in this summary.

If you retire on or after January 1, 2006, you may elect coverage for any eligible dependent who was eligible for medical/healthcare benefits under the University of Pennsylvania Health and Welfare Program at the time you retired. Alternatively, you may defer coverage for any dependent who meets the requirements for eligibility on your last day of service. In either case,

you must make an election to cover dependents or defer coverage by completing the required forms within the 90 day period prior to your last day of service. After you retire you may not subsequently add coverage for any dependent acquired after retirement or any dependent you had at the time of retirement who was not named on the required form. Further, if you drop coverage for a dependent, you may not subsequently elect coverage for that dependent. Notwithstanding this general rule, you may enroll dependent children in the following special circumstances:

- a child who met the requirements for eligibility on your last day of service loses medical coverage under another plan; or
- a child who meets the requirements for eligibility on your last day of service, except that the child is not a full-time student, enrolls in school full-time and thus meets the eligibility requirements.

Retirees who retired before July 1, 1996 were permitted to add coverage for new dependents at any time. However, effective January 1, 2006, this group of retirees will not be able to add coverage for new dependents, except as described above. For purposes of the Plan, an "eligible dependent" shall include:

- your spouse (including a spouse of a common law marriage) 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 their 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.
- 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 their 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.

You will 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 by completing and submitting the Student Certification Letter each year during the annual selection period. In addition, 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.)

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. Contact your insurance carrier for more information on coverage for disabled dependent children.

- **Electing Coverage:** Within the 90 days prior to your last day of service, you will be required to complete an enrollment form and/or comply with such other enrollment procedures as may be established by the Plan Administrator. If you do not elect coverage during this enrollment period, you must select the deferral option (see below) on the enrollment form or you will permanently waive participation in the Plan and you will not be able to enroll at a later date. If you elect coverage, your initial election under the Plan will be effective for the remainder of the calendar year in which you retire. After this initial coverage election, you will have an opportunity to change coverage options for the upcoming calendar year during an annual selection period. Any coverage change that you elect during the annual selection period will be effective as of January 1 and generally cannot be changed during the year unless you have a qualifying event. The only three qualifying events are (i) moving to a residence outside an HMO zip code area, (ii) divorce or (iii) the death of a spouse. In any of these instances, you have 30 days from the date of a qualifying event to make a change to your coverage election. If you are Medicare-eligible and elect to waive coverage in the prescription drug plan during the annual selection period you will permanently waive participation in the Plan and you will not be able to reenroll at a later date.
- **Deferring Coverage:** You may defer coverage for yourself and any dependent who meets the eligibility requirements on your last day of service. Dependents need not be covered under the University of Pennsylvania Health and Welfare Program on your last day of service in order to be eligible for deferred coverage. In order for your dependent(s) to enroll at some future date, you must also be enrolled as of that future date or enroll yourself as of that date if not already enrolled. If you do not elect to defer enrollment within the 90 day period prior to your last day of service, you and your eligible dependents will be deemed to have permanently waived coverage and coverage will not be available at a later date.
- **Rehired Retirees :** Retirees who return to work at the University in a full-time capacity will be treated as active employees. All benefits and policies in effect for active employees will apply. If you are enrolled in Medicare Parts A and B, you should inform any health care providers of your employment status so that Medicare is not billed as the primary payor of benefits. (Under federal law, the University of Pennsylvania Health and Welfare Program is primary to Medicare in the case of active employees enrolled in Medicare.) Upon your subsequent retirement, you may once again be eligible for coverage under this plan subject to the University's policies, procedures and premiums in effect at that time. Retirees who return to work on a temporary

assignment are not eligible to participate in the medical program for active employees and will, therefore, remain covered under this retiree medical plan.

- **Other Miscellaneous Rules:** To enroll in the Plan, you may be asked to complete certain enrollment or other forms. In addition, the Plan Administrator or the contracts between the University and its benefit providers (the "Contracts") may establish other rules or requirements for receiving Plan benefits (e.g., time periods for returning election forms, etc.). Any such other rules will be communicated to you when you first are eligible to enroll in the Plan and from time to time thereafter.

IMPORTANT: The University reserves the right to modify, amend, or terminate any or all of the benefits under the Plan at any time and for any reason.

CESSATION OF PARTICIPATION

- **Cessation of Coverage for Retirees:** Your coverage under the Plan will end on the earliest of:
 - the date on which the University decides to terminate or modify coverage under the Plan;
 - the date as of which you fail to satisfy the eligibility requirements of the Plan or any applicable Contract;
 - the date as of which you fail to make any required contributions (See the special rule in the "Contribution" section below relating to late payment of contributions);
 - the date as of which you elect to cease participation; or
 - the date of your death.
- **Cessation of Coverage for Covered Eligible Dependents:** Coverage for your spouse, same-sex domestic partner or any of your eligible dependents under the Plan will end on the earliest of:
 - the date on which the University decides to terminate or modify coverage under the Plan;
 - the date your dependent ceases to be an eligible dependent under the Plan or under the provisions of the applicable Contract;
 - the date as of which you, or if applicable, your spouse, same-sex domestic partner or your eligible dependent, fail to make any required contributions (See the special rule in the "Contribution" section below relating to late payment of contributions); or
 - the date as of which you drop your spouse, same-sex domestic partner or eligible dependent from coverage.

Any individual who is covered as an eligible dependent under the Plan may continue receiving Plan benefits after your death. You surviving spouse/same-sex domestic partner may continue receiving coverage until they remarry or die. Your eligible unmarried dependent children may continue receiving coverage until they no longer satisfy the Plan's eligibility requirements (e.g., age requirements, full-time student requirements, requirements applicable to disabled children).

Notwithstanding the foregoing, the University or any insurance company or other benefit provider, as applicable, may in its sole discretion, terminate your coverage (or that of your eligible dependent) if you (or your eligible dependent) provide false information or makes misrepresentations in connection with a claim for benefits; permit a non-participant to use a membership or other identification card for the purpose of wrongfully obtaining benefits; obtain or attempt to obtain benefits by means of false, misleading or fraudulent information, acts or omissions; or fail to pay any co-payment, supplemental charge or other amount due with respect to a benefit.

BENEFITS

The benefits that are available to you and any eligible dependents are described briefly in Appendix A to the SPD as updated from time to time. For a more complete description of the benefits available under each coverage option, please refer to the separate descriptive booklets and/or Contracts that were provided to you by the applicable benefit providers. In addition to these benefit descriptions, please keep in mind that there are some special rules that apply to Plan benefits. These special rules are described below.

- **Special Coverages Required by the Women's Health and Cancer Rights Act:** 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
 - Protheses and physical complications in all stages of a mastectomy, including lymphedemas.

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

- **Continuation of Coverage for Eligible Dependents:** The section of this booklet entitled "Continuation of Coverage Under COBRA" describes certain circumstances under which healthcare coverage may be continued for eligible dependents after the date coverage would otherwise end.

CONTRIBUTIONS

You and/or your eligible dependents may be required to contribute toward the cost of retiree benefits that you select for you and/or your eligible dependents. The contributions that you are required to pay are determined by the amount of the University's subsidy toward your medical and prescription drug coverage as follows:

- **University Subsidy for Employees Retiring Before July 1, 1996:** If you retired prior to July 1, 1996, the University subsidizes 100% of the cost of medical and prescription drug coverage for you, your spouse/ same-sex domestic partner and eligible dependents.
- **University Subsidy for Employees Retiring On or After July 1, 1996 and Who Were Hired Before January 1, 2006:** If you retire(d) on or after July 1, 1996 and you were hired before January 1, 2006, the University will subsidize 60% of the cost of medical and prescription drug

coverage for you, your spouse/ same-sex domestic partner and eligible dependents. This subsidy will be based on the lowest cost medical plan premium for pre-65 retirees and the lowest cost indemnity plan premium for Medicare-eligible retirees. You (or your spouse/same-sex domestic partner or eligible dependent) will be responsible for any premium cost associated with the options you elect that exceed the University's subsidy.

- **University Subsidy for Employees Hired On or After January 1, 2006:** If you were hired on or after January 1, 2006, the University will subsidize 60% of the cost of medical and prescription drug coverage for you and 30% of the cost of medical and prescription drug coverage for your spouse/ same-sex domestic partner and eligible dependents. This subsidy will be based on the lowest cost medical plan premium for pre-65 retirees and the lowest cost indemnity plan premium for Medicare-eligible retirees. You (or your spouse/same-sex domestic partner or eligible dependent) will be responsible for any premium cost associated with the options you elect that exceed the University's subsidy.

IMPORTANT: Please keep in mind that the University reserves the right to change the amount of your or your eligible dependents' contributions at any time and for any reason.

Your premium payments for each month of coverage are due as of the 25th day of the prior month. If premiums are more than 90 days late, your coverage will be permanently canceled back to the last date for which you have made the required premium payment. This means that you may be required to pay back any reimbursements made to your provider by the carrier.

MEDICARE ELIGIBILITY

If you are receiving medical/healthcare benefits under the Plan and you become eligible for Medicare upon attaining your Social Security retirement age (age 65, 66 or 67, depending on the year in which you were born), you will only be eligible to receive benefits under one of the Plan's coverage options that coordinates with Medicare. You will be transitioned to one of these Medicare coverage options as soon as administratively practicable after you become eligible for Medicare coverage.

COORDINATION OF BENEFITS

Benefits will be coordinated between plans, or within this Plan, in accordance with the following provisions, to the extent not inconsistent with the provisions of any applicable insurance contract, in which case the provisions of the insurance contract shall control.

- **Coordination of Benefits with Other Plans.** Benefits under the Plan will be coordinated, as provided for below, when you or your dependents have health coverage under more than one plan, program or other arrangement for the provision of similar benefits. Other coverage includes (i) coverage under motor vehicle insurance which provides for health insurance protection (including "no-fault" coverage of medical care) where the named insured is given the option of selecting coverage under this Plan or the motor vehicle insurance as the primary coverage for certain eligible medical expenses, (ii) governmental benefit programs provided or required by law (such as Medicare), and (iii) other group health plans covering you or your dependents, including student coverage provided through a school above the high school level. The Plan shall not coordinate benefits with individual health contracts.
- **Primary Plan.** The primary plan shall be determined in the following order:

- **General Rule.** A plan that does not coordinate with other plans will be the primary plan.
- **Covered Employees.** The benefits of the plan which covers the person as an employee-subscriber is the primary plan.
- **Determining the Primary Plans for Dependent Children.** If both plans cover the individual as a dependent child, the plan covering the parent whose birthday falls earlier in the calendar year is the primary plan. If both parents have the same birthday, the plan covering one of the parents for the longer period of time is the primary plan. If this Plan is coordinating benefits with a plan that uses a rule based on gender, except as described below, the plan of the male parent is primary.
- **Divorce or Separation.** If both plans cover the individual as a dependent and the parents are separated or divorced, the primary plan will be determined in the following order:
 - The plan of the parent who has responsibility for the child's health care expenses pursuant to the specific terms of a court decree
 - The plan of the parent with custody of the child
 - The plan of the step-parent to the parent with custody of the child and
 - The plan of the parent who does not have custody of the child.

If the specific terms of a court decree state that the parents shall share joint custody, without stating that one parent has responsibility for the child's health care expenses, the primary plan shall be determined as described above under "Determining the Primary Plans for Dependent Children."

- **Default.** When the determination of the primary plan cannot be made under the above rules, the plan that has covered the individual for the longer period of time will be the primary plan except that the plan which covers the individual as an active employee/subscriber (or a dependent of such person) is the primary plan over a plan that covers the individual as a laid-off person or retired person (or a dependent of such person): and if either plan does not have this condition, then it does not apply and the plan which has been in effect the longer period of time is primary.
- **Motor Vehicle Insurance.** Notwithstanding any provision in this Plan to the contrary, in determining whether this Plan or another plan is the primary plan, this Plan will be secondary to: a) coverage provided under any "no-fault" coverage of medical care or treatment to the extent required to meet the requirements of any motor vehicle insurance statute or similar statute, and b) coverage provided under motor vehicle insurance which provides for health insurance protection, even if the participant or COBRA participant selects coverage under the motor vehicle insurance as secondary for eligible medical care or treatment. Thus, if you or your dependent decline to select health care coverage under motor vehicle insurance as primary but such insurance provides health care coverage that purports to be secondary to coverage under a health care plan maintained by an employer, this Plan will nevertheless pay benefits second if at all. This provision is expressly intended to avoid the possibility that this Plan will be determined to be primary to coverage that is available under motor vehicle or "no-fault" insurance.
- **The Coordinated Benefit.** Benefits provided under this Plan will be paid in full when this Plan is

the primary plan. When this Plan is the secondary plan, this Plan will provide a benefit so that the combined benefits under both the primary and secondary plans will not exceed the amount which would have been paid under this Plan, if there were no other plans involved. When benefits are reduced under the primary plan because a subscriber does not comply with a plan provision, the amount of such reduction will not be considered an allowable benefit. Whenever payments that should have been made by the Plan have been made by another plan, the Plan may pay the other plan any amount necessary to satisfy the coordination of benefits provisions of this section. Amounts paid will be considered benefits paid under this Plan and to the extent of such payments, the Plan will be fully released from any liability regarding the person for whom payment was made. Whenever payments that should have been made by another plan have been made by the Plan, the Plan may recover the expense already paid in excess of its liability as the secondary plan.

CLAIMS PROCEDURE

The booklets and other materials that describe a particular benefit under the Plan generally will contain a specific set of claims and appeals procedures that you must follow to make a claim to receive that particular benefit and/or to appeal a denied claim for that particular benefit. Although these separate claims and appeals procedures will be very similar in most respects, there may be important differences. As such, you should follow the specific claims and appeals procedures for a particular benefit very carefully. If the booklets and other materials that describe a particular benefit do not contain a specific set of claims and appeals procedures, the Plan's default procedures as described below will apply.

IMPORTANT: If you have any questions about which set of claims and appeals procedures to follow or any other questions about making a claim, you should contact the specific claims administrator at the address/number set forth in Appendix A. After talking to the claims administrator, if you still have questions about how a claim should be processed, you should contact the Plan Administrator.

For purposes of this section of the SPD describing the Plan's default claims and appeals procedures, the Plan Administrator (or any third party to whom the Plan Administrator has delegated the authority to review and evaluate claims, such as an insurance company) shall be referred to as the "Claims Administrator" at the initial claim level and the "Appeals Administrator" at the appeal level.

A request for benefits is a "claim" subject to these procedures only if you or your authorized representative file it 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 Appendix A. Any claim that does not relate to a specific benefit under the Plan (for example, a general eligibility claim) must be filed with the Plan Administrator at the address set forth in the "Additional Information" section below. 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 allow the Claims Administrator 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 Claims Administrator and/or the Appeals Administrator identifying such authorized representative. In the case of a claim for medical benefits involving urgent care, a healthcare professional who has knowledge of your medical condition may act as your authorized representative with or without prior notice.

- **Types of 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) depend 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.
- *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 the Plan, the Claims Administrator will respond to your claim within the following time periods:
 - *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.
 - *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.
 - *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 the Claims Administrator denies your initial claim for benefits, 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:
 - *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.
 - *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.
 - *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.

CONTINUATION OF COVERAGE UNDER COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") is a federal law that has several provisions designed to protect you and your eligible dependents against a sudden loss of healthcare coverage if there is a "qualifying event" (explained below) that would cause the loss of healthcare coverage under the Plan. The following information outlines the continuation of coverage available under COBRA.

- General Explanation of COBRA Continuation Coverage:** COBRA requires most employers who sponsor group healthcare plans to provide a temporary extension of healthcare coverage to employees and their eligible dependents when, due to certain circumstances, coverage would otherwise terminate under the employer's plan. This temporary extension of benefits is commonly called "continuation coverage." Individuals who are eligible for COBRA coverage are called "qualified beneficiaries". The events which entitle them to coverage are called "qualifying events". To be a qualified beneficiary for a specific type of healthcare coverage (e.g., medical or dental coverage), the qualified beneficiary must have had that particular coverage under the plan(s) on the day before a qualifying event occurs.
- Who Must Provide Notice When Coverage is Lost:** When a qualifying event occurs, you and your covered eligible dependents have certain responsibilities. If the qualifying event is divorce or a legal separation, or loss of eligible dependent status, you or a covered eligible dependent must notify the Plan Administrator in writing within 60 days of the qualifying event.

When the Plan Administrator is notified or learns of a qualifying event, the Plan Administrator will send your spouse, same-sex domestic partner and/or eligible dependents a written explanation of the right to elect continuation coverage. They will then have 60 days from the later of the date of this explanation from the Plan Administrator or the date on which their existing coverage would end to notify the Plan Administrator of their election. If your spouse, same-sex domestic partner, and/or an eligible dependent does not respond in writing within the time limit, the right to elect to continue coverage under COBRA will be lost. The following chart describes who may be eligible for COBRA benefits and how long those benefits will last.

PERSON AFFECTED (Qualified Beneficiary)	REASON FOR LOSS OF COVERAGE (Qualifying Event)	PERIOD OF CONTINUATION COVERAGE
Covered Spouse/Same-Sex Domestic Partner of a Retiree	<ul style="list-style-type: none"> Divorce or legal separation from retiree 	36 months
	<ul style="list-style-type: none"> Death of employee (but coverage only ceases if spouse or same-sex domestic partner remarries or establishes a new same-sex domestic partner relationship following death) 	36 months
Covered Eligible Dependent Child of a Retiree	<ul style="list-style-type: none"> Divorce or legal separation of retiree and spouse or same-sex domestic partner 	36 months
	<ul style="list-style-type: none"> Failure of child to qualify as an eligible dependent under the Plan 	36 months

The 36 month continuation coverage begins on the date that coverage would originally end.

- **If Continued Coverage is Elected:** Each covered eligible dependent who is eligible to elect continuation coverage may make a separate election to continue coverage, or one covered eligible dependent may make an election that covers some or all of the others. If continued coverage is elected, the covered individual must pay a total premium equal to the cost to the Plan of such coverage, plus a 2% monthly administration charge (or such higher charge as may be permitted by law). The total premium includes both the University's contribution and any contribution that an active retiree would be required to make under the Plan for the same coverage. The first payment must be made within 45 days following the date of the election and must cover the number of full months from the date coverage ended to the time of the election. Premiums for each month after the election are due by the 1st day of the month and must be paid not later than the last day of that month. Premium rates will change periodically for all qualified beneficiaries if costs to the University change. Continuation coverage will be identical to the coverage provided to similarly situated retirees and/or eligible dependents. Healthcare coverage will continue to be provided by the insurer, or other provider that is providing benefits on the date of the qualifying event. Should benefit levels increase or decrease, both active and COBRA participants will experience the same change.
- **Coverage That May Be Elected:** Qualified beneficiaries may elect to continue only those coverages that were in effect on the date of the qualifying event.
- **When COBRA Benefits End:** Generally, continuation coverage runs for 36 months as described in the chart above. However, COBRA benefits will end immediately if:
 - the person whose coverage is being continued fails to pay the premium on time;
 - the person whose coverage is being continued becomes, after the date of the election of continuation coverage, covered under another employer's group health plan unless the other group health plan contains an exclusion or limitation with respect to a preexisting condition of the person (other than an exclusion or limitation which does not apply to, or is satisfied by, the person under applicable provisions of federal law);
 - the person whose coverage is being continued becomes, after the date of the election of continuation coverage, entitled to Medicare benefits; or
 - the University no longer maintains any plan covering any employee.
- **Conversion to an Individual Policy:** At the end of the 36-month continuation period, a qualified beneficiary may be eligible to convert their medical coverage to an individual policy to the extent permitted under the Contract. If eligible, they must apply in writing and pay the first premium for the converted policy within 31 days after the date his/her insurance coverage ceases.

PLAN ADMINISTRATOR

The Plan Administrator is the Vice President of Human Resources of the University. The name, business address, and business telephone number are provided under the section below entitled "Additional Information". In general, the Plan Administrator is the sole judge of the application and interpretation of the Plan, and has the discretionary authority to construe the provisions of the Plan, to resolve disputed issues of fact, and to make determinations regarding eligibility for benefits. 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 Plan to various service providers.

As the Plan Administrator's delegate, these service providers have the authority to make decisions under the Plan 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, Plan interpretations, and disputed issues of fact) will be final and binding on all parties.

PLAN AMENDMENT OR TERMINATION

The Vice President of Human Resources of the University (or the Vice President's delegate) shall have the right to amend or modify the Plan at any time and for any reason with respect to both current and former employees and their eligible dependents. Such changes may include, but are not limited to, the right to (1) change or eliminate benefits, (2) increase or decrease employee contributions, (3) increase or decrease deductibles and/or copayments, (4) change the class(es) of employees and/or eligible dependents covered by the Plan, and (5) change insurers or other providers. In addition, the Vice President of Human Resources of the University (or the Vice President's delegate) shall have the right to terminate the Plan, or any portion of the Plan, at any time and for any reason. No amendment, termination or partial termination of the Plan will affect claims incurred for which items or services have been provided prior to the date of amendment, termination, or partial termination.

ADDITIONAL INFORMATION

- **Plan Sponsor Information:** The sponsor of the Plan is The Trustees of the University of Pennsylvania. The address and telephone number as well as the employer identification number assigned to the University of Pennsylvania by the Internal Revenue Service are as follows:

Address: 3401 Walnut Street, Suite 527A
Philadelphia, Pennsylvania 19104

Telephone: 215-898-6884
Employer ID #: 23-1352685

- **Plan Administrator Information:** The Vice President of Human Resources of the University is the Plan Administrator. The Plan Administrator can be contacted at the same address and telephone number as the Plan Sponsor.

- **Plan Information:** Specific information for the Plan is as follows:

Plan Name: The University of Pennsylvania Retiree Health Plan

Plan ID #: 530

Plan Year: Begins on January 1 and ends on December 31

Type of Plan: The Plan is a welfare benefit plan providing medical coverage and is a "group health plan" within the meaning of ERISA.

Administration and Funding: Benefits under the Plan are administered in accordance with Contracts that the University has entered into with various providers, and other providers or administrators of medical benefits. Benefits may be "insured" (provided through insurance Contracts pursuant to which the University pays

premiums) or "self-insured" (paid directly out of the University's general assets) or a combination of insured and self-insured. Benefits also may be paid out of any trust fund that is established for the Plan. A list of providers and their roles under the Plan is included in Appendix A.

- **Agent for Legal Process:** The agent for the service of legal process for the Plan is the Plan Administrator at the address set forth above.

THIRD PARTY RECOVERY

General Principle

When you or your dependent receive benefits under the Plan which are related to medical expenses that are also payable under Workers' Compensation, any statute, any uninsured or underinsured motorist program, any no fault or school insurance program, any other insurance policy or any other plan of benefits, or when related medical expenses that arise through an act or omission of another person are paid by a third party, whether through legal action, settlement or for any other reason, you or your dependent shall reimburse the Plan for the related benefits received out of any funds or monies you or your dependent recovers from any third party.

Specific Requirements and Plan Rights

Because the Plan is entitled to reimbursement, the Plan shall be fully subrogated to any and all rights, recovery or causes of actions or claims that you or your dependent may have against any third party. The Plan is granted a specific and first right of reimbursement from any payment, amount or recovery from a third party. This right to reimbursement is regardless of the manner in which the recovery is structured or worded, and even if you or your dependent has not been paid or fully reimbursed for all of their damages or expenses.

The Plan's share of the recovery shall not be reduced because the full damages or expenses claimed have not been reimbursed unless the Plan agrees in writing to such reduction. Further, the Plan's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorney's fund" doctrine, regulatory diligence or any other equitable defenses that may affect the Plan's right to subrogation or reimbursement.

The Plan may enforce its subrogation or reimbursement rights by requiring you or your dependent to assert a claim to any of the benefits to which you or your dependent may be entitled. The Plan will not pay attorneys fees or costs associated with the claim or lawsuit without express written authorization from the University.

If the Plan should become aware that you or your dependent has received a third party payment, amount or recovery and not reported such amount, the Plan, in its sole discretion, may suspend all further benefits payments related to you or any of your dependents until the reimbursable portion is returned to the Plan or offset against amounts that would otherwise be paid to or on behalf of you or your dependents.

Participant Duties and Actions

By participating in the Plan you and your dependents consent and agree that a constructive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party. In accordance with that constructive trust, lien or equitable lien by agreement, you

and your dependents agree to cooperate with the Plan in reimbursing it for Plan costs and expenses.

Once you or your dependent has any reason to believe that you or they may be entitled to recovery from any third party, you or your dependent must notify the Plan. And, at that time, the you and your dependent (and your or their attorney, if applicable) must sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses arising from circumstances that entitle you or your dependent to any payment, amount or recovery from a third party.

If you or your dependent fails or refuses to execute the required subrogation/reimbursement agreement, the Plan may deny payment of any benefits to you and any of your dependents until the agreement is signed. Alternatively, if you or your dependent fails or refuses to execute the required subrogation/reimbursement agreement and the Plan nevertheless pays benefits to or on behalf of you or your dependent, your or your dependent's acceptance of such benefits shall constitute agreement to the Plan's right to subrogation or reimbursement.

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

RECOUPMENT

The Plan 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 Plan, 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.

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 healthcare provider, if any, shall be done as a convenience to the covered person and will not constitute an assignment of benefits under the Plan.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan, 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, all documents governing the Plan and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available in the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation

of the Plan and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or latest annual report and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

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

APPENDIX A

Information Relating to Third Party Providers

(As of January 1, 2006)

(Please note that the University reserves the right to change the coverage options available under the Plan or the terms of such coverage options (including, without limitation, retirees' cost for any such coverage option) at any time and for any reason.)

Medical Coverage

Independence Blue Cross PPO (Under 65 Only)

The University has contracted with the above provider to provide medical benefits and claims services under the Plan. This particular coverage option (available only to retirees under age 65) is referred to as PENNCare/Personal Choice and is a Preferred Provider Organization (PPO). Under this coverage option, you may use any healthcare provider, but your out-of-pocket expenses will be limited when you utilize the PENNCare or Personal Choice networks of preferred providers. You do not have to choose a primary care physician or obtain referrals under the PENNCare/Personal Choice plan.

For more information about this coverage option or to process claims for benefits, you should refer to the provider booklets provided to you or you can contact Independent Blue Cross at the following address and phone number:

Contact Information:

Pennsylvania Blue Shield
Group Number: 33204
Non- Preferred Providers
P. O. Box 890016
Camp Hill, PA 17089-0016
(215) 241-2990 or outside local area (800) 841-1992

Medical Coverage

Health Maintenance Organization (HMOs) by Aetna and Keystone/AmeriHealth (Under 65 Only)

The University has contracted with the above providers to provide medical benefits and claims services under the Plan. These particular coverage options (available only to retirees under age 65) are Health Maintenance Organizations (HMOs) provided by two separate carriers, Aetna and Keystone Health Plan East. Under these HMOs, you must coordinate your care through a Primary Care Physician (PCP) who is part of the Aetna or Keystone Preferred provider networks. You must obtain referrals from your PCP for most services. When you follow these procedures and use providers in your carrier network, you do not have to meet a deductible and the Plan pays 100% (after applicable co-payments) for covered services.

For more information about this coverage option or to process claims for benefits, you should refer to the provider booklets provided to you or you can contact Aetna or Keystone Health Plan East at the following address and phone number:

Contact Information:

Aetna Health Administrators
Group Numbers: 0416 for Pennsylvania
and Delaware, and 603 for New Jersey
Solution Department
P. O. Box 981137
El Paso, TX 79998-1107
(888) 287-4296
(800) 323-9930 (California)

Keystone/AmeriHealth
Self Referred Care
P.O. Box 890016
Camp Hill, PA 17089-0016
(215) 241-2273 or outside local area (800) 227-3114

Prescription Coverage**Caremark Prescription Drug Coverage (All Retirees)**

The University has contracted with the above provider to provide prescription drug and claims services under the Plan. This particular coverage option (available only to all retirees) is referred to as the Caremark Prescription Drug Coverage Option. If you are enrolled in one of the options listed, prescription drug coverage for you and your enrolled dependents will be provided through Caremark Prescription Services. Participating Caremark pharmacies offer discounted prices for prescription drugs. If you are enrolled in a Pre-65 medical plan, prescription coverage is automatically provided as part of the medical plan. If you are enrolled in a Medicare-eligible plan, you are eligible to enroll in Penn's prescription plan or Medicare Part D. You cannot enroll in both Penn's prescription plan and Medicare Part D. Note that Penn's prescription drug plan constitutes "creditable coverage" meaning that it is equal to or better than the coverage provided under the standard Medicare Part D plan design.

Note: Special rules apply when a retiree is Medicare-eligible and his/her spouse/same-sex domestic partner is not Medicare-eligible or when the retiree is not Medicare-eligible and his/her spouse/same-sex domestic partner is Medicare-eligible:

- Retiree under age 65 and dependent age 65 and older – If the retiree enrolls for medical coverage under this Plan, prescription drug coverage is automatically provided. The dependent must also enroll in Penn's prescription drug plan even though he/she is eligible for Medicare Part D.
- Retiree age 65 and older and dependent under 65 – If the retiree elects to receive prescription drug coverage under Medicare Part D, his/her spouse/same-sex domestic partner dependent can remain covered under this Plan's prescription drug coverage only until he/she becomes Medicare-eligible.

For more information about this coverage option or to process claims for benefits, you should refer to the provider booklets provided to you or you can contact Caremark at the following address and phone number:

Contact Information:

Caremark Prescription Services
P.O. Box 686005
San Antonio, TX 78268-6005
(800) 378-0802

Medical Coverage

Keystone/AmeriHealth and Aetna Medicare Advantage Plans (Age 65 and Over Only)

The University has contracted with the above providers to provide medical benefits and claims services under the Plan. This particular coverage option (available only to retirees over age 65) is referred to as a Medicare Advantage Plan and is available through both Aetna and Keystone. Medicare beneficiaries may opt to enroll in one of these products instead of the "Original Medicare Plan" (currently, Medicare Parts A and B). When you enroll in Medicare, you will automatically be in the Original Medicare Plan unless you elect to enroll in one of these Medicare Advantage plans. You also must be enrolled in Medicare Parts A and B, pay the Part B monthly premium (which is deducted from your Social Security check), and live in the plan's service area to be eligible. These plans are Medicare approved networks of doctors, hospitals and other health care providers that agree to give care in return for a set monthly payment from Medicare. They cover all the services covered by Original Medicare, and in addition, include a prescription drug benefit (which Original Medicare does not).

For more information about this coverage option or to process claims for benefits, you should refer to the provider booklets provided to you or you can contact Aetna or Keystone at the following address and phone number:

Contact Information:

Keystone/AmeriHealth	Aetna
P.O. Box 898815	1425 Union Meeting Road
Camp Hill, PA 17089-8815	Blue Bell, PA 19422
(215) 241-2365 or outside local area (800) 645-3965	(800) 282-5366

Medical Coverage

Blue Cross/Blue Shield 65 Special Indemnity Plan (Age 65 and Over Only)

The University has contracted with the above provider to provide medical benefits and claims services under the Plan. This particular coverage option (available only to retirees over age 65) is referred to as the Blue Cross/Blue Shield 65 Special Plan. The Blue Cross portion of this coverage option provides hospital-related bills in conjunction with Medicare and the Blue Shield portion of this coverage option provides doctors' reasonable charges in conjunction with Medicare. This coverage option, in its current form, will not be available to any employees hired by the University on or after January 1, 2006.

For more information about this coverage option or to process claims for benefits, you should refer to the provider booklets provided to you or you can contact Blue Cross/Blue Shield at the following address and phone number:

Contact Information:

Independence Blue Cross	Independence Blue Cross
Attention: Claims Department	Major Medical Claims Department
1901 Market Street	P.O. Box 13497
Philadelphia, PA 19103-1480	Philadelphia, PA 19101-3497

For both: (215) 241-2990 or outside local area (800) 841-1992

Medical Coverage

Aetna Indemnity Plan (Age 65 and Over Only)

The University has contracted with the above provider to provide medical benefits and claims services under the Plan. This particular coverage option (available only to retirees over age 65) is referred to as the Aetna Indemnity Plan. This coverage option provides hospital-related bills and doctor's charges in conjunction with Medicare.

For more information about this coverage option or to process claims for benefits, you should refer to the provider booklets provided to you or you can contact Aetna at the following address and phone number:

Contact Information:

Aetna
P.O. Box 981106
El Paso, TX 79998-1106
(800) 233-6697

For information about Medicare, please call 1-800-633-4227 or 1-877-486-2048 if you are hearing-impaired. You may also visit www.medicare.gov.

Other Benefits

Some retirees are eligible for non-medical benefits through the Plan during their period of retirement. For example, most retirees are eligible for some level of life insurance coverage during retirement and some retirees who retire pursuant to the FIAP may be eligible for dental or vision coverage benefits for a short period of time following retirement. In the event you are eligible for any of these benefits, you will receive more detailed information about the benefits (including, without limitation, the cost, the duration and other material terms) at the time that you retire and become eligible to receive them.

Dental Coverage

There are two options available. These options are not part of the Retiree Health Plan, but are instead made available to you by the carriers. There is no University contribution toward these coverages.

- The Aetna Vital Savings Dental Plan. Retirees who elect this option and visit a participating provider will receive an average discount of 28%. Contact Aetna at 1-866-368-4825 for more information.
- A MetLife Preferred Dentist Program (effective January 1, 2007). This plan provides coverage when you receive treatment from any dentist or specialist you wish. Use MetLife providers to pay less out of your pocket because preferred providers accept the plan's negotiated fees as payment in full. Contact MetLife at 1-800-438-6388 for more information.

When you retire, you may be eligible to continue your existing dental coverage under the Health and Welfare Program (Penn Faculty Practice or MetLife dental) through COBRA for up to 18 months. For more information on COBRA, review Penn's online Health and Welfare Program Summary Plan Description at <http://www.hr.upenn.edu/benefits/spd.pdf> or contact the Penn Benefits Center at 1-888-PENNBEN (1-888-736-6236) and press option #4.

Vision Coverage

Retirees who enroll in the Aetna Vital Savings Dental Plan (see above) will automatically have access to the Aetna Vision One discount program (effective January 1, 2007). Under this program, participants have access to providers in nearly 13,000 participating Vision Centers. Contact Aetna at 1-800-793-8616 for more information. This option is not part of the Retiree Health Plan, but is instead made available to you by the carrier. There is no University contribution toward this coverage.

When you retire, you may be eligible to continue your existing vision coverage under the Health and Welfare Program through COBRA for up to 18 months. For more information on COBRA, review Penn's online Health and Welfare Program Summary Plan Description at <http://www.hr.upenn.edu/benefits/spd.pdf> or contact the Penn Benefits Center at 1-888-PENNBEN (1-888-736-6236) and press option #4.

Life Insurance

If you meet the eligibility requirements for retirement, the University provides a life insurance benefit of \$2,000. In addition, within 31 days of your retirement date, you may convert your basic, supplemental and/or dependent 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. This coverage is currently provided through Aetna. 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. You must apply for conversion to an individual policy within 31 days of your retirement 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.

Pre-Tax Expense Accounts

Your participation in the Pre-Tax Expense Accounts ends when you retire. Your contributions end with your final paycheck. However, you may be eligible to continue your Health Care Pre-Tax Expense Account coverage under the Health and Welfare Program through COBRA until the end of the Plan Year (June 30) in which you retire. For more information on COBRA, review Penn's online Health and Welfare Program Summary Plan Description at <http://www.hr.upenn.edu/benefits/spd.pdf> or contact the

Penn Benefits Center at 1-888-PENNBEN (1-888-736-6236) and press option #4. You may continue to submit requests for reimbursements for expenses incurred while you were employed. Expenses must be submitted by September 30th following the Plan Year in which you retire. For more information, contact the Penn Benefits Center at 1-888-PENNBEN (1-888-736-6236) and press option #3.

Long-Term Care Insurance

A group long-term care insurance plan administered by John Hancock is available. You may apply for coverage at any time while actively employed or after retiring by contacting John Hancock directly. Employees, retirees, spouses/domestic partners, parents, parents-in-law, grandparents, grandparents-in-law, and other eligible family members can enroll in this plan. To apply for this benefit, please call John Hancock at 1-800-711-2899.

Tuition Benefits

Retired University faculty and staff, who meet University eligibility requirements and retirement criteria are eligible for the same faculty and staff, spouse/same-sex domestic partner and dependent scholarship benefits for which they were eligible immediately prior to retirement. Go to www.hr.upenn.edu/benefits/tuition/default.asp to view Penn's tuition policies.

Disability Benefits

Coverage under the short-term disability (STD) program and the long-term disability (LTD) program stops after your final day of employment. However, your benefits under the respective plan will continue assuming that you continue to meet the eligibility requirements under the terms of the plan and continue to submit proof of your continuing disability.