SUMMARY PLAN DESCRIPTION

FOR THE

UNIVERSITY OF PENNSYLVANIA
HEALTH AND WELFARE PLAN FOR
RETIREES AND DISABLED EMPLOYEES

(Prepared For Disabled Employees)

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 2021

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INTRODUCTION

The University of Pennsylvania Health and Welfare Plan for Retirees and Disabled Employees (the "Plan") provides benefits for eligible disabled employees (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, claims administrators and/or health maintenance organizations ("HMOs"), constitute the SPD for the Plan. This SPD describes the Plan as in effect as of January 1, 2021.

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 disabled employee 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.

If you believe you are entitled to a benefit that you have not received or if you disagree with any determination made by the Plan Administrator (or its delegate) regarding your Plan benefits, you may submit a claim for benefits under the Plan. However, the time period for submitting a claim for benefits is limited. If you fail to make a timely claim for benefits or you fail to timely appeal a claim, you may lose your right to those benefits. For important information regarding the process for submitting a claim for benefits and the deadlines for submitting such a claim, see the "General Rules Regarding Claims Procedure" 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.

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

ELIGIBILITY TO PARTICIPATE

- **Eligibility Rules for Disabled Employees:** If you are receiving long term disability benefits under the University of Pennsylvania Health and Welfare Program, you are eligible to receive

benefits under this Plan. Note that your long term disability benefits continue to be provided under the Health and Welfare Program.

If you cease to be disabled, you may be able to continue coverage under this Plan if you meet the eligibility requirements for retirees, as described in the Plan document and in a separate version of this summary plan description (SPD) prepared for retirees. (You may obtain a copy of the Plan and/or the Retiree SPD upon request to the Plan Administrator.)

If you cease to be disabled and you do not meet the eligibility requirements for retiree coverage under the Plan, you may be eligible to continue coverage as described in the "Continuation Coverage Under COBRA" section below.

If you elect to retire from the University in order to commence pension benefits, you will continue coverage under this Plan only if you meet the eligibility requirements for retirees, even if your long term disability benefits continue. You cannot be covered under this Plan as a disabled employee and a retiree.

- **Eligibility Rules for Dependents:** You may elect coverage for any eligible dependent. For purposes of the Plan, an "eligible dependent" shall include:

    - Your spouse and your pouses child up to the end of the month in which your child reaches age 26.

    - Your or your spouse's beyond age 26 if the child is incapable of self-support because of a mental or physical condition that existed prior to age 26, and who was covered as a dependent prior to age 26 under this Plan or another plan.

  A child includes a biological child, stepchild, child placed with you for adoption, legally adopted child, the biological or adopted child of your spouse's child 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.

  Call the Penn Benefits Center at 1-866-799-2329 if you have any questions about a dependent's eligibility.

- **Electing Coverage:** If you become an eligible disabled employee, you may (i) continue any benefits being provided to you under the Health and Welfare Program at the time you become disabled, (ii) cease receiving any benefits being provided at the time you become disabled, (iii) elect to receive different benefits as may be available at the time you become disabled or (iv) elect to defer medical coverage. You cannot defer dental or vision coverage if you were previously enrolled prior to becoming disabled. If you are not enrolled in dental, vision or supplemental life insurance coverage on the date immediately preceding the date you become disabled, you will not be permitted to enroll in these benefit plans at a later date. If you are enrolled in supplemental life insurance coverage at the time you become disabled, you can continue the coverage that was in effect at that time, decrease the amount of coverage or cancel such coverage, but you will not be permitted to increase the amount of such coverage. If you

elect coverage under the Plan, your initial election will be effective for the remainder of the Plan Year in which you become disabled. Thereafter, 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. Qualifying events include (i) moving to a residence outside an HMO zip code area, (ii) divorce, (iii) the death of a spouse. In any of these instances, you have 30 days from the date of the event to make a change to your coverage election. You may add coverage for a new or existing eligible dependent(s).

- **Deferring Coverage:** You may choose to defer medical coverage for yourself and any eligible dependents if previously enrolled prior to the date you become disabled.

- **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.

NOTE: If you are receiving healthcare benefits under the Plan and you become eligible for Medicare as a result of your disability or age, you will only be eligible to receive benefits under one the Plan's Medicare coverage options. You will be transitioned to one of these Medicare coverage options as soon as administratively practicable. This Medicare coordination also applies to a spouse or dependent child who becomes eligible for Medicare, due to age or disability. If one family member is transitioned to a Medicare coverage option, other family members who are not eligible for Medicare will be eligible for any other coverage option generally available to retirees who are not eligible for Medicare.

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 Disabled Employees:** 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;

- the date as of which you are no longer disabled, subject to your continued participation as a retiree, if you meet the applicable requirements; or

- the date of your death.

- **Cessation of Coverage for Covered Eligible Dependents:** Coverage for your spouse 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 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);

  - the date as of which your coverage terminates; or

  - the date as of which you drop your spouse 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 if you met the eligibility requirements for retiree benefits at the time of your death. Your surviving spouse 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).

Discretion to Terminate Coverage for Misbehavior

Notwithstanding the foregoing, the University or any insurance company, HMO 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 behave in a manner that is disruptive, unruly, abusive, threatening, or uncooperative .

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 which may be requested directly from the applicable benefit providers or the University's Benefits Department.

IMPORTANT: The University reserves the right to amend or terminate any of the Plan's benefits at any time and for any reason.

In addition to these benefit descriptions, please keep in mind that there are some special rules that apply to Plan benefits, as follows:

- **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

  - Prostheses 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 benefits that you select for you and/or your eligible dependents. The contributions that you are required to pay are determined by the University; the University subsidizes the balance of the cost.

- **University Subsidy for Employees on LTD Before July 1, 1998:** If you are eligible for LTD prior to July 1, 1998, the University subsidizes 100% of the cost of medical, dental, basic life and supplemental life. You pay the full cost for vision benefits.

- **University Subsidy for Employees on LTD On or After July 1, 1998 and Before July 1, 2005:** If you are eligible for LTD on or after July 1, 1998 and before July 1, 2005, the University subsidy for the cost of medical and dental is the same as for active employees. The University subsidizes 100% of the cost for basic and supplemental life insurance. You pay the full cost for vision benefits.

- **University Subsidy for Employees on LTD On or After July1, 2005:** If you are eligible for LTD on or after July 1, 2005, the University subsidy for the cost of medical and dental is the same as for active employees. The University subsidizes 100% of the cost for basic life. You pay the full cost for vision and supplemental life benefits.

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 by the first of the month. If premiums are more than 60 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.

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 claims as described below will apply. In all cases, the Plan's "General Rules Regarding Claims Procedures" as described below apply to claims under the Plan.

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.

General Rules Regarding Claims Procedures

The Plan Administrator has complete and final discretionary authority to determine all questions regarding an employee's participation and benefits and to interpret and to construe the provisions of the Plan document including any uncertain terms. When deciding claims, the Plan Administrator is using its full discretionary authority to determine facts, interpret the Plan, and resolve any questions. Decisions made by the Plan Administrator will be given full deference by any court of law and the Plan Administrator's decision on review will be final and binding on all parties.

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.

You must follow the claim procedures within the deadlines described below if you wish to preserve any rights you may have to a benefit under the Plan, including your right to pursue your claim in court or seek a ruling or judgment of any kind against the Plan, a Plan fiduciary, or any other party associated with the Plan. If you don't present all your evidence and arguments during the claims and appeals procedure, you will have waived the opportunity to present them and won't be able to bring them forward at a later time. This means that the court's review will be limited to the facts, evidence, and issues you present during the Plan's claims and appeals procedure described here. Issues not raised during the claims and appeal process will be deemed waived.

After you have exhausted the Plan's claims and appeals procedure (but not before), you may file a lawsuit in the United States District Court, Eastern District of Pennsylvania. Any such claim or lawsuit must be filed by the "Claims Deadline," which is 24 months after whichever of the following events happened first:

- Your first benefit payment was made or should have been made;
- The Plan Administrator first denied your claim; or
- You first knew or should have known the important facts relating to your claim.

You are not permitted to bring a claim under the Plan's claims and appeals procedure or bring a lawsuit in a court or other forum after the Claims Deadline. However, if you start the Plan's claims and appeals procedure before the Claims Deadline and the Claims Deadline passes before the claims and appeals procedure is completed, you may still file your lawsuit during the three-month period after the Committee sends the final notice of denial of your appealed claim.

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 you, your spouse, same-sex domestic partner and/or eligible dependents (each a "qualified beneficiary") 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 you, 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
Disabled Employee, Covered Spouse or Covered Dependent Child	• No longer disabled and not eligible for benefits as a retiree	18 months; may be extended to 29 months if a qualified beneficiary is disabled*
Covered Spouse of a Disabled Employee	• Divorce or legal separation from disabled employee	36 months
	• Death of disabled employee (but coverage only ceases if spouse remarries	36 months
Covered Eligible Dependent Child of a Disabled Employee	• Divorce or legal separation of disabled employee and spouse	36 months
	• Failure of child to qualify as an eligible dependent under the Plan	36 months

*To be eligible for the 11-month extension, the disabled qualified beneficiary must 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 Benefit Services (see Appendix A) 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 18, 29 or 36 month continuation coverage begins on the date that coverage would originally end.

- **If Continued Coverage is Elected:** Each qualified beneficiary 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 a disabled employee 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.

- **Second Qualifying Event:** If continuation coverage is elected after your are determined to no longer be disabled 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 Benefit Services in writing at the address listed in Appendix A, of the occurrence of the second event.

- **When COBRA Benefits End:** Generally, continuation coverage runs for 18, 29 or 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 18-, 29- or 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:	600 Franklin Building 3451 Walnut Street, Philadelphia, Pennsylvania 19104-6205
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 Health and Welfare Plan for Retirees and Disabled Employees
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.

- **Plan Trustee Information:** The Trustees of the University of Pennsylvania is trustee of the Retiree Medical and Death Benefits Trust. The trustee's address is 3451 Walnut Street, Suite 329, Philadelphia, PA 19104-6221.

- **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. Legal process may also be served on the trustee 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, 2021)

(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.)

Coverage for Non-Medicare LTD Members/Dependents

Medical

- **PENNCare/Personal Choice Preferred Provider Organization (PPO)**

This is a Preferred Provider Organization (PPO) administered by Independence Blue Cross. This particular coverage option 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, please contact Independent Blue Cross at the following address and phone number:

Contact Information:

Independence Blue Cross
Non- Preferred Providers
P. O. Box 69352
Harrisburg, PA 17106-9352
(800) ASK-BLUE or (800) 275-2583
www.ibx.com

- **Keystone/AmeriHealth (HMO)**

This particular coverage option is a Health Maintenance Organizations (HMO) provided by Keystone Health Plan East. Under this HMO, you must coordinate your care through a Primary Care Physician (PCP) who is part of the Keystone Preferred provider network. 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 these coverage options or to process claims for benefits, please contact Keystone Health Plan East at the following address and phone number:

Contact Information:

Keystone/AmeriHealth HMO
P.O. Box 69353
Solution Department
Harrisburg, PA 17106-9353
(800) ASK-BLUE or (800) 275-2583
www.ibx.com

- **Aetna Choice Point-of-Service (POS) II**

This option is administered by Aetna and does not require a Primary Care Provider (PCP) or referrals, even when using in-network providers. You can go to any provider, but your out-of-pocket costs are based on the type of provider you use:

- **In-Network Providers** - When you use health care providers who are part of the Aetna Choice POS II network, preventive care services are covered at 100%, provider office visits are covered at 100% after copays and most other services are covered at 80% after a deductible; you pay 20% of the covered charges.

- **Out-of-Network Providers** - When you use health care providers who aren't part of the Aetna Choice POS II network, most services, including preventive care, are covered at 60% after a deductible; you pay 40% of the covered charges.

For more information, view a summary of benefits for this plan.

Find in-network providers using the Aetna Provider Directory.

For more information about this coverage or to process claims for benefits, please contact Aetna at the following address and phone number:

Contact Information:

Aetna (Group #811778 EE)
PO Box 981106
El Paso, TX 79998-1106
(888) 302.8742
www.aetna.com

Prescription

Retirees and dependents under age 65 who elect medical coverage under this Plan will automatically be covered under the Plan's retiree prescription drug option provided through

CVS/caremark.

Participating CVS/caremark pharmacies offer discounted prices for prescription drugs.

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. If the dependent enrolls in the Medicare Advantage Plan, the dependent must also enroll in SilverScripts, the Medicare Part D Plan.

- Retiree age 65 and older and dependent under 65 – If the retiree elects to receive prescription drug coverage under an individual Medicare Part D plan, his/her spouse/same-sex domestic partner dependent can remain covered under this Plan's prescription drug coverage until he/she becomes Medicare-eligible.

For more information about this coverage or to process claims for benefits, please contact CVS/caremark at the following address and phone number:

Contact Information:

CVS/caremark
P. O. Box 52136
Phoenix, AZ 85072-2136
(844) 833-6390
www.caremark.com

Coverage for Medicare Eligible LTD Members/Dependents

Medical

- **Aetna Medicare Plan (PPO) (Group Number AE 379518)**

This particular coverage option is referred to as a Medicare Advantage Plan and is available through Aetna. Medicare beneficiaries may opt to enroll in this plan 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 this Medicare Advantage plan. You also must be enrolled in Medicare Parts A and B, pay the Part B monthly premium (which can be deducted from your Social Security check), and live in the plan's covered service area to be eligible

You may use any provider you wish, and you do not need to select a Primary Care Physician (PCP) or obtain referrals. Benefits differ according to the health care provider you use. If you use health care providers who are part of the Aetna Medicare network, most services are covered at 100% after applicable copays. If you use health care providers who are not part of the Aetna Medicare network, most services are covered at 80%.

Contact Information:

Aetna Medicare PPO
P.O. Box 981106
El Paso, TX 79998-1106
(800) 282-5366 Member Service

(800) 307-4830 Pre-Enrollment Information Line
www. Aetna.com

- **Independence Blue Cross (IBC) Medigap Security 65 Plans (Standard Plan –Plan N and Premium Plan – Plan C)**

The University has contracted with the above provider to provide medical benefits and claims services under the plans. These particular coverage options are referred to as the IBC Medigap Security 65 Plans. There are two options: a Standard and a Premium plan. These plans combine the benefits of traditional Medicare with the features of a private health plan. They help pay expenses that Medicare doesn't fully cover, such as copayments, coinsurance and emergency care when traveling outside the United States. They also offer the freedom and flexibility of no referrals and virtually no claim forms.

For more information about this coverage option or to process claims for benefits, please

contact Blue Cross/Blue Shield at the following address and phone number:

Contact Information:

Independence Blue Cross
Attention: Claims Department
1901 Market Street
Philadelphia, PA 19103-1480

Independence Blue Cross
Major Medical Claims Department
P.O. Box 13497
Philadelphia, PA 19101-3497

For both: (800) ASK-BLUE or (800) 275-2583

www.ibx.com

Prescription

- **SilverScript Insurance Company**

The University has contracted with the above provider to provide prescription drug and claims services under the Plan. This particular coverage option is referred to as the SilverScript Medicare Part D Plan. If you are enrolled in one of the options listed above, prescription drug coverage for you and your enrolled Medicare-eligible dependents will be provided through SilverScript.

For more information about this coverage option or to process claims for benefits, please contact SilverScript at the following address and phone number:

Contact Information:

For Paper Claims
Med D Paper Claims
P.O. Box 52066
Phoenix, AZ 85072-2066

For Mail Order
CVS Caremark
P.O. Box 94467
Palatine, IL 60094-4467

(888) 613-7038

http://upenn.silverscript.com

COBRA Administration

The University contracts with Wageworks to handle COBRA administration, billing, and premium collection.

Contact Information:

Wageworks

PO Box 226101

Dallas, TX 75222

(888) 678-4884

Other Benefits

Dental Coverage

- The Penn Family 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. Contact MetLife at 1-800-942-0854 for more information.

- The Aetna Vital Savings Dental Plan. LTD members who elect this option and visit a participating provider will receive an average discount of 28%. Contact Aetna at 1-877-698-4825 for more information. Promotional Code # 882016015. This is not a benefit provided under the Plan, but is instead made available to you by the carrier. There is no University contribution toward this coverage.

Vision Coverage

- The Davis Vision plan provides coverage when you obtain vision care from any provider you wish. Use in-network providers to receive higher coverage and pay less out of your pocket. You receive the highest level of coverage when using Scheie Eye providers. Most services are covered once every 12 months, although you may receive discounts for additional services provided by Scheie Eye and Davis Vision preferred providers. This is not a benefit provided under the Plan, but is instead a continuation of the vision benefit provided under the University's Health and Welfare Program. For more information, contact Davis Vision at (888) 393-2583 or visit http://www.ibx.com/index.jsp

- The VSP Vision plan provides coverage when you obtain vision care from any provider you wish. Use in-network providers to receive higher coverage and pay less out of your pocket. Most services are covered once every 12 months, although you

may receive discounts for additional services when using in-network providers. This is not a benefit provided under the Plan, but is instead a continuation of the vision benefit provided under the University's Health and Welfare Program. For more information, contact VSP Vision at (800) 877-7195 or visit http://vsp.com/eye-doctor.html

- LTD members who enroll in the Aetna Vital Savings Dental Plan (see above) will automatically have access to the Aetna Vision One discount program. Under this program, participants have access to providers in nearly 13,000 participating Vision Centers. Contact Aetna at 1-877-698-4825 for more information. Promotional Code #882016015. This is not a benefit provided under the Plan, but is instead made available to you by the carrier. There is no University contribution toward this coverage.

Life Insurance

Basic life insurance continues while you are receiving LTD benefits. If you were enrolled in supplemental life as an employee, you may continue this benefit at the same level of coverage in effect prior to your disability, unless you elect to reduce the level of coverage or cancel coverage. Once you reduce the coverage level or cancel supplemental life coverage, you cannot increase the coverage level or reenroll for coverage.

Pre-Tax Expense Accounts

Your participation in the Pre-Tax Expense Accounts ends when you are on LTD. Your contributions end with your final paycheck. However, you may be eligible to continue your Health Care Pre-Tax Expense Account overage 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 1-866-799-2329. 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 866-799-2329.

Long-Term Care Insurance

Coverage continues if you continue to pay the required premiums directly to the insurance carrier.

Contact Information:

John Hancock
John Hancock Place B-6
P.O. Box 111
Boston, MA 02117

Tuition Benefits

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