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The University of Pennsylvania Health and Welfare Program Summary Plan Description

As of July 1, 2020

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SECTION 1

Introduction to Your Benefits

Introduction

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

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

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

Important Notes on the Plan Summaries

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

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

The PennChoice Benefits Options

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

PennChoice offers some unique opportunities. Through PennChoice you can:

- Choose the level of coverage that best meets your needs.

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

- Pay for certain uninsured health care and dependent care expenses through the Flexible Spending Accounts.

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

Eligibility for Coverage

Employees Eligible for Coverage

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

- Regular Full-time Staff (weekly and monthly paid) working 35 or more hours per week for 12 months of the year.

- Full-time Faculty in a benefits eligible title (the University's Benefits Office will verify Faculty Appointments and benefits eligibility).

- Limited Service Staff (weekly and monthly paid) scheduled to work at least 35 hours a week for nine months of the year.

- Regular Part-time Staff (weekly and monthly paid) who work 17½ to 35 hours per week in accordance with the 'Part-time' policy.

- Part-time Faculty in a benefits eligible title (the University's Benefits Office will verify Faculty Appointments and benefit eligibility).

- Full-time Visiting Faculty.

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

Special Rule for Certain Full Time Employees under the Affordable Care Act: In some cases, faculty and staff members may fall outside of the eligibility requirements described above, but nonetheless be treated as "full time" employees under the Affordable Care Act (ACA) (as determined by the University) which means that all benefit coverage under the Program will terminate except that such full time employee will be offered **only** ACA-compliant medical coverage (including prescription benefits) for him/herself and his/her eligible dependents. That coverage will meet applicable requirements as to minimum value and affordability and is described in separate enrollment and other descriptive material prepared by Aetna. The medical plan descriptions contained in this SPD will not apply to these ACA

full-time faculty and staff members. If this ACA-compliant medical coverage is elected, payment must be made by personal check and not through payroll deductions. The University has contracted with a third party billing organization for this purpose.

Dependents Eligible for Coverage

Your dependents may also be enrolled for the Medical, Dental, Vision and Dependent Life Insurance plans. In order to cover them, you must submit documentation verifying that your dependents are eligible under Penn's plan rules. Shortly after you enroll a dependent(s), you will receive a personalized letter with full details about what documentation is required, when it must be provided and where to send it. If you fail to provide the required documentation, your dependent(s) will be considered ineligible for coverage and they will be disenrolled retroactively.

Eligible dependents include:

- your spouse (including a spouse of a common law marriage)
- your or your spouse's child up to the end of the month in which your child reaches age 26
- your or your spouse's child 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 (for purposes of dependent life insurance, you must submit both a request to continue coverage and the attending physician's review in support of the child's disability to Aetna within 31 days of the child reaching age 26).

A *child* includes a biological child, stepchild, child placed with you for adoption, legally adopted child, and a 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.

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

If both you and your spouse are benefit eligible employees of the University and eligible to participate in the Program:

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

Special Note About Domestic Partners: Your same-sex domestic partner is eligible for coverage if he or she is an individual who (1) prior to July 1, 2016, was participating with you in a same-sex domestic partnership that is registered with the University's Benefits Office and (2) was enrolled for coverage in

the Plan as of July 1, 2016 and has been continuously covered since that time. Excepted at otherwise noted, all references to "spouse" in this SPD will include a reference to same-sex domestic partner.

Enrolling in the Plans: Initial Eligibility

You must enroll within 30 days of the date you and/or your dependent(s) become eligible to make elections through the University Benefit offering. You will need your PennKey and password to enroll.

When Coverage Begins Healthcare coverage is effective the first day of the month, if you are hired on the first day of the month. If you are hired any day after the 1st of the month coverage is effective the 1st of the following month. The following matrix provides you with examples of hire dates, eligibility and deadlines for enrolling:

If Your Hire Date Is:	**Your Benefits Begin:**	**Your Deadline to Enroll Is:**
November 1	November 1	November 30
November 16	December 1	December 31

Visiting Faculty are eligible for benefits as of their date of hire.

Faculty and staff who experience a change in employment status which affects their benefits (e.g., changing from part-time to full-time status) are eligible for benefits on the first day of the month following the date of the change in status.

When Coverage Begins – Basic Life and AD&D Insurance

With respect to Basic Life and AD&D Insurance, your coverage begins on your first day of employment.

When Coverage Begins -- The Dependent Care Flexible Spending Account

With respect to the Dependent Care Flexible Spending Account, you are eligible for coverage on your benefits effective date

If You Do Not Enroll

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

- Full-time faculty and staff who are newly eligible for coverage and do not enroll online within 30 days **will not** participate in Medical, Dental, Vision, Supplemental Life, Dependent Life or Flexible Spending Accounts. You will be defaulted to Basic Life and AD&D Insurance, if you are actively at work on your coverage effective date.

- Part-time faculty and staff who are newly eligible for coverage and do not enroll online within 30 days **will not** participate in Medical, Dental, Vision or Optional Life. You will be defaulted to Basic Life.

- Visiting Faculty who are newly eligible for coverage and do not enroll online within 30 days will be defaulted to single medical coverage under the Keystone Health Plan East HMO plan.

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

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

Annual Choices

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

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

Available Options

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

Full-Time Faculty (Benefits Eligible), Regular Full-Time Staff, and Limited Service Staff*		
Plan	**Your PennChoice Options**	**Funding**
Medical, Behavioral Health and Substance Abuse and Prescription Drug	You can choose from among the available Medical plans or waive coverage. You can choose employee, employee + spouse/same-sex partner, employee +child(ren) or employee+family coverage. Medical plans generally include Behavioral Health and Substance Abuse Coverage and Prescription Drug Coverage.	You and the University share the cost of coverage.
Dental	You can choose from the available Dental plans or waive coverage. You can choose employee,	You and the University share the cost of coverage.

Full-Time Faculty (Benefits Eligible), Regular Full-Time Staff, and Limited Service Staff*		
Plan	**Your PennChoice Options**	**Funding**
	employee + spouse/same-sex partner, employee +child(ren) or employee+family coverage.	
Vision	You can choose from the available Vision Care plans or waive coverage. You can choose employee, employee + spouse/same- sex partner, employee +child(ren) or employee+family coverage.	You pay the full cost of coverage.
Basic Life and AD&D Insurance	You automatically receive Basic Life Insurance coverage equal to one times your annual base salary not to exceed $300,000 and AD&D Insurance coverage equal to two times your annual base salary, up to a maximum benefit of $125,000. If your salary is over $50,000, you have the option of limiting your Basic Life Insurance $50,000 (amounts over $50,000, up to $300,000, result in imputed income to you; see "Taxes on Your Coverage" under Life Insurance, below, for more information).	The University pays the full premium for Basic Life Insurance and AD&D Insurance.
Supplemental Life Insurance	You can elect optional Supplemental Life Insurance coverage of up to 5 times your annual base salary in increments of one-half of your base salary. Total combined Basic and Supplemental Insurance cannot exceed $1,300,000. If your supplemental coverage exceeds $750,000, you must provide Evidence of Insurability (EOI) to the insurance company. You may choose to limit your Supplemental coverage to $750,000 so you don't have to submit EOI.	You pay the full premium for any Supplemental Life Insurance you elect.
Dependent Life Insurance	You can elect optional Dependent Life Insurance coverage for your spouse and/or eligible dependent children who are 14 days or older. The maximum is $10,000 per child, $20,000 for a spouse.	You pay the full premium for any Dependent Life Insurance you elect.
Health Care Flexible Spending Account	You can contribute up to $2,700 for the plan year to an account to reimburse yourself for eligible health care expenses.	You pay the full cost of contributing to this account.
Dependent Care Flexible Spending Account	You can contribute up to $5,000 for the plan year to reimburse yourself for eligible dependent care expenses. You must be age 21 to be eligible. Individuals classified as highly compensated (according to IRS rules, this means W-2 earnings of $120,000 and above) may contribute up to $1,800. This amount is subject to change based on results of the annual non-discrimination testing required by federal law.	You pay the full cost of contributing to this account.

Full-Time Faculty (Benefits Eligible), Regular Full-Time Staff, and Limited Service Staff*		
Plan	**Your PennChoice Options**	**Funding**
Long-Term Disability	You automatically receive LTD coverage equal to 60% of your base salary at the onset of disability, up to $15,000 per month; minus income from other sources (see "Long-Term Disability (LTD) Benefits").	The University pays the full cost of coverage.
Long-Term Care	You can choose from among daily benefit amounts ranging from $100 to $300 per day for long-term care services and supplies. A Future Purchase Option (FPO) is available which offers a voluntary coverage increase without proof of good health every three years or you may choose the Automatic Benefit Increase (ABI) in which the Nursing Home Daily Maximum Benefit (DMB) will increase at an annual rate of 5% compounded.	You pay the full cost of coverage.

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

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

Part-Time Faculty (Benefits Eligible) and Regular Part-Time Staff		
Plan	**Your PennChoice Options**	**Funding**
Medical, Behavioral Health and Substance Abuse and Prescription Drug	You can choose from among the available Medical plans or waive coverage. You can choose employee, employee + spouse/same-sex partner, employee +child(ren) or employee+family coverage. Medical plans include Behavioral Health and Substance Abuse Coverage and Prescription Drug Coverage.	You and the University share the cost of coverage.
Dental	You can choose from the available Dental plans or waive coverage. You can choose employee, employee + spouse/same-sex partner, employee +child(ren) or employee+family coverage.	You pay the full cost of coverage
Vision	You can choose from the available Vision Care plans or waive coverage. You can choose employee, employee + spouse/same- sex partner, employee +child(ren) or employee+family coverage.	You pay the full cost of coverage.

Part-Time Faculty (Benefits Eligible) and Regular Part-Time Staff		
Plan	**Your PennChoice Options**	**Funding**
Basic Life and AD&D Insurance	You automically receive Basic Life insurance in a flat amount of $50,000. If you elect optional coverage, you automatically receive AD&D Insurance coverage equal to two times your annual base salary, up to a maximum benefit of $125,000.	The University pays the full premium for Basic Life Insurance and AD&D Insurance.
Optional Life and AD&D Insurance	You can elect Optional Life Insurance equal to two times your annual base salary (in increments of one-half of your base salary) or waive coverage.	You pay the full premium for Optional Life Insurance.
Long-Term Care	You can choose from among daily benefit amounts ranging from $100 to $300 per day for long-term care services and supplies. You can also elect non-forfeiture protection that assures benefits even if you stop paying premiums. You also have the option to elect an automatic benefit increase to assist with future inflation.	You pay the full cost of coverage.

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

Full-Time Visiting Faculty		
Plan	**Your PennChoice Options**	**Funding**
Medical, Behavioral Health and Substance Abuse and Prescription Drug	You can choose from among the available Medical plans or waive coverage. You can choose employee, employee + spouse/same-sex partner, employee +child(ren) or employee+family coverage. Medical plans include Behavioral Health and Substance Abuse Coverage and Prescription Drug Coverage.	You pay the full cost of coverage.

Note: You may receive other benefits if explicitly provided in the Provost Staff Conference Minutes.

If You Do Not Enroll During Open Enrollment

If you were previously enrolled under PennChoice and do not make a change online during open enrollment or within 30 days of a qualifying life change event (unless the event is divorce or legal separation, in which case notice must be provided within 60 days of the date of the event), your default

coverage, including participation in the Flexible Spending Accounts, will remain at the same coverage levels and options in which you were enrolled for the prior plan year (although the University reserves the right to replace coverage options that are no longer available with similar coverage options currently available). You will be responsible for any contributions associated with this default coverage.

Changing Your Benefits During the Year

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

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

- Marriage, divorce or legal separation when allowed under state law in the state in which you reside
- Death of your spouse
- Birth or adoption of a child or placement of a child for adoption, gaining a step-child, becoming legal guardian of a child
- Death of your child or your spouse's child
- A child's change in dependent status due to age
- Loss of a dependent's dependent status under the Plan
- Qualification of a Medical Child Support Order
- Your or your spouse's dependents gain or loss of other coverage as a result of a change in employment status or work schedule (including beginning or end of a leave of absence)
- Change in coverage under a non-Penn sponsored plan due to (1) a change in status under that plan or (2) a differing election period (these events will not allow a change under the Health Care Flexible Spending Account)
- Change in your dependent care provider
- Change in the cost of dependent care, if the provider is not your relative
- Change in your employment status resulting in a change in eligibility (e.g., change from full-time to part-time)
- Termination of employer contributions to your spouse's (this will not allow a change under the Health Care Flexible Spending Account)
- Change in your or a dependent's residence
- Expiration of non-Penn sponsored COBRA coverage for yourself or a dependent

- Eligibility for Medicaid

- Reduction of Hours During Plan Year. You may make an election change by cancelling your health coverage if you experience a reduction of hours below 30 hours per week during a Plan Year and you obtain coverage on a Health Insurance Marketplace/Exchange within two months of the cancellation of your coverage under this Plan.

- Health Insurance Marketplace Coverage. You may make an election change by cancelling your health coverage if you experience a special enrollment period under a Health Insurance Marketplace/Exchange and you obtain coverage on a Health Insurance Marketplace/Exchange immediately upon the cancellation of your coverage under this Plan.

Note: To be eligible to change your benefits following a qualifying life change event, you must report the event online via the University of Pennsylvania enrollment website and submit any necessary forms and documentation (as applicable) within 30 days after the event (unless the event is divorce or legal separation, in which case you must report the event within 60 days after the event). The Plan Administrator reserves the right to determine whether you have experienced an event that would permit an election change and whether your requested election change is consistent with such event.

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

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

Special Enrollment Rights

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

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

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

Finally, if you or your dependent (1) loses Medicaid or the Children's Health Insurance Program ("CHIP") coverage as a result of a loss of eligibility for such coverage or (2) becomes eligible for a premium assistance subsidy under Medicaid or CHIP, you will be able to enroll yourself and your

dependents in the Medical Plan, provided that a request for enrollment is made within 60 days after the loss of such coverage or premium assistance eligibility.

To request special enrollment or obtain more information, go to www.pennbenefits.upenn.edu or contact the Benefits Solution Center (*powered by Health Advocate*) at 1-866-799-2329.

When Participation Ends

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

If your staff position has been discontinued or transformed, under the current Position Discontinuation and Staff Transition (PDST) Policy (#628), coverage ends as follows:

- Your Medical, Dental and Vision benefits continue through the last day of the month in which your pay continuation period ends subject to your payment of the required contributions toward such coverage.

- Your Health Care Flexible Spending Account coverage will continue through the earlier of the last day of the month in which your pay continuation period ends or the last day of the Plan Year in which your termination of employment occurs.

- You may continue Long Term Care coverage by making premium payments directly to the insurance company.

- All other benefits under PennChoice (i.e., Life Insurance (basic and supplemental), Long-Term Disability, and the Dependent Care Flexible Spending Account) cease at the beginning of the severance period.

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

Your Contributions

Your contributions for medical, dental and vision benefits, and the Flexible Spending Accounts, are made with pre-tax dollars.* That is, they are deducted from your pay before any federal income tax, FICA (Social Security) tax and Medicare Insurance tax are withheld. Pre-tax contributions lower the amount of your taxable income and, therefore, lower the taxes you pay. There are exceptions to the pre-tax status of your contributions for a same-sex domestic partner and a partner's child(ren) who are not your dependents for federal income tax purposes, as noted below.

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

All contributions are taken from your paycheck and are deducted in the current month in which your coverage is effective. Coverage costs may be revised from time to time.

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

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

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

If your same-sex domestic partner and his or her children are not your dependents for tax purposes, the payments for coverage under the University's benefit programs will be deducted from your salary on a pre-tax basis and then the total **value** of the coverage provided on behalf of your same-sex domestic partner and his or her children under the University's benefit programs will be considered taxable income to you.

SECTION 2

Health Care Benefits

Introduction to Your Medical, Dental, and Vision Benefits

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

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

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

About the Medical Plans:

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

- You can join a Preferred Provider Organization (PPO). This type of plan offers preferred and non- preferred provider coverage. PPOs pay for preventive care as well as eligible expenses when you are ill. In general, you pay less out of pocket when you use preferred providers. You may pay a co-pay, coinsurance or a deductible for physician's office visits. Benefits under the non-preferred provider portion of the Plan are traditional insurance benefits. When you use non-preferred providers, the Plan reimburses you (or the physician or hospital) for eligible expenses you incur. (Payments are based on the rates that have been negotiated with preferred providers.) If a non-preferred provider is used, the Plan's payments are subject to deductibles, co-insurance and out-of-pocket maximums. This plan does not require referrals for care.

- You can join a Health Maintenance Organization (HMO). This type of plan is a managed care plan. Your care is coordinated through a primary care physician. HMOs pay for preventive care and eligible expenses when you are ill. You may pay a co-pay for office visits. A deductible plus coinsurance and a deductible may apply for certain services. In general, you must receive medical services from care providers (physicians, hospitals, etc.) that are part of the HMO network and must have referrals from your primary care physician in order for most specialist services to be paid by the HMO. You pay the cost of services obtained through providers who do not participate in the HMO and for services rendered without a referral from your primary care physician. There are exceptions to these general guidelines. You should refer to the Plan literature of the HMOs for more information about these exceptions.

- You can also join a Point-of-Service Plan (POS). A POS plan is similar to a PPO plan. The Plan pays for preventive care as well as eligible expenses when you are ill. In general, you pay less out of pocket when you use preferred providers. You may pay a co-pay, coinsurance and a deductible for physician's office visits. Benefits under the non-preferred provider portion of the Plan are traditional insurance benefits. When you use non-preferred providers, the Plan reimburses you (or the physician or hospital) for eligible expenses you incur. (Payments are based on the rates that have been negotiated with preferred providers.) If a non-preferred

provider is used, the Plan's payments are subject to deductibles, co-insurance and out-of-pocket maximums. This plan does not require referrals for care.

- You can also join a High-Deductible Health Plan (HDHP) with a Health Savings Account (HSA) You don't need a Primary Care Provider (PCP) or referrals for this plan. You can receive your care from any provider you choose, but your out-of-pocket costs are based on the type of provider you use. This plan carries a high deductible and you need to meet that deductible before the plan begins paying benefits. This applies to most services, including prescription drugs and office visits. However, the deductible does not apply to in-network preventive care and preventive generic prescription drugs. This plan has an HSA, a tax savings account that you can contribute to via payroll deduction and use the money to offset the cost of care. Penn will also contribute money to the HSA on your behalf—$1,000 if you have employee only coverage under the HDHP or $2,000 if you cover any dependents.

- You can choose the specific Plan that meets your needs for medical care and protection against high health care costs.

- For any Plan that provides services through a network of providers, provider lists can be found on the insurance company's website.

IMPORTANT NOTES:

-- Please keep in mind that the University may change the available coverage options (for example, adding, dropping or replacing coverage options) at any time and for any reason.

-- The medical plans offered DO NOT guarantee that all covered services will be available through preferred or in-network providers. If a preferred or in-network provider is not available and you utilize a non-preferred or out-of-network provider, the expense will be processed as an out-of-network expense in accordance with the terms of the Plan.

-- You should also note that in-network providers might refer you to providers who are outside the network. Anytime you use an out-of-network provider, your services will be processed accordingly (non-preferred or self-referred). You should always verify whether or not the provider is in-network by calling the number on the back of your ID card.

IMPORTANT CHANGES UNDER HEALTH CARE REFORM:

The Patient Protection and Affordable Care Act of 2010 (PPACA) mandated certain benefit changes that apply to all Medical Plans.

No Lifetime or Annual Limits. The Plan shall not impose a lifetime or annual limit on the dollar value of essential health benefits provided as part of any Benefits under the Plan.

No Rescission of Coverage. The Plan shall not cancel or discontinue Benefits under the Plan with a retroactive effect with respect to a Participant or covered Dependents except in the event of fraud or intentional misrepresentation or otherwise permitted under regulations (such as for non-payment of premiums).

No Cost Sharing on Recommended Preventive Care. No medical plan option (other than a grandfathered option) will require participant cost-sharing on recommended preventive care provided by

in-network providers. Preventive care services covered in-network at 100% will be reviewed annually and updated prospectively to comply with recommendations of:

- the United States Preventive Care Task Force;
- the Advisory Committee on Immunization Practices that have been adopted by the Director of the Centers for Disease Control and Prevention; and
- the Comprehensive Guidelines supported by the Health Resources and Services Administration.

No Preexisting Condition Exclusions. No medical plan option will impose a preexisting condition exclusion.

Coverage of Clinical Trials. No medical plan option will deny participation in an approved clinical trial for which you or your dependent is a qualified individual with respect to the treatment of cancer or another life-threatening disease or condition, or deny (or limit or impose additional conditions on) the coverage of routine patient costs for drugs, devices, medical treatment, or procedures provided or performed in connection with participation in such an approved clinical trial. The Plan will not discriminate against you on the basis of your participation in an approved clinical trial.

Cost Sharing. All medical plan options (other than a grandfathered option) will comply with the overall cost-sharing limit (i.e., out-of-pocket maximum) mandated by the Affordable Care Act, indexed annually. For purposes of this provision, cost-sharing includes deductibles, co-insurance, co-payments or similar charges, and any other required expenditure that is a qualified medical expense with respect to essential health benefits covered under the Plan. Cost-sharing shall not include premiums, balance billing amounts for non-network providers or spending for services that are not covered under the Plan.

Mental Health Parity. The Plan will provide parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and health insurance coverage offered in connection with the Plan. Specifically:

- Lifetime or Annual Dollar Limits. The Plan will not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.

- Financial Requirement or Treatment Limitations. The Plan will not apply any financial requirement or treatment limitation (whether quantitative or nonquantitative) to mental health or substance use disorder benefits in any classification (as determined by the Plan Administrator in accordance with applicable regulations) that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

- Criteria for Medical Necessity Determinations. The criteria for making medical necessity determinations relative to claims involving mental health or substance use disorder benefits will be made available by the Plan Administrator to any current or potential participant, beneficiary, or in-network provider upon request.

The manner in which these restrictions apply to the Plan will be determined by the Plan Administrator in its sole discretion in light of applicable regulations and other guidance.

Medical Loss Ratio Rebates. With respect to any insurance company rebate received by Wistar that is subject to the Medical Loss Ratio ("MLR") provisions of the Affordable Care Act, the Plan Administrator will determine what portion (if any) of such rebate must be treated as "plan assets" under ERISA. If any portion of the rebate must be treated as plan assets, the Plan Administrator will determine in its sole discretion the manner in which such amounts will be used by the Plan or applied to the benefit of participants; which participants need not be the same Participants who made contributions under the policy that issued the rebate.

The Preferred Provider Organization (PPO)

PennCare/Personal Choice PPO

This Preferred Provider Organization (PPO) plan administered by Independence Blue Cross has three components. You may receive your care through any provider you choose at any time, but your out-of-pocket costs are based on which component of the plan you're using at that time. You don't need a Primary Care Provider (PCP) or referrals for this plan.

- PennCare Network Providers: Use health care providers who are part of or affiliated with the UPHS network. Preventive care services are covered at 100%. Most other services are covered at 90% after a deductible; you pay only 10% of the covered charges.

- Personal Choice Preferred Providers: Use health care providers who are part of the Personal Choice network. Preventive care services are covered at 100%. Provider office visits are covered at 100% after copays. Most other services are covered at 80% after a deductible; you pay 20% of the covered charges.

- Non-Preferred Providers: Use health care providers who are not part of either the PennCare or Personal Choice networks. Most services, including preventive care, are covered at 60% after a deductible; you pay 40% of the covered charges.

Important Notes:

- Emergency visits are covered at 100% after a $100 copay. If you are admitted to the hospital, your copay will be waived and in-patient charges will be processed based on whether the facility is in-network or out-of-network.

- If services are rendered at a "free-standing facility", you must contact Member Services to confirm whether or not the facility is in-network.

- Services rendered at an "urgent care facility" in the Personal Choice Network are covered after a $50 copay.

- Services rendered at a "walk-in clinic" are covered at the specialist copay.

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

Aetna Choice POS II

Administered by Aetna, this is a new type of POS plan that offers more freedom: you don't need a Primary Care Provider (PCP) or referrals, even when using in-network providers. It has two components: in-network or out-of-network. You may receive your care through any provider you choose at any time, but your out-of-pocket costs are based on which component of the plan you're using at that time.

- In-Network Providers: 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. Most other services are covered at 80% after a deductible; you pay 20% of the covered charges.

- Out-of-Network Providers: Use health care providers who are not 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.

IMPORTANT: This is only a brief description of the Aetna Choice POS II plan. Please refer to your booklet for further information about this coverage.

Important Notes:

- **Emergency visits are covered at 100% after a $150 copay. If you are admitted to the hospital, your copay will be waived and in-patient charges will be processed based on whether the facility is in-network or out-of-network. If you are admitted to an out-of-network hospital through the emergency room, clinicians from Aetna's Utilization Management area will confirm that the admission was clinically necessary before the admission will be covered at the network rate. If the Utilization Management professionals determine the admission was not a true emergency, the out-of-network benefit level will apply.**

- **If services are rendered at a "free-standing facility", you must contact Member Services to confirm whether or not the facility is in-network.**

- **Services rendered at an "urgent care facility" in the Aetna Choice POS II Network are covered after a $50 copay.**

- **Services rendered at a "walk-in clinic" are covered at the specialist copay.**

Health Maintenance Organization (HMO)

HMOs are managed care plans. Penn offers the following HMO: *Keystone Health Plan East/AmeriHealth HMO*. The HMO pays for preventive care and care when you are ill. All care is coordinated through your primary care physician (PCP). This means care must either be provided or referred by your PCP for the HMO to cover the services. Care obtained without a referral or from out-of-network providers is not covered (exceptions are made for emergency care). Preventive care services are covered at 100%. Office visits and most outpatient services are covered at 100% after copays. Most other services are covered at 90% after a deductible.

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

Important Notes:

- **Emergency visits are covered at 100% after a $150 copay. If you are admitted to the hospital, your copay will be waived and in-patient charges will be processed based on whether the facility is in-network or out-of-network.**
- **If services are rendered at a "free-standing facility", you must contact Member Services to confirm whether or not the facility is in-network.**
- **Services rendered at an "urgent care facility" in the Keystone HMO Network are covered after a $50 copay.**
- **Services rendered at a "walk-in clinic" are covered at the specialist copay.**

Emergency Care Information for HMO Subscribers

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

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

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

The High Deductible Health Plan with a Health Savings Account

The Aetna High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) is designed to give you more choice and control over how you spend your health care dollars. Under this plan, you can see any provider of your choice without a referral and choose whether to go in-network or out-of-network each time you need care. As the name implies, this plan carries a high deductible and you need to meet that deductible before the plan begins paying benefits. This applies to all services, including prescription drugs and office visits. However, the deductible does not apply to in-network preventive care. After you meet the deductible, your out-of-pocket costs are based on whether you use in-network or out-of-network providers.

The Aetna HDHP with HSA is not available to Visiting Scholars or the members of Locals 54, 115 and 590.

The Health Savings Account

When you enroll in the HDHP, you may establish an HSA. An HSA is a tax savings account that you can use to pay for eligible health care expenses for you and your eligible dependents now, as well as save to pay for future health care expenses.

The HSA provides a triple tax advantage: money goes in tax-free, grows tax-free and is tax-free when used to pay for eligible medical expenses. If you don't use all of the money in the HSA during the plan year, it rolls over to the next year. Once your balance reaches $1,000 you can invest your account in a selection of investment funds through WageWorks. You can also take the money in the HSA if you leave Penn or retire. Once money is in the account, it's yours to keep or use toward eligible medical expenses.

Important HSA Rules

- You are not allowed to be enrolled in any other health coverage plan, including Medicare, or union plans (i.e., no secondary coverage permitted under spouse's plan).

- You cannot participate in the Health Care Flexible Spending Account if you elect the Aetna HDHP with HSA. Also, you will not be permitted to make contributions to an HSA if your spouse has a health care pre-tax spending account with his or her employer, other than a special "limited purpose" FSA that is designed to work with HSAs.

- For the 2020 calendar year, the maximum amount you can contribute to an HSA is $3,550 if you have single HDHP coverage and $7,100 if you have family coverage. For 2021, the maximum amount is $3,6003,500 for single coverage and $7,200 for family coverage. The University will contribute $1,000 for single coverage or $2,000 for family coverage to your HSA. This contribution as well as any pre-tax contributions that you authorize will be made to an HSA with PayFlex. You may make after-tax contributions to an HSA with any financial institution of your choosing.

- If you are age 55 or older, you can contribute an additional $1,000 per year.

- The University's contribution amount and any post-tax contributions must be counted towards the HSA limits.

- Money must be in an HSA account to receive reimbursement.

- After-tax contributions can be made by anyone to your HSA.

- You may change your HSA pre-tax contribution amounts anytime during the year.

IMPORTANT: This is only a brief description of the HDHP/HSA option. Please refer to your booklet for further information about this coverage.

Maternity Hospital Stays

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

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However,

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

Women's Health and Cancer Rights Act Notice

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

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

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

Prescription Drug Coverage

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

Major pharmacy chains and many local pharmacies participate in the CVS/caremark network. You may obtain up to a 30-day supply at a retail pharmacy. If you use your CVS/caremark ID card at a participating pharmacy, you pay 10% of the discounted price for generic drugs ($7.50 minimum co-insurance, $20 maximum co-insurance), 30% of the discounted price for brand name drugs with no generic equivalents ($15 minimum co-insurance, $100 maximum co-insurance) and 10% of the discounted price for brand name drugs that have generic equivalents ($15* minimum co-insurance, $100* maximum co-insurance). For specialty drugs, you pay 30% of the discounted price ($15 minimum/$100 maximum).

** Note that if you purchase brand name drugs that do have generic equivalents, you'll pay the 10% brand name cost plus the cost difference between the brand name and generic. The cost difference between brand name and generic does not count toward the minimums and maximums.*

These same percentages apply to behavioral health-related prescriptions. If you purchase brand name drugs that have generic equivalents, you'll pay the brand name coinsurance amount plus the difference in cost between the brand name and generic drug.

If you do not use your CVS/caremark ID card at a participating pharmacy or if you fill your prescription at a non-participating pharmacy, you pay the full cost of the prescription at the time of purchase and file a claim form with CVS/caremark to be reimbursed.

Mail Service Program: CVS/caremark offers mail order services for long-term maintenance prescriptions. You may obtain up to a three-month supply through this program. When you use the

mail order services, you pay 10% of the discounted price for generic drugs ($15 minimum co-insurance, $40 maximum co-insurance for a 3-month supply), 20% of the discounted price for brand name drugs with no generic equivalents ($20 minimum co-insurance, $100 maximum co-insurance for a 3-month supply) and 10% of the brand name drugs that have generic equivalents ($30* minimum co-insurance, $200* maximum co-insurance for a 3-month supply).

90-Day Maintenance Program: You may receive a 90 day supply of long-term maintenance medication at CVS at the mail service coinsurance rates.

** Note that if you purchase brand name drugs that do have generic equivalents, you'll pay the 10% brand name cost plus the cost difference between the brand name and generic. The cost difference between brand name and generic does not count toward the minimums and maximums.*

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

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

When you enroll in the Aetna High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), the amount you pay for prescription drugs depends on whether your prescription is a preventive generic drug or some other drug type. When you take generic preventive drugs, you're not subject to the deductible; for all other drugs, you must reach your deductible before the plan begins to pay benefits.

Aetna High Deductible Health Plan (HDHP) with a Health Savings Account (HSA)

Annual Deductible*	$1,500 individual/$3,000 family
Annual Out-of-Pocket Maximum*	$3,000 individual/$6,000 family
Preventive Generic Drugs (any retail or mail order, maintenance or non-maintenance)	10%, no deductible
Preventive Brand Name Drugs (with or without generic equivalent, any retail or mail order, maintenance or non-maintenance)	10% after deductible
Non-Preventive Drugs (generic or brand, with or without generic equivalent, any retail or mail order, maintenance or non-maintenance)	10% after deductible

** Amounts you pay toward medical and behavioral health/substance abuse also count toward the deductible and out-of-pocket maximum. After the out-of-pocket maximum is reached, all covered prescription drugs are paid at 100%.

Behavioral Health and Substance Abuse Benefits

Under all Medical Plan options, your behavioral health and substance abuse coverage is provided for you and your dependents.

If you are in the Keystone/AmeriHealth HMO, behavioral health benefits are provided by Magellan Health Services.

If you are in the Aetna High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) or the Aetna POS II plan, behavioral health benefits are provided by the Aetna Network.

If you are in the PennCare/Personal Choice plan, your behavioral health benefits are provided through Quest.

The Dental Assistance Plans

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

You currently have a choice between two Dental Assistance Plans:

- ***The Penn Family Plan*** provides services through the University's Dental Care Centers. The Plan pays all or most of the cost of many dental services if they are received through a Dental Care Center.

- ***The MetLife Preferred Dentist Program (MetLife PDP)*** offers the option of selecting a dentist of your choice or one from a network of preferred providers. When you use a MetLife preferred provider dentist, you pay a percentage of the negotiated fee and therefore, pay less out-of-pocket. When you use a non-preferred dentist, the Plan will reimburse you a percentage of the reasonable and customary charge for services.

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

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

Comparing Benefits and Services

The following chart compares benefits and services of both the Penn Family Plan and the MetLife Preferred Dentist Program. You may also obtain additional information from the Plan booklets issued by the Penn Faculty Practice Plan and MetLife or by visiting the Penn Family Plan Web site at https://mypenndentist.org/about-us/insurance-plans/ and the MetLife Web site at www.metlife.com/dental.

Dental Plan Comparison Chart (showing what participants pay)

	Penn Family Plan (PFP Plan)*	**MetLife Preferred Dentist Program (PDP)****	
		Preferred Provider	**Non-Preferred Provider**
Deductible	None	$50 individual	$50 individual
Diagnostic Care (e.g., exams, x-rays)***	$0 copay	$0 copay	$0 copay of R&C**

	Penn Family Plan (PFP Plan)*	MetLife Preferred Dentist Program (PDP)**	
		Preferred Provider	Non-Preferred Provider
Preventive Care (e.g., cleanings)	$0 copay Limited to two visits per plan year (7/1 - 6/30)	$0 copay Limited to two visits per plan year (7/1 - 6/30)	$0 copay of R&C** Limited to two visits per plan year (7/1 - 6/30)
Restorative Care (e.g., fillings)	$0 copay	10% after deductible	10% of R&C**after deductible
Oral Surgery (e.g., extractions)	$0 copay	$0 copay	$0 copay of R&C**
Endodontics (e.g., root canal therapy)	20%	20% after deductible	20% of R&C**after deductible
Periodontics (e.g., gum treatment)	20%	20% after deductible	20% of R&C**after deductible
Prosthodontics (e.g., bridges, dentures)	40%	50% after deductible	50% of R&C** after deductible
Crowns and restorations	40%	50% after deductible	50% of R&C** after deductible
Implants	50%****	50%	50% of R&C
Orthodontics****	40%***** *$2000 lifetime maximum benefit for each child/adult* *One time Invisalign benefit of $1000 for full case and $500 for limited express case per child/adult*	50% *$1500 lifetime maximum benefit per child/adult* *Invisalign included*	50% of R&C** *$1500 lifetime maximum benefit per child/adult*
Cosmetics (e.g., veneers, bleaching)	50%	Not covered	Not covered
Annual Maximum (maximum the plan will pay)	$3000 per individual	$2000 per individual	$2000 per individual

*Please reference the PFP plan document for limitations and exclusions. Note that if you receive dental treatment anywhere other than a Penn Family (PFP) Plan office, no benefits will be paid unless due to an emergency that occurs outside of the Philadelphia area (outside a 50-mile radius of a PFP office). Reimbursement will be at the PFP Plan coverage level, based on PFP network fees.

**Please reference the MetLife plan summary for limitations and exclusions. Note that benefits at a MetLife PDP provider are based on the fee negotiated by MetLife with the provider. Non-preferred provider benefits are based on the Plan's

reasonable and customary limits (R&C). Non-preferred dentists are not required to accept the R&C as payment in full, so you may pay not only your coinsurance amount but also the difference between R&C and the dentist's actual charge

***Please reference the plan documents for limitations and exclusions.

**** Covered if tooth was extracted while the participant was covered by a University plan within the last 60 months.

*****Any amounts applied to the lifetime maximums for orthodontics apply toward the annual benefit maximums as well.

Predetermination of Benefits

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

Changing Plans in the Middle of Treatment

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

Vision Care Plan

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

You currently have a choice between two Vision Care Plans:

- **The Davis Vision Plan** allows you to choose any vision provider you'd like. You'll pay less out-of- pocket when using in-network providers, enjoying the lowest copays and highest allowances when using a Scheie Eye provider. Most services are covered once every fiscal year, although you may receive discounts for additional services when using in-network providers. For more information, contact Davis Vision at 888-393-2583 or visit https://www.davisvision.com/.

- **The VSP Vision Plan** allows you to choose any vision provider you'd like. You'll pay less out-of- pocket when using in-network providers, enjoying the lowest copays and highest allowances when using a VSP Choice network provider. Most services are covered once every fiscal year, although you may receive discounts for additional services when using in-network providers. For more information, contact VSP at 800-877-7195 or visit https://www.vsp.com/.

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

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

Comparing Benefits and Services

The following chart compares benefits and services of both the Davis Vision Plan and the VSP Vision Plan. You may obtain additional information at https://www.hr.upenn.edu/PennHR/benefits-pay/health-life-and-fsa/planrates/vision.

Vision Plan Comparison Chart (showing what participants pay)

Davis Vision Plan			
	Scheie Eye Providers	**Davis Vision**	**Out of Network**
Glasses	***Covered once every 12 months***		
Eye Exam and Refraction	$0 copay	$10 copay	Up to $32 reimbursement
Frames	Up to $100 retail allowance or select from designer frame collection	Up to $65 retail allowance or select from designer frame collection	Up to $30 reimbursement
Standard Lenses			
Single	$0 copay	$0 copay	Up to $30 reimbursement
Bifocal			Up to $36 reimbursement
Trifocal			Up to $50 reimbursement
Aphakic/Lenticular			Up to $72 reimbursement
Polycarbonate Lenses			
Single	$0 copay if under age 19; discounted prices if age 19 and over	$0 copay if under age 19; discounted prices if age 19 and over	Up to $30 reimbursement
Bifocal			Up to $36 reimbursement
Trifocal			Up to $50 reimbursement
Progressive Lenses	Discounted prices	Discounted prices	Up to $36 reimbursement
Contact Lenses	***Evaluation and fitting covered once every 12 months; contact lenses covered once every 12 months in lieu of glasses***		
Evaluation and Fitting			
Daily Wear	$0 copay	$0 copay	Up to $20 reimbursement
Extended Wear			Up to $30 reimbursement
Disposable			Up to $75 reimbursement
Standard Contact Lenses			
Medically Necessary	Up to $200 allowance	Up to $200 allowance	Up to $200 reimbursement
Disposable	Up to $80 allowance	Up to $75 allowance	Up to $75 reimbursement

Davis Vision Plan			
	Scheie Eye Providers	**Davis Vision**	**Out of Network**
Specialty Contact Lenses	Up to $110 allowance	Up to $75 allowance	Up to $60 reimbursement
Additional Discounts	***Discounts available only at the point of purchase***		
Lens options (e.g.,	Discounted prices ($0 copay for tints)	Discounted prices ($0 copay for tints)	Not covered
Additional Eyewear	Discounted prices	Discounted prices*	Not covered
Laser Vision Correction	$1,000 discount	Up to 25% off usual and customary fees or 5% off advertised specials, whichever is	Not covered

*Members selecting non-covered materials (i.e., second pair of eyeglasses, sunglasses, etc.) will receive up to a 20% courtesy discount and up to a 10% discount on disposable contacts at most participating providers.

VSP Vision Plan

	Choice Providers	**Participating Scheie Locations/Providers**	**Out-of-Network**
Glasses (Covered once every 12 months)			
Eye Exam and Refraction	$10 copay	$10 copay	Reimbursed up to $45
Frames	Up to $150 retail allowance plus 20% off amount exceeding allowance ($80 allowance at Costco)	Up to $150 retail allowance	Reimbursed up to $70
Standard Lenses (Covered once every 12 months)			
Single	$20 copay	$20 copay	Reimbursed up to $30
Lined Bifocal	$20 copay	$20 copay	Reimbursed up to $50
Lined Trifocal	$20 copay	$20 copay	Reimbursed up to $65
Lined Aphakic/Lenticular	$20 copay	$20 copay	Reimbursed up to $100
Polycarbonate lenses for children up to age 19	Covered in full	Covered in full	No additional reimbursement
Contact Lenses (Evaluation and fitting covered once every 12 months; contact lenses covered once every 12 months in lieu of glasses)			
Evaluation, Fitting and Lenses			
Daily Wear	$20 copay for evaluation and fitting; up to $150 allowance for contact lenses	Usual & customary fees for evaluation and fitting; up to $150 allowance for contact lenses	Reimbursed up to $105 (fitting, evaluation and contact lenses)
Extended Wear	$20 copay for evaluation and fitting; up to $150 allowance for contact lenses	Usual & customary fees for evaluation and fitting; up to $150 allowance for contact lenses	Reimbursed up to $105 (fitting, evaluation and contact lenses)

	Choice Providers	Participating Scheie Locations/Providers	Out-of-Network
Disposable	$20 copay for evaluation and fitting; up to $150 allowance for contact lenses	Usual & customary fees for evaluation and fitting; up to $150 allowance for contact lenses	Reimbursed up to $105 (fitting, evaluation and contact lenses)
Additional Discounts	**Discounts available only at the point of purchase**		
Lens options (e.g., anti-reflective coatings and progressive lenses)	Average savings of 20-25%	Usual & customary fees	Not covered
Additional Eyewear	20% discount; Costco pricing applies	Usual & customary fees	Not covered
Laser Vision Correction	15% discount or 5% off any promotional price through VSP contracted service locations	Usual & customary fees	Not covered

Coordination of Benefits

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

How Plans Coordinate with Each Other

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

How Primary and Secondary are Determined

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

1. The plan covering the patient directly, rather than as a dependent, is primary. The other plan is secondary.

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

If the parents are separated or divorced, the plans pay in this order:

A. If a court decree has established financial responsibility for the child's health care expenses, the plan of the parent with this responsibility;

B. The plan of the parent with custody of the child;

C. The plan of the step-parent married to the parent with custody of the child;

D. The plan of the parent without custody of the child.

3. If the employee or spouse is either laid off or retired, the plan covering the other person (as an active employee) is primary.

4. Expenses incurred for the treatment of injury arising out of the maintenance or use of a motor vehicle shall be eligible for coverage only to the extent that such benefits are in excess of, and not in duplication of, benefits paid or payable:

   A. under a plan or policy of motor vehicle insurance, provided that non-duplication as contained herein is not prohibited by law or;

   B. through a program or other arrangement of qualified or certified self-insurance.

5. If none of the above applies, the plan covering the patient the longest is primary.

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

Special Situations Affecting Your Medical, Dental and Vision Benefits

If You Take a Leave of Absence

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

Unpaid Leave of Absence

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

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

You will receive a bill each month with instructions for submitting payment. Your premium payments will be on an after-tax basis.

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

Paid Leave of Absence

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

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

If you choose to waive any coverage during the leave of absence (whether paid or unpaid), you must re-enroll within 30 days of the date on which you return to active status. In addition, if the open enrollment period occurs while you are on leave and you want to change your medical, dental and/or vision coverage elections, you may make any coverage changes for the next fiscal year while on leave.

Disability Leave of Absence

See "If You Become Disabled" below for details.

When Coverage Ends

Your coverage ends the last day of the month in which your employment with the University ends or you become ineligible for coverage. Life Insurances ends on your separation date. If your dependent child becomes ineligible because of age coverage ends on the last day of the month after the child becomes ineligible.

You must record the event using the online enrollment system at www.pennbenefits.upenn.edu within 30 days of the event.

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

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

Extension of Benefits

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

If You Become Disabled

If you qualify for Long-Term Disability (LTD) benefits, your medical and dental coverage may continue under the University's Health and Welfare Plan for Retired and Disabled Employees. You and the University share the cost of medical coverage, with the University paying the higher amount. You and the University share the cost of dental coverage. If you have vision coverage when you qualify for LTD benefits, you pay the full cost. **IMPORTANT: Please keep in mind that the University reserves the right to change this cost-sharing structure in the future or to eliminate coverage entirely. Also, keep in mind that you cannot receive benefits under the University's Health and Welfare Plan for Retired and Disabled Employees as both a disabled individual and as a retiree.**

If You Retire

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

If you retire on or after July 1, 2017, you are eligible to participate in the Plan upon your retirement if you satisfy the "Rule of 75" (that is, the sum of your whole age and whole years of service totals at least 75). The Rule of 75 also has minimum age and service requirements. You must be at least age 55 and have 10 or more years of service. Service must be full-time and continuous.

IMPORTANT: All determinations as to your eligibility for retiree health coverage will be made in accordance with the University's Health and Welfare Plan for Retired and Disabled Employees. Also, keep in mind that you cannot receive benefits under the University's Health and Welfare Plan for Retired and Disabled Employees as both a disabled individual and as a retiree.

If You Are Re-employed

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

If you are enrolled in Medicare Parts A and B, you also need to contact Medicare to inform them of your return to active employment.

Your Right to Continue Coverage - COBRA

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

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

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

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

*To be eligible for the 11-month extension, the disabled qualified beneficiary must be determined to have been disabled at any time during the first 60 days of COBRA coverage and written notice of such determination must be provided to ADP within 60 days of the date of the determination and before the original 18-month COBRA period expires.

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

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the COBRA Administrator has been notified, that a qualifying event has occurred. If the qualifying event is divorce

or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child, you must notify the COBRA administrator within 60 days after the qualifying event occurs. Upon receiving notification, they will issue a COBRA election notice for the qualified beneficiaries to complete. Qualified beneficiaries must return the completed election notice within 60 days of receiving the notice for coverage to continue under COBRA.

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

If you elect to continue coverage following a termination of employment or a reduction in hours and, during the 18-month period of continuation coverage, a second event occurs that would have caused your dependents to lose coverage under the Plan (if they had not lost coverage already), they may be given the opportunity to extend the period of continuation coverage to a total of 36 months. You or your dependent must notify ADP in writing at the address listed in Section 9: Carrier Directory, of the occurrence of the second event. In addition, if you (the covered employee) become entitled to Medicare benefits and during the subsequent 18-month period lose coverage due to a termination of employment (for reasons other than gross misconduct) or a reduction in hours of employment, all qualified beneficiaries other than you will be entitled to a maximum of 36 months of coverage from the date of Medicare entitlement.

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

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

Continuation Coverage During Military Service

Employees and dependents who lose health coverage due to the employee's military leave of absence under the Uniformed Services Employment and Reemployment Rights Act of 1994 may elect to

continue coverage for up to 24 months. Any individual who elects to continue such coverage will be required to make the same premium payments as a COBRA participant.

Conversion of Medical Coverage

If medical coverage is continued through COBRA, the individuals covered under COBRA are generally eligible to convert their coverage to an individual policy then offered through the insurer.

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

Dental coverage cannot be converted to an individual policy.

Neither Vision Plan coverage nor Health Care Flexible Spending Account coverage can be converted to an individual policy.

Where You Can Learn More

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

SECTION 3

Group Life Insurance

Introduction to Your Group Life Insurance

The Life Insurance Plan provides life, accident, and special disability insurance coverage. Most participants are eligible to elect from a number of different levels of protection. Certain job classifications may be eligible for a fixed amount of life insurance only and are not eligible for all types of protection. See "Your PennChoice Options and Funding" under Section 1: Introduction to Your Benefits or contact the Benefits Solution Center (*powered by Health Advocate*) at 1-866-799-2329 for more information.

The Life Insurance Plan includes several types of protection:

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

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

Enrollment and Beneficiary Designation

When you enroll for coverage you complete an enrollment form and name a beneficiary to receive benefits in case of your death. You may name anyone as your beneficiary and can change your beneficiary at any time via the online enrollment system. You do not need the consent of your beneficiary to do so. Your new beneficiary designation will take effect on the date you make the change. Remember to keep a record of your current beneficiary. See "Payment of Benefits", below for how benefits are paid if you do not name a beneficiary. (You cannot name the University of Pennsylvania as a beneficiary.)

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

Life Insurance

• Full-time Faculty in benefits eligible title *or* • Regular Full-time or Limited Service Staff. *Note: The provisions of applicable collective bargaining agreements govern the Health and Welfare benefits of employees in collective bargaining units.*	• Basic Life Insurance: – One times your benefits base salary rounded up to the next higher $100, not to exceed $300,000, is provided at no cost to you. – Coverage effective on your date of hire – If your benefits base salary is more than $50,000, you can choose to limit your Basic Life Insurance coverage to $50,000 in order to avoid paying imputed income tax. (See "Taxes on Your Coverage", below for more information on imputed income.) • Supplemental Life Insurance: – You can elect up to an additional five times your benefits base salary, rounded up to the next higher $100, at your own cost. – During each open enrollment (or if you have a qualifying life change event) you can increase your coverage in increments of one- half times your benefits base salary, up to one multiple of salary, not to exceed 5 times your benefits base salary. • Coverage is effective the first day of the month following your hire date. Basic and Supplemental Life Insurance combined cannot exceed $1,300,000. *If your supplemental coverage is more than $750,000 you must provide satisfactory evidence of insurability to the insurance company*. You may choose to limit your supplemental coverage to $750,000 so you don't have to submit EOI.
• Part-time Faculty in a benefits eligible title *or* • Regular Part-time Staff.	• Basic Life Insurance: - Coverage effective on your date of hire - Coverage amount of $50,000 • Optional Life Insurance: - You can elect two times your benefits base salary, rounded up to the next highest $100, at your own cost. - Coverage is effective the first day of the month following your hire date.
• Full-time Visiting Faculty	• Life Insurance coverage of $50,000 if indicated in the Provost Staff Conference minutes.

	• Coverage begins on your date of hire

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

Payment of Benefits

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

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

Accelerated Death Benefits

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

Taxes on Your Coverage

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

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

For example, a 49-year-old employee with $150,000 of Basic Life Insurance would have $100,000 subject to imputed income ($150,000 minus $50,000). This will result in an additional $180 in income

on his or her federal income tax return ($100,000 divided by 1,000, multiplied by .15 (from the table below), then multiplied by 12 months). Assuming a combined federal, FICA, state and local income tax rate of 40%, the result is $72 in additional taxes for the year. As you can see, the overall impact of the additional coverage is small in relation to the protection this coverage provides.

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

Age	**Rate per $1,000 per month**
Under 30	$ .028
30 – 34	$ .037
35 – 39	$ .042
40 – 44	$ .046
45 – 49	$ .069
50 – 54	$ .106
55 – 59	$ .198
60 – 64	$ .300
65 – 69	$ .576
70 -74	$1.043
75 and Over	$1.151

Accidental Death and Dismemberment Insurance (AD&D)

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

Schedule of AD&D Benefits

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

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

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

*To a maximum of $125,000

For benefits to be payable, death or the loss suffered must be the direct result of the accidental injury, and from no other cause (i.e., self-inflicted). Coverage is provided for the loss of a hand, foot, or sight that occurs within 90 days of the accident. The loss of a hand or foot means that it is completely severed at or above the wrist or ankle joint. Loss of eyesight means the complete and permanent loss of sight.

Exclusions

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

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

Payment of Benefits

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

Dependent Life Insurance

Full-time faculty in a benefits eligible title and regular full-time or limited service staff can elect to purchase Dependent Life Insurance coverage for your spouse and eligible children who are at least 14 days old, but less than 26), under the Dependent Life Insurance program. Regular part-time staff, part-time faculty in benefits eligible title and visiting faculty are not eligible for Dependent Life Insurance. Coverage may continue for an incapacitated (disabled) child beyond age 26 if you submit a request to continue coverage and the attending physician's review in support of the child's disability to Aetna within 31 days of reaching age 26.

Please note that if both you and your spouse are eligible to purchase Dependent Life Insurance through the University, each of you may purchase a policy covering the other. However, only one of you may elect to purchase a Dependent Life policy covering your children.

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

Coverage Options

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

Option	Coverage Amount	
	Spouse/Partner	**Child**
1	No coverage	No coverage
2	$20,000	No coverage
3	No coverage	$10,000 per child
4	$20,000	$10,000 per child

Payment of Benefits

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

Tax Status

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

Special Situations Affecting Your Group Life Insurance

If Your Employment Ends

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

If you:	Life Insurance	AD&D Insurance	Dependent Life Insurance
Die	Paid to your beneficiary.	Paid to your beneficiary if death is caused by an accident.	Coverage continues for 6 months after your death. Your dependents can elect to convert coverage to an individual policy.

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

If You Stop Making Contributions

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

If You Take a Leave of Absence

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

Unpaid Leave of Absence

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

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

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

Paid Leave of Absence

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

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

If You Retire

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

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

If you retire on or after July 1, 2020, you are eligible to participate in the Plan upon your retirement if you satisfy the "Rule of 75" (that is, the sum of your whole age and whole years of 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 and have 10 or more years of service. Service must be full-time and continuous.

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

If You Are Re-Employed

If you are retired, age 65 or older, eligible for retiree life insurance benefits and return to work at Penn in a position eligible for life insurance benefits, your coverage under the University's Health and Welfare Plan for Retired and Disabled Employees will cease and you will again be eligible for coverage under the active Life Insurance Plans. You will be required to contribute to your coverage under the same guidelines as an active employee with the same job title.

If the Plan Ends or Your Eligibility Ends

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

Converting Coverage

If you retire, leave the University for any reason, or become ineligible for coverage, you may convert your life insurance coverage (but not your AD&D coverage) to an individual whole life policy that is equal to or less than the amount of your coverage prior to coverage ending. No evidence of insurability is required to convert your coverage. Your converted policy as a retiree combined with the University-provided coverage of $5,000 cannot exceed the amount of your coverage prior to retirement. If you become re-employed by the University and are again eligible for coverage under the group policy, your conversion policy will terminate.

You must apply for conversion to an individual policy within 31 days of your retirement or termination date.

Porting Coverage

If you are no longer in an eligible class and no longer eligible for coverage and are not disabled, you may port your life insurance coverage (but not your AD&D coverage) to an individual term life policy that is equal to or less than the amount of your coverage prior to coverage ending. No evidence of insurability is required to port your coverage. Your ported policy as a retiree combined with the University-provided coverage of $5,000 cannot exceed the amount of your coverage prior to retirement. If you become re- employed by the University and are again eligible for coverage under the group policy, your port policy will terminate.

You must apply to port to an individual policy within 31 days of termination of coverage.

How to File a Claim

In the event of death, a claim must be filed with the University's life insurance carrier. If your covered dependent (spouse or child) dies, you should contact the Benefits Solution Center and press Option #2 as soon as possible. A MetLife representative will help you with the necessary forms and documents needed for processing the claim. You will be asked to provide the insurance company with a certified copy of the death certificate. Additional proof of death or loss may also be required for all claims. Once proof acceptable to the insurance company is received, benefits will be paid as soon as possible.

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

Claim Payments

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

Situations Affecting Plan Benefits

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

- If you or your beneficiary do not file a claim or furnish proof of loss to MetLife, insurance payments will be delayed until you or your beneficiary furnish such information.

- If you or a dependent (spouse or dependent child) are no longer eligible for the Plan, your coverage will end, regardless of the Dependent Life Insurance option, or any premiums paid in error. Dependent coverage ends for your dependent on the date he/she ceases to be an eligible dependent.

- If you fail to make any timely payment of any required contributions, your coverage will end (Supplemental, Optional, and/or Dependent Life Insurance).

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

Assignment of Coverage

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

Where You Can Learn More

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

MetLife Life Insurance Company

SECTION 4

Flexible Spending Accounts

Introduction to Your Flexible Spending Accounts

The Flexible Spending Accounts let you pay certain expenses with pre-tax dollars. There are two accounts:

- The Health Care Flexible Spending Account - to help pay for uninsured medical and dental expenses and

- The Dependent Care Flexible Spending Account - to help pay for dependent care expenses that are necessary for you (and your spouse, if you are married) to work.

The Advantages of These Accounts

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

Eligibility and Participation

Full-time benefits-eligible faculty and regular full-time and limited service staff are eligible to participate in the Health Care Flexible Spending Account upon hire (up to $2,750 per year) and the Dependent Care Flexible Spending Account upon hire (up to $5,000 per year).

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

Your Contribution Decision

You decide how much you want to contribute for the plan year during the annual enrollment period—or if you are newly eligible or have a qualifying change in status, within 30 days of eligibility or the qualifying event. Your contributions are set aside from your pay and held for you in your account. When you have an eligible expense, you file a request for reimbursement. A minimum contribution amount of $50 is required.

Important Government Restrictions

Because of the tax advantages offered through the Flexible Spending Accounts, the federal government places important restrictions on their funding and use.

- You decide how much to contribute for each plan year. Only expenses incurred during the plan year in which you participate are eligible. Contributions for expenses you incur before your participation begins, or after it ends, cannot be reimbursed from your account.

- Once you make your decision, it may only be changed if you have a qualifying change in status. If you choose to decrease your election as a result of a change in status and you have already received reimbursements from your Health Care Flexible Spending Account, you must reduce your election by an amount equal to or greater than the amount of your reimbursement(s).

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

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

The Health Care Flexible Spending Account

You can use the Health Care Flexible Spending Account for eligible expenses incurred by you, by your spouse, by your natural child, stepchild, adopted child or foster child (through the end of the calendar year in which they attain age 26) or by any dependent with respect to whom you are entitled to claim a deduction on your federal income tax return (or would be entitled to claim a deduction but for the dependent's gross income). These dependents are not required to be enrolled in your medical plan in order to qualify.

Your Contributions to the Health Care Flexible Spending Account

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

- There is a $50 minimum contribution.
- The maximum contribution for full-time benefits-eligible faculty and regular full-time and limited service staff is $2,750 for the plan year.).
- You are able to roll over up to $500 of unused money in your Health Care FSA to the following plan year. You will forfeit any remaining balance over $500. (See "Special Carryover Option" below.)

If you and your spouse are both Penn employees and participating in a Health Care Flexible Spending

Account, you each have a $2,750 limit.

Eligible Expenses

In general, your Health Care Flexible Spending Account can be used for expenses that the Internal Revenue Service would consider deductible for federal income tax purposes, although there are some exceptions. Special rules apply if you have coverage under the Aetna HDHP, as noted in the "*CAUTION*" below. You can only use the account for expenses not covered by your health plan. The following list provides some examples:

- medical, dental, vision and prescription drug plan deductibles, co-payments and coinsurance amounts
- vision expenses, including eyeglasses, contact lenses, and office visits as well as the cost of a guide dog for the blind and special education devices for the blind, such as a special typewriter

- confinement in a facility primarily for screening tests and physical therapy or hydrotherapy
- general physical exams
- cosmetic surgery due to birth defects, disease or trauma
- chiropractic treatments
- physical therapy
- services for chromosome or fertility studies
- treatment (other than surgery) of corns, bunions, calluses, foot structural disorders, etc.
- immunizations
- well-baby care
- menstrual care items
- bandages, support hose or other pressure garments
- charges in excess of the usual and customary rate or usual and prevailing charge for covered expenses
- acupuncture for pain relief as performed by a licensed practitioner
- syringes, needles and injections
- vitamins and mineral supplements prescribed for treatment of illness
- transportation expenses to receive medical care, including fares for public transportation and actual out-of-pocket car expenses, such as gas and oil (in lieu of out-of-pocket expenses, a standard mileage rate of $.17 per mile may be used in 2020)
- expenses not paid by Penn's medical, dental or vision plans, or not paid in full by the Program (such as orthodontia and durable medical equipment)
- hearing expenses, including hearing aids, special instructions or training for the deaf (such as lip reading), the cost of acquiring and training a dog for the deaf, and special telephone and audio display equipment for the deaf
- individual psychiatric or psychological counseling one-on-one or within a group
- miscellaneous expenses, including birth control pills, installation and monthly rental charges for fluoride treatment to home water when recommended by a dentist, a stop-smoking program, a weight-loss program prescribed by a physician to treat a specific illness, and hypnosis for treatment of an illness

- over-the-counter medicines and drugs that are used for medical care
- breast pumps and supplies that assist lactation
- "halfway house" care to help individuals adjust from life in a mental hospital to community living
- tutoring by a licensed school or therapist for a child with a severe learning disability, and special schooling for the handicapped
- fees paid to a medical information plan maintaining an individual's medical information by computer
- special car controls for the handicapped

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

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

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

CAUTION – Special Rules if you have Aetna HDHP Coverage

If you have coverage under the Aetna HDHP, the type of expenses that can be reimbursed must be restricted in order to preserve your ability to make and receive contributions to your Health Savings Account. Therefore, your Health Care Flexible Spending Account will be "converted" to what is known as a "Limited Purpose Account" that can be used ONLY to reimburse dental and vision expenses and expenses associated with certain preventive services. (Keep in mind that many preventive services are covered 100% under the Aetna HDHP.)

Ineligible Expenses

Here are some examples of expenses that are not eligible for reimbursement through the Health Care Flexible Spending Account:

- premiums paid to employer-sponsored health, dental, vision, prescription drug or contact lens insurance coverage incurred by you or your dependents

- premiums paid for long-term care insurance coverage and certain other long term care expenses

- premiums for private insurance (not provided by an employer) and for medical care included in the tuition fee of a college or university when billed separately

- marriage or family counseling

- salary of a licensed practical nurse (LPN) incurred in connection with the care of a normal and healthy newborn even when such care may be required due to the death of the mother in childbirth

- funeral and burial expenses

- household and domestic help even when recommended by a qualified physician due to an employee's or dependent's inability to perform physical housework

- custodial care in an institution

- costs of sending a child with behavioral and/or learning problems to a special school for benefits the child may receive from the course of study and disciplinary methods

- health club dues, YMCA dues, steam bath, etc.

- social activities, such as dance lessons or classes (even when recommended by a qualified physician for general health improvement)

- membership fees or costs associated with weight-loss for general health and well-being purposes

- maternity clothes, diaper service, etc.

- cosmetics, toiletries, toothpaste, etc.

- the segment of automobile insurance premiums providing medical coverage for persons injured through an accident involving an employee's car

- the segment of life insurance premiums paid for loss of earnings or for accidental loss of life, limb, sight, etc.

- vacation or travel taken for general health purposes, a change in environment, improvement of morale, etc., or taken to relieve physical or mental discomfort not related to a particular disease or physical defect

- transportation expenses to and from work, even though a physical condition may require special means of transportation

- non-prescription items (such as vitamins) that are merely beneficial for your or your dependent's general health

- elective cosmetic surgery, face lifts, facial hair removal by electrolysis, liposuction, etc.

- cosmetic dental work

- confinement in a nursing home for illness or injury

- medical or dental expenses provided to an individual(s) who is not your tax dependent, or your pets. If the expense is paid by a health care plan it is not eligible for reimbursement. For example, suppose your spouse has an expense covered by the medical plan where he or she works, your Health Care Flexible Spending Account could only be used to reimburse you for amounts not paid by that medical plan, such as deductible and coinsurance amounts.

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

Special Carryover Option

Unused amounts of up to $500 remaining in an employee's Health Care Flexible Spending Account at the end of any plan year can be used to reimburse eligible expenses that are incurred during the following plan year. The following requirements will apply to the Health Care Flexible Spending Account carryover:

- The amount that can be carried over is equal to the lesser of 1) any unused amounts from the prior plan year after the end of the prior plan year's run-out period; or 2) $500. The run-out period is the period ending on September 30 after the end of the plan year during which the employee can submit expenses incurred in the prior plan year for reimbursement.

- Carryovers may NOT be cashed out or converted to any other taxable or nontaxable benefit, and will not count towards the maximum dollar limit under the Health Care Flexible Spending Account .

- Eligible medical expenses that are incurred in the current plan year will be reimbursed first from an employee's unused Health Care Flexible Spending Account amounts credited for that plan year and then from amounts carried over from the preceding plan year. Carryovers that are used to reimburse an eligible expense in a current plan year will reduce the amount available to pay eligible expenses incurred in the prior plan year during the run-out period, cannot exceed $500, and will count against the $500 maximum carryover amount. The carryover is only available for the Health Care Flexible Spending Account (see below) even if a Health Care Flexible Spending Account election is not made for a subsequent plan year. It does not apply to the Dependent Care Flexible Spending Account.

- Any balance in excess of $500 shall not be carried over to reimburse eligible expenses incurred during a subsequent plan year and shall not be available to the employee in any other form or

manner. Any unused amounts exceeding $500 shall remain the property of the University and, where possible, used to defray the expenses of administering the Plan.

- ***CAUTION*: If you elect coverage under Aetna HDHP for a plan year and you have any amount left in your Health Care Flexible Spending Account on June 30 of the prior plan year, your funds will be rolled into a Limited Purpose Account and can be used to reimburse for eligible dental, vision and preventive care expenses. This carryover to a Limited Purpose Account will occur even if you do not elect to make Health Care Flexible Spending Account contributions in that next year. Claims submitted but not yet paid do not count against the cash balance for this purpose.**

Submitting Claims

The expense must have been *incurred* during the plan year and not before your participation began or after your participation ended. Expenses are considered to be incurred on the day the service is provided, not when you are billed or when it is paid.

- You can use the Health Care FSA debit card to pay for your eligible expenses without having to submit a claim for reimbursement. Just like your bank account debit card, the Health Care FSA debit card will automatically debit your FSA account. That means you don't have to pay for expenses with out-of-pocket money, and there's no need to file a claim. However, you'll still need to save your receipts in case you need to produce them to substantiate that an expense is an eligible medical expense. If the debit card vendor does not obtain the required information, your debit card may be made inaccessible for further purchases and other actions may be taken to recover the unsubstantiated payment in accordance with applicable government regulations.

- If you submit an electronic claim, your request form must be accompanied by documentation showing the nature of the item or service, and the date the expense was incurred

- If your expense is eligible under the University's medical plan, or any other plan(s) covering you or the family member who incurred the expense, you must first file a claim under that plan(s). When claims are submitted to your insurance plan(s), you receive an "Explanation of Benefits" (EOB). This is a statement showing how your benefits were calculated and the out-of-pocket amount you are responsible for paying. You must attach all EOBs you receive to your request for reimbursement from the Health Care Flexible Spending Account.

- The maximum amount reimbursable under the Plan for expenses incurred in a plan year is an amount equal to the total of your contributions for that plan year, not in excess of $2,750 per year.

- You have until September 30 following the end of a plan year to submit claims to the Health Care Flexible Spending Account for expenses incurred during that plan year. (For example, claims incurred from July 1, 2020 through June 30, 2021 must be submitted by September 30, 2021 to be applied against your 2020-2021 account balance.)

- When you submit a claim for reimbursement, you must provide all required supporting documentation and certify on the claim form that the expense is an eligible expense.

- If your request for reimbursement is denied for any reason, you have certain rights as a plan participant. These rights are described in the section entitled "Administrative Information".

Special Rules for Military Service Personnel

If you are on an approved "Military Leave of Absence" (as defined below) for a period of more than 179 days (or for an indefinite period of time), you may be entitled to a distribution of some or all of your Health Care Flexible Spending Account balance which otherwise may be forfeited. The following rules apply:

- You are on an approved "Military Leave of Absence" if you are in the Armed Forces (such as the Army, Navy, Air Force, Marines, Coast Guard, the Army and Air National Guards or the corps of the Public Health Service), are covered under USERRA, and comply with the notice requirements under the University's military leave of absence policies.

- A distribution may be requested even if you have not incurred an eligible health care expense during the Plan Year. Amounts received under this special rule will not be available to reimburse you for eligible health care expenses incurred during the Plan Year.

- Any amounts distributed in accordance with this special rule and which are not reimbursements for eligible health care expenses, will be treated as taxable income paid to you and will be subject to income tax withholding.

- A request for a distribution under this special rule must be in writing and received by the Plan Administrator before September 30 of the Plan Year following the Plan Year in which the Military Leave of Absence commenced. You may be required to submit proof of the duration of your approved Military Leave of Absence and comply with any administrative procedures adopted by the Plan Administrator.

When Participation Ends

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

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

- You may be reimbursed for expenses incurred prior to your termination date, up to the amount you elected to contribute, less any previous reimbursements.

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

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

The Dependent Care Flexible Spending Account

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

Your Dependent Care Flexible Spending Account Contribution

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

- There is a $50 minimum contribution.

- The maximum contribution is $5,000 for the plan year (eligible to contribute upon attaining age 21). However, the amount of reimbursement you are permitted to exclude from your federal taxable income may be less than $5,000, as described in the next section. In addition, the Plan Administrator has the right to limit the contribution that can be made by "highly compensated employees" in order to help the Plan pass a statutory nondiscrimination test that prohibits a disproportionate amount of benefits to be paid on behalf of highly compensated employees. This right has been exercised in the past. If you are affected by this limit you will be notified. Individuals classified as highly compensated (according to IRS rules, W-2 earnings of $120,000 and above) may contribute up to $1,800.

Maximum Tax-Free Reimbursement

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

- $5,000 ($2,500 if you are married and filing separate federal income tax returns);

- Your annual income; or

- Your spouse's annual income.

If your spouse is (1) a full-time student for at least five months during the year or (2) physically and/or mentally handicapped, there is a special rule to determine his or her annual income. To calculate the income, determine your spouse's actual taxable income (if any) earned each month that he or she is a full-time student or disabled. Then, for each month, compare this amount to either $250 (if you claim expenses for one dependent) or $500 (if you claim expenses for two or more dependents). The amount you use to determine your spouse's annual income is the greater of the actual earned income or these assumed monthly income amounts of either $250 or $500.

If you are married and filing separate federal income tax returns, the $2,500 limit described above will not apply if you are (1) legally separated or (2) your spouse did not reside with you for the last six months of the calendar year, you maintained a household that was your dependent's primary residence for more than six months during the year and you paid more than half of the expenses of that household.

If your child is enrolled at the Penn Children's Center, the amount you can receive from the Dependent Care Flexible Spending Account tax-free is reduced by the subsidy that the University provides to the Center. The University subsidy is the difference between the rate charged to you and the rate charged to

center users who are not University employees or faculty members plus any additional direct subsidy or fee reduction provided by the University to you. If you have questions about whether you are credited with a subsidy or the amount of the subsidy, please contact the University Benefits Office.

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

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

Some Special Timing Considerations

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

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

Eligible Expenses

You can use the Dependent Care Flexible Spending Account to reimburse yourself for eligible expenses directly related to the "well-being and protection" of a "qualifying individual" (defined below) if those expenses are necessary for you to work. If you are married, your spouse must also be employed (or seeking employment), enrolled as a full-time student, or disabled for your expenses to qualify. Expenses incurred while you are not working (e.g., sick day, vacation, etc.) do not qualify for reimbursement. However, expenses incurred during certain "short" or "temporary" absences for illness or vacation may be eligible for reimbursement if you are required to pay for dependent care on a weekly or longer basis. Also, if you work part-time, you do not have to allocate expenses between time worked and time not worked if you are required to pay for care on a weekly or longer basis.

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

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

- a disabled spouse who resides in your household for more than one-half of the year; and

- a disabled relative or household member who is principally dependent on you for support and who resides in your household for more than one-half of the year.

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

- Eligible dependent care expenses include:

- services provided to care for eligible dependents while you are at work, as long as the provider submits a tax ID or social security number

- household services, if attributable to the care of your dependent

- the services of a day care center (if the center provides care for more than six individuals, other than residents, it must comply with all applicable state and local laws)

- the services at a day camp, including a camp that specializes in a particular activity (such as a soccer or computer camp)

- care for a disabled dependent provided outside your home as long as the dependent is a child under age 13 or is in your home for at least eight hours a day

- certain education expenses—for example, the cost of nursery school, including lunches—if your child is not yet in the first grade. (Note: Kindergarten expense reimbursement requests will be approved to the extent that the request shows that a portion of a kindergarten expense was primarily for the care (and not the education) of a dependent child. Reimbursement requests marked simply as "kindergarten" expenses will not be approved.)

- expenses for care provided in your home, as long as the care is not provided by someone you or your spouse claims as a dependent on your federal income tax return, or your child who is under age 19 (even if you no longer claim that child as a dependent)

- agency fees, application fees or deposits, if you are required to pay these expenses in order to obtain the related care

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

Ineligible Expenses

Here are some examples of expenses that are not eligible for reimbursement through the Dependent Care Flexible Spending Account:

- non-employment related care, such as babysitting fees during non-working hours or expenses incurred on days when you (or your spouse) are not working due to vacation or illness; provided, however, that care provided during certain "short" or "temporary" absences for illness or vacation may be eligible if you are required to pay for such care on a weekly or longer basis. Also, if you work part-time, you do not have to allocate expenses between time worked and time not worked if you are required to pay for care on a weekly or longer basis

- transportation expenses (other than transportation expenses that are incurred by a dependent care provider)

- convalescent or nursing home expenses for a parent or disabled spouse

- overnight camp expenses

- educational expenses for a child in the first grade or above

- dependent care expenses that enable you or your spouse to do volunteer work

Comparing the Dependent Care Flexible Spending Account and Tax Credit

A federal tax credit is available for the same dependent care expenses that can be reimbursed through the dependent care Flexible Spending Account. The tax credit is an alternative to the account. As a general rule, the higher your gross family income, the less valuable the tax credit becomes to you. Whether it is better for you to contribute to an expense account or take advantage of the tax credit depends on your individual circumstances. Here is approximately how they compare:

- The tax credit allows you to subtract a part of your expenses directly from the federal income taxes you owe. With the expense account you reduce your taxable income by the amount of your contributions. This, in turn, reduces the total taxes you owe. The tax advantage of the expense account depends on you being able to exclude any reimbursement from your gross income for tax purposes (see above). In general, you can exclude up to $5,000, unless you are married filing a separate income tax return, in which case you can exclude only $2,500.

- The expenses you can apply toward the tax credit are limited to $3,000 if you have one dependent and $6,000 if you have more than one. With the expense account, your IRS filing status, rather than the number of dependents you have, determines the amount of reimbursement that you can exclude from your gross income.

- As a *very* general guideline, if your household income is $39,000 or more, the expense account is more advantageous than the tax credit. ***This determination depends on a number of factors. You should consult a personal tax advisor before making your election.***

- You may use both the dependent tax credit and the expense account in one year, but not for the same expenses. Moreover, your contributions to the account lower, dollar for dollar, the amount you may apply toward the tax credit.

- If you contribute $5,000 to an expense account and you have two or more dependents, you may use the tax credit for dependent care expenses in excess of $5,000 (subject to the $6,000 limit).

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

Again, you should consult a professional tax advisor to determine whether the Dependent Care Flexible Spending Account makes sense for you.

Submitting Claims

The expense must have been *incurred* during the plan year and during the first 2½ months of the following plan year (see discussion below regarding this extension) and not before your participation began or after your participation ended. Expenses are considered to be incurred on the day the service is provided, not when you are billed or when it is paid.

- The federal government requires you to report the taxpayer identification number of your care provider on your claim form. If the care provider is an individual, the individual's Social Security number is the taxpayer identification number.

- Your request form must be accompanied by documentation showing the date of service

- Requests are processed weekly.

- If you do not have enough money in your account to cover the full amount of your reimbursement request, you will receive only as much as you have in your account. The balance of your request will be held until another contribution is made. You will then receive another reimbursement check to make up the difference.

- The maximum amount reimbursable under the Plan for expenses incurred in a plan year is an amount equal to the total of your contributions for that plan year.

- You have until September 30 following the end of a plan year to submit claims to the Dependent Care Flexible Spending Account for expenses incurred during that plan year and during the first 2½ months of the following plan year. (For example, claims incurred from July 1, 2020 through September 15, 2021 must be submitted by September 30, 2021 to be applied against your 2020-2021 account balance.) This 2½ month extension will apply to you if you remain covered by the Dependent Care Flexible Spending Account through the end of the current plan year, even if you terminate employment during the extension. In addition, the extension will apply even if you do

not have a Dependent Care Flexible Spending Account for the plan year in which the extension falls. Claims for extension period expenses that are not submitted by September 30, or that exceed the prior year Dependent Care Flexible Spending Account balance, can still be applied against the Dependent Care Flexible Spending Account balance for the plan year in which the extension falls.

- When you submit a claim for reimbursement, you must certify on the claim form that the expense is an eligible expense. ADP is entitled to rely on this certification for all purposes.

- If your request for reimbursement is denied for any reason, you have certain rights as a plan participant. These rights are described in the administrative chapter of this book.

When Participation Ends

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

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

Except in the case of the 2½ month extension described above, contributions made in a prior plan year (prior to July 1) may not be used to reimburse expenses incurred in a subsequent plan year (after July 1).

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

Special Situations Affecting Your Flexible Spending Accounts

If You Take a Leave of Absence

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

Unpaid Leave of Absence

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

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

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

Paid Leave of Absence

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

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

If You Are Enrolled in the Aetna High Deductible Plan (HDHP)

If you enroll in the Aetna High Deductible Health Plan (HDHP), your Health Care Flexible Spending Account will be a Limited Purpose Account, as described above.

If You Become Disabled

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

In the Event of Your Death

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

Where You Can Learn More

WageWorks administers the Flexible Spending Accounts. For more information on Flexible Spending Accounts, contact WageWorks at www.wageworks.com.

SECTION 5

Long-Term Care

Introduction to Long-Term Care

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

Eligibility and Enrollment

Eligible, actively-at-work, full-time faculty (including faculty on a scholarly leave with salary), regular full-time staff, retirees, and limited service staff employees, working at least 35 hours per week on the U.S. payroll

The following family members are also eligible to apply for Long-Term Care insurance whether or not the employee elects to enroll:

- spouse
- surviving spouses of eligible faculty and staff
- parents and/or parents-in-law
- step-parents and/or step-parents-in-law
- grandparents and/or grandparents-in-law
- step-grandparents and/or step-grandparents-in-law
- siblings and spouses of siblings (must be age 18 or older)
- adult children

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

Long-Term Care Insurance is fully administered by Genworth Financial. Genworth must receive your application within 90 days of your eligibility date. Otherwise, you can enroll anytime outside your initial eligibility period, but will be required to provide Evidence of Insurability to Genworth.

Cost

You pay the full cost of Long-Term Care Insurance. Rates are based on the option elected and the age of the covered individual when coverage begins. You can obtain current rates from Genworth by calling 1-800-416-3624.

Your Long-Term Care Options

The options vary in the maximum daily benefits they pay—$150, $200, $250, $300 or $350 a day. In addition, options include a non-forfeiture of benefits provision. This feature assures a reduced level of benefits—even if you stop paying premiums. Another option available is the Future Purchase Option (FPO) which offers a voluntary coverage increase without proof of good health every three years. Or you may choose the Automatic Benefit Increase (ABI) for an additional cost. In this case, the Nursing Home Daily Maximum Benefit (DMB) will increase at an annual rate of 5% compounded or 5% simple.

Covered Long-Term Care Services

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

- nursing home care
- home health care
- adult day care
- care in an assisted living facility
- community based care
- informal care
- hospice care
- respite care

An Overview of Long-Term Care Benefits

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

When Benefits Begin When a covered individual can no longer perform two or more of the following activities of daily living:

When Benefits Begin	When a covered individual can no longer perform two or more of the following activities of daily living: • bathing • transferring • dressing • continence • toileting • eating due to a loss of functional capacity or severe cognitive impairment
Benefit Options	Daily maximum benefit options of $150, $200, $250, $300 and $350

Benefit Waiting Period	90 days.
Inflation Protection	Opportunity to purchase additional amounts of coverage available every three years.
Automatic Benefit Increase	The Nursing Home DMB will increase at an annual rate of 5% compounded or 5% simple.
Non-Forfeiture Protection	At the end of three years of coverage, you may cease to make contributions and retain a reduced Lifetime Maximum Benefit.
Waiver of Premium	Premium payments are waived after 90 days of benefits while a covered individual continues to receive benefits.
Lifetime Maximum	Calculated as 1825 (5 years) X DMB.
Institutional Care	Skilled nursing home, intermediate care or custodial facility, assisted living facility and hospice care are paid at 100% up to the daily maximum.
Community Based Care	Home health care, adult day care, adult foster care, home hospice care are paid at 75% of the daily maximum.
Informal Care	Paid at 25% of the daily maximum for up to 30 days in a calendar year.
Caregiver/Respite	Paid at 100% of the daily maximum benefit for up to 21 days in a calendar year.
Bed Reservation Benefit	Up to 60 days per calendar year, for any reason
Alternate Plan of Care	Under an Alternate Plan, payment may be made for caregiver services and/or modifications to the home if the care coordinator identifies alternative to the current plan that are both appropriate to the insured and cost effective. Benefits paid reduce the Lifetime Maximum Benefit (LMB).
Stay at Home Benefit	30 x Nursing Home DMB while insured, does not reduce the LMB, Includes care planning visits, caregiver training (max of 5 X DMB), home modifications, emergency medical response systems, home safety checks, provider care checks, and durable medical equipment

Claiming Benefits

All claims should be submitted to the insurance company.

Maximum Lifetime Benefits

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

Tax Status

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

If Your Employment Terminates

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

Termination of Coverage

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

Where You Can Learn More

Long-Term Care Insurance is insured and administered through Genworth Financial. For questions on Genworth policies:

- Visit Genworth's website (group ID: UPenn; code: groupltc) or contact Genworth at 800-416-3624

SECTION 6

Long-Term Disability

Introduction to Your Long-Term Disability (LTD) Benefits

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

Eligibility

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

Cost

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

Enrollment

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

Plan Benefits

LTD benefits are payable after:

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

  and

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

The term "disability" or "disabled" means:

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

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

The LTD benefits provided under the Plan (in combination with income from other sources) pays 60% of your "benefits base" at the onset of disability, up to a maximum benefit of $15,000 per month. In no event will the monthly benefit, after application of all applicable offsets as described below be less than

the greater of (1) 10% of your benefits base, or (2) $100. For this purpose, your "benefits base" is your monthly base salary and excludes all extra compensation, such as bonuses, overtime, incentive compensation, summer teaching or research salaries, amounts earned for teaching responsibilities for executive education courses at The Wharton School, and evening school or College of General Studies salaries, but includes any additional salary paid to a faculty member for performing services as an administrator so long as the administrative appointment is for a period of not less than 12 months. **Note: "benefits base" does not include pay received for services performed for CPUP.**

If you receive "income from other sources", your LTD benefits will be reduced by those amounts. "Income from other sources" includes, but is not limited to, disability or retirement benefits paid by Social Security (including dependents' benefits), Retirement Allowance, Workers' Compensation, other government plans or employer plans, unemployment, monthly disability payments from a pension plan, or any settlement or damage award received from the University that is attributable to earnings related to the disability. It also includes 50% of income from part-time or rehabilitative employment and income from any other employer. If you receive a lump sum from these sources, this lump sum amount will be deductible from your future LTD benefits. It is extremely important that you notify the MetLife immediately upon receipt of any such award.

Further, if you are eligible for, but fail to apply for benefits or waive participation under any of the programs described above, your LTD benefits will be reduced by the amount of what would normally be awarded under such programs had you not waived participation or failed to apply. In addition, LTD benefits will also be offset by any settlement or damage award or lump sum payment payable to you or your family to the extent that such settlement or award or payment is attributable to (or in compensation for) lost earnings on account of your disability.

Finally, if you are a "CHOP Eligible Employee" (as defined below) and you receive an award of Social Security disability (or the amount of such an award is presumed under the preceding paragraph), the portion of the Social Security disability benefit that will be applied as an offset will be determined by multiplying the Social Security disability benefit by a fraction, the numerator of which is your monthly benefits base and the denominator of which is an amount equal to the sum of such monthly benefits base plus the monthly base salary used by CHOP for purposes of determining the monthly long term disability benefit under the CHOP Master Welfare Benefit Plan. All determinations relating to the calculation of this Social Security offset amount (including, without limitation, the amount of your CHOP monthly base salary) shall be made by the Plan Administrator in its sole discretion and in accordance with its uniform and nondiscriminatory procedures. The term "CHOP Eligible Employee" means an eligible employee who (i) has a dual appointment with the University and The Children's Hospital of Philadelphia ("CHOP"), (ii) is covered by a long-term disability plan sponsored by CHOP, and (iii) is not covered by a long-term disability plan sponsored by the Clinical Practices of the University of Pennsylvania.

MetLife may help you in applying for Social Security Disability Income Benefits.

"Income from other sources" does not include:

- cost of living increases from any income from other sources which become effective while you are disabled and eligible to receive payments (this exception does not apply to any increases in earnings if you work while disabled)

- amounts you receive:
  - for reimbursement of hospital, medical or surgical expenses
  - which represent reasonable attorney's fees incurred in connection with the claim for income from other sources
  - from a tax deferred annuity plan (TDA), an employer-sponsored retirement plan, non-qualified deferred compensation plan, individual retirement account (IRA), Keogh (HR-10) plan, or a retirement plan under a professional service corporation with respect to principals or shareholders
  - benefits from any individual disability insurance policy.

Duration of LTD Benefits

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

LTD benefits end upon one of the following events:

- You stop being disabled, as determined by MetLife. This includes situations where you are disabled because you meet the "own occupation" definition of disability for the first 24 months, but stop being disabled because you do not meet the "any occupation" definition of disability after the first 24 months.
- You have received benefits for the maximum benefit period determined under the following table based on your age when your disability began:

Date Disability Begins	Maximum Benefit Period
Before Age 60	Through Social Security Normal Retirement Age
Age 60	84 months (7 years)
Age 61	72 months (6 years)
Age 62	60 months (5 years)
Age 63	48 months (4 years)
Age 64	36 months (3 years)
Age 65-69	24 months (2 years)
Age 70 or older	12 months (1 year)

- Your death.
- You fail to furnish proof, as required by MetLife, of your continued disability.

Note: If your disability began prior to July 1, 2019, your maximum benefit period will be determined under the LTD plan provisions in effect as of the date your disability began.

Recurrence of a Disability

LTD benefits will be restored if you return to active employment following a period of disability absence and if you suffer a recurrence of the disability, as determined by MetLife, within 180 days after returning to active employment.

Return to Work Benefits

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

Exclusions

There is no LTD coverage for disabilities relating to the following:

- for disabilities beginning on or after July 1, 2019, any disability which occurs during the first 12 months of your employment and for which you received medical treatment during the three months prior to your date of employment
- service in the Armed Forces or Merchant Marine of the United States or any other country
- warfare
- willful participation in any criminal act
- intentionally self-inflicted or self-incurred injury not resulting from other medical or mental conditions; or
- use of drugs or narcotics or any other chemical substance or compound contrary to law.

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

Other Benefits During Disability

While you are receiving LTD benefits, certain other Plan benefits may be continued in which you were enrolled in immediately prior to disability (provided that you otherwise satisfy the conditions and requirements for receiving such benefits):

Medical Benefits	Medical coverage continues while you are receiving LTD benefits. You and the University share the cost. Employees approved prior to July 1, 1998, do not pay any premium for their medical benefits.
Dental Benefits	Dental coverage continues while you are receiving LTD benefits. Effective July 1, 2007, you and the University share the cost. Employees approved prior to July 1, 1998, do not pay any premium for their dental benefits.

Vision Benefits	Vision coverage continues while you are receiving LTD benefits. You pay the full cost.
Life Insurance	Basic Life Insurance continues while you are receiving LTD benefits, up to age 70. If you were also enrolled in supplemental life insurance, this benefit will continue at the same age-based rates in effect prior to your disability. Employees approved prior to July 1, 2005, do not pay any premium for their supplemental life insurance benefits.
Accidental Death and Dismemberment Insurance	Coverage stops.
Dependent Life Insurance	Coverage stops. You have the option to convert to an individual policy.
Health Care Flexible Spending Account	Your coverage ends as of the last day for which you receive a paycheck from the University. You may continue to submit requests for reimbursement while disabled through the end of the grace period. Your requests must be for eligible expenses incurred prior to the date coverage ends, up to your account election for the year. You can elect to continue coverage through COBRA until the end of the plan year. (See "Your Right to Continue Coverage – COBRA" under Section 2: Health Care Benefits.)
Dependent Care Flexible Spending Account	Your coverage ends as of the last day for which you receive a paycheck from the University. You may continue to submit requests for reimbursement while disabled through the end of the grace period. Your requests must be for eligible expenses incurred prior to the date coverage ends, up to the balance in your account at the time coverage ends
Long-Term Care Insurance	Coverage continues if you continue to pay the required premiums directly to the insurance company.
Tax-Deferred Retirement Plan	Certain "basic" University contributions will continue under the University's Tax-Deferred Retirement Plan ("TDR Plan") during a period of disability regardless of whether you are contributing to the TDR Plan. Other "matching" University contributions may continue if you continue to contribute to the TDR Plan during a period of disability.
Educational Benefits	Benefits currently continue as they were in effect at the time you became disabled.

***IMPORTANT*: Please note that these benefits are neither permanent nor guaranteed. The University may make changes to these benefits (for example, eliminating certain benefits entirely or changing the cost-sharing amounts to increase the amounts paid by disabled employees) at any time and for any reason.**

Claiming Benefits

You or a family member should contact MetLife Disability at 833-622-0135 or 800-300-4296 to report your disability and begin your application process. LTD benefits cannot begin until the forms and necessary proof of disability have been submitted to and approved by MetLife. Claims for LTD benefits must be submitted no later than 120 days after the end of the six-month elimination period. Otherwise, no LTD benefits will be paid.

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

- you became disabled while covered under the Plan from a condition which the Plan does not exclude;
- you are and have been under the regular care of a physician; and
- you satisfy the definition of disability as described above.
- You will also be asked to submit documentation for the following:
- authorization to obtain information;
- any other sources of income you are or may become entitled to receive;
- authorization to obtain Social Security award or denial information; and
- work history and education questionnaire.

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

Involuntary Applications for Standing Faculty

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

Termination of Coverage

LTD coverage stops on the date:

- you are no longer eligible as described above;
- you are no longer actively at work at the University for any reason; or

- you terminate your employment with the University for any reason. LTD coverage cannot be continued or converted to individual coverage.

SECTION 7

Administrative Information

Introduction to Administrative Information

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

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

Benefits Solution Center (*powered by Health Advocate*)
3043 Walton Road
Plymouth Meeting, PA 19462
eapinfo@healthadvocate.com
(866) 799-2329

Plan Sponsor and Administrator

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

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

John J. Heuer, Ed.D.
Vice President for Human Resources
The University of Pennsylvania
3451 Walnut Street, 600 Franklin Building
Philadelphia, PA 19104-6205
(215) 898-6884

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

If you have any questions about your benefits, contact the Benefits Solution Center (*powered by Health Advocate*) at 1-866-799-2329 first. If the Benefits Solution Center cannot immediately answer your question, someone will get back to you with the answer or the name of the person, department or agency that can provide you with the information you need.

Plan Identification

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

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

Plan Year

The records for each plan are maintained on a twelve-month basis. The plan year is the same as the

University's fiscal year: it begins on July 1 and ends on June 30.

Agent for Service of Legal Process

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

John J. Heuer, Ed.D.
Vice President for Human Resources
The University of Pennsylvania
3451 Walnut Street, 600 Franklin Building
Philadelphia, PA 19104-6205
(215) 898-6884

Not a Contract of Employment

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

Plan Continuation

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

Plan Funding

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

Your Rights as a Plan Participant

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

Receive Information About Your Plan and Benefits

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

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator through the Benefits Solution Center (*powered by Health Advocate*) at 1-866-799-2329. If you have any questions

about this statement or about your rights under ERISA, or if your need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Authority of Plan Administrator

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

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

Decisions on Medical Care

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

Qualified Medical Child Support Order ("QMCSO")

A QMCSO is a court order giving a child who otherwise might not be eligible for coverage under the Program, a right to such coverage. Normally, the court in connection with a divorce or separation, issues such an order. Before the Plan Administrator complies with a QMCSO, it must determine that the court order meets the requirements of applicable law pertaining to QMCSOs. You will be notified, if the Plan Administrator receives a court order relating to you and of the procedure used by the Plan Administrator to determine whether the order is a QMCSO. Participants and beneficiaries may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Privacy of Health Information

Effective April 14, 2003, the receipt, use and disclosure of protected health information is governed by regulations issued under the Health Insurance Portability and Accountability Act (commonly referred to

as “HIPAA”). In accordance with these regulations, the Plan Administrator, certain employees working with, and on behalf of, the Plan and the Plan’s business associates may receive, use and disclose protected health information in order to carry out the payment, treatment and health care operations under of the Plan. These entities and individuals may use protected health information for such purposes without your authorization. If your protected health information is used or disclosed for any other purpose (other than as specifically required or authorized under HIPAA), the Plan must first obtain your written authorization for such use or disclosure.

Third Party Recovery/Subrogation

General Principle

When you or your dependent receive benefits under the Program 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 Program for the related benefits received out of any funds or monies you or your dependent recovers from any third party.

Specific Requirements and Program Rights

Because the Program is entitled to reimbursement, the Program 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 Program 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 Program’s share of the recovery shall not be reduced because the full damages or expenses claimed have not been reimbursed unless the Program agrees in writing to such reduction. Further, the Program’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 Program’s right to subrogation or reimbursement.

The Program 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 Program will not pay attorney’s fees or costs associated with the claim or lawsuit without express written authorization from the University.

If the Program should become aware that you or your dependent has received a third party payment, amount or recovery and not reported such amount, the Program, 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 Program 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 Program you and your dependents consent and agree that a constructive trust, lien or an equitable lien by agreement in favor of the Program 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 Program in reimbursing it for Program 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 Program. 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 Program's subrogation rights and the Program'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 Program 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 Program 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 Program'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 Program's consent. As such, the Program's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the University.

Recoupment

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

Benefit Payments to Third Parties

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

No Assignment or Alienation of Benefits

Benefits payable under this Program may not be assigned, transferred or in any way made over to another party by a participant or beneficiary for any reason. The Program will not recognize any assignment of any rights under this Program or ERISA, and any attempt to assign such rights shall be void. The payment of benefits directly to a health care or other provider, if any, shall be done as a

convenience to you and shall not make the provider an assignee. In no event shall any provider of benefits be a "participant" or "beneficiary" under the Program and no provider shall have standing under ERISA or the claims procedures of this Program. Neither the University nor the Program shall be in any manner liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits hereunder.

Claims Information

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

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

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

Medical Plans

- ***PennCare/Personal Choice***

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

- ***Aetna POS II***

  When you use in-network and out-of-network care, you do not need to file claims.

- ***Aetna High Deductible Health Plan with Health Savings Account***

  When you use in-network and out-of-network care, you do not need to file claims.

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

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

- ***Behavioral Health and Substance Abuse Benefits***

Please follow the claims procedures set forth in the Benefits Explanation provided to you by Quest Behavioral Health. Magellan claims should be processed through Keystone/AmeriHealth HMO plan. The Aetna High Deductible Health Plan with Health Savings Account should be processed through the Aetna Network.

Dental Plans

- ***Penn Family Plan***

You do not have to file any claims.

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

Your dentist will complete the MetLife PDP Claim form and mail it to MetLife. You may obtain a claim form from MetLife directly on their Web site: www.metlife.com/dental. You should take this form with you when you visit your dentist.

Vision Plans

- **Davis Vision**

When you use Davis preferred providers, you do not have to file any claims. When you use non-preferred providers, you must file a claim form. You may obtain a claim form from their website https://www.davisvision.com/. Complete the form according to the instructions on the form and mail it with any documentation noted to the address on the form.

- ***VSP Vision Plan***

When you use VSP Choice Providers and VSP Affiliate Providers, you do not have to file any claims. When you use an out-of–network provider, you must file a claim form. You may obtain a claim form by visiting the VSP website at www.vsp.com. Complete the form according to the instructions on the form and mail it with any documentation noted to the address on the form.

Prescription Drug Coverage through CVS/caremark Health Systems, Inc.

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

Group Life Insurance

- ***Basic, Supplemental, and Optional Life***: Upon your death, your beneficiary should contact the University's Life Insurance Carrier. ***Dependent Life***: Upon your dependent's death, you should contact Health Advocate at .

- ***Accidental Death and Dismemberment***: In the event of an accidental death or dismemberment, you or your beneficiary should contact the University's Life Insurance Carrier. m.

Flexible Spending Accounts

- ***Health Care***: You can use the Health Care Flexible Spending Account debit card to pay for your eligible expenses without having to submit a claim for reimbursement. Just like your bank account debit card, the Health Care Flexible Spending Account debit card will automatically debit your Flexible Spending Account. That means you don't have to pay for expenses with out-of-pocket money, and there's no need to file a paper claim. However, you'll still need to save your receipts in case you need to produce them to substantiate that an expense is an eligible medical expense. Visit www.hr.upenn.eduor complete details and a list of retail merchants that accept the debit card. If you want to file a paper claim, complete and sign a Health Care Flexible Spending Account Request for Reimbursement form and return it to WageWorks with your explanation of benefits (EOB), proof of payment and any other information specified on the form.

- ***Dependent Care***: Complete, sign and return a Dependent Care Flexible Spending Account Reimbursement Form to WageWorks with your original itemized bill, your proof of payment and any other information specified on the form.

Long-Term Care

To file a claim, the individual must contact Genworth Financial at 800-416-3624.

Long-Term Disability

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

- The application process for LTD benefits should begin after an eligible individual who is expected to remain disabled for at least 12 months has been off from work for 3 months. MetLife generally will make a decision on a completed application within 60 days before the end of the elimination period. (The elimination period begins when the eligible individual first become disabled and ends after 6 months of disability.)

- Claims for LTD benefits must be submitted but no later than 120 days after the end of the 6-month elimination period. Otherwise, no benefits will be paid.

General Claim Provisions

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

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

Time Periods for Responding to Initial Claims

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

Notice and Information Contained in Notice Denying Initial Claim

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

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

- In the case of a claim involving disability benefits, the following additional information:

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

  a discussion of the decision including an explanation of the basis for disagreeing with or not following (i) the views of health care professionals treating you and vocational professionals who evaluated you, if those views were presented by you to the Plan, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination made on your behalf by the Social Security Administration, if that determination was presented by you to the Plan.

  a statement that the you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.

  Note that an adverse benefit determination involving disability benefits shall include rescissions of coverage, regardless of whether the rescission had an adverse effect on any particular benefit.

Appealing a Denied Claim for Benefits

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

Time Periods for Responding to Appealed Claims

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

Notice and Information Contained in Notice Denying Appeal

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

- Reason for the Denial - the specific reason or reasons for the denial;

- Reference to Plan Provisions - reference to the specific Plan provisions on which the denial is based;

- Statement of Entitlement to Documents - a statement that you are entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to your claim and/or appeal for benefits;

- Description of Any Internal Rules - in the case of a claim involving disability benefits:

  a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the appeal determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to you free of charge at your request;

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

  a discussion of the decision including an explanation of the basis for disagreeing with or not following (i) the views of health care professionals treating you and vocational professionals who evaluated you, if those views were presented by you to the Plan, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination made on your behalf by the Social Security Administration, if that determination was presented by you to the Plan; and

- Statement of Right to Bring Action - a statement that you are entitled to bring a civil action in Federal court under Section 502 of ERISA to pursue your claim for benefits.

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

If Your Claim for Health Benefits is Denied (Medical, Dental, Vision, Prescription and Health Care Flexible Spending Account) Types of Health Claims

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

- Pre-Service Claim - A "pre-service claim" is a claim for a particular benefit under the Plan that is conditioned upon you receiving prior approval in advance of receiving the benefit. A pre-service claim must contain, at a minimum, the name of the individual for whom benefits are being claimed, a specific medical condition or symptom, and a specific treatment, service or product for which approval is being requested.

- Post-Service Claim - A "post-service claim" is a claim for payment for a particular benefit or for a particular service after the benefit or service has been provided. A post-service claim must contain the information requested on a claim form provided by the applicable provider.

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

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

- Concurrent Care Review Claim - A "concurrent care review claim" is a claim relating to the continuation/reduction of an ongoing course of treatment.

Time Periods for Responding to Initial Claims

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

- Pre-Service Claim - In the case of a pre-service claim, the Claims Administrator shall respond to you within 15 days after receipt of the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 15-day period that the Claims Administrator needs up to an additional 15 days to review your claim. If such an extension is because you failed to provide the information necessary to evaluate your claim, the notice of extension will describe the information that you need to provide to the Claims Administrator. You will have no less than 45 days from the date you receive the notice to provide the requested information.

- Post-Service Claim - In the case of a post-service claim, the Claims Administrator shall respond to you within 30 days after receipt of the claim. If the Claims Administrator determines that an

extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 30-day period that the Claims Administrator needs up to an additional 15 days to review your claim. If such an extension is necessary because you failed to provide the information necessary to evaluate your claim, the notice of extension will describe the information that you need to provide to the Claims Administrator. You will have no less than 45 days from the date you receive the notice to provide the requested information.

- Urgent Care Claim - In the case of an urgent care claim, the Claims Administrator shall respond to you within 72 hours after receipt of the claim. If the Claims Administrator determines that it needs additional information to review your claim, the Claims Administrator will notify you within 24 hours after receipt of the claim and provide you with a description of the additional information that it needs to evaluate your claim. You will have no less than 48 hours from the time you receive this notice to provide the requested information. Once you provide the requested information, the Claims Administrator will evaluate your claim within 48 hours after the earlier of the Claims Administrator's receipt of the requested information, or the end of the extension period given to you to provide the requested information. There is a special time period for responding to a request to extend an ongoing course of treatment if the request is an urgent care claim. For these types of claims, the Claims Administrator must respond to you within 24 hours after receipt of the claim by the Plan (provided, that you make the claim at least 24 hours prior to the expiration of the ongoing course of treatment).

- Concurrent Care Review Claim - If the Plan has already approved an ongoing course of treatment for you and contemplates reducing or terminating the treatment, the Claims Administrator will notify you sufficiently in advance of the reduction or termination of treatment to allow you to appeal the Claims Administrator's decision and obtain a determination on review before the treatment is reduced or terminated.

Note that the above time frames may be shorter if the Claims Administrator provides more than one level of appeal. In some cases, there may be one level of review for certain kinds of claims and two levels of review for other kinds of claims. For example, CVS/caremark will provide only one level of appeal for an "administrative denial" which is an adverse determination based solely on the terms of the Plan, including the preferred drug lists or formularies, and which does not involve a determination of medical necessity. For claim involving all other adverse determinations, CVS/caremark will provide two levels of appeal (or arrange for a second review to be performed by an independent third party). Your right to one or two levels of appeal will be described in the information you receive regarding any denial. If the Claims Administrator's procedures, etc. differ from and offer greater rights than these procedures, the Claims Administrator's procedures will apply in determining whether your claim is approved or denied under the Plan.

Notice and Information Contained in Notice Denying Initial Claim

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

- Reason for the Denial - the specific reason or reasons for the denial;

- Reference to Plan Provisions - reference to the specific Plan provisions on which the denial is based;

- Description of Additional Material - a description of any additional material or information necessary for you to perfect your claim and an explanation as to why such information is necessary;

- Description of Any Internal Rules - a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to you free of charge at your request; and

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

Appealing a Denied Claim for Benefits

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

Time Periods for Responding to Appealed Claims

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

- Pre-Service Claim - In the case of an appeal of a denied pre-service claim, the Appeals Administrator shall respond to you within 30 days after receipt of the appeal.

- Post-Service Claim - In the case of an appeal of a denied post-service claim, the Appeals Administrator shall respond to you within 60 days after receipt of the appeal.

- Urgent Care Claim - In the case of an appeal of a denied urgent care claim, the Appeals Administrator shall respond to you within 72 hours after receipt of the appeal.

- Concurrent Care Review Claim - In the case of an appeal of a denied concurrent care review claim, the Appeals Administrator shall respond to you before the concurrent or ongoing treatment in question is reduced or terminated.

Notice and Information Contained in Notice Denying Appeal

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

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

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

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

Notwithstanding the foregoing, the Plan will comply with the applicable requirements of the Patient Protection and Affordable Care Act of 2010 relative to all claims for medical benefits (unless the benefit is an "excepted benefit" to which the Affordable Care Act does not apply, as determined by the Claim Administrator), including but not limited to the following:

- *Adverse Benefit Determination*. The definition of adverse benefit determination shall include rescissions of coverage, regardless of whether the rescission had an adverse effect on any particular benefit;

- *Right to Review Claim File*. Claimants shall be given the right to review their claim file, including access to and copies of documents, records and other information relevant to their claim;

- *Opportunity to Present Evidence and Testimony*. Claimants shall be given the opportunity to present evidence and testimony as part of the appeals process. The terms "evidence" and "testimony" shall be interpreted in accordance with Department of Labor guidance;

- *Disclosure of New Rationale and Opportunity to Respond*. In the event the Plan (or the entity hearing an internal appeal of an adverse benefits determination on behalf of the Plan) considers, relies upon or generates new or additional evidence in connection with the claim, or is considering a new or additional rationale for the denial of the claim at the internal claims appeal stage, the Plan will advise the claimant in advance of the determination of the new evidence or rationale being considered, and shall allow the claimant no less than 45 days to respond to such new evidence or rationale, except with respect to appeals of urgent care claims, in which event the claimant will be provided no less than two (2) days to respond to the new evidence or rationale;

- *No Conflict of Interest*. To the extent Plan personnel are involved in the claims process, the Plan will not consider in connection with any decision regarding the hiring, compensation, promotion, termination or other similar matters with respect to an individual involved, directly or indirectly, with the evaluation or determination of the claims or appeals of any claimant, whether or not such individual is likely to support the denial of benefits to a claimant; and

- *External Review*. Except in the case of a medical plan option that is grandfathered, external review is available for final adverse benefit determinations involving (1) medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment) as determined by the external reviewer, or (2) rescission of coverage (i.e., a retroactive termination of coverage, whether or not the rescission has any effect on any particular benefit at the time). Claimants in urgent care situations and those receiving an ongoing course of treatment may proceed with expedited external review at the same time as the internal appeals process. External review is not available for final adverse determinations that relate to a failure to meet the eligibility requirements under the Plan.

Statute of Limitations - Any lawsuit seeking benefits under this Plan must be brought within two years of the when you or your representative (as applicable) knows or should have known that a claim for benefits has been, or likely would be, denied. To be clear, the two year period starts running from the earliest possible date of those described above. In the event that you do not submit a claim for benefits by the "Claim Deadline" applicable to a particular benefit, then the claim shall be deemed denied as of the Claim Deadline and the two year Statute of Limitations shall begin to run from the Claim Deadline.

SECTION 8

Glossary

Glossary

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

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

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

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

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

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

Out-of-Pocket Maximum: The most you have to pay out of your own pocket during the benefit year in coinsurance after you meet your deductible as long as you use providers who accept your plan's UCR.

Once you reach the out-of-pocket maximum, the Plan pays 100% of UCR. If you use providers who do not accept your plan's UCR, your actual out-of-pocket maximum may be greater than the maximum stated by the Plan because expenses that exceed the plan's UCR do not count toward the Plan's out-of-pocket maximum. Out-of-pocket maximums stated by plans are based on your use of providers that accept the Plan's UCR.

Point of Service Plan (POS): A managed care plan with a network of providers that provides reduced benefits for services received outside of the network. No referrals are needed.

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

SECTION 9

Carrier Directory

Carrier Directory

PennChoice Plan	Send Claims to (Claims Administrator):	Important Numbers (Customer Service and Emergency)	Send Appeals to (Appeals Administrator):
Prescription Drug			
CVS/caremark (Self-insured by the University and administered through Express Scripts/Medco Prescription Services, Inc.) Group/Policy #: UPENNRX	www.caremark.com	Customer Service: 844-833-6390	CVS/caremark 844-833-6390
Medical			
PennCare/ **Personal Choice** (Self-insured by the University and administered through Independence Blue Cross and PA Blue Shield) Group/Policy #: 10041473 COBRA 606133-5533209	*Preferred Providers:* Not Applicable *Non-Preferred Providers:* Personal Choice Claims P.O. Box 69352 Harrisburg, PA 17106-9352	Customer Service: 215-241-2990 If you are calling from outside the 215 area code, call 1-800-275-2583 For inpatient admission, pre-certification is required except for maternity or emergency admissions. Call 1-800-275-2573- or 215-241-2990 for pre-certification.	Member Appeals Department P.O. Box 41820 Philadelphia, PA 19101-1820 1-888-671-5276
Aetna Choice POS II Group/Policy # 811778	Aetna P.O. Box 981106 El Paso, TX 79998-1106	Customer Service: 1-800- 302-8742 For an emergency out of the area, go to the nearest hospital. Hospital must call 1-888-632-3862	

PennChoice Plan	Send Claims to (Claims Administrator):	Important Numbers (Customer Service and Emergency)	Send Appeals to (Appeals Administrator):
Keystone Health Plan East/AmeriHealth HMO (Self-insured by the University and administered through Keystone Health Plan East) Group/Policy #: 10049781	Keystone Claims P.O. Box 69353 Harrisburg, PA 17106-9352	Member Services: 215-241-2990 If you are calling from outside the 215 area code, call 1-800-275-2583 Call Primary Physician and HMO within 48 hours of emergency care. For an emergency out of the area go to the nearest hospital. Contact Primary Physician within 48 hours. Hospital must call 1-800-275-2583 Sick Care out of the area: 1-800-810-BLUE.	Member Appeals Department P.O. Box 41820 Philadelphia, PA 19101-1820 1-888-671-5276
Aetna High Deductible Health Plan with Health Savings Account Group/Policy #: 811778	Aetna Inc. P.O. Box 981106 El Paso, TX 79998-1106	Customer Service: 1-888-302-8742 For an emergency out of the area, go to the nearest hospital. Hospital must call 1-888-632-3862	Aetna Inc. P.O. Box 981106 El Paso, TX 79998-1106
Behavioral Health and Substance Abuse Benefits			
Quest Behavioral Health	www.qbh.com		
Vision			
Davis Vision (IBC vision plan administered by Davis Vision.) Group/Policy #: 10054917	Vision Care Processing Unit P.O. Box 1525 Latham, NY 12110	Customer Service: 1-800-275-2583	Member Appeals Department P.O. Box 41820 Philadelphia, PA 19101-1820 1-888-671-5276

PennChoice Plan	Send Claims to (Claims Administrator):	Important Numbers (Customer Service and Emergency)	Send Appeals to (Appeals Administrator):
		1-888-393-2583 (claims/benefit questions)	
VSP Vision Plan Group/Policy # 30031862	www.vsp.com	1-800-877-7195	1-800-877-7195
Dental			
Penn Family Plan (Self-insured and administered through PFPP) Group/Policy # 512	N/A	215-898-4615(Schattner Center) 215-573-8400 (University City) Evenings and weekends: Call any Dental Care Network office for instructions on how to reach the dentist on call. Or, call the emergency answering service at 215-952-8029. If outside a 50-mile radius of any office, use any dentist for emergency treatment.	Penn Family Plan 220 South 40th Street Philadelphia, PA 19104-6387
MetLife Preferred Dentist Program (Self-insured and administered through MetLife) Group/Policy #: 300187	*In-network:* Not Applicable *Out-of-network:* MetLife Dental Claims P.O. Box 981282 El Paso, TX 79998-1282	Customer Service: 1-800-942-0854	MetLife Dental Claims P.O. Box 981282 El Paso, TX 79998-1282
Long Term Disability			
Long Term Disability Self-Insured, but administered by MetLife.	MetLife		
Long Term Care			
Long Term Care Insurance	Genworth	Customer Service: 1-800-416-3624	

PennChoice Plan	Send Claims to (Claims Administrator):	Important Numbers (Customer Service and Emergency)	Send Appeals to (Appeals Administrator):
(Insured and administered by Genworth Financial)			
Life Insurance			
Life, AD&D, Dependent Life (Insured and administered through MetLife	www.metlife.com	800-638-6420	
Flexible Spending Accounts			
Health Care and Dependent Care Flexible Spending Accounts (Self-insured by the University and administered WageWorks	www.wageworks.com	888-678-4881	