

Penn State

RETIRED FACULTY/STAFF BENEFITS

Medical Benefits

Effective July 1, 2015

Office of Human Resources

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GENERAL

This Summary Plan Document describes the eligibility criteria and administrative information for your University-sponsored retiree medical benefit plan as of July 1, 2015. This Document can help you understand and use your benefit plan and replaces previous versions of the Document.

Your retiree medical benefits are self-insured by the University and administered by a claims service provider. The specific benefits under the plan are described in detail in the Certificate of Coverage that is provided to you by the claims service provider and the University.

Any and all rights or benefits accruing to you or your dependents under the plan are subject to all terms and conditions of the official plan document.

The adoption and maintenance of the plan do not constitute a contract between the University and any retiree.

ACCESSING YOUR BENEFITS INFORMATION

For complete details of your medical benefits, you should review this Summary Plan Document and the plan's Certificate of Coverage.

Your benefit information is also available:

- Online, by accessing this website: www.ohr.psu.edu/benefits
- By contacting the Employee Benefits Division by telephone at (814) 865-1473 or by email at benefits@psu.edu.
- By speaking to a Highmark Blue Shield claims service provider by telephone at (800) 914-4384 for non-Medicare-eligible retirees and Signature 65 Medicare plan retirees. Medicare-eligible retirees should call Highmark at (866) 918-5285.

ELIGIBILITY

If you were hired prior to January 1, 2010:

You may elect medical coverage for you and your eligible dependents under the retiree medical plan if, at retirement, you meet the following conditions:

- You are at least sixty (60) years of age;
- You have at least fifteen (15) years of regular full-time employment;
- You have participated in a University-sponsored medical plan for fifteen (15) continuous years immediately preceding retirement;

OR

- You have twenty-five (25) years of regular full-time employment;
- You have ten (10) years of continuous participation in a University-sponsored medical plan immediately preceding retirement.

If you, your spouse is Medicare-eligible, medical plan coverage will be provided under a retiree Medicare plan.

If you or your spouse is not Medicare-eligible, your coverage in the retiree plan will be identical to the same University-sponsored medical plan in which you were enrolled prior to retirement.

As you and your spouse become Medicare-eligible, your coverage will change to a University-sponsored retiree Medicare plan. Regardless of the plan you are enrolled in, you will be billed by the University on a semi-annual basis for medical benefits.

If you were hired after January 1, 2010:

The University will contribute funds each month on your behalf to a retirement healthcare savings account. Please see the Fact Sheet, located at the below listed website, to assist you in determining how you can use the funds to pay for qualified medical and health-related expenses in retirement, including the purchase of a health insurance policy.

(<http://ohr.psu.edu/benefits/retirement/documents/RetirementHealthcareSavingsPlan-FactSheet.pdf>)

You will be eligible to access your Penn State Retirement Healthcare Savings Plan (RHSP) when you are no longer actively employed at the University, and have met the following conditions:

- Completed twenty-five (25) years of continuous full-time service; and
- Are age sixty (60) or older;

OR

- Completed a minimum of fifteen (15) years of continuous full-time service; and
- Are age sixty-five (65) or older

You may choose not to be covered under the retiree medical plan. However, it is important to note that, once you refuse coverage, you will not be permitted to re-enroll in the plan.

If your spouse is an active University employee, you may not be covered as a dependent under your spouse's University-sponsored medical plan coverage after you retire.

Dependents

Eligible dependents are your spouse (unless legally separated or divorced), your dependent children, and any children under a qualified medical child support order.

Dependent children are defined as:

- A birth child;
- A step-child;
- A legally adopted child, or a child who is lawfully placed with you for legal adoption;
- A child for whom you have legal guardianship;
- A physically or mentally handicapped child who is incapable of self-sustaining employment, regardless of age, provided he/she is covered and continues to be covered prior to the maximum age otherwise applicable.

Your dependent child is eligible for coverage up to the age of twenty-six (26). Eligibility is regardless of whether he/she qualifies as your tax dependent, is a full-time student, or is married. If your child is married, only your child is eligible for coverage and not the child's dependents.

Dependents' Eligibility

Your dependents are eligible for coverage on the day your coverage begins or whenever they become eligible dependents.

Dependent children can be enrolled only under one parent's plan if both parents are retired from the University and are eligible for retiree medical benefits.

If your spouse has coverage elsewhere and has not been on the University plan, they are eligible to enroll in the Penn State medical plan at such time that they lose coverage elsewhere, resulting in a qualifying even status change.

The University may partner with another company to conduct a dependent verification program. The dependent verification program will be a requirement for all newly-hired employees choosing to add eligible dependents to their University-sponsored medical, dental, and/or vision plan(s), as well as a requirement for any existing employee who experiences a qualifying life status change event such as a marriage, birth of a child, adoption of a child, etc. requiring the addition of eligible dependents to the University-sponsored plan(s). Those employees will be contacted by either the University or the partnering company in order to gather the documentation for the dependent verification program.

ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

You may enroll for retiree-only coverage or retiree plus dependent coverage.

Filing of Information

You and your dependents must file with the University such pertinent information as the University or the plan administrator may specify, including proof or continued proof of eligibility, and in such manner and form as the University or the plan administrator may specify or provide; and you and your dependents are not entitled to any benefits or further benefits under the plan unless this information is filed by or on behalf of you and/or your dependents.

For Retired Faculty and Staff Members

Your coverage is effective on your date of retirement, provided you have complied with the requirements of the plan administrator for continuing your active employee medical coverage.

For Dependents of Retired Faculty and Staff Members

No dependent coverage can be elected unless you are covered in the plan. Your dependents' coverage begins on the same day that your coverage begins.

It is important that you give prompt notice to the Employee Benefits Division of any change in your dependent's status.

If you are enrolled for retiree-only coverage and thereafter marry or otherwise acquire a dependent, dependent coverage will become effective on the date that you acquire the dependent, provided you enroll for dependents' coverage not later than thirty-one (31) days following the date you acquire them.

Your newborn child will be covered automatically for thirty-one (31) days following the birth. If you enroll your newborn child on or before the thirty-first (31st) day following birth, such child's coverage will continue.

The effective date of coverage for an adopted child is the date of the *Intent to Adopt* form, if that form is received by the Employee Benefits Division within thirty-one (31) days of the date the form was executed. For a newborn adopted child, coverage is effective on the child's date of birth, provided the *Intent of Adopt* form is executed and received by the Employee Benefits Division within thirty-one (31) days of such date.

Enrollment Under a Qualified Medical Child Support Order (“QMCSO”)

A QMCSO is a judgment from a state court or an order issued through an administrative process under state law that requires you to provide coverage for a dependent child under the plan. The plan provides coverage for a child under the terms of a QMCSO when:

- You do not have legal custody of the child; and/or
- The child is not dependent on you for support.

Upon receipt of QMCSO documentation, the Employee Benefits Division will send a Request for Change Form that the retiree will be required to complete in order to add the eligible child. When the University receives a valid QMCSO, the custodial parent or state agency can enroll the affected child if you do not.

Federal law requires that a QMCSO must meet certain form and content requirements to be valid. The University follows certain procedures to determine if a medical child support order is “qualified”. You may request a copy of the plans’ QMCSO administrative procedures, free of charge, from the plan administrator. If you become subject to an order, you and each child will be notified about further procedures.

COST OF COVERAGE

You and the University share the cost of coverage under the medical plan. The amount of your retiree contribution is determined by the number of dependents you cover. The University will communicate your retiree contribution amount annually. The University bills retirees for medical benefits on a semi-annual basis. Medical benefits will continue, provided the required contributions are paid when due. Coverage will be terminated for non-payment of contributions.

In June 2015, the US government issued a ruling that same-sex couples who are legally married will be recognized as such for federal tax purposes.

However, the ruling does not apply to **registered domestic partnerships, civil unions or similar formal relationships** recognized under state law.

CHANGING YOUR COVERAGE

If you initially declined coverage under the plan for your dependents or spouse because they had other group medical coverage, and you can prove that the other group coverage was canceled for an eligible dependent, coverage under the plan may be extended to that dependent, provided that your written request for enrollment is received by the Employee Benefits Division within thirty-one (31) days after the loss of the other group coverage.

Your dependents will qualify for special enrollment due to loss of coverage only after:

- Losing eligibility for the other coverage, including losing eligibility as a result of legal separation, divorce, ending dependent status, death of an employee, termination of employment, reduction in the number of hours of employment, or no longer living or working in the other coverage’s network service area and no other coverage is available under the other coverage;
- Employer contributions for the other coverage stop;

- The other coverage was canceled and no longer offered; or
- Exhausting COBRA coverage that was in effect when you initially declined coverage under the plan.

Your dependents do not have special enrollment rights if they lose their other coverage as a result of failure to pay for premiums or for cause (e.g., fraudulent claims).

New Dependents

If you have a new dependent as a result of marriage, affirmation of domestic partnership, birth, adoption, or placement for adoption, you may be able to enroll your dependents, provided that you request enrollment, by written request to the Employee Benefits Division, within thirty-one (31) days after the marriage, affirmation of domestic partnership, birth, adoption, or placement of adoption.

Gain or Loss of Medicare or Medicaid Coverage

If your dependents are eligible for coverage under the plan, but you are unable to afford the contributions, some states have premium assistance programs that can help pay for coverage. If your dependents are already enrolled in Medicaid or a state child health plan (“CHIP”), you can contact your state Medicaid or CHIP office to find out if premium assistance is available.

If your dependents are NOT currently enrolled in Medicaid or CHIP, and you think your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office or dial 1 (877) KIDS NOW or www.insurekidsnow.gov to find out how to apply.

You may request special enrollment in the plan if:

- Your dependent is not enrolled in coverage under the plan and your dependent loses coverage under a Medicaid plan or CHIP due to loss of eligibility for such coverage; or
- If your dependent becomes eligible for assistance, with respect to coverage under the plan, under such Medicaid plan or CHIP.

Special enrollment must be requested no later than sixty (60) days after the date of termination of the Medicaid or CHIP coverage or the date that your dependent is determined to be eligible for such assistance.

RESPONSIBILITY OF INDIVIDUALS AS THEY REACH MEDICARE ELIGIBILITY (TYPICALLY AGE SIXTY-FIVE [65])

When you retire, if you are eligible to continue medical benefits, you may elect coverage under a University-sponsored plan, as follows:

- If you are not eligible for Medicare at the time of retirement, you may elect to continue coverage under the active employee plan until the beginning of the month in which you become Medicare-eligible. The same applies for your spouse. You must notify the Employee Benefits Division three (3) months prior to your sixty-fifth (65th) birthday in order to be enrolled in the University-sponsored Medicare health plan.
- If you or your spouse are Medicare-eligible, benefits will be provided through the University-sponsored Medicare health plan. In order to be eligible for this coverage, an individual must enroll in Medicare Parts A and B when eligible.

- A dependent child may continue in accordance with the provisions in the above two bullets, provided all other eligibility requirements are satisfied. (Please refer to the *Eligibility* section.)

To enroll in Medicare, you should contact the local Social Security office three (3) months before reaching your sixty-fifth (65th) birthday.

RETIREE MEDICAL PLAN DEFER ELIGIBILITY OPTION

To participate in the University-sponsored Medicare health plan, both you, as the retiree, and/or your spouse must enroll in the Medicare Part A (hospital) and Part B (medical). If you or your spouse are not enrolled in both parts of Medicare due to one of the circumstances listed below, you may elect as a one-time option to defer enrollment in the plan and enroll at a later time.

If you or your eligible dependent who is Medicare-eligible has group coverage through another employer or another group employer retiree benefit plan, you or your eligible dependent may make a one-time request to defer enrollment in the University-sponsored Medicare health plan with the option to re-enroll at a later date if the group coverage is discontinued and proof of discontinuance is provided to the University within thirty-one (31) days of the event.

Once deferred, to enroll in the University-sponsored Medicare health plan, you must notify the Employee Benefits Division within thirty-one (31) day of the termination of the alternative coverage. Proof that the alternative coverage has ceased will be required.

If you fail to contact the Employee Benefits Division within thirty-one (31) days from the date of loss of your alternative coverage, you may forfeit your right to enroll in the University-sponsored Medicare health plan.

To defer retiree medical benefits, please contact the Employee Benefits Division for the appropriate forms.

Circumstances to Defer Enrollment

Medicare-Eligible Retiree

If you are eligible for Medicare, but currently covered by another active employer group health plan or covered by your spouse's active non-University group employer health plan, you may elect to defer enrollment in the University-sponsored Medicare health plan until you are no longer covered under the other active group health plan.

Medicare-Eligible Retiree with Medicare-Eligible Spouse Covered Under Active Group Health Plan

If your spouse is covered under his/her active group employer medical coverage, you may elect to defer dependent enrollment in the University-sponsored Medicare health plan until he/she is no longer eligible for active group medical coverage.

Retiree and Spouse Both Enrolled in Another Group Employer Medicare Advantage Plan

If you and your spouse are covered by a non-University Medicare Advantage plan, you may elect to defer your University-sponsored Medicare health plan coverage for both you and your dependent until loss of coverage under the other Medicare Advantage plan.

Retiree Eligible for Medicare With a Spouse Not Eligible for Medicare

If your spouse is not eligible for Medicare, but is covered under his/her active group employer medical plan, you may defer his/her coverage under the University-sponsored Medicare health plan.

A retiree whose spouse is an active Penn State employee may not be covered as a dependent under the spouse's ACTIVE medical plan.

A newly acquired spouse may be added to the plan's coverage within thirty-one (31) days of marriage or affirmation. If you do not add your newly acquired spouse within thirty-one (31) days, they will not be eligible to join the health plan unless they experience a qualifying event status change. There is no "open enrollment" for retiree coverage.

BENEFITS UNDER THE PLAN

The University provides Highmark Blue Shield PPOBlue for retirees and their eligible dependents that are not yet eligible for Medicare Part A (hospital) and Medicare Part B (medical). These medical benefits are separately described in the plan's Certificate of Coverage.

Retirees or their eligible dependents who are Medicare-eligible must elect coverage under the University-sponsored Medicare health plan. The University-sponsored Medicare health plan includes Medicare Part D (prescription drug) coverage. In order to participate in the University-sponsored Medicare health plan, you cannot be enrolled in another Medicare Advantage or Medicare Part D plan.

At your retirement, your coverage for dental and vision benefits is discontinued. If applicable, coverage may be continued for those benefits immediately following retirement under the provisions of COBRA.

WHEN COVERAGE ENDS

For You

Your coverage ends on the:

- Day you terminate your coverage;
- Day you no longer meet the plans' eligibility requirements;
- Day you become covered as a dependent or retiree under a University-sponsored plan;
- Day you die; or
- Day the plans end or the day the official plan documents are amended to eliminate coverage for all participants or a group of participants that includes you.

For Your Dependents

Your dependents' coverage ends on the:

- Day your coverage ends;
- Day your dependent no longer meets the plan's eligibility requirements;
- Day your dependent begins active military duty;
- Day your dependent becomes covered under a University-sponsored plan, as an employee, retiree, or dependent of another employee or retiree; or

- Day the official plan document is amended to eliminate coverage for a group of participants that includes your dependents.

When coverage ends, your dependents may be eligible to continue benefits under the provisions of COBRA. Additionally, your coverage may be discontinued due to lack of communication in response to retiree billing invoices and/or other documented billing communications in an attempt to collect an outstanding balance.

VOLUNTARY TERMINATION OF COVERAGE

You may voluntarily terminate your coverage under the plan at any time by contacting the Employee Benefits Division.

If you are not Medicare-eligible, your coverage will terminate on the date indicated on the form, if the form is received by the Employee Benefits Division within thirty-one (31) days of the date on the form. Otherwise, your coverage will terminate on the date the form is received by the Employee Benefits Division.

If you are Medicare-eligible, your coverage will terminate the first of the month following receipt of the form by the Employee Benefits Division. If you have a Medicare-eligible spouse or dependent child, they will each need to complete a form to terminate their coverage.

Refunds for contributions for coverage will not be made, unless the overpayment resulted from a University error.

Please also note that by voluntarily terminating your coverage through the University-sponsored plan, you automatically become ineligible to join the plan in the future. You will want to decide carefully before electing to voluntarily terminate coverage.

DEPENDENT PROTECTION AFTER YOUR DEATH

If you are a retiree who is eligible to continue medical benefits after retirement, your spouse must be covered on your health plan, in order to have the surviving spouse benefits outlined below. Your surviving spouse's Penn State medical benefits may be continued, provided the required contributions are paid when due, but not beyond the earlier of:

- The remarriage of your spouse; or
- The lifetime of your spouse

Medical coverage for your dependent children who are covered under the plan at the time of your death will continue, provided the required contributions are paid when due, but terminate when the child reaches age twenty-six (26).

Medical coverage for a *disabled dependent child* covered under the plan at the time of your death may continue beyond age twenty-six (26) upon approval of a disability by the insurance carrier and provided the required contributions are paid when due, under the same spouse conditions outlined above:

- Not to continue beyond the marriage of a disabled dependent child; or
- The lifetime of a disabled dependent child.

Should the disabled dependent lose coverage due to marriage or voluntarily choose to no longer be covered under the retiree medical plan, once coverage is terminated for either reason, they will be ineligible to join the plan in the future.

In addition, coverage for your dependent children may be extended after your death under the provisions of COBRA.

CONTINUATION OF COVERAGE UNDER COBRA

Under the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”), you and your dependents may temporarily continue health coverage, subject to certain conditions and your payment of contributions.

Who Is Entitled to COBRA Continuation

Continuation rights are available to “qualified beneficiaries” following a “qualifying event” that would cause the qualified beneficiary to otherwise lose coverage under the plan. A qualified beneficiary may include the following individuals who were covered by the plan on the day the qualifying event occurred: you, your spouse, and your dependent children.

Qualifying Events and COBRA Continuation Periods

The qualifying events and the maximum coverage periods are:

Qualifying Event Causing Loss of Coverage	Qualified Beneficiary Eligible to Elect Continuation	Maximum Continuation Periods
You divorce or legally separate and are no longer responsible for dependent coverage.	Your dependents	36 months
Your covered dependent children no longer qualify as dependents under the plans.	Your dependent children	36 months
You die.	Your dependents	36 months
You are a retiree eligible for health coverage and your former employer files for bankruptcy.	You and your dependents	You as retiree: your date of death; your dependents: 36 months after your death

University’s Notification Requirements

The University is required to provide you and/or your dependents with the following notices:

- An initial notification of COBRA continuation rights must be provided within ninety (90) days after your (or your spouse’s) coverage under the plan begins. If you and/or your dependents experience a qualifying event before the end of that ninety (90) day period, the initial notice must be provided within the time frame required for the COBRA coverage election notice, as explained below; and
- If the qualifying event is your death, a COBRA coverage election notice must be provided to you and/or your dependents within the following timeframes:
 - If the plan provides that COBRA coverage and the period within which the University must notify the plan administrator of a qualifying event starts upon the loss of coverage, forty-four (44) days after loss of coverage under the plan; or
 - If the plan provides that COBRA coverage and the period within which the University must notify the plan administrator of a qualifying event starts upon the occurrence of a qualifying event, forty-four (44) days after the qualifying event occurs.

You Must Give Notice of Certain Qualifying Events

If you or your dependent(s) experience one of the following qualifying events, you must notify the plan administrator within sixty (60) calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

- Your divorce or legal separation; or
- Your child ceases to qualify as a dependent under the plan.

Notice must be made in writing and must include: the name of the plan, your name and address, the name(s) and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

The plan administrator will then provide a COBRA coverage election notice to all qualifying beneficiaries within fourteen (14) days.

If you or your dependent fails to notify the plan administrator within sixty (60) days after the qualifying event, the qualified beneficiary will not be entitled to elect COBRA coverage.

How to Elect COBRA Coverage

Qualified beneficiaries are permitted to continue the same coverage under which they were covered on the day before the qualifying event occurred, unless they move out of a service area or the plan is no longer available. Generally, qualified beneficiaries cannot change plan options unless they experience a qualifying event status change. There is no "open enrollment" period for retirees.

The COBRA coverage election notice will list the qualified beneficiaries and inform you of the applicable cost. The notice will also include instructions for electing COBRA coverage. You must notify the plan administrator of your election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be postmarked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the notice, you and your dependents who are qualified beneficiaries will lose the right to elect COBRA coverage. If you reject COBRA coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date. In that case, your COBRA coverage will start as of the date you furnish the completed election form.

Each qualified beneficiary has an independent right to elect COBRA coverage. Coverage may be elected for only one, several, or for all dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their dependent children. You or your spouse may elect coverage on behalf of all the qualified beneficiaries. You are not required to elect COBRA coverage in order for your dependents to elect COBRA coverage.

Determining Your Contributions For COBRA Coverage

Your contributions are regulated by law, and contributions may never exceed one hundred two percent (102%) of plan costs, including both University and employee contribution amounts.

If you alone elect COBRA coverage, you will be charged one hundred two percent (102%) of the active employee contribution amount. If your spouse or one dependent child alone elects COBRA coverage, he/she will be charged one hundred two percent (102%) of the active employee contribution amount. If more than one qualified beneficiary elects COBRA coverage, they will be charged one hundred two percent (102%) of the applicable family cost.

When and How to Make COBRA Payments

First Payment For COBRA Coverage

If you elect COBRA coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than forty-five (45) calendar days after the date of your election. (This is the date the election notice is postmarked, if mailed.) If you do not make your first payment within the outlined forty-five (45) days, you will lose all COBRA continuation rights under the plan.

Subsequent Payments

After you make your first payment for COBRA coverage, you will be required to make subsequent payments of the required cost for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage under the plan will continue for that coverage period without any break.

Grace Periods For Subsequent Payments

Although subsequent payments are due by the first day of the month, you will be given a grace period of thirty (30) days after the first day of the coverage period to make each monthly payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if your payment is received after the due date, your coverage under the plan may be suspended during this time. Any providers who contact the plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA coverage under the plan.

When You Acquire a Dependent During a Continuation Period

If you acquire a new dependent during the continuation period, through birth, adoption or marriage, your dependent can be added to the plan for the remainder of the continuation period if:

- He/she meets the definition of an eligible dependent;
- The plan administrator is notified about your dependent within thirty-one (31) days of eligibility; and
- Additional contributions for continuation are paid on a timely basis.

Your newborn or adopted dependent child is a qualified beneficiary and may continue COBRA coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event.

When Your COBRA Coverage Ends

Your COBRA coverage will end when the first of the following events occurs:

- You or your dependents reach the maximum thirty-six (36) month COBRA continuation period. (Coverage for a newly acquired dependent who has been added for the balance of a continuation period would end at the same time your continuation period ends;
- You or your dependents do not pay required contributions;
- You or your dependents become covered under another group plan that does not restrict coverage for preexisting conditions. If your new plan limits preexisting condition coverage, the COBRA coverage under the plan may remain in effect until the pre-

existing clause ceases to apply or the maximum continuation period is reached under the plan;

- The date the University no longer offers the plan;
- The date you or a dependent becomes enrolled in benefits under Medicare. This does not apply if it is contrary to the Medicare Secondary Payer Rules or other federal law;
- You or your dependent dies; or
- Any reason the plan would terminate coverage of a participant or beneficiary who is not receiving COBRA coverage (e.g., fraud).

Trade Act of 2002

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (eligible individuals). Under the tax provisions, eligible individuals can either take a tax credit or get advance payment of a part of payments made for qualified health coverage, including COBRA coverage. If you have questions about these tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at (866) 628-4282. TDD/TYY callers may call toll-free at (866) 626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

In addition, if you initially declined COBRA coverage and, within sixty (60) days after your loss of coverage under the plans, you are deemed eligible by the U.S. Department of Labor or a state labor agency for trade adjustment assistance (“TAA”) benefits and the tax credit, you may be eligible for a special sixty (60) day COBRA election period. The special election period begins on the first day of the month that you become TAA-eligible. If you elect COBRA coverage during this special election period, COBRA coverage will be effective on the first day of the special election period and will continue for eighteen (18) months, unless you experience one of the events discussed above under the *When Your COBRA Coverage Ends* section. Coverage will not be retroactive to the initial loss of coverage. If you receive a determination that you are TAA-eligible, you must notify the plan administrator immediately.

Please contact the plan administrator for the more information about this premium assistance.

CERTIFICATES OF CREDITABLE COVERAGE

If your coverage under the plan stops, you and your dependents will receive a certificate that shows your period of coverage under the plan. This is provided to you in accordance with the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). You may need to furnish the certificate to another group health plan if you become eligible under that plan and it excludes coverage for certain medical conditions that you have before you enroll (a pre-existing condition). You may also need the certificate to buy, for yourself or your family, an individual insurance policy that excludes coverage for medical conditions that are present before you enroll. The certificate:

- Identifies the individuals who had coverage and the beginning and ending dates of coverage; and
- Generally, reduces the amount of time you are subject to a pre-existing condition exclusion under another plan.

The University provides a certificate, free of charge, if:

- You lose coverage under the plan;

- You become entitled to elect coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA);
- Your COBRA coverage ends;
- You request a certificate before losing coverage; or
- You and your dependents request a certificate within twenty-four (24) months after losing coverage under the plan.

The new plan is not required to pay benefits for a pre-existing condition for twelve (12) months (or eighteen (18) months for late enrollees) after your enrollment date into the new plan. However, the length of this pre-existing condition exclusion period must be reduced by the amount of your prior creditable coverage, as outlined on the certificate.

If you or your dependents go sixty-three (63) days or more without coverage (called a break in coverage), you or your dependents may be subject to the pre-existing condition exclusion period. Check with your new employer or health insurer to verify the length of your pre-existing condition exclusion period.

THIRD PARTY LIABILITY LIMITATION

The plan will not pay for covered expenses for injuries received as a result of an accident for which a third party is liable. However, if the third party's liability is less than the amount that would otherwise be paid by the plan, the difference will be paid by the plan.

If you or your dependents incur expenses for injuries received in an accident for which a third party is liable, you will be asked to sign an agreement stating that you will refund any amount paid by the plan for which a third party is later determined to be liable.

PAYMENT TO OTHER THAN COVERED INDIVIDUAL

If the University finds that any person to whom any benefits are payable under the medical plan is unable to care for his/her personal affairs, is a minor, or has died, then any payment due that person or his/her estate (unless a prior claim has been made by a duly appointed legal representative) may be paid to the spouse, a child, a relative, or an institution maintaining or having custody of such person otherwise entitled to payment; or the University may, in its discretion, hold such payment until a legal representative is appointed. Any such payment shall be a complete discharge of the liabilities of this plan.

COORDINATION OF BENEFITS PROVISION

The plan contains a nonprofit provision coordinating it with other similar plans under which you or your dependents are covered, so that the total benefits available will not exceed one hundred percent (100%) of the allowable expenses.

An "allowable expense" is any necessary, reasonable, and customary expense covered, at least in part, by a plan of the same type (medical). "Plan" means these types of medical benefits:

- Coverage (other than Medicare or Medicaid) under a governmental program or provided or required by statute, including no-fault coverage to the extent required in policies or contracts by a motor vehicle insurance statute or similar legislation; and
- Group insurance or other coverage for a group of individuals, including student coverage obtained through an educational institution.

When a claim is made, the primary plan pays its benefits without regard to any other plans. The secondary plans adjust their benefits so that the total benefits available will not exceed the allowable expenses. No plan pays more than it would without these coordination provisions.

A plan without a coordinating provision similar to the one for the University's plan is always the primary plan. If all plans have such a provision:

- The plan covering the patient as an employee or retiree, rather than as a dependent, is primary, and the other plans are secondary;
- If a child is covered under both parents' plans, the plan of the parent whose birthday falls earlier in a year is the primary plan. If both parents have the same birthday, the plan which covered the parent longer is the primary plan. If the other plan does not have this "birthday" rule, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule of the other plan will determine the order of benefits. When the parents are separated or divorced, their plans pay in this order:
 - If a court decree has established financial responsibility for the child's health care expenses, the plan of the parent with the responsibility;
 - The plan of the parent with custody of the child;
 - The plan of the step-parent married to the parent with custody of the child; or
 - The plan of the parent not having custody of the child; and
- If neither of the above rules applies, the plan covering the patient longest is primary, except as follows:
 - The benefits of a plan which covers the person as an employee other than as a retired employee, or a dependent of such person, shall be determined before the benefits of a plan which covers the person as a retired employee or a dependent of such person; and
 - If either plan does not have a provision regarding retired employees, and, as a result, each plan determines its benefits after the other, then the above provision shall not apply.

OVERPAYMENTS

If you have been paid benefits under the plan which are in excess of the benefits that should have been paid, or which should not (under the provisions of the plan) have been paid, the University, or the plan administrator, may deduct the amount of the excess or improper payment from any subsequent benefits payable to you or from other present or future amounts payable to you or recover the amount by any other appropriate method that the University, in its sole discretion, shall determine.

By enrolling in the plan, you authorize the deduction of any excess or improper payment from such subsequent benefits or from other present or future amounts payable to you.

NO WAIVER OR ESTOPPEL

No term, condition, or provision of the plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of the plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than specifically waived.

RIGHT TO RECEIVE AND RELEASE INFORMATION

For the purpose of determining the applicability of implementing the terms of these benefits, the University and/or the plan administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine acceptability of any applicant for participation in the plan. In so acting, the University and/or the plan administrator shall be free from any liability that may arise with regard to such action. You and your dependents claiming benefits under the plan must furnish to the University and/or the plan administrator any information as may be necessary to implement this provision.

NOTICES

Any notice, application, instruction, designation, or other form of communication required to be given or submitted by you or your dependents shall be in the form prescribed from time to time by the University or the plan administrator and sent by first class mail or delivered in person to the plan administrator. Any notice, statement, report, or other communication from the University or the plan administrator to you or your dependents shall be deemed to have been duly delivered when given to you or your dependents or mailed to your address last appearing on the records of the University or the plan administrator.

You and your dependents entitled to receive a payment under the plan shall file with the plan administrator a complete mailing address and any subsequent change to that mailing address. If the University or the plan administrator shall be in doubt as to whether payments are being received by a person entitled to them, the plan administrator may, by registered mail addressed to his/her last known address, notify that person that all future payments will be withheld until he/she submits proper a mailing address and any other information as the University or the plan administrator may reasonably request. All mailing address information must be submitted to the University and the plan administrator.

WORKER'S COMPENSATION NOT AFFECTED

The plan is not in lieu of, and does not affect, any requirements for coverage by worker's compensation insurance.

MISSTATEMENTS

In the event of any misstatement of any fact(s) affecting coverage under the plan, the true facts will be used to determine the proper coverage. Coverage means eligibility, as well as the amount of any benefits under the plan.

AMENDMENT OR TERMINATION OF PLAN

The University has established the plan described in this Document with the intention of maintaining it for an indefinite period. However, the University reserves the right at any time to amend or terminate the plan, or any part thereof, including by way of illustration and not limitation:

- The coverage and benefits provided under the plan; and
- The level of retiree contributions, deductibles, co-payments, and coordination of benefits between the plan and any contract, program, or group plan providing medical benefits

maintained by you, your dependents, another employer, or any federal or state government authority or any subdivision thereof.

The right to amend or terminate the plan is vested in the Associate Vice President for Human Resources, as delegated by the President of the University.

Except as otherwise provided in the plan, the right to amend or terminate the plan shall not in any way affect the right of you or your dependents to claim benefits, or diminish or eliminate any claim for benefits, with respect to expenses incurred for services rendered to you or your dependents prior to termination or amendment of the plan.

The plan is not a contract, and the University does not guarantee and makes no promise to offer a specific level of benefits under the plan in the future. The right to future benefits under any plan will never vest.

Your eligibility to continue benefits into retirement does not confer upon you or your dependents any right to continued benefits under any plan.

HIPAA PRIVACY RIGHTS

The HIPAA Privacy Rule applies to “Protected Health Information”, which is defined as any written, oral, or electronic health information that meets the following three (3) requirements:

- The information is created or received by a health care provider, the plan, or the University;
- The information includes specific identifiers that identify you or could be used to identify you; and
- The information relates to one of the following:
 - Providing health care to you;
 - Your past, present, or future physical or mental condition; or
 - The past, present, or future payment for your health care.

The Notice of Privacy Practices for the plan contains a complete explanation of your rights under the HIPAA Privacy Rule. The notice describes how Protected Health Information may be used and disclosed and how you can get access to that information. The following is a summary of those uses and disclosures of Protected Health Information and your rights with respect to Protected Health Information:

- The plan may use or disclose your Protected Health Information for purposes of conducting health care operations or paying your health care claims;
- The plan may use or disclose your Protected Health Information to tell you about treatment alternatives or to provide you with information about other health-related benefits or services that may be of interest to you;
- The plan may disclose your Protected Health Information to the University, as sponsor of the plan, to assist the University in the performance of plan administrative functions. The plan also may provide summary health information to the University, as plan sponsor, so that the University may obtain premium bids or modify, amend, or terminate the plan. Summary health information does not directly identify you, but summarizes claims history, claims expenses, or types of claims experienced. Finally, the plan may disclose your enrollment and disenrollment information to the University as plan sponsor;

- The plan may disclose your Protected Health Information when required to do so by any federal, state, or local law and when permitted to do so under the circumstances set out in the University's Notice of Privacy Practices;
- The plan may disclose your Protected Health Information to a law enforcement official for certain law enforcement purposes. For example, the plan may disclose your Protected Health Information pursuant to a law requiring the reporting of certain types of wounds or other physical injuries;
- The plan may disclose your Protected Health Information to health care providers to assist them in connection with their treatment or payment activities. In addition, the plan may disclose your Protected Health Information to other entities subject to the HIPAA Privacy Rule to assist them with their payment activities or certain of their health care operations. For example, the plan might disclose your Protected Health Information to a health care provider when needed by the provider to render treatment to you; and
- Other than as permitted or required by law, the plan will not use or disclose your Protected Health Information without your written authorization. If you authorize the plan to use or disclose your Protected Health Information, you may revoke that authorization in writing at any time. If you revoke the authorization, the plan no longer will use or disclose your Protected Health Information for the reasons covered by your written authorization. Your revocation will not affect any uses or disclosures the plan already have made prior to the date the plan receives notice of the revocation.

In general, you have the following rights regarding the Protected Health Information retained by the plan:

- You have the right to request that the plan restrict uses and disclosures of your Protected Health Information to carry out payment or health care operations;
- You have the right to request that the plan communicate with you in a certain way if you feel that the disclosure of your Protected Health Information could endanger you;
- You have the right to inspect and obtain a copy of your Protected Health Information;
- If you believe that the Protected Health Information the plan have about you is inaccurate or incomplete, you have the right to request a correction;
- You have a right to request a list of disclosures made by the plan of your Protected Health Information, other than those disclosures for which an accounting is not required; and
- You have a right to request and receive a paper copy of the Notice of Privacy Practices for the plan, even if you have received this notice previously or agreed to receive this notice electronically.

For more information regarding these rights and the privacy policies of the plan, please review the Notice of Privacy Practices for the plan. The Notice of Privacy Practices for the plan is available from the plan administrator.

YOUR RIGHTS FOLLOWING A MASTECTOMY (WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE)

The medical plan provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and treatment of physical complications resulting from a mastectomy (including lymphedema). These benefits comply with the Women's Health and Cancer Rights Act of 1998. For more information, contact the plan administrator.

MATERNITY RIGHTS (NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT)

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 forty-eight (48) hours following a vaginal delivery or less than ninety-six (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 forty-eight (48) hours (or ninety-six (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 forty-eight (48) hours (or ninety-six (96) hours).

CLAIM DETERMINATION PROCEDURES

Disagreements about benefit eligibility or benefit amounts can arise. The University has formal appeal procedures in place for the plan.

Eligibility or Benefit Claims and Appeals

There are two (2) types of claims and appeals, as follows:

- Eligibility and Enrollment Claims: A claim to participate or enroll in the plan or to change an election to participate mid-year.
- Benefit Claims and Appeals: A claim for a specific benefit under the plan. It typically includes your initial request for benefits.

Eligibility and Enrollment Claims

All claims regarding your eligibility and enrollment for benefits under the plan are determined by the University, in its sole discretion.

Benefit Claims and Appeals

All claims for benefits, and the appeal of any denied benefit claims, are determined by the claims service provider, according to its claims and appeals process. See the Certificate of Coverage for more information about your rights and responsibilities under the claims and appeals process.

ADMINISTRATIVE INFORMATION

Plan Names/Identification

The name of the plan is the University-Sponsored Retiree Medical Benefit Plan.

Plan Sponsor

The plan sponsor is:

The Pennsylvania State University
Attn: Employee Benefits Division
Office of Human Resources
James M. Elliott Building

University Park, PA 16802
(814) 865-1473

Plan Administrator

The plan administrator is:

The Pennsylvania State University
Attn: Employee Benefits Division
Office of Human Resources
James M. Elliott Building
University Park, PA 16802
(814) 865-1473

Claims Service Provider

The claims service provider is:

Highmark Blue Cross Blue Shield
Downtown Pittsburgh Service Center
501 Penn Ave Place
Pittsburgh, PA 15222
1 (800) 294-9568

Authority to Review Claims

The plan administrator has the full discretionary authority to interpret the plan in accordance with its terms and determine eligibility under the plan. The plan administrator has delegated its authority for the administration of the plan and its authority to make final claims determinations to the claims service provider. Benefits under the plan are paid only if the claims service provider decides in its discretion that the claimant is entitled to them.

The claims service provider's decisions are final and binding on all parties to the full extent permitted under applicable law, unless the claimant later proves that the claims service provider's decision was an abuse of administrator discretion.

Plan Year

The plan year is January 1 through December 31.

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