

Penn State

**FACULTY, STAFF, & TECHNICAL
SERVICE BENEFITS**

**Medical
Dental
Vision**

Effective January 1, 2023

**Penn State Employee Benefits
Human Resources**

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GENERAL

This Summary Plan Document describes the eligibility, enrollment, continuation, and other administrative information for your University-sponsored medical, dental, and vision benefit plans as of January 1, 2018. This Document can help you understand and use your benefit plans and replaces previous versions of the Document.

Your medical, dental, and vision benefits are self-insured by the University and administered by claims service providers. The specific benefits under the plans are described in detail in Certificates of Coverage that are provided to you by the claims service providers and the University.

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

The adoption and maintenance of these plans do not constitute a contract between the University and any employee and do not constitute consideration for, or an inducement or condition of, employment of any employee. Neither participation nor anything contained in the plans shall give any employee the right to be retained in the employ of the University, nor shall it interfere with the right of the University to discharge any employee at any time.

ACCESSING YOUR BENEFITS INFORMATION

For complete details of your medical, dental, and vision benefits, you should review this Summary Plan Document and the plans' Coverage Booklets.

Your benefit information is also available:

- Online, by accessing this website: <https://hr.psu.edu/benefits>
- By contacting HR Services at (814) 865-1473
- By logging an inquiry through the WorkLion portal at worklion.psu.edu
- By speaking to the Highmark Concierge Team at 844-945-5509 for medical plan and prescription questions

ELIGIBILITY

You are eligible to enroll in the medical, dental, and/or vision plans if you are a full-time faculty, staff, or technical service employee.

Dependents

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

Dependent children are defined as:

- A natural child.
- A stepchild.
- A legally adopted child, or a child who is lawfully placed with you for legal adoption.
- A child for whom you have legal guardianship.

- Or physically or intellectually disabled children who are incapable of self-sustaining employment, regardless of age, provided they are covered prior to the maximum age otherwise applicable and have started the disability certification process with an appropriate benefit vendor prior to end of the month that they turn age 26 (additional information on Disabled Dependent Eligibility is below)

The newborn child of a covered employee will be covered immediately from birth for the first 31 days if (1) the employee was covered under the Plan on the child's date of birth, and (2) the newborn meets the definition of eligible dependent. Notice to the Plan Administrator does not add the newborn to the employee's medical or dental plan. For the newborn to have coverage beyond the first 31 days, the employee must add the dependent to existing coverage via the WorkLion within 31 days after the child's birth (even if the employee is currently enrolled in Family or Employee/Child coverage).

In accordance with the federal Affordable Care Act (ACA) legislation, an adult dependent child of an employee is eligible for coverage through the end of the month in which they turn age 26, regardless of whether he/she qualifies as the employee's tax dependent, is a full-time student, or is married. Please note that while some states may allow coverage beyond age 26, Penn State operates in many states and remains consistent by following only the ACA legislation. If your child is married, only your child is eligible for coverage and not the child's dependents; however, your eligible child's newborn child will be covered for the first 31 days only from the date of birth.

A Workday notification is sent to the employee one (1) month prior to a dependent child turning age 26. The notification includes information concerning a dependent child who may be eligible to continue coverage if that dependent is physically or intellectually handicapped, to be incapable of earning a living when coverage would normally terminate due to age. After your dependent child is no longer eligible, your dependent child will receive information regarding continuing benefits under COBRA. Please note that most health care companies will not complete a dependent disability certification until six (6) months prior to the 26th birthday.

After a dependent child is no longer eligible, that dependent child will receive information from regarding continuation of benefits under COBRA.

Dependents' Eligibility

You are responsible for notifying the University of any change that affects the employee's dependent eligibility, for example, marriage or divorce. An enrollee ceases to be a covered dependent of all employee benefit plans on the date the enrollee no longer meets the definition of a dependent, regardless of when notice is given to the University. The employee is responsible for notifying the University within 31 days to initiate any reduction in premium contribution. Covering a dependent who does not meet the eligibility criteria, intentionally or unintentionally, may result in disciplinary action, up to and including termination of employment.

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

Your dependent spouse is eligible to be enrolled as your dependent even if your spouse also is an employee of the University. However, no one is eligible to be enrolled as a dependent spouse under a plan if he/she already is enrolled as an employee under that plan, or vice versa.

Dependent children can be enrolled only under one parent's plan if both parents are employed by the University and are eligible for benefits.

ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

You may enroll yourself and your dependents for coverage. The Plan may offer different levels of coverage. Please consult the Certificate(s) of Coverage for details. You and your dependents may enroll for coverage in the medical plan only, the dental plan only, the vision plan only, or any combination of the three.

Filing of Information

You and/or 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 plans unless this information is filed by or on behalf of you and/or your dependents.

The University conducts dependent verification through Workday. The dependent verification program will be a requirement for dependents added to your university-sponsored medical plan, dental plan, vision plan, and/or the Tuition Discount. Active employees will need to act on notifications provided in Workday to successfully submit required documentation to complete the dependent verification program.

For Faculty, Staff, & Technical Service Members

Your coverage becomes effective on your date of hire, provided you have completed the necessary enrollment in Workday no later than thirty-one (31) days following your date of employment (31 days includes the date of hire).

An active employee whose spouse is a RETIREE of Penn State may not be covered as a dependent under the Retiree's Penn State medical plan and vice versa.

As an active employee whose spouse is a RETIREE of Penn State, you are required to carry your own ACTIVE plan. If your retiree spouse would become deceased, and you are still actively working at Penn State, you will remain on your ACTIVE plan. At the time you leave Penn State, if you qualify to retire with benefits on your own right, you will be enrolled in the retiree plan offered at that time.

If you do NOT qualify to retire with benefits on your own right, AT THAT TIME, you would have the ability to become the dependent spouse on the deceased retiree's plan, within 31 days of leaving the University. In this event, please contact HR Services at 814-865-1473.

For Dependents of Faculty and Staff Members

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

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

If you are enrolled for employee-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, effective as of the date of birth.

The effective date of coverage for an adopted child is the date of the *Intent to Adopt* form, if that form is received by Penn State Employee Benefits 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 Penn State Employee Benefits within thirty-one (31) days of such date.

Enrollment Due to 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 plans. The plans provide 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.

You do not have to wait for the annual open enrollment period to enroll a child under a QMCSO. Upon receipt of the QMCSO documentation, Penn State Employee Benefits will complete the order request by adding the dependent(s) coverage within Workday. 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, dental, and vision plans. The amount of your employee contribution is determined by the plans you enroll in and the number of dependents you cover. Your contribution amount is paid on a pre-tax basis, deducted from your paycheck before taxes are withheld. The University will communicate your employee contribution amount during the annual benefits open enrollment period.

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.

Spousal Insurance Surcharge

Employees must pay an additional cost to cover a spouse who has the option to elect health care coverage through their employer. The additional cost, or surcharge, to the University employee will be \$100 per month. If the above situation applies to you, you will want to consider how the additional cost may impact your coverage choice. *The spousal insurance surcharge does not apply to members of Teamsters’ Local 8 through 2024 per their collective bargaining agreement.*

During Benefits Open Enrollment each November, you will verify the above criteria through Workday.

To help you determine if the surcharge applies to your situation, please consider the following scenarios:

YES Surcharge:

- If your spouse is working at an employer who offers group health insurance but has declined that coverage and wants to remain on the University health plan.
- If your spouse is eligible and/or enrolled in Medicare, but is still actively working at their own employer, who offers group health insurance.
- If your spouse is offered coverage for any period throughout the year with their employer, and you choose to continue their coverage under the Penn State health plan.

NO Surcharge:

- If you and your spouse are BOTH employed at Penn State and are both covered on the University health plan under either you or your spouse's coverage.
- If your spouse is eligible and/or enrolled in Medicare but is currently covered on your active employee University health plan.
- If your spouse is a retiree from another employer but is not actively working.
- If your spouse is self-employed, regardless of whether they offer insurance to their employees.
- If your spouse is a part-time employee and has NO access to health coverage.
- If your spouse has insurance available through their own employer, but the employer makes NO contribution toward the cost of the insurance.
- If your spouse is a graduate student at Penn State; even though they are offered insurance, they are considered a student, not an employee of Penn State.

CHANGING YOUR COVERAGE

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") establishes special enrollment rights that allow certain employees or dependents, who experience a qualifying event, to enroll in the plans without waiting until the next annual open enrollment period. You and/or your dependents, including newborn children, must enroll in health care benefits within thirty-one (31) days of your date of eligibility, and your enrollment elections stay in effect for the calendar year. If you do not enroll when you are first eligible, you and/or your dependents must wait until the University's annual open enrollment period, and coverage will be effective on January 1 of the subsequent year.

You may decide to cancel your coverage at any time throughout the plan year. Because of the tax laws, you may be required to pay the premiums for coverage for the entire year (unless you have a qualifying event), even if you decide to forego coverage under this plan for some reason during the year. For this reason, it is very important that you consider this issue if you plan to drop coverage without a qualifying event.

Loss of Coverage

If you initially declined coverage under the plans for yourself and/or your dependents (including your spouse) because of other health coverage, you may in the future be able to enroll yourself and your dependents in the plans, provided you request enrollment, within Workday within thirty-one (31) days after you lose your other coverage. You will qualify for special enrollment due to loss of coverage only after:

- Losing eligibility for the other coverage, including losing eligibility because 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 plans.

You do not have special enrollment rights if you lose your other coverage because of failure to pay for premiums or for cause (e.g., fraudulent claims).

For all health plans, if your spouse has coverage elsewhere and has not been on the University plan, they are eligible to join the Penn State health plan:

- **At such time that they lose coverage elsewhere, resulting in a qualifying event status change.**
- **During Benefits Open Enrollment period prior to your retirement.**
- **At the time of YOUR retirement from Penn State.**

For health plans that include the Spousal Surcharge, if you add your spouse during Benefits Open Enrollment, the Spousal Insurance Surcharge will apply if they have other group coverage available through their employer.

Also see section [Dependent Protection After Your Death](#) for additional information.

New Dependents

If you have a new dependent because of marriage, birth, adoption, or placement for adoption, you may be able to enroll your dependents through Workday within thirty-one (31) days after the marriage, birth, adoption, or placement of adoption/intent to adopt.

Gain or Loss of Medicaid Coverage

If you are eligible for health coverage under the plans, but are unable to afford the contributions, some states have premium assistance programs that can help pay for coverage. If you or 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 you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of 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 plans if:

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

eligible for such assistance.

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

If you voluntarily discontinue your medical coverage, it may adversely affect your eligibility to continue medical insurance after you retire from Penn State, if you were hired prior to January 1, 2010.

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

Active Employees

As a regular full-time employee, you will continue to be covered under the current active medical plan, even though you are eligible for Medicare. You may be automatically enrolled in Medicare Part A; however, you should decline Part A if you are a current member of a High Deductible Health Plan (PPO Savings Plan) due to IRS regulations. You do not have to enroll for Part B immediately, but you should contact your local Social Security office three (3) months prior to your retirement. This will aid your transition to the Penn State Medicare-eligible health plan if you are eligible to retire with medical benefits. If you are eligible to retire with medical benefits, you should notify HR Services three (3) months prior to your retirement.

Coordination With Medicare

If you are eligible for Medicare, the medical plan pays benefits as if you are enrolled in Medicare Parts A and B, regardless of whether you are enrolled or receive Medicare benefits.

So, if Medicare pays benefits before the medical plan pays benefits (i.e., if Medicare pays primary or “first”), it is critical that you and your dependents enroll in Medicare Parts A and B as soon as you are eligible. Whether Medicare pays primary or secondary depends largely on your employment status with the University and “why” you are receiving Medicare.

Medicare Eligibility

You generally become eligible for Medicare at these times:

- When you reach age sixty-five (65).
- If you become disabled and have received Social Security disability benefits for 24 months; or
- If you have End Stage Renal Disease (“ESRD”).

However, just being eligible for Medicare does not necessarily make Medicare the primary payer. Instead, “coordination rules” define when Medicare is the primary payer, and when it is the secondary payer.

Which Plan Is Primary?

Whether the medical plan or Medicare is the primary payer, or the secondary payer depends, in part, on your (the employee’s) employment status. Generally, you have “current employment status” when you are actively employed by the University. If you do not have “current employment status” with the University or your “current employment status” changes, different Medicare coordination rules apply for you and your dependents. Please refer to the Summary Plan Document for retired faculty/staff benefits, or contact Medicare, for additional information regarding Medicare coordination when you no longer have “current employment status” with the University.

If you (the employee) have “current employment status” with the University, the medical plan is the primary payer when any of these apply:

- You or your dependents are not eligible to participate in Medicare.
- You or your spouse is eligible for Medicare due to reaching age sixty-five (65).
- You or any dependent, including your spouse, is under age sixty-five (65) and is eligible for Medicare due to a disability. The medical plan will be the primary payer if you continue to work. However, if you no longer continue to work, the medical plan generally will be the secondary payer (and Medicare the primary payer) after the first twenty-four (24) months of Social Security disability entitlement; or
- You or any dependent is eligible for or entitled to Medicare due to ESRD, but only for the first thirty (30) months of Medicare eligibility. After the first thirty (30) months of Medicare eligibility, the medical plan becomes the secondary payer.

If you (the employee) have “current employment status” with the University, Medicare is assumed to be the primary payer when any of these apply:

- Your dependent, other than your spouse, is eligible for Medicare due to reaching age sixty-five (65).
- Your dependent, other than your spouse, is eligible for Medicare due to reaching age sixty-five (65) and subsequently becomes eligible for, or entitled to, Medicare due to ESRD. Medicare will continue to be the primary payer in this event; or
- You or any dependent is eligible for, or entitled to, Medicare due to ESRD and your or your dependent has been Medicare-eligible due to ESRD for more than thirty (30) months.

Medicare Part B Enrollment

Medicare Part B is considered a voluntary benefit, and you will get an opportunity to dis-enroll from Part B. However, dis-enrolling from Part B can have adverse consequences if Medicare pays primary for you. For most active employees, Medicare will not pay primary. However, if you retire, become disabled, or have ESRD, you will need to ensure that you enroll in Part B to avoid missing important benefits under the University’s retiree medical plan. If you are eligible to Medicare, the medical plan pays benefits as if you are enrolled in Medicare Parts A and B, regardless of whether you are enrolled or receive Medicare benefits. So, it is critical that you and your dependents enroll in Medicare Parts A and B as soon as you are eligible. To enroll in Medicare, you should contact the local Social Security office three (3) months before reaching your sixty-fifth (65th) birthday.

You should notify HR Services three (3) months prior to your planned retirement date to be enrolled in the appropriate University-sponsored medical plan for Medicare-eligible retirees.

BENEFITS UNDER THE PLANS

The benefits under the medical, dental, and vision plans are separately described in the plans’ Coverage Booklets.

WHEN COVERAGE ENDS

For You

Your coverage ends on the:

- Last day of the pay period in which your University employment terminates.
- Day you no longer meet the plans' eligibility requirements.
- If retiring: Last day of the month in which you retire.
- If terminating: Last day of the pay period during which you stop making required employee contributions.
- 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.

When coverage ends, you may be eligible to continue benefits under the provisions of COBRA. In addition, you may be able to continue benefits when you retire. Please refer to the Summary Plan Document for retired faculty, staff & technical service benefits for additional information regarding retiree benefits when you no longer have "current employment status" with the University.

For Your Dependents

Your dependents' coverage ends on the:

- Day your coverage ends (except for your death).
- Day your dependent no longer meets the plans' eligibility requirements.
- 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 documents are 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.

COVERAGE CONTINUATION IF YOU CEASE ACTIVE WORK

Due to Retirement

Medical Coverage: You and your dependents may be eligible to continue coverage under the University's retiree medical plan if, at retirement, you meet specific requirements.

Dental and Vision Coverage: Your dental and vision plan coverage terminate at retirement. However, you may elect to continue one or both plans under the provisions of COBRA. You may also be eligible to enroll as the spouse or dependent of an active University employee.

If you were hired prior to January 1, 2010:

You may continue medical coverage under the University's plan for you and your eligible dependents 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 or 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 like the University-sponsored medical plan in which you were enrolled prior to retirement. As you or your spouse become Medicare-eligible, 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 quarterly 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 Plan (RHSP). 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.

Dependent Protection After Your Death

Active employee who IS eligible to continue medical benefits after retirement:

As an active employee, if you have met the criteria outlined above under Retiring with Benefits and were hired prior to January 1, 2010:

You are **NOT** required to carry your spouse on your medical plan, in the event of your death as an active employee. ***For the surviving spouse and other eligible dependents that are not on your health plan at the time of your death, they will have 60 days from the date of your death to contact Penn State Employee Benefits office to enroll.***

In either situation, 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

Dependent children: Medical coverage for your dependent children will continue after your death,

provided the required contributions are paid when due, but terminated when the child reaches age twenty-six (26).

Active employee who is NOT eligible to continue medical benefits after retirement:

Should you die while you are an active employee who is not eligible to continue medical benefits after retirement, with benefits in force for a dependent spouse, then medical benefits may be continued under the provisions of COBRA. The University will continue employer contributions for the first twelve (12) months of COBRA coverage. After the first twelve (12) months, the cost of coverage will be at the full COBRA rate.

Dependent children: Medical coverage for your dependent children will continue after your death, provided the required contributions are paid when due, but terminate when the child reaches age twenty-six (26).

In addition, benefits for your dependents may be extended beyond the period after your death under provisions of COBRA.

Due to Disability

If you were hired **BEFORE January 1, 2010, AND** you have five or more years of continuous full-time service **AND** participation in the University-sponsored health plan **AND** meet one of the following conditions, you and your eligible dependents may continue University sponsored medical benefits only. This does not include dental, vision, Grant-in-Aid tuition discount, nor any other Retiree benefits (as outlined in HR 54), **for the period of your disability.**

1. You qualify for a disability retirement from the State Employees Retirement System (SERS) or the Public School Employee Retirement System (PSERS).

OR

2. You are a member of the TIAA-CREF retirement plan and qualify for a disability through either the total and permanent disability benefit under the level premium group term life insurance plan or the University-sponsored long-term disability plan.

OR

3. You are not participating in either the level premium life insurance plan or the University-sponsored long term disability plan but are approved for social security disability. Any dependents' coverage ceases at your death. Dental, Vision, and Accidental Death and Dismemberment coverage will not be continued during disability retirement.

Upon your return to work, your health plan will be governed by the plan available to all benefits-eligible employees. If you become deceased, your eligible dependents would be offered COBRA in accordance with federal law (see page 18).

Due to Leave of Absence or Reduction in Force

If your leave of absence is without pay due to sickness or maternity, formal study, or leave in lieu of temporary layoff, you may continue medical, dental, and vision coverage and will be

billed for the employee contribution portion of the monthly cost.

If your position is terminated due to a Layoff, as outlined in Policy HR 97, you may continue your medical, dental, and vision coverage for a period of up to one hundred and twenty (120) days by paying the employee contribution portion of the monthly cost if you cease work because of a reduction in force other than the end of a fixed-term appointment. Benefits may be continued beyond one hundred and twenty (120) days under the provisions of COBRA.

For all other leaves of absence, you may continue coverage by paying the full cost of the premium. If you decline benefits during your leave, your “return to work” is a life status change that qualifies you to add medical, dental and vision at that time. If you have cancelled life insurance and or the long-term disability/annuity premium benefit, you will be required to go through the Evidence of Insurability/Proof of Good Health process to re-enroll.

Due to FMLA Leave of Absence

Any provisions of the plans that provide for continuation of coverage during a leave of absence and reinstatement of coverage following a return to active service are modified by the following provisions of the federal Family and Medical Leave Act of 1993 (FMLA), where applicable:

Continuation of Coverage During FMLA Leave

Your coverage under the plans will be continued during a leave of absence if:

- That leave qualifies as a leave of absence under the FMLA; and
- You are an eligible employee under the terms of the FMLA.

The plan administrator will give you more detailed information about the FMLA. However, you are eligible for FMLA leave if you need to provide care:

- After the birth or legal adoption of a child.
- To a spouse, child, or parent due to his/her serious illness; or
- For your own serious health condition.

If you meet the applicable service requirements, the FMLA allows you to:

- Take up to twelve (12) work weeks of leave each calendar year for the specified family and medical reasons.
- Take up to twenty-six (26) work weeks of leave each calendar year if you are caring for a family member in the Armed Forces (including the National Guard and Reserves) who is under-going medical treatment, recuperation, or therapy; or is otherwise in outpatient status; or is otherwise on the temporary disability retired list, for a serious injury or illness.
- Take up to twenty-six (26) work weeks of leave each calendar year if you are caring for a family member who is a veteran undergoing medical treatment, recuperation, or therapy for a serious injury or illness, if that veteran was a member of the Armed Forces (including the National Guard and Reserves) at any time during the five (5) years preceding the date on which the veteran undergoes that medical treatment, recuperation, or therapy; and
- Be restored to your former position or an equivalent position and pay when you return to work.

A “serious illness or injury” means:

- For a person in the Armed Forces (including the National Guard and Reserves), an

injury or illness that was incurred while on active duty (or existed prior to the beginning of active duty and was aggravated by active-duty service) and that may render the person medically unfit to perform the duties of his or her office, grade, rank, or rating.

- For a veteran who was a member of the Armed Forces (including the National Guard and Reserves), a qualifying injury or illness that was incurred while on active duty (or existed prior to the beginning of active duty and was aggravated by active-duty service) and that manifested itself before or after the person became a veteran; the U.S. Secretary of Labor will define a “qualifying injury or illness”.

Benefits Coverage While on FMLA Leave

The University will continue your coverage under the plans during your FMLA leave just as if you were still employed. The cost of your coverage during an FMLA leave must be paid, and you must make all required employee contributions on an after-tax basis in accordance with the agreement reached between you and the University prior to your FMLA leave becoming effective.

A newly acquired dependent is eligible for coverage while your coverage is continued during FMLA leave.

Continued coverage ends on the earliest date that you:

- Terminate employment; or
- Do not make the required employee contributions.

If your employment does not terminate during your leave, but you do not return to work once your leave ends, you can choose to continue coverage under the provisions of COBRA.

Reinstatement of Canceled Coverage Following FMLA Leave

Upon your return to your employment following an FMLA leave of absence, any terminated coverage can be reinstated as of the date of your return.

You will not be required to satisfy any eligibility requirements or the requirements of any pre-existing condition limitation to the extent that they had been satisfied prior to the start of your leave of absence.

Benefits Coverage for a Qualifying Exigency

If you are an eligible employee, you can take up to twelve (12) combined weeks of FMLA leave in a single twelve (12) month period for a “qualifying exigency” to spend time with a spouse, son, daughter, or parent who is covered on active duty or was notified of an impending call to covered active duty.

Qualifying exigencies include the following:

- Short notice deployment.
- Military events and related activities.
- Childcare and school activities.
- Financial and legal arrangements.
- Counseling.
- Rest and recuperation.
- Post deployment activities.
- Additional activities related to the active duty or call to duty, and for which the leave is agreed to by the University.

“Covered active duty” means:

- For a person in a regular component of the Armed Forces, duty during deployment to a foreign country; or
- For a person in the National Guard and Reserves, duty during deployment to a foreign country under a call or order to active duty under applicable federal law.

State Family and Medical Leave Laws

The University’s FMLA policy must comply with any state law that provides greater family or medical leave rights than those provided under its FMLA policy. If your leave qualifies under FMLA and under a state law, you will receive the greater benefit.

If the University Changes Benefits

If the University offers new benefits or changes its benefits while you are on FMLA leave, you are eligible for the new or changed benefits but your employee contributions for these benefits may increase.

Due to USERRA Leave of Absence

The Uniformed Services Employment and Re-employment Rights Act of 1994 (“USERRA”) sets requirements for continuation of medical coverage and re-employment in regard to an employee’s military leave of absence. If you are granted a military leave of absence, you may elect to continue employee-only coverage and/or dependent coverage under the plans by paying the employee contribution portion of the monthly rate. You must notify Penn State Employee Benefits prior to the effective date of your military leave.

Continuation of Coverage

For leaves of less than thirty-one (31) days, coverage will continue as described above in the *Due to Leave of Absence or Reduction in Force* section.

For leaves of thirty-one (31) days or more, you may continue coverage for yourself, and your dependents as follows:

- You are eligible to continue coverage until the earliest of the following:
 - Twenty-four (24) months from the date on which your military absence begins.
 - The day after you fail to return to work; and
 - The date the plans terminate.
- The University may charge you and your dependents up to one hundred two percent (102%) of the total cost.

Reinstatement of Benefits

If you discontinue coverage during the leave of absence, you may become covered again when you resume full-time employment if:

- You gave the University advance written or verbal notice of your military service leave; and
- The duration of all military leaves while you are employed with the University does not exceed five (5) years.

You and your dependents will be subject to only the balance of a preexisting condition limitation that was not yet satisfied before your leave began. However, if an injury or illness occurs or is aggravated during the military leave, full plan limitations will apply.

Any 63-day break in coverage rule regarding credit for time accrued toward a preexisting condition limitation waiting period will be waived.

If your coverage under the plans terminates because of your eligibility for military health coverage and your order to active duty is canceled before your active-duty service commences, these reinstatement rights will continue to apply.

Due to Termination of Employment

If your employment is terminated for any reason other than outlined above, when you are no longer eligible or when the plans terminate, all coverage under the plans ceases at the end of the pay period in which the termination occurs.

If you cease active work, your benefits under the plans may be continued under 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 plans. A qualified beneficiary may include the following individuals who were covered by the plans 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
Your active employment ends for reasons other than gross misconduct.	You and your dependents	18 months
Your working hours are reduced.	You and your dependents	18 months
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

Medicare Extension for Dependents

When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B, or both) within the eighteen (18) months before the qualifying event, COBRA coverage for your dependents will last for up to thirty-six (36) months after the date you became enrolled in Medicare. Your COBRA coverage will last for up to eighteen (18) months from the date of your termination of employment or reduction in work hours.

Secondary Qualifying Events

If, as a result of your termination of employment or reduction in work hours, your dependent(s) have elected COBRA coverage and one or more dependents experience another COBRA qualifying event, the affected dependents may elect to extend their COBRA coverage for an additional eighteen (18) months (seven (7) months if the secondary event occurs within the disability extension period discussed below) for a maximum of thirty-six (36) months from the initial qualifying event. The second qualifying event must occur before the end of the initial eighteen (18) months of COBRA coverage or within the disability extension period discussed below. Under no circumstances will COBRA coverage be available for more than thirty-six (36) months from the initial qualifying event. Secondary qualifying events are:

- Your death.
- Your divorce or legal separation; or
- For a dependent child, failure to continue to qualify as a dependent under the plans.

Disability May Increase Maximum Continuation to Twenty-Nine (29) Months

If you or your dependent qualifies for disability status under Title II or XVI of the Social Security Act during the eighteen (18) month continuation period, you and all of your covered dependents:

- Have the right to extend coverage beyond the initial eighteen (18) month maximum continuation period.
- Qualify for an additional eleven (11) month period, subject to the overall COBRA conditions.
- Must notify the plan administrator within sixty (60) days of the disability determination status and before the eighteen (18) month continuation period ends; and
- Must notify the plan administrator within thirty (30) days after the date of any final determination that you or a dependent is no longer disabled.

The Social Security Administration (“SSA”) must determine that the disability occurred prior to or within sixty (60) days after the disabled individual elected COBRA coverage. In addition, the eleven (11) month disability extension will terminate for all qualified beneficiaries on the first day of the month that is more than thirty (30) days after the date the SSA makes a final determination that the disabled individual is no longer disabled.

All causes listed below in the *When Your COBRA Coverage Ends* section will also apply to the period of disability extension.

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 plans 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, your termination of employment, the reduction in your employment hours, or your eligibility for Medicare, a COBRA coverage election notice must be provided to you and/or your dependents within the following timeframes:
 - If the plans provide 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 plans; or
 - If the plans provide 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 because of the qualifying event:

- Your divorce or legal separation; or
- Your child ceases to qualify as a dependent under the plans; or
- The occurrence of a secondary qualifying event as discussed above under the *Secondary Qualifying Events* section (this notice must be received prior to the end of the initial eighteen (18) or twenty-nine (29) month COBRA period).

Also refer to the *Disability May Increase Maximum Continuation to Twenty-Nine (29) Months* section for additional notice requirements.

Notice must be made in writing and must include: the name of the plans, 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 plans are no longer available. Generally, qualified beneficiaries cannot change plan options until the next annual open enrollment period, or a qualifying event status change.

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 if 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 for your dependents to elect COBRA coverage.

Determining Your Contributions for COBRA Coverage

Your contributions are regulated by law, based on the following:

- For the eighteen (18) or thirty-six (36) month periods, contributions may never exceed one hundred two percent (102%) of plan costs, including both University and employee contribution amounts; and
- During the eighteen (18) through twenty-nine (29) month periods, contributions for coverage during an extended disability period may never exceed one hundred fifty percent (150%) of plan costs.

If you alone elect COBRA coverage, you will be charged one hundred two percent (102%) (or one hundred fifty percent (150%)) 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%) (or one hundred fifty percent (150%)) of the active employee contribution amount. If more than one qualified beneficiary elects COBRA coverage, they will be charged one hundred two percent (102%) (or one hundred fifty percent (150%)) of the applicable family cost.

When and How to Make COBRA Payments

First Payment for COBRA Coverage

If you elect COBRA coverage, you need to send 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 plans.

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 plans 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 if 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 plans may be suspended during this time. Any providers who contact the plans 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 plans.

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 plans 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 COBRA continuation period: the end of the eighteen (18), twenty-nine (29), or thirty-six (36) months. (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, if he/she is not disabled nor eligible for an extended maximum).
- 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 plans may remain in effect until the pre-existing clause ceases to apply or the maximum continuation period is reached under the plans.
- The date the University no longer offers the plans.
- 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 plans 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.

CONVERSION PRIVILEGE

The state of Pennsylvania does not require an offer of coverage conversion for self-insured medical plans, though some states still require it.

If your coverage under the medical plan terminates for any reason other than your failure to pay any required employee contribution amounts, you may be entitled to convert to an individual policy of insurance with the claims service provider, without submitting evidence of good health, if you were covered for at least three (3) months. Please note that conversion of medical coverage is only available if the insurance provider recognizes conversion of coverage for the state in which you reside. You will want to reach out directly to the insurance carrier prior to your loss of coverage or within 30 days of your loss of coverage to determine if conversion of coverage is available to you.

NOTE: There is no conversion privilege for the dental or vision plans.

THIRD PARTY LIABILITY LIMITATION

The plans will not pay for covered expenses for injuries received because 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 plans, the difference will be paid by the plans.

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 plans 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, dental, or vision 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 the plans.

COORDINATION OF BENEFITS PROVISION

The plans contain a nonprofit provision coordinating them 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 one of the plans of the same type (medical, dental, or vision). "Plans" means these types of medical, dental and vision 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.

- Your COBRA coverage ends.
- You request a certificate before losing coverage; or

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 like the one for the University's plans is always the primary plan. If all plans have such a provision:

- The plan covering the patient as an employee, 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 fall 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 stepparent 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 a University-sponsored plan which are in excess of the benefits that should have been paid, or which should not (under the provisions of the plans) 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 plans, 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 these plans shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of these plans, 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.

CANCELLATION OF HEALTH CARE BENEFITS

If the University is unable to ascertain the whereabouts of you or your dependents for whom benefits are payable under these plans, and if, after one year from date such payment is due, a notice of such payment due is mailed to the last known address of such person as shown on the records of the University and, within three (3) months after such mailing, such person has not filed with the plan administrator a written claim for the benefits, the University may direct that such payment be canceled and forfeited and, upon such cancellation of these plans, shall have no further liability for the benefits.

RIGHT TO RECEIVE AND RELEASE INFORMATION

To determine 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 these plans. In so acting, the University and/or the plan administrator shall be free from any liability that may arise regarding such action. You and your dependents claiming benefits under these plans 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 plans 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.

Employee Notices – Penn State shall furnish each employee covered by the Plan written notice that Penn State has complete financial liability for the payment of Plan benefits. Penn State shall inform its Plan Participants, in a manner that satisfies applicable law, that confidential information relating to their benefit claims may be disclosed to third parties in connection with plan administration.

WORKER'S COMPENSATION NOT AFFECTED

These plans are not in lieu of, and do 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 these plans, the true facts will be used to determine the proper coverage. Coverage means eligibility, as well as the amount of any benefits under the plans.

AMENDMENT OR TERMINATION OF PLANS

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

- The coverage and benefits provided under the plans; and
- The level of employee contributions, deductibles, co-payments, and coordination of benefits between the plans 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 a 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 plans, the right to amend or terminate the plans 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 plans are not a contract, and the University does not guarantee and makes no promise to offer a specific level of benefits under the plans 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 plans, 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 plans 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 plans may use or disclose your Protected Health Information for purposes of conducting health care operations or paying your health care claims.
- The plans 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 plans may disclose your Protected Health Information to the University, as sponsor of the plans, to assist the University in the performance of plan administrative functions. The plans 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 plans. Summary health information does not directly identify you, but summarizes claims history, claims expenses, or types of claims experienced. Finally, the plans may disclose your enrollment and disenrollment information to the University as plan sponsor.
- The plans 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 plans may disclose your Protected Health Information to a law enforcement official for certain law enforcement purposes. For example, the plans may disclose your Protected Health Information pursuant to a law requiring the reporting of certain types of wounds or other physical injuries.
- The plans may disclose your Protected Health Information to health care providers to assist them in connection with their treatment or payment activities. In addition, the plans 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 plans 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 plans will not use or disclose your Protected Health Information without your written authorization. If you authorize the plans to use or disclose your Protected Health Information, you may revoke that authorization in writing at any time. If you revoke the authorization, the plans 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 plans already have made prior to the date the plans receive notice of the revocation.

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

- You have the right to request that the plans 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 plans 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 plans 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 plans 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 plans, 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 plans, please review the Notice of Privacy Practices for the plans. The Notice of Privacy Practices for the plans is available from the plan administrator.

HEALTH CARE REFORM CHANGES

In March 2010, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act were passed. These two laws are referred to as the "Affordable Care Act".

Under the Affordable Care Act, the following provisions are applicable to your medical benefits, effective January 1, 2011. For more information, contact the plan administrator.

- There are no longer any annual limits on the dollar value of essential health benefits. Note that the Affordable Care Act does not prohibit other limits, such as limits on the number or frequency of a covered service. The Secretary of the U.S. Department of Health and Human Services may allow restricted annual limits through January 1, 2014. The Secretary will be issuing guidance to define an "essential health benefit", but the Affordable Care Act states that essential health benefits include the following general categories:
 - Ambulatory patient services.
 - Emergency services.
 - Hospitalization.
 - Maternity and newborn care.
 - Mental health and substance use disorder services, including behavioral health treatment.
 - Prescription drugs.
 - Rehabilitative and habilitative services and devices.
 - Laboratory services.
 - Preventive and wellness services and chronic disease management; and
 - Pediatric services, including oral and vision care.

- The medical plan cannot retroactively cancel or discontinue your coverage or your benefits (a "rescission") without a thirty (30) day advance, written notification, unless you have committed fraud or intentionally misrepresented any fact or statement or failed to pay any required premiums or contributions. However, the plan may prospectively cancel or discontinue coverage or benefits.

- The medical plan will not impose any pre-existing condition exclusion for any enrollee who is under the age of nineteen (19).

- The medical plan is required to provide certain preventive services to you at no charge. For a complete list of these preventive services, contact the plan administrator or visit the federal government's website at <http://www.HealthCare.gov/center/regulations/prevention.html>. The plan will pay for these preventive services at one hundred (100%). However, this only applies to in-network services and providers. You will pay your normal out-of-network co-pays and co-insurance if you obtain these preventive services from an out-of-network provider.

- The medical plan will allow you to obtain emergency care from the emergency department of a hospital without preauthorization. Even if the care is obtained at the emergency room of an out-of-network hospital, you will only have to pay your in-network

co-pays and co-insurance.

- The medical plan's claims and appeals procedures have been amended to comply with the provisions of the Affordable Care Act. These updated claims and appeals procedures are effective on and after January 1, 2011. The Affordable Care Act includes provisions for a new external review process. On August 23, 2010, the U.S. Departments of Labor, Treasury, and Health and Human Services and the Employee Benefits Security Administration issued interim guidance for this external review process. The University and its claims service providers and other named fiduciaries will comply with the external review process and this interim guidance.

Please note that this interim guidance is subject to further review and change by these agencies. The University will update these claims and appeals procedures when any additional guidance is issued by the agencies.

- Beginning with the IRS Form W-2 that you receive in January 2013 (for the 2012 tax year), the plan will report the value of your health care benefits on your Form W-2.
- The medical plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the plan's network and who is available to accept you or your dependents. For information on how to select a primary care provider, and for a list of participating primary care providers, contact the plan administrator.
 - For children, you may designate a pediatrician as the primary care provider.
 - You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the plan's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the plan administrator.
- The lifetime limit on the dollar value of essential health benefits under the plan no longer applies. The Secretary of the U.S. Department of Health and Human Services will be issuing guidance to define an "essential health benefit", but the Affordable Care Act states that essential health benefits include the following general categories:
 - Ambulatory patient services.
 - Emergency services.
 - Hospitalization.
 - Maternity and newborn care.
 - Mental health and substance use disorder services, including behavioral health treatment.
 - Prescription drugs.
 - Rehabilitative and habilitative services and devices.
 - Laboratory services.
 - Preventive and wellness services and chronic disease management; and
 - Pediatric services, including oral and vision care.

**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 more than 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 plans.

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

Eligibility and Enrollment Claims

All claims regarding your eligibility and enrollment for benefits under the plans 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 providers, according to their claims and appeals processes. See the Certificates of Coverage for more information about your rights and responsibilities under the claims and appeals processes.

ADMINISTRATIVE INFORMATION

Plan Names/Identification

The names of the plan are the University-Sponsored Medical, Dental, and Vision Benefit Plan.

Plan Sponsor

The plan sponsor is:

The Pennsylvania State University
Penn State Employee Benefits
Human Resources
The 331 Building
University Park, PA 16802
814-865-1473

Plan Administrator

The plan administrator is:

The Pennsylvania State University
Penn State Employee Benefits
Human Resources
The 331 Building
University Park, PA 16802
814-865-1473

Claims Service Providers

The claims service providers are:

Health & Prescription Plan:
Highmark Blue Shield
PO Box 890382
Camp Hill, PA 17089-0382
844-945-5509

Vision Plan:
EyeMed
4000 Luxottica Place
Cincinnati, OH 45040
866-939-3633

Dental Plan:
United Concordia Companies, Inc.
Dental Claims
P. O. Box 69421
Harrisburg, PA 17106
800-423-8217

Authority to Review Claims

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

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

Plan Year

The plan year is January 1 through December 31.