

SUMMARY PLAN DESCRIPTION

FOR THE

**UNIVERSITY OF PENNSYLVANIA
RETIREE HEALTH PLAN**

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

As of July 1, 2002

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INTRODUCTION

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

One of the many requirements of the Employee Retirement Income Security Act of 1974 (ERISA), a federal law applying to employee benefit plans, is that employers must supply employees with a description of the various benefit plans it maintains. Such information must be included in a summary plan description ("SPD") for each plan. This document, together with any booklets or other descriptive material you receive from the University, insurance companies, and health maintenance organizations ("HMOs"), constitutes the SPD for the Plan. This SPD describes the Plan as in effect as of July 1, 2002.

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

The Plan, any changes to it, or any payments to you under its terms, does not constitute a contract of employment with the University and does not give you the right to be retained in the employment of the University or its subsidiaries or affiliates.

ELIGIBILITY TO PARTICIPATE

This section of the SPD describes the eligibility requirements that a retiree must satisfy to participate in the Plan.

- **Existing Retirees and Eligible Dependents:** This summary generally describes the retiree benefits that are available to eligible retirees on or after July 1, 2002. If you or your "eligible dependents" (as defined below) were receiving retiree benefits before July 1, 2002, you will continue to receive these benefits on and after July 1, 2002, but these retiree benefits will be subject to the provisions described in this summary.
- **New Retirees:** If you are a new retiree, you are eligible to participate in the Plan upon your retirement only if (1) you retire on or after reaching age 62 with 10 or more "years of service", or (2) you retire between age 55 and 61 with 15 or more "years of service". The term "years of service" means years of full-time and continuous service with the University as reflected in the University's records; note that service with the University before July 1, 1996 (the date the Plan was last updated) shall be taken into account only if you were continuously employed in full-time and continuous service for the entire 12-month period ending June 30, 1996. If you do not otherwise satisfy these age and service requirements, you may still be eligible for benefits under

the Plan if you retire pursuant to the University's Faculty Income Allowance Plan ("FIAP"), as long as you otherwise satisfy the requirements for retiring under the FIAP.

In addition to satisfying these age and service requirements, to be eligible for retiree coverage under the Plan, you also must have been eligible for medical/healthcare coverage (even if you are not actually covered) under the "University of Pennsylvania Health and Welfare Program" on the day immediately preceding your retirement. The University of Pennsylvania Health and Welfare Program (the "Program") is the health and welfare benefit plan maintained for active employees of the University.

- **New Eligible Dependents:** If you are a new retiree, you may elect coverage for any eligible dependents who were eligible for medical/healthcare benefits (even if they were not actually covered) under the Program at the time you retired. For purposes of the Plan and this SPD, an eligible dependent shall include your legally married spouse, an unmarried child who is under 19, an unmarried child who is between 19 and 23 and who is a full-time student, and a disabled child who first became disabled before age 19 and who is incapable of self-support. An eligible dependent shall also mean any individual who you certify is your "domestic partner" in accordance with the University's policies and procedures and any child of your domestic partner who fits within one of the categories described in the preceding sentence.

(Note: Any individual who first becomes your eligible dependent after you retire and start receiving benefits under the Plan is not eligible for benefits from the Plan; note that this exclusion does not apply to you if you retired before July 1, 1996.)

- **Electing Coverage:** When you first become eligible for benefits under the Plan, you will be required to complete an enrollment form and/or comply with such other enrollment procedures as may be established by the Plan Administrator. If you do not elect coverage when you are first eligible, you may enroll at a later date in accordance with the procedures established by the Plan Administrator. Once per calendar year, you will be permitted to make an election to change coverage options. An election to change your coverage when you first retire (that is, to change the coverage you were receiving as an active employee), will count as this one election change per year limit.
- **Other Miscellaneous Rules:** To enroll in the Plan, you may be asked to complete certain enrollment or other forms. In addition, the Plan Administrator or the contracts between the University and its benefit providers (the "Contracts") may establish other rules or requirements for receiving Plan benefits (e.g., time periods for returning election forms, etc.). Any such other rules will be communicated to you when you first are eligible to enroll in the Plan and from time to time thereafter.

IMPORTANT: Notwithstanding the foregoing eligibility provisions, please keep in mind that the University reserves the right to modify or eliminate the benefits provided to new or existing retirees, eligible dependents, or disabled former employees at any time and for any reason.

CESSATION OF PARTICIPATION

- **Cessation of Coverage for Retirees:** Your coverage under the Plan will end on the earliest of:
 - the date on which the University decides to terminate or modify coverage under the Plan;

- the date as of which you fail to satisfy the eligibility requirements of the Plan or any applicable Contract;
- the date as of which you fail to make any required contributions;
- the date as of which you elect to cease participation; or
- the date of your death.
- **Cessation of Coverage for Covered Eligible Dependents:** Coverage for your spouse, domestic partner or any of your eligible dependents under the Plan will end on the earliest of:
 - the date on which the University decides to terminate or modify coverage under the Plan;
 - the date your dependent ceases to be an eligible dependent under the Plan or under the provisions of the applicable Contract;
 - the date as of which you, or if applicable, your spouse, domestic partner or your eligible dependent, fail to make any required contributions; or
 - the date as of which you drop your spouse, domestic partner or eligible dependent from coverage.

Any individual who is covered as an eligible dependent under the Plan may continue receiving Plan benefits after your death until such time as your eligible dependent otherwise fails to satisfy the Plan's eligibility requirements. If your spouse remarries after your death and becomes eligible for coverage under the plan of his/her new spouse, your spouse will no longer be eligible for coverage under the Plan.

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

BENEFITS

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

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

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance; and
- Prostheses and treatment for physical complications in all stages of a mastectomy, including lymphedemas.

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

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

CONTRIBUTIONS

You and/or your eligible dependents may be required to contribute toward the cost of retiree benefits that you select for you and/or your eligible dependents. The contributions that you are required to pay are determined by the University each year and will be communicated to you when you first become eligible for benefits under the Plan and periodically thereafter. Please keep in mind that the University reserves the right to change the amount of your or your eligible dependents' contributions at any time and for any reason.

MEDICARE ELIGIBILITY

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

DISABLED EMPLOYEES

If you are a disabled employee and you are eligible to receive disability benefits under the University's long-term disability program, you generally will be eligible to receive medical/healthcare benefits under the Plan during your period of disability. With a few exceptions, these medical/healthcare benefits will be provided to disabled former employees in accordance with the provisions described in this summary. The few exceptions are as follows:

- **Cessation of Disability:** If you are disabled and you are receiving medical/healthcare benefits under the Plan, your benefits will stop as of the first day of the month following the date that you are no longer disabled.
- **Coverage and Benefits:** Disabled employees generally are eligible for the coverage options that are available to other similarly situated retirees, but the University will only subsidize a specific

portion of the cost of a particular coverage option (currently, an amount equal to the cost of electing coverage under one of the available HMO coverage options).

- **Medicare Eligibility:** If you are a disabled employee who is receiving medical/healthcare benefits under the Plan and you become eligible for Medicare as a result of your disability, you will only be eligible to receive benefits under one of the Plan's coverage options that coordinates with Medicare. You will be transitioned to one of these Medicare coverage options as soon as administratively practicable after you become eligible for Medicare coverage.

CLAIMS PROCEDURE

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

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

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

A request for benefits is a "claim" subject to these procedures only if you or your authorized representative file it in accordance with the Plan's claim filing guidelines. In general, claims must be filed in writing (except urgent care claims, which may be made orally) with the applicable provider identified in Appendix A. Any claim that does not relate to a specific benefit under the Plan (for example, a general eligibility claim) must be filed with the Plan Administrator at the address set forth in the "Additional Information" section below. A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" under these rules, unless it is determined that your inquiry is an attempt to file a claim. If a claim is received, but there is not enough information to allow the Claims Administrator to process the claim, you will be given an opportunity to provide the missing information. If you want to bring a claim for benefits under the Plan, you may designate an authorized representative to act on your behalf so long as you provide written notice of such designation to the Claims Administrator and/or the Appeals Administrator identifying such authorized representative. In the case of a claim for medical benefits involving urgent care, a healthcare professional who has knowledge of your medical condition may act as your authorized representative with or without prior notice.

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

under the Plan are as follows:

- *Post-Service Claim* - A "post-service claim" is a claim for payment for a particular benefit or for a particular service after the benefit or service has been provided. A post-service claim must contain the information requested on a claim form provided by the applicable provider.
- *Pre-Service Claim* - A "pre-service claim" is a claim for a particular benefit under the Plan that is conditioned upon you receiving prior approval in advance of receiving the benefit. A pre-service claim must contain, at a minimum, the name of the individual for whom benefits are being claimed, a specific medical condition or symptom, and a specific treatment, service or product for which approval is being requested.
- *Urgent Care Claim* - An "urgent care claim" is a claim for benefits or services involving a sudden and urgent need for such benefits or services. A claim will be considered to involve urgent care if the Claims Administrator or a physician with knowledge of your condition determines that the application of the claims review procedures for non-urgent claims (i) could seriously jeopardize your life or your health, or your ability to regain maximum function, or (ii) in your physician's opinion, would subject you to severe pain that cannot adequately be managed without the care or treatment that is the subject of the claim.
- *Concurrent Care Review Claim* - A "concurrent care review claim" is a claim relating to the continuation/reduction of an ongoing course of treatment.
- **Time Periods for Responding to Initial Claims** - If you bring a claim for benefits under the Plan, the Claims Administrator will respond to your claim within the following time periods:
 - *Post-Service Claim* - In the case of a post-service claim, the Claims Administrator shall respond to you within 30 days after receipt of the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 30-day period that the Claims Administrator needs up to an additional 15 days to review your claim. If such an extension is necessary because you failed to provide the information necessary to evaluate your claim, the notice of extension will describe the information that you need to provide to the Claims Administrator. You will have no less than 45 days from the date you receive the notice to provide the requested information.
 - *Pre-Service Claim* - In the case of a pre-service claim, the Claims Administrator shall respond to you within 15 days after receipt of the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 15-day period that the Claims Administrator needs up to an additional 15 days to review your claim. If such an extension is because you failed to provide the information necessary to evaluate your claim, the notice of extension will describe the information that you need to provide to the Claims Administrator. You will have no less than 45 days from the date you receive the notice to provide the requested information.
 - *Urgent Care Claim* - In the case of an urgent care claim, the Claims Administrator shall respond to you within 72 hours after receipt of the claim. If the Claims Administrator determines that it needs additional information to review your claim, the Claims Administrator will notify you within 24 hours after receipt of the claim and provide you with a description of the additional information that it needs to evaluate your claim. You will have no less than 48 hours from the time you receive this notice to provide the requested information. Once you provide the

requested information, the Claims Administrator will evaluate your claim within 48 hours after the earlier of the Claims Administrator's receipt of the requested information, or the end of the extension period given to you to provide the requested information. There is a special time period for responding to a request to extend an ongoing course of treatment if the request is an urgent care claim. For these types of claims, the Claims Administrator must respond to you within 24 hours after receipt of the claim by the Plan (provided, that you make the claim at least 24 hours prior to the expiration of the ongoing course of treatment).

- *Concurrent Care Review Claim* - If the Plan has already approved an ongoing course of treatment for you and contemplates reducing or terminating the treatment, the Claims Administrator will notify you sufficiently in advance of the reduction or termination of treatment to allow you to appeal the Claims Administrator's decision and obtain a determination on review before the treatment is reduced or terminated.
- **Notice and Information Contained in Notice Denying Initial Claim** - If the Claims Administrator denies your claim (in whole or in part), the Claims Administrator will provide you with written notice of the denial (although initial notice of a denied urgent care claim may be provided to you orally). This notice will include the following:
 - *Reason for the Denial* - the specific reason or reasons for the denial;
 - *Reference to Plan Provisions* - reference to the specific Plan provisions on which the denial is based;
 - *Description of Additional Material* - a description of any additional material or information necessary for you to perfect your claim and an explanation as to why such information is necessary;
 - *Description of Any Internal Rules* - a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to you free of charge at your request; and
 - *Description of Claims Appeals Procedures* - a description of the Plan's appeals procedures and the time limits applicable for such procedures (such description will include a statement that you are eligible to bring a civil action in Federal court under Section 502 of ERISA to appeal any adverse decision on appeal and a description of any expedited review process for urgent care claims).
- **Appealing a Denied Claim for Benefits** - If the Claims Administrator denies your initial claim for benefits, you may appeal the denial by filing a written request (or an oral request in the case of an urgent care claim) with the Appeals Administrator within 180 days after you receive the notice denying your initial claim for benefits. If you decide to appeal a denied claim for benefits, you will be able to submit written comments, documents, records, and other information relating to your claim for benefits (regardless of whether such information was considered in your initial claim for benefits) to the Appeals Administrator for review and consideration. You will also be entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to your appeal.
- **Time Periods for Responding to Appealed Claims** - If you appeal a denied claim for benefits, the

Appeals Administrator will respond to your claim within the following time periods:

- *Post-Service Claim* - In the case of an appeal of a denied post-service claim, the Appeals Administrator shall respond to you within 60 days after receipt of the appeal.
- *Pre-Service Claim* - In the case of an appeal of a denied pre-service claim, the Appeals Administrator shall respond to you within 30 days after receipt of the appeal.
- *Urgent Care Claim* - In the case of an appeal of a denied urgent care claim, the Appeals Administrator shall respond to you within 72 hours after receipt of the appeal.
- *Concurrent Care Review Claim* - In the case of an appeal of a denied concurrent care review claim, the Appeals Administrator shall respond to you before the concurrent or ongoing treatment in question is reduced or terminated.
- **Notice and Information Contained in Notice Denying Appeal** - If the Appeals Administrator denies your claim (in whole or in part), the Appeals Administrator will provide you with written notice of the denial (although initial notice of a denied urgent care claim may be provided to you orally or via facsimile or other similarly expeditious means of communication). This notice will include the following:
 - *Reason for the Denial* - the specific reason or reasons for the denial;
 - *Reference to Plan Provisions* - reference to the specific Plan provisions on which the denial is based;
 - *Statement of Entitlement to Documents* - a statement that you are entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to your claim and/or appeal for benefits;
 - *Description of Any Internal Rules* - a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the appeal determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to you free of charge at your request; and
 - *Statement of Right to Bring Action* - a statement that you are entitled to bring a civil action in Federal court under Section 502 of ERISA to pursue your claim for benefits.

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

CONTINUATION OF COVERAGE UNDER COBRA

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

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

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

PERSON AFFECTED (Qualified Beneficiary)	REASON FOR LOSS OF COVERAGE (Qualifying Event)	PERIOD OF CONTINUATION COVERAGE
Covered Spouse/Domestic Partner of a Retiree	• Divorce or legal separation from retiree	36 months
	• Death of employee (but coverage only ceases if spouse or domestic partner remarries or establishes a new domestic partner relationship following death)	36 months
Covered Eligible Dependent Child of a Retiree	• Divorce or legal separation of retiree and spouse or domestic partner	36 months
	• Failure of child to qualify as an eligible dependent under the Plan	36 months

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

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

PLAN ADMINISTRATOR

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

Administrator has delegated certain administrative functions under the Plan to various service providers. As the Plan Administrator's delegate, these service providers have the authority to make decisions under the Plan relating to benefit claims, including determinations as to the medical necessity of any service or supply. The decisions of the Plan Administrator (or its delegate) in all matters relating to the Plan (including, but not limited to, eligibility for benefits, Plan interpretations, and disputed issues of fact) will be final and binding on all parties.

PLAN AMENDMENT OR TERMINATION

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

ADDITIONAL INFORMATION

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

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

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

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

Plan Name: The University of Pennsylvania Retiree Health Plan

Plan ID #: 530

Plan Year: Begins on July 1 and ends on June 30

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

Administration
and Funding:

Benefits under the Plan are administered in accordance with Contracts that the University has entered into with various providers, and other providers or administrators of medical benefits. Benefits may be "insured" (provided through insurance Contracts pursuant to which the University pays premiums) or "self-insured" (paid directly out of the University's general assets) or a combination of insured and self-insured. Benefits also may be paid out of any trust fund that is established for the Plan. A list of providers and their roles under the Plan is included in Appendix A.

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

THIRD PARTY RECOVERY

As a condition to receiving medical benefits under the Plan, covered person(s), including all eligible dependents, agree to transfer to the Plan their rights to recover damages in full for such benefits when the injury or illness occurs through the act or omission of another person. Alternatively, if a covered person or an eligible dependent receives any recovery, by way of judgment, settlement, or otherwise, from another person or business entity, the covered person or eligible dependent agrees to reimburse the Plan in full, in first priority, for any medical benefits expenses paid by it (i.e., the Plan shall be first reimbursed fully to the extent of any and all benefits paid by it from any monies received, with the balance, if any, retained by the Plan participant).

The obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the settlement or judgment specifically designates the recovery, or a portion thereof, as including medical expenses and regardless of whether you have been "made whole" by the settlement. You must hold any recovery in constructive trust for the Plan. If a repayment agreement is required to be signed, this clause remains in effect regardless of whether it is actually signed. The Plan's rights of full recovery, either by way of subrogation or right of reimbursement, may be from funds the covered person, eligible dependent, or guardian receives or is entitled to receive from the third party, any liability or other insurance covering the third party, the insured's own uninsured motorist insurance, underinsured motorist insurance, any medical payments, no-fault or school insurance coverages which are paid or payable. The Plan expressly disavows the application of the "collateral source" rule and the "common fund" rule as legal theories intended to prevent or limit the Plan's recovery from any payment that may be received from a third party.

The Plan may enforce its reimbursement or subrogation rights by requiring you or your eligible dependent to assert a claim to any of the foregoing coverages to which he/she may be entitled. The Plan will not pay attorney fees or costs associated with the Plan member's claim/lawsuit without express written authorization from the University.

RECOUPMENT

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

NO ASSIGNMENT OF BENEFITS

You cannot assign, pledge, encumber or otherwise alienate any legal or beneficial interest in benefits under the Plan, and any attempt to do so will be void. The payment of benefits directly to a healthcare provider, if any, shall be done as a convenience to the covered person and will not constitute an assignment of benefits under the Plan.

STATEMENT OF ERISA RIGHTS

Regulations of the U.S. government require that this summary include the statement that is set forth below. The statement was drafted by the government and is reproduced here with quotation marks. Neither the University, nor the Plan Administrator, nor any of their representatives take any responsibility whatsoever for the accuracy or completeness of any assertion in the statement.

"As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or latest annual report and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the plan's money,

or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

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

APPENDIX A

Information Relating to Third Party Providers

(As of July 1, 2002)

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

Medical Coverage: Independence Blue Cross PPO (Under 65 Only)

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

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

Pennsylvania Blue Shield
Group Number: 33214
Non- Preferred Providers
P. O. Box 890016
Camp Hill, PA 17089-0016
(215) 241-2990 or outside local area (800) 841-1992

Medical Coverage: Keystone Point of Service (Under 65 Only)

The University has contracted with the above provider to provide medical benefits and claims services under the Plan. This particular coverage option (available only to retirees under age 65) is referred to as Keystone Point of Service (POS) and is a managed care plan. Under this coverage option, you may use any healthcare provider, but you receive care at the lowest cost to you when you coordinate your care through a Primary Care Physician (PCP) who is part of the University of Pennsylvania Health System (UPHS) or Keystone networks of preferred providers. You must select a PCP when enrolling in this plan, and obtain referrals to receive the highest level of coverage.

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

Keystone POS
Group Number: 200214
Self Referred Care
P. O. Box 41574
Philadelphia, PA 19101-1574
(215) 567-3550 or outside local area (800) 253-3854

Medical Coverage: Health Maintenance Organization (HMOs) by Aetna and Keystone (Under 65 Only)

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

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

Aetna HMO
Group Number: 416-0002
Solution Department
P.O. Box 1125
Blue Bell, PA 19422
(800) 323-9930

Keystone HMO
Group Number: 900164
P.O. Box 898815
Camp Hill, PA 17089-8815
(215) 241-2273 or outside local area (800) 227-3114

Medical Coverage: Blue Cross/Blue Shield Plan 100 (Under 65 Only)

The University has contracted with the above provider to provide medical benefits and claims services under the Plan. This particular coverage option (available only to retirees under age 65) is referred to as the Blue Cross/Blue Shield Plan 100. This coverage option is an indemnity plan that reimburses you, the physician, or the hospital for out-of-pocket medical expenses if you become ill. This coverage option does not cover preventive care and deductibles or co-payments, and out-of-pocket limits are applied to covered services. Referrals are not required for care, and payment for services is based on the Plan's UCR (UCR or R&C refers to the usual, customary and reasonable fees that physicians, healthcare facilities or other healthcare providers in the same geographical area charge for similar services).

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

Blue Cross
Group Number: 76284
Independence Blue Cross
1901 Market Street
Philadelphia, PA 19103-3487

Blue Shield
Group Number: 76284
P.O. Box 890062
Camp Hill, PA 17089-0062

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

Medical Coverage: Caremark Prescription Drug Coverage (Under 65 Only)

The University has contracted with the above provider to provide prescription drug and claims services under the Plan. This particular coverage option (available only to retirees under age 65) is referred to as the Caremark Prescription Drug Coverage Option. If you are enrolled in one of the above-65 coverage options listed, prescription drug coverage for you and your enrolled dependents will be provided through Caremark Prescription Services. Participating Caremark pharmacies offer discounted prices for prescription drugs.

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

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

Medical Coverage: Keystone and Aetna Over 65 Managed Care Plans (Over 65 Only)

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

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

Keystone 65
Group Numbers: 840064 (City); 832794 (Suburban)
P.O. Box 898815
Camp Hill, PA 17089-8815
(215) 241-2365 or outside local area (800) 645-3965

Aetna Golden Medicare
Group Number: US00416-0002
1425 Union Meeting Road
Blue Bell, PA 19422
(800) 628-3323

Medical Coverage: Blue Cross/Blue Shield 65 Special Plan (Over 65 Only)

The University has contracted with the above provider to provide medical benefits and claims services

under the Plan. This particular coverage option (available only to retirees over age 65) is referred to as the Blue Cross/Blue Shield 65 Special Plan. The Blue Cross portion of this coverage option provides hospital-related bills in conjunction with Medicare and the Blue Shield portion of this coverage option provides doctors' reasonable charges in conjunction with Medicare.

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

Independence Blue Cross
Group Number: 55061
Attention: Claims Department
1901 Market Street
Philadelphia, PA 19103-1480

Independence Blue Cross
Group Number: 55061
Major Medical Claims Department
P.O. Box 13497
Philadelphia, PA 19101-3497

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

Other Non-Medical Coverage

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