

Penn State

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

Effective as of January 1, 2023

**Penn State Employee Benefits
Human Resources**

Table of Contents

- GENERAL..... 4
- ACCESSING YOUR BENEFITS INFORMATION 4
- ELIGIBILITY 4
 - Dependents 5
 - Dependents’ Eligibility 6
- ENROLLMENT AND EFFECTIVE DATE OF COVERAGE..... 6
 - Filing of Information 6
 - For Retired Faculty and Staff Members 7
 - For Dependents of Retired Faculty and Staff Members 7
 - Enrollment Under a Qualified Medical Child Support Order (“QMCSO”) 8
- COST OF COVERAGE..... 8
- CHANGING YOUR COVERAGE 8
 - New Dependents 9
 - Gain or Loss of Medicare or Medicaid Coverage 9
- RESPONSIBILITY OF INDIVIDUALS AS THEY REACH MEDICARE ELIGIBILITY (TYPICALLY AGE SIXTY-FIVE [65]) 9
- RETIREE MEDICAL PLAN DEFER ELIGIBILITY OPTION 10
 - Circumstances to Defer Enrollment 10
- BENEFITS UNDER THE PLAN 12
- WHEN COVERAGE ENDS..... 12
- VOLUNTARY TERMINATION OF COVERAGE 13
- DEPENDENT PROTECTION AFTER YOUR DEATH 13
- CONTINUATION OF COVERAGE UNDER COBRA 14
 - Who Is Entitled to COBRA Continuation 14
 - Qualifying Events and COBRA Continuation Periods 14
 - University’s Notification Requirements 14
 - You Must Give Notice of Certain Qualifying Events..... 15
 - How to Elect COBRA Coverage 15
 - Determining Your Contributions for COBRA Coverage 15
 - When and How to Make COBRA Payments 16
 - When You Acquire a Dependent During a Continuation Period..... 16
 - When Your COBRA Coverage Ends 16
 - Trade Act of 2002 17
- CONVERSION PRIVILEGE 17
- THIRD PARTY LIABILITY LIMITATION..... 18
- PAYMENT TO OTHER THAN COVERED INDIVIDUAL 18

COORDINATION OF BENEFITS PROVISION.....	18
OVERPAYMENTS	19
NO WAIVER OR ESTOPPEL	19
RIGHT TO RECEIVE AND RELEASE INFORMATION	19
NOTICES.....	20
WORKER’S COMPENSATION NOT AFFECTED	20
MISSTATEMENTS	20
AMENDMENT OR TERMINATION OF PLAN.....	20
HIPAA PRIVACY RIGHTS	21
HEALTH CARE REFORM CHANGES.....	22
YOUR RIGHTS FOLLOWING A MASTECTOMY	24
MATERNITY RIGHTS.....	24
CLAIM DETERMINATION PROCEDURES	25
Eligibility or Benefit Claims and Appeals.....	25
Eligibility and Enrollment Claims	25
Benefit Claims and Appeals	25
ADMINISTRATIVE INFORMATION.....	25
Plan Names/Identification.....	25
Plan Sponsor.....	25
Plan Administrator	25
Claims Service Provider	25
Authority to Review Claims.....	26
Plan Year	26

GENERAL

This Summary Plan Document describes the eligibility criteria and administrative information for your university-sponsored retiree medical benefit plan as of January 1, 2018. This Document can help you understand and use your benefit plan and replaces previous versions of the Document.

The specific benefits under the plan are described in detail in the Certificate of Coverage that is provided to you by the claims service provider and the University.

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

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

ACCESSING YOUR BENEFITS INFORMATION

For complete details of your medical benefits, you should review this Summary Plan Document and the plan's 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 speaking to the Highmark Concierge Team at 844-945-5509 for non-Medicare-eligible retiree medical plan and prescription questions or Highmark Freedom Blue at 866-918-5285 for Medicare-eligible retiree medical plan and prescription questions.

ELIGIBILITY

If you were hired prior to January 1, 2010:

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

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

OR

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

If you and/or your spouse are 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 similar to the same University-sponsored medical plan in which you were enrolled prior to retirement. As you and your spouse become Medicare-eligible, your coverage will change to a University-

sponsored retiree Medicare plan. Regardless of the plan you are enrolled in, you will be billed by the University on a 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 account. Please see the Fact Sheet, located at the below listed website, to assist you in determining how you can use the funds to pay for qualified medical and health-related expenses in retirement, including the purchase of a health insurance policy.

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

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

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

OR

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

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

A newly acquired spouse may be added to the plan's coverage within thirty-one (31) days of marriage. If you do not add your newly acquired spouse within thirty-one (31) days, they will not be eligible to join the health plan unless they experience a qualifying event status change.

There is no "open enrollment" for retiree coverage; we permit non-Medicare retirees to "switch" health plans only during November for a January 1 effective date.

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. 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. If you have a dependent who is physically or intellectually handicapped, to be incapable of earning a living when coverage would normally terminate due to age, please contact Penn State Employee Benefits prior to the child's 26th birthday for more information on how to obtain disability certification for your dependent.

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 an including termination of employment.

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

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

Dependent children can be enrolled only under one parent's plan if both parents are retired from the University and are eligible for retiree medical benefits; this rule also applies if one parent is retired and the other parent is an active employee of the University.

ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

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

Filing of Information

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

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

The University conducts dependent verification through Workday. The dependent verification program will be a requirement for dependents added to your university-sponsored medical plan and/or the Grant-in-Aid tuition discount. Retirees who need to complete dependent verification will receive a mailing to their home address with instruction to complete.

For Retired Faculty and Staff Members

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

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

As a retiree whose spouse is an ACTIVE employee of Penn State, the active employee is required to carry their own ACTIVE medical plan. If your active employee spouse does NOT qualify to retire with benefits when they chose to leave the University, AT THAT TIME, you would have the ability to add them as a dependent spouse on your retiree medical coverage.

If you as the retiree would become deceased before your ACTIVE employee spouse leaves University employment, your active employee spouse will remain on your ACTIVE plan. At the time your ACTIVE employee spouse leaves Penn State and they do NOT qualify for their own retiree medical plan, they will be able to enroll as a dependent on your retiree plan as a surviving spouse at that time.

Likewise, a retiree whose spouse is also a retiree of Penn State will maintain separate retiree eligibility and retiree medical coverage.

For Dependents of Retired Faculty and Staff Members

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

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

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

Your newborn child will be covered automatically for thirty-one (31) days following the birth. If you enroll your newborn child on or before the thirty-first (31st) day following birth, such child's coverage will continue, 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 Under a Qualified Medical Child Support Order (“QMCSO”)

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

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

Upon receipt of QMCSO documentation, Penn State Employee Benefits will make the necessary enrollment change for the retiree in accordance with the QMCSO. When the University receives a valid QMCSO, the custodial parent or state agency can enroll the affected child if you do not.

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

COST OF COVERAGE

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

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

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

CHANGING YOUR COVERAGE

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) establishes special enrollment rights that allow those who experience a qualifying event, to enroll in the plans throughout the plan year. While retirees must elect and remain in their retiree medical plan at the time of enrollment to remain eligible, you may add newly eligible dependents, including newborn children, within thirty-one (31) days of the qualifying event.

You may decide to cancel your coverage at any time throughout the plan year, again keeping in mind that if you choose to disenroll from retiree coverage you will not have an opportunity to join the University-sponsored retiree medical plan later. 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 plan for your dependents or spouse because they had other group medical coverage, and you can prove that the other group coverage was canceled for an eligible dependent, coverage under the plan may be extended to that dependent, provided that your written request for enrollment is received by Penn State Employee Benefits within thirty-one (31) days after the loss of the other group coverage.

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

- Losing eligibility for the other coverage, including losing eligibility as a result of legal separation, divorce, ending dependent status, death of an employee, termination of employment, reduction in the number of hours of employment, or no longer living or working in the other coverage's network service area and no other coverage is available under the other coverage.
- Employer contributions for the other coverage stop.
- The other coverage was canceled and no longer offered; or
- Exhausting COBRA coverage that was in effect when you initially declined coverage under the plan.

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

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, provided you request enrollment, by written request to Penn State Employee Benefits, within thirty-one (31) days after the marriage, birth, adoption, or placement of adoption.

Gain or Loss of Medicare or Medicaid Coverage

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

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

You may request special enrollment in the plan if:

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

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

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

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

- If you are not eligible for Medicare at the time of retirement, you may elect to continue coverage under the active employee plan until the beginning of the month in which you become Medicare-eligible. The same applies for your spouse. You must notify Penn State Employee Benefits three (3) months prior to your sixty-fifth (65th) birthday to be enrolled in the University-sponsored Medicare health plan.

- If you or your spouse are Medicare-eligible, benefits will be provided through the University-sponsored Medicare health plan. To be eligible for this coverage, an individual must enroll in Medicare Parts A and B when eligible.
- A dependent child may continue in accordance with the provisions in the above two bullets, provided all other eligibility requirements are satisfied. (Please refer to the *Eligibility* section.)

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

RETIREE MEDICAL PLAN DEFER ELIGIBILITY OPTION

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

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

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

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

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

Circumstances to Defer Enrollment

Non-Medicare-Eligible Retiree or Dependent

If you or your dependent will be travelling outside of the United States, in a country that requires participation in their healthcare system, you may defer enrollment until such time that you re-enter the United States. Upon re-entry to the United States, you must contact Penn State Employee Benefits and request a change of coverage to re-add the retiree medical plan. You will need to provide supporting documentation with the request, for which most individuals experience a change in coverage due to travel will provide a copy of their passport stamp upon re-entry to the United States.

Medicare-Eligible Retiree

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

Medicare-Eligible Spouse Covered Under Active Group Health Plan

If your spouse is covered under his/her active group employer medical coverage, you may elect to defer dependent enrollment in the University-sponsored Medicare health plan until he/she is

no longer eligible for active group medical coverage.

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

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

Retiree Eligible for Medicare with a Spouse Not Eligible for Medicare

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

BENEFITS UNDER THE PLAN

The University provides PPO-type medical plan for retirees and their eligible dependents that are not yet eligible for Medicare Part A (hospital) and Medicare Part B (medical). These medical benefits are separately described in the plan's Coverage Booklets.

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

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

WHEN COVERAGE ENDS

For You

Your coverage ends on the:

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

For Your Dependents

Your dependents' coverage ends on the:

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

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

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

VOLUNTARY TERMINATION OF COVERAGE

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

If you are not Medicare-eligible, your coverage will terminate on the first of the month following receipt of the form by Penn State Employee Benefits.

If you are Medicare-eligible, your coverage will terminate the first of the month following receipt of the form by Penn State Employee Benefits.

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

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

DEPENDENT PROTECTION AFTER YOUR DEATH

You are **NOT** required to carry your spouse or other dependents on your medical plan, in the event of your death as a retiree. ***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.***

Your surviving spouse's Penn State medical benefits may be continued, provided the required contributions are paid when due, but not beyond the earlier of:

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

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

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

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

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

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

CONTINUATION OF COVERAGE UNDER COBRA

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

Who Is Entitled to COBRA Continuation

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

Qualifying Events and COBRA Continuation Periods

The qualifying events and the maximum coverage periods are:

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

University’s Notification Requirements

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

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

- If the plan provides that COBRA coverage and the period within which the University must notify the plan administrator of a qualifying event starts upon the occurrence of a qualifying event, forty-four (44) days after the qualifying event occurs.

You Must Give Notice of Certain Qualifying Events

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

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

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

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

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

How to Elect COBRA Coverage

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

The COBRA coverage election notice will list the qualified beneficiaries and inform you of the applicable cost. The notice will also include instructions for electing COBRA coverage. You must notify the plan administrator of your election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be postmarked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the notice, you and your dependents who are qualified beneficiaries will lose the right to elect COBRA coverage. If you reject COBRA coverage before the due date, you may change your mind 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, and contributions may never exceed one hundred two percent (102%) of plan costs, including both University and employee contribution amounts.

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

When and How to Make COBRA Payments

First Payment for COBRA Coverage

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

Subsequent Payments

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

Grace Periods for Subsequent Payments

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

When You Acquire a Dependent During a Continuation Period

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

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

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

When Your COBRA Coverage Ends

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

- You or your dependents reach the maximum thirty-six (36) month COBRA continuation period. (Coverage for a newly acquired dependent who has been added for the balance of a continuation period would end at the same time your continuation period ends.
- You or your dependents do not pay required contributions.
- You or your dependents become covered under another group plan that does not restrict coverage for preexisting conditions. If your new plan limits preexisting condition coverage, the COBRA coverage under the plan may remain in effect until the pre-existing clause ceases to apply or the maximum continuation period is reached under the plan.
- The date the University no longer offers the plan.
- The date you or a dependent becomes enrolled in benefits under Medicare. This does not apply if it is contrary to the Medicare Secondary Payer Rules or other federal law.
- You or your dependent dies; or
- Any reason the plan would terminate coverage of a participant or beneficiary who is not receiving COBRA coverage (e.g., fraud).

Trade Act of 2002

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

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

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

CONVERSION PRIVILEGE

For non-Medicare retirees, 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: Medicare plans, such as the Medicare Advantage plan offered to post-65 retirees, are not subject to a conversion privilege.

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

THIRD PARTY LIABILITY LIMITATION

The plan 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 plan, the difference will be paid by the plan.

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

PAYMENT TO OTHER THAN COVERED INDIVIDUAL

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

COORDINATION OF BENEFITS PROVISION

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

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

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

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

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

- The plan covering the patient as an employee or retiree, rather than as a dependent, is primary, and the other plans are secondary.
- If a child is covered under both parents' plans, the plan of the parent whose birthday falls earlier in a year is the primary plan. If both parents have the same birthday, the plan which covered the parent longer is the primary plan. If the other plan does not have this "birthday" rule, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule of the other plan will

determine the order of benefits. When the parents are separated or divorced, their plans pay in this order:

- If a court decree has established financial responsibility for the child's health care expenses, the plan of the parent with the responsibility.
- The plan of the parent with custody of the child.
- The plan of the 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 the plan which are in excess of the benefits that should have been paid, or which should not (under the provisions of the plan) have been paid, the University, or the plan administrator, may deduct the amount of the excess or improper payment from any subsequent benefits payable to you or from other present or future amounts payable to you or recover the amount by any other appropriate method that the University, in its sole discretion, shall determine.

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

NO WAIVER OR ESTOPPEL

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

RIGHT TO RECEIVE AND RELEASE INFORMATION

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 the plan. 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 the plan must furnish to the University and/or the plan administrator any information as may be necessary to implement this provision.

NOTICES

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

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

WORKER'S COMPENSATION NOT AFFECTED

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

MISSTATEMENTS

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

AMENDMENT OR TERMINATION OF PLAN

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

- The coverage and benefits provided under the plan; and
- The level of retiree contributions, deductibles, co-payments, and coordination of benefits between the plan and any contract, program, or group plan providing medical benefits maintained by you, your dependents, another employer, or any federal or state government authority or any subdivision thereof.

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

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

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

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

HIPAA PRIVACY RIGHTS

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

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

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

- The plan may use or disclose your Protected Health Information for purposes of conducting health care operations or paying your health care claims.
- The plan may use or disclose your Protected Health Information to tell you about treatment alternatives or to provide you with information about other health-related benefits or services that may be of interest to you.
- The plan may disclose your Protected Health Information to the University, as sponsor of the plan, to assist the University in the performance of plan administrative functions. The plan also may provide summary health information to the University, as plan sponsor, so that the University may obtain premium bids or modify, amend, or terminate the plan. Summary health information does not directly identify you, but summarizes claims history, claims expenses, or types of claims experienced. Finally, the plan may disclose your enrollment and disenrollment information to the University as plan sponsor.
- The plan may disclose your Protected Health Information when required to do so by any federal, state, or local law and when permitted to do so under the circumstances set out in the University’s Notice of Privacy Practices.
- The plan may disclose your Protected Health Information to a law enforcement official for certain law enforcement purposes. For example, the plan may disclose your Protected Health Information pursuant to a law requiring the reporting of certain types of wounds or other physical injuries.
- The plan may disclose your Protected Health Information to health care providers to assist them in connection with their treatment or payment activities. In addition, the plan may disclose your Protected Health Information to other entities subject to the HIPAA Privacy Rule to assist them with their payment activities or certain of their health care operations. For example, the plan might disclose your Protected Health Information to a health care provider when needed by the provider to render treatment to you; and

- Other than as permitted or required by law, the plan will not use or disclose your Protected Health Information without your written authorization. If you authorize the plan to use or disclose your Protected Health Information, you may revoke that authorization in writing at any time. If you revoke the authorization, the plan no longer will use or disclose your Protected Health Information for the reasons covered by your written authorization. Your revocation will not affect any uses or disclosures the plan already has made prior to the date the plan receives notice of the revocation.

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

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

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

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 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 plan.

Eligibility or Benefit Claims and Appeals

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

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

Eligibility and Enrollment Claims

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

Benefit Claims and Appeals

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

ADMINISTRATIVE INFORMATION

Plan Names/Identification

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

Plan Sponsor

The plan sponsor is:

The Pennsylvania State University
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 Provider

The claims service provider is:

Non-Medicare Retiree Health & Prescription Plan:

Highmark Blue Shield

PO Box 890382
Camp Hill, PA 17089-0382
844-945-5509

Medicare Retiree Health Plan:

Highmark Blue Shield

Freedom Blue PPO
P.O. Box 1068
Pittsburgh, PA 15230-1068
866-918-5285

Authority to Review Claims

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

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

Plan Year

The plan year is January 1 through December 31.