

PENNSSTATE



FACULTY/STAFF BENEFITS

HealthAmerica/HealthAssurance

Dental

Vision

To: All Faculty and Staff

From: Billie S. Willits, Associate Vice President for Human Resources

I am pleased to present to you a “Summary Plan Document” for your University sponsored medical, dental and vision plans. This document contains important information regarding eligibility criteria for faculty, staff and their dependents during the period of active University employment and after leaving Penn State service. I encourage everyone to carefully review this information. The details of each specific plan will be included in the Plan Administrators “Certificate of Coverage.”

Changes to the employee contribution amounts are communicated in the “Time to Choose” material that is provide during the annual open enrollment period. Other important information regarding benefits also is included.

Questions regarding the “Summary Plan Document” may be directed to the Employee Benefits Division at (814) 865-1473 or by email at benefits@psu.edu.

FOREWORD

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This booklet describes general information regarding your plan of health care benefits.

If there is anything in this booklet that requires further clarification, or if you have questions relative to specific plan provisions, please contact the Employee Benefits Division or refer to your "Certificate of Coverage."

While the University expects to continue its benefits plans indefinitely, it reserves the right to amend, suspend or terminate any plan at any time. If the University deems such action as necessary, you will be notified prior to such actions.

On February 28, 1995, Act 165, which addresses insurance fraud, was signed into law in Pennsylvania. Pursuant to this law, and effective October 1, 1995, all Pennsylvania insurance claims forms and policy applications for new business and renewals must carry the following insurance fraud warning:

"Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties."

OHR March 21, 2007

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GENERAL

Any and all rights or benefits accruing to any Covered Individual under these Plans shall be subject to all terms and conditions of these Plans. The adoption and maintenance of these Plans shall not constitute a contract between The Pennsylvania State University and any Employee or be a consideration for, or an inducement or condition of, employment of any Employee. Neither participation nor anything contained in the Plans shall give any Employee the right to be retained in the employ of the University, nor shall it interfere with the right of the University to discharge any Employee at any time.

ELIGIBILITY

You are eligible to be enrolled in these Plans if you are actively employed in the regular, full-time service of the University.

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

A dependent spouse or same-sex domestic partner who was eligible for coverage prior to age sixty-four but not enrolled prior to age sixty-four may not, thereafter, be eligible for coverage purposes.

ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

Employees and dependents may enroll for coverage in the Medical Plan only; Dental only; Vision only; or any combination of the three.

An employee may cover his/her dependent spouse or same-sex domestic partner even if that dependent spouse also is an employee of the University. However, no one is eligible to be covered as a spouse, dependent, or same-sex domestic partner under a University-sponsored plan if he/she already is covered as an employee under a University-sponsored plan, or vice versa.

Children can be covered under only one parent's University-sponsored plan if both parents are employed by the University and are eligible for benefits.

Filing of Information

Each enrolled Employee or covered dependent shall file with the University such pertinent information concerning the Covered Individual 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 such person shall not have right or be entitled to any benefits or further benefits hereunder unless such information is filed by the Covered Individual or on the Covered Individual's behalf.

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For Faculty and Staff Members

Your coverage becomes effective on your date of hire, provided you have completed the necessary enrollment forms no later than thirty-one days from your date of employment.

For Dependents of Faculty and Staff Members

No dependent coverage can be elected unless the employee is covered.

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

If you are enrolled for personal coverage only 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 days following the date you acquire them.

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

The effective date of coverage for an adopted child is the date of the Intent to Adopt form if that form is received by the Employee Benefits Division within thirty-one 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 Adoption form is executed and received by the Employee Benefits Division within thirty-one days of such date.

In order to extend healthcare benefits to a same-sex domestic partner, you must file an *Affirmation of Domestic Partnership*. This document can be obtained by contacting the Employee Benefits Division. The *Affirmation of Domestic Partnership* will remain in effect until the same-sex domestic partnership ends. It is your responsibility to notify Penn State's Employee Benefits Division should the same-sex domestic partnership end.

Normally, the Internal Revenue Code does not allow you to pay for healthcare coverage for your same-sex domestic partner on a pre-tax basis. However, if your same-sex domestic partner meets Internal Revenue Code dependency guidelines, then your share of the premium will be made on a pre-tax basis and you will not be taxed for the value of the University's share of the premium. These dependency guidelines require that:

- The employee provides more than 50 % of the same-sex domestic partner's support.
- The employee and same-sex domestic partner share the same household.
- The same-sex domestic partner's income does not exceed current IRS limits.

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If you feel that you meet this qualification, you must note this fact on the “*Affirmation of Domestic Partnership*”, in order to qualify for this special treatment. Alternatively, if you and your same-sex domestic partner are considered separately for tax purposes, the University’s contribution for your same-sex domestic partner’s coverage will be taxable to you as income and your payroll deduction for your partner’s coverage will be on an after-tax basis.

LATE ENROLLMENT

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To avoid a serious break in coverage, you and/or your dependents, including newborn children, must be enrolled in health care benefits within thirty-one days of the date of eligibility. Otherwise, you and/or your dependents must wait until the University’s annual open enrollment and coverage will be effective on January 1 of the subsequent year.

If an employee can prove that other group coverage was canceled, coverage may be extended to the employee and eligible dependents provided that the written request is received by the Employee Benefits Division within thirty-one days of Loss of Coverage. (See Special Enrollment Rights)

Special Enrollment Rights

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) establishes special enrollment rights that will allow certain employees or dependents to enroll in the plan without waiting until the next open enrollment period.

Loss of Coverage

If you initially declined coverage for yourself or your dependents (including your spouse or same-sex domestic partner) because of other health insurance coverage, you may in the future be able to enroll yourself and your dependents in this plan, provided that you request enrollment within thirty days after you lose your coverage. You will qualify for special enrollment due to loss of coverage only after losing eligibility for other coverage, after employer contributions for the other coverage stops, or after exhausting COBRA coverage that was in effect when you initially declined coverage. An individual does not have special enrollment rights if the individual loses other coverage as a result of failure to pay for premiums or for cause (e.g. fraudulent claim).

New Dependents

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

Voluntary Termination of Coverage

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Coverage can be terminated for employees or dependents at any time by submitting a Request for Change of Healthcare to the Employee Benefits Division. Coverage will terminate on the date indicated if received by the Employee Benefits Division within thirty-one days of that date. Otherwise, coverage will terminate on the date notification is received in the Employee Benefits Division.

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

If you voluntarily discontinue your medical coverage, it may adversely affect your eligibility to continue medical insurance after you retire from Penn State.

DEFINITIONS

Dependents

Eligible dependents are your spouse (unless legally separated), same-sex domestic partner, and dependent children.

Dependent children are covered until their 19th birthday, or until their 24th birthday if they are full-time students (including a student who is on a leave of absence granted by the school for a period of not more than one term or semester). Dependent children are defined as unmarried children, adopted children or stepchildren until their 19th birthday or until reaching their 24th birthday if they are full-time students or physically handicapped or mentally retarded children who are incapable of self-sustaining employment, regardless of age, provided they are covered prior to the maximum age otherwise applicable.

If a dependent child is mentally retarded or physically handicapped so as to be incapable of earning a living when coverage would terminate due to age, coverage may be continued. Contact the Employee Benefits Division within thirty-one days before coverage terminates for the appropriate form to continue coverage.

Occupational Disability

A disability due to accidental bodily injuries arising out of and in the course of the employee's employment with any employer or due to disease with respect to which benefits are payable under any Worker's Compensation, occupational disease, or similar law.

Payment to Other than Covered Individual

If the University finds that any person to whom any benefits are payable under any medical, dental, or vision plan is unable to care for his/her personal affairs, is a minor or has died, then any payment due a Covered Individual or the estate (unless a prior claim has been made by a duly appointed legal representative) may be paid to the spouse, a child, a relative, 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

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legal representative is appointed. Any such payment shall be a complete discharge of the liabilities of this Plan.

COORDINATION OF BENEFITS PROVISION

The healthcare plan contains a nonprofit provision coordinating it with other similar plans under which an individual is covered so that the total benefits available will not exceed 100% of the allowable expenses.

An “allowable expense” is any necessary, reasonable and customary expense covered, at least in part, by one of the plans of the same type (medical, dental or vision).

“Plans” means these types of medical, dental and vision benefits: (a) 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 (b) 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 coordination provisions.

A plan without a coordinating provision similar to ours is always the primary plan. If all plans have such a provision: (1) the plan covering the patient directly, rather than as an employee’s dependent, is primary and the others secondary; (2) 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. But, if both parents have the same birthday, the plan which covered the parent longer is the primary plan. However, if the other plan does not have this 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: (a) if a court decree has established financial responsibility for the child’s health care expenses, the plan of the parent with the responsibility; (b) the plan of the parent with custody of the child; (c) the plan of the stepparent married to the parent with custody of the child; (d) the plan of the parent not having custody of the child; (3) if neither (1) nor (2) applies, the plan covering the patient longest is primary, except as follows: (i) 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 (ii) 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 provisions of (i) shall not apply.

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PROVISIONS APPLICABLE IF YOU CEASE ACTIVE WORK

Due to Disability

All coverage will be continued during the period for which you continue to receive your regular wages or salary from the University. Thereafter, coverage may be continued during a period for which you have been granted a leave of absence without pay for illness or injury. At the conclusion of any such leave of absence, all coverage will be terminated except under the following conditions:

1. If you have five or more years of regular, full-time continuous University service and qualify for a disability retirement from the retirement plan of which you are a member, you will be eligible to continue medical benefits (not dental and vision care benefits) for yourself and eligible dependents at the employee contribution rate for the period of your disability.
2. If you have five or more years of continuous regular, full-time University service and are a member of TIAA retirement plan and the total and permanent disability benefit under the level premium group term life insurance plan or Standard long-term disability plan is approved, you will be eligible to continue medical benefits (not dental and vision care).
3. If you have five or more years of regular full-time continuous service and are not participating in either the level premium life insurance plan or the Standard long term disability plan, the approval of social security disability will be the determining factor for continuation of medical benefits.

Any dependents' coverage ceases at your death.

Dental, Vision, and Accidental Death and Dismemberment coverage will not be continued during disability retirement.

Due to Leave of Absence or Reduction in Force

If your leave of absence is without pay due to sickness or maternity, formal study, or leave in lieu of temporary layoff, you will be billed for the employee contribution of the monthly cost. For all other leaves of absence, you may continue coverage by paying the full cost (University's contribution, plus employee's contribution). If medical coverage is declined for the period of the leave, you will be required to wait until the University's annual open enrollment period to enroll. Healthcare benefits will be effective January 1, of the subsequent year.

You may continue your coverage for a period of up to 120 days by paying the employee contribution of the monthly cost. If your termination of employment is other than the end of a fixed-term appointment and results from a reduction in force, benefits may be continued beyond 120 days under provisions of COBRA up to the maximum of 18 months. You should contact the Employee Benefits Division for details.

An employee granted a military leave of absence may elect to continue employee only coverage and/or dependent coverage by paying the employee contribution of the monthly

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rate and notifying the Employee Benefits Division prior to the effective date of military leave. If you discontinue coverage, you may become covered again when you resume full-time employment.

Due to Termination of Employment

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

If you cease active work, benefits may be continued under provisions of COBRA up to a maximum of 18 months.

Due to Retirement

After you retire, you may continue to be covered for the benefits available to eligible retired employees and their eligible dependents, provided you meet the following conditions as applicable:

Medical Coverage

You may continue medical coverage after retirement for yourself and eligible dependents if you:

1. have reached your sixtieth birthday as of retirement, and you have at least fifteen years of continuous regular full-time employment and continuous participation in a University-sponsored medical plan immediately preceding retirement.

OR

2. have twenty-five years of regular full-time employment with ten years continuous participation in any University-sponsored medical plan immediately preceding retirement.

If you and/or your spouse are Medicare eligible, medical plan coverage will be provided under the University Medicare Supplement or, you may select a Medicare Risk HMO if one is offered by the University in your area. You will be billed by the University for your contributions on a semi-annual basis.

Dental and vision coverage terminate at retirement. However, you may be eligible to continue these plans for up to an additional 18 months under provisions of COBRA.

Life Insurance

The University provides each regular full-time employee with \$5,000 of life insurance at no cost. If you meet the eligibility requirements to continue medical coverage after retirement, this University paid life insurance also will continue.

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RESPONSIBILITY OF INDIVIDUALS AS THEY REACH AGE SIXTY-FIVE

Active Employees

As a regular full-time employee of the University, you will continue to be covered under your current medical plan even though you are eligible for Medicare.

It is recommended that you, your spouse and/or same-sex domestic partner, when eligible, enroll in Medicare Part A (hospital coverage), which is provided at no cost.. You should apply for Medicare Part B (physician's coverage) three months prior to your retirement in order to avoid a serious gap in your medical coverage.

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

You must notify the Employee Benefits Division three (3) months prior to your planned retirement date in order to be enrolled in the appropriate University-sponsored medical plan for Medicare-eligible retirees.

Retired Employees

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

- (a) If you are not eligible for Medicare at the time of retirement, you may elect to continue coverage under a University-sponsored Medical plan until the beginning of the month in which you become Medicare eligible. The same applies for your spouse or same-sex domestic partner. You must notify the Employee Benefits Division three (3) months prior to your 65th birthday in order to be enrolled in the appropriate University-sponsored medical plan for Medicare-eligible retirees.
- (b) If you or your spouse or same-sex domestic partner are Medicare eligible, benefits will be provided through one of two plans: (1) University Medicare Supplement (UMS) or (2) University-sponsored Medicare Risk HMO (if available in your county of residence). These plans are available to eligible retirees who are enrolled in Medicare Part A and Part B. (To avoid a serious gap in their health insurance protection, an individual must enroll in Medicare Parts A and B when eligible. University benefits are payable based on the assumption that Medicare A and B are in effect.)
- (c) A dependent child may continue in accordance with (a) or (b) provided all other eligibility requirements are satisfied. (Refer to "Eligibility".)

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DEPENDENT PROTECTION AFTER YOUR DEATH

If, as a retiree or an active employee eligible to continue benefits into retirement, you die while benefits are in force for your dependents, Medical benefits may be continued, but not beyond the earlier of: (1) the remarriage of your spouse, or (2) the lifetime of your spouse, provided the required contributions are paid when due. (See “Due to Retirement”.)

Coverage for dependent children of a deceased retiree will terminate when they reach age 19 (or 24 if they are full-time students).

Should you die as an active employee who is not eligible for benefits after retirement, with benefits for dependents in force, such coverage may be continued, provided the required contributions are paid when due, for a period not exceeding the earlier of: (a) the remarriage of your spouse, or (b) one year beyond the date of your death.

Coverage for dependent children of a deceased employee may terminate earlier than (a) or (b) above if they become ineligible as dependents.

In addition, benefits for dependents may be extended beyond the one year after death to a maximum of 36 months after provisions of COBRA. The Employee Benefits Division must be contacted within 60 days if coverage is to be continued.

CONTINUATION OF COVERAGE FOR DEPENDENT CHILDREN

Dependent children who reach age 19, or cease to be a full-time student prior to age 24 or reach age 24 while still a full-time student may continue coverage under provisions of COBRA for a maximum of 36 months. The Employee Benefits Division must be notified when the dependent child turns 19, ceases to be a full-time student, or reaches age 24 to ensure that appropriate action is taken based on eligibility.

DEPENDENT PROTECTION AFTER DIVORCE OR TERMINATION OF A SAME-SEX DOMESTIC PARTNER RELATIONSHIP

Coverage for a spouse or same-sex domestic partner may be continued under provisions of COBRA for a maximum of 36 months following the divorce of an employee or the termination of a same-sex domestic partner relationship. The Employee Benefits Division must be notified within 60 days of the divorce if coverage is to be continued.

HEALTH CERTIFICATES

If your coverage under this plan stops, you and your covered dependents will receive a certificate that shows your period of coverage under the plan. You may need to furnish the certificate if you become eligible under another group health plan if it excludes

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coverage for certain medical conditions that you have before you enroll. You may also need the certificate to buy, for yourself or your family, an individual insurance policy that does not exclude coverage for medical conditions that are present before you enroll. You and your dependent may also request a certificate within 24 months of losing coverage under this plan.

CONVERSION PRIVILEGE

If your medical plan terminates for any reason other than your failure to pay any required contributions, you will be entitled to convert to an individual policy of insurance, without submitting evidence of good health, if you were covered for at least three months. You must make written application and pay the first premium to the claims service provider prior to the thirty-first day after such coverage terminates, or prior to the fifteenth day after such coverage terminates, or prior to the fifteenth day after you have been given the notice of the existence of the conversion privilege if a later date, but in no event later than 90 days after such coverage terminates. Except as stated below, the converted policy will cover you and those of your dependents who were covered on the date your coverage terminated. The converted policy, if issued, will become effective the day after such coverage terminates.

The Claims Service Provider may refuse to issue a converted policy covering any person who is or could be covered by Medicare. Furthermore, the Claims Service Provider may refuse to issue or renew a converted policy covering any person if its benefits and the benefits of the other coverage that such person has, or is eligible for on a group basis, would result in over-insurance or duplication of benefits according to the rules of the Claims Service Provider.

Conversion as provided above shall be available (a) on your death if the plan provides a continuation of dependents' coverage following your death, to your surviving spouse and children as are then covered under the plan, otherwise to your surviving children covered under the plan, (b) on your spouse's ceasing to be an eligible dependent while you remain covered under the plan, to your spouse with respect to such of your spouse and children whose coverage terminates at the same time, and (c) on your child's ceasing to be an eligible dependent, to that child solely with respect to himself or herself, if conversion is not otherwise provided above.

Ask the Claims Service Provider for the details of the available converted policy. The converted policy need not provide (a) maternity benefits or (b) benefits in excess of those provided under the current University-sponsored plan.

The Claims Service Provider may elect to provide Group Insurance coverage instead of issuing a converted policy.

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

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THIRD PARTY LIABILITY LIMITATION

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

If you or your covered 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.

OVERPAYMENTS

If a covered individual has been paid benefits under a University-sponsored health care plan which are in excess of the benefits that should have been paid, or which should not (under the provisions of the Plans) have been paid, the University, or the Plan Administrator, may cause the deduction of the amount of such excess or improper payment from any subsequent benefits payable to such Covered Individual or other present or future amounts payable to such person, or recover such amount by any other appropriate method that the University, in its sole discretion, shall determine. Each Covered Individual hereby authorizes the deduction of such excess payment from such benefits or other present or future compensation payments.

NO WAIVER OR ESTOPPEL

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

CANCELLATION OF HEALTH CARE BENEFITS

If the University is unable to ascertain the whereabouts of any Covered Individual to whom benefits are payable under these Plans, and if, after one year from date such payment is due, a notice of such payment due is mailed to the last known address of such person as shown on the records of the University and within three months after such mailing, such person has not filed with the Plan Administrator written claim therefore, the University may direct that such payment be canceled and forfeited and, upon such cancellation of these Plans, shall have no further liability therefore.

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RIGHT TO RECEIVE AND RELEASE INFORMATION

For the purpose of determining the applicability of implementing the terms of these benefits, the University and/or the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine acceptability of any applicant for participation in these Plans. In so acting, the University and/or the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Covered Individual claiming benefits under these Plans shall furnish to the University and/or the Plan Administrator such 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 any Covered Individual shall be in such form as is prescribed from time to time by the University or the Plan Administrator 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 any Covered Individual shall be deemed to have been duly delivered when given to such person or mailed to such person at the Covered Individual's address last appearing on the records of the University or the Plan Administrator. Each person entitled to receive a payment under the Plans shall file in accordance here in the Covered Individual's complete mailing address and each change therein. If the University or the Plan Administrator shall be in doubt as to whether payments are being received by the person entitled thereto, the Plan Administrator may, by registered mail addressed to such person's last known address, notify such person that all future payments will be withheld until such person submits proper mailing address and such information as the University or the Plan Administrator may reasonably request. All address information must be submitted to the University and the Plan Administrator.

WORKER'S COMPENSATION NOT AFFECTED

These Plans are 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 these Plans, the true facts will be used to determine the proper coverage. Coverage means eligibility as well as the amount of any benefits thereunder.

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AMENDMENT OR TERMINATION OF PLANS

The University has established the Plans described herein with the intention of maintaining them 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:

- (a) the coverage and benefits provided under the Plans, and
- (b) the level of employee contributions, deductibles, co-payments and coordination of benefits between the Plans and any contract, program, or group plan providing medical benefits maintained by any participant, eligible dependent, another employer, or any federal or state government authority, or any subdivision thereof.

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

Except as otherwise provided in a Plan, the right to amend or terminate the Plan shall not in any way affect the right of a participant or eligible dependent to claim benefits, or diminish or eliminate any claim for benefits, with respect to expenses incurred for services rendered to a participant or eligible dependent prior to termination or amendment of a Plan.

A 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.

Eligibility of a faculty or staff member to take benefits into retirement does not confer upon such individual or eligible dependent of such individual, any right to continued benefits under any Plan.