

UNIVERSITY OF MISSOURI

*Retiree*  
*Insurance*

*Life Insurance Plan*  
*Dependent Life Insurance Plan*  
*Accidental Death & Dismemberment Plan*  
*Dental Benefits Plan*  
*Long Term Care Insurance Plan*  
*Medical Insurance Plans*

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This booklet is designed to provide an overview of the University of Missouri's benefit programs available to retirees of the University of Missouri. It includes information on Life Insurance, Dependent Life Insurance, Accidental Death & Dismemberment Insurance, Dental Benefits, and Long Term Care Insurance. A separate booklet describing the Medical Benefits options for retirees is also available. In addition to this booklet, the University will continue to use other methods of communication, such as letters, bulletins, and newsletter articles to help you stay informed.

While the University hopes to offer these programs indefinitely, it has the right to amend or terminate any benefit plan.

Some plans are governed by a legal document called a plan document. The University has taken care to accurately present the information contained in this booklet in a way that is easy to understand. However, in the event of a disagreement between this booklet and the plan document, the plan document will be followed.

It is important for you to have a good understanding of all these plans have to offer. Please review this booklet carefully.

It is important for you to understand that retirees may not increase any coverage after retirement. Also, no additional dependent coverage may be added. If, after retirement, any retiree or dependent coverage is dropped, the retiree or dependent may not re-enroll.

If you have any questions, contact your Retiree Benefits Representative at:

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**Faculty & Staff Benefits Department Webpage:**

<http://www.system.missouri.edu/hrs/benefits/welcome.htm>

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# ***Eligibility***

## ***Retirees***

In order for University retirees to be eligible for the benefits described in this booklet they must have been covered under the respective plans immediately prior to their retirement, and either ...

- a. retire from the University of Missouri and immediately begin to receive retirement benefits under the University of Missouri Retirement, Disability and Death Benefit Plan, Civil Service Retirement System, Federal Employees Retirement System or Missouri State Employees Retirement System, or
- b. terminate employment with the University and be eligible *at that time* to begin receipt of retirement benefits under the University of Missouri Retirement, Disability and Death Benefit Plan, Civil Service Retirement System, Federal Employees Retirement System or Missouri State Employees Retirement System but elect to defer receipt of their benefits to a later date.

## ***Dependent coverage***

Dependent coverage for each benefit type is explained in the section describing the specific benefit.

# ***Life Insurance Plan***

The Life Insurance Plan provides your family with valuable financial protection in the event of your death.

This Plan offers two options through a basic life insurance program and a supplemental life insurance program. The benefits available under each are described in this booklet.

This summary is designed to give you an overview of the major points of the Plan. If any description in this summary differs from the policies, the terms of the policies will be followed.

*Note: The life insurance coverage described in this booklet is applicable only to those who retired on or after December 1, 1980. If you retired prior to that date, contact your Retiree Benefits Representative for details concerning your life insurance coverage.*

## ***Coverage options***

The Life Insurance Plan offers you the following coverage options:

<b>Option</b>	<b>Benefit amount</b>	<b>Who pays for this coverage?</b>
<i>Basic Life Insurance</i>		
Group Term Life Insurance Plan A	One times base salary*	The University
- or -		
Group Term Life Insurance Plan B	Two times base salary*	You and the University

### *Supplemental Life Insurance*

Optional Group Term Life Insurance	One, two or three times base salary*	You
- or -		
Group Universal Life Insurance	One, two or three times base salary*	You

\*Salary for the year in which you retired. Please see page 5 for information regarding reduction for age.

### ***Group Term Life Insurance coverage***

Group Term Life Insurance provides a benefit when you die. The death benefit is equal to the coverage amount in effect at that time and is payable to your beneficiary.

### ***Group Universal Life Insurance coverage***

Group Universal Life Insurance, like Group Term Life Insurance, provides a benefit when you die. The benefit is equal to the coverage amount in effect when you die and is payable to your beneficiary/ies.

Unlike term insurance, universal life insurance *also* includes a savings fund that earns tax-deferred interest at competitive rates. Any savings and earned interest are available to you for withdrawal or can be held "in reserve" to continue coverage if you elect to stop paying premiums for periods of time. At retirement, you can withdraw some or all of your savings, or use your money to buy paid-up life insurance. The balance of your savings fund will be paid to your beneficiary/ies if you die before withdrawing your money.

### ***Cost of coverage***

#### **Basic Life Insurance**

The cost of your coverage depends on the level of group/term coverage you are enrolled in immediately prior to retirement. If you are enrolled in Plan A, the University will pay the full cost of coverage.

If you are enrolled in Plan B, the plan giving a higher level of coverage, the additional cost will be shared by you and the University. The amount of contribution required will be determined annually by the insurance company.

According to Internal Revenue Service rules, a retiree must recognize the value of Group Term Life Insurance coverage in excess of \$50,000 as additional taxable income (as calculated using life insurance premium statistics published by the IRS). This income will be reflected on an annual W-2 Form.

#### **Supplemental Life Insurance**

You pay the entire premium for this coverage regardless of whether you are enrolled in the Optional Group Term Life or Group Universal Life Plan.

Premiums for the Optional Group Term Life Plan increase as you get older.

## ***Amount of coverage***

### **Basic Life Insurance**

The amount of your coverage depends on the *base salary you were receiving at retirement* and the *level of coverage* for which you are enrolled at that time.

- Plan A provides a benefit of 1 x your base salary.
- Plan B provides a benefit of 2 x your base salary.
- The amount of coverage will be reduced at certain ages as shown below.

<b>Age</b>	<b>Coverage Reduced</b>	<b>Percentage of Coverage Retained</b>
Younger than 55	0%	100%
55 - 59	25%	75%
60 - 64	50%	50%
65 - 69	65%	35%
70 and older	100%	0%

These reductions are effective on the January 1 following the date you reach the specified age. To determine the amount of your life insurance after age 55:

1. Multiply your base salary by 1 (Plan A) or 2 (Plan B).
2. Apply the percentage shown for your age (under the *Percentage of Coverage Retained* heading) to that amount.

For example, if your salary at retirement was \$20,000, you are age 67, and you are covered under Plan Option B (two times salary), your life insurance benefit is \$14,000.

$$(\$20,000 \times 2 \times 35\% = \$14,000)$$

For life insurance calculations, salary is rounded up to the next \$1,000. For example, if your final salary was \$20,100, it would be rounded up to \$21,000. After achieving age 70, conversion rights to an individual policy are available to you.

**Note:** *If you retire after attaining age 70, your basic life insurance terminates as of the date of your retirement. Conversion rights to an individual policy are available to you.*

### **Supplemental Life Insurance**

The amount of your coverage depends on your base salary at retirement and the level of coverage for which you were enrolled at that time. Supplemental Term Life insurance does not increase in amount; however, the premium is age related, and will increase at ages 55, 60, 65 and each year beginning at age 70. If you are enrolled for Group Universal Life, the amount going into the savings plan is adjusted when premiums for Supplemental Universal Life change.

## ***Making changes in choice of coverage***

### **Basic Life Insurance**

You may not increase your coverage from Plan A to Plan B, however, you may *decrease* your coverage from Plan B to Plan A.

### **Supplemental Life Insurance**

You may make the following changes twice each year, effective on January 1 and on July 1:

- Decrease your coverage.
- Transfer from the Universal Life Insurance to the Optional Group Term Life Insurance. (In this case, you must surrender your Universal Life insurance certificate and the full value of your Universal Life savings fund will be paid to you.)
- Increase your contributions for the Group Universal Life Insurance Plan for faster growth of your savings fund.

## ***Designating a beneficiary***

### **Basic Life Insurance and Supplemental Life Insurance**

You may name a different beneficiary at any time by completing a new beneficiary designation form.

## ***How benefits are paid***

### **Basic Life Insurance and Supplemental Life Insurance**

The insurance company will pay benefits to your beneficiary upon receiving written proof of your death. Death benefit proceeds in excess of \$5,000 are automatically placed in a guaranteed money market account.

## ***When coverage will end***

### **Basic Life Insurance and Supplemental Life Insurance**

Coverage will end on the earliest of the following dates:

- the date you stop making contributions;
- the date the University discontinues this Plan;
- in the case of Basic Life Insurance, the January 1 following your 70th birthday. (Those reaching age 70 between December 2nd and December 31 will continue coverage through the following calendar year.)

When your Basic or Optional Group Term coverage ends, you can convert all or part of your life insurance to an individual insurance policy. You will not have to pass a medical exam to qualify for coverage. However, you must submit your application and first premium payment within 31 days after your group coverage terminates. The premiums for this coverage, which you will pay directly to the insurance company, will depend on the type of policy you choose and your age.

If you become totally and permanently disabled before you reach age 60 and after you have been covered under Supplemental Life Insurance for one year, you will be eligible for a waiver of premiums for that coverage. This means that, starting nine months after your disability begins, you will not have to pay premiums for your coverage. This benefit will remain in effect until you recover, reach age 65 or die, whichever comes first. If you have Universal Life insurance coverage, the cash in your accumulation fund will continue to earn interest at the declared rate. However, no additional cash will be added to your fund, except by your own direct contributions. In addition, premiums remain the same as you get older, unless you decide to change the level of coverage.

## ***Dependent Life Insurance Plan***

If you were enrolled for Dependent Life Insurance immediately prior to retirement, you are eligible to continue that coverage into retirement. Dependents eligible for this coverage include your spouse and your unmarried dependent children who are from 14 days of age to 19. Children ages 19 to 25 may also be covered if they are full-time students. No coverage is available for children ages 25 or older. If you did not have dependent life insurance immediately prior to retirement, you are not eligible for coverage. If, after retirement, you drop coverage on any of your dependents, you may not re-enroll them in the Plan.

### ***Coverage Amounts***

Spousal coverage is available in increments of \$10,000 from a minimum of \$10,000 to a maximum amount equal to 50% of the salary you were receiving at the time of your retirement. Coverage on your natural children, adopted children, or stepchildren who normally live with you in a parent-child relationship is available in \$5,000 increments from a minimum of \$5,000 to a maximum of \$25,000.

### ***Cost of Coverage***

You pay the full cost of this coverage.

### ***Changing coverage***

You may lower the amount of Dependent Life Insurance during the enrollment change period each November. You may cancel the coverage at any time by providing written notice to the Retiree Benefits Office. You may not increase Dependent Life Insurance at any time after retirement.

### ***The beneficiary***

You, the retiree, are automatically the beneficiary of any Dependent Life Insurance coverage.

### ***How benefits are paid***

Death benefit proceeds in excess of \$5,000 are automatically placed in a guaranteed money market account.

### ***When coverage will end***

Dependent life coverage will end on the earliest of the following dates:

- The date you stop paying the premiums;
- The date your spouse or child ceases to be eligible for coverage. (You must notify your Retiree Benefits Representative in order to stop your payroll deduction.)
- The date the retiree or eligible member dies.
- The date the University discontinues this Plan.

## ***Accidental Death & Dismemberment Plan***

If you were enrolled for Accidental Death and Dismemberment (AD&D) coverage immediately prior to retirement you are eligible to continue coverage into retirement. You must re-enroll when you retire and your coverage as a retiree begins on the first day of the month following receipt of your completed enrollment form by the Retiree Benefits Representative.

If you are enrolled for AD&D coverage, you and your family will benefit in the event of an accidental death. The Plan also helps you financially if you suffer other losses as described in the section titled, *What benefits are paid by the Plan?*

### ***Coverage amounts available***

If you are under age 70, you may select a level of coverage in multiples of \$5,000 from a minimum of \$10,000 to a maximum of \$50,000, as long as the amount you select does not exceed the Principal Sum amount for which you were enrolled prior to retirement. If you are 70, but not yet 75, the maximum available coverage is \$25,000. If you are 75, but less than 80, you may be covered for \$10,000. You can lower your coverage level during the annual enrollment period by submitting a new enrollment form to your Retiree Benefits Representative. Retirees do not have the option of increasing this coverage.

If you elect to insure your spouse and children under the Plan, the amount of their coverage is a percentage of your benefit amount, as shown below:

<b><i>Covered Dependent</i></b>	<b><i>% of Your Benefit Amount</i></b>
Spouse only (no children)	50%
Spouse and children	40% (spouse) and 5% (each child)
Children only (no spouse)	15% (each child)

### ***Eligible dependents***

You can continue to insure your spouse, if under age 80, and children under this Plan. Your unmarried child is eligible for coverage from birth to 19 years of age (or to age 23 if a full-time student and solely dependent on you for financial support). After exceeding this age limit, your child's coverage would normally end. However, your child will remain eligible for coverage after reaching the age limit if:

- Your child is unable to support himself or herself due to a mental or physical handicap and;
- Your child is dependent on you for maintenance and support.

You must notify your Retiree Benefits Representative within one month of your child's attainment of the age limit. In the case of a child unable to support himself, or herself, due to a mental handicap, written proof of incapacity must be submitted every six months for the next two years and once a year thereafter.

### ***Designating a beneficiary***

You may change your beneficiary designation at any time by completing the appropriate form.

### ***Cost of coverage***

You pay the full cost of your optional AD&D coverage.

### ***What is covered by the AD&D Plan***

The Plan offers full 24-hour protection against accidents anywhere in the world, on or off the job. Air travel is included while you are flying only as a passenger (not as a pilot or a member of the crew) in a certified, airworthy, civilian aircraft or military transport aircraft.

### ***What benefits are paid by the Plan***

Your AD&D benefit depends on the amount of coverage you chose when you enrolled.

Benefits are payable as shown below:

<b><i>For loss of:</i></b>	<b><i>The plan pays this percentage of your coverage amount:</i></b>
Life	115%
Both hands or both feet or sight in both eyes	115%
One hand and one foot	115%
One hand or one foot and the sight of one eye	115%
Speech and hearing	115%
Total paralysis of both arms and both legs	115%
Total paralysis of three limbs	86.25%
One hand or one foot or the sight of one eye	57.50%
Speech or hearing	57.50%
Total paralysis of both arms or both legs	57.50%
Thumb and index finger of the same hand	28.75%
Total paralysis of an arm or leg	28.75%

Only one of the amounts, the largest, is payable for all losses resulting from one accident. The loss must occur within one year after an accident to be eligible to receive these benefits.

The following are further specific definitions that apply to the losses covered under this benefit:

- Loss of hand or foot means complete and permanent severance through or above the wrist or ankle joint.
- Loss of sight means the total and permanent loss of sight. A loss that may be corrected by surgery or lenses is not considered total and permanent.
- Loss of hearing means total and permanent loss in both ears.
- Loss of speech means total and permanent loss of speech.

- Loss of thumb and index finger if the same hand means complete and permanent severance through the joints joining the thumb and index finger to the hand.
- Total paralysis means an injury to the spinal cord of an insured. The insured must be paralyzed and under care of a physician for twelve straight months from the date the paralysis began. At the end of this time, it must be medically determined that the paralysis is total and not reversible.

### ***Does coverage reduce as I grow older?***

The coverage amount is reduced for you or your spouse at certain ages, as shown below:

<b>Age</b>	<b>Percentage of Principal Sum</b>
70-74	70%
75-79	45%
80-85	30%
86 & older	15%

### ***Conditions under which AD&D benefits are not paid***

AD&D benefits will not be paid for losses as a result of:

- Suicide while sane or intentional self-inflicted injury.
- War or act of war, whether declared or undeclared.
- Injury sustained while in the armed forces of any country or international authority. This exclusion does not apply if you sustain a loss while a member of an armed force reserve corps or National Guard unit while attending an authorized active or inactive duty training session or other active duty that is less than 30 days.
- Riding as a passenger or otherwise in any flying device that does not have a valid and current standard Airworthiness Certificate, or being piloted by an unlicensed or improperly licensed pilot or on a flight requiring a special permit or waiver from the civil aviation authority. A permit given to fly over or land on territory is not considered a special permit.

### ***When AD&D coverage ends***

Your coverage will end on the earliest of these dates:

- The date you are no longer eligible for coverage.
- The date the group policy ends.
- December 31 of the year in which you attain the age of 80 years.
- The last day of the month for which you pay the required premium.

### ***How to file a claim***

Contact the Retiree Benefit Office for the necessary forms. They should be completed according to the instructions provided, and ***submitted within 90 days after the date of the loss.***

## ***Dental Benefits Plan***

The Dental Plan is designed to help you meet the expense of dental care by providing a broad range of benefits for you and your family. The Plan encourages preventive dental care, but also provides meaningful benefits if you incur large dental bills.

The Plan provides payment for covered dental expenses for you and your eligible dependents. Covered dental expenses are the usual charges of a dentist for services and supplies that are necessary for treatment of a dental condition. These charges are covered only to the extent they are reasonable and customary for services and supplies normally used for treatment of that condition.

This summary is designed to give you an overview of the major points of the Plan. The Plan is governed by a legal document.

In the event of a conflict between this summary and the Plan document, the Plan document will control.

### ***Benefits summary***

<b>Expenses covered</b>	<b>Plan benefit</b>
Type A - Preventive dental care	100% - no deductible
Type B - Basic dental care	80% - after satisfying the deductible
Type C - Major dental care	50% - after satisfying the deductible

#### **Deductible amounts**

For an individual each calendar year	\$100
For the family each calendar year	\$300

#### **Maximum benefit**

For preventive, basic and major dental care combined, the maximum benefit is \$1,500 per calendar year for each covered individual.

### ***Cost of coverage***

The cost of dental coverage is shared by you and the University. The University contribution amount is determined on the basis of your retirement date and the actual Plan under which your retirement benefit is payable.

If you retired prior to September 1, 1990 under the University of Missouri Retirement, Disability and Death Benefit Plan or Missouri State Employees Retirement System, or if you retire under the Civil Service Retirement System, or the Federal Employees Retirement System, the University pays an amount equal to 50% of the cost of the Dental Plan. You pay the remaining cost. This percentage is applicable to coverage for yourself as well as for any eligible dependents you may have covered. The University Plan will pay 25% of the cost of the Plan for widows/widowers.

If you retire on or after September 1, 1990 under the University of Missouri Retirement, Disability and Death Benefit Plan or Missouri State Employees Retirement System, the University will pay a percentage of the cost of your own coverage. The percentage will be computed individually for each retiree, based on age and length of service at retirement. The University's percentage for retirees will not exceed 50% for dental coverage. 50% of the percentage applicable to you will be paid toward the cost of coverage for your dependents.

## ***Eligible Dependents***

### ***Dependent eligibility***

Your eligible dependents include your spouse and each of your unmarried natural children younger than age 19.

Children age 19 and older are also eligible for coverage if they meet one of the following requirements:

- They are unmarried, at least age 19 but less than age 23 and dependent on you or your spouse for principal support.
- They are unmarried full-time students, at least age 19 but less than age 25, enrolled in an accredited school and dependent on you or your spouse for principal support.
- They are unmarried, dependent on you because of a physical or mental disability and are incapable of self-sustaining employment prior to reaching the maximum age for coverage as a dependent. In this situation, you must notify the University and submit proof of the child's status within 31 days of the date he or she would otherwise become ineligible. Disabled children may be covered by the Plan as long as they remain incapacitated and dependent, and proof is submitted when requested.

In addition to your natural children, a child who lives with you in a parent-child relationship will be considered eligible under these conditions if he or she is placed in your home for legal adoption, or is a legally adopted child, stepchild or foster child.

For the purposes of this Plan,, an eligible foster child is a child for whom you or your spouse have assumed legal responsibility and control. In no event will the Plan cover a child:

- Who is temporarily living in your home; or
- Who is placed in your home by a social service agency that retains control of the child; or
- Whose natural parent is in a position to exercise or share parental responsibility and control.
- Who becomes your dependent after the date of your retirement.

### ***When benefits are payable***

Dental benefits are paid when covered expenses are incurred that either exceed or are not subject to the deductible amount.

No coverage is provided to replace teeth missing before your effective date of coverage until the individual has been covered under this Plan for at least five consecutive years.

### ***The deductible amount***

The deductible amount is equal to the first \$100 of covered expenses for basic (Type B) and major (Type C) dental care incurred in a calendar year. The deductible does not apply to covered expenses for preventive (Type A) dental care.

The deductible amount is \$300 per family per calendar year. The family deductible will be considered satisfied once an entire family has had a total of \$300 applied toward the calendar year deductible.

Covered expenses incurred and applied toward the deductible on or after October 1 cannot be used to satisfy the next calendar year's deductible.

## ***Covered expenses***

Covered expenses include only reasonable and customary charges that you or your covered dependents incur for the following types of services and supplies:

### **Type A - preventive services**

The following preventive dental services are reimbursed at 100% with no deductible:

- Routine oral examinations and prophylaxis (scaling and cleaning of teeth), not more than twice during any one calendar year.
- Dental X-rays, including full mouth X-rays (not more than once every three years), supplementary bitewing X-rays (not more than twice in one calendar year) and such other dental X-rays as required in connection with the diagnosis of a specific condition requiring treatment.
- Topical application of fluoride for covered individuals under age 19, but not more than twice during any one calendar year.
- Space maintainers to replace prematurely lost teeth for children younger than age 19.
- Emergency pain-relief treatment.
- Sealants for individuals under age 16.

### **Type B - basic services**

The following basic dental services are reimbursed at 80% after you have satisfied the deductible:

- Extractions.
- Oral surgery not covered under the Medical Plan.
- Fillings (amalgam, silicate, acrylic, synthetic porcelain and composite).
- General anesthetics when medically necessary and administered in connection with oral or dental surgery.
- Treatment of periodontal and other diseases of the gums and tissues of the mouth.
- Endodontic treatment, including root canal therapy.
- Injection of antibiotic drugs.
- Repair or recementing of crowns, inlays, onlays, bridgework or dentures.
- Adjusting, relining or rebasing of dentures, if performed at least six months after the denture is installed, but not more than one relining or rebasing in any three-year period.
- In addition, charges for services and supplies provided by a hospital for inpatient or outpatient services in connection with covered dental services are reimbursed as Type B expenses, when:
  - the individual receiving the services and supplies is covered for medical benefits through the University of Missouri Medical Benefits Plan, and
  - the medical program under which the individual is covered does not cover hospital services or supplies in connection with dental services, and
  - the services and supplies are medically necessary for the covered dental service.

Any benefits payable for such hospital services or supplies will not be subject to the calendar year Plan maximum.

## **Type C - basic services**

The following major dental services are reimbursed at 50% after you have satisfied the deductible:

- Inlays, onlays, gold fillings or crown restorations to restore diseased or accidentally broken teeth, but only when the tooth cannot be restored with an amalgam, silicate, acrylic, synthetic porcelain or composite filling.
- Initial installation of fixed bridgework (including inlays and crowns abutments) to replace one or more natural teeth extracted while the individual is covered.
- Initial installation of partial or full removable dentures (including adjustments during the six-month period following installation) to replace one or more natural teeth extracted while the individual is covered.
- Replacement of an existing partial denture or fixed bridgework by new fixed bridgework or the addition of teeth to existing fixed bridgework. However, replacements or additions to existing dentures or bridgework will be covered only if one of the following applies:
  - The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed and while the individual was covered.
  - The existing denture or bridgework cannot be made serviceable and was installed at least five years prior to its replacement.
  - The existing denture is an immediate temporary denture which cannot be made permanent and replacement by a permanent denture takes place within 12 months from the date the immediate temporary denture was installed.

## ***The Plan maximum***

The most any covered individual can receive in dental benefits in one calendar year is \$1,500.

## ***Alternate treatment plans***

Situations frequently arise where there are two or more possible methods of treating a particular dental condition. In these situations, the amount included as covered dental expenses will be limited to the "reasonable and customary" charges for services which are:

- Customarily employed nationwide in the treatment of that condition, and
- Recognized by the profession to be appropriate in accordance with broadly accepted nationwide standards of dental practice, taking into account the total current oral condition of the covered individual.

*For example, if a tooth can be adequately restored with a filling material such as amalgam, but you and your dentist elect to use a crown instead, Plan benefits will be based on the amount that would have been payable for the cost of the filling.*

## ***Advance claim review***

If a course of treatment for you or one of your dependents can reasonably be expected to involve covered dental expenses of \$200 or more, a description of the procedures to be performed and an estimate of the

dentist's charges should be filed with the Plan's claims administrator before beginning the course of treatment. (Your Retiree Benefits Representative has a supply of the proper forms.)

The claims administrator will notify you and your dentist of the estimated benefits payable based upon the course of treatment. In determining the amount of benefits payable, consideration will be given to alternate procedures, services or other possible courses of treatment available to accomplish the desired result. If you and your dentist agree to a charge higher than the amount predetermined by the claims administrator, the excess will not be paid by the Plan. If a description of the procedures to be performed and an estimate of the dentist's charges are not submitted in advance, benefits will be payable in accordance with the standard features of the Plan and may be less than you expect.

Predetermination of benefits is not mandatory and is not intended to interfere with the dentist/patient relationship. Rather, it is intended to provide useful information to you and your dentist. You are both informed, in advance of the treatment, of the estimated benefits payable for the proposed course of treatment and of the expenses that will remain your full responsibility.

### ***Courses of treatment in progress when coverage begins***

Benefits are provided only for covered dental expenses that you or your dependents incur while covered by the Plan. A charge is considered to have been incurred on the date when the services, supplies or treatments are received.

In addition, no benefits are payable for dentures, bridgework or crowns that were ordered while the patient was not covered by this Plan. The term "ordered" means that impressions have been taken and in the case of bridgework or crowns, the teeth have been prepared to receive the item.

### ***Reasonable and customary charges***

Only that part of a charge for a service or supply that is reasonable and customary is covered. Generally speaking, a charge by your dentist is considered reasonable and customary if it does not exceed the customary charges for the same or similar dental care, services or supplies made for cases of comparable nature and severity at the time and place where the dental care is received.

### ***Dental services which are not covered***

- Dental expenses for the following are not covered by the Plan:
- Any dental services not specifically listed in this booklet under Type A, Type B or Type C dental services.
- Sealants for individuals over age 16, oral hygiene and dietary instruction or plaque control programs.
- Orthodontia, or any treatment, services or supplies provided for orthodontic purposes.
- Failure to keep a scheduled visit with the dentist.
- Completion of a claim form.
- Charges for any dental services and supplies that are covered expenses in whole or in part by the medical Plan.

- Charges for treatment by someone other than a dentist, except that scaling or cleaning teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of the dentist.
- Charges for services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures.
- Charges for replacement of a lost, missing or stolen prosthetic device.
- Charges for dentures, crowns, inlays, onlays, bridgework or other appliance or service to increase vertical dimension.
- Charges for services and supplies not necessary to improve oral condition or that are not approved by the attending dentist or physician or charges that exceed reasonable and customary limits.
- Charges that are made only because the insurance exists or charges that you are not legally obligated to pay.
- Charges for services or supplies required by reason of an act of war or insurrection.
- Charges for services or supplies which are furnished in a facility operated under the direction of or at the expense of the U.S. Government (or its agency) or by a doctor employed by such a facility and for which no payment would be required if the covered individual did not have this coverage.
- Services, supplies or treatment related to an occupational illness or injury or that are covered by any Workers' Compensation laws or Employer's Liability acts or that an employer is required by law to furnish in whole or in part.
- Charges for services or supplies that are experimental in nature.

### ***Example***

Here is an example of one retiree's dental expenses and how benefits are paid:

<b>Dental Service</b>	<b>Fee</b>	<b>Deductible</b>	<b>Amount the Plan Pays</b>	<b>Amount the Retiree Pays</b>
<b><i>Type A Preventive Services</i></b>				
Dental examination, cleaning & X-rays	\$65	\$0	\$65	\$0
<b><i>Type B Basic Services</i></b>				
Five fillings (\$50 each)	\$250	\$100	\$120 (80%)	\$130 (deductible + (20%))
Two extractions (\$65 each)	\$130	Satisfied	\$104 (80%)	\$26 (20%)
<b><i>Type C Major Services</i></b>				
One fixed bridge	\$400	Satisfied	\$200 (50%)	\$200 (50% of balance)
<b>TOTAL</b>	<b>\$845</b>	<b>\$100</b>	<b>\$489</b>	<b>\$356</b>

### ***When a family has other group dental coverage***

Your Dental Plan has a "coordination of benefits" (COB) provision, which means that if you or your dependents are covered under other group insurance programs, (or entitled to payments from a "no fault" auto insurance policy), combined benefits from all plans will pay up to, but not more than, 100% of your covered dental expenses.

Under COB, one plan is considered "primary" and the other "secondary". The plan that is primary pays first, and usually pays full regular benefits. The primary plan is determined as follows:

- If a plan covers the patient as an employee, then that plan is primary.
- If the patient is a dependent child whose parents are not divorced or separated, the plan of the parent whose birthday is earlier in the calendar year is primary.
- If the patient is a dependent child whose parents are divorced or separated, the following rules apply:
  1. A plan that covers a child as a dependent of a parent who by court decree must provide health coverage is primary.
  2. When there is no court decree that requires a parent to provide health coverage to a dependent child, then the plan of the parent who has custody of the child is primary. (The plan of the custodial parent's spouse is secondary and the plan of the other natural parent is third.)

If none of the above rules apply, the plan that has covered the patient for the longer period of time will usually be primary. After the primary plan pays its benefits, the secondary plan will, in most cases, pay the balance of your eligible dental expenses.

To ensure you receive the benefits to which you are entitled under both plans, it is important to submit your claims properly. For example, when you file a claim for your spouse, be sure to file under his or her Plan first. After you have received payment from your spouse's Plan, then you can submit for payment to your Plan. When you submit a claim to the second Plan, be sure to include the explanation of benefits from the primary Plan, as well as another copy of the bill. Remember, if you coordinate your benefits correctly, you will receive payment more promptly, and still have the advantage of coordinated coverage under both plans.

### ***When coverage ends***

Dental coverage will end on the earliest of the following dates:

- When you cease making the required Dental Plan contribution.
- When the University terminates the Plan.

Your dependent's coverage will terminate on the earliest of the following dates:

- When all dependent coverage under the Plan terminates.
- When the individual no longer meets the Plan's definition of a dependent.
- When your coverage terminates.
- When you cease making the required contribution for dependent coverage.

### ***Re-enrollment in the Dental Plan***

Once you terminate any part of your dental coverage, you, or your dependents, cannot re-enroll in the Dental Plan.

### ***Coverage continuation for the family after the retiree's death***

If you die, your eligible spouse may continue coverage after your death. In addition, the continuation of coverage is available for your children, but only when spousal coverage is also continued. The continuation of coverage under the provision is subject to the payment of monthly contributions by the spouse. The University will continue to contribute a portion of the total cost of coverage, however, the portion paid by the University is smaller than that paid by the University for a retiree. An eligible spouse, for the purposes of this provision, is the spouse to whom you were married on the date of your retirement, and to whom you had been married to for at least one year preceding your death. Eligible children are described on page 8.

No continued coverage is available for children unless the spouse is also covered.

Enrollment for continued coverage must be made within 31 days after your death.

Coverage for any dependent will terminate on the earliest of:

- the date the individual no longer meets this Plan's definition of an eligible dependent
- the date all dependent coverage is discontinued under this Plan
- the end of the period for which any required contributions have been made.

### ***Continuation of Dental Plan coverage (COBRA)***

Federal law (Consolidated Omnibus Reconciliation Act) requires the Plan to offer covered dependents the opportunity to continue Dental Plan coverage when it ends for certain specified reasons. The following provisions outline the requirements for continued coverage in accordance with the law. These provisions apply only to the extent that the required period of continued coverage has not already been provided under other Plan provisions.

### ***Eligibility for continued coverage***

Dependents may continue their dental coverage under the group Plan for up to 36 months if their coverage ends for any of the following reasons:

- Divorce or legal separation from the retiree.
- The death of the retiree when coverage is not available as an eligible surviving spouse.
- The dependent child reaches the limiting age or otherwise ceases to qualify as a dependent under the Plan.

These periods of continued coverage begin on the date of the event that caused loss of coverage, for instance, the date a dependent becomes ineligible.

In no event will more than a total of 36 months of continued coverage be provided to any individual, even if more than one of the above events occur.

Continued coverage ends automatically if any of the following occur:

- The cost of continued coverage is not paid on or before the date it is due.
- An individual becomes covered under another group Dental Plan, unless coverage under the other Plan is limited due to the individual's pre-existing condition.
- An individual becomes entitled to Medicare.

- The Plan terminates for all employees and retirees.
- The applicable maximum coverage period ends.

### ***Application for continued coverage***

When the Retiree Benefits Office is notified that one of these events has happened, you will be sent an election form notifying you of the conditions that apply to continued coverage.

However, in the event you become divorced or legally separated, or when your dependent child no longer qualifies as a covered dependent under the Plan, you or your covered spouse or your covered child must notify the Retiree Benefits Representative within 60 days. If you fail to do this, your dependent's rights to continued coverage will be forfeited.

Continued coverage is not automatic. You must submit the completed election form within 60 days from the later of the following dates:

- The date you cease to be eligible under the group Plan.
- The date you receive the election form.

### ***Cost of continued coverage***

Any person who elects to continue coverage under the Plan must pay the total cost of that coverage plus any additional amount permitted by law on a monthly basis. The first payment for continued coverage must be made within 45 days of the date the election form is signed. Payment must be sufficient to pay the applicable costs retroactive to the day following the event which caused coverage to end.

### ***Benefits under continued coverage***

Continued coverage will be exactly the same dental coverage your dependent would have been entitled to if his or her dependent status had not changed. Any future changes in the benefits or cost of coverage for the Plan will also apply.

### ***Extended benefits***

Benefits will be payable for covered expenses incurred in connection with dentures, fixed bridgework or crowns and the fitting thereof which were ordered while the individual was covered under this Plan if the item is finally installed or delivered to such individual within 60 days after termination of coverage.

However, this extension of benefits will not apply if you have received continued dental coverage as a result of total disability, explained in the following section.

### ***Total disability***

If you or your dependent is totally disabled on the date that coverage terminates, dental coverage for the disabled individual will be continued until the earliest of the following dates:

- 12 months.
- The date the individual becomes covered under another group dental plan.

## ***How to file a claim for dental benefits***

All forms required to file dental claims are available from your Retiree Benefits Representative. The completed claim forms should be submitted to the claims administrator at the address shown on the form. The instructions on the form should be followed carefully. This will speed the processing of your claim. Be sure all questions are answered fully.

The claims administrator may require submission of X-rays and other appropriate diagnostic and evaluative materials or records. When these materials are not available, and to the extent that verification of covered dental services cannot reasonably be made based on the information available, benefits for the course of treatment may be for a lesser amount than that which otherwise would have been payable. All claims should be reported promptly. The deadline for filing a claim for benefits is 12 months after the date the dental expense is incurred.

If, through no fault of your own, you are unable to meet the deadline for filing a claim, your claim will still be accepted if you file as soon as reasonably possible, but not later than one year after the deadline unless you are legally incapacitated. Otherwise, late claims will not be covered.

## ***How will benefits be paid?***

Benefits will be paid as soon as the necessary written proof to support the claim is received.

All benefits are payable to you. However, the claims administrator has the right to pay benefits directly to the provider of services unless you have specified otherwise by the time you file the claim.

Also, if you are a minor or otherwise legally unable to give a valid release, or if any benefit is payable to your estate, the claims administrator has the right to pay up to \$1,000 of any benefit directly to any of your relatives whom it may determine to be fairly entitled to the payment.

## ***Claim questions***

If any portion of a claim is not paid, or if you do not understand or do not agree with the handling of a claim, there are several things that you can do to appeal the decision. Most of your questions can be answered quickly and efficiently by either calling or writing the claims administrator's office at the address shown on the claim forms.

If any part of your claim is denied, you or your beneficiary will be notified in writing. The notice will include the following information:

*Specific reason for denial:*

- a) Specific references to pertinent Plan provisions on which the denial is based.
- b) A description of any additional material or information necessary for you to substantiate your claim and an explanation of why such material is needed.

The claims administrator intends to respond to claims promptly. However, if you do not receive a response within 90 days, allowing reasonable time for mailing, assume your claim has been denied and proceed to the claim review stage.

Within 60 days after receiving notice that your claim has been denied, you or your authorized representative may submit a written request for review to the claims administrator. In your request, state the reasons you believe the claim denial was improper, and submit any additional information, material or comments you consider appropriate. You may review any pertinent Plan provision on which it is based.

The Dental Plan is provided directly by the University. The responsibility of the claims administrator referred to in this section is limited to administering benefits according to the rules established by the University.

## ***Long Term Care Insurance***

The University's Long Term Care Plan offers retirees, under age 80, the opportunity to purchase insurance coverage for qualified expenses in a nursing home or community based care environment.

The Plan is underwritten by Continental Casualty Company, of the CNA Companies of Chicago, Illinois, under Group Policy Number 01-A-9456. Any questions about the coverage, or benefits should be directed to the insurance company at 1-800-528-4582.

***The Long Term Care Plan is the only benefit program offered by the University which permits enrollment after retirement, without the retiree having been enrolled as an active employee.***

### ***Coverage eligibility***

If you are a retiree of the University, you are eligible for coverage subject to approval of evidence of insurability. If you are married, your spouse may apply for coverage, subject to approval of evidence of insurability, without you enrolling yourself.

### ***Commencement of coverage***

Coverage must be approved by the insurance company on the basis of information provided by you, or your spouse. The insurance company requires that you, or your spouse, be able to perform all of the activities of daily living (eating, dressing, toileting, general mobility, and managing medications) without assistance, or supervision and must be free of cognitive impairment. Specific information on these requirements is described on pages 24 & 25 of the Outline of Coverage. Coverage will become effective on the first day of the second month following the date the insurance company approves the coverage.

### ***Cost of coverage***

You pay the full cost of Long Term Care coverage, but it is made available to you on a group basis through the University in order to obtain favorable rates. Premiums for retirees and spouses will be deducted from their retirement benefit and transmitted to the insurance company by the University. Premiums for anyone for whom a payroll deduction is not possible will be billed directly by the insurance company.

### ***How to file a claim***

There are no claim forms to file. Call 1-800-528-4582.

### ***How do I collect benefits?***

Since you are going to be paying your premiums on a regular basis, one of the first things you are going to want to know is how and when you will qualify to receive benefits. There are only a few conditions you will have to meet:

- To qualify for benefits, you must be certified as Chronically Ill by a physician, registered nurse, or licensed social worker, which means that for a period of 90 days you meet one of the following two requirements:
  1. You are unable to perform (without substantial assistance from another individual) at least two Activities of Daily Living. The Activities of Daily Living are bathing, continence, dressing, eating, toileting, and transferring (moving into or out of a bed, chair, or wheelchair); or

2. You require substantial supervision to protect yourself from threats to health and safety due to a Cognitive Impairment, such as Alzheimer's Disease.
- You have to satisfy the terms of the pre-existing conditions limitation. If you have a condition for which you were treated or advised or diagnosed within the six months before your coverage went into effect, you will not receive benefits for services that are due to this condition **unless** those services begin six months or more after your coverage goes into effect. If you receive services due to your pre-existing condition within the first six months after your coverage goes into effect, you must go for a full six months without services to be eligible to receive benefits due to this condition. If we ask you to submit evidence of your good health when you sign up for this coverage, the pre-existing condition limitation does not apply to you.
  - We won't cover long term care that you receive for conditions that are the result of any war or act of war. There are other exclusions such as care received outside the USA, care in drug and alcohol rehabilitation facilities and care that is paid for by Workers' Compensation. You will find all of these spelled out in detail in the Outline of Coverage.

### ***The effect of inflation on long term care benefits***

Inflation has been taken into account in designing this Plan. Check your Outline of Coverage for a complete description of the way you can make sure your benefits stay up to date.

### ***Current and future costs***

The premium you pay is based on the benefits you choose and on your age on the day your insurance takes effect. The premiums have been designed to stay the same as you get older. If you are 60 when you sign up, you will pay the 60-year-old premium for life. That premium may change; there is no guarantee that it won't. But for premiums to change, CNA would have to change premiums for everyone in your age category who has the kind of coverage Plan that you do. You can never be singled out for a rate increase because you get older or become ill, or because of claims you file.

### ***Customized care plans***

Each person's needs are different. A nursing home stay isn't for everyone. Other types of appropriate family or community care not ordinarily covered by this Plan may be available to allow you to remain in familiar surroundings. CNA will review your case when you file a claim, and if it's to your benefit, CNA may suggest an alternate plan of care that includes these options. This alternate plan is always voluntary. You, your physician, and CNA must all agree on any alternate plan. And since this plan of care is created especially for you, it will be designed to make your benefit dollars go further. If you do not choose to accept the alternate plan of care, your standard plan benefits will still be payable.

### ***Under some conditions you won't have to pay premiums***

Check your Outline of Coverage for the details of how you can qualify for Waiver of Premium while you are on claim. After your Waiver of Premium period begins, you will not have to pay any further premiums while you receive benefits. Your regular premium payments will not resume until you stop receiving benefits for six consecutive months. The premiums are completely forgiven; you will never have to make them up.

## ***Here's all you do to enroll***

Complete the enrollment form. Then sign it and return it to your Retiree Benefits Representative. Do not send money; premiums will be paid by payroll deduction.

## ***Outline of Coverage***

### ***Read this introduction first.***

This document is the heart of your enrollment package. It describes the specific benefits and features of your plan, and it answers the important question of how much the Plan costs.

The following language in italics, submitted by CNA, is a legal document, one that is written to achieve two aims:

- To present to you the benefits of the group long term care policy exactly as they are presented in the policy, and
- To describe the policy's benefits in a way that makes them easy to compare to other long term care coverage options that may be presented to you.

Long term care insurance is relatively new and is more complex than some other kinds. So let us make two suggestions.

- First, keep this document handy as you look at the other pieces in your information kit.
- Second, if you have any questions or need any clarification, call CNA. It's toll-free. The number is **1 (800) 528-4582**.

**LONG TERM CARE INSURANCE**

**OUTLINE OF COVERAGE**

**THIS OUTLINE OF COVERAGE IS A QUALIFIED LONG TERM CARE  
INSURANCE PLAN UNDER THE FEDERAL TAX CODE**

**Continental Casualty Company  
CNA Plaza  
Chicago, IL 60685  
1-(800)-528-4582**

*In this outline of coverage the Continental Casualty Company is referred to as "we," "our" or "us." The insured is referred to as "you" or "your."*

**Caution: If you complete an application to obtain this coverage, please be advised that issuance of coverage is based upon your responses to the questions in that application. If your answers are incorrect or untrue, we have the right to deny benefits or rescind your coverage.**

**If your age has been misstated, the benefit will be in an amount that the premiums paid would have purchased at your true age. If coverage would not have been issued, we will refund the premium paid.**

**A copy of the application or the enrollment form, as applicable, is attached to your certificate. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact us at Continental Casualty Company, PO Box 593925, Orlando, FL 32859-9987.**

**Notice to Buyer: The Policy may not cover all the costs associated with Long Term Care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all Policy limitations.**

SKS1AA-24-TQ

1. *The policy is a group policy issued to the University of Missouri in the state of Missouri.*
2. **PURPOSE OF OUTLINE OF COVERAGE.** *This outline of coverage provides a very brief description of the important features of your coverage. This is not the insurance contract. Only the actual policy provisions will control. The policy itself sets forth in detail both your rights and obligations and ours. It is therefore important that you **READ YOUR CERTIFICATE CAREFULLY!***
3. **TERMS UNDER WHICH THE CERTIFICATE MAY BE RETURNED AND PREMIUMS REFUNDED.** *You have the right to return your certificate within 30 days (In Washington, this period is 30 days for persons in the employee/spouse eligible class; it is 60 days for persons in all other eligible classes.) for a refund of the initial premium if you are not satisfied with the coverage.*
4. **THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.** *If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from us.*

**Neither we nor our agents represent Medicare, the federal government or any state government.**

5. **LONG TERM CARE COVERAGE.** *Policies of this type are designed to provide coverage for one or more diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services received in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home. Your benefits are described in the Benefits Provided by the Policy provision. They may be limited as provided in the Limitations and Exclusions provisions.*

SKS2AA

6. **BENEFITS PROVIDED BY THE POLICY.** To receive benefits under this Policy, a Licensed Health Care Practitioner must certify that you are Chronically Ill pursuant to a plan of care.

**LONG TERM CARE BENEFIT FOR NURSING HOME CARE.** The benefit payable for nursing home care is stated in the attached Benefit Exhibit. Nursing home care consists of nursing care and custodial care. It must be received in a nursing home licensed by the state in which it is located and which meets the other requirements stated in the policy. A nursing home may be a free standing facility or a ward, wing, unit or swing bed of a hospital or other institution.

SKNH2AA

**LONG TERM CARE BENEFIT FOR COMMUNITY BASED CARE.** The benefit payable for community based care is stated in the attached Benefit Exhibit. Community based care consists of home health care, adult day care, assisted living care and adult foster care. It must be received from a provider which is licensed or certified by the state in which it is located and which meets the other requirements stated in the certificate. We will waive the licensing and certification requirement for adult day care centers in states which do not regulate these facilities, providing they are certified by a recognized accrediting agency.

SKNH3AA

**LONG TERM CARE BENEFIT FOR HOSPICE CARE.** The benefit payable for hospice care is stated in the attached Benefit Exhibit. Hospice Care can be received in a Hospice Care Facility or at your home. In order to receive benefits, it must be certified by a physician that you are expected to live less than 6 months. If care is in a facility, it must be a stand-alone facility or ward/wing of a Nursing Home that specializes in hospice care and is licensed by the state in which it is located. If care is received at your home, it must be received from a provider which is licensed or certified by the state in which it is located and which meets the other requirements stated in the certificate.

SKHC1AB

**LIFETIME MAXIMUM BENEFIT.** We will pay the lifetime maximum benefit shown in the attached Benefit Exhibit. All amounts paid under any benefit provision in or attached to your certificate, including any payments under the Alternate Plan of Care provision, count towards this maximum.

SKNH4AA

**CHRONICALLY ILL.** You must be certified by a Licensed Health Care Practitioner as being unable to perform (without substantial assistance from another individual) at least 2 Activities of Daily Living for a period of 90 days due to loss of functional capacity or requiring substantial supervision to protect you from threats to health and safety due to a Cognitive Impairment.

You will not be considered Chronically Ill unless within the preceding 12 months a Licensed Health Care Practitioner has certified that the above requirements have been met.

SKNH8AA-TQ

**ACTIVITIES OF DAILY LIVING.** Your inability to perform without human assistance or substantial supervision from another person at least two of the Activities of Daily Living listed and defined below.

SKNH9AA-TQ

**Bathing.** Washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

**Continence.** The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for a catheter or colostomy bag.

SKNH5BA-6

**Dressing.** Putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.

SKNH5BA-2

**Eating.** Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

SKNH5BA-1

**Toileting.** Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

SKNN5BA-3

**Transferring.** Moving into or out of a bed, chair or wheelchair.

SKNH5BA-8

**COGNITIVE IMPAIRMENT.** A severe deficiency in the Insureds short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

SKNH10AA-TQ

## 7. **LIMITATIONS AND EXCLUSIONS**

SKL1AA

**WAITING PERIOD.** To receive the long term care benefit you must first complete the waiting period stated in the attached Benefit Exhibit.

SKL2AA

**EXCLUSIONS.** We will not pay benefits for the following:

SKL3AA

(a) Loss due to or resulting from war or an act of war whether declared or undeclared.

SKL3AA-1

(b) Long term care which would be provided without charge in the absence of insurance.

SKL3AA-3

(c) Treatment for neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder which is not of organic origin. Alzheimer's disease and similar dementias are covered, subject to the provisions of the policy.

SKL3AA-4

(d) Nursing Home Care received in a hospital or clinic or a rehabilitation hospital, except as provided in the definition of Nursing Home; or in a facility or section of a facility which operates primarily for the treatment of alcoholics or drug addicts or the mentally ill.

SKL3CB-5

(e) Long term care received outside the United States and its possessions.

SKL3AA-6

**PRE-EXISTING CONDITIONS LIMITATIONS.** We will not pay benefits for long term care due to a condition for which you received medical advice, treatment or a diagnosis in the 6 months before your coverage effective date, unless the long term care due to such condition starts after your coverage has been in force for at least 6 months. If the long term care due to such condition starts during those 6 months, no benefits will be payable for it while it continues without interruption. We will consider that the long term care due to a particular condition is continuing without interruption until at least 6 months pass during which you receive no long term care due to such condition.

This provision does not apply if you are required to submit evidence of insurability for our approval.

SKL4AA

### **OTHER LIMITATIONS.**

SKL5AA

**COORDINATION OF BENEFITS.** Benefits under the Policy shall be coordinated with benefits payable for Long Term Care under any group health plan or any governmental program or government agency program, except Medicaid.

SKL7AA-TQ

**THE POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.**

SKL6AA

8. **RELATIONSHIP OF COST OF CARE AND BENEFITS.** *Because the costs of long term care will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. The benefit level is not guaranteed to increase over time unless an automatic benefit increase option or other inflation benefit is elected.*

SKS3AA

9. **TERMS UNDER WHICH YOUR COVERAGE MAY BE CONTINUED IN FORCE OR DISCONTINUED.**

**OUR RIGHT TO CHANGE THE PREMIUM.** *Your premium is based on your age on your coverage effective date. Your premium will not increase as you grow older. It will remain the same unless the rates are increased for everyone in your age group; you cannot be singled out for a rate increase for any reason.*

SKS4AA

**NON-RENEWAL.** *The holder may elect not to renew the policy at any time by written notice to us. We guarantee to renew the policy at the end of each renewal period unless the holder fails without good and sufficient cause to duly perform in good faith any obligation pertaining to the policy, or the number of eligible persons insured is less than we require. Coverage may be continued as provided below if the policy is not renewed.*

SKS5BA

**CONTINUATION OF COVERAGE.** *You become eligible to elect continuation of coverage on the date your coverage under the policy terminates. Coverage will be continued under the continuation of coverage policy with the same benefits and provisions as under your old policy. If you elect continuation of coverage, your coverage under the new policy is effective as of the date your coverage under the old policy terminates. You may not continue coverage if termination is due to nonpayment of premium or to the lifetime maximum benefit being reached.*

SKS6AA

**CONTINUATION OF COVERGE DUE TO DEATH OR DIVORCE OF SPOUSE.** *If you are no longer eligible for coverage due to the death of, or divorce from, your spouse, your coverage will continue inforce under the policy, subject to its provisions.*

SKS7AA

**WAIVER OF PREMIUM.** *We will waive premiums starting with the first premium due after you complete the waiting period stated in the attached Benefit Exhibit. We will continue to waive premiums until no benefits have been paid for 6 months.*

SKS8BA

10. **ALZHEIMER'S DISEASE AND SIMILAR DEMENTIAS.** *Loss due to Alzheimer's Disease and similar dementias are covered subject to the provisions of the policy.*

SKS9AA

11. **PREMIUM.** *Premium rates are shown in the attached Benefit Exhibit.*

SKS10AA

12. **ADDITIONAL FEATURES.**

SKE1AA

**UNDERWRITING.** *Employees, as defined in the master application, will not be subject to underwriting if they enroll during the enrollment period stated in the master application. All other eligible classes may obtain coverage subject to our approval of evidence of insurability.*

SKE2BA

**INTERRUPTION IN CARE.** *If you have completed the waiting period, we will consider the long term care for the same or for a related condition to be continuing without interruption until 6 months pass during which you receive no long term care due to such condition. When long term care for the same or for a related condition recurs, you must complete the full waiting period before benefits again become payable and premiums are again waived for long term care due to such condition.*

SKE3BA

**ALTERNATE PLAN OF CARE.** *If you require long term care, we may pay for alternate services, devices or types of care under a written alternate plan of care. It will be developed by or with health care professionals. The plan must be mutually agreeable to you, your physician and us. It must be a medically acceptable option.*

SKE4AA

**TEMPORARY BED HOLDING BENEFIT.** *We will pay the temporary bed holding benefit stated in the Benefit Exhibit if you are temporarily absent from the nursing home due to hospitalization or other event and continue to incur a charge for a bed in the nursing home. This benefit is payable for up to 21 days per calendar year.*

SKE10AA

**RESPITE BENEFIT.** *We will pay the respite benefit stated in the attached Benefit Exhibit for up to three respite intervals per calendar year.*

**Companion Care** means care furnished during a respite interval for up to 24 hours per day by a home health care provider.

**Respite Beneficiary** means the person who benefits from the respite interval. A person who is paid for caring for you cannot be a respite beneficiary.

**Respite Interval** means a period of one or more consecutive days on which you receive long term care or companion care so that the respite beneficiary is temporarily relieved of the duties of caring for you.

SKE7BA

**CAREGIVER BENEFIT.** *We will pay the Caregiver Benefit stated in the attached Benefit Exhibit for informal care provided by an informal caregiver.*

SKE21AA

**CAREGIVER TRAINING BENEFIT.** *We will pay the caregiver training benefit stated in the attached Benefit Exhibit for training necessary for the informal caregiver to care for you in your residence.*

SKE8AA

**EMERGENCY ALERT SYSTEM BENEFIT.** *We will pay the emergency alert system benefit stated in the attached Benefit Exhibit for the rental or lease of an emergency alert system for your residence while you are receiving benefits for community based care. This is a communication system located in your residence which is used to summon medical attention in care of a medical emergency.*

SKE9AA

## ***Benefit Exhibit***

This plan is a tax qualified plan under the Health Insurance Portability and Accountability Act of 1996. Because of this, premiums may be deductible and benefits will be tax-free.

We strongly recommend you consult your tax adviser for more information.

## ***Long Term Care Benefit***

- (1) 100% of the eligible expense per day of nursing home care, not to exceed a benefit of \$90, \$120 or \$150 per day, as elected by the eligible person.
- (2) 100% of the eligible expense per day of community based care, not to exceed 50% of the benefit elected in (1) above.

An eligible expense is the actual expense incurred by you for long term care and other services covered by the policy. For community based care, it does not include the cost of transportation (except for adult day care), supplies and rent or those costs which you would incur regardless of the presence of a qualifying impairment.

## ***Waiting Period***

The waiting period begins on the date CNA receives notice of your claim and ends 90 consecutive calendar days later. You do not need to receive long term care during this period but you must have a qualifying impairment during the entire waiting period. Days of long term care received within 6 months before CNA receives the written notice will also count toward the 90-day waiting period.

## ***Lifetime Maximum Benefit***

<b><i>Daily Benefit for Nursing Home Care</i></b>	<b><i>Lifetime Maximum Multiplier</i></b>	<b><i>Corresponding Lifetime Maximum Benefit</i></b>
\$ 90	(2,000)	\$180,000
120	(2,000)	240,000
150	(2,000)	300,000
	or	
90	(5,000)	450,000
120	(5,000)	600,000
150	(5,000)	750,000
	or	
90		Unlimited
120		Unlimited
150		Unlimited

## ***Caregiver Training Benefit***

100% of the actual expense incurred, not to exceed the benefit stated below.

<b><i>Daily Benefit for Community Based Care</i></b>	<b><i>Corresponding Caregiver Training Benefit</i></b>
\$ 45	\$135
60	180
75	225

### ***Emergency Alert Benefit***

100% of the actual expense incurred, not to exceed the benefit stated below.

<b><i>Daily Benefit for Community Based Care</i></b>	<b><i>Corresponding Emergency Alert Benefit</i></b>
\$ 45	\$ 45
60	60
75	75

### ***Hospice Care Benefit***

100% of the Long Term Care Benefit payable for nursing home care, or community based care depending on where the care is received.

### ***Respite Benefit***

Daily benefit is 100% of the eligible expense not to exceed the Long Term Care benefits.

<b><i>Daily Benefit For Long Term Care</i></b>	<b><i>Corresponding Calendar Year Maximum For Respite Benefit</i></b>
\$ 90	\$1260
120	1680
150	2100

### ***Temporary Bed Holding Benefit***

Daily benefit is 100% of the eligible expense not to exceed the Long Term Care benefit, up to 21 days per year.

<b><i>Daily Benefit For Long Term Care</i></b>	<b><i>Corresponding Calendar Year Maximum For Temporary Bed Holding Benefit</i></b>
\$ 90	\$1890
120	2520
150	3150

### ***Caregiver Benefit***

25% of the Daily Benefit, up to 30 days per calendar year for a trained informal caregiver to provide care.

<b><i>Daily Benefit For Long Term Care</i></b>	<b><i>Corresponding Daily Benefit For 30 Day Caregiver Benefit</i></b>
\$ 90	\$22.50
120	30.00
150	37.50

## Monthly Rates — Group Long Term Care

### Lifetime Maximum — 2,000 x Daily Nursing Home Benefit

Age at Issue	Daily Maximum Benefit: \$90	Daily Maximum Benefit: \$120	Daily Maximum Benefit: \$150	Age at Issue	Daily Maximum Benefit: \$90	Daily Maximum Benefit: \$120	Daily Maximum Benefit: \$150
<25	\$5.08	\$6.76	\$8.46	58	43.34	57.80	72.24
25	5.80	7.74	9.66	59	47.62	63.48	79.36
26	5.90	7.86	9.82	60	52.16	69.54	86.94
27	6.06	8.08	10.10	61	56.82	75.74	94.68
28	6.24	8.32	10.40	62	61.48	81.98	102.48
29	6.44	8.60	10.74	63	65.78	87.70	109.62
30	6.66	8.88	11.08	64	69.80	93.08	116.34
31	6.90	9.20	11.50	65	74.10	98.80	123.52
32	7.22	9.62	12.02	66	79.20	105.60	132.00
33	7.62	10.16	12.70	67	85.68	114.22	142.78
34	8.10	10.80	13.48	68	93.12	124.16	155.20
35	8.62	11.50	14.38	69	101.24	135.00	168.74
36	9.22	12.28	15.36	70	110.52	147.36	184.20
37	9.84	13.12	16.40	71	121.48	161.98	202.48
38	10.50	13.98	17.48	72	134.70	179.58	224.48
39	11.16	14.88	18.60	73	150.26	200.36	250.44
40	11.88	15.84	19.80	74	167.88	223.86	279.82
41	12.66	16.88	21.10	75	187.30	249.72	312.16
42	13.44	17.92	22.40	76	208.26	277.68	347.10
43	14.26	19.02	23.76	77	230.52	307.36	384.20
44	15.08	20.10	25.12	78	253.94	338.58	423.22
45	15.94	21.26	26.58	79	278.64	371.52	464.40
46	16.92	22.56	28.20	80	304.92	406.56	508.20
47	18.02	24.02	30.04	81	332.98	443.96	554.96
48	19.18	25.58	31.98	82	363.04	484.06	605.08
49	20.40	27.20	34.00	83	395.96	527.94	659.92
50	21.78	29.04	36.28	84	431.58	575.44	719.30
51	23.36	31.16	38.94	85	468.66	624.88	781.10
52	25.30	33.74	42.16	86	505.92	674.56	843.20
53	27.58	36.76	45.96	87	542.12	722.82	903.52
54	30.10	40.14	50.18	88	577.10	769.48	961.84
55	32.92	43.90	54.86	89	611.76	815.68	1,019.60
56	36.04	48.06	60.08	90	646.28	861.72	1,077.14
57	39.48	52.64	65.80				

## Monthly Rates — Group Long Term Care

### Lifetime Maximum — 5,000 x Daily Nursing Home Benefit

Age at Issue	Daily Maximum Benefit: \$90	Daily Maximum Benefit: \$120	Daily Maximum Benefit: \$150	Age at Issue	Daily Maximum Benefit: \$90	Daily Maximum Benefit: \$120	Daily Maximum Benefit: \$150
<25	\$7.00	\$9.34	\$11.68	58	\$60.24	\$80.32	\$100.40
25	8.14	10.86	13.56	59	65.96	87.94	109.92
26	8.32	11.10	13.88	60	72.00	96.00	120.00
27	8.60	11.48	14.34	61	78.14	104.18	130.22
28	8.96	11.94	14.92	62	84.20	112.26	140.32
29	9.30	12.38	15.48	63	89.62	119.50	149.38
30	9.64	12.86	16.06	64	94.60	126.14	157.68
31	10.06	13.40	16.76	65	99.94	133.24	166.56
32	10.58	14.10	17.62	66	106.36	141.82	177.28
33	11.20	14.94	18.66	67	114.72	152.96	191.22
34	11.96	15.94	19.92	68	124.50	165.98	207.48
35	12.78	17.04	21.30	69	135.16	180.22	225.28
36	13.70	18.26	22.84	70	147.44	196.60	245.74
37	14.66	19.54	24.42	71	162.06	216.08	270.10
38	15.62	20.84	26.04	72	179.74	239.66	299.58
39	16.66	22.22	27.76	73	200.74	267.66	334.58
40	17.74	23.66	29.58	74	224.60	299.46	374.32
41	18.88	25.18	31.48	75	250.90	334.54	418.16
42	20.04	26.72	33.40	76	279.32	372.42	465.52
43	21.20	28.26	35.34	77	309.40	412.52	515.66
44	22.36	29.82	37.28	78	340.90	454.54	568.16
45	23.60	31.46	39.32	79	374.12	498.84	623.54
46	24.94	33.24	41.56	80	409.42	545.90	682.36
47	26.46	35.26	44.08	81	447.08	596.10	745.14
48	28.04	37.38	46.72	82	487.46	649.94	812.42
49	29.68	39.58	49.46	83	531.66	708.88	886.10
50	31.52	42.02	52.52	84	579.52	772.70	965.88
51	33.64	44.86	56.08	85	629.34	839.10	1,048.88
52	36.24	48.32	60.40	86	679.36	905.82	1,132.26
53	39.28	52.36	65.46	87	727.90	970.52	1,213.16
54	42.66	56.88	71.08	88	774.80	1,033.06	1,291.32
55	46.40	61.88	77.34	89	821.18	1,094.90	1,368.64
56	50.54	67.38	84.22	90	867.36	1,156.46	1,445.58
57	55.10	73.46	91.84				

## Monthly Rates — Group Long Term Care

### Lifetime Maximum — Unlimited x Daily Nursing Home Benefit

Age at Issue	Daily Maximum Benefit: \$90	Daily Maximum Benefit: \$120	Daily Maximum Benefit: \$150	Age at Issue	Daily Maximum Benefit: \$90	Daily Maximum Benefit: \$120	Daily Maximum Benefit: \$150
<25	\$11.86	\$15.80	\$19.76	58	\$72.60	\$96.80	\$121.00
25	13.24	17.66	22.08	59	78.42	104.54	130.68
26	13.24	17.66	22.08	60	84.68	112.90	141.12
27	13.24	17.66	22.08	61	91.48	121.96	152.46
28	13.24	17.66	22.08	62	98.94	131.92	164.90
29	13.24	17.66	22.08	63	106.68	142.24	177.80
30	15.22	20.30	25.38	64	114.62	152.82	191.02
31	15.22	20.30	25.38	65	123.32	164.42	205.52
32	15.22	20.30	25.38	66	133.38	177.84	222.30
33	15.22	20.30	25.38	67	145.40	193.86	242.34
34	15.22	20.30	25.38	68	158.74	211.64	264.56
35	19.02	25.36	31.68	69	173.00	230.66	288.32
36	19.02	25.36	31.68	70	189.14	252.18	315.22
37	19.02	25.36	31.68	71	208.06	277.42	346.78
38	19.02	25.36	31.68	72	230.74	307.66	384.56
39	19.02	25.36	31.68	73	256.96	342.62	428.28
40	22.28	29.70	37.14	74	286.12	381.48	476.86
41	23.56	31.40	39.24	75	318.48	424.62	530.78
42	24.92	33.24	41.54	76	354.34	472.44	590.54
43	26.38	35.16	43.96	77	393.94	525.26	656.58
44	27.92	37.22	46.52	78	437.34	583.12	728.92
45	29.56	39.42	49.26	79	484.32	645.76	807.22
46	31.36	41.82	52.26	80	530.14	706.86	883.56
47	33.34	44.44	55.56	81	579.00	772.00	965.00
48	35.42	47.22	59.02	82	631.38	841.84	1,052.28
49	37.58	50.12	62.64	83	688.74	918.32	1,147.90
50	39.96	53.28	66.58	84	750.84	1,001.12	1,251.40
51	42.64	56.84	71.06	85	815.42	1,087.22	1,359.02
52	45.76	61.02	76.26	86	880.18	1,173.58	1,466.96
53	49.30	65.74	82.16	87	942.86	1,257.14	1,571.42
54	53.18	70.90	88.62	88	1,003.22	1,337.64	1,672.04
55	57.40	76.54	95.68	89	1,062.80	1,417.08	1,771.34
56	62.04	82.72	103.40	90	1,121.96	1,495.94	1,869.92
57	67.14	89.52	111.90				

## ***Medical Insurance Plans***

The University offers retirees and their eligible dependents financial protection against a wide range of health care expenses resulting from illness or injury.

As part of the University's continuing efforts to provide benefits to meet the varying needs of its retirees, the medical benefits program offers several options. The plans available to you will depend on your age and the location in which you live. The cost for you for any of the plans available depends upon your retirement status, the plan you select, and whether you have individual or family coverage. A separate booklet describing your medical coverage will be provided to you.

### ***Enrollment Change Policy***

You may change your medical program enrollment once each year with an effective date of January 1. To make a change, you must submit a new enrollment form to the Retiree Benefits Representative during the annual enrollment period. However, in order to change to a plan which offers a broader range of benefits or pays a higher benefit, you must furnish evidence of good health for yourself and each family member. In this situation, the change will not become effective until the evidence of good health has been reviewed and approved by the University.

You and your dependents must be covered by the same medical coverage plan.

You may elect to suspend coverage for yourself and/or your covered dependents during any period that you are covered under another non-University health care plan (other than Medicare or Medicaid) that has a calendar year deductible of no greater than \$1,000 and has a coinsurance requirement of no greater than 20%. Coverage may be suspended only as of the last day of any calendar month and you must notify the Retiree Benefits Representative in advance and in writing that you wish to do so. Following the suspension of coverage, you may subsequently resume participation in this plan by requesting it no later than December 1 and coverage will resume as of the next January 1. At that time you must provide satisfactory proof that the other coverage was in effect during the period of suspension.

### ***Re-Enrollment in the Medical Program***

If you elect to terminate your medical program coverage either for yourself and/or any eligible dependents, coverage may not be reinstated at a later date except as described under the Enrollment Change Policy above.