UNIVERSITY OF MISSOURI

Retiree Insurance

Life Insurance Plan
Dependent Life Insurance Plan
Accidental Death & Dismemberment Plan
Dental Benefits Plan
Vision Benefits Plan
Medical Insurance Plans

Effective January 1, 2016
This booklet is designed to provide an overview of the University of Missouri's retiree benefit programs: life, dependent life, accidental death & dismemberment, and dental insurance. A separate booklet is provided for retiree medical insurance options.

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 an easy-to-understand manner. 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. 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 cancelled, the retiree or dependent may not re-enroll in the benefit.

If you have any questions, contact your retiree benefits representative at:

<table>
<thead>
<tr>
<th>UM myTotalRewards Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mailing Address:</td>
</tr>
<tr>
<td>myTotal Rewards</td>
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<tr>
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<td>Columbia, MO 65211</td>
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<tr>
<td>Office Address:</td>
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<td>1000 West Nifong Boulevard</td>
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<td>Columbia, MO 65211</td>
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<td>Fax:</td>
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<td>E-mail:</td>
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<tr>
<td><a href="mailto:retirement@umsystem.edu">retirement@umsystem.edu</a></td>
</tr>
<tr>
<td>Total Rewards department webpage: [<a href="http://www.umsystem.edu">http://www.umsystem.edu</a> /totalrewards](<a href="http://www.umsystem.edu">http://www.umsystem.edu</a> /totalrewards)</td>
</tr>
</tbody>
</table>
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Eligibility

Retirees
To be eligible for the retiree benefits described in this booklet, you must have been covered under the respective plan(s) immediately prior to your retirement, and one of the following:

- Retire from the University of Missouri, and immediately begin to receive retirement benefits under the UM Retirement, Disability and Death Benefit Plan, Civil Service Retirement System, Federal Retirees Retirement System or Missouri State Retirees Retirement System, OR
- Terminate employment with the university and be eligible at that time to receive retirement benefits under the University of Missouri Retirement, Disability and Death Benefit Plan, Civil Service Retirement System, Federal Retirees Retirement System or Missouri State Retirees Retirement System.

Dependent coverage
Dependent coverage is described under each benefit section in this document.

Life Insurance
To be eligible for the retiree benefits described in this section, you must have been covered under the respective plan(s) immediately prior to your 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 myTotalRewards Programs representative.

The Life Insurance plan provides your family with valuable financial protection in the event of your death. This plan offers two enrollment options: Basic and Supplemental life insurance programs.

This summary is designed to give you an overview of the major points of the Life Insurance plan. If any description in this summary differs from the policies, the terms of the policies will be followed. The Plan is underwritten by Minnesota Life under group policy number 32898G.

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 retirement benefits representative for details concerning your life insurance coverage.

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.

Cost of coverage
Basic Life Insurance
The cost of your coverage depends on the level of 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. 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:

<table>
<thead>
<tr>
<th>Age</th>
<th>Coverage Reduced</th>
<th>Percentage of Coverage Retained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Younger than 55</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>55-59</td>
<td>25%</td>
<td>75%</td>
</tr>
<tr>
<td>60-64</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>65-69</td>
<td>65%</td>
<td>35%</td>
</tr>
</tbody>
</table>

These reductions are effective on the Jan. 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), and
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 $40,000, you are age 67, and you are covered under Plan Option B (two times salary), your life insurance benefit is $28,000.

($40,000 \times 2 \times 35\% = $28,000)

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 your retiree coverage ends.

Conversion rights to an individual policy are available to you. Conversion information will be provided to you in October of the year you have, or will, achieve age 70.

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.

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 decrease your coverage at any time.

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.

Accelerated Benefits

The plan will pay accelerated benefits, up to 100% of the face amount, in lieu of death benefit for insured with a life expectancy of 12 months or less.

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 Jan.1 following your 70th birthday.

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 you will be eligible for a waiver of premiums for that coverage. This means that, starting six 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.

Dependent Life Insurance Plan

To be eligible for the retiree benefits described in this section, you must have been covered under the respective plan(s) immediately prior to their 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 myTotalRewards Programs representative.

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 26. No coverage is available for children ages 26 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 of $50,000. 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 year. You may cancel the coverage at any time by providing written notice to the myTotalRewards Programs Office. You may not add or 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 are paid to you, the beneficiary, upon receiving written proof of death.

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 myTotalRewards Programs representative in order to stop your payroll deduction.)

You can insure your spouse or sponsored adult dependent and children under this plan. Your child is eligible for coverage from 14 days of age to 26 years of age. 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 Campus Benefits Representative or Campus HR Service Delivery personnel within one month prior to your child’s attainment of the age limit. If your child is disabled, the application for continuation of Dependent status for such a Child must be made thirty-one days prior to the Child's attaining such maximum age. Review of the disability will be done as often as is deemed necessary, but in any event not less than once a year. However, it is your responsibility to notify your Campus Benefits Representative when you no longer have a spouse or sponsored adult dependent or children who are eligible for this coverage.
- The date the retiree or eligible member dies.
- The date the university discontinues this plan.

Accidental Death & Dismemberment Plan
For a university retiree to be eligible for the benefits described in this section, the retiree must have been covered under the respective plan(s) immediately prior to their 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 myTotalRewards Programs representative.

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 myTotalRewards Programs 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, shown on the next page.

This summary is designed to give you an overview of the major points of the plan. The plan is underwritten by Minnesota Life under policy number 32900G. If any description in this summary differs from the policy, the terms of the policy will be followed.

Coverage amounts available
If you are under age 70, you may select a level of coverage of $10,000, $25,000 or $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 coverage amounts available are $10,000 and $25,000. If you are 75, but younger 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 myTotalRewards Programs 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:

<table>
<thead>
<tr>
<th>Covered Dependent</th>
<th>% of Your Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse only (no children)</td>
<td>50%</td>
</tr>
<tr>
<td>Spouse and children</td>
<td>40% (spouse) and 5% (each child)</td>
</tr>
<tr>
<td>Children only (no spouse)</td>
<td>15% (each child)</td>
</tr>
</tbody>
</table>

**Eligible dependents**
You can continue to insure your spouse, if under age 80, and children under this plan. Your child is eligible for coverage from birth to 26 years of age. 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 myTotalRewards Programs representative within one month of your child’s attainment of the age limit. If your child is disabled, then the application for continuation of Dependent status for such a Child must be made 31 days prior to the Child's attaining such maximum age. Review of the disability will be done as often as is deemed necessary, but in any event not less than once a year. In the case of a child unable to support him or herself, due to a mental disability, 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.

Accidental death or dismemberment by accidental injury means that death or dismemberment results, directly and independently of all other causes, from an accidental injury which is unintended, unexpected, and unforeseen.

The injury must occur while coverage is in force. The death or dismemberment must occur within 365 days after the date of the injury and while his or her coverage is in force.

**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:

<table>
<thead>
<tr>
<th>Type of Loss</th>
<th>Percent of Amount of Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>115%</td>
</tr>
<tr>
<td>Loss of one hand and one foot</td>
<td>115%</td>
</tr>
<tr>
<td>Loss of one hand and one foot and sight of one eye</td>
<td>115%</td>
</tr>
<tr>
<td>Loss</td>
<td>Percentage</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Speech and Hearing</td>
<td>115%</td>
</tr>
<tr>
<td>Quadriplegia</td>
<td>115%</td>
</tr>
<tr>
<td>Triplegia</td>
<td>86.25%</td>
</tr>
<tr>
<td>Paraplegia</td>
<td>57.50%</td>
</tr>
<tr>
<td>Loss of one hand or one foot or one eye</td>
<td>57.50%</td>
</tr>
<tr>
<td>Speech or hearing</td>
<td>57.50%</td>
</tr>
<tr>
<td>Hemiplegia</td>
<td>57.50%</td>
</tr>
<tr>
<td>Thumb and index finger of one hand</td>
<td>28.75%</td>
</tr>
<tr>
<td>Uniplegia</td>
<td>28.75%</td>
</tr>
</tbody>
</table>

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 specific definitions that apply to the losses covered under this benefit:

- Loss of hands or feet means complete severance at or above the wrist or ankle joints.
- Loss of sight, speech, or hearing means the entire and irrecoverable loss of sight, speech, or hearing which cannot be corrected by medical or surgical treatment or by artificial means.
- Loss of thumb and index finger means complete severance of both the thumb and the index finger at or above the metacarpophalangeal joints.
- Quadriplegia means total paralysis of both upper and lower limbs.
- Triplegia means total paralysis of three members.
- Paraplegia means total paralysis of both lower limbs.
- Hemiplegia means total paralysis of upper and lower limbs on one side of the body.
- Uniplegia means total paralysis of one limb.

A benefit is not payable for both loss of thumb and index finger of one hand and the loss of one hand for injury to the same hand as a result of any one accident.

A surgically reattached hand or foot will be deemed a permanent loss if, 12 months after reattachment, the limb has regained less than 50% of its normal function. The percentage of normal function must be certified by a licensed physician.

**Disappearance Benefit**
If an insured's body has not been found after one year from the date the conveyance in which he or she was traveling disappeared, exploded, sank, became stranded, made a forced landing or was wrecked, it shall be presumed, subject to all other terms of the policy, that the insured has died as a result of an accidental injury which was unintended, unexpected and unforeseen. Such death shall be considered a covered loss.

**Exposure Benefit**
If an insured is unavoidably exposed to the elements by reason of a covered accident and suffers a loss that is included in the list of covered losses as a result of such exposure, such loss will be covered under the terms of this policy.

**Conditions under which AD&D benefits are not paid**
AD&D benefits will not be paid for losses as a result of:

- Suicide or attempted suicide, while sane; or
- Intentionally self-inflicted injury or any attempt at self-inflicted injury, while sane; or
- The insured's participation in or attempt to commit a crime, assault or felony; or
- Bodily or mental infirmity, illness or disease; or
- Medical or surgical treatment including diagnostic procedures; or
- Alcohol, drugs, unless administered on the advice of a licensed physician, poisons, gases or fumes, voluntarily taken, administered, absorbed, inhaled, ingested or injected; or
• Infection, other than pyogenic infection occurring simultaneously with, and as a result of, the accidental injury; or
• Bacterial infection, other than infection occurring simultaneously with, and as a result of, the accidental injury and bacterial infection due to accidental ingestion of a contaminated substance; or
• Travel or flight in or on any vehicle used for aerial navigation including getting in, out, on, or off such vehicle, if the insured is:
  o Riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; or
  o A student taking a flying lesson, unless riding as a passenger; or
  o Hang gliding; or
  o Parachuting, except when the insured has to make a parachute jump for self-preservation; or
• War or any act of war, whether declared or undeclared; or
• Riot or civil insurrection; or
• Service in the military of any nation

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.
• Dec. 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
If you suffer a covered loss, you or your beneficiary should provide written notice to the insurance company within 30 days. The insurance company will furnish the necessary forms which should be completed according to the instructions provided. Claims must be submitted within 90 days after the date of the loss.

Dental Benefits
For a university retiree to be eligible for the benefits described in this section, the retiree must have been covered under the respective plan(s) immediately prior to their 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 myTotalRewards Programs representative.

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.

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.

How the plan works
The dental plan utilizes a passive network. You may receive services from network providers or non-network providers. Member access is not restricted to network providers. Preventive dental care is covered at 100% of reasonable and customary charges, with no deductible. For expenses that are covered as basic or major dental care you will pay a coinsurance amount after you have satisfied your annual deductible. The coinsurance is the same regardless of whether you utilize a network or non-network provider. The dentists that have contracted to
be a part of the network have agreed to charge negotiated rates for specific services and member coinsurance rates will remain the same.

Benefits summary

<table>
<thead>
<tr>
<th>Expenses Covered</th>
<th>Plan benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type A - Preventive dental care</td>
<td>100% - no deductible</td>
</tr>
<tr>
<td>Type B - Basic dental care</td>
<td>80% - after satisfying the deductible</td>
</tr>
<tr>
<td>Type C - Major dental care</td>
<td>50% - after satisfying the deductible</td>
</tr>
</tbody>
</table>

Deductible Amounts

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>For an individual each calendar year</td>
<td>$100</td>
</tr>
<tr>
<td>For the family each calendar year</td>
<td>$300</td>
</tr>
</tbody>
</table>

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.

If you retired prior to Sept. 1, 1990 under the University of Missouri Retirement, Disability and Death Benefit Plan or Missouri State Retirees Retirement System, or if you retire under the Civil Service Retirement System, or the Federal Retirees 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 Sept. 1, 1990 under the University of Missouri Retirement, Disability and Death Benefit Plan or Missouri State Retirees 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

Note: Proof of relationship documentation is required for spouse, sponsored adult dependent and children to be covered.

Your eligible dependents include your spouse, your sponsored adult dependent and each of your natural children, stepchildren, foster children, adopted children or child placed in your home for adoption younger than age 26.

If your child is dependent on you because of a physical or mental disability they may remain covered by the plan as long as they remain incapacitated. The child must be unmarried, dependent on your or your spouse for principal financial support and 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 prior to the date he or she would otherwise become ineligible.

If you are eligible for coverage based on your employment with the University you may be covered under your own employment or you may be covered as a dependent. You may not be covered both as a dependent and as a retiree.

If you and your spouse or sponsored adult dependent work for the University and you have children, only one of you may claim the children as covered dependents.

**When benefits are payable**

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

**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 applies separately to each covered person. If the expenses applied to the deductible for all of your covered family members combined reach $300 in one calendar year, no additional deductible will be applied for any of the family members for the remainder of the year.

**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.
- 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 re-cementing 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:
  o The individual receiving the services and supplies is covered for medical benefits through the University of Missouri Medical Benefits Plan, and
  o The medical program under which the individual is covered does not cover hospital services or supplies in connection with dental services, and
  o 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:
  o 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.
  o The existing denture or bridgework cannot be made serviceable and was installed at least five years prior to its replacement.
  o 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.

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 myTotalRewards Programs representative has the proper forms.)

The claims administrator will notify you and your dentist of the estimated benefits payable based upon the course of treatment. 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 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
- Oral hygiene and dietary instruction or plaque control problems.
- 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 obliged 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 treatments 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:

<table>
<thead>
<tr>
<th>Dental service</th>
<th>Fee</th>
<th>Deductible</th>
<th>Amount plan pays</th>
<th>Amount retiree pays</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type A - Preventive services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental examination, cleaning and X-rays</td>
<td>$65</td>
<td>$0</td>
<td>$65</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Type B - Basic services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two fillings ($90 each)</td>
<td>$180</td>
<td>satisfied</td>
<td>$144</td>
<td>$36 (20%)</td>
</tr>
<tr>
<td>Two extractions ($180 each)</td>
<td>$360</td>
<td>satisfied</td>
<td>$288</td>
<td>$72 (20%)</td>
</tr>
<tr>
<td><strong>Type C - Major services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One fixed bridge</td>
<td>$750</td>
<td>$100</td>
<td>$325</td>
<td>$425 (deductible and 50% of balance)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>$1,355</td>
<td>$849</td>
<td></td>
<td>$533</td>
</tr>
</tbody>
</table>

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 a retiree, 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.)
  3. 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 18.

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 retirees.
- The applicable maximum coverage period ends.

**Application for continued coverage**

When the myTotalRewards Program 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 myTotalRewards Programs 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 myTotalRewards Programs representative or on the myTotal Rewards website (http://www.umsystem.edu/totalrewards/benefits/benefit_forms). 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 benefits are 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.
- Specific references to plan provisions for which the denial is based.
- 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.

Vision Benefits
How the Plan works
The Vision Benefit Plan is designed to help you meet vision care expenses and to encourage you to include eye care as part of your regular healthcare routine. You may select from either the Full Service Plan or the Discount Plan.

The Plan provides payment for covered vision expenses for you and your eligible dependents. The Plan offers specific coverage with designated copay and allowance amounts for materials and services obtained from VSP providers. The Plan does give allowances when you obtain services and materials from non-network providers.

Unless otherwise stated the rules apply to retirees where retirees are mentioned. If you sign up for vision coverage but, drop the coverage at a later date you cannot elect coverage again.

### Benefit Summary – VSP Choice Full Service Plan

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Frequency</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examinations</td>
<td>Once per calendar year</td>
<td>$10 copayment</td>
<td>Reimbursed up to $45 after $10 copayment</td>
</tr>
<tr>
<td><strong>Materials</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One copay of $25 applies when both lenses and frames are purchased.</td>
<td>Lenses</td>
<td>Only one type of lens will be covered every calendar year.</td>
<td></td>
</tr>
<tr>
<td>Single vision Lenses</td>
<td>Once per calendar year</td>
<td>$25.00 copayment</td>
<td>Reimbursed up to $45 after $25 copayment</td>
</tr>
<tr>
<td>Bifocal Lenses*</td>
<td>Once per calendar year</td>
<td>$25.00 copayment</td>
<td>Reimbursed up to $65 after $25 copayment</td>
</tr>
<tr>
<td>Trifocal Lenses*</td>
<td>Once per calendar year</td>
<td>$25.00 copayment</td>
<td>Reimbursed up to $85 after $25 copayment</td>
</tr>
<tr>
<td>Lenticular Lenses*</td>
<td>Once per calendar year</td>
<td>$25.00 copayment</td>
<td>Reimbursed up to $125 after $25 copayment</td>
</tr>
<tr>
<td>Polycarbonate lenses are provided for dependent children at no additional cost at in network provider locations.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frames</td>
<td>Once every other calendar year</td>
<td>$25.00 copayment</td>
<td>Reimbursed up to $47 after $25 copayment</td>
</tr>
<tr>
<td>Contact Lenses (in lieu of lenses and frames)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective</td>
<td>Once per calendar year</td>
<td>$140 allowance towards contact lens materials</td>
<td>Reimbursed up to $130</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Maximum copayment of $60 for contact lens fitting and evaluation**</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: copayment may be less but will never exceed $60</td>
<td></td>
</tr>
<tr>
<td>Medically Necessary (requires prior approval)</td>
<td>Once per calendar year</td>
<td>$25.00 copayment</td>
<td>Reimbursed up to $210 after $25 copayment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Covered in full</td>
<td></td>
</tr>
</tbody>
</table>

*Additional charge applies to no-line multi-focal lenses.

**The contact evaluation exam is in addition to the vision exam.
All Low Vision services are subject to prior approval by VSP’s Optometric Consultants.

Professional services, as necessary, for severe visual problems not correctable with regular lenses, All Low Vision services are subject to prior approval by VSP.

<table>
<thead>
<tr>
<th>Supplemental Testing</th>
<th>Maximum benefit for all Low Vision services and materials is $1,000 every two years</th>
<th>Covered in full (evaluation, diagnosis and prescription of visual aids where indicated)</th>
<th>Up to $125 (evaluation, diagnosis and prescription of visual aids where indicated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplemental Aids</td>
<td>Same as above</td>
<td>75% of approved amount up to $1,000 every two years</td>
<td>75% of approved amount up to $1,000 every two years</td>
</tr>
</tbody>
</table>

**EXTRA DISCOUNTS AND SAVINGS**

VSP offers discounts for members enrolled in the Full Service Plan.

Laser vision correction discounts are available through contracted laser centers.

**Prescription Glasses**
- Average 20-25% savings on lens extras such as scratch resistant and anti-reflective coatings and progressives
- 20% off additional prescription glasses and sunglasses*

**Contacts**
- 15% off cost of contact lens exam (fitting & evaluation)

*Available from any VSP provider within 12 months of your last covered Exam.

**Access to Services and Materials**

To access services, you call a VSP provider to make an appointment. You will need to let the provider know that you have coverage with VSP and they will then verify your eligibility with VSP prior to your appointment. VSP does not issue identification cards. To verify eligibility, plan coverage, and obtain authorization, the provider will need the UM Peoplesoft retiree identification number preceded by two 8’s.

Example of identification number for VSP:
UM Peoplesoft Retiree ID: 01234567
Alternate ID Number for VSP would be: 8801234567 (88+01234567)

All VSP providers do provide dispensing materials and services. You may, at your option, receive an exam from one provider and materials (frames, lenses or contacts) from another provider. You will need to make an appointment for the exam with one provider and then make another appointment for materials with the provider of choice. The VSP providers will contact VSP directly to verify the patient’s eligibility, plan coverage and to obtain authorization.

**VSP Providers**

You can access the University of Missouri network VSP providers at [www.vsp.com](http://www.vsp.com). You may also call VSP at 800-877-7195 for a provider directory.

**Payment for Services**

**Network Services**

When you receive services from a VSP provider, you will only need to make your copayment unless services and materials received exceed the allowed amounts. If you exceed the allowed amounts or select optional items not covered by the Plan, you will directly reimburse the provider. If the amount exceeds the allowance, there is a 20% discount on frames for the overage amount and an average 20-25% savings on additional lens options such as scratch resistant and anti-reflective coatings.

Optional items include but are not limited to:
- Frames that exceed the Plan’s allowed amount
- Tints
- Coatings
- No-line multifocal lenses

**Non-Network Services**
Services obtained through out-of-network providers are subject to the same copayment(s) and limitations as services through VSP doctors. Bills for services from out-of-network providers may be submitted within 365 days of the date of service to VSP for reimbursement up to the amounts shown in the Benefit Summary.

**Benefit Summary – Discount Option**
The Discount Option is only available to retirees and their family if no one in the family is enrolled in the Full Service plan. Retirees and their families will be automatically enrolled in the Discount Option if not enrolled in the Full Service Plan. There is no premium cost to the Discount Option. Please note that this plan is available for retirees not enrolled in the Full Service option but is not available for COBRA participants.

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well vision Exam</td>
<td>$50 with purchase of complete pair of prescription glasses.</td>
<td>once a calendar year</td>
</tr>
<tr>
<td></td>
<td>20% off without purchase</td>
<td></td>
</tr>
<tr>
<td>Lenses (with purchase of a complete pair of prescription glasses)</td>
<td>Single vision $40</td>
<td>once a calendar year</td>
</tr>
<tr>
<td></td>
<td>Lined bifocals $60</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lined Trifocals $75</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Polycarbonate for children $0</td>
<td></td>
</tr>
<tr>
<td>Frame Discount</td>
<td>25% discount when a complete pair of prescription glasses is purchased.</td>
<td>once a calendar year</td>
</tr>
<tr>
<td>Contact Lens Exam Discount</td>
<td>15% discount off the contact lens fitting and evaluation exam</td>
<td>once a calendar year</td>
</tr>
<tr>
<td>Laser vision correction</td>
<td>Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted</td>
<td></td>
</tr>
</tbody>
</table>

*The discount option is only available from a VSP provider*

**Exclusions**
- The following services and/or materials are excluded under the Vision plan.
- Vision training
- Non-prescription (plano) lenses
- Two pairs of glasses instead of bifocals
- Replacement/repair of lost/broken lenses or frames
- Medical or surgical treatment
- Services or materials covered under worker’s compensation
- Eye examinations required as a condition of employment

**Claims Questions**
If you do not understand or agree with the handling of your vision benefit, you should first contact VSP to discuss. If you do not agree with the coverage, you may appeal the decision per the following process:
Claim Denial Appeals: If, under the terms of the Policy, a claim is denied in whole or in part, a request may be submitted to VSP by Covered Person, or Covered Person's authorized representative, for a full review of the denial. Covered Person may designate any person, including his/her provider, as his/her authorized representative. References in this section to "Covered Person" include Covered Person's authorized representative, where applicable.

Initial Appeal: The request must be made within one hundred eighty (180) days following denial of a claim and should contain sufficient information to identify the Covered Person for whom the claim was denied, including the VSP Enrollee's name, the VSP Enrollee's Member Identification Number, the Covered Person's name and date of birth, the provider of services and the claim number. The Covered Person may review, during normal working hours, any documents held by VSP pertinent to the denial. The Covered Person may also submit written comments or supporting documentation concerning the claim to assist in VSP's review. VSP's response to the initial appeal, including specific reasons for the decision, shall be provided and communicated to the Covered Person as follows:

1. Prior Authorization for Visually Necessary or Appropriate Services: within thirty (30) calendar days after receipt of a request for an appeal from the Covered Person; or
2. Denied Claims for Services Rendered: within thirty (30) calendar days after receipt of a request for an appeal from the Covered Person.

Second Level Appeal: If the Covered Person disagrees with the response to the initial appeal of the claim, the Covered Person has a right to a second level appeal. Within sixty (60) calendar days after receipt of VSP's response to the initial appeal, the Covered Person may submit a second appeal to VSP along with any pertinent documentation. VSP shall communicate its final determination to the Covered Person in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for the determination.

Other Remedies: When the Covered Person has completed the appeals process stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. For additional information, you may contact the U.S. Department of Labor or the state insurance regulatory agency.

Coordination of Benefits

Coordination of Benefits with Medical Plan Administrators
Your Vision Plan has a “coordination of benefits” provision; however, due to the routine vision care benefit, overlap does not occur in most cases with your medical plan. If this should occur, your VSP provider will communicate with the patient’s physician to coordinate benefits available under both the vision and medical plans.

Coordination of Benefits with Non-Medical Plans
If you are coordinating benefits with a non-medical plan, the patient must provide the VSP provider with both covered members’ names and member ID numbers.
Determining Primary and Secondary Coverage
- The Plan that covers the patient as a retiree is primary.
- The Plan that covers the patient as a dependent is secondary.
- If the patient is a dependent child and is covered under both parent’s plans, the parent whose birth date falls first in the calendar year has the primary plan.

Coverage
The primary plan pays as if the secondary plan does not exist. If a VSP plan is the secondary plan, the patient will receive allowances (examination, lenses and frame) that will be used to pay up to, but not more than, the patient’s out-of-pocket expenses.

Options for Duplicate VSP Coverage
When a patient is covered under two VSP plans, the following options for coordinating benefits are applied:

| One pair of glasses | When the patient obtains one complete pair of glasses, the VSP benefits can be coordinated to offset plan copayment(s), lens options, and/or frame coverage. |
| Two pairs of glasses | When the patient obtains two pairs of glasses, the secondary examination amount can be applied toward out-of-pocket expenses on both complete pairs of glasses. |
| Contact lenses | When the patient receives contact lenses and an eye exam, the exam can be paid using the primary benefit. The contact lens allowances under both plans and a secondary exam amount can be applied toward the contact lenses. |
| Contact lenses & glasses | When the patient receives a complete pair of glasses and contact lenses, the exam amount available on the secondary benefit can be applied to offset out-of-pocket expenses from the complete pair of glasses and contact lenses. |

Coordination of Benefits with Out-of-Network Services
If the patient obtains services from a provider who is not part of the VSP network, the itemized bill should be sent to VSP. VSP will reimburse the eligible patient up to the contracted out-of-network allowed amount, not to exceed the actual charges.

Eligibility for Coverage
Retiree Eligibility
In order for University retirees to be eligible for the benefits described in this booklet, they must have:
1. Retire(d) from the University of Missouri and immediately began to receive retirement benefits under the University of Missouri Retirement, Disability and Death Benefit Plan, Civil Service Retirement System, Federal Retirees Retirement System or Missouri State Retirees Retirement System, or
2. Terminate(d) 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 Retirees Retirement System or Missouri State Retirees Retirement System, but elect to defer receipt of their benefits to a later date

Dependent Eligibility
Note: Proof of relationship documentation is required for spouse or sponsored adult dependent and children to be covered.

Your eligible dependents include your spouse or sponsored adult dependent and each of your natural children, stepchildren, foster children, adopted children or child placed in your home for adoption younger than age 26 (note the term "stepchild" does not include the children of your sponsored adult dependent).
If your child is dependent on you because of a physical or mental disability they may remain covered by the Plan as long as they remain incapacitated. The child must be unmarried, dependent on your or your spouse or sponsored adult dependent for principal financial support and 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 prior to the date he or she would otherwise become ineligible.

If you are eligible for coverage based on your employment with the University, you may be covered under your own employment or you may be covered as a dependent. You may not be covered both as a dependent and as a retiree.

If you and your spouse or sponsored adult dependent both work for the University and you have children, only one of you may claim the children as covered dependents.

For the purposes of this Plan, your “sponsored adult dependent” means an adult person who meets all of the following criteria:

- Has had the same principal residence as you for at least 12 months, and continues to have the same principle residence as you, disregarding temporary absences due to special circumstances including illness, education, business, vacation or military service;
  - Is 18 years of age or older;
  - Is not current married to another person under either statutory or common law;
  - Is not related to you by blood or a degree of closeness that would prohibit marriage in the law of the state in which you reside.

**Premium Payment**
The retiree pays the full cost of the premium for vision coverage.

If you are a retiree, your contribution will be made on a before-tax basis for yourself, your spouse, and any eligible dependent children, which lowers the current income taxes you pay, unless you choose to contribute on an after-tax basis. Your contribution for a sponsored adult dependent will be on an after-tax basis unless the sponsored adult dependent is a qualified tax dependent under IRS rules. Please note that retirees may only make premium payments on an after-tax basis. For more details about how the before-tax feature works, refer to your Flexible Benefits Plan booklet.

**Coverage Begin Date**

**Retiree**
Coverage begins on the first of the year following the annual enrollment period.

**Dependent**
Dependent coverage becomes effective on the date the retiree personal coverage becomes effective, provided you have completed and returned the Plan enrollment form with each dependent’s name and Social Security number listed. If, after your coverage becomes effective, you acquire a new dependent — by marriage, for example — you have 31 days to obtain coverage by completing the appropriate enrollment form and returning it to your Campus Benefits Representative.

In the case of an adopted child or a child placed in your home for adoption, you also have 31 days to obtain coverage from the date the child is placed in your custody.

It is your responsibility to notify the University of the addition of a dependent or of any changes in your family status. Contact your Campus Benefits Representative to obtain any necessary forms. In instances where applications for enrollment are submitted subsequent to 31 days following the initial date of eligibility, two situations may apply.

1. If a specific premium contribution is required for coverage (i.e., coverage for other children did not already exist), coverage will become effective on the date a properly completed enrollment form
(including proof of relationship) is submitted to your campus benefits representative provided it is done so within 180 days from the date the child was first eligible. If the enrollment form is submitted after 180 days, coverage will not become effective until the following January 1.

2. If a specific premium is not required for coverage (i.e., coverage already exists for other eligible dependent children), coverage will be made effective on the date the child first became eligible for coverage. However, before claims can be paid, a properly completed enrollment form (including proof of relationship) must be submitted to your Campus Benefits Representative.

Changing Coverage - Qualifying Family/Employment Status Changes
You may change your coverage level (including beginning or ending coverage or adding or dropping dependents) during the Plan year only if you have a qualifying family/employment status change. Please note that retirees may not add a spouse or sponsored adult dependent or child dependent to the Plan as a result of a family status change.

Qualifying family/employment status changes are limited to:
- marriage, divorce, legal separation or annulment
- death of a spouse or sponsored adult dependent
- a change in the number of dependent children as a result of birth, death, adoption or placement of a child for adoption
- the termination or commencement of employment of your spouse or sponsored adult dependent
- a change in your work schedule, or that of your spouse or sponsored adult dependent, that involves an increase or decrease in work hours, a strike, a lockout or an unpaid leave of absence
- a change in residence or worksite location of you, or your spouse or sponsored adult dependent
- receipt by the University of a valid Notice of Order to Enroll under Missouri law
- a change in entitlement to Medicare or Medicaid for you, your spouse or sponsored adult dependent or a dependent child
- a significant change in health coverage provided by your spouse or sponsored adult dependent’s employer that affects you or your spouse or sponsored adult dependent
- a leave of absence under the Family and Medical Leave Act of 1993 (FMLA)

If any of these qualifying family/employment status changes occur, you may change your level of coverage provided the change is consistent with the status change itself. Contact your Campus Benefits Representative to complete the appropriate form, which must be completed and returned within 31 days of the date of the status change. After that, changes can be made only during the annual enrollment change period, except as required by the Health Insurance Portability and Accountability Act (HIPAA), described later in this section.

Benefit changes, when made within 31 days as described above, will be effective as follows:
- changes due to birth, adoption, placement of a child for adoption or death will be effective on the date of the event.
- changes resulting from all other qualifying family/employment status changes will be effective on the day the completed enrollment form is received by your Campus Benefits Representative.

Under the Health Insurance Portability and Accountability Act, you or an eligible dependent may also enroll for coverage if:
1. You are an eligible dependent declined coverage under the University plan because you had other coverage, and
2. The other coverage ends, and
3. You contact your Benefits Representative and complete an enrollment form and provide written proof that the other coverage ended for the individual involved within 31 days after this event occurs.

OR
1. You declined coverage under the University Plan because you had other coverage, and
2. your dependents other coverage ends, and
3. you contact your Benefits Representative and complete an enrollment form and provide written proof that the other coverage ended for the individual involved within 31 days after this event occurs.

OR

1. Due to marriage, birth, adoption or placement for adoption- for these specific situations eligible dependents include your spouse or sponsored adult dependent and newly acquired child/ren dependent/s (existing child dependents are not eligible for enrollment). You must enroll within 31 days of the event. This is called a special enrollment period. Coverage will be effective on the date of the event provided your enrollment form is received by your Benefits Representative within 31 days of the date of the event.

Coverage Termination
Your vision coverage will end on the earlier of the following dates:
- Coverage will end on the last day of the month of the employment termination
- When you are no longer eligible for coverage.
- When you cease making the required vision 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.

Coverage after Retiree Death
If you die while actively employed by the University and after becoming vested in the University Retirement Plan (completed at least 5 years of creditable service), or if you would be vested if you were covered under the University Retirement Plan instead of the Civil Service Retirement Plan or the Federal Retirees Retirement Plan, your eligible spouse or sponsored adult dependent may continue coverage after your death. In addition, the continuation of coverage is available for your children, but only when spouse or sponsored adult dependent coverage is also continued. The continuation of coverage under this provision is subject to the payment of monthly contributions by the spouse or sponsored adult dependent. An eligible spouse, for the purposes of this provision is the spouse to whom you were married on the date of your death, provided you had been married to this spouse for at least one year preceding your death. An eligible sponsored adult dependent, for the purposes of this provision is the sponsored adult dependent for whom you provided an affirmation with the university of a sponsored adult partnership at least one year preceding your death.

If you die after retirement from the University, your eligible spouse or sponsored adult dependent may continue coverage after your death, as described above, including coverage for your children. It is important to note, however, that the coverage for the spouse or sponsored adult dependent of a retiree is available only to the person to whom the retiree was married or had an affirmation of sponsored adult partnership with the university on the day preceding the date of retirement.

No continued coverage is available for children unless the spouse or sponsored adult dependent is also covered.

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

Continued coverage 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 with respect to your class of eligible retirees.
• The end of the period for which any required contributions have been made.

Continuation of Vision Plan Coverage (COBRA)
Federal law, pursuant to the Consolidated Omnibus Budget Reconciliation Act (COBRA), requires the Plan to offer covered retirees and dependents the opportunity to continue Vision Plan coverage when the individual's coverage 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
A retiree and covered dependents may continue vision coverage for up to 18 months if coverage ends because of either a reduction in the number of hours worked or termination of employment for any reason other than gross misconduct.

Dependents may continue their vision 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.
• 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 you leave the company or 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 occurs.

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 vision plan, unless coverage under the other plan is limited due to the individual's pre-existing condition.
• The Plan terminates for all retirees.
• The applicable maximum coverage period ends.

Extension of Maximum Coverage Period
Disabled individuals — An exception applies if a retiree or a dependent is determined to be totally disabled during the first 60 days of continued vision coverage due to a reduction in hours worked or termination of employment. The maximum coverage period for the disabled individual will be 29 months, rather than 18 months. In order to be eligible for the extended period, the disabled individual must meet the definition of disability under the Social Security Act and notify the University during the first 18 months of continued coverage and within 60 days after the date of determination of disability has been made by Social Security. (The disabled individual is required to notify the University within 30 days after any final determination by the Social Security Administration that the individual is no longer disabled.)

Dependents of a retiree entitled to Medicare — If a retiree becomes entitled to Medicare, the maximum coverage period for dependents will not end until at least 36 months after the date on which the retiree became entitled to Medicare.

Divorced or widowed spouses or sponsored adult dependents at least age 55 — Medical coverage can continue beyond the COBRA period if the continuation coverage under the Plan expires when a divorced or
widowed spouse or sponsored adult dependent is at least age 55. Coverage can continue for the spouse or sponsored adult dependent and eligible dependents until the sponsored adult dependent reaches age 65.

Application for Continued Coverage

When the Campus Benefits Representative 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 sponsored adult dependent or your covered child must notify the Campus 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 on a monthly basis the total cost of that coverage plus any additional amount permitted by law. Your first payment for continued coverage must be made within 45 days of the date you sign the election form. Your 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 vision coverage you or your dependent would have been entitled to if your retiree or his or her dependent status had not changed. Any future changes in the benefits or cost of coverage for the Plan also will apply to you.

Extended Benefits

Benefits will be payable for covered expenses incurred in connection with vision services and materials which were ordered while the individual was covered under this plan if the item is finally delivered to such individual within 60 days after termination of coverage.

Confidentiality of Information

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan’s privacy notice, which was distributed to you upon enrollment and is available from the benefits manager.

This Plan, and the University, will not use or further disclose information that is protected by HIPAA (“protected health information”) except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA’s privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or retiree benefit plan of the University.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with
the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan maintains a privacy notice, which provides a complete description of your rights under HIPAA’s privacy rules. For a copy of the notice, please contact your Campus Benefits Representative. If you have questions about the privacy of your health information or wish to file a complaint under HIPAA, please contact the Privacy Officer identified in the privacy notice.

**Medical Insurance Plans**
For a university retiree to be eligible for the benefits described in this section, the retiree must have been covered under the respective plan(s) immediately prior to their 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 *myTotalRewards* Programs representative.

The university offers retirees and their eligible dependents financial protection against a wide range of healthcare expenses.

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 Medicare eligibility. 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 Summary Plan Description (SPD) describing your medical coverage is available online at [umurl.us/SPD](http://umurl.us/SPD).

**Enrollment change policy**
You may change your medical program enrollment once each year with an effective date of Jan. 1. To make a change, you must submit a new enrollment form to the *myTotalRewards* Programs representative during the annual enrollment period. 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 healthcare plan (other than Medicare or Medicaid) that has a calendar year deductible of no greater than $1,500 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 *myTotalRewards* Programs 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 during Annual Enrollment and coverage will resume as of the next Jan. 1. At that time you must provide satisfactory proof that the other comparable 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.