State University System

UCF Financial Wellness with Long Term Disability

April 3, 2019

TheStandard®

About The Standard

Deep Expertise in Nonmedical Benefits

Life and Disability are our core specialties.

For more than a century, we've helped people protect their families and their futures. By keeping our promises, we've built a national reputation for quality products, personalized service and strong financial performance.

Founded in
1906
in Portland, Oregon

89%
of company revenue comes from **employee benefits** (Life & Disability)

A Excellent
A.M. Best Company

A+ Strong
Standard & Poor's

A1 Good
Moody's

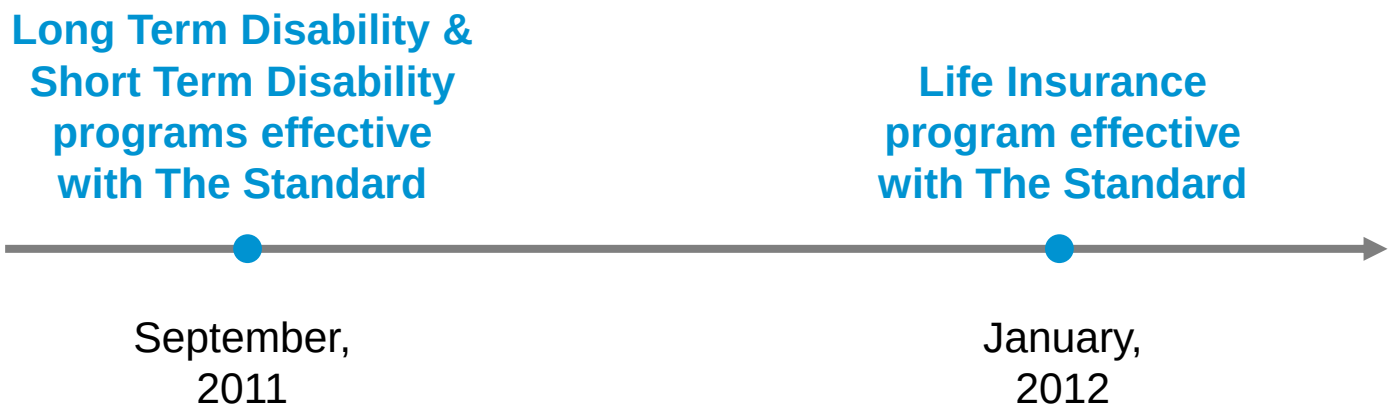
These ratings are for Standard Insurance Company as of January 2018.

Our Corporate Values

IMAGINE POSSIBILITIES	We anticipate what's needed for future success.
DO WHAT MATTERS	We act in the best interest of our customers – internal and external.
CARE ABOUT PEOPLE	We care about each other, our customers and our community.
ENSURE A SUSTAINABLE FUTURE	We make decisions with the short- and long-term impact in mind.
TAKE THE HIGH ROAD	We conduct business with the highest ethical standards.
OWN YOUR CHOICES	We take responsibility for the choices we make.

Current Products and Services

Historical Summary of Products & Services



DisabilityCanHappen.org

30-Day Plan

- Combination of Short Term and Long Term Disability coverage
- 24-hour coverage
- 3/12 pre-ex limitation
- Partial disability included (STD) and partial disability definition (LTD)
- Temporary recovery period included

	STD	LTD
Benefits Begin	On the 31st day	On the 91st day
Maximum Benefit Period	9 weeks	To age 65 or SSNRA
Benefit Percentage	66 2/3% of weekly predisability earnings	60% of monthly predisability earnings
Minimum/Maximum Benefit Amounts	Min. = $25/week* Max. = $3,462/week	Min. = $100/month* Max. = $15,000/month

* Or 10% of your benefit, whichever is greater

90-Day Plan

- No Short Term Disability coverage with this option
- 24-hour coverage
- 3/12 pre-ex limitation
- Partial disability definition
- Temporary recovery period included

	LTD
Benefits Begin	On the 91st day
Maximum Benefit Period	To age 65 or SSNRA
Benefit Percentage	60% of monthly predisability earnings
Minimum/Maximum Benefit Amounts	Min. = $100/month*; Max. = $15,000/month

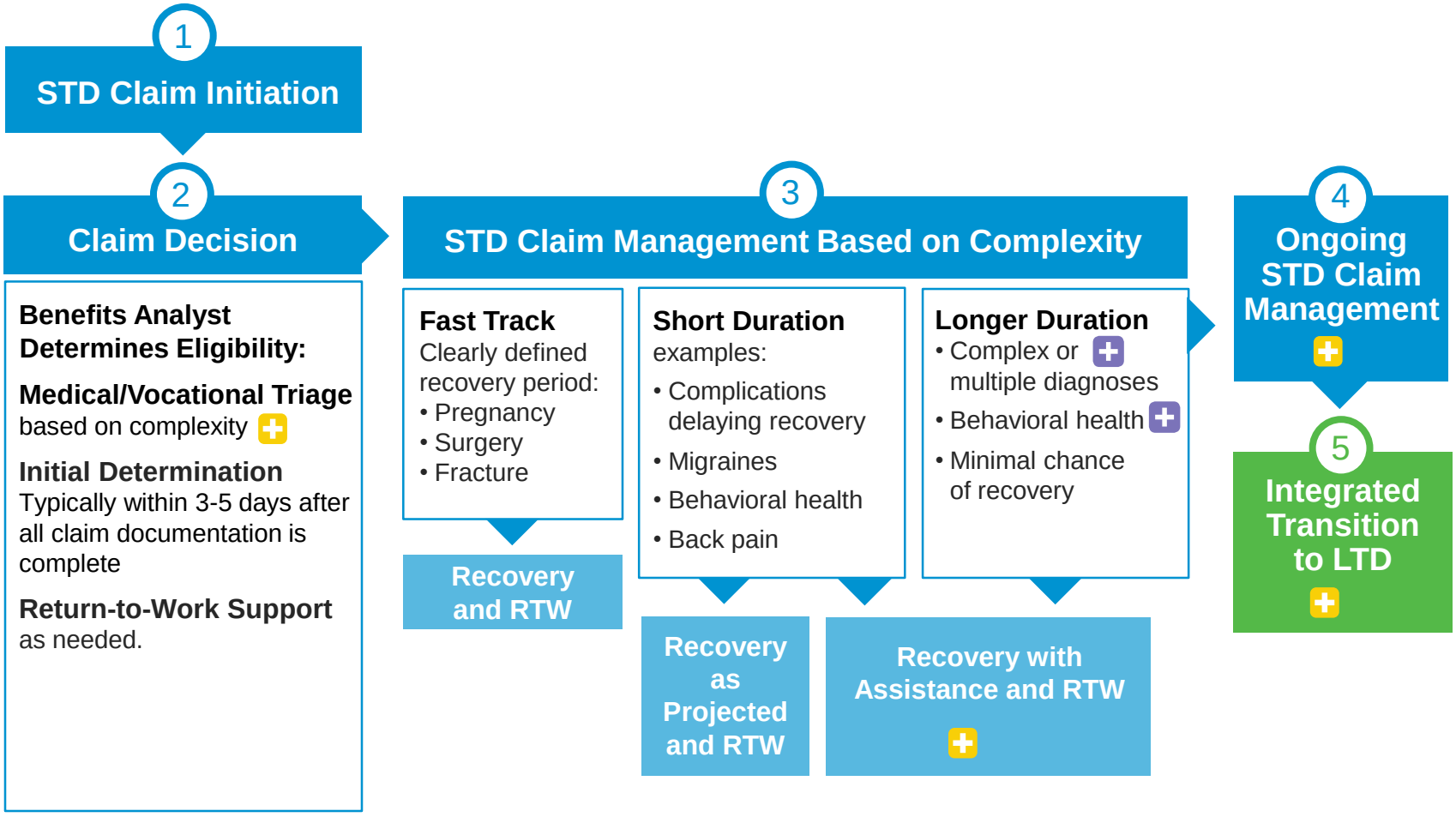
* Or 10% of your LTD benefit, whichever is greater

Key Provisions of the LTD Plan

The following enhancements are exclusive to the LTD benefits:

- **Assisted Living Benefit**
  Increases benefit to 80% for catastrophic disabilities
- **Lifetime Security Benefit**
  Extends LTD benefits beyond the Maximum Benefit Period
- **Annuity Contribution Benefit**
  11% of monthly PDEs deposited in an annuity
- **Family Care Expense Benefit**
  Reduces work earnings for qualified expenses
- **$25,000 Reasonable Accommodation Expense Benefit**
  Used for approved worksite modifications
- **Cost of Living Adjustment**
  Increases LTD benefit annually
- **Survivor Benefit**
  Three months' of benefits with no offsets

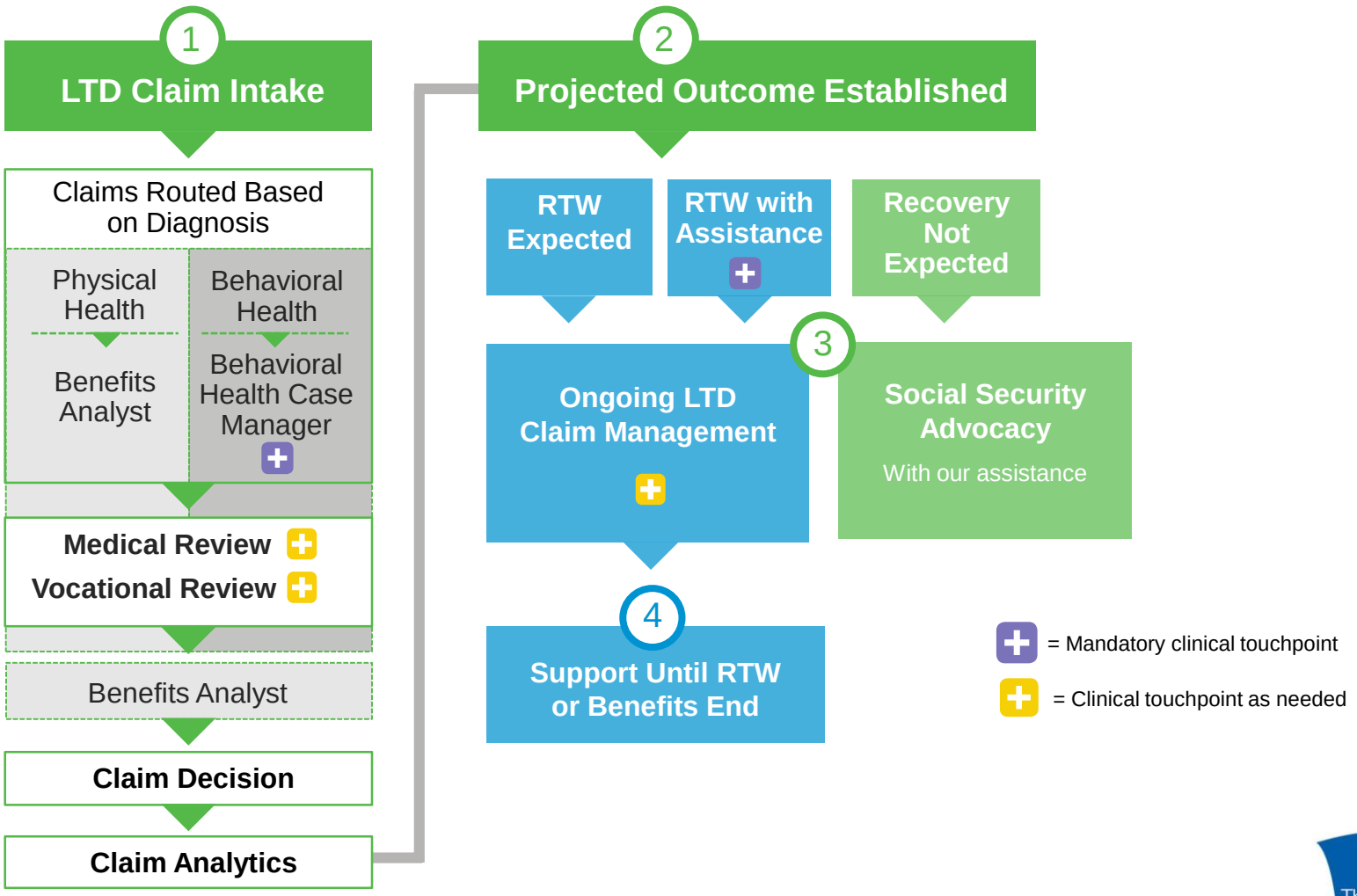
Our STD Claim Process



= Clinical touchpoint as needed

= Mandatory clinical touchpoint

Our LTD Claim Process



Frequently Asked Questions

What is the process after a claim is filed?

Paper claims can be submitted by fax or postal mail. When we receive any portion of the claim packet, The Standard sets up the claim and confirms receipt by letter with a description of any missing claim documentation. The employee is responsible for completing and returning all necessary statements to The Standard. Employers can submit their information electronically via AdminEASE or by paper.

For claims with an incomplete status, we send the employee updates at least every 15 work days until we receive all necessary forms. Once all information is received, the Intake team notifies the employee that the claim is complete. We then assign the claim to a Benefits Examiner or Benefits Analyst for review.

Following assignment, we review the claim based on the available information and the contract and make an initial decision within 3-5 business days for STD claims and 7 days for LTD. If we need additional information to reach a final decision, the Benefits Examiner/Analyst will request this information and actively follow up to avoid unnecessary delay. The Benefits Examiner/Analyst will notify the disabled employee of the investigation status by letter every 15 days. We notify the employee and employer via letter once we have reached a decision.

As part of this decision process, the Benefits Examiner/Analyst, may request input from a Nurse Case Manager, Mental Health Case Manager and Vocational Case Manager, as needed. The Nurse Case Manager or Mental Health Case Manager focuses on medical information to determine limitations, treatment and potential for return to work. The Vocational Case Manager establishes the physical demands and material duties of the disabled employee's own occupation. For benefits to become and remain payable, the medical documentation not just the diagnosis, must substantiate the level of impairment.

Once we approve a claim, we work with our team of Nurse Case Managers and Vocational Case Managers to manage appropriate duration and limitations for each claim. We advise the disabled employee of the duration for which the claim is approved, and we provide instructions on how to request an extension of benefits, if appropriate. We base our follow-up activities on the diagnosis, expected date of recovery or expected return-to-work date.

How are Maternity Benefits Paid?

Benefits become payable after the benefit waiting period has been satisfied.

Benefits are paid only for the period of disability following the benefit waiting period.

For all occupations, claimants are considered disabled for six weeks after a vaginal delivery and eight weeks for a C-section. The disability period may be extended if complications arise.

No benefits are payable for child-parent bonding or child illness.

Maternity claims can be initiated as early as 30 days in advance of the expected date of delivery.

For more information, go to https://www.standard.com/eforms/16118.pdf

How is the date of disability determined?

We rely on information provided by the treating physician to determine the disability date. Depending on the nature of the disability, this may be the date of a planned surgery or may be the day after the last day worked.

Does this date ever vary?

Occasionally, there may be discrepancies on this date. However, we must have reasonable medical support for the established date of disability.

How are offsets applied to the benefit?

The method of applying an offset depends on the type of income and may also be impacted by how and when it is received (lump sum vs. for the period). Please refer to the issued policy for details. If an employee is receiving sick pay, annual or personal leave pay or other salary continuation, we will reduce the benefit dollar for dollar by the amount received for the same time period of the claim. Similarly, Social Security benefits including Social Security Dependent benefits are offset dollar for dollar. Those working while disabled have another method for offsetting those work earnings. For example, if an employee who has been off work for 6 months is improving medically and is able to return to work part time, we would only offset the amount that exceeds 100% of their predisability earnings when combining the work earnings and gross benefit for the first 24 months.

Is deductible income often received after benefits begin?

Yes, this is most common with the pursuit of Social Security Disability benefits. Typically, the Social Security administration will deny a claim at the initial level and additional appeals and pursuit occurs at the reconsideration and hearings level. As a result, when an approval determination is made, benefits are paid retroactively. The process often takes 1-2 years so when paid retroactively, an overpayment on the claim occurs.

The Standard assists employees in pursuing Social Security through the various stages. We fully explain the impact of other income and the potential for overpayment at the beginning of the claims process. When assisting in the pursuit, we also provide overpayment repayment services to repay this directly to the claim once Social Security is approved.

What are the most common offsets?

The most common offsets include employer sick pay, salary continuation, Social Security benefits and retirement benefits. While not listed in either the Deductible Income provision or the Exceptions of Deductible Income, military retirement benefits and VA/Veterans Affairs pension benefits are not deductible.

How is the Own Occupation definition of disability determined?

During the first 24 months, disability is based on one's Own Occupation. Thus, disability is defined being unable to perform with reasonable continuity the material duties of his/her own occupation as a result of a physical disease, injury, pregnancy or mental disorder. In determining the demands of one's own occupation, we review the job title in conjunction with the physical and mental demands provided within the job description or job analysis form completed by the employer. We then evaluate the information the disabled employee's physician provides to determine how completely and objectively it documents limitations and restrictions and the disabled employee's prognosis.

How is the Any Occupation definition of disability determined?

After 24 months, continuation of benefits is based on an inability to perform Any Occupation for which he/she is reasonably fitted by education, training, and experience. When reviewing a claim to determine if benefits will remain payable beyond the change in the definition of disability, the Benefits Analyst works with the Nurse Case Manager and Vocational Case Manager. While each claim is unique, and review steps may vary from claim to claim, the general outline of our review process follows:

- The Benefits Analyst refers the medical information to a Nurse Case Manager and/or Physician Consultant to determine the individual's current medical status, specifically related to limitations and restrictions, as well as to prognosis.
- If the medical review indicates that the disabled employee has work ability, the Benefits Analyst identifies an appropriate wage range and labor market and refers the file to a Vocational Case Manager for review.
- The Vocational Case Manager identifies suitable alternative occupations based on the information from the Benefits Analyst, considering factors such as the employee's education, training, experience, reasonable wage expectations and, from a medical standpoint, the individual's ability to work. The Vocational Case Manager may conduct a transferable skills analysis and/or labor market study, as needed. After this review, the file is returned to the Benefits Analyst.
- The Benefits Analyst is responsible for assessing all the available medical and vocational reviews and contract provisions to reach a determination regarding the individual's ability to perform "any occupation" as defined by the policy.

How does the Lifetime Security Benefit work?

The Lifetime Security Benefit extends benefits beyond the regular Maximum Benefit Period for severely disabled employees whose inability to perform two or more Activities of Daily Living (bathing, continence, dressing, eating, toileting and transferring) or severe cognitive impairment is expected to last 90 days or more. One year before the maximum benefit period, we review the claim for eligibility for this benefit by requesting a disabled employee complete an activities of daily living (ADL) questionnaire and obtaining updated medical information. If we determine the disabled employee is eligible for this benefit, a separate claim will be set up and begin paying after the LTD claim closes at the maximum benefit period. We will continue to review ongoing eligibility for this benefit with periodic medical updates and ADL questionnaires.

How does the Assisted Living Benefit work?

The Assisted Living Benefit is a modified Long Term Care-style benefit that is offered to severely disabled employees requiring additional care. This contract provision increases the Long Term Disability (LTD) benefit by 20% for claimants unable to perform two or more Activities of Daily Living or suffering severe cognitive impairment and expected to last 90 days or more. The maximum benefit amount cannot exceed $5,000 in addition to the LTD benefit. When the LTD claim is approved, we will review for eligibility for this benefit. Similar to the Lifetime Security Benefit, we evaluate the medical information and request completion of the activities of daily living (ADL) questionnaire. If we determine the disabled employee is eligible for this benefit, a separate claim will be set up and will pay concurrently with the LTD claim.

What are the common reasons claims are denied?

The most common reasons for denials are failure to provide proof of loss (i.e. the initial claim forms), pre-existing conditions, returned/recovery during the benefit waiting period and not disabled from own occupation. We consider number of claims denied proprietary information.

What happens when a claimant returns to work from an approved disability?

If you cease to be a Member because of a covered Disability following the Benefit Waiting Period, your insurance will end; however, if you become a Member again immediately after LTD Benefits end, the Eligibility Waiting Period will be waived and, with respect to the condition(s) for which LTD Benefits were payable, the Preexisting Condition Exclusion will be applied as if your insurance had remained in effect during that period of Disability.

The Preexisting Conditions Exclusion will be applied as if insurance had remained in effect in the following instances:

a. If you become insured again within 90 days.

b. If required by federal or state-mandated family or medical leave act or law and you become insured again immediately following the period allowed under the family or medical leave act or law.

In no event will insurance be retroactive.

Questions?