This contains only a summary of plan benefits. University of Miami reserves the right, at its discretion, to amend, revise, or terminate any benefit program at any time.
# MEDICAL INSURANCE

- What the Plan Can Do For You ...
- Dependent Coverage ...
- Surcharges ...
- Qualifying Status Changes ...
- HIPAA, PHI and GINA ...
- CHIP ...
- Newborns’ Act Disclosure ...
- Women’s Health And Cancer Rights ...
- Summaries of Benefits and Coverages ...
- Glossary of Common Terms ...
- Coordination of Benefits ...
- Hospital Services Covered ...
- Other Covered Benefits ...
- What is Not Covered ...
- Well Child Care ...
- Preventive Care ...
- Hospice Care ...
- Second Surgical Opinion ...
- Travel Medical Benefits ...
- Bariatric Surgery ...
- UHealth Imaging ...
- Aetna ...
- Pharmacy Plan ...
- Aetna Rx Home Delivery (Mail Order Benefit) ...
- Maintenance Choice at CVS (Retail Pharmacy Benefit) ...
- Generic Incentives ...
- Step Therapy ...
- HRA Fund ...
- Deductibles ...
- Annual Out-Of-Pocket Maximums ...
- Concordia Behavioral Health ...
- Autism and other Pervasive Developmental Disorders ...
- Enhanced Benefits for Learning Disabled Children ...
- Termination and Continuation of Coverage ...
<table>
<thead>
<tr>
<th>Claims</th>
<th>56</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subrogation</td>
<td>57</td>
</tr>
<tr>
<td>Qualified Medical Child Support Order (QMCSO)</td>
<td>58</td>
</tr>
<tr>
<td>Early Retirement</td>
<td>58</td>
</tr>
<tr>
<td>Retirees over 65</td>
<td>58</td>
</tr>
<tr>
<td>Long Term Disability</td>
<td>58</td>
</tr>
<tr>
<td>Faculty/ Staff Assistance Program</td>
<td>58</td>
</tr>
<tr>
<td>Vision Benefit</td>
<td>58</td>
</tr>
</tbody>
</table>
Health Care Insurance

What the Plan Can Do For You

The University of Miami group health insurance offers you valuable protection against the cost of health care. The four plan options cover the same medical services, but differ primarily in the design of their provider networks and out of pocket expense options.

You are eligible to join the University of Miami health care plans if you are a regular full-time or part-time faculty, staff or members of affiliates working at least 50% full-time effort. Coverage will begin on your date of hire.

Enrollment must be completed via benefits enrollment in Workday. If enrollment is not completed within 15 days after date of hire, you will not be eligible to enroll until the following Open Enrollment period unless a Qualified Status Change occurs.

Health care premiums are deducted on a pre-tax basis with salary reduction equal to the current cost of coverage selected. Once elected, the employee’s income, which is subject to Federal income tax and Social Security withholding (FICA), will be reduced. This may affect future amounts received from Social Security. Except for Qualified Status Changes, elections for group health insurance may not be changed during the Plan year.

The amount of your premium will depend on the plan option you choose and whether you elect to cover eligible family members. Only UM/UMH employees permanently residing outside of Miami-Dade or Broward counties are eligible to elect the HRA Out of Area plan. Eligibility is determined by HR-Benefits. Election for this plan may only be made upon first enrollment into the health plan or during Open Enrollment.

Health care costs are subsidized by the University at approximately 80%. The University’s health plan is self-insured, so premium equivalent rates are developed and evaluated annually. Since these are premium equivalents and not actual insured premiums, they are subject to change.

Dependent Coverage

Eligible dependents may be enrolled at the time the employee enrolls. Enrollments can also occur during an Open Enrollment period or at the time of a Qualified Status Change.

A dependent is defined as the child of the subscriber, provided that the following conditions apply:

- The child is the biological child or stepchild of the subscriber or legally adopted child (from the moment of placement in compliance with Florida law) in the custody of the subscriber; written evidence of adoption must be furnished to the Plan Administrator upon request. Except as specifically noted, the child must meet all requirements for eligibility listed herein:
  1. The child has not reached the Limiting Age which is defined in this Section as the last day of the birth month in which he/she turns age 26 (except for paragraph b) below);
  2. Coverage will be extended where the child is either physically incapacitated or mentally challenged, is not capable of supporting him or herself and regularly receives over 50% of his/her support from the subscriber, provided that the dependent was covered under the University’s Group Health Plan prior to reaching the age 26.
    a. Proof of incapacitation or mental challenge (e.g. written documentation from the child’s physician) is required for coverage after the child has reached the age 26.
    b. Coverage for dependent child who is physically incapacitated or mentally challenged may be discontinued at the end of the calendar month in which the child reaches age 26 and/or:
       i. the child is no longer disabled; or
       ii. the child is capable of supporting him or herself; or
       iii. the child no longer receives more than 50% of his/her support from the subscriber; or
iv. the child receives less than 50% of his/her support from the subscriber and the subscriber is no longer obligated to provide medical care for said child by court order.

3. Coverage will be extended where the subscriber has agreed to regularly provide medical care for the child by court order regardless of adoption.

4. Coverage will be extended where a Qualified Medical Child Support Order (QMSCO) exists; Whether or not said child resides with the employee.

5. A newborn child of a covered dependent child is ineligible for medical coverage after delivery

- Your legally recognized spouse. This includes same-sex spouses who are legally married in any state or jurisdiction.
- Same sex domestic partner provided the relationship has existed for at least 12 consecutive months, the domestic partner shares living arrangements and a state of financial co-dependency exists. Neither partner may be married to anyone else. Coverage is available for eligible dependent children of a same sex domestic partner as well. When requesting coverage for a same sex domestic partner via Workday, eligibility requirements, documentation and tax consequences may be reviewed with potential enrollees.

For all covered dependents, proof of relationship is required in the applicable form of a government issued marriage license, government issued birth certificate, divorce decree, etc. The University reserves the right to audit employee records and request these documents at any time if not already on file. If the documents cannot be provided to the University within a reasonable amount of time when requested, we reserve the right to terminate coverage for the applicable dependent.

**Surcharges**

If you are a smoker, your monthly premium will be increased by $100, and if your spouse/same sex domestic partner is a smoker, your monthly premium will be increased by an additional $100. Therefore, if you and your spouse/same sex domestic partner are smokers, your monthly premium will be increased by $200. To waive this surcharge, the individual must have been smoke free for 12 months at the time of initial enrollment or annual Open Enrollment, or the individual must have successfully completed the University’s BeSmokeFree smoking cessation program. The non-smoker certification field must be completed via Workday. If it is medically unadvisable for the employee/spouse to complete the smoking-cessation program or to quit smoking, please contact HR-Benefits to request an alternative to have the surcharge waived.

A $250 monthly spousal surcharge will apply to spouses/same sex domestic partners who are eligible to participate in their employer sponsored medical plan but choose to participate in the University’s group medical plan. The surcharge will be waived if the spouse/same sex domestic partner does not have access to medical coverage through his/her employer. To waive this surcharge, the spousal surcharge field must be completed via Workday. If a spouse/same sex domestic partner becomes eligible for or loses coverage during the plan year, HR-Benefits must be notified of the change within 30 days of the change via Workday.

**Qualifying Status Changes**

IRS Section 125 rules regarding pre-tax premium plans do not allow for enrollment, additions, changes, or cancellations except with the occurrence of a Qualifying Status Change (QSC) event, followed by written application for a change within 30 days or during the annual open enrollment period. The federal government determines the events that qualify as QSCs, and this list is subject to periodic change.

After declining health coverage. If you are declining enrollment in the Health Care Plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependents in these plans in the future, provided that you request enrollment within 30 days after your other coverage ends.
New dependents. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

The following are additional events, but not necessarily all, valid QSC events:
- Loss of coverage through Medicaid or other SCHIP or new enrollment in Medicaid or other SCHIP
- Change in employment status of employee, spouse, or dependent including:
  1. Termination of spouse’s or dependent’s employment
  2. Unpaid leave of absence over 30 calendar days
  3. Change from part-time to full-time status or vice versa

An enrollee wishing to change a benefit election on the basis of a QSC must complete the following steps:
1. Report the QSC to HR-Benefits via Workday and requesting the corresponding change to benefits.
2. Provide required supporting documentation (e.g., government issued marriage certificate, government issued birth certificate, divorce decree, etc.). QSCs cannot be processed without the corresponding required supporting documentation.
3. HR-Benefits must receive the request via Workday and related documentation within 30 days of the QSC event or the request for change(s) will be denied and cannot be made until the next annual open enrollment period. NOTE: The enrollee should report the event immediately if supporting documentation is not readily available; a period of 60 days may be allowed to provide the necessary documentation. For Medicaid or other SCHIP events, a period of 60 days is allowed to make a change.

Termination of dependents. If you have a spouse, domestic partner or child who no longer qualifies for coverage, you are required to notify HR-Benefits via Workday within 30 days of the event in order to remove the individual from coverage.

Non Compliance. Falsifying information/documentation in order to obtain/continue insurance coverage is considered a dishonest act and could lead to disciplinary action and criminal prosecution. Inadvertent or negligent failures to update or correct information related to eligibility of an employee’s listed dependent are also subject to penalty. Employees are responsible for updating dependent information within 30 calendar days of the occurrence of any event affecting eligibility; for example, a divorce severing a marriage. The University may impose a financial penalty, including, but not limited to, repayment of all insurance premiums the university made on behalf of the ineligible dependent and/or any claims paid by the insurance companies. Disciplinary action up to and including dismissal may also be imposed if deemed appropriate.

To make an enrollment change based on a QSC, the QSC must result in a gain or loss of eligibility for coverage, and general consistency rules must be met. For example, if an enrollee with family health insurance coverage is divorced and no longer has dependents, that enrollee may change from family to individual coverage but cannot cancel enrollment in health insurance because the QSC merely changes the level of coverage eligibility. Cancellation would not be consistent with the nature of the QSC event.

Health Insurance Portability and Accountability Act (HIPAA), Protected Health Information (PHI) and Genetic Information Nondiscrimination (GINA)
The Aetna plan conforms to the standards for protection of individual private health information (PHI). Neither the University of Miami nor Aetna condition enrollment in the plan based on an individual’s health status. Medical claims are submitted according to electronic data standards required by the act. The University of Miami subscribes to the use of the minimum necessary standard when it comes to an individual’s PHI. Access to PHI must be authorized in writing by the individual employee or representative. The plan may not discriminate in health coverage based on genetic information. The plan may not use genetic information to adjust premium or contribution amounts, request or require an individual or their family members to undergo a genetic test, or request, require, or purchase genetic
information for underwriting purposes or prior to or in connection with an individual’s enrollment in the plan.

**Medicaid and the Children’s Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families**

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer’s health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer’s plan. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

**Newborns’ Act Disclosure**

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

**Women’s Health and Cancer Rights**

Do you know that your plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Contact HR-Benefits at 305-284-3004 for more information.
Aetna Select 1
Summary of Benefits and Coverages (SBC): What this plan covers and what it costs.
This is only a summary. For more information or for a paper copy of this SBC, please contact HR-Benefits at 305-284-3004 or www.miami.edu/benefits/ask.

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>Why this Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0</td>
<td>There is no deductible to meet before this plan begins to pay for covered services you use.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No. There are no other deductibles in this plan.</td>
<td>With no deductible to meet, your plan begins to pay for covered services right away.</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my medical expenses?</td>
<td>Yes. For participating providers $3,000 per person/$9,000 per family</td>
<td>The out-of-pocket limit is the most you could pay during the calendar year for your share of the cost of covered medical services. This limit helps you plan for health care expenses.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, and health care services this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Is there an overall annual limit on what the plan pays?</td>
<td>No.</td>
<td>The chart starting on page 2 describes any limits on what the plan will pay for specific covered services.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes. See <a href="http://www.aetna.com">www.aetna.com</a> for a list of participating providers. Network: Aetna Select (Open Access)</td>
<td>If you use an in-network provider, this plan will pay some or all of the costs of covered services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.</td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>No. You don’t need a referral to see a specialist.</td>
<td>You can see the in-network specialist you choose without permission from this plan.</td>
</tr>
<tr>
<td>Are there services this plan doesn’t cover?</td>
<td>Yes. Visit <a href="http://www.aetna.com">www.aetna.com</a> to learn more.</td>
<td>See your plan document or <a href="http://www.aetna.com">www.aetna.com</a> for additional information about excluded services.</td>
</tr>
</tbody>
</table>
### Aetna Select 1

**Summary of Benefits and Coverages (SBC):** What this plan covers and what it costs.
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- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- The amount the plan pays for covered services is based on the **allowed amount**.
- This plan encourages you to use UM providers by charging you lower copayments amounts.

<table>
<thead>
<tr>
<th>Medical Event</th>
<th>Services you may need</th>
<th>Aetna Select 1</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you wish to visit a health care provider’s office</td>
<td>Primary care visit to treat injury or illness</td>
<td>$15 copay</td>
<td>$20 copay</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$25 copay</td>
<td>$50 copay</td>
</tr>
<tr>
<td></td>
<td>Preventive care (see list at <a href="http://www.miami.edu/benefits">www.miami.edu/benefits</a>)</td>
<td>No charge</td>
<td>(Skin Cancer Screening covered only at UHealth)</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic Testing (lab work-Quest)</td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td></td>
<td>High-End Imaging (CT/PET scans, MRI)</td>
<td>$150 copay</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>$100 copay</td>
<td>$100 copay</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>N/A</td>
<td>$0 copay</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>N/A</td>
<td>$50 copay</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care (office-based)</td>
<td>$25 copay for first visit, then all office visits covered at 100%</td>
<td>$50 copay for first visit, then all office visits covered at 100%</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>$150 copay per day ($1,000 max per admission)</td>
<td>$250 copay per day ($1,250 max per admission)</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic, preferred brand, non-preferred brand and specialty drugs</td>
<td>Prescription drug costs are determined by the four-tier structure at miami.edu/benefits. Copays range from $10 to $100.</td>
<td>Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order or CVS)</td>
</tr>
</tbody>
</table>

**Coverage Period:** 01/01/2015 - 12/31/2015

**Plan Type:** Open Access HMO
**Aetna Select 1**

**Summary of Benefits and Coverages (SBC):** What this plan covers and what it costs.

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**Plan Type:** Open Access HMO

**Coverage Period:** 01/01/2015 - 12/31/2015

<table>
<thead>
<tr>
<th>Medical Event</th>
<th>Services you may need</th>
<th>Aetna Select 1</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>UM Providers</td>
<td>In-network</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (ambulatory surgery center)</td>
<td>$100 copay</td>
<td>$150 copay</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>No charge</td>
<td>Visit <a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental health services are offered through University of Miami Behavioral Health (UMBH). For more information, please visit <a href="http://conordiabh.com">conordiabh.com</a> or call 1-800-294-8642.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>$15 copay</td>
<td>$20 copay</td>
<td>Visit <a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>No charge</td>
<td>Visit <a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td>Hospice service</td>
<td>No charge</td>
<td>No charge</td>
<td>Visit <a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td>If you or your child needs dental or eye care</td>
<td>Routine eye exam (glasses only)</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Glasses</td>
<td>Discount offered through Aetna/EyeMed</td>
<td>Discount offered through Aetna/EyeMed</td>
<td>Discount offered on glasses, frames and contacts. <a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td>Dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Visit <a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
</tbody>
</table>
Aetna Select 1
Summary of Benefits and Coverages (SBC): What this plan covers and what it costs.
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Plan Type: Open Access HMO
Coverage Period: 01/01/2015 - 12/31/2015

Services Your Plan Does NOT Cover (This isn’t a complete list. Check your policy or plan document for other excluded services.)
- Cosmetic surgery
- Dental care
- Artificial means of achieving pregnancy
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care

Your Rights to Continue Coverage:
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact HR-Benefits at 305-284-3004 or Aetna at 1-800-824-6411. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272, or the U.S. Department of Health and Human Services at 1-877-267-2323, x-61565.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact Aetna at 1-800-824-6411.

Health Care Reform:
Does this coverage provide minimum essential coverage?
The ACA requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan does provide minimum essential coverage.

Does this coverage meet the minimum value standard?
The ACA establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.
**Aetna Select 1**  
**Summary of Benefits and Coverages (SBC):** What this plan covers and what it costs.
This is only a summary. For more information or for a paper copy of this SBC, please contact HR-Benefits at 305-284-3004 or [www.miami.edu/benefits/ask](http://www.miami.edu/benefits/ask).

**Plan Type:** Open Access HMO  
**Coverage Period:** 01/01/2015 - 12/31/2015

**About these examples:** These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans. **This is NOT a cost estimator.** Don’t use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

### Having a Baby  
*(normal delivery)*

- **Amount owed to providers:** $7,540  
- **Plan pays:** $6,670  
- **Patient pays:** $870

**Sample care costs:**

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
</tr>
<tr>
<td>Routine obstetric care</td>
<td>$2,100</td>
</tr>
<tr>
<td>Hospital charges (mother)</td>
<td>$900</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
</tr>
<tr>
<td>Laboratory Tests</td>
<td>$500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$7,540</strong></td>
</tr>
</tbody>
</table>

**Patient pays:**

- **Deductibles:** $0  
- **Copays:** $870  
- **Limits or exclusions:** $0  
- **Total:** $870

### Managing Type 2 Diabetes*  
*(routine maintenance of a well-controlled condition)*

- **Amount owed to providers:** $5,400  
- **Plan pays:** $4,780  
- **Patient pays:** $620

**Sample care costs:**

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2,900</td>
</tr>
<tr>
<td>Medical Equipment &amp; Supplies</td>
<td>$1,300</td>
</tr>
<tr>
<td>Office Visits &amp; Procedures</td>
<td>$700</td>
</tr>
<tr>
<td>Education</td>
<td>$300</td>
</tr>
<tr>
<td>Laboratory Tests</td>
<td>$100</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$5,400</strong></td>
</tr>
</tbody>
</table>

**Patient pays:**

- **Deductibles:** $0  
- **Copays:** $620  
- **Limits or exclusions:** $0  
- **Total:** $620

*These numbers assume patient is participating in Aetna’s diabetes wellness program. Call 1-866-269-4500 for details.*

**NOTE:** Costs don’t include premiums. Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan. All services and treatments started and ended in the same coverage period. There are no other medical expenses for any member covered under this plan. Out-of-pocket expenses are based only on treating the condition in the example. The patient received all care from in-network providers. To use Coverage Examples from other SBCs to compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.
Aetna Select 1
Summary of Benefits and Coverages (SBC): What this plan covers and what it costs. This is only a summary. For more information or for a paper copy of this SBC, please contact HR-Benefits at 305-284-3004 or www.miami.edu/benefits/ask.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?
- Costs don’t include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?
For each treatment situation, the Coverage Example helps you see how deductibles and copayments can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.

Does the Coverage Example predict my own care needs?
No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?
No. Coverage Examples are not cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?
Yes. When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?
Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you’ll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as flexible spending arrangements (FSAs) that help you pay out-of-pocket expenses.
Allowed Amount
Maximum amount on which payment is based for covered health care services. This may be called “negotiated rate.”

Appeal
A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing
When a provider bills you for the difference between the provider’s charge and the allowed amount. For example, if the provider’s charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services.

Coinsurance
The set percentage of the total cost you pay for certain medical services (based on Aetna’s negotiated rate with the provider).

Complications of Pregnancy
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren’t complications of pregnancy.

Copayment
The flat dollar amount you pay when you receive medical care or prescription drugs.

Deductible
Expense you must incur before an insurer will assume any liability for all or part of the remaining cost of covered services.

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips.

Emergency Medical Condition
An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Services
Evaluation of an emergency medical condition and treatment to keep the condition from worsening.

Excluded Services
Health care services that your health insurance or plan doesn’t cover.

Generic Drug
A drug that is exactly the same as a brand-name drug, which is allowed to be produced after the brand-name drug’s patent has expired.

Grievance
A complaint that you communicate to your health insurer or plan.

Health Insurance
A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care
Health care services a person receives at home.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness, and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

In-Network
When you visit a provider who has an agreement with Aetna, you are receiving “in-network” care. By using in-network providers, you pay less for health care.
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Plan Type: Open Access HMO
Coverage Period: 01/01/2015 - 12/31/2015

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**Medically Necessary**
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

**Network**
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

**Non-Preferred Provider**
A provider who doesn’t have a contract with your health insurer or plan to provide services to you. This plan does not cover services provided by non-preferred providers except in cases of emergency room services, emergency inpatient admissions and hospital based provides.

**Out-Of-Network**
Health care providers who have not contracted with the health plan to provide services. This plan does not cover services provided by non-preferred providers except in cases of emergency room services, emergency inpatient admissions and hospital-based provides.

**Out-Of-Pocket Limit**
The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium or health care your insurance or plan doesn’t cover.

**Plan**
A benefit your employer, union or other group sponsor provides to you for your health care services.

**Preferred Provider**
A provider who has a contract with your health insurer or plan to provide services to you.

**Preauthorization**
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn’t a promise your health insurance or plan will cover the cost.

**Premium**
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly or biweekly.

**Prescription Drug Coverage**
Health insurance or plan that helps pay for prescription drugs and medication.

**Provider**
A physician (M.D. or D.O.), health care professional or health care facility licensed, certified or accredited as required by state law.

**Specialist**
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>Why this Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$250 per person $750 per family</td>
<td>There is a deductible to meet before this plan begins to pay for covered medical services you use.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No. There are no other deductibles in this plan.</td>
<td>There is a deductible to meet before this plan begins to pay for covered medical services you use.</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my medical expenses?</td>
<td>Yes. For participating providers, $4,000 per person/ $12,000 per family.</td>
<td>The out-of-pocket limit is the most you could pay during the calendar year for your share of the cost of covered medical services. This limit helps you plan for health care expenses.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, and health care services this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Is there an overall annual limit on what the plan pays?</td>
<td>No.</td>
<td>The chart starting on page 2 describes any limits on what the plan will pay for specific covered services.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes. See <a href="http://www.aetna.com">www.aetna.com</a> for a list of participating providers. Network: Aetna Select (Open Access)</td>
<td>If you use an in-network provider, this plan will pay some or all of the costs of covered services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.</td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>No. You don’t need a referral to see a specialist.</td>
<td>You can see the in-network specialist you choose without permission from this plan.</td>
</tr>
<tr>
<td>Are there services this plan doesn’t cover?</td>
<td>Yes. Visit <a href="http://www.aetna.com">www.aetna.com</a> to learn more.</td>
<td>See your plan document or <a href="http://www.aetna.com">www.aetna.com</a> for additional information about excluded services.</td>
</tr>
</tbody>
</table>
Aetna Select 2
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- Copayments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- The amount the plan pays for covered services is based on the allowed amount.
- This plan encourages you to use UM providers by charging you lower copayments amounts.

<table>
<thead>
<tr>
<th>Medical Event</th>
<th>Services you may need</th>
<th>Aetna Select 2</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>UM Providers</td>
<td>In-network</td>
<td></td>
</tr>
<tr>
<td>If you wish to visit a health care provider’s office</td>
<td>Primary care visit to treat injury or illness</td>
<td>Deductible, then $20 copay</td>
<td>Deductible, then $25 copay</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>Deductible, then $35 copay</td>
<td>Deductible, then $60 copay</td>
</tr>
<tr>
<td></td>
<td>Preventive care (see list at <a href="http://www.miami.edu/benefits">www.miami.edu/benefits</a>)</td>
<td>No charge</td>
<td>No charge (Skin Cancer Screening covered only at UHealth)</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic Testing (lab work-Quest)</td>
<td>Deductible, then $0 copay</td>
<td>Deductible, then $0 copay</td>
</tr>
<tr>
<td></td>
<td>High-End Imaging (CT/PET scans, MRI)</td>
<td>Deductible, then $150 copay</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>Deductible, then $150 copay</td>
<td>Deductible, then $150 copay</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>N/A</td>
<td>Deductible, then $0 copay</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>N/A</td>
<td>Deductible, then $75 copay</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care (office-based)</td>
<td>Deductible, then $35 copay for first visit, then all office visits covered at 100%</td>
<td>Deductible, then $60 copay for first visit, then all office visits covered at 100%</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>Deductible, then $200 copay per day ($1,000 max per admission)</td>
<td>Deductible, then $300 copay per day ($1,500 max per admission)</td>
</tr>
</tbody>
</table>

Coverage Period: 01/01/2015 - 12/31/2015
Plan Type: Open Access HMO
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<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic, preferred brand, non-preferred brand and specialty drugs</td>
<td>Prescription drug costs are determined by the four-tier structure found at <a href="http://miami.edu/benefits">miami.edu/benefits</a>. Copays range from $10 to $100.</td>
<td>Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order or CVS)</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (ambulatory surgery center)</td>
<td>Deductible, then $100 copay</td>
<td>Visit <a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Deductible, then $0 copay</td>
<td>Visit <a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental health services are offered through University of Concordia Behavioral Health. For more information, please visit <a href="http://conordiabhh.com">conordiabhh.com</a> or call 1-800-294-8642.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>Deductible, then $0 copay</td>
<td>Visit <a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>Deductible, then $20 copay</td>
<td>Visit <a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>Deductible, then $0 copay</td>
<td>Visit <a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>Deductible, then $0 copay</td>
<td>Visit <a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td>If you or your child needs dental or eye care</td>
<td>Routine eye exam (glasses only)</td>
<td>$0 copay</td>
<td>One exam per year</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>Discount offered through Aetna/Eyemed</td>
<td>Discount offered on glasses, frames and contacts. <a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>Covered under dental plan</td>
<td>Covered under dental plan</td>
</tr>
</tbody>
</table>

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Services Your Plan Does NOT Cover (This isn’t a complete list. Check your policy or plan document for other excluded services.)
- Cosmetic surgery
- Dental care
- Artificial means of achieving pregnancy
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Your Rights to Continue Coverage:
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact HR-Benefits at 305-284-3004 or Aetna at 1-800-824-6411. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272, or the U.S. Department of Health and Human Services at 1-877-267-2323, x-61565.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance.
For questions about your rights, this notice, or assistance, you can contact Aetna at 1-800-824-6411.

Health Care Reform:
Does this coverage provide minimum essential coverage?
The ACA requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan does provide minimum essential coverage.

Does this coverage meet the minimum value standard?
The ACA establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.
Aetna Select 2

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About these examples: These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans. This is NOT a cost estimator. Don’t use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

### Having a Baby
(normal delivery)

- Amount owed to providers: $7,540
- Plan pays: $6,260
- Patient pays: $1,280

**Sample care costs:**

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
</tr>
<tr>
<td>Routine obstetric care</td>
<td>$2,100</td>
</tr>
<tr>
<td>Hospital charges (mother)</td>
<td>$ 900</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$ 900</td>
</tr>
<tr>
<td>Laboratory Tests</td>
<td>$ 500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$ 200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$ 200</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$  40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$7,540</strong></td>
</tr>
</tbody>
</table>

**Patient pays:**

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$ 250</td>
</tr>
<tr>
<td>Copays</td>
<td>$1,030</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$ 0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$1,280</strong></td>
</tr>
</tbody>
</table>

### Managing type 2 diabetes*
(routine maintenance of a well-controlled condition)

- Amount owed to providers: $5,400
- Plan pays: $4,490
- Patient pays: $910

**Sample care costs:**

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2,900</td>
</tr>
<tr>
<td>Medical Equipment &amp; Supplies</td>
<td>$1,300</td>
</tr>
<tr>
<td>Office Visits &amp; Procedures</td>
<td>$ 700</td>
</tr>
<tr>
<td>Education</td>
<td>$ 300</td>
</tr>
<tr>
<td>Laboratory Tests</td>
<td>$ 100</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$ 100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$5,400</strong></td>
</tr>
</tbody>
</table>

**Patient pays:**

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$ 250</td>
</tr>
<tr>
<td>Copays</td>
<td>$ 660</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$ 0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$ 910</strong></td>
</tr>
</tbody>
</table>

*These numbers assume patient is participating in Aetna’s diabetes wellness program. Call 1-866-269-4500 for details.

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Questions and answers about the Coverage Examples:

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For each treatment situation, the Coverage Example helps you see how deductibles and copayments can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.

Does the Coverage Example predict my own care needs?
No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?
No. Coverage Examples are not cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?
Yes. When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?
Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you’ll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as flexible spending arrangements (FSAs) that help you pay out-of-pocket expenses.
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Complications of Pregnancy
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Emergency Medical Condition
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Grievance
A complaint that you communicate to your health insurer or plan.

Health Insurance
A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care
Health care services a person receives at home.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness, and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

In-Network
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Coverage Period: 01/01/2015 - 12/31/2015

Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider
A provider who doesn’t have a contract with your health insurer or plan to provide services to you. This plan does not cover services provided by non-preferred providers except in cases of emergency room services, emergency inpatient admissions and hospital-based providers.

Out-Of-Network
Health care providers who have not contracted with the health plan to provide services. This plan does not cover services provided by non-preferred providers except in cases of emergency room services, emergency inpatient admissions and hospital-based providers.

Out-Of-Pocket Limit
The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium or health care your insurance or plan doesn’t cover.

Plan
A benefit your employer, union or other group sponsor provides to you for your health care services.

Preferred Provider
A provider who has a contract with your health insurer or plan to provide services to you.

Preauthorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn’t a promise your health insurance or plan will cover the cost.

Premium
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly or biweekly.

Prescription Drug Coverage
Health insurance or plan that helps pay for prescription drugs and medication.

Provider
A physician (M.D. or D.O.), health care professional or health care facility licensed, certified or accredited as required by state law.

Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.
Aetna Health Reimbursement Account (HRA)
Summary of Benefits and Coverages (SBC): What this plan covers and what it costs.
This is only a summary. For more information or for a paper copy of this SBC, please contact HR-Benefits at 305-284-3004 or www.miami.edu/benefits/ask.

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<tr>
<th>Question</th>
<th>Answer</th>
<th>Why this Matters</th>
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<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>In-Network: $1,500 per person ($4,500 per family)</td>
<td>There is a deductible to meet before this plan begins to pay for covered medical services you use.</td>
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<tr>
<td></td>
<td>Out-of-Network: $3,000 per person ($9,000 per family)</td>
<td></td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No. There are no other deductibles in this plan.</td>
<td>There is a deductible to meet before this plan begins to pay for covered medical services you use.</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my medical expenses?</td>
<td>Yes. In-Network Providers: $4,000 per person ($12,000 per family). Out-of-Network Providers: $8,000 per person ($24,000 per family)</td>
<td>The out-of-pocket limit is the most you could pay during the calendar year for your share of the cost of covered medical services. This limit helps you plan for health care expenses.</td>
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<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance billing, and health care services this plan doesn't cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Is there an overall annual limit on what the plan pays?</td>
<td>No.</td>
<td>The chart starting on page 2 describes any limits on what the plan will pay for specific covered services.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes. See <a href="http://www.aetna.com">www.aetna.com</a> for a list of participating providers.</td>
<td>This plan will pay some or all of the costs of covered services when using in- or out-of-network providers. Plans use the term in-network, preferred, or participating for providers in their network.</td>
</tr>
<tr>
<td></td>
<td>Network: Aetna Choice POS II</td>
<td></td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>No. You don’t need a referral to see a specialist.</td>
<td>You can see the specialist you choose without permission from this plan.</td>
</tr>
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<td>Are there services this plan doesn’t cover?</td>
<td>Yes. Visit <a href="http://www.aetna.com">www.aetna.com</a> to learn more.</td>
<td>See your plan document or <a href="http://www.aetna.com">www.aetna.com</a> for additional information about excluded services.</td>
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- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan’s **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200.
- The amount the plan pays for covered services is based on the **allowed amount**.
- This plan encourages you to use UM providers by charging you lower **copayments** and **coinsurance amounts**.

### Medical Event

<table>
<thead>
<tr>
<th>Services you may need</th>
<th>Aetna HRA</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you wish to visit a health care provider’s office</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat injury or illness</td>
<td>Deductible, then $15 copay</td>
<td>Deductible, then $20 copay</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>Deductible, then $25 copay</td>
<td>Deductible, then $50 copay</td>
</tr>
<tr>
<td>Preventive care (see list at <a href="http://www.miami.edu/benefits">www.miami.edu/benefits</a>)</td>
<td>No charge</td>
<td>No charge (Skin Cancer Screening covered only at UHealth)</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Testing (lab work-Quest)</td>
<td>Deductible, then $0 copay</td>
<td>Deductible, then $0 copay</td>
</tr>
<tr>
<td>High-End Imaging (CT/PET scans, MRI)</td>
<td>Deductible, then $100 copay</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency room services</td>
<td>Deductible, then $100 copay</td>
<td>Deductible, then $100 copay</td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>N/A</td>
<td>Deductible, then 20% coinsurance</td>
</tr>
<tr>
<td>Urgent care</td>
<td>N/A</td>
<td>Deductible, then $35 copay</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prenatal and postnatal care (office-based)</td>
<td>Deductible, then $25 copay for first visit, then all office visits covered at 100%</td>
<td>Deductible, then $50 copay for first visit, then all office visits covered at 100%</td>
</tr>
<tr>
<td>Delivery and all inpatient services</td>
<td>Deductible, then $100 copay per day ($500 max per admission)</td>
<td>Deductible, then $200 copay per day ($1,000 max per admission)</td>
</tr>
</tbody>
</table>

**Coverage Period:** 01/01/2015 - 12/31/2015
**Plan Type:** Aetna Choice POS II Open Access
## Aetna Health Reimbursement Account (HRA)

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<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic, preferred brand, non-preferred brand and specialty drugs</td>
<td>Deductible, then copay based on the drug tier. Prescription drug costs are determined by the four-tier structure at <a href="http://miami.edu/benefits">miami.edu/benefits</a>. Copays range from $10-$100.</td>
<td>Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order or CVS)</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (ambulatory surgery center), Physician/surgeon fees</td>
<td>Deductible, then $50 copay, Deductible, then $0 copay</td>
<td>Visit <a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td><strong>If you have mental health, behavioral health, or substance abuse needs</strong></td>
<td>Mental health services are offered through Concordia Behavioral Health. For more information, please visit <a href="http://concordiabh.com">concordiabh.com</a> or call 1-800-294-8642.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Home health care, Rehabilitation services, Durable medical equipment, Hospice service</td>
<td>Deductible, then 20% coinsurance, Deductible, then 20% coinsurance, Deductible, then 20% coinsurance</td>
<td>Visit <a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td><strong>If you or your child needs dental or eye care</strong></td>
<td>Routine eye exam, Glasses, Dental check-up</td>
<td>No charge, Discount offered through Aetna/EyeMed, Covered under dental plan</td>
<td>One exam per year, Not covered, Covered under dental plan</td>
</tr>
</tbody>
</table>
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Services Your Plan Does NOT Cover (This isn’t a complete list. Check your policy or plan document for other excluded services.)
- Cosmetic surgery
- Dental care
- Artificial means of achieving pregnancy
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care

Your Rights to Continue Coverage:
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact HR-Benefits at 305-284-3004 or Aetna at 1-800-824-6411. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272, or the U.S. Department of Health and Human Services at 1-877-267-2323, x61565.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact Aetna at 1-800-824-6411.

Health Care Reform:
Does this coverage provide minimum essential coverage?
The ACA requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan does provide minimum essential coverage.

Does this coverage meet the minimum value standard?
The ACA establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.
**Aetna Health Reimbursement Account (HRA)**

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**About these examples:** These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans. **This is NOT a cost estimator.** Don’t use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

### Having a Baby

*(normal delivery)*

- Amount owed to providers: $7,540
- Plan pays: $5,920
- Patient pays: $1,620

**Sample care costs:**

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
</tr>
<tr>
<td>Routine obstetric care</td>
<td>$2,100</td>
</tr>
<tr>
<td>Hospital charges (mother)</td>
<td>$ 900</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$ 900</td>
</tr>
<tr>
<td>Laboratory Tests</td>
<td>$ 500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$ 200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$ 200</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$ 40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$7,540</strong></td>
</tr>
</tbody>
</table>

**Patient pays:**

- Deductibles                      | $ 900  |
- Copays                           | $ 720  |
- Coinsurance                      | $ 0    |
- Limits or exclusions             | $ 0    |
| **Total**                         | **$1,620** |

### Managing type 2 diabetes*

*(routine maintenance of a well-controlled condition)*

- Amount owed to providers: $5,400
- Plan pays: $3,880
- Patient pays: $1,520

**Sample care costs:**

<table>
<thead>
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<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2,900</td>
</tr>
<tr>
<td>Medical Equipment &amp; Supplies</td>
<td>$1,300</td>
</tr>
<tr>
<td>Office Visits &amp; Procedures</td>
<td>$ 700</td>
</tr>
<tr>
<td>Education</td>
<td>$ 300</td>
</tr>
<tr>
<td>Laboratory Tests</td>
<td>$ 100</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$ 100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$5,400</strong></td>
</tr>
</tbody>
</table>

**Patient pays:**

- Deductibles                      | $ 900  |
- Copays                           | $ 620  |
- Coinsurance                      | $ 0    |
- Limits or exclusions             | $ 0    |
| **Total**                         | **$1,520** |

*These numbers assume patient is participating in Aetna’s diabetes wellness program. Call 1-866-269-4500 for details.

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**NOTE:** Costs don’t include premiums. Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan. All services and treatments started and ended in the same coverage period. There are no other medical expenses for any member covered under this plan. Out-of-pocket expenses are based only on treating the condition in the example. The patient received all care from in-network providers. To use Coverage Examples from other SBCs to compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.
Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don’t include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.

Does the Coverage Example predict my own care needs?

No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

No. Coverage Examples are not cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

Yes. When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you’ll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as flexible spending arrangements (FSAs) that help you pay out-of-pocket expenses.
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Allowed Amount
Maximum amount on which payment is based for covered health care services. This may be called “negotiated rate.”

Appeal
A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing
When a provider bills you for the difference between the provider’s charge and the allowed amount. For example, if the provider’s charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services.

Complications of Pregnancy
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency cesarean section aren’t complications of pregnancy.

Copayment
The flat dollar amount you pay when you receive medical care or prescription drugs.

Deductible
Expense you must incur before an insurer will assume any liability for all or part of the remaining cost of covered services.

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips.

Emergency Medical Condition
An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Services
Evaluation of an emergency medical condition and treatment to keep the condition from worsening.

Excluded Services
Health care services that your health insurance or plan doesn’t cover.

Generic Drug
A drug that is exactly the same as a brand-name drug, which is allowed to be produced after the brand-name drug’s patent has expired.

Grievance
A complaint that you communicate to your health insurer or plan.

Health Insurance
A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care
Health care services a person receives at home.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness, and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

In-Network
When you visit a provider who has an agreement with Aetna, you are receiving “in-network” care. By using in-network providers, you pay less for health care.
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Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider
A provider who doesn’t have a contract with your health insurer or plan to provide services to you. You’ll pay more to see a non-preferred provider.

Out-Of-Network
Health care providers who have not contracted with the health plan to provide services. See Balance Billing.

Out-Of-Pocket Limit
The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your insurance or plan doesn’t cover.

Plan
A benefit your employer, union or other group sponsor provides to you for your health care services.

Preauthorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn’t a promise your health insurance or plan will cover the cost.

Premium
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly or biweekly.

Prescription Drug Coverage
Health insurance or plan that helps pay for prescription drugs and medication.

Provider
A physician (M.D. or D.O.), health care professional or health care facility licensed, certified or accredited as required by state law.

Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.
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<tr>
<td></td>
<td>Out-of-Network: $3,000 per person ($9,000 per family)</td>
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</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No. There are no other deductibles in this plan.</td>
<td>There is a deductible to meet before this plan begins to pay for covered medical services you use.</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my medical expenses?</td>
<td>Yes. In-Network Providers: $4,000 per person ($12,000 per family)</td>
<td>The out-of-pocket limit is the most you could pay during the calendar year for your share of the cost of covered medical services. This limit helps you plan for health care expenses.</td>
</tr>
<tr>
<td></td>
<td>Out-of-Network Providers: $8,000 per person ($24,000 per family)</td>
<td></td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance billing, and health care services this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Is there an overall annual limit on what the plan pays?</td>
<td>No.</td>
<td>The chart starting on page 2 describes any limits on what the plan will pay for specific covered services.</td>
</tr>
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</table>
| Does this plan use a network of providers?                               | Yes. See [www.aetna.com](http://www.aetna.com) for a list of participating providers.  
*Network: Aetna Choice POS II* | This plan will pay some or all of the costs of covered services when using in- or out-of-network providers. Plans use the term in-network, preferred, or participating for providers in their network. |
| Do I need a referral to see a specialist?                                | No. You don’t need a referral to see a specialist.                       | You can see the specialist you choose without permission from this plan.         |
| Are there services this plan doesn’t cover?                              | Yes. Visit [www.aetna.com](http://www.aetna.com) to learn more.         | See your plan document or [www.aetna.com](http://www.aetna.com) for additional information about excluded services. |
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- **Plan Type:** Aetna Choice POS II Open Access

Copayments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service. 

Coinsurance is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan’s allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200.

The amount the plan pays for covered services is based on the allowed amount.

This plan encourages you to use UM providers by charging you lower copayments and coinsurance amounts.

<table>
<thead>
<tr>
<th>Medical Event</th>
<th>Services you may need</th>
<th>Aetna HRA (Out-of-Area)</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-network</td>
<td>Out-of-network</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Deductible, then $15 copay</td>
<td>Deductible, then 30% coinsurance</td>
<td>Visit <a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td>If you wish to visit a health care provider’s office</td>
<td>Primary care visit to treat injury or illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>Deductible, then $25 copay</td>
<td>Deductible, then 30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Preventive visit (see list at <a href="http://www.miami.edu/benefits">www.miami.edu/benefits</a>)</td>
<td>No charge</td>
<td>No charge (Skin Cancer Screening covered only at UHealth)</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic Testing (lab work-Quest)</td>
<td>Deductible, then $0 copay</td>
<td>Deductible, then 30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>High-End Imaging (CT/PET scans, MRI)</td>
<td>Deductible, then $100 copay</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>Deductible, then $100 copay</td>
<td>Deductible, then 20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>N/A</td>
<td>Deductible, then 30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>N/A</td>
<td>Deductible, then 30% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care (office-based)</td>
<td>Deductible, then $25 copay for first visit, then all office visits covered at 100%</td>
<td>Deductible, then 30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>Deductible, then $100 copay per day ($500 max per admission)</td>
<td>Deductible, then 30% coinsurance</td>
</tr>
</tbody>
</table>
**Aetna Health Reimbursement Account (HRA) Out of Area**

**Summary of Benefits and Coverages (SBC):** What this plan covers and what it costs. This is only a summary. For more information or for a paper copy of this SBC, please contact HR-Benefits at 305-284-3004 or [www.miami.edu/benefits/ask](http://www.miami.edu/benefits/ask).

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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-network</td>
<td>Out-of-network</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic, preferred brand, non-preferred brand and specialty drugs</td>
<td>Deductible, then copay based on drug tier. Prescriptions drug costs are determined by the four-tier structure at <a href="http://miami.edu/benefits">miami.edu/benefits</a>. Copays range from $10-$100.</td>
<td>Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order or CVS)</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (ambulatory surgery center)</td>
<td>Deductible, then $50 copay</td>
<td>Deductible, then $100 copay</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Deductible, then $0 copay</td>
<td>Deductible, then 30% coinsurance</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental health services are offered through Concordia Behavioral Health. For more information, please visit <a href="http://concordiabh.com">concordiabh.com</a> or call 1-800-294-8642.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>Deductible, then 20% coinsurance</td>
<td>Deductible, then 30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>Deductible, then $15 copay</td>
<td>Deductible, then $20 copay</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>Deductible, then 20% coinsurance</td>
<td>Deductible, then 30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>Deductible, then 20% coinsurance</td>
<td>Deductible, then 30% coinsurance</td>
</tr>
<tr>
<td>If you or your child needs dental or eye care</td>
<td>Routine eye exam (glasses only)</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>Discount offered through Aetna/EyeMed</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>Covered under dental plan</td>
<td>Covered under dental plan</td>
</tr>
</tbody>
</table>
Aetna Health Reimbursement Account (HRA) Out of Area

Summary of Benefits and Coverages (SBC): What this plan covers and what it costs.
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Services Your Plan Does NOT Cover (This isn’t a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care
- Artificial means of achieving pregnancy
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care

Your Rights to Continue Coverage:
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact HR-Benefits at 305-284-3004 or Aetna at 1-800-824-6411. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272, or the U.S. Department of Health and Human Services at 1-877-267-2323, x-61565.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact Aetna at 1-800-824-6411.

Health Care Reform:
Does this coverage provide minimum essential coverage?
The ACA requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan does provide minimum essential coverage.

Does this coverage meet the minimum value standard?
The ACA establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.
**Aetna Health Reimbursement Account (HRA) Out of Area**

**Summary of Benefits and Coverages (SBC):** What this plan covers and what it costs. This is only a summary. For more information or for a paper copy of this SBC, please contact HR-Benefits at 305-284-3004 or www.miami.edu/benefits/ask.

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**About these examples:** These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans. **This is NOT a cost estimator.** Don’t use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

### Having a Baby
*(normal delivery)*

- **Amount owed to providers:** $7,540
- **Plan pays:** $6,245
- **Patient pays:** $1,295

**Sample care costs:**

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
</tr>
<tr>
<td>Routine obstetric care</td>
<td>$2,100</td>
</tr>
<tr>
<td>Hospital charges (mother)</td>
<td>$900</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
</tr>
<tr>
<td>Laboratory Tests</td>
<td>$500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$7,540</strong></td>
</tr>
</tbody>
</table>

**Patient pays:**

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$900</td>
</tr>
<tr>
<td>Copays</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$395</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$1,295</strong></td>
</tr>
</tbody>
</table>

### Managing type 2 diabetes *
*(routine maintenance of a well-controlled condition)*

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,980
- **Patient pays:** $1,420

**Sample care costs:**

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2,900</td>
</tr>
<tr>
<td>Medical Equipment &amp; Supplies</td>
<td>$1,300</td>
</tr>
<tr>
<td>Office Visits &amp; Procedures</td>
<td>$700</td>
</tr>
<tr>
<td>Education</td>
<td>$300</td>
</tr>
<tr>
<td>Laboratory Tests</td>
<td>$100</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$5,400</strong></td>
</tr>
</tbody>
</table>

**Patient pays:**

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$900</td>
</tr>
<tr>
<td>Copays</td>
<td>$520</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$1,420</strong></td>
</tr>
</tbody>
</table>

*These numbers assume patient is participating in Aetna’s diabetes wellness program. Call 1-866-269-4500 for details.*

**NOTE:** Costs don’t include premiums. Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan. All services and treatments started and ended in the same coverage period. There are no other medical expenses for any member covered under this plan. Out-of-pocket expenses are based only on treating the condition in the example. The patient received all care from in-network providers. To use Coverage Examples from other SBCs to compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.
Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?
- Costs don’t include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?
For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.

Does the Coverage Example predict my own care needs?
No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?
No. Coverage Examples are not cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?
Yes. When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?
Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you’ll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as flexible spending arrangements (FSAs) that help you pay out-of-pocket expenses.
Allowed Amount
Maximum amount on which payment is based for covered health care services. This may be called “negotiated rate.”

Appeal
A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing
When a provider bills you for the difference between the provider’s charge and the allowed amount. For example, if the provider’s charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services.

Coinsurance
The set percentage of the total cost you pay for certain medical services (based on Aetna’s negotiated rate with the provider).

Complications of Pregnancy
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren’t complications of pregnancy.

Copayment
The flat dollar amount you pay when you receive medical care or prescription drugs.

Deductible
Expense you must incur before an insurer will assume any liability for all or part of the remaining cost of covered services.

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips.

Emergency Medical Condition
An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Services
Evaluation of an emergency medical condition and treatment to keep the condition from worsening.

Excluded Services
Health care services that your health insurance or plan doesn’t cover.

Generic Drug
A drug that is exactly the same as a brand-name drug, which is allowed to be produced after the brand-name drug’s patent has expired.

Grievance
A complaint that you communicate to your health insurer or plan.

Health Insurance
A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care
Health care services a person receives at home.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness, and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

In-Network
When you visit a provider who has an agreement with Aetna, you are receiving “in-network” care. By using in-network providers, you pay less for health care.
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Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider
A provider who doesn’t have a contract with your health insurer or plan to provide services to you. You’ll pay more to see a non-preferred provider.

Out-Of-Network
Health care providers who have not contracted with the health plan to provide services. See Balance Billing.

Out-Of-Pocket Limit
The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your insurance or plan doesn’t cover.

Plan
A benefit your employer, union or other group sponsor provides to you for your health care services.

Preferred Provider
A provider who has a contract with your health insurer or plan to provide services to you at a discount.

Preauthorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn’t a promise your health insurance or plan will cover the cost.

Premium
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly or biweekly.

Prescription Drug Coverage
Health insurance or plan that helps pay for prescription drugs and medication.

Provider

A physician (M.D. or D.O.), health care professional or health care facility licensed, certified or accredited as required by state law.

Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.
**Glossary of Common Terms**

To better understand your benefits, you should be aware of the meaning of the following terms:

**BALANCE BILLING**
Out-of-network providers may bill patients for the balances remaining on the charges associated with services rendered, after the insurance reimbursement amount is paid. You are responsible for the difference between out-of-network billed charges and Aetna’s maximum allowable fee.

**COINSURANCE**
Your share of the costs of a covered healthcare expense calculated as a percent based on the contracted Aetna rate you pay for services after your deductible is met.

**CO-PAYMENT (CO-PAY)**
The fixed dollar amount you pay for in-network provider services or medical supplies.

**DEDUCTIBLE**
The dollar amount you must pay before the plan will pay for certain services before the insurer begins to make payments for covered medical services. Co-payments do not apply to the deductible.

**MAXIMUM ALLOWABLE FEE**
An amount determined by Aetna to be the prevailing charge for the service. This amount is based on a national database, complexity of services, range of services and prevailing charge in the geographic area.

**OUT-OF-POCKET MAXIMUM**
The maximum dollar amount you are required to pay out of pocket during the calendar year. When the amount of combined covered expenses paid by you and/or all your covered dependents (family) satisfies the out-of-pocket maximums, Aetna will pay 100% of covered expenses for the remainder of the calendar year. Under Aetna Select 1 and Aetna Select 2, copayments for Rx do not apply to the out of pocket maximum.

**USUAL, CUSTOMARY AND REASONABLE**
The usual charge made by a physician or other provider of services that does not exceed the general level of charges made by other providers for the same care in the same geographic area.

**Coordination of Benefits**
The health care plan coordinates benefits with any other group plan that provides health insurance for you or your dependents. “Other Plans”, include without limitation, policies and organizations that provide medical, hospitalization, surgical and disability benefits, government programs, group insurance programs and no fault automobile insurance. This provision limits the total benefits payable under your University of Miami Plan and other group plans to the total of all allowable expenses. Allowable expenses are any necessary, customary and reasonable expenses covered at least in part by this or another group insurance plan.

When you or an insured member of your family is covered under two or more plans, one is the primary plan (for example, if covered as an employee rather than as a dependent), and all other plans are secondary plans. The primary plan pays its benefits first, without regard to the other plans. The secondary plan then makes up the difference, up to 100% of allowable expenses. The deductibles under both plans will apply. For dependent coverage, the plan of the parent whose birthday comes first in the year is the primary plan.

**Hospital Services Covered**
The following benefits are available under the plans:

- Semi-private hospital room and board, for an unlimited number of days
• Use of operating and recovery rooms, including outpatient surgery
• Prescribed drugs and medicines while hospitalized
• Intravenous solutions
• Dressings, including ordinary casts
• Anesthetics and their administration
• Transfusion supplies and equipment, including whole blood or blood plasma
• Diagnostic x-rays, ultrasounds and computerized tomography
• Laboratory and pathology services
• Electrocardiogram (EKG) tests to monitor heartbeat, and EEGs for brain waves
• Physical, respiratory and radiation therapy

Other Covered Benefits
The Plan will also consider coverage for the following types of care and treatment:

• Maternity benefits, including delivery, pre and post-natal care, false labor, toxemia and certain other complications of pregnancy. (If you have family coverage, the plan covers newborn baby from birth.) Federal Law requires coverage for 48 hours in hospital after vaginal delivery and at least 96 hours following cesarean section.
• Diagnostic x-rays and lab tests, including pathology services, radiation therapy, EKGs and EEGs.
• Ambulance service to or from your home or a hospital (including emergency air transportation), if medically necessary to the closest treating facility
• Services & supplies, including prescribed drugs and medicines and prosthetics (such as artificial limbs and certain braces)
• Emergency/accident care
• Prescription drug coverage
• Outpatient surgery
• Bariatric surgery

What is Not Covered
Health Care Benefits will not be paid for:

• Routine dental services and supplies
• Cosmetic surgery
• Transportation services (except for approved ambulance service)
• Treatment resulting from war or an act of war
• Charges resulting and illness or injury that occurs while at work
• Care or treatment in any governmental institution for military-service related disabilities, except inpatient hospital care provided by a government-owned facility will be covered for military dependents, military retirees and their dependents, and veterans with non-service disabilities
• Services you receive from a relative
• Prescription drugs for weight control
• Non-medically necessary services and supplies

Well Child Care
Well child care benefits are provided on an outpatient basis for a covered dependent child and include periodic examination (which may include a history, physical examinations, developmental assessment and anticipated guidance) necessary to monitor the normal growth and development of an infant, limited to oral and/or intramuscular injection for the purpose of immunization; and laboratory tests.
Preventive Care
All services considered preventive and therefore covered at 100% under the Patient Protection and Affordable Care Act are covered as such under all four medical plans. For a complete list, please visit www.healthcare.gov.

Hospice Care
Hospice Care facilities provide care in a home-like atmosphere for terminally ill patients. For this benefit to be paid; hospice must meet certain standards and the attending physician must certify that the patient is not expected to live more than six months. The physician must also submit a hospice care program for approval by the Plan.

Second Surgical Opinion
Often surgery is only one of several options to treat a medical condition, and surgeons differ in their prescribed methods of treatment. To encourage you to get a second opinion for surgery, the plan will pay 100% of the usual, customary and reasonable cost of a second opinion less the applicable copay. If the first and second doctor differs in their recommendations, the plan will pay the full cost for you to obtain a third opinion less the applicable copayment.

Travel Medical Benefits
Emergency coverage is provided to all covered members worldwide through the Aetna medical plan. For those traveling internationally on University business, additional coverage is available as described below:

Faculty/Staff Coverage
Workers Compensation coverage will be extended to all University of Miami employees while in the course and scope of employment whether traveling domestically or internationally. The Risk Management Department’s Travel Form must be completed and approved prior to trip departure. For those insured by the University of Miami health plans, emergent and routine medical services during international travel on University business will be covered by the health plans. Faculty and staff traveling on University business are also encouraged to register on red24 for additional travel benefits and emergency/medical evacuation.

Dependent Coverage
Coverage can be extended to the dependent/spouse of the university’s traveling employee. These family members must be included on the completed and approved Travel Form. This form must be reviewed in the Risk Management Department prior to trip departure. This coverage extension is only for dependents of those faculty and administrators who are currently enrolled in a University of Miami health plan, and includes coverage for emergent and routine medical services during international travel on University business.

Bariatric Surgery
Bariatric surgery is a covered procedure under the University’s health plans. Coverage will be provided if all of the criteria below are met:

1. Employment requirement
   a. The patient is a University of Miami/UMH employee covered by the University of Miami health plan
   b. The patient is a former employee of the University of Miami/UMH on UM/Aetna COBRA/Retiree coverage.
2. Provider requirement
a. Surgical procedure is performed at University of Miami Hospital by the UM Division of Bariatric Surgery

3. Clinical requirement
   a. UM Division of Bariatric surgery has obtained precertification for the procedure from Aetna and all of Aetna’s clinical requirements/guidelines have been met.

**UHealth Imaging**

High end imaging services (MRI, PET and CT scans) are only covered when performed at UHealth (including Jackson Health System). To schedule an appointment or obtain information on UHealth imaging locations, please call 305-243-CARE and select Option 3.

Coverage will not be provided for these services when received outside of UHealth unless one or more of the following exceptions applies:

1. Service is performed on a child age 13 or under
2. Service is performed outside of Miami-Dade or Broward counties
3. Service is performed concurrent with daily radiation therapy
4. Service required is an open or standing MRI, or other procedure not available within UHealth
5. Service is received in an emergency room or inpatient setting

For these exceptions, excluding emergency room services, coverage will be provided at the UHealth copay when using an Aetna In-Network facility.

**Aetna**

There are four health plan options available within the University of Miami Group Health Plan: two HMO-type plans, one PPO-type plan known as Health Reimbursement Account, and a Health Reimbursement Account plan for employees residing outside of Miami-Dade and Broward counties. All plans are administered by Aetna on behalf of the University of Miami.

Monthly health care premium amounts for the current calendar year can be found on the HR-Benefits website located at [www.miami.edu/benefits](http://www.miami.edu/benefits).
**Aetna Select 1**

This option allows you and your covered dependents a full range of health care benefits when using Aetna Select Open Access Network providers. Referrals for office visits to specialists are not required. Should you choose to use UM physicians and UM facilities, your costs may be lower.

<table>
<thead>
<tr>
<th>Service</th>
<th>UM Providers</th>
<th>Select Open Access</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PRIMARY CARE (PCP):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>$15 copay</td>
<td>$20 copay</td>
</tr>
<tr>
<td><strong>SPECIALTY CARE (SPEC):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>$25 copay</td>
<td>$50 copay</td>
</tr>
<tr>
<td><strong>MATERNITY CARE:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First OB Prenatal Visit</td>
<td>$25 copay</td>
<td>$50 copay</td>
</tr>
<tr>
<td>All Other Prenatal Visits</td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Hospital Inpatient</td>
<td>(refer to hospital services below)</td>
<td>(refer to hospital services below)</td>
</tr>
<tr>
<td><strong>HOSPITAL SERVICES:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td>$150/day x 5 days per admission</td>
<td>$250/day x 5 days per admission</td>
</tr>
<tr>
<td><strong>EMERGENCY SERVICES:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room (waived if admitted)</td>
<td>$100 copay</td>
<td>$100 copay</td>
</tr>
<tr>
<td>Urgent Care Facility</td>
<td>$50 copay</td>
<td>$50 copay</td>
</tr>
<tr>
<td><strong>OUTPATIENT SURGERY:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td>$100 copay</td>
<td>$150 copay</td>
</tr>
<tr>
<td>Physician</td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td><strong>OUTPATIENT DIAGNOSTIC HIGH END (including MRI, MRA, CT, PET):</strong></td>
<td>$150 copay</td>
<td>Not covered – exceptions apply</td>
</tr>
<tr>
<td><strong>OUTPATIENT DIAGNOSTIC LOW END:</strong></td>
<td>$0 copay</td>
<td>$30 copay</td>
</tr>
<tr>
<td><strong>PHYSICAL, SPEECH AND OCCUPATIONAL THERAPY SERVICES:</strong></td>
<td>$15 copay</td>
<td>$20 copay</td>
</tr>
<tr>
<td><strong>OUTPATIENT CHEMOTHERAPY AND RADIATION:</strong></td>
<td>$0 copay</td>
<td>$20 copay</td>
</tr>
</tbody>
</table>

* This is a summary only and not intended as a complete description of covered services.
**Aetna Select 2**

This option allows you and your covered dependents a full range of health care benefits when using Aetna Select Open Access Network providers. Referrals for office visits to specialists are not required. Should you choose to use UM physicians and UM facilities, your costs may be lower.

<table>
<thead>
<tr>
<th>Service</th>
<th>UM Providers</th>
<th>Select Open Access</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PRIMARY CARE (PCP):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>Deductible, then $20 copay</td>
<td>Deductible, then $25 copay</td>
</tr>
<tr>
<td><strong>SPECIALTY CARE (SPEC):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>Deductible, then $35 copay</td>
<td>Deductible, then $60 copay</td>
</tr>
<tr>
<td><strong>MATERNITY CARE:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First OB Prenatal Visit</td>
<td>Deductible, then $35 copay</td>
<td>Deductible, then $60 copay</td>
</tr>
<tr>
<td>All Other Prenatal Visits</td>
<td>Deductible, then $0 copay</td>
<td>Deductible, then $0 copay</td>
</tr>
<tr>
<td>Hospital Inpatient</td>
<td>(refer to hospital services below)</td>
<td>(refer to hospital services below)</td>
</tr>
<tr>
<td><strong>HOSPITAL SERVICES:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td>Deductible, then $200/day x 5 days per admission</td>
<td>Deductible, then $300/day x 5 days per admission</td>
</tr>
<tr>
<td><strong>EMERGENCY SERVICES:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room (waived if admitted)</td>
<td>Deductible, then $150 copay</td>
<td>Deductible, then $150 copay</td>
</tr>
<tr>
<td>Urgent Care Facility</td>
<td>Deductible, then $75 copay</td>
<td>Deductible, then $75 copay</td>
</tr>
<tr>
<td><strong>OUTPATIENT SURGERY:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td>Deductible, then $100 copay</td>
<td>Deductible, then $250 copay</td>
</tr>
<tr>
<td>Physician</td>
<td>Deductible, then $0 copay</td>
<td>Deductible, then $0 copay</td>
</tr>
<tr>
<td><strong>OUTPATIENT DIAGNOSTIC HIGH END (including MRI, MRA, CT, PET):</strong></td>
<td>Deductible, then $150 copay</td>
<td>Not covered – exceptions apply</td>
</tr>
<tr>
<td><strong>OUTPATIENT DIAGNOSTIC LOW END:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Deductible, then $0 copay</td>
<td>Deductible, then $30 copay</td>
</tr>
<tr>
<td><strong>PHYSICAL, SPEECH AND OCCUPATIONAL THERAPY SERVICES:</strong></td>
<td>Deductible, then $20 copay</td>
<td>Deductible, then $25 copay</td>
</tr>
<tr>
<td><strong>OUTPATIENT CHEMOTHERAPY AND RADIATION:</strong></td>
<td>Deductible, then $0 copay</td>
<td>Deductible, then $20 copay</td>
</tr>
</tbody>
</table>

*This is a summary only and not intended as a complete description of covered services.*
Aetna Choice POSII Health Reimbursement Account (HRA)*
This option provides you and your covered dependents with the choice of using services from Aetna Choice
POSII Open Access Network providers as well as from non-participating providers. Should you choose to use
UM physicians and UM facilities, your costs may be lower. Members in this plan receive an HRA fund of $600 per
individual (maximum of $1,800 per family).

<table>
<thead>
<tr>
<th>Service</th>
<th>UM Providers</th>
<th>CPII Open Access</th>
<th>Out of Network **</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRIMARY CARE (PCP):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>Deductible, then $15 copay</td>
<td>Deductible, then $20 copay</td>
<td>Deductible, then 30% coinsurance</td>
</tr>
<tr>
<td>SPECIALTY CARE (SPEC):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>Deductible, then $25 copay</td>
<td>Deductible, then $50 copay</td>
<td>Deductible, then 30% coinsurance</td>
</tr>
<tr>
<td>MATERNITY CARE:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First OB Prenatal Visit</td>
<td>First OB Prenatal Visit</td>
<td>First OB Prenatal Visit</td>
<td>First OB Prenatal Visit</td>
</tr>
<tr>
<td>All Other Prenatal Visits</td>
<td>All Other Prenatal Visits</td>
<td>All Other Prenatal Visits</td>
<td>All Other Prenatal Visits</td>
</tr>
<tr>
<td>Hospital Inpatient</td>
<td>(refer to hospital services below)</td>
<td>(refer to hospital services below)</td>
<td>(refer to hospital services below)</td>
</tr>
<tr>
<td>HOSPITAL SERVICES:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td>Deductible, then $100/day x 5 days per admission</td>
<td>Deductible, then $200/day x 5 days per admission</td>
<td>Deductible, then 30% coinsurance</td>
</tr>
<tr>
<td>Physician</td>
<td>Deductible, then $0 copay</td>
<td>Deductible, then $0 copay</td>
<td>Deductible, then 30% coinsurance</td>
</tr>
<tr>
<td>EMERGENCY SERVICES:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room (waived if admitted)</td>
<td>Deductible, then $100 copay</td>
<td>Deductible, then $100 copay</td>
<td>Deductible, then $100 copay</td>
</tr>
<tr>
<td>Urgent Care Facility</td>
<td>Deductible, then $35 copay</td>
<td>Deductible, then $35 copay</td>
<td>Deductible, then 30% coinsurance</td>
</tr>
<tr>
<td>OUTPATIENT SURGERY:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td>Deductible, then $50 copay</td>
<td>Deductible, then $150 copay</td>
<td>Deductible, then 30% coinsurance</td>
</tr>
<tr>
<td>Physician</td>
<td>Deductible, then $0 copay</td>
<td>Deductible, then $0 copay</td>
<td>Deductible, then 30% coinsurance</td>
</tr>
<tr>
<td>OUTPATIENT DIAGNOSTIC HIGH END (including MRI, MRA, CT, PET):</td>
<td>Deductible, then $150 copay</td>
<td>Not covered – exceptions apply</td>
<td>Not covered – exceptions apply</td>
</tr>
<tr>
<td>OUTPATIENT DIAGNOSTIC LOW END:</td>
<td>Deductible, then $0 copay</td>
<td>Deductible, then $40 copay</td>
<td>Deductible, then 30% coinsurance</td>
</tr>
<tr>
<td>PHYSICAL, SPEECH AND OCCUPATIONAL THERAPY SERVICES:</td>
<td>Deductible, then $15 copay</td>
<td>Deductible, then $20 copay</td>
<td>Deductible, then 30% coinsurance</td>
</tr>
<tr>
<td>OUTPATIENT CHEMOTHERAPY AND RADIATION:</td>
<td>Deductible, then $0 copay</td>
<td>Deductible, then $20 copay</td>
<td>Deductible, then 30% coinsurance</td>
</tr>
</tbody>
</table>

* This is a summary only and not intended as a complete description of covered services.
** Out of Network services are subject to balance billing.
Aetna Choice POSII Health Reimbursement Account (HRA) for Out of Area Employees*

Only employees who permanently reside outside of Miami-Dade and Broward counties may elect this option. Eligibility is determined by HR-Benefits. This plan may be chosen upon initial enrollment in the health plan or during Open Enrollment.

This option provides you and your covered dependents with the choice of using services from Aetna Choice POSII Open Access Network providers as well as from non-participating providers. Members in this plan receive an HRA fund of $600 per individual (maximum of $1,800 per family).

<table>
<thead>
<tr>
<th>Service</th>
<th>CPII Open Access</th>
<th>Out of Network **</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRIMARY CARE (PCP):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>Deductible, then $15 copay</td>
<td>Deductible, then 30% coinsurance</td>
</tr>
<tr>
<td>SPECIALTY CARE (SPEC):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>Deductible, then $25 copay</td>
<td>Deductible, then 30% coinsurance</td>
</tr>
<tr>
<td>MATERNITY CARE:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First OB Prenatal Visit</td>
<td>Deductible, then $25 copay</td>
<td>Deductible, then $60 copay</td>
</tr>
<tr>
<td>All Other Prenatal Visits</td>
<td>Deductible, then $0 copay</td>
<td>Deductible, then $0 copay</td>
</tr>
<tr>
<td>Hospital Inpatient</td>
<td>(refer to hospital services below)</td>
<td>(refer to hospital services below)</td>
</tr>
<tr>
<td>HOSPITAL SERVICES:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td>Deductible, then $100/day x 5 days per admission</td>
<td>Deductible, then 30% coinsurance</td>
</tr>
<tr>
<td>EMERGENCY SERVICES:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room (waived if admitted)</td>
<td>Deductible, then $100 copay</td>
<td>Deductible, then $100 copay</td>
</tr>
<tr>
<td>Urgent Care Facility</td>
<td>Deductible, then $35 copay</td>
<td>Deductible, then 30% coinsurance</td>
</tr>
<tr>
<td>OUTPATIENT SURGERY:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td>Deductible, then $50 copay</td>
<td>Deductible, then 30% coinsurance</td>
</tr>
<tr>
<td>Physician</td>
<td>Deductible, then $0 copay</td>
<td>Deductible, then 30% coinsurance</td>
</tr>
<tr>
<td>OUTPATIENT DIAGNOSTIC HIGH END (including MRI, MRA, CT, PET):</td>
<td>Deductible, then $100 copay</td>
<td>Not covered – exceptions apply</td>
</tr>
<tr>
<td>OUTPATIENT DIAGNOSTIC LOW END:</td>
<td>Deductible, then $0 copay</td>
<td>Deductible, then 30% coinsurance</td>
</tr>
<tr>
<td>PHYSICAL, SPEECH AND OCCUPATIONAL THERAPY SERVICES:</td>
<td>Deductible, then $15 copay</td>
<td>Deductible, then 30% coinsurance</td>
</tr>
<tr>
<td>OUTPATIENT CHEMOTHERAPY AND RADIATION:</td>
<td>Deductible, then $0 copay</td>
<td>Deductible, then 30% coinsurance</td>
</tr>
</tbody>
</table>

* This is a summary only and not intended as a complete description of covered services.
** Out of Network services are subject to balance billing.
Pharmacy Plan

The Pharmacy Plan available to members who are enrolled in health care is called Aetna’s Four Tier Open Formulary. It is administered by Aetna. Under the Four Tier Open Formulary Plan, prescription drugs assigned to one of four different levels with corresponding copayments:

- Level 1 = $10
- Level 2 = $45
- Level 3 = $75
- Level 4 = $100

Please note that in the HRA plans, the copayments above do not apply until after the fund has been exhausted and the deductible has been met. The pharmacy plan monthly premium equivalents are already included in the medical plan premium equivalent rates. In accordance with the Patient Protection and Affordable Care Act, many generic oral contraceptives and some contraceptive devices are covered at 100% by the plan. Please visit www.aetna.com for a complete list.

Aetna Rx Home Delivery (Mail Order Benefit)

Maintenance medications are medications taken over long periods of time. If you are taking a maintenance medication, you may use Aetna Rx Home Delivery to obtain a 3 month supply of your medication for 2.5 copays (for HRA, copays apply after the deductible is met). If you prefer to purchase your maintenance medication at your local retail pharmacy in 30 day increments, your monthly copay will increase to 2.5x the typical copay after you’ve purchased two 30-day supplies at retail. If you are using a discount program that does not submit claims to Aetna, or the amount you pay each month is less than the full copay, the increase in copay for continuing to purchase monthly will not apply.

Maintenance Choice at CVS (Retail Pharmacy Benefit)

Maintenance medications are medications taken over long periods of time. If you are taking a maintenance medication, you may also visit any CVS retail pharmacy to purchase a 3 month supply of your medication for 2.5 copays (for HRA, copays apply after the deductible is met). If you prefer to purchase your maintenance medication in 30 day increments at CVS or any other retail pharmacy, your monthly copay will increase to 2.5x the typical copay after you’ve purchased two 30-day supplies at retail. If you are using a discount program that does not submit claims to Aetna, or the amount you pay each month is less than the full copay, the increase in copay for continuing to purchase monthly will not apply.

Generic Incentive

If you fill a brand name medication when a generic is available, you will be responsible for the higher copay, plus the difference in cost between the generic and the brand name medication. If your physician believes that the generic will not result in the same outcome for you, he/she may contact Aetna to request an authorization to fill the brand name medication without the additional cost.

Step Therapy

The UM/Aetna medical plan covers thousands of medications. Some of these medications have equally effective, but much less expensive, alternatives. The Step Therapy program gives you options regarding these medical conditions:

- Try It and Like It: If you choose to try the lower cost alternative and like it, you may continue to use this new drug, which will help you save money on your prescription drug copay.

- Try It and Don’t Like It: If you choose to try the lower cost alternative, but it does not work as well for you, your doctor can call Aetna to let them know and you may be able to use the more expensive medication at its regular copay.
If you use the more expensive prescription without first trying one of the lower cost alternatives, you will be required to pay the full cost of the medication.

If your physician believes that the alternative medications will not result in the same outcome for you, he/she may contact Aetna to request an authorization to fill the original medication at the standard copay.

**HRA Fund**

The fund is applied each January 1st for the calendar year. For those who enroll mid-year, the entire annual fund is deposited when coverage takes effect. The full annual deductible applies regardless of coverage effective date. If dependents are covered, the entire family shares the fund. Unused fund dollars are rolled over to the following calendar year if the HRA plan is selected again. HRA fund dollars are used first before any Flexible Spending elections. Amounts deducted from the HRA fund are based on the contracted rate for the service/product between Aetna and the health care provider. If a member leaves the plan during the year but other family members remain on the same subscriber’s coverage, the funds assigned to that family member are recovered by the plan if not used.

**Deductibles**

The individual deductible is the amount you pay toward your own or a dependent's covered expenses each calendar year, before the plan begins sharing the cost with you. Each plan also has a maximum family deductible to set a limit on the amount of money you spend before the plan begins sharing the cost. No one individual goes beyond their own deductible, but the family’s medical expenses can be combined to satisfy the family deductible. These are the deductibles for each plan:

### Deductibles (Participating Providers)

<table>
<thead>
<tr>
<th></th>
<th>AETNA SELECT 1</th>
<th>AETNA SELECT 2</th>
<th>AETNA CHOICE POSII</th>
<th>AETNA CHOICE POSII HRA OUT OF AREA</th>
</tr>
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<tbody>
<tr>
<td><strong>Individual</strong></td>
<td>$0</td>
<td>$250</td>
<td>$1,500</td>
<td>$1,500</td>
</tr>
<tr>
<td><strong>EE+1 Dep</strong></td>
<td>$0</td>
<td>$500</td>
<td>$3,000</td>
<td>$3,000</td>
</tr>
<tr>
<td><strong>Family</strong></td>
<td>$0</td>
<td>$750</td>
<td>$4,500</td>
<td>$4,500</td>
</tr>
</tbody>
</table>

### Deductibles (Non-Participating Providers)

<table>
<thead>
<tr>
<th></th>
<th>AETNA SELECT 1</th>
<th>AETNA SELECT 2</th>
<th>AETNA CHOICE POSII</th>
<th>AETNA CHOICE POSII HRA OUT OF AREA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual</strong></td>
<td>N/A</td>
<td>N/A</td>
<td>$3,000</td>
<td>$3,000</td>
</tr>
<tr>
<td><strong>EE+1 Dep</strong></td>
<td>N/A</td>
<td>N/A</td>
<td>$6,000</td>
<td>$6,000</td>
</tr>
<tr>
<td><strong>Family</strong></td>
<td>N/A</td>
<td>N/A</td>
<td>$9,000</td>
<td>$9,000</td>
</tr>
</tbody>
</table>
Annual Out-of-Pocket Maximums
Deductibles, medical copayments, prescription drug copayments and Concordia Behavioral Health copayments count towards the out of pocket maximum in all plans (no deductible in Select 1). As with the deductible, out of pocket maximums are capped per person. However, the entire family’s medical expenses can be combined to meet the family’s out of pocket maximum. After the out of pocket maximum is met, all medical copayments and coinsurance will be paid at 100% by the plan for the rest of the calendar year.

### Out of Pocket Maximums (Participating Providers)

<table>
<thead>
<tr>
<th>Provider</th>
<th>AETNA SELECT 1</th>
<th>AETNA SELECT 2</th>
<th>AETNA CHOICE POSII HRA</th>
<th>AETNA CHOICE POSII HRA OUT OF AREA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$3,000</td>
<td>$4,000</td>
<td>$4,000</td>
<td>$4,000</td>
</tr>
<tr>
<td>EE+1</td>
<td>$6,000</td>
<td>$8,000</td>
<td>$8,000</td>
<td>$8,000</td>
</tr>
<tr>
<td>Family</td>
<td>$9,000</td>
<td>$12,000</td>
<td>$12,000</td>
<td>$12,000</td>
</tr>
</tbody>
</table>

### Out of Pocket Maximums (Non-Participating Providers)

<table>
<thead>
<tr>
<th>Provider</th>
<th>AETNA SELECT 1</th>
<th>AETNA SELECT 2</th>
<th>AETNA CHOICE POSII HRA</th>
<th>AETNA CHOICE POSII HRA OUT OF AREA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>N/A</td>
<td>N/A</td>
<td>$8,000</td>
<td>$8,000</td>
</tr>
<tr>
<td>EE+1</td>
<td>N/A</td>
<td>N/A</td>
<td>$16,000</td>
<td>$16,000</td>
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<tr>
<td>Family</td>
<td>N/A</td>
<td>N/A</td>
<td>$24,000</td>
<td>$24,000</td>
</tr>
</tbody>
</table>

**Concordia Behavioral Health**

Concordia Behavioral Health is a licensed managed behavioral health program which provides outpatient, inpatient and partial hospitalization behavioral health and substance abuse services to any employee and family member enrolled in one of the medical plans. Concordia offers a full spectrum of mental health services that are essential and medically necessary. Covered services for adults, adolescents and children include: individual and group outpatient services: inpatient psychiatric and substance abuse treatment; intensive outpatient and partial hospitalization; family counseling and 24 hour emergency care services. The network for Concordia is primarily in South Florida. If you or your covered dependent permanently resides outside of South Florida, please contact Concordia to arrange for coverage in your area.

For South Florida, Aetna Select 1 and Aetna Select 2 in-network coverage is available. For the HRA plans, in and out of network coverage is available. For the HRA plans, out of network coverage is paid at 70% of reasonable and customary charges.

Please note that before accessing services, you should contact Concordia Behavioral Health Member Services at 1-800-294-8642 to confirm network status of the provider you wish to see.
In-Network Concordia Behavioral Health benefits for all Aetna plans

<table>
<thead>
<tr>
<th>Outpatient</th>
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<tbody>
<tr>
<td>Individual Therapy</td>
</tr>
<tr>
<td>$20/visit</td>
</tr>
<tr>
<td>Group Therapy</td>
</tr>
<tr>
<td>No co-payment</td>
</tr>
<tr>
<td>Benefit Payment</td>
</tr>
<tr>
<td>100% of negotiated fee</td>
</tr>
<tr>
<td>Maximum Calendar Year Benefit</td>
</tr>
<tr>
<td>Based on medical necessity</td>
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</tbody>
</table>

In-Network Concordia Behavioral Health benefits for all Aetna plans

<table>
<thead>
<tr>
<th>Inpatient</th>
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</thead>
<tbody>
<tr>
<td>Deductible per admission</td>
</tr>
<tr>
<td>$0</td>
</tr>
<tr>
<td>Benefit payment</td>
</tr>
<tr>
<td>100% of allowable charges</td>
</tr>
<tr>
<td>Maximum Days</td>
</tr>
<tr>
<td>Based on medical necessity</td>
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<tr>
<td>Pre-Certification</td>
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<tr>
<td>Required</td>
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</table>

Out-of-network Concordia Behavioral Health benefits for the POSII/HRA Plans

<table>
<thead>
<tr>
<th>Inpatient/Outpatient</th>
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</thead>
<tbody>
<tr>
<td>Coverage at 70% of reasonable and customary charges</td>
</tr>
<tr>
<td>Pre-Certification</td>
</tr>
<tr>
<td>Required</td>
</tr>
<tr>
<td>Maximum Calendar Year Benefit</td>
</tr>
<tr>
<td>Based on medical necessity</td>
</tr>
</tbody>
</table>

Remember: To receive benefit coverage, you must contact Concordia to receive pre-authorization and a referral. If you or your covered dependent resides outside of the Concordia service area and require Concordia services, please contact 1-800-294-8642 to arrange for services in your area.

Coverage for Autism and other Pervasive Developmental Disorders

The services that will be eligible for coverage will include the following: speech therapy, occupational therapy, physical therapy, and applied behavioral analysis (ABA) for individuals under 18 years of age, or for those 18 years or older who are in high school and were diagnosed as having a developmental disability at 8 years of age or younger.

Coverage shall be limited to services that are prescribed by the subscriber’s treating physician in accordance with a treatment plan. The treatment plan shall include, but is not limited to, a diagnosis, the proposed treatment by type, the frequency and duration of treatment, the anticipated outcomes stated as goals, the frequency by which the treatment plan will be updated, and signature of the treating physician.

Coverage for these services has no annual or lifetime limit, but is subject to co-payments and coverage limitations. Certification of eligibility and coordination of benefits will be required.

Exclusions under this benefit will include: diagnostic testing and treatment related to mental retardation or deficiency, learning disability, behavioral problems and developmental delay. Expenses for remedial, special education, counseling or therapy for mental retardation are not covered in this Autism Spectrum Disorder coverage.

Definitions:

“Applied Behavioral Analysis” means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including, but not limited to, the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.
"Autism spectrum disorder" means any of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:

1. Autistic disorder;
2. Asperger's syndrome;
3. Pervasive developmental disorder not otherwise specified.

**Autism**

Autism is a complex developmental disability that typically appears during the first three years of life; and is the result of a neurological disorder that affects the normal functioning of the brain, impacting development in the areas of social interaction and communication skills.

Autism is one of five disorders that fall in under the umbrella of Pervasive Developmental Disorders (PDD), a category of neurological disorders characterized by “severe and pervasive impairment in several areas of development.”

The Centers for Disease Control and Prevention estimate that 1 in 88 children are affected by this disorder. The latest reports are estimating that the prevalence is higher. Autism affects boys almost five times more than girls.

Children with autism typically have difficulties with:

- Verbal and nonverbal communication
- Pretend play
- Social interactions
- Sensory Integration

**Enhanced Benefits for Learning Disabled Children**

Children who are developmentally delayed may be eligible for additional benefits from the University of Miami through the Rehabilitative Services benefit. These benefits are offered directly through the University and are not part of the Aetna health plan, but enrollment in the UM/Aetna medical plan is required. The additional benefit is not offered to those not currently enrolled in a UM/Aetna medical plan.

The Rehabilitative Services program provides for evaluation by a psychiatrist and/or psychologist, as well as coverage for other non-experimental, peer reviewed interventions needed as a result of a congenital syndrome or acquired neurological damage (including deafness) during the birthing process as a limited covered benefit. The benefit is unlimited, but claims are paid on a reimbursement basis for expenses incurred. All treatment plans must be pre-approved by Concordia Behavioral Health. This benefit ends at the end of the calendar year in which the dependent child turns 18.

Benefits require pre-authorization from Concordia Behavioral Health. For more information, contact 1-800-294-8642.

Autism coverage is unlimited and will include all benefits used through Aetna, Concordia Behavioral Health and Special Employee Benefits except for ABA. Medical copayments and deductibles apply according to plan. Benefits are based on medical necessity and are for enrollees 18 years of age or younger. Enrollment in UM/Aetna coverage is required. If you visit UM CARD for your initial assessment, coverage is available through the Special Employee Benefits. Authorization from CBH must be obtained prior to the UM CARD initial assessment.
**Aetna Benefits**
- Speech Therapy
- Occupational Therapy
- Physical Therapy
- Neurological Evaluation

Use of the Aetna network is encouraged. Out of network providers may also be used for this benefit. Members will be responsible for their Aetna network copay for both in and out of network providers.

Claims should be submitted to:
Aetna
P.O. Box 981106
El Paso, TX 79998-1106

**Concordia Benefits**
- Applied Behavioral Analysis (ABA)
- Medication Management by a Psychiatrist

Use of the Concordia network is encouraged. Out of network providers may also be used for this benefit. Members will be responsible for their Concordia network copay for both in and out of network providers. Prior authorization is required for all services (in and out of network).

Claims should be submitted to:
Concordia Claims Department
Attn. Finance Director
1320 South Dixie Hwy.
Suite 400
Coral Gables, FL 33146

**Special Employee Benefits for Rehabilitation**
- Coverage for evaluation by Psychiatrist and/or Psychologist, including assessment by UM CARD
- Coverage of other non-experimental, peer reviewed interventions will be considered and reviewed for medical necessity

Claims for these benefits are paid on a reimbursement basis. Concordia/Aetna network usage is not required.

Claims should be submitted to:
Concordia Behavioral Health
Attn: Finance Director
Special Employee Benefit Claims
1320 South Dixie Hwy.
Suite 400
Coral Gables, FL 33146

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**Termination and Continuation of Coverage**
Coverage for you and your insured dependents will terminate when your employment terminates, you enter the Armed Forces, you die or when the master contract terminates. Insurance for dependents will also terminate when your coverage terminates or when they are no longer eligible dependents as described. Coverage will end the last day of the month in which you are no longer a full-time regular or part-time employee.

**Introduction**
This SPD contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This is a general explanation of COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.
IMPORTANT INFORMATION
ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS

What is continuation coverage?
Federal law requires that most group health plans including this Plan give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee or retired employee covered under the group health plan, the covered employee's spouse, and the dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment and special enrollment rights.

How long will continuation coverage last?
In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee last until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries. Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of COBRA continuation coverage?
If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify HR-Benefits of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability
An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. Premiums for qualified beneficiaries who are determined by Social Security to be disabled may be increased from 102% to 150% of the full cost of coverage if the qualified
beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Plan of that fact within 31 days after the Social Security Administration’s determination.

Second Qualifying Event
An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee’s becoming entitled to Medicare benefits, or a dependent child’s ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

How can you elect COBRA continuation coverage?
Wageworks, Inc. is our COBRA administrator. To elect continuation coverage, you must complete the Wageworks Election Form that was mailed to you and furnish it according to the directions of the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee’s spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee’s spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that failure to continue your group health coverage will affect your future rights under Federal law. First, you can lose the right to avoid having pre-existing condition exclusion applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse’s employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?
Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice. When and how must payment for COBRA continuation coverage be made?

First payment for continuation coverage
If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible
for making sure that the amount of your first payment is correct. You may contact the Plan Administrator to confirm the correct amount of your first payment.

**Periodic payments for continuation coverage**

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the first of the month for that coverage period. The Plan will not send periodic notices of payments due for these coverage periods.

**Grace periods for periodic payments**

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is postmarked before the end of the grace period for that payment.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Your first payment and all subsequent periodic payments for continuation coverage should be sent to:

Wageworks, Inc.
P.O. Box 14055
Lexington, KY 40512-4055

**For more information**

If you have any questions concerning the information in the notice, your rights to coverage, you should contact HR-Benefits at 305-284-3004.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability ACT (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

**Keep Your Plan Informed of Address Changes**

In order to protect your and your family's rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

**Plan Contact Information**

University of Miami, HR-Benefits
PO Box 248106
Coral Gables, FL 33124-2902
305-284-3004

**Claims**

Aetna is the claims administrator for the University of Miami Health Plan. A claim which has not been timely filed (timely filing defined as not more than 365 days after the date of service) with Aetna shall be considered waived if, on the date notice of it is received by Aetna, that claim would otherwise have been waived by Florida Statute of Limitations if asserted in a civil court.

Faculty and staff receiving a bill for covered services from an Aetna provider should do the following:

In-Network
1. Make a copy of your Aetna ID card (front and back) and a copy of the bill. Send a copy of both to the provider who is sending you the bill. This will alert the provider to bill the insurance company. Provide an explanation of the issue.

2. Follow the same procedures as in step 1, but mail the information to the Aetna claims address on the back of your Aetna ID card. Provide an explanation of the issue.

Out-of-Network

1. Utilize the claim form located at www.miami.edu/benefits/forms or

2. Send Aetna a copy of your Aetna ID card and a copy of the itemized bill. When filing a claim you will need to provide all the information below:
   - Member ID number
   - Patient date of birth (DOB)
   - Diagnosis code(s)
   - Procedure code(s)
   - Billed charges
   - Provider name and address or provider tax ID number
   - Indicate on the bill if the charges were paid by the member

Aetna Claims Center
PO Box 981106
El Paso, TX 79998-1106

Subrogation

Sometimes, members are involved in liability cases that involve a third party. An example would be if you were injured as a result of negligence from a third party such as tripping and falling on public property due to the public authority’s failure to maintain a public sidewalk. In the event any payment for benefits provided to a member under this Plan is made to or on behalf of the member, the Plan Administrator to the extent of such payment, shall be subrogated to all causes of action and all rights of recovery such member has against any person or organization. Such subrogation rights shall extend and apply to any settlement of a claim, irrespective of whether litigation has been initiated.

The member shall execute and deliver such instruments and papers pertaining to such settlement of claims, settlement negotiations or litigation as may be requested by the Plan Administrator, shall do whatever is necessary to enable the Plan Administrator to exercise the Plan’s rights of subrogation and shall disclose to the Plan Administrator any amount recovered from any person or organization that may be liable for bodily injuries and shall not make any settlements without the Plan Administrator’s prior written consent.

No waiver, release of liability or other documents executed by the member or authorized representative without such notice to the Plan Administrator and cooperation by the member if requested, shall be binding upon the Plan Administrator.

Medical care benefits are not payable to or for a member when an injury or illness to the member occurs through the omission of another person. However, the Plan may elect advance payment for medical care expenses for an injury or illness in which a third party may be liable. For this to occur, the member must sign an agreement with the Plan to pay the Plan, in full, any sums advanced to cover such medical expenses from a judgment or settlement he or she receives.
Qualified Medical Child Support Order (QMCSO)
Participants may obtain a copy of the plan’s procedures without cost by contacting HR-Benefits.

Early Retirement
You and/or your covered family members may continue your current group health plan coverage if you qualify for early retirement [age 55 with ten years of service or Rule of 70 (age plus years of service are equal to 70 and you are less than 65 years of age)]. Premiums are at the full group rate rather than the active employee rate. Registration is required within 30 days of your retirement or the entitlement is lost. You may continue coverage until age 65. If you continue coverage for a spouse/same sex domestic partner, his/her coverage will end at his/her age 65. Any covered dependents who maintain coverage through the Early Retiree coverage of the employee/parent may stay on the plan until his/her age 26, and will be offered COBRA thereafter. If the employee is over age 65 at the time of separation, but the covered family members are under age 65 or 26 as applicable, they may continue their coverage until the limiting age listed even though the retiree is not covered by the plan beyond age 65. Coverage for dependents ends at age 26. Contact HR-Benefits for more information on early retirement.

Retirees over 65
If you are still working for the University after age 65 when you become eligible for Medicare, you may continue to be covered under the Plan and it will be your primary benefit source before Medicare. There is no employer administered plan for a retired person over age 65.

Long Term Disability
If you are receiving long term disability benefits through the University, your medical plan coverage may be continued at the time you are approved for disability or the entitlement is lost. Your health and dental coverage will continue as long as you continue to pay for your portion of the premium. If you have health and/or dental coverage on a spouse/partner or dependent and wish to continue those benefits, you must pay for the full cost of their coverage. Coverage ends on the last day of the month of your approved disability.

If you are approved for Medicare benefits while you are on LTD, you will be required to enroll in Medicare Parts A and B. Your new Medicare coverage will become your primary insurance. Should you wish to keep your UM medical insurance, it will act as your secondary insurance after Medicare. The University of Miami will reimburse your Part B premiums while you are covered by the UM medical plan.

Faculty/Staff Assistance Program
Faculty/Staff Assistance Program (FSAP) is a free, confidential service available as a basic benefit of employment. FSAP serves as an assessment and referral service and covers three sessions annually. FSAP assists in management of difficulties such as alcohol or chemical dependency, depression, anxiety, marital and family problems, legal, financial and job related concerns. To arrange for an appointment, call Coral Gables campus at 305-284-6604 or 1-800-341-8060. If follow-up or long term care is needed, FSAP may refer you to Concordia Behavioral Health; provided you are covered under one of the University health plans.

Vision Benefit
Routine vision care for University of Miami faculty, staff, and dependents will be provided in the form of one routine vision exam per year at no charge. In order to receive this benefit, one must be enrolled in the UM/Aetna medical plan. Aetna also offers vision benefits to UM plan participants through EyeMed, which includes a free routine eye exam and discounts on materials such as contacts, frames and lenses. Please visit www.miami.edu/benefits for additional information.
## DENTAL INSURANCE

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>What the Plan Can Do For You</td>
<td>60</td>
</tr>
<tr>
<td>Dependent Coverage</td>
<td>60</td>
</tr>
<tr>
<td>Qualifying Status Changes</td>
<td>61</td>
</tr>
<tr>
<td>CIGNA Dental Care Plan (DHMO)</td>
<td>62</td>
</tr>
<tr>
<td>Delta Dental PPO Plan</td>
<td>63</td>
</tr>
<tr>
<td>HIPAA Privacy</td>
<td>64</td>
</tr>
</tbody>
</table>
Dental Insurance

What the Plan Can Do For You
The University of Miami offers optional dental coverage through the Dental Plan. There are two options available, a DHMO administered by CIGNA and a PPO administered by Delta Dental. To join this Plan you will need to authorize monthly payroll deductions for your coverage on the enrollment form.

You are eligible to join the University of Miami dental plans if you are a regular full-time or part-time faculty, staff or members of affiliates working at least 50% effort. Coverage will begin on your date of hire.

Enrollment must be completed via benefits enrollment in Workday. If enrollment is not completed within 15 days after date of hire, you will not be eligible to enroll until the following Open Enrollment period unless a Qualified Status Change occurs.

Dental premiums are deducted on a pre-tax basis with salary reduction equal to the current cost of coverage selected. Once elected, the employee’s income, which is subject to Federal income tax and Social Security withholding (FICA), will be reduced. This may affect future amounts received from Social Security. Except for Qualified Status Changes, elections for group dental insurance may not be changed during the Plan year.

The amount of your premium will depend on the plan option you choose and whether you elect to cover eligible family members.

Dependent Coverage
Eligible dependents may be enrolled at the time the employee enrolls. Enrollments can also occur during an Open Enrollment period or at the time of a Qualified Status Change.

A dependent is defined as the child of the subscriber, provided that the following conditions apply:

- The child is the biological child or stepchild of the subscriber or legally adopted child (from the moment of placement in compliance with Florida law) in the custody of the subscriber; written evidence of adoption must be furnished to the Plan Administrator upon request. Except as specifically noted, the child must meet all requirements for eligibility listed herein:
  a. The child has not reached the Limiting Age which is defined in this Section as the last day of the month in which he or she turns age 26 (except for paragraph b) below);
  b. Coverage will be extended where the child is either physically incapacitated or mentally challenged, is not capable of supporting him or herself and regularly receives over 50% of his/her support from the subscriber, provided that the dependent was covered under the University’s Group Health Plan prior to reaching age 26.
    i. Proof of incapacitation or mental challenge (e.g. written documentation from the child’s physician) is required for coverage after the child has reached age 26.
    ii. Coverage for dependent child who is physically incapacitated or mentally challenged may be discontinued at the end of the calendar month in which the child reaches age 26 and:
      1. the child is no longer disabled; or
      2. the child is capable of supporting him or herself; or
      3. the child no longer receives more than 50% of his/her support from the subscriber; or
      4. the child receives less than 50% of his/her support from the subscriber and the subscriber is no longer obligated to provide medical care for said child by court order.
  c. Coverage will be extended where the subscriber has agreed to regularly provide medical care for the child by court order regardless of adoption.
d. Coverage will be extended where a Qualified Medical Child Support Order (QMSCO) exists; Whether or not said child resides with the employee.
e. A newborn child of a covered dependent child is ineligible for dental coverage after delivery.

- Your legally recognized spouse. This includes same-sex spouses who are legally married in any state or jurisdiction.
- Same sex domestic partner provided the relationship has existed for at least 12 consecutive months, the domestic partner shares living arrangements and a state of financial co-dependency exists. Neither partner may be married to anyone else. Coverage is available for eligible dependent children of a same sex domestic partner as well. When requesting coverage for a same sex domestic partner via Workday, eligibility requirements, documentation and tax consequences may be reviewed with potential enrollees.

For all covered dependents, proof of relationship is required in the applicable form of a government issued marriage license, government issued birth certificate, divorce decree, etc. The University reserves the right to audit employee records and request these documents at any time if not already on file. If the documents cannot be provided to the University within a reasonable amount of time when requested, we reserve the right to terminate coverage for the applicable dependent.

**Qualifying Status Changes**

IRS Section 125 rules regarding pre-tax premium plans do not allow for enrollment, additions, changes, or cancellations except with the occurrence of a Qualifying Status Change (QSC) event, followed by written application for a change within 30 days or during the annual open enrollment period. The federal government determines the events that qualify as QSCs, and this list is subject to periodic change. The following events are some, but not necessarily all, valid QSC events:

- Marriage or divorce
- Death of a spouse or dependent
- Birth or adoption
- Change in dependent eligibility
- Loss of coverage through Medicaid or other SCHIP or new enrollment in Medicaid or other SCHIP
- Change in employment status of employee, spouse, or dependent including:
  1. Termination of spouse’s or dependent’s employment
  2. Unpaid leave of absence over 30 calendar days
  3. Change from part-time to full-time status or vice versa

An enrollee wishing to change a benefit election on the basis of a QSC must complete the following steps:

1. Report the QSC to HR-Benefits via Workday and requesting the corresponding change to benefits.
2. Provide required supporting documentation (e.g. government issued marriage certificate, government issued birth certificate, divorce decree, etc.). QSCs cannot be processed without the corresponding required supporting documentation.
3. HR-Benefits must receive the request via Workday and related documentation within 30 days of the QSC event or the request for change(s) will be denied and cannot be made until the next annual open enrollment period. NOTE: The enrollee should report the event immediately if supporting documentation is not readily available; a period of 60 days may be allowed to provide the necessary documentation. For Medicaid or other SCHIP events, a period of 60 days is allowed to make a change.
Termination of dependents
If you have a spouse, domestic partner or child who no longer qualifies for coverage, you are required to notify HR-Benefits via Workday within 30 days of the event in order to remove the individual from coverage.

Non Compliance
Falsifying information/documentation in order to obtain/continue insurance coverage is considered a dishonest act and could lead to discipline and criminal prosecution. Inadvertent or negligent failures to update or correct information related to eligibility of an employee’s listed dependent is also subject to penalty. Employees are responsible for updating dependent information within 30 calendar days of the occurrence of any event affecting eligibility; for example, a divorce severing a marriage. The University may impose a financial penalty, including, but not limited to, repayment of all insurance premiums the university made on behalf of the ineligible dependent and/or any claims paid by the insurance companies. Disciplinary action up to and including dismissal may also be imposed if deemed appropriate.

To make an enrollment change based on a QSC, the QSC must result in a gain or loss of eligibility for coverage, and general consistency rules must be met. For example, if an enrollee with family health insurance coverage is divorced and no longer has dependents, that enrollee may change from family to individual coverage but cannot cancel enrollment in health insurance because the QSC merely changes the level of coverage eligibility. Cancellation would not be consistent with the nature of the QSC event.

CIGNA Dental Care Plan (DHMO)
Under the CIGNA Dental Care Plan you select the dental provider that best meets your family’s needs from a list of licensed private dental practices located anywhere in the US. You must elect a primary care dental provider from a list of participating providers. Information on participating providers is available at www.CIGNA.com. You can change dentists at any time of the years by contacting CIGNA at 800-367-1037 or logging into their website. The change will be effective the first of the following month. This plan covers the cost of most dental care expenses.

The Dental Plan is designed to correct and prevent dental problems before they become serious. Therefore, under the Plan there is no charge for:

- Diagnostic examinations (every six months)
- Fillings
- Space maintenance
- X-rays
- Cleanings (every six months)
- Certain types of emergency care

The following services are also available at copayments below the dentist’s usual and customary charge:

- Crowns
- Bridges
- Gum treatment
- Oral surgery
- Orthodontics (children and adults)

For more information visit www.CIGNA.com.
**Delta Dental PPO**

The PPO Plan offers the use of any dentist you choose. If your dental provider is in the Delta Dental PPO network, your claim will be filed electronically. If your dental provider is not in the network, you must complete a Delta Dental Expense Claim Form and submit it to Delta Dental for reimbursement. Claims must be filed within 365 days from the date of service to be considered as filed timely. For more information contact Delta Dental Customer Service at 1-800-521-2651 or visit Delta Dental at [www.deltadentalins.com](http://www.deltadentalins.com). Benefits are maximized when using participating dentists.

### 2014 FEATURES (Total for In-Network and Out-of-Network)

<table>
<thead>
<tr>
<th>Feature</th>
<th>Delta Dental Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Benefit</td>
<td>$2,500 In-Network (Includes $1,500 Out of Network)</td>
</tr>
<tr>
<td>Annual Deductible</td>
<td>$50 per member/$150 per family</td>
</tr>
<tr>
<td>Lifetime Orthodontic Maximum (child)</td>
<td>$1,500</td>
</tr>
<tr>
<td>Lifetime Orthodontic Maximum (adult)</td>
<td>$1,500</td>
</tr>
</tbody>
</table>

#### Delta Dental BENEFITS

**Type A Preventive**

<table>
<thead>
<tr>
<th>Service</th>
<th>Delta Dental In Network</th>
<th>Delta Dental Out of Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Exams (twice per calendar year)</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>X-rays (full mouth/panorex) (1) every 3 years</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>X-rays (bitewing) (1) per calendar year; (1) in 6 consecutive months for children</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Prophylaxis/Cleaning twice per calendar year</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Fluoride Treatments (1) in 12 consecutive months (child to age 19)</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Space Maintainers (child to age 16)</td>
<td>100%</td>
<td>80%</td>
</tr>
</tbody>
</table>

**Type B Basic**

<table>
<thead>
<tr>
<th>Service</th>
<th>Delta Dental In Network</th>
<th>Delta Dental Out of Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sealants/Fillings</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Endodontics/Root Canal</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Simple Extractions</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Surgical Extractions/Oral Surgery</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
</tbody>
</table>

**Type C Major**

<table>
<thead>
<tr>
<th>Service</th>
<th>Delta Dental In Network</th>
<th>Delta Dental Out of Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rebases/Relines</td>
<td>50% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Crown Build-ups</td>
<td>50% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Dentures</td>
<td>50% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Bridges</td>
<td>50% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Inlays/Onlays</td>
<td>50% after deductible</td>
<td>40% after deductible</td>
</tr>
</tbody>
</table>

**Type D Orthodontia**

<table>
<thead>
<tr>
<th>Service</th>
<th>Delta Dental In Network</th>
<th>Delta Dental Out of Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthodontia</td>
<td>50%</td>
<td>40%</td>
</tr>
</tbody>
</table>

* Delta Dental reimbursement is based on maximum allowable charge.
HIPAA Privacy

The CIGNA and Delta Dental plans conform to new standards for protection of individual private health information (PHI). Neither the University of Miami nor CIGNA/Delta Dental condition enrollment in the plan based on an individual’s health status. Dental claims are submitted according to electronic data standards required by the act. The University of Miami subscribes to the use of the minimum necessary standard when it comes to an individual’s PHI. Access to PHI must be authorized in writing by the individual employee or representative.
# LONG TERM DISABILITY

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>What The Plan Can Do For You</td>
<td>66</td>
</tr>
<tr>
<td>Pre-Existing Condition</td>
<td>66</td>
</tr>
<tr>
<td>Definition of Disability</td>
<td>66</td>
</tr>
<tr>
<td>Employee Status and Benefits</td>
<td>66</td>
</tr>
<tr>
<td>Salary Continuation</td>
<td>67</td>
</tr>
<tr>
<td>While You Are Receiving Benefits</td>
<td>67</td>
</tr>
<tr>
<td>When Benefits Are Paid</td>
<td>67</td>
</tr>
<tr>
<td>How Long Benefits Are Payable</td>
<td>68</td>
</tr>
<tr>
<td>When Your Coverage Ends</td>
<td>68</td>
</tr>
<tr>
<td>Disabilities Not Covered</td>
<td>68</td>
</tr>
</tbody>
</table>
Long Term Disability

What The Plan Can Do For You
In case of an extended illness or injury, you may be eligible for continued income on a long-term basis. Income protection during these times is vital to many aspects of your life and the lives of your family members - particularly if the disability extends over several months or years.

The University's Long Term Disability Insurance Plan provides protection for you and your family when an illness or injury keeps you away from work. This Plan can continue as part of your salary through:

- Salary Continuation for up to six months, upon approval of Long Term Disability benefit
- Long Term Disability (LTD) benefits, which begin after six months and provide 60% of your salary (to a maximum benefit of $25,000 per month) for as long as the disability lasts, except for limitations noted later.

Here are definitions of certain terms used in this section:

Pre-Existing Condition
A pre-existing condition is a condition for which you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines for your condition.

For UMMG members hired on/before June 1, 2009 – If you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the three months prior to June 1, 2009, and your disability begins on/before May 31, 2010, your maximum monthly benefit will be limited to 60% of earnings to $15,000/month.

For UMMG members hired on/after June 1, 2009 - A pre-existing condition is a condition for which you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines for your condition in the three months prior to your coverage effective date, and your disability begins in the first twelve months of your coverage. Pre-existing conditions are not covered under the policy.

Definition of Disability
You are disabled when Unum determines that:
1. You are limited from performing the material and substantial duties of your regular occupation due to your sickness/injury, and
2. You have a 20% or more loss in your monthly earnings due to the same sickness/injury

Employee Status and Benefits
In the event you become disabled and you are approved for LTD by the third party administrator, your employment status changes and you are no longer a full-time or a part-time regular employee of the University of Miami. You are considered a disabled former employee of the University of Miami. Your position with the University becomes vacant as of the first day you are eligible for LTD benefits. Your department is allowed to fill your position.

You will continue to accrue time credit toward retirement. If you were hired after June 1, 2013, you will not receive University contributions each month toward your retirement while on LTD.
- If you are receiving long term disability benefits through the University, your medical plan coverage may be continued at the time you are approved for disability or the entitlement is lost. Your health and dental coverage will continue as long as you continue to pay for your portion of the premium. If you
have health and/or dental coverage on a spouse/partner or dependent and wish to continue those benefits, you must pay for the full cost of their coverage. Coverage ends on the last day of the month in which you are approved for disability if your health and/or dental coverage is not continued. Additionally, as part of the long term disability program, you are required to apply for Social Security Disability benefits. Aetna will assist you with the application process. If you are approved for Social Security Disability benefits, your Aetna disability payment will be offset by the new Social Security Disability payments. This will not reduce the total disability payment you receive.

- If you are approved for Medicare benefits while you are on LTD, you will be required to enroll in Medicare parts A and B. Your new Medicare coverage will become your primary insurance. Should you wish to keep your UM medical insurance, it will act as your secondary insurance after Medicare. The University of Miami will reimburse your Part B premiums while you are covered by the UM medical plan.

If you completed five years or more of full-time or part-time regular employment at the University of Miami, tuition remission for yourself, spouse and dependents will continue. If you have fewer than five years of full-time regular service then tuition remission will not continue for yourself and/or your spouse/partner and dependents unless you or they are already enrolled in a program and receiving tuition remission.

Anyone hired after June 1, 2013, will not receive retirement contributions while on LTD.

### Salary Continuation

When you become totally disabled, the University will continue to pay your regular monthly salary (including salary from the V.A. Hospital) after you exhaust all accrued vacation and sick leave. Your salary will continue until you recover or until Long-Term Disability benefits begin after six months.

### While You Are Receiving Long-Term Disability Benefits

While you are receiving LTD benefits:

- Your health care coverage will continue.
- Your life insurance coverage will continue unless you are age 65 or older at the time of disability and your disability prevents you from doing any work for which you could become qualified by education, training or experience; but the benefit stops at age 65.
- If you are a participant in the Faculty Retirement Plan, the University will continue making Plan contributions to your account to the end of the year in which you reach age 65.

Group LTD benefits are offset by any individual disability benefits, Social Security and certain other benefits, including any severance pay from the University.

### When Benefits Are Paid

You must be continuously disabled through your elimination period (180 days). Unum will treat your disability and continuous if your disability stops for 30 days or less during the elimination period. The days that you are not disabled will not count toward your elimination period.

Unum will send you the monthly payment if you are disabled and your monthly disability earnings, if any, are less than 20% of your indexed monthly earnings due to the same sickness or injury.

If you are disabled and your monthly disability earnings are from 20% through 80% of your indexed monthly earnings due to the same sickness or injury, Unum figure your payment as follows:

During the first 12 months of payments, while working, your monthly payment will not be reduced as long as disability earnings plus the gross disability payment does not exceed 100% of indexed monthly earnings.
After 12 months of payments, while working, you will receive payments based on the percentage of income you are losing due to your disability.

If you have a recurrent disability, Unum will treat your disability as part of your prior claim and you will not have to complete another elimination period if:

- You were continuously insured under the plan for the period between the end of your prior claim and your recurrent disability;
- Your recurrent disability occurs within 6 months from the end of your prior claim.

Any disability which occurs after 6 months from the date your prior claim ended will be treated as new claim. The new claim will be subject to all of the policy provisions, including the elimination period.

**How Long Benefits Are Payable**

Unum will send you a payment each month up to the maximum period of payment. The maximum period of payment is based on your age at disability as follows:

<table>
<thead>
<tr>
<th>Age At Disability</th>
<th>Maximum Period of Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than age 62</td>
<td>To age 67</td>
</tr>
<tr>
<td>Age 62</td>
<td>60 months</td>
</tr>
<tr>
<td>Age 63</td>
<td>48 months</td>
</tr>
<tr>
<td>Age 64</td>
<td>42 months</td>
</tr>
<tr>
<td>Age 65</td>
<td>36 months</td>
</tr>
<tr>
<td>Age 66</td>
<td>30 months</td>
</tr>
<tr>
<td>Age 67</td>
<td>24 months</td>
</tr>
<tr>
<td>Age 68</td>
<td>18 months</td>
</tr>
</tbody>
</table>

Unum will stop sending you payments and your claim will end on the earliest of the following:

- When you are able to work in your regular occupation on a part time basis but you choose not to
- If you are working and your monthly disability earnings exceed 80% of your indexed monthly earnings
- The end of the maximum period of payment
- The date you are no longer disabled under the terms of the plan
- The date you fail to submit proof of continuing disability
- After 12 months of payments if you are considered to reside outside the US or Canada.
- The date you die

The lifetime cumulative maximum benefit period for all disabilities due to mental illness and disabilities based primarily on self-reported symptoms is 24 months.

**When Your Coverage Ends**

While you remain with the university as a member of UMMG, your coverage can continue indefinitely as long as you are employed on a full time basis.

When you leave the University, you can convert a portion of the coverage at standard coverage provisions with you by paying the coverage costs yourself

**Disabilities Not Covered**

This coverage does not include disabilities resulting from:

- Intentionally self-inflicted injuries
- Active participation in a riot
- Loss of a professional license, occupational license or certification
- Attempt to commit or commission of a crime
- Commission of a crime for which you have been convicted
- Pre-existing condition
- War (declared or undeclared, or any act of war)
- Incarceration
LONG TERM CARE INSURANCE

Plan Summary 71
Level of Care 71
Benefits 71
Long Term Care Insurance

Plan Summary

<table>
<thead>
<tr>
<th>Plan 1 Base</th>
<th>Plan 2 Base Plan with Inflation Protection Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long Term Care/Nursing Home Facility, Assisted Living Facility and Professional Home Care Services</td>
<td>Long Term Care/Nursing Home Facility, Assisted Living Facility, Professional Home Care Services and Simple Growth Capped Inflation Protection</td>
</tr>
</tbody>
</table>

| Daily Benefit: | $70, $100, $130, $150, or $200 per day, paid monthly |
| Benefit Duration: | 6-Years |
| Elimination Period: | 90 Days per Lifetime |

Level of Care

**Long Term Care/Nursing Home Facility:** This type of facility is state licensed, and provides skilled, intermediate or custodial care under the orders of a physician and under the supervision of professional nurses.

**Assisted Living Facility (ALF):** This type of facility is licensed by the appropriate agency (if required) to provide ongoing care and services to a minimum of 10 inpatients in one location. The Assisted Living Facility Benefit is equal to 60% of the Long Term Care/Nursing Home Facility Daily/Monthly Benefit.

**Professional Home Care Services (PHC):** Professional Home Care Services are provided through a licensed Home Health Care Provider. It can include physical, respiratory, occupational, and dietary or speech therapy, skilled nursing care and homemaker services. The Professional Home Care Services benefit is based on 50% of the Long Term Care/Nursing Home Facility Daily/Monthly Benefit.

**Simple Growth Capped Inflation Protection:** Your pool of benefit dollars will increase each year so that after 20 years the pool of benefit dollars will double.

Benefits

**Daily Benefit:** Your choices are $70, $100, $130, $150 or $200 per day for Long Term Care/Nursing Home Facility. Your Lifetime Maximum will depend on the benefit amount and benefit duration you choose.

**Benefit Duration:** This is the length of time benefits would be paid as long as you continue to have a covered disability. You may move between facility and home care – depending on your need – and still receive benefits. Your benefit duration is 6 years, for LTC/Nursing Home Facility Care.

**Lifetime Maximum:** The Lifetime Maximum is the maximum benefit dollar amount UNUM will pay over the life of your coverage. This dollar amount is based on the Long Term Care/Nursing Home Facility Benefit Amount and the Benefit Duration you choose.

*For example:* If you choose the Base Plan of $100 per day Long Term Care/Nursing Home Facility Benefit Amount with 6 Year Duration, your Lifetime Maximum is as follows: $100 / day X 365 days X 6 years = $219,000.

**Elimination Period:** A period of 90 consecutive days of continuous disability that occurs after the effective date of coverage and during which you are receiving care. This 90-day period must be satisfied before benefits would begin. This 90-day Elimination Period must be satisfied only once during your lifetime.
**Guaranteed Issue:** You are eligible for guaranteed enrollment within 90 days from your date of hire if you are a full time faculty or staff member, with the exception of the $200 per day benefit amount, which requires an evidence of insurability form. The $200 per day election requires an evidence of insurability form. Any time after 90 days, you may apply for coverage by providing an evidence of insurability form.

**Medical Underwriting:** Spouses, retirees and their spouses and eligible family members must provide evidence of insurability to qualify for any level of coverage.

**Eligible Family Members:** Employee’s spouse, parents & grandparents; spouse’s parents & grandparents; retirees, retiree’s spouse and certified domestic partners.

**Converting to and Individual Policy:** If your coverage ends because your employment with the University terminates you may convert your LTC to an individual policy paying the same rate. You must request conversion within 60 days of termination to continue coverage. To convert your LTC plan to an individual policy, contact HR-Benefits at 305-284-3004.
# LIFE INSURANCE AND ACCIDENT INSURANCE

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>What the Plans Can Do For You</td>
<td>74</td>
</tr>
<tr>
<td>Who May Participate</td>
<td>74</td>
</tr>
<tr>
<td>One Month Salary Benefit</td>
<td>75</td>
</tr>
<tr>
<td>Basic Group Life Insurance</td>
<td>75</td>
</tr>
<tr>
<td>Voluntary Excess Life Insurance</td>
<td>75</td>
</tr>
<tr>
<td>Basic Group Accidental Death &amp; Dismemberment</td>
<td>76</td>
</tr>
<tr>
<td>Voluntary Accidental Death &amp; Dismemberment</td>
<td>77</td>
</tr>
<tr>
<td>University Retirement Plans</td>
<td>79</td>
</tr>
<tr>
<td>Social Security</td>
<td>79</td>
</tr>
<tr>
<td>Workers' Compensation</td>
<td>79</td>
</tr>
<tr>
<td>Naming Your Beneficiary</td>
<td>79</td>
</tr>
<tr>
<td>Your Salary</td>
<td>80</td>
</tr>
<tr>
<td>How Benefits are Paid</td>
<td>80</td>
</tr>
<tr>
<td>When Coverage Ends</td>
<td>80</td>
</tr>
<tr>
<td>Converting to an Individual Policy</td>
<td>80</td>
</tr>
<tr>
<td>Claims for Benefits</td>
<td>80</td>
</tr>
</tbody>
</table>
Life Insurance and Accident Insurance

What the Plans Can Do For You

Your life insurance needs depend on your family status, your financial situation and other individual considerations. To accommodate the diverse needs of University of Miami Medical Group (UMMG) members, the University of Miami offers a broad range of life and accident insurance coverage. By selecting the combination of plans and coverage amounts best suited to your needs, you can customize this protection to meet your personal circumstances.

A Summary of Survivor Protection

<table>
<thead>
<tr>
<th>Plan</th>
<th>Who Pays</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Group Life</td>
<td>University</td>
<td>$500,000 ($450,000 with UNUM and $50,000 with Aetna) up to age 69.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$342,500 ($292,500 with UNUM and $50,000 with Aetna) on or after age 70.</td>
</tr>
<tr>
<td>Basic Group AD&amp;D</td>
<td>University</td>
<td>$150,000 (full or partial benefit for dismemberment) ($100,000 with UNUM and $50,000 with Aetna)</td>
</tr>
<tr>
<td>Voluntary Excess Life</td>
<td>You, with after-tax earnings</td>
<td>One to six times your annual salary (rounded to nearest $1,000) to a maximum of 1 million dollars.</td>
</tr>
<tr>
<td>Voluntary AD&amp;D</td>
<td>You, with either pre- or after-tax earnings</td>
<td>From $10,000 - $500,000. If you choose more than $150,000 your benefit amount must not be more than ten times your salary.</td>
</tr>
<tr>
<td>One month death benefit</td>
<td>University</td>
<td>One month’s base salary</td>
</tr>
</tbody>
</table>

If you are disabled at the time of termination or reduction in hours, you may be entitled to continue coverage for up to a total of 29 months. University coverage may also be continued for a covered dependent for up to 36 months if coverage ends because:

- You die
- You divorce or become legally separated
- The child ceases to qualify for dependent coverage under the terms of your plan (see dependent eligibility for more information)

If you choose to continue your coverage, you and/or your covered dependent must pay the entire cost plus 2% for the continued coverage. Other provisions apply if you qualify for benefits under the Long Term Disability Plan.

Who May Participate

You may participate in any of the University’s survivor protection plans described in this section if you are a member of the UM Medical Group (UMMG).

For plans that the University provides at no cost to you – Basic Group Life and Basic Group AD&D – your coverage begins automatically on your first day of employment, provided you are actively at work on that day. If you are not, your coverage begins automatically on the day you return to work.

For extra protection you may purchase – Voluntary AD&D and Voluntary Excess Life Insurance – you must enroll to participate. On the enrollment form, you designate your beneficiary and authorize the University to withhold premiums for the coverage from your paycheck. Your first opportunity to enroll will be during your first 90 days of employment. Your coverage then begins on the first of the month following the
approval of your application. You may also enroll any time after 90 days of employment, but for Voluntary Excess Life Insurance you will be asked to provide evidence of good health. Your coverage will begin on the first day of the month following approval of your application.

**One Month Salary Benefit**
If you die while employed by the University, your spouse, named beneficiary or estate will receive a death benefit of one month’s base salary in a single lump sum payment.

**Basic Group Life Insurance**
Group Life Insurance is provided at no cost to you by the University of Miami while you are employed. The Plan provides you with life insurance coverage of $500,000. When you reach age 70, coverage amount is reduced to $342,500. If you die while insured by the Plan, benefits will be paid to your beneficiary. The University pays the full cost of your Group Life Insurance, but there are certain income tax consequences on amounts exceeding $50,000. Please contact HR-Benefits for further details on the tax consequences.

**If You Become Disabled**
If you become totally disabled before you reach age 65, your Group Life Insurance will continue as long as you are disabled and your disability prevents you from doing any work for which you could become qualified by education, training, or experience, provided that:

- You file for continued coverage within the first 12 months of disability
- You have been insured under the plan at the time the disability occurs
- Your disability continues for at least nine consecutive months before a claim is filed
- You furnish evidence of continued disability upon request each year
- Your life disability benefit will terminate on the earliest of these dates: the date you are no longer totally disabled; the date you fail to give continuing proof of your total disability; the date you refuse to be examined as required; your retirement date.

**Voluntary Excess Life Insurance**
Voluntary Excess Life Insurance lets you supplement the University-provided survivor protection plans if you want additional life insurance coverage. The insurer guarantees a level of three times your annual salary to a max of $250,000 in coverage for faculty and staff enrolling in the Plan during the first ninety days of employment. Coverage in excess of three times your salary or $250,000 requires review and acceptance by the insurer of a completed health questionnaire. If you decide to purchase coverage after you are first eligible, evidence of insurability is required. The benefit paid upon your death will depend on the level of coverage you choose. You may select from six levels of coverage, with a maximum coverage amount not to exceed $1 million dollars:

- One times your salary
- Two times your salary
- Three times your salary
- Four times your salary
- Five times your salary
- Six times your salary

Your coverage will be automatically rounded to the nearest $1,000. Salary for the purposes of this Plan is “base salary.”

**For Example:**

<table>
<thead>
<tr>
<th>Your base salary</th>
<th>$75,600</th>
</tr>
</thead>
<tbody>
<tr>
<td>You select 1x base salary</td>
<td>$76,000</td>
</tr>
<tr>
<td>(Rounded to the nearest $1,000)</td>
<td></td>
</tr>
</tbody>
</table>
Your Voluntary Excess Life Insurance $76,000

Your premium for Voluntary Excess Life Insurance is deducted automatically from your paycheck each month. You pay a group rate, based on:

- The level of coverage you select
- Your age
- Whether or not you are a smoker

You are eligible for the lower non-smoker rates if you have not smoked one or more cigarettes in the last 12 months. Your contributions will be recalculated each January 1 based on your age and salary. Rates will be reviewed annually and increased or decreased based on the actual experience of the Plan. Contact HR-Benefits for detailed information on the cost of Voluntary Excess Life Insurance.

Spousal Coverage
The Voluntary Excess Life Insurance Plan also allows insurance coverage for a spouse completion of health statement, with acceptance by insurer. Spousal coverage is limited to 50% of the employee’s coverage, or $50,000 (whichever is less). The minimum spousal coverage is $5,000. Spouses are required to be performing normal duties and not be confined in an institution during the ninety days prior to enrollment. Spousal coverage cost will be added to employee cost and deducted from the employee’s payroll check. The monthly cost of the spouse's coverage is based on the amount of protection selected and the spouse’s age.

Dependent Coverage
The Voluntary Excess Life Insurance Plan also allows insurance coverage for dependent children. Dependent coverage is limited to $5,000, $10,000 or $15,000 per dependent. The dependent coverage cannot exceed 50% of the employee’s salary. Dependents are required to be non-confined and performing normal duties. Eligible children must be 14 days to 19 years of age, or up to age 26 if full-time students. Dependent coverage cost will be added to employee cost and deducted from the employee’s payroll check.

You may continue your Voluntary Excess Life Insurance while you are disabled by paying the required premiums. If you continue to be totally disabled after six months, you may apply for a waiver of premium. The same amount of coverage you had when you became disabled will continue at no cost to you if you are approved for a waiver of premium.

Voluntary Excess Life Insurance pays a benefit if you die for any reason (except as a result of suicide any time during the first two years of your coverage).

Please refer to the Voluntary Excess Life Insurance Plan Document for more information.

Basic Group Accidental Death and Dismemberment Insurance
Basic Accidental Death and Dismemberment (AD&D) coverage is provided at no cost to you by the University of Miami. You are automatically enrolled. This coverage pays your beneficiary the full benefit amount if your death results from an accident, and pays a full or partial benefit to you for accidental dismemberment. The full Dismemberment benefit amount equals your annual salary up to a maximum benefit of $150,000.

If you accidentally suffer the loss of a hand, foot or sight in an eye, or a combination of these, you will receive the following benefits:

<table>
<thead>
<tr>
<th>Loss</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two or more</td>
<td>Full benefit amount</td>
</tr>
<tr>
<td>Single loss</td>
<td>One-half amount</td>
</tr>
<tr>
<td>Thumb and index finger on the same hand</td>
<td>One-quarter amount (Aetna only)</td>
</tr>
</tbody>
</table>

University of Miami Medical Group - 2015 76
Voluntary Accidental Death & Dismemberment

Full-time and part-time regular faculty and staff, who are under 70 years of age, may purchase Voluntary Accidental Death and Dismemberment (AD&D) coverage. Voluntary AD&D offers additional insurance protection if you or an enrolled dependent dies as the result of an accident. Voluntary AD&D also pays a benefit for your accidental dismemberment. You may purchase this coverage in amounts ranging from $10,000 to $500,000, but no more than ten times your salary (if coverage is greater than $150,000). The Plan also offers a total disability benefit, and a special education benefit to provide for your children’s schooling if you die before they finish college.

If you are covered under the Plan, you may also purchase coverage for your spouse and dependent children – including stepchildren, foster children and legally adopted children – who are not self-supporting and who are between the ages of 14 days and 19 years old, (or 25 years old if attending an institution of higher learning on a full-time or part-time basis).

An eligible person may not be covered more than once. For example, if you are covered as an employee, you cannot be covered as a spouse or dependent child.

Your spouse will be covered for 50% of your benefit amount, or 40% if you have eligible children. Each of your eligible children will be insured for 15% of your benefit amount for loss of life and 50% of your benefit amount for determining dismemberment benefit if there is no insured spouse at the time of the accident; or 10% of your benefit amount for loss of life benefit and 50% of your benefit amount for determining dismemberment benefit if your spouse is eligible for coverage.

If you die accidentally, the full amount will be a percentage of your selected benefit depending on your age on the date of death.

<table>
<thead>
<tr>
<th>Age on date of death</th>
<th>Selected principal sum</th>
</tr>
</thead>
<tbody>
<tr>
<td>69 or younger</td>
<td>100%</td>
</tr>
<tr>
<td>70-74</td>
<td>87.5%</td>
</tr>
<tr>
<td>75-79</td>
<td>57.5%</td>
</tr>
<tr>
<td>80-84</td>
<td>37.5%</td>
</tr>
<tr>
<td>85 and older</td>
<td>20%</td>
</tr>
</tbody>
</table>

When a covered injury results in any of the following losses to an insured person within 365 days after the date of the accident, payment of the indicated percent of the Principal Sum will be made:

<table>
<thead>
<tr>
<th>For Loss of:</th>
<th>Percentage of Principal Sum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both hands or both feet</td>
<td>100%</td>
</tr>
<tr>
<td>Sight of both eyes</td>
<td>100%</td>
</tr>
<tr>
<td>One hand and one foot</td>
<td>100%</td>
</tr>
<tr>
<td>One hand and entire sight of one eye</td>
<td>100%</td>
</tr>
<tr>
<td>One foot and entire sight of one eye</td>
<td>100%</td>
</tr>
<tr>
<td>One hand or one foot</td>
<td>50%</td>
</tr>
<tr>
<td>Sight of one eye</td>
<td>50%</td>
</tr>
<tr>
<td>Speech of hearing in both ears</td>
<td>50%</td>
</tr>
<tr>
<td>Thumb and index finger of same hand</td>
<td>25%</td>
</tr>
</tbody>
</table>

“Loss” as used above with reference to hand or foot means the actual and complete severance through or above the wrist or ankle joint; as used with reference to eye means irrecoverable loss of entire sight; as used with reference to speech means complete and irrecoverable loss of entire ability to speak; as used with the reference to hearing in an ear means complete and irrecoverable loss of the entire ability to hear in that ear; and as used with respect to thumb and index finger means the actual and complete severance through or above the metacarpophalangeal joint of both digits.
If more than one loss is sustained by an Insured Person as a result of the same accident, only one amount, the largest, will be paid.

If loss of life benefits are payable as the result of a covered injury to you, and your eligible family members are covered under the policy on the date of the accident, one of the following benefits will also be payable.

1. Education Benefit for each of your dependent children who, on the date of the accident, are enrolled as a full-time student,
   a. In a school for higher learning or
   b. In the 12th grade but enrolls as full-time student in a school for higher learning within one year after your death.

2. If there are no dependent children who qualify under 1.a) or 1.b), payment of 2% of your Principal Sum will be distributed to your beneficiary.

**Common Disaster Benefit**

If you and your insured spouse both die due to injuries caused by the same accident or separate accidents which occur within 24 hours of each other, the Principal Sum for your insured spouse is increased to equal yours.

**Permanent Total Disability**

If you are permanently and totally disabled within 100 days of a covered accident occurrence, 2% of your Principal Sum each month after 12 consecutive months of permanent total disability will be paid for as long as the permanent total disability continues, up to a maximum of 50 consecutive months. The total amount payable is reduced by any amount paid or payable under the Accidental Death and Dismemberment Benefit for the same accident. If you die before the end of the maximum benefit period, the unpaid benefits will be paid in one lump sum to your beneficiary.

The Permanent Total Disability benefit does not cover your family member and this benefit is not available if you are age 70 or older.

**Emergency Evacuation Benefit**

If the Insured Person suffers an Injury or Emergency Sickness that warrants his or her Emergency Evacuation while he or she is outside a 100 mile radius from his or her current place of primary residence, the policy will pay for Covered Emergency Evacuation Expenses reasonably incurred, up to a maximum of $30,000 for all Emergency Evacuations due to all Injuries from the same accident or all Emergency Sicknesses from the same or related causes.

**Repatriation of Remains Benefit**

If an Insured Person suffers loss of life due to Injury or Emergency Sickness while outside a 100 mile radius from his or her current place of primary residence, the policy will pay for covered expenses reasonably incurred to return his or her body to his or her current place of primary residence, up to a maximum of $3,000.

**Exclusions**

Benefits are paid from your Basic AD&D and Voluntary AD&D coverage for all losses except those resulting from:

- Suicide or intentionally self-inflicted injury
- Physical or mental disease
- War or an act of war, declared or not
- Your commission of a felony
- Travel or flight in an aircraft not intended for passengers
- Performing and/or training to become a flight crew member
• Riding in an aircraft owned, leased or operated by the Policyholder or by the Insured Person’s employer
• The Insured person being under the influence of drugs or intoxicants, unless taken under the advice of a Physician.
• Sickness, disease or infections of any kind; except bacterial infections due to an accidental cut or wound, botulism or ptomaine poisoning.

Cost of Coverage
Your premium for Voluntary AD&D coverage is deducted automatically from your paycheck each month. You pay a group rate, based on the amount of coverage you select. The cost for family coverage is slightly more. You can elect to pay these premiums on a pre-tax basis either when you enroll within 30 days of employment or during any annual Open Enrollment period.

Conversion Privilege
You and your insured family members may apply for a conversion policy of Accidental Death and Dismemberment insurance if insurance under the policy terminates for any reason except:

• Non-payment of premium
• When the terminated coverage is replaced within 31 days by similar coverage sponsored or arranged by your employer

There are also survivor protection benefits under other University and statutory plans. Among them:

University Retirement Plans
Death benefits from each of the retirement plans are generally paid in a single lump sum, but installment payments may be arranged if requested. For more information, contact HR-Benefits.

Social Security
Your family could be eligible for monthly income from Social Security when you die. For more information regarding Social Security death benefits please call 1-800-772-1213 or visit their website at www.ssa.gov.

Workers’ Compensation
FL’s Workers’ Compensation, which is paid for by the University, provides continuing monthly income for your surviving spouse and eligible children if you die as a result of an on-the-job illness or injury.

Naming Your Beneficiary
You designate who will receive benefits from each of your survivor protection plans by naming a beneficiary for each plan. In order to designate a beneficiary, you must do so on workday.miami.edu. You may name anyone you wish, selecting the same beneficiary for all your coverages, or different beneficiaries for each. You may also name more than one beneficiary.

Generally, you name your beneficiary when you enroll in a plan. You may also change your beneficiary designation at any time at workday.miami.edu.

If you do not name a beneficiary or your named beneficiary is not living when benefits become payable, the death benefit will be paid in accordance with the Plan document or policy governing each benefit.
Your Salary
Some of the coverage described in this section is based on your salary. For these plans, your salary is either your annual contract earnings or your base salary, depending on your job category. Overtime and overload pay or any other extraordinary compensation is not considered to be part of your salary for the purpose of these plans. As your salary and your age change, the amount of your coverage or your premiums for certain plans may need to be adjusted to reflect these changes. These adjustments will be made each January 1 for any changes during the prior year that would affect either your level of coverage or your premiums.

How Benefits are Paid
Death benefits from each of the other plans are generally paid in a single lump sum, but installment payments may be available. For more information, contact HR-Benefits.

When Coverage Ends
Coverage from these University-sponsored survivor protection plans will continue until the last day of the month in which the earliest of the following occurs (unless you convert your coverage to an individual policy):
- You leave the University or retire
- You are no longer working the minimum required hours for coverage under the plan
- You stop making any required premiums toward the coverage’s cost
- The applicable plan terminates

Converting to an Individual Policy
If your coverage ends because your employment with the University terminates, you may convert all or part of your Basic Group Life Insurance, Voluntary Excess Life insurance and Voluntary AD&D coverage to individual policies available from the insurance company for that Plan subject to medical evidence of insurability, if applicable. Your Basic Group AD&D Plan may not be converted.

HR-Benefits will provide you with specific details and the necessary applications for conversion. Rates and terms of coverage will depend on the policies available at the time you convert.

Your application and first monthly premium must be received within 30 days of the date your insurance terminates. If you die within 30 days following the date your insurance ends, your beneficiary will receive the full amount of your Voluntary AD&D (if applicable), Basic Group Life and Voluntary Excess Life Insurance coverage (if applicable) whether or not you decided to convert to an individual policy.

Claims for Benefits
Your beneficiary should notify HR-Benefits of your death and provide a death certificate. HR-Benefits will calculate the amount of benefit payable to your beneficiary and notify your beneficiary in writing. HR-Benefits will complete applicable claim forms and obtain your beneficiary’s signature on the forms as required. Written claim forms must be filed before benefits can be processed and paid from any of these plans.

If you have a claim for dismemberment benefits, contact HR-Benefits to obtain the necessary forms and for an explanation of the claim procedure.
## FLEXIBLE SPENDING ACCOUNTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>What the Plan Can Do For You</td>
<td>82</td>
</tr>
<tr>
<td>Who May Participate</td>
<td>82</td>
</tr>
<tr>
<td>Qualifying Status Changes</td>
<td>82</td>
</tr>
<tr>
<td>Health Care Reimbursement Account</td>
<td>83</td>
</tr>
<tr>
<td>WageWorks Visa Card</td>
<td>83</td>
</tr>
<tr>
<td>Dependent Care Reimbursement Account</td>
<td>84</td>
</tr>
<tr>
<td>Caution When Setting Aside Funds</td>
<td>85</td>
</tr>
<tr>
<td>Claim Procedures</td>
<td>86</td>
</tr>
<tr>
<td>Effect on Other Benefits</td>
<td>87</td>
</tr>
<tr>
<td>Paying for Other Benefits Pre-Tax</td>
<td>87</td>
</tr>
<tr>
<td>HIPAA Privacy</td>
<td>87</td>
</tr>
</tbody>
</table>
Flexible Spending Accounts

What the Plan Can Do For You

The University of Miami Flexible Spending Account Plan (FSA) helps you save on your annual taxes by allowing you to pay eligible out-of-pocket health and dependent care expenses with a portion of your earnings that are tax-free. When you contribute to an FSA, you reduce your federal income and Social Security taxes and thereby increase the level of your spendable income for the year. An FSA designed to meet current federal laws is just another part of the flexibility the University of Miami provides in your benefit program.

Who May Participate

You may participate in an FSA if you are a regular, full-time or part-time regular member of the University of Miami faculty or staff. To participate, you must enroll during your initial benefits eligibility period. You must re-enroll each year during the annual "Open Enrollment Period” for participation beginning the next January 1. FSA deductions stop automatically at the end of each calendar year. You must make an election each year if you wish to participate.

If your spouse works for the University and is eligible to participate in an FSA, each of you can join the Plan individually. An eligible expense may be reimbursed through one account or the other, but not both.

Qualifying Status Changes

IRS Section 125 rules regarding pre-tax premium plans do not allow for enrollment, additions, changes, or cancellations except with the occurrence of a Qualifying Status Change (QSC) event, followed by written application for a change within 30 days or during the annual open enrollment period. The federal government determines the events that qualify as QSCs, and this list is subject to periodic change. The following events are some, but not necessarily all, valid QSC events:

- Change in cost of dependent child care (for Dependent Care FSA)
- Marriage or divorce
- Death of a spouse or dependent
- Birth or adoption
- Change in dependent eligibility
- Loss of coverage through Medicaid or other SCHIP or new enrollment in Medicaid or other SCHIP
- Change in employment status of employee, spouse, or dependent including:
  1. Termination of spouse’s or dependent’s employment
  2. Unpaid leave of absence over 30 calendar days
  3. Change from part-time to full-time status or vice versa

An enrollee wishing to change a benefit election on the basis of a QSC must complete the following steps:

1. Contact HR-Benefits via Workday to report the event and request the corresponding change.
2. Provide required supporting documentation (e.g. government issued marriage certificate, government issued birth certificate, divorce decree, etc.). QSCs cannot be processed without the corresponding required supporting documentation.
3. HR-Benefits must receive the request via Workday within 30 days of the QSC event or the request for change(s) will be denied and cannot be made until the next annual open enrollment period. NOTE: The enrollee should report the event immediately even if supporting documentation is not readily available; a period of 60 days is allowed to provide the necessary documentation. For Medicaid or other SCHIP events, a period of 60 days is allowed to make a change.
**Termination of dependents.** If you have a spouse, domestic partner or child who no longer qualifies for coverage, you are required to notify HR-Benefits via Workday within 30 days of the event in order to remove the individual from coverage.

**Non Compliance.** Falsifying information/documentation in order to obtain/continue insurance coverage is considered a dishonest act and could lead to discipline and criminal prosecution. Inadvertent or negligent failures to update or correct information related to eligibility of an employee’s listed dependent is also subject to penalty. Employees are responsible for updating dependent information within 30 calendar days of the occurrence of any event affecting eligibility; for example, a divorce severing a marriage. The University may impose a financial penalty, including, but not limited to, repayment of all insurance premiums the university made on behalf of the ineligible dependent and/or any claims paid by the insurance companies. Disciplinary action up to and including dismissal may also be imposed if deemed appropriate.

To make an enrollment change based on a QSC, the QSC must result in a gain or loss of eligibility for coverage, and general consistency rules must be met. For example, if an enrollee with family health insurance coverage is divorced and no longer has dependents, that enrollee may change from family to individual coverage but cannot cancel enrollment in health insurance because the QSC merely changes the level of coverage eligibility. Cancellation would not be consistent with the nature of the QSC event.

**Electing Annual Amount**
When you enroll, you designate how much you will contribute to a flexible spending reimbursement account to pay for health and/or dependent care expenses. You may choose to contribute to the Plan to pay only dependent care expenses, or health care expenses or both types. Throughout the year, you may draw money out of the account to reimburse health or dependent care expenses. You cannot use the portion of your contribution designated for health care expenses to pay for dependent care expenses or vice versa.

**Health Care Reimbursement Account**
FSA allows you to pay up to $2,550 a year in eligible health care expenses for you and your dependents with tax-free dollars contributed to the Plan. Dependents for purposes of this Plan include anyone you can claim an exemption for on your federal income tax return.

Eligible expenses will be reimbursed as long as:

- You incur the expense during the same calendar year for which you make the contribution, or during the grace period of the following year
- The expense is not eligible for payment by your University Health Care Plan, other insurance coverage or another source

Generally, any health care expense you could claim as a deduction on your federal income tax return can be reimbursed through the Plan (although once reimbursed through FSA, the same expenses cannot be claimed as a federal income tax deduction).

**WageWorks Visa Card**
When you enroll in a Health Care Spending Account, you will receive the WageWorks Visa card in the mail. You can use this card only to pay for eligible health care expenses wherever Visa debit cards are accepted, including in-network pharmacies, doctor’s offices, and hospitals.

When you present the card for payment, you need to select “Credit,” not “Debit,” when paying for eligible expenses with your WageWorks Visa card. Be sure to sign for the payment to ensure funds are deducted from your Health Care FSA. You cannot use the card to pay for dependent care expenses. Eligible charges are automatically deducted from your FSA. If you receive a medical bill with a “Patient Balance Due,” write the card number on the bill and return it to the provider (doctor, pharmacy, or hospital). Having
the card typically means you do not need to submit a paper claim form and wait for reimbursement. However, in certain circumstances, WageWorks will not be able to automatically substantiate your claim. Therefore, you will have to submit receipts.

For more information, review the WageWorks User’s Guide at www.miami.edu/benefits.

**Eligible Health Care Expense Examples**
- Copayments, deductibles and coinsurance for Health Care coverage
- Expenses exceeding reasonable and customary charges or scheduled amounts as determined under your health care coverage
- Out-of-pocket dental expenses - including orthodontia (a letter of medical necessity is required for orthodontia to be reimbursed)
- Vision care expenses - including eye exams, frames, lenses and contact lenses
- Hearing exams and hearing aids
- Certain over-the-counter (OTC) medicines and drugs – For more information on the requirements to be reimbursed for OTC medicines visit www.wageworks.com or www.miami.edu/benefits.

A sample list of deductible health care expenses can be found in IRS Publication 502, “Medical and Dental Expenses,” which is available from the IRS. Note: not all health care expenses deducted by the IRS for taxation purposes are eligible FSA health care expenses.

**Ineligible Health Care Expense Examples**
- Insurance premiums
- Vision warranties and service contracts
- Cosmetic surgery not deemed medically necessary to alleviate, mitigate or prevent a medical condition

**Dependent Care Reimbursement Account**
You may contribute up to $5,000 - per family - to a dependent care FSA each year to pay for eligible dependent care expenses. If your UM salary is at least $115,000 per year, your maximum Dependent Care contribution through UM is $2,500 per year. The care must be for an eligible dependent and be necessary to enable you and, if you are married, your spouse to work, look for work or attend school full-time. IRS guidelines define dependents as:
- Children under age 13 who live with you
- Any dependent for whom you claim federal tax exemption, including your spouse or elderly parents who are physically or mentally incapable of caring for themselves, provided the dependent spends at least eight hours a day in your home

Generally, any dependent care expenses for which you could receive a credit on your federal income tax return are considered eligible for reimbursement through an FSA. Examples of eligible dependent care expenses include:

**Eligible Dependent Care Expense Examples**
- Babysitters - in or outside your home (care cannot be provided by you, your spouse or other tax dependent)
- Licensed day care centers and nursery schools caring
- Local day camp fees
- Disabled dependent care centers that comply with state and local laws and regulations

**Ineligible Dependent Care Expense Examples**
- Child support payments or child care if you are a non-custodial parent
- Dependents who could be cared for by your employed spouse whose work hours do not coincide with yours
- Payments for dependent care services provided by your dependent, your spouse’s dependent or your child who is under age 19
- Healthcare costs or educational tuition
- Overnight care for your dependent (unless it allows you and your spouse to work during that time)
- Nursing home fees
- Diaper services
- Kindergarten expenses
- Services which are paid for by another organization or provided without cost
- Transportation to or from the dependent care location
- Care provided in full-time residential institutions, such as nursing homes and homes for the mentally disabled
- Expenses you plan to take as a credit on your income tax return
- Clothing, entertainment or food
- Housekeeping unless part of those services are for the care of an eligible dependent

If you are married, your spouse unless disabled must also work, be looking for work or attend school full-time for expenses to be eligible under the Plan. Your reimbursement is then limited by the following conditions:

- If your spouse works, your dependent care reimbursement cannot exceed your income or your spouse’s, whichever is less
- If your spouse attends school full-time or is disabled, you may be reimbursed a maximum of $3,000 annually for the care of one dependent and up to $5,000 annually for two dependents

**Dependent Care FSA vs. Dependent Care Tax Credit**

Whether it is better for you to use the FSA instead of the tax credit depends on your household income, marital status and the amount of your eligible expenses. As a rule of thumb, using the FSA is better if your adjusted gross family income is $40,000 or more. If it is less than $40,000, taking the income tax credit generally provides greater, but not immediate, tax savings. Again, whether or not you should claim credits or participate in FSA’s depends on your individual tax situation.

The expenses eligible for reimbursement through your dependent care FSA are the same as those that qualify for a federal tax credit. However, the maximum you can claim as a tax credit at the end of the year will be reduced by any amount that has been reimbursed through your dependent care FSA during the year.

For most families earning over $40,000 a year, using the dependent care FSA will result in a greater tax reduction than claiming a tax credit on their federal tax return. For specific guidance on which method would be best for your particular circumstances, you should consult your tax advisor.

**Caution When Setting Aside Funds**

Before you enroll in Health Care or Dependent Care Flexible Spending Account, you should be aware of the risk involved in setting aside tax-free earnings in the Plan. In exchange for the tax advantage provided by the Plan, the IRS restricts the use of your money to the reimbursement of eligible expenses incurred in that calendar year only. If you are unable to use your entire account balance for eligible expenses you incur during the year, you will forfeit the unused portion. You cannot receive cash back or carry unused amounts forward to pay for the next year’s expenses outside of the grace period. You also cannot use amounts deposited for health care expenses to pay dependent care expenses and vice versa. To be sure you do not forfeit any of your contribution, estimate your anticipated expenses carefully.

Should you separate from the University during the year and subsequently return, your Health Care FSA deduction will be reinstated, you will need to notify HR/ Benefits upon returning to work.
Claim Procedures

Participants enrolled in a Health Care Flexible Spending Account and/or a Dependent Care Flexible Spending Account have an additional 2 ½ month period (following the end of the plan year) in which to incur expenses (in the subsequent year) and make claim for reimbursement against any funds remaining from the prior plan year’s account.

Participants enrolled in the 2015 Health Care and/or Dependent Care FSA plan may incur expenses (receive treatment, purchase supplies or receive child care services) from 1/01/15 through 3/15/16 and use 2014 plan year funds for reimbursement of eligible health care and/or dependent care expenses. Participants will continue to have a 3 month run-out period to file for reimbursement of claims incurred during 1/01/15 through 3/15/16. The run-out period will end 6/15/16.

You should submit a claim for reimbursement any time you have eligible expenses.
- If a health care expense exceeds the amount in your account, you will be advanced the balance, provided your total health care contributions for the year will be sufficient to cover the expense; the outstanding claim amount will be charged to your account as additional deposits are made during the year.
- Dependent care expenses will be reimbursed only up to the amount that can be paid out for the contributions already in your account; if a dependent care expense exceeds this amount, you will be reimbursed the balance as additional contributions are credited to your account.

Dependent care and health care expenses must be filed on the appropriate reimbursement form available at www.miami.edu/benefits. After you have completed the appropriate form, you must mail, fax or upload a correctly completed FSA Reimbursement Request Form along with one or more of the following:

For Health Care Reimbursement
- A receipt, invoice or bill listing the name of the provider, the date the service was received, the cost of the service, the specific type of service and the person for whom the service was provided.
- An Explanation of Benefits (EOB) from your health insurance provider that shows the specific type of service you received, the date and cost of the service and any uninsured portion of the cost.
- A written statement from your healthcare provider indicating that service was medically necessary if the service is listed as requiring such documentation on www.wageworks.com. Please note that the letter of medical necessity must be accompanied by the receipt, invoice or bill for the service.

For Dependent Care Reimbursement
Be sure to obtain and mail or fax the information below when requesting reimbursement from your Dependent Care FSA. This information is required with each request for reimbursement.

- The name, address and telephone number of the dependent care provider or
- The name, address and signature of the individual providing the dependent care service
- The date your dependent received the care (for example, February 9, 2015 through February 20, 2015) - not the date you paid for the service.
- The amount of the expense
- The Social Security number or tax identification number of the provider

If Your Employment Status Changes
If you retire, die or leave the University while you are participating in the Plan, your FSA contribution will stop as of your last paycheck from the University. Claims for qualified expenses incurred may only be submitted for expenses incurred though the last day of the month in which you separate from the University. The deadline to submit claims for former employees is the same as the deadline for active employees but your card will be deactivated as of your last day of employment.
Effect on Other Benefits
You do not pay Social Security (FICA) taxes on the earnings you place in FSA if your taxable wages, after pre-tax deposits to the Plan, are less than the Social Security wage base. As a result, your Social Security benefit - when you retire or if you become disabled - may be reduced. The reduction, based in part on the number of years you participate in FSA prior to retirement, is usually more than compensated for by current tax savings.

Paying for Other Benefits Pre-Tax
Although your contributions to the Plan reduce your reported W-2 earnings, they will not affect the value of your other benefits including University-provided life insurance and your benefit or contributions made on your behalf under University retirement plans. These plans will continue to be based on your full base salary, before your FSA contribution is deducted.

The following University benefits are deducted pre-tax:

- University Health Care
- Dental Care
- Voluntary Accidental Death & Dismemberment Insurance

Contributions for any of these plans are deducted from your paycheck just as though they are FSA contributions - before federal income and Social Security taxes are withheld.

Pre-tax deductions for any required plan contributions are not included in the annual maximum FSA contribution for health care expenses.

HIPAA Privacy
The WageWorks plan conforms to the standards for protection of individual private health information (PHI). Neither the University of Miami nor Aetna condition enrollment in the plan based on an individual’s health status. Medical claims are submitted according to electronic data standards required by the act. The University of Miami subscribes to the use of the minimum necessary standard when it comes to an individual’s PHI. Access to PHI must be authorized in writing by the individual employee or representative. The plan may not discriminate in health coverage based on genetic information. The plan may not use genetic information to adjust premium or contribution amounts, request or require an individual or their family members to undergo a genetic test, or request, require, or purchase genetic information for underwriting purposes or prior to or in connection with an individual’s enrollment in the plan.
# FACULTY RETIREMENT PLAN (FRP)

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>What the Plan Can Do for You</td>
<td>89</td>
</tr>
<tr>
<td>Who Is Eligible to Participate</td>
<td>89</td>
</tr>
<tr>
<td>When You Can Participate</td>
<td>89</td>
</tr>
<tr>
<td>Designating a Beneficiary</td>
<td>90</td>
</tr>
<tr>
<td>What the University Contributes</td>
<td>90</td>
</tr>
<tr>
<td>Where the Contributions Are Invested</td>
<td>91</td>
</tr>
<tr>
<td>What You Can Expect at Termination or Retirement</td>
<td>91</td>
</tr>
<tr>
<td>Death and Disability</td>
<td>92</td>
</tr>
<tr>
<td>If You Have a Frozen ERP Benefit</td>
<td>93</td>
</tr>
<tr>
<td>Additional Information</td>
<td>93</td>
</tr>
</tbody>
</table>
Faculty Retirement Plan (FRP)

What the Plan Can Do for You
The Faculty Retirement Plan will accumulate University contributions and earnings for you in order to provide a monthly income when you retire. The amount of your monthly income will depend on the amount accumulated in your account, the type of benefit payment you elect and annuity rates. Along with Social Security, prior retirement plan benefits and your own retirement savings and investments, this plan can help you prepare for a financially secure retirement.

Who Is Eligible to Participate
You are eligible to participate in the Faculty Retirement Plan if you were hired before June 1, 2007 and:

- You are a full professor, associate professor, assistant professor or an instructor or lecturer (except for visiting faculty) and
- You hold a regular tenure earning appointment or receive an annual contract from the University as a full-time or part-time regular faculty member
- You did not elect to end your participation in this plan and begin participating in the Retirement Savings Plan.

This summary plan description describes the Faculty Retirement Plan in effect as of January 1, 2015.

IMPORTANT NOTE: If you transferred to the Retirement Savings Plan, you will not lose the benefits you have already earned under the Faculty Retirement Plan. You will receive a benefit from the Faculty Retirement Plan once you retire or terminate employment. This summary plan description describes the benefits you have earned through your date of transfer from the Faculty Retirement Plan. Note that your account will continue to be adjusted to reflect investment gains and losses until you receive payment. Refer to the summary plan description for the Retirement Savings Plan for information about the benefit you earn for your service with the University of Miami on and after your transfer date.

When You Can Participate
When your plan participation begins will depend on your rank and when you were appointed as a faculty member.

<table>
<thead>
<tr>
<th>RANK</th>
<th>PARTICIPATION BEGINS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professor, associate professor or assistant professor appointed:</td>
<td></td>
</tr>
<tr>
<td>• Before June 1, 1989</td>
<td>On your appointment date or June 1, 1980, whichever was later</td>
</tr>
<tr>
<td>• On or after June 1, 1989</td>
<td>After you complete one contract year or 12 months of service, whichever comes first</td>
</tr>
<tr>
<td>Instructor or lecturer</td>
<td>On the June 1 after you complete two contract years or 24 months of service, whichever comes first</td>
</tr>
</tbody>
</table>

A "contract year of service" means employment as a faculty member for two regular academic semesters (excluding the summer session) in a 12-month period ending on December 31. A "month of service" is a calendar month of employment as a faculty member, plus any period of full-time or part-time regular employment at the University immediately preceding appointment as a faculty member.
Designating a Beneficiary
You should also name a beneficiary as soon as you become eligible for the Faculty Retirement Plan. Your beneficiary is the person who will receive your benefit if you die before receiving payment from the plan. You may change your beneficiary at any time, subject to spousal consent rules, by completing and returning the appropriate designation of beneficiary form to your investment company.

If you are married, you must name your spouse as the beneficiary of your retirement plan benefit. If you want to name someone other than your spouse as your beneficiary, you must obtain your spouse’s written, notarized consent.

Please note that if you are unmarried, name a beneficiary and subsequently marry, your prior designation is invalid and your spouse will automatically be your beneficiary, unless you obtain proper spousal consent to a different beneficiary. Similarly, if you become divorced, any prior beneficiary designation becomes invalid and you will need to complete a new designation of beneficiary form and return the completed form to your investment company.

If there is no valid beneficiary form on file when you die, your spouse (if you are married) or your estate (if you are single) will automatically become your beneficiary.

What the University Contributes
The University pays the entire cost of the Faculty Retirement Plan through regular contributions based on service, tenure status and salary (excluding expense allowances and reimbursements).

• If you were hired on or after October 1, 1984, the University will contribute 7% of your salary* until the June 1 after:
  1. You complete seven years of contract service or
  2. Your tenure is approved.

• If you were hired before October 1, 1984, the University will contribute 7% of your salary* until the June 1 after:
  1. You reach age 40 or
  2. You complete five years of contract service or
  3. Your tenure is approved.

After you satisfy the above requirements, the University contribution will increase to 11% of your salary*.

Note: These contributions are directed to the insurance or investment company you choose from a University approved list. If you wish to contribute to your retirement savings on a tax-favored basis, you may do so by enrolling in the Supplemental Retirement Annuity Program.

* The Internal Revenue Service sets a limit on the amount of salary that can be taken into account for purposes of determining University contributions to the plan. For 2015, this limit is $265,000 and may change annually as determined by the Internal Revenue Service.

Sabbatical And Other Leaves of Absence
University contributions to the Faculty Retirement Plan during a sabbatical leave will be based upon your full contract salary. Although no contributions are made during an unpaid leave of absence, special contributions may be made after you return from an unpaid leave of absence for public service.

IMPORTANT NOTE: During the first year of your appointment as a professor, associate professor or assistant professor, you are not eligible to receive contributions for the Faculty Retirement Plan. However, so that you do not lose retirement income, the University will make contributions of 7% of your eligible pay (11% for tenured faculty) to either a pre-tax account or a post-tax account as you elect for that first year. Once you satisfy the eligibility requirements noted above, the University’s regular contributions will go into the Faculty Retirement Plan.
Where the Contributions Are Invested

Fidelity Investments is the master record-keeper for plan investments and TIAA-CREF record keeps their own annuities. The following is the investment structure:

**Tier One – Fidelity Freedom Index Funds**
- The funds in this tier are monitored by the University of Miami 403(b) Investment Committee.

**Tier Two – Passive and Active Mutual Funds**
- The funds in this tier are monitored by the University of Miami 403(b) Investment Committee.

**Tier Three – TIAA-CREF Annuities**
- The funds in this tier are monitored by the University of Miami 403(b) Investment Committee.

**Tier Four – Fidelity BrokerageLink**
- The funds in this tier are NOT monitored by the University of Miami 403(b) Investment Committee.

For detailed information about the funds offered through the plan please visit [https://umshare.miami.edu/web/wda/benefits/Retirement/NewTierStructure.pdf](https://umshare.miami.edu/web/wda/benefits/Retirement/NewTierStructure.pdf)

It is important to thoroughly review and carefully consider the investments available on a regular basis and to make changes as needed. It is also vital that you keep your beneficiary designation current. If you wish to change your beneficiary, you must request the form directly from Fidelity Investments or TIAA-CREF.

**Protection Under ERISA Section 404(c)**

The Faculty Retirement Plan is intended to meet the requirements of ERISA Section 404(c). This means that it provides participants with diversified investment options plus information on those options. It also refers you to the appropriate investment managers whose responsibility it is to provide you with additional investment information to carry out your investment elections. Under 404(c), plan fiduciaries are relieved of liability for any losses which result from a participant’s investment decisions.

**What You Can Expect at Termination or Retirement**

You may elect to receive your account from the Faculty Retirement Plan upon your separation from service. You may also elect to defer the payment of your distribution. In general, under the tax law, distributions must begin no later than April 1 of the year following attainment of age 70-½ and must satisfy certain “minimum distribution” rules. Your distribution options are described below.

The amount accumulated in your account will depend on the total amount of contributions and the investment earnings on the contributions.

**An Example**

We’ll take a faculty member who becomes eligible for the Faculty Retirement Plan at age 30, when earning $70,000 a year, and advances to full professor with annual earnings of $265,600 a year by retirement at age 65.

The University will contribute increasing amounts, ranging from 7% of $70,000 ($4,900) for the first year, up to 11% of $265,600 ($29,216) for the last year of employment. In round figures these contributions will add up to:

- First 7 years @ 7% $38,700
- Next 28 years @ 11% $506,300
- Combined contributions = $545,000
Total Accumulation
These contribution amounts will accumulate over the years with compounding tax-deferred investment return credited to the chosen investment. To illustrate how the faculty member’s total accumulation could vary depending on what these contributions earn, here are just two of many possibilities. The first illustration is based on a 5% annual rate of growth; the second illustration is based on a 10% annual rate of growth.

Total at 65, 5% return: $1,110,000
Total at 65, 10% return: $2,674,000

Investment Company Selection
The wide range of possible accumulations in the example demonstrates the importance of your choice of an investment company and fund, and emphasizes the potential magnitude of the sum you are responsible for investing. The University cannot give investment advice, but it does have information available on providers who offer a broad range of investment options.

Distribution Options
When you are eligible to receive payments from the Plan, the value of your account may be rolled over into an IRA or another employer’s retirement plan or paid as a full lump sum. Annuity options are also available.

If your account exceeds $5,000 and you are married when benefit payments begin, the normal form of payment is a joint and survivor annuity with at least one-half of your benefit paid to your spouse after your death. You must obtain your spouse’s notarized written consent if you select a different form of payment and/or beneficiary. The amount of your benefit will depend on the value of your account, the benefit option you elect, your age and, if applicable, the age of your beneficiary at the time you begin receiving benefits.

If you are not married when benefit payments begin, you may select from the wide range of annuity options available through the investment companies referenced in the section “Where the Contributions Are Invested.”

Lump sum distributions received before age 59½ are generally subject to a 10% penalty per IRS regulations. See “Withholding” in the “Additional Retirement Information” section.

Employment After Retirement
Once you have retired and begin receiving University retirement distributions, you must wait at least 90 days before being rehired by the University in any capacity.

Personal Statements
The investment company you choose will provide quarterly statements showing the status of your Faculty Retirement Plan account. You may request a projection of the amount of retirement income your account will produce directly from the investment company.

Death and Disability
Termination from employment and retirement are not the only circumstances in which the Faculty Retirement Plan may provide benefits.

If You Should Die
If you were to die before retirement, your account balance in the Faculty Retirement Plan will be payable to your beneficiary. Distribution options vary depending upon the investment company and the funds in which assets are invested.
**If You Become Disabled**
Should you become totally and permanently disabled and qualify for Social Security Disability benefits and for benefits under the University of Miami Long Term Disability Plan, the University will continue its contributions for you under the Faculty Retirement Plan. Contributions will be based on your University compensation during the 12 months before your regular salary stops. Contributions will continue as long as you remain eligible for disability benefits up to the end of the plan year that you attain age 65.

**If You Have a Frozen ERP Benefit**
Faculty members who were employed at the University by June 1, 1979 may receive their University-funded retirement income from both a defined benefit pension from the Employees’ Retirement Plan trust and from contributions made under the Faculty Retirement Plan.

Your eligibility for a benefit from the Employees’ Retirement Plan and the amount of that benefit is determined by your service and salary before joining the Faculty Retirement Plan. This “frozen” benefit has been calculated and held in trust for future payment under the provisions of the Employees’ Retirement Plan.

**Additional Information**
Please refer to the sections “Additional Information” and “Retirement Claim/Appeal Procedures” for information including how the Faculty Retirement Plan is administered and your rights under the Employee Retirement Income Security Act of 1974 (ERISA) as amended.
# RETIREMENT SAVINGS PLAN (RSP)

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>What the Plan Can Do for You</td>
<td>95</td>
</tr>
<tr>
<td>Who Is Eligible to Participate</td>
<td>95</td>
</tr>
<tr>
<td>When You Can Participate</td>
<td>95</td>
</tr>
<tr>
<td>Enrolling in the Plan</td>
<td>96</td>
</tr>
<tr>
<td>Designating a Beneficiary</td>
<td>96</td>
</tr>
<tr>
<td>How Your Account Can Grow</td>
<td>97</td>
</tr>
<tr>
<td>Where the Contributions Are Invested</td>
<td>98</td>
</tr>
<tr>
<td>Vesting</td>
<td>99</td>
</tr>
<tr>
<td>What You Can Expect at Retirement or Termination</td>
<td>100</td>
</tr>
<tr>
<td>Death and Disability</td>
<td>101</td>
</tr>
<tr>
<td>Loans</td>
<td>101</td>
</tr>
<tr>
<td>Withdrawals</td>
<td>102</td>
</tr>
<tr>
<td>Additional Information</td>
<td>102</td>
</tr>
</tbody>
</table>
Retirement Savings Plan (RSP)

What the Plan Can Do for You
With the Retirement Savings Plan, the University of Miami sets up an account in your name and each year your account can grow with:

- **An automatic core contribution.** If you are eligible, the University will make a contribution to your retirement account, based on your earnings.
- **Voluntary and matching contributions.** You may also contribute to your retirement account. If you do, you will benefit from current tax savings. The University will also match a percentage of your contributions.
- **Rollover Contributions.** You may roll over to the Plan distributions that you receive from certain other retirement arrangements, such as other Section 403(b) plans, individual retirement accounts (“IRAs”), tax-qualified plans (including 401(k) or other 401(a) plans). However, the Plan will not accept a rollover that includes after-tax employee contributions.
- **Investment earnings.** You decide how to invest your account balance – including the core contributions, your voluntary contributions (and rollover contributions, if any) and the matching contributions. You have several investment companies from which to choose.

Under this plan, you have access to the value of your voluntary contributions and rollover contributions while you are employed through loans and withdrawals (see Loans and Withdrawal sections below). When you separate from service, you decide how and when to receive payment. Along with Social Security, any supplemental retirement annuities you purchase, prior retirement plan benefits and your own investments, this plan can help you prepare for a financially secure retirement.

Who Is Eligible to Participate
You are eligible to participate in the Retirement Savings Plan if you were hired prior to June 1, 2007 and elected to participate in the Retirement Savings Plan or if you were hired on or after June 1, 2007 and:

- You are a full professor, associate professor, assistant professor or an instructor or lecturer (except for visiting faculty) and you hold a regular tenure earning appointment or receive an annual contract from the University as a full-time or part-time regular faculty member, or
- You are a non-faculty employee of the University unless you are in one of the excluded job classifications noted below.

Note that University of Miami Hospital employees, leased employees, residents of the University Hospital, interns and students are not eligible for this plan. Employees who are active participants in the Employees’ Retirement Plan are also not eligible for the Retirement Savings Plan.

This summary plan description describes the Retirement Savings Plan in effect as of June 1, 2013.

IMPORTANT NOTE: If you were hired before June 1, 2007 and you elected to participate in the Retirement Savings Plan, you will not lose the benefits you have already earned under the Faculty Retirement Plan or the Employees’ Retirement Plan, provided you are vested when you separate from service. The benefit you have earned under those plans as of your date of transfer will be paid to you at retirement from the plan in which you were participating. This summary plan description describes the benefits you earn after your date of transfer under the Retirement Savings Plan. Refer to the summary plan description for the Faculty Retirement Plan or the Employees’ Retirement Plan for information about the benefit you earned for your service with the University of Miami before your transfer date.

When You Can Participate
You become eligible to make pre-tax contribution following your date of hire. You become eligible to receive matching and core contributions after you complete one year of service. For employees other
than faculty members, you will earn a year of service if you complete 1,000 hours during the 12-month period immediately following your date of hire. If you do not complete 1,000 hours during your initial employment year, you will be credited with a year of service if you complete 1,000 hours of service during any plan year (June 1 to May 31). For faculty members, you will earn a year of service for each 12-month period of employment between your date of hire and the date you separate from service.

Enrolling in the Plan

Employee Contributions

Affirmative Election Contributions. You are eligible to make employee pre-tax contributions on the first day of any payroll period following the date you become eligible to participate in the Plan. You can make contributions to the Plan by visiting www.netbenefits.com/um and making your on-line election or by contacting Fidelity Investments at 1-800-343-0860. Your employee contributions for a payroll period will be made as soon as reasonably practical following the end of the payroll period.

Automatic Employee Contributions. If you have no salary reduction agreement in effect providing for employee contributions to the Plan, an amount equal to 1.5% of your compensation will automatically be set up after you have completed the one year of service requirement referenced above. HR Benefits will notify you of your eligibility and you will have the opportunity to stop making the automatic 1.5% of compensation contributions to the Plan by making an affirmative election to make contributions at a different percentage of your compensation, or to stop making employee contributions altogether.

You may increase, decrease or stop your contributions at any time by visiting www.netbenefits.com/um or by contacting Fidelity Investments at 1-800-343-0860.

Rollover Contributions. You may roll over the Plan distributions they receive from certain other retirement arrangements, such as other Section 403(b) plans, individual retirement accounts (“IRAs”), tax-qualified plans (including 401(k) or other 401(a) plans).

Investment Elections. You may change your investment company and/or your investment funds at any time. See the “Where the Contributions Go” section for more information.

Employer Contributions

You become eligible for matching and core contributions after you complete one year of service.

Designating a Beneficiary

You should also name a beneficiary as soon as you become eligible for the Retirement Savings Plan. Your beneficiary is the person who will receive your benefit if you die before receiving payment from the plan. You may change your beneficiary at any time, subject to spousal consent rules, by completing and returning the appropriate designation of beneficiary form to your investment company.

If you are married, you must name your spouse as the beneficiary of your retirement plan benefit. If you want to name someone other than your spouse as your beneficiary, you must obtain your spouse’s written, notarized consent.

Please note that if you are unmarried, name a beneficiary and subsequently marry, your prior designation is invalid and your spouse will be your beneficiary, unless you obtain proper spousal consent to a different beneficiary.

If there is no valid beneficiary form on file when you die, your spouse (if you are married) or your estate (if you are single) will automatically become your beneficiary.
How Your Account Can Grow

The Automatic Core Contribution

The University will make contributions of 5% of your compensation to the plan as a core contribution each pay period after you become eligible. For purposes of determining your core contribution, your compensation includes the total paid to you by the University as shown on your W-2 form including summer compensation for teaching or research activities, overload and overtime earnings and any pre-tax contributions you make to purchase benefits through any of the University's benefit plans. Compensation does not include any imputed income reported on your W-2 such as amounts under the University's tuition remission program.

You do not need to make voluntary contributions to receive the automatic core contribution.

If you are on a paid sabbatical leave of absence or unpaid leave for public service approved by the University, the University will continue making core contributions to your plan account.

Example: Core Contribution

Let's assume that you are a plan participant and that your annual compensation is $48,000. In this example, your automatic core contribution – for the year – will equal $2,400:

\[
\text{\$48,000} \times 5\% = \$2,400
\]

Remember, though, that core contributions are actually contributed to your account each pay period throughout the year.

Sabbatical And Other Leaves of Absence

The University’s automatic core contributions to the Retirement Savings Plan during a sabbatical leave will be based upon your full contract salary. No contributions are made during an unpaid leave of absence. However, special contributions may be made after you return from an unpaid approved leave of absence for public service.

Your Voluntary Contributions

When you become eligible, you are automatically set up to save 1.5% of your compensation in the plan as your voluntary contributions – unless you elect not to contribute or elect to contribute at a different level at that time. You may increase, decrease or stop contributing at any time. The change will become effective as of the next applicable pay period or as soon as administratively feasible.

You may contribute any percentage of your compensation from 1% to 100% or any flat dollar amount to the plan, up to federal limits. Your voluntary contributions are deducted from your paycheck before federal taxes are withheld. Because your contributions are made on a pre-tax basis, you do not pay current federal (or state, as applicable) taxes on the amount you save.

Impact on Taxes

Although your income taxes may be lower as a result of making voluntary contributions to the Retirement Savings Plan, your Social Security taxes are based on your gross compensation. This means there will be no reduction in any benefits payable from Social Security related to your participation in this plan. In addition, contributing to the Retirement Savings Plan will not reduce any benefits payable to you from any other University of Miami-sponsored plans.

Rollover Contributions

You may roll over to the Plan distributions you receive from certain other retirement arrangements, such as other Section 403(b) plans, individual retirement accounts ("IRAs"), tax-qualified plans (including 401(k) or other 401(a) plans).

Catch-Up Contributions

In order to give those who are closest to retirement an additional opportunity to put away more money on a tax-favored basis for retirement, an additional savings option ("catch-up contributions") is available under the Retirement Savings Plan. If you are over age 50 or will reach age 50 during the year, you may
contribute up to an additional $5,500 in 2015 on a before-tax basis as a catch-up contribution to the plan. You must save the maximum allowed under the plan on a pre-tax basis in order to make catch-up contributions. The maximum allowed catch-up contribution may change as determined by the Internal Revenue Service.

Matching Contributions

The University will match a percentage of the voluntary contributions you make to your retirement account. You will receive a dollar-for-dollar match on the first 5% of compensation you save. The matching contribution goes into your account each pay period, just like your own contributions.

True-Up Contributions

You may receive an additional match (a “true-up match”) to ensure that you receive the full employer matching contribution over the course of the year. The true-up match feature may apply to you if you changed your rate of voluntary contributions or were affected by the annual contribution limits during the year (see below) and did not receive the full matching contribution that you might have received if you had contributed evenly over the year.

Internal Revenue Code Limits

Your total voluntary contributions to the Retirement Savings Plan – not including any catch-up contributions – may not exceed the annual dollar limit for pre-tax deferrals as specified under the Internal Revenue Code (IRC) and adjusted by the Internal Revenue Service (IRS) each calendar year. For 2015, the dollar limit for pre-tax contributions is $18,000. If you are at least age 50, you may contribute more – up to $23,000 in 2014.

The IRS also adjusts the total annual contributions that can be made to the Retirement Savings Plan. Total annual contributions include automatic core contributions, your voluntary contributions and matching contributions. Catch-up contributions are not included in this limit. For 2015, the limit on total annual contributions is $53,000.

An additional limit specified under the IRC and adjusted by the IRS is the amount of compensation that can be taken into account for purposes of determining University core and matching contributions. For 2015, this limit is $265,000.

In future years, these limits may change as determined by the Internal Revenue Service.

Excess Contributions

If you exceed the limit on your voluntary contributions due to your participation in the plan of another employer, you may elect to have excess voluntary contributions returned to you from this plan. To do so, you must provide a written request to HR-Benefits no later than the March 1 following the end of the year in which the excess contributions were made. Your written request must state the reason for the return of contributions and the refund amount you are requesting. Upon HR-Benefits approval of your request, the excess contributions will be returned to you.

Where the Contributions are Invested

Fidelity Investments is the master record-keeper for plan investments and TIAA-CREF record keeps their own annuities. The following is the RSP investment structure:

 Tier One – Fidelity Freedom Index Funds
- The funds in this tier are monitored by the University of Miami 403(b) Investment Committee.

 Tier Two – Passive and Active Mutual Funds
- The funds in this tier are monitored by the University of Miami 403(b) Investments Committee.

 Tier Three – TIAA-CREF Annuities
- The funds in this tier are monitored by the University of Miami 403(b) Investments Committee.
Tier Four – Fidelity BrokerageLink

- The funds in this tier are NOT monitored by the University of Miami 403(b) Investments Committee.

For detailed information about the funds offered through the plan please visit https://umshare.miami.edu/web/wda/benefits/Retirement/NewTierStructure.pdf

It is important to thoroughly review and carefully consider the investments available on a regular basis and to make changes as needed. It is also vital that you keep your beneficiary designation current. If you wish to change your beneficiary, you must request the form directly from Fidelity Investments or TIAA-CREF.

If you do not make an investment election, your contributions, the University’s core and any matching contributions will automatically be invested in a Fidelity Investments Freedom Index Fund. With this type of fund, the mix of stocks, bonds and short-term investments is adjusted over time based on a retirement age of 65. You can change your investment election at any time under the regular rules of the plan. For more information, contact HR-Benefits.

Protection Under ERISA Section 404(c)
The Retirement Savings Plan is intended to meet the requirements of ERISA Section 404(c). This means that it provides participants with diversified investment options plus information on those options. It also refers you to the appropriate investment managers whose responsibility it is to provide you with additional investment information to carry out your investment elections. Under 404(c), plan fiduciaries are relieved of liability for any losses which result from a participant’s investment decisions.

Vesting

Vesting means that you have a nonforfeitable right to the value of your account. You are always 100% vested in the value of your voluntary contributions, rollover contributions and the matching contributions that you receive from the University.

You become vested in the value of the automatic core contributions made to your account and any investment earnings of that account after you complete three years of vesting service. You also become vested, regardless of your years of vesting service, if you reach age 65 or die while you are employed by the University.

You earn a year of vesting service for each plan year in which you work at least 1,000 hours from your date of hire to your date of termination, subject to the plan’s break in service rules.

Break in Service Rules
A one-year break in service occurs when you have a plan year in which you do not complete at least 501 hours of service. An hour of service is any hour for which you are directly or indirectly paid or entitled to payment by the University for the performance of duties or for periods of vacation, holiday, illness, incapacity, disability, layoff, jury duty, military duty or leave of absence. If you were a participant in the plan, you may rejoin the plan as soon as you return to active employment. If you are on a leave for maternity or paternity reasons, you will be credited with your usual hours of service to prevent a break in service from occurring during that year. Up to 501 hours can be credited during this time to prevent a break in service. If the number of hours you would have worked during that period cannot be determined, you can be credited with up to eight hours a day to prevent a break in service.

If you are not vested in your core contribution account balance and you incur five or more consecutive one-year breaks in service, your account balance will be forfeited. If you are reemployed by the University of Miami after five consecutive one-year breaks in service, the forfeiture will not be restored to your account balance.
If you are not vested in your core contribution account balance when you separate from service and you are reemployed before incurring five consecutive one-year breaks in service, your account balance will be restored.

What You Can Expect at Termination or Retirement
You may elect to receive the vested portion of your account from the Retirement Savings Plan upon your separation from service. You may also elect to defer the payment of your distribution. In general, under the tax law, distributions must begin no later than April 1 of the year following attainment of age 70-½ and must satisfy certain “minimum distribution” rules. Your distribution options are described below.

Example: How Your Account Grows
It’s important to understand what the value of the automatic core contribution means for your retirement years – and how you may want to save on a voluntary basis to ensure a financially secure retirement. We’ll assume that you become eligible for the Retirement Savings Plan at age 30, when earning $30,000 a year. We’ll assume that your pay grows by 3% per year and that you contribute 5% of your compensation to the plan and receive a 5% matching contribution.

Your contributions and the University’s contributions will accumulate over the years with compounding tax-deferred investment returns. To illustrate how your total accumulation could vary depending on what these contributions earn, here are just two of many possibilities. The first illustration is based on a 5% annual investment return; the second illustration is based on a 10% annual investment return.

| Total at 65, 5% return: | $415,000 |
| Total at 65, 10% return: | $1,138,000 |

Investment Company Selection
The wide range of possible accumulations in the example demonstrates the importance of your choice of an investment company and fund allocations, and emphasizes the potential magnitude of the sum you are responsible for investing. The University cannot give investment advice, but it does have information available on providers who offer a broad range of annuity investment and payment options.

Distribution Options
When you are eligible to receive payments from the plan, the value of your vested account may be rolled over into an IRA or paid as a full lump sum. Annuity options are also available.

If you are married when benefit payments begin, the normal form of payment is a joint and survivor annuity with at least one-half of your benefit paid to your spouse after your death. You must obtain your spouse’s notarized written consent if you select a different form of payment and/or beneficiary. The amount of your benefit will depend on the value of your account, the benefit option you elect, your age and, if applicable, the age of your beneficiary at the time you begin receiving benefits.

If you are not married when benefit payments begin, you may select from the wide range of annuity options available through the investment companies referenced in the section “Where the Contributions Go.”

Lump sum distributions received before age 59½ are generally subject to a 10% penalty per IRS regulations. See “Withholding” in the “Additional Retirement Information” section.

Personal Statements
The investment company you choose will provide quarterly statements showing the status of your Retirement Savings Plan account. You may request a projection of the amount of retirement income your account will produce directly from the investment company.
Death and Disability
Termination from employment and retirement are not the only circumstances in which the Retirement Savings Plan may provide benefits.

If You Should Die
If you were to die before retirement, your account balance in the Retirement Savings Plan will be payable to your beneficiary. Distribution options vary depending upon the investment company and the funds in which assets are invested.

If You Become Disabled
Hired Prior to June 1, 2013: If you were hired by the University of Miami prior to June 1, 2013, and you become totally and permanently disabled while employed at the University and qualify for total and permanent disability benefits under the Social Security Act, the University will continue its automatic core contributions for you under the Retirement Savings Plan. Contributions will be based on your University compensation during the 12 months before your date of disability. Contributions will continue as long as you qualify for disability benefits under Social Security and will stop on the earlier of the date you terminate your employment with the University, your 65th birthday, or the date your disability ends or you die.

Hired On or After June 1, 2013: If you were hired by the University of Miami on or after June 1, 2013, and you become totally and permanently disabled while employed at the University and qualify for total and permanent disability benefits under the Social Security Act, core contributions under the Retirement Savings Plan will not be made. You may elect to receive a distribution of your vested account.

Loans
Although the Retirement Savings Plan is intended to provide you with a long-term savings and investment vehicle, it does offer you the option to take loans while you are actively employed, according to specific IRS rules.

Only the value of your own voluntary contributions and any rollover contributions are available for a loan. You may have multiple loans outstanding at any time. In general, however, the maximum amount of the outstanding loans cannot exceed 50% of the value of your voluntary contributions or $50,000, whichever is less. The minimum amount you may borrow is $1,000.

If you take a loan, you will pay a set-up fee and a loan maintenance fee in accordance with the terms established by the investment provider. Loan payments will be repaid to your account. You will pay interest on your loan, which will be set at the prime rate of interest as published in the "money rate" section of the "Wall Street Journal" plus 1% as of the first business day of the month before the loan originated. All loan repayments, including the interest you pay to yourself, will be credited directly back to your own account, according to your current investment elections.

Loans can only be administered by Fidelity Investments. If your account is at TIAA-CREF or any prior investment provider, you must transfer enough funds from your investment provider to Fidelity to support the loan amount and then request a loan from your Fidelity account. Please contact Fidelity Investments for assistance.

The period of repayment must be agreed upon by you and Fidelity Investments. The maximum period of repayment is five years (20 years for loans used to purchase your principal residence). You may prepay your loan in full at any time without penalty.

If you are married, you must obtain your spouse's notarized consent to be able to take a loan from the plan.

To apply for a loan, please contact Fidelity Investments.
Withdrawals

The plan’s primary aim is to provide a long-term savings and investment program for retirement. However, the plan does permit limited withdrawals while you are employed. You may take withdrawals from your retirement account as long as you meet the following requirements:

Withdrawals After Age 59½
When you are at least age 59½, you may take a withdrawal of the current value of your voluntary pre-tax contributions at any time and for any reason.

Before Reaching Age 59½
Before reaching age 59½, you may withdraw the current value of your pre-tax voluntary contributions in the case of “financial hardship” as defined by the IRS. The University's automatic core and matching contributions and any investment earnings cannot be withdrawn while you are employed. A financial hardship withdrawal must be approved by the University in advance.

Financial hardships currently include the following:

- Unreimbursed medical expenses (described in IRC Code Section 213(d)) for which advance payment is necessary in order to obtain medical services for you, your spouse or your dependents and/or amounts needed to pay medical expenses already incurred by you, your spouse or your dependents
- Purchase of your primary residence (not mortgage payments)
- Tuition and related fees (excluding room, board and books) for the next 12 months, semester or quarter of post-secondary education for you, your spouse or your dependents
- Prevention of eviction from, or foreclosure on the mortgage of your primary residence
- Funeral or burial expenses for your deceased parent, spouse, children or dependent
- Expenses for the repair of damage to your principal residence that would qualify for the casualty deduction under IRC Section 165 (determined without regard to whether the loss exceeds 10% of adjusted gross income)
- Any other expenses that the IRS announces as a qualifying hardship under the safe harbor provisions of IRC Code Section 401(k).

You must have taken any other available loans or withdrawals before you request a financial hardship withdrawal. A financial hardship withdrawal cannot be for more than is required to meet your need, but can be increased to take into account the income taxes and penalties you will pay on a withdrawal. You will need to provide documentation confirming the cause of your financial need. When you take a financial hardship withdrawal, you will not be allowed to contribute to the Retirement Savings Plan for a six-month period following the date of the withdrawal. You may reenter the plan as of the next available payroll period following the six-month suspension period.

If you are married, you must obtain your spouse’s notarized consent before you can make a withdrawal from the plan.

You may also withdraw amounts in your rollover account at any time.

Amounts withdrawn for any reason while actively employed cannot be repaid to your account. All withdrawals are subject to federal and state income taxes in the calendar year in which you receive the withdrawal amount. A 10% federal penalty tax may also apply to the withdrawal amount if you receive it prior to age 59½.

Additional Information
Please refer to the sections “Additional Information” and “Retirement Claim/Appeal Procedures” for information including how the Retirement Savings Plan is administered and your rights under the Employee Retirement Income Security Act of 1974 (ERISA) as amended.
SUPPLEMENTAL RETIREMENT ANNUITIES (SRA)

What the Plan Can Do for You .................................................. 104
When You Can Participate ......................................................... 104
Designating a Beneficiary ......................................................... 104
The Tax Advantages ................................................................. 104
Investment Options ................................................................. 105
Loans ................................................................................... 106
Withdrawals ........................................................................... 106
When Benefits Are Paid ............................................................ 107
Benefit Payment Options ......................................................... 107
Information for Participants Who Joined the RSP ...................... 107
Additional Information ............................................................. 108
Supplemental Retirement Annuities (SRA)

What the Plan Can Do For You
If you are eligible to participate in the Faculty Retirement Plan or the Employees’ Retirement Plan, you may also save and invest your own money on a pre-tax basis to build additional assets for the future through the Supplemental Retirement Annuity Program. The amount you can save annually in the Supplemental Retirement Annuity Program is based on your taxable compensation and provisions in the law. Contact HR-Benefits for information on individual limits.

When You Can Participate
If you are eligible to participate in the Faculty Retirement Plan or the Employees’ Retirement Plan, you may enroll in the Supplemental Retirement Annuity Program at any time after you are employed. When you enroll, you sign a salary reduction agreement, authorizing the University to reduce a portion of your salary and remit it to the investment company you choose. You also complete an investment company application indicating your fund elections. Contact HR-Benefits to obtain enrollment applications.

Certain other employees of the University are not eligible to participate in the Supplemental Retirement Annuity Plan. This includes students, employees regularly scheduled to work less than 20 hours per week or employees eligible for the Retirement Savings Plan or the Retirement Savings Plan II (which is available for Hospital employees).

Designating a Beneficiary
You should also name a beneficiary as soon as you enroll in the Supplemental Retirement Annuity Program. Your beneficiary is the person who will receive your benefit if you die before receiving payment from the plan. You may change your beneficiary at any time, subject to spousal consent rules, by completing and returning the appropriate designation of beneficiary form to your investment company.

If you are married, you must name your spouse as the beneficiary of your retirement plan benefit. If you wish to name someone other than your spouse as your beneficiary, you must obtain your spouse’s written, notarized consent.

Please note that if you are unmarried, name a beneficiary and subsequently marry, your prior designation is invalid and your spouse will be your beneficiary, unless you obtain proper spousal consent to a different beneficiary. Similarly, if you become divorced, any prior beneficiary designation becomes invalid and you will need to complete a new designation of beneficiary form and return the completed form to your investment company.

If there is no valid beneficiary form on file when you die, your spouse (if you are married) or your estate (if you are single) will automatically become your beneficiary.

The Tax Advantages
Under Section 403(b) of the Internal Revenue Code, your contributions to the Supplemental Retirement Annuity Program are not subject to current federal income tax. You declare and pay tax only on the balance of your salary after your contributions to the Supplemental Retirement Annuity Program. Other benefits, however, such as your group life insurance, pension and Social Security, are figured on your full base salary before your contributions to the Supplemental Retirement Annuity Program are deducted from your pay.

The funds in your account, including any earnings on your investment, will not be taxed until you receive them. Access to your account is limited except as allowed by law. Loans and withdrawals may also be offered through this program.
An Example:
If you earn $40,000 a year and elect to invest 10% or $4,000 a year in the Supplemental Retirement Annuity Program (assuming this amount is within IRC limitations), you need to declare as taxable income only the remaining $36,000.

Internal Revenue Code Limits
Your voluntary contributions to the Supplemental Retirement Annuity Program – not including any catch-up contributions – may not exceed the annual dollar limit for pre-tax contributions as specified under the Internal Revenue Code (IRC) and adjusted by the Internal Revenue Service (IRS) each calendar year. For 2015, the dollar limit for pre-tax contributions is $18,000.

In order to give those who are closest to retirement an additional opportunity to put away more money on a tax-favored basis for retirement, an additional savings option (“catch-up contributions”) is available under the Supplemental Retirement Annuity Program. If you are over age 50 or will reach age 50 during the year, you may contribute up to an additional $6,000 in 2015 on a pre-tax basis as a catch-up contribution to the plan. You must save the maximum allowed under the plan on a pre-tax basis in order to make catch-up contributions. In future years, these limits may change as determined by the Internal Revenue Service.

An additional catch-up contribution may be available to participants who have 15 or more years of service at the University. Contact HR-Benefits to determine if you qualify.

Investment Options
Fidelity Investments is the master record-keeper for plan investments and TIAA-CREF record keeps their own annuities. The following is the SRA investment structure:

- **Tier One – Fidelity Freedom Index Funds**
  The funds in this tier are monitored by the University of Miami 403(b) Investments Committee.

- **Tier Two – Passive and Active Mutual Funds**
  The funds in this tier are monitored by the University of Miami 403(b) Investments Committee.

- **Tier Three – TIAA-CREF Annuities**
  The funds in this tier are monitored by the University of Miami 403(b) Investments Committee.

- **Tier Four – Fidelity BrokerageLink**
  The funds in this tier are NOT monitored by the University of Miami 403(b) Investments Committee.

For detailed information about the funds offered through the plan please visit [https://www6.miami.edu/benefits/Retirement/NewTierStructure.pdf](https://www6.miami.edu/benefits/Retirement/NewTierStructure.pdf).

It is important to thoroughly review and carefully consider the investments available on a regular basis and to make changes as needed. It is also vital that you keep your beneficiary designation current. If you wish to change your beneficiary, you must request the form directly from Fidelity Investments or TIAA-CREF.

Protection Under ERISA Section 404(c)
The Retirement Savings Plan is intended to meet the requirements of ERISA Section 404(c). This means that it provides participants with diversified investment options plus information on those options. It also refers you to the appropriate investment managers whose responsibility it is to provide you with additional investment information to carry out your investment elections. Under 404(c), plan fiduciaries are relieved of liability for any losses which result from a participant’s investment decisions.
Loans

Although this program was set up to encourage you to save for your retirement, it does offer you the option to take loans while you are actively employed, according to specific IRS rules. You may have multiple outstanding loans at any time. In general, the maximum amount of all loans cannot exceed 50% of the value of your voluntary contributions or $50,000, whichever is less. The minimum amount you may borrow is $1,000.

If you take a loan, you will pay a set-up fee and a loan maintenance fee in accordance with the terms established by Fidelity Investments. Loan payments will be repaid to your account. You will pay interest on your loan, which will be set at the prime rate of interest as published in the “money rate” section of the “Wall Street Journal” plus 1% as of the first business day of the month before the loan originated. All loan repayments, including the interest you pay to yourself, will be credited directly back to your own account, according to your current investment elections.

Loans can only be administered by Fidelity Investments. If your account is at TIAA-CREF or any prior investment provider, you must transfer enough funds from your investment provider to Fidelity to support the loan amount and then request a loan from your Fidelity account. Please contact Fidelity Investments for assistance.

The period of repayment must be agreed upon by you and Fidelity Investments. The maximum period of repayment is five years (20 years for loans used to purchase your principal residence). You may prepay your loan in full at any time without penalty.

If you are married, you must obtain your spouse’s notarized consent to be able to take a loan from the plan.

To apply for a loan, please contact Fidelity Investments.

Withdrawals

The plan’s primary aim is to provide a long-term savings and investment program for retirement. However, the plan does permit limited withdrawals while you are employed. You may take withdrawals from your retirement account as long as you meet the following requirements:

Withdrawals After Age 59½
When you are at least age 59½, you may take a withdrawal of the current value of your voluntary contributions at any time and for any reason.

Before Reaching Age 59½
Before reaching age 59½, you may withdraw the current value of your pre-tax voluntary contributions in the case of “financial hardship” as defined by the IRS. The University’s automatic core and matching contributions and any investment earnings cannot be withdrawn while you are employed. A financial hardship withdrawal must be approved by the University in advance.

Financial hardships currently include the following:

- Unreimbursed medical expenses (described in IRC Code Section 213(d)) for which advance payment is necessary in order to obtain medical services for you, your spouse or your dependents and/or amounts needed to pay medical expenses already incurred by you, your spouse or your dependents
- Purchase of your primary residence (not mortgage payments)
- Tuition and related fees (excluding room, board and books) for the next 12 months, semester or quarter of post-secondary education for you, your spouse or your dependents
- Prevention of eviction from, or foreclosure on the mortgage of your primary residence
- Funeral or burial expenses for your deceased parent, spouse, children or dependent
• Expenses for the repair of damage to your principal residence that would qualify for the casualty deduction under IRC Section 165 (determined without regard to whether the loss exceeds 10% of adjusted gross income)
• Any other expenses that the IRS announces as a qualifying hardship under the safe harbor provisions of IRC Code applicable to this plan.

You must have taken any other available loans or withdrawals before you request a financial hardship withdrawal. A financial hardship withdrawal cannot be for more than is required to meet your need, but can be increased to take into account the income taxes and penalties you will pay on a withdrawal. You will need to provide documentation confirming the cause of your financial need. When you take a financial hardship withdrawal, you will not be allowed to contribute to the Supplemental Retirement Annuity Plan for a six-month period following the date of the withdrawal. You may reenter the plan as of the next available payroll period following the six-month suspension period.

If you are married, you must obtain your spouse's notarized consent before you can make a withdrawal from the plan.

Amounts withdrawn for any reason while actively employed cannot be repaid to your account. All withdrawals are subject to federal and state income taxes in the calendar year in which you receive the withdrawal amount. A 10% federal penalty tax may also apply to the withdrawal amount if you receive it prior to age 59½.

When Benefits Are Paid
Please contact the investment company in which your contributions are invested for information about when you may receive payment.

Benefit Payment Options
Distribution Options
When you are eligible to receive payments from the plan, the value of your vested account may be rolled over into an IRA or paid as a full lump sum. Annuity options are also available.

If you are married when benefit payments begin, the normal form of payment is a joint and survivor annuity with at least one-half of your benefit paid to your spouse after your death. You must obtain your spouse’s notarized written consent if you select a different form of payment and/or beneficiary. The amount of your benefit will depend on the value of your account, the benefit option you elect, your age and, if applicable, the age of your beneficiary at the time you begin receiving benefits.

If you are not married when benefit payments begin, you may select from the wide range of annuity options available through the investment companies referenced in the section “Where the Contributions Go.”

Lump sum distributions received before age 59½ are generally subject to a 10% penalty per IRS regulations. See “Withholding” in the “Additional Retirement Information” section.

Personal Statements
The investment company you choose will provide quarterly statements showing the status of your Retirement Savings Plan account. You may request a projection of the amount of retirement income your account will produce directly from the investment company.

Information for Participants Who Joined the RSP
If you were contributing to the Supplemental Retirement Annuity Program and you elected to participate in the Retirement Savings Plan, the contributions you had been making to the Supplemental Retirement Annuity Program stopped as of the date you began participating in the Retirement Savings Plan. To
continue making voluntary tax-deferred contributions, you need to complete a new salary reduction agreement under the Retirement Savings Plan. Your account under this program will continue to be invested according to your most recent investment direction.

Additional Information
Please refer to the sections “Additional Information” and “Retirement Claim/Appeal Procedures” for information including how the Supplemental Retirement Annuity Program is administered and your rights under the Employee Retirement Income Security Act of 1974 (ERISA) as amended.
TUITION REMISSION

What the Plan Can Do For You 110
Glossary of Common Terms 110
Employee Coverage 110
Dependent/Spouse Coverage 111
Financial Aid Requirements 112
Admission & Normal Progress Requirements 112
Dependent Eligibility Requirements 112
Change in Employee Status 112
Away Tuition Remission 114
Graduate Taxation 114
What Is Not Covered 114
What the Plan Can Do For You
To provide financial assistance regarding tuition as an incentive for self-improvement and a means of encouraging higher education for current and retired employees, as well as their dependents.

Glossary of Common Terms
Continuous Employment - Uninterrupted and working regularly scheduled hours including time away from work for vacation and sick leave, based on the date of acceptance of the position or date of hire.

Dependent – A spouse recognized under Florida Law, a University certified domestic partner or dependent child as defined below. A marriage license is proof of dependency for spouse.

Dependent Child – A biological, adopted or stepchild receiving 50% or more support from the University employee.

Normal Progress – Continuous enrollment in a degree-seeking program, enrollment in a minimum of six credits per semester (both Fall & Spring) and earn 12 credits per year.

Regular Full-Time – An employee who is scheduled to work 100% time on a continuing basis or at least 80% time working via an approved alternative work arrangement.

Regular Part-Time – An employee who is scheduled to work 50% time or more on a continuing basis.

Retired Employee – An employee who separates from service and meets the following criteria is eligible to retain tuition remission benefit at the rate in effect at the time of separation, subject to changes in the tuition remission policy:

1. An employees who separates from service on or after age 65 with a minimum of five years of service
2. An employees who separates from service on or after age 55 with a minimum of ten years of service
3. An employee who meets the Rule of 70 (age at separation from service plus years of service is at least 70)

Employee Coverage
Employee
The University will grant tuition remission to all full-time or part-time regular employees who have completed 90 calendar days of continuous employment at the University prior to the first scheduled day of class as published in the University Bulletin. If the completion of the 90 days falls after the first scheduled day of class, eligibility shall commence at the next successive regular registration.

Full-Time Employees are eligible for 100% tuition remission for up to two courses per semester with a maximum of 15 credits per calendar year.

Accountability:
Employees who do not successfully complete a course (i.e. do not receive credit for the course within the semester in which it was taken) will be responsible for all or a portion of the tuition cost for the course. The charge to the employee will be based on the amount actually charged to tuition remission for the unsuccessful course. The charge will be applied to the employee’s student account.

Full-time Employees Attending Class
Full-Time employees may attend class during assigned regular working hours with the prior approval from the supervisor and appropriate vice president/dean.
Part-Time Regular Employee
Part-Time regular employees are eligible for prorated tuition remission for:

- Up to two courses per semester with a maximum of 15 credits per calendar year.

Part-Time Employees Attending Class
Part-time regular employees may not attend classes during their scheduled working hours.

Retired Employees
Retired employees are eligible for 100% tuition remission for themselves and their dependents that meet all requirements.

MBA Programs
Full-time regular employees accepted into the one year MBA “lock-step” program are eligible for a maximum of 32 credits per calendar year. Full-time regular employees accepted into the two year MBA “lock-step” program are eligible for a maximum of 24 credits per calendar year. Full-time regular employees must submit a signed form, generated by Human Resources, of approval by their supervisor to participate in this program.

The Executive MBA & Working Professional Program are not eligible for tuition remission.

Doctoral Level Study is not eligible for tuition remission.

Non-Credit Courses are not covered under tuition remission.

Test Prep Courses
Preparatory classes (GRE, GMAT, LSAT, SAT, etc.) are not eligible for tuition remission.

Dependent/Spouse Coverage

Credit Limit
Dependents of full time regular employees are eligible for tuition remission at the University of Miami for a total of 128 attempted credits. There are restrictions as described in this policy.

Dependents of part-time regular employees are eligible for prorated tuition for a total of 128 attempted credits; there are restrictions as described in this policy.

Dependents (child or spouse) who are hired at the University as a benefits eligible employee will only be entitled to the employee tuition remission benefit.

Credit Counting
Coursework that is begun or attempted but not completed for any reason will count against the 128 attempted credits maximum for dependents and spouses. Coursework that is failed will count against the 128 attempted credits maximum.

Level of Coverage
Dependents of employees hired before September 1, 2002 will receive 75% tuition remission during the employee’s first five years of full-time regular employment, and 100% thereafter. The five years must be completed prior to the first day of class as advised in the University bulletin, otherwise 100% tuition remission will begin with the next semester.

A dependent of an employee hired on or after September 1, 2002 is eligible for tuition remission at the University of Miami after completion of one full year of full-time regular employment at the rate of 70% during years two through five, 85% during years six through ten and 100% thereafter. For the rate of tuition to be changed due to reaching successive years the time must be completed prior to the first day of classes.
as published by the University bulletin, otherwise the new rate of tuition would commence at the next semester.

Dependents (child or spouse) who are hired at the University as a benefits eligible employee will only be entitled to the employee tuition remission benefit.

Please contact HR-Benefits for information regarding dependent tuition remission for part-time regular employees.

Financial Aid Requirements
BFRAG REQUIREMENTS - All full-time undergraduate dependents who plan to use tuition remission are required to apply for the William L. Boyd, IV, Florida Resident Access Grant (BFRAG). In order to qualify for funding from the BFRAG, all dependents must complete the Free Application for Federal Student Aid (FAFSA) each academic year. All dependents who qualify for the BFRAG will have the amount of the BFRAG subtracted from their charges for tuition and fees, and tuition remission will cover the remaining entitled costs. If a dependent qualifies for the BFRAG and does not apply as required, tuition remission will be reduced by the amount of the BFRAG. This BFRAG policy affects only dependents that are full-time undergraduate students eligible for 100 percent tuition remission. This BFRAG policy does not affect dependents receiving less than 100 percent tuition remission.

Admission & Normal Progress Requirements
Admission Requirements
Employees and dependents must meet the admissions requirements set forth by the University. This means that all grade point average and SAT requirements must be met as well as any other requirements for admission. An employee or dependent will not be admitted solely on the basis of employment. The application fee is waived for employees and dependents.

Age Requirements
Dependent children must be enrolled in a college degree-seeking program before they reach age of 23. Dependent children then must make normal progress as defined toward graduation or until the maximum benefit has been received per this policy. During the time that the dependent is receiving benefits they must continue to prove dependency on a yearly basis. The dependent child will not be eligible for tuition remission for any semester that begins after reaching age 27.

Break in Normal Progress
If a semester (s) is/are missed due to extenuating circumstances, documentation may be submitted to HR-Benefits who will consider each request on a case-by-case basis.

Normal Progress after graduation from Undergraduate Program
Normal progress towards graduation requirements is modified for dependents who obtain an undergraduate degree using the tuition remission and who wish to pursue a graduate course study at the University of Miami. Within a two-year period following the graduation date, a dependent may resume utilizing tuition remission for graduate study credits using the balance of the original 128 credits. To be eligible for resumption the dependent must submit certification of dependency. They must continue to make normal progress toward the degree or expiring of benefit.

Dependent Eligibility Requirements
Proof of Dependency
Certification of a dependent child normally requires a copy of the employees most recent IRS tax return (1040 US Individual Income Tax Return) showing the child as a dependent; exceptions will be made on a case-by-case basis for certain circumstances such as divorce. This proof must be provided each year the dependent is utilizing the benefit.
Change in Employee Status

Termination of an Employee
Upon the effective date of termination of an employee, (excluding involuntary termination, death or retirement), all tuition remission ceases for the employee and/or dependents. The former employee or dependent has the option of continuing in that semester’s class by paying the prorated share of tuition.

Involuntary Termination
An employee who leaves the University through an involuntary termination (excluding layoff) is eligible for the tuition remission benefit for him/herself, spouse and dependent children through the end of the semester or summer session then in progress.

Employees Placed on Layoff
An employee who is placed on layoff is eligible to continue through the end of the semester that falls within the 13-month layoff period as long as he or she has started classes or has been accepted and confirmed prior to the effective layoff date. Tuition remission benefit eligibility for employees on layoff status is based on the benefit in effect at the time of layoff. The employee will continue to be exempt from taxation for undergraduate courses through the end of the semester in which the effective date of layoff occurs. For subsequent semesters during the 13-month layoff period, employees on layoff will be exempt for the first $5,250 of undergraduate and graduate tuition remission per calendar year. The value of undergraduate and graduate tuition remission received by an employee on layoff status over $5,250 per calendar year will be taxable income.

Dependent child(ren) of an employee placed on layoff will continue through the end of the semester that falls within the 13-month layoff period as long as he or she has started classes or has been accepted and confirmed prior to the effective layoff date. Tuition remission benefit eligibility for dependent children is based on the benefit in effect at the time of the effective date of layoff. Tuition remission benefits for graduate level programs will only continue through the end of the semester in which the effective date of layoff occurs. Dependents will continue to be exempt from taxation for undergraduate courses through the end of the semester in which the effective date of layoff occurs. For subsequent semesters during the 13-month layoff period, the value of all undergraduate tuition remission received by dependent children during the 13-month layoff period will be taxable income to the person on layoff status.

Dependent spouse or certified domestic partner of an employee who is on layoff will continue through the end of the active semester or summer session in which he/she is taking classes.

Returning to Employment
An employee who is placed on layoff has 13 months in which to return as an active employee and, therefore, receive tuition remission at the same level as when he/she was last employed.

If an employee is involuntary terminated or resigns, he/she must become reemployed as an active employee within 31 days to receive an immediate tuition remission benefit otherwise, 90 calendar days of continuous employment must be completed to receive tuition remission.

Bridging Time
An employee hired who has completed five or more years of continuous full-time or part-time regular employment and returns to full-time or part-time regular employment after being separated from employment for a period less than he/she had worked prior to separation will be eligible to receive the same tuition remission percentage he/she was entitled to upon leaving the University.

Disability of an Employee
Employees approved for Long Term Disability are eligible for tuition remission for themselves and eligible dependents as set forth in this policy at the same rate eligible when approved for long-term disability.
Death of an Employee
Upon the death of a full-time or part-time regular employee who has five or more full years of service to the University at the time of death or upon death of a retired employee, his/her dependents are eligible for tuition remission as set forth in this policy at the same rate eligible at time of death.

University Leave
All military, medical, or industrial leaves (i.e. Worker’s Compensation) are excused absences. Tuition remission continues while on one of the above leave of absences. Leaves of absence without pay are not eligible for tuition remission.

Away Tuition Remission Policy
Dependent children of employees (including children of retired or deceased employees) who established eligibility prior to June 1, 1972, and who have been in continuous full-time service are eligible for tuition up to 120 credits or eight semesters (whichever is greater) at either the University of Miami or at other accredited universities or colleges (undergraduate level dollars only).

These above indicated individuals are also eligible for additional credits at the University of Miami only, up to a combined total not to exceed 14 semesters or 225 credits, whichever is greater. However, the institution each student is attending must certify that the student is making normal progress toward graduation. This tuition benefit is available to dependent children who begin a college program before age 23 and are making normal progress toward a degree. If the student attends elsewhere, tuition remission cannot exceed the current tuition cost the employee would receive at the University of Miami.

Graduate Taxation
The University manages its tuition remission plan in accordance with Internal Revenue Service (IRS) regulations. Graduate tuition remission is subject to Federal Income and Social Security withholding taxes.

Employee Graduate Tuition Taxation
All faculty and staff enrolled in graduate level courses will be exempt from taxation for the first $5,250 of graduate tuition remission per calendar year. The value of graduate tuition remission received by employees over $5,250 per calendar year is taxable income to the employee. The value of graduate tuition remission received by employees over $5,250 per calendar year will be allocated over the remaining pay periods in the semester for which the graduate tuition remission is received unless the employee has contacted HR-Benefits regarding the allocation of an estimate of the entire years graduate tuition remission and allocate the taxes over the entire calendar year.

Dependent Graduate Tuition Taxation
Employees will be taxed on all graduate tuition remission received by dependents. The value of graduate tuition remission received by dependents will be allocated over the employees remaining pay periods in the calendar year.

Estimation of Taxation
It is advised to complete a Graduate Tuition Taxation Estimate Form at the beginning of each calendar year. This will help to spread out the taxation costs over the year and avoid being heavily taxed at the end of the calendar year. This can be done for employee and dependent graduate taxation. Please notify HR-Benefits during the year of any changes to the estimate.

Taxation Notification
Employees are notified by mail or email of the amount of taxable income reported to the IRS for graduate tuition remission. If an employee or dependent drops taxable graduate courses after the course withdrawal date, the course remains taxable to the employee.

What Is Not Covered
Tuition Remission is not available in the following:

- School of Law or School of Medicine
- Special programs including the Executive MBA, Working Professional MBA, (unless awarded a scholarship) and the Master of International Business Programs in the Graduate School or Undergraduate School.
- UOnline Master’s degree programs in Finance and Sports Administration
- Private music lessons
- All private lessons and hobby courses
- Auditing of courses
- In-service courses in Miami Dade County Schools
- Courses required for certification or licensure that are conducted in whole or in part by outside vendors
- Non-credit courses
- CME courses sponsored by the University of Miami or another educational institution

Exceptions to the above policy will be made for adult education courses through the School of Continuing Studies in the non-hobby, non-sports category, provided that the course offers job related training for University personnel, as certified by the department chair or supervisor, charges market rates for tuition, and has space available after all regular tuition paying enrollees are accommodated and has no more than 20% of the enrollees eligible for tuition remission. Non-credit language courses will have to meet the previous requirements for an exception to the non-credit course tuition remission policy; however, no more than 30% of the enrollees in the non-credit language-training course will be eligible for tuition remission.

Governing Policy: It is the responsibility of the employee to review and comply with the current University of Miami policy. The Tuition Remission Policy is the governing policy on tuition remission. Any other printed material is not binding on HR-Benefits and therefore, will not be considered as policy.

Granting Procedure:
The granting of tuition remission is an automatic process. Forms are not required to claim tuition remission. If the employee anticipates that his/her dependent or domestic partner will be attending the University of Miami and using tuition remission, the employee must provide proof of dependency or marriage, or certification of domestic partnership, if the dependent is not currently covered on the employee’s medical and/or dental plan.

If proof of dependency is not received by HR-Benefits, the employee’s tuition remission for that dependent will be delayed until proof is received. If there is such a delay and the dependent is dropped from classes for non-payment, the employee will be responsible for any re-instatement fees incurred. This notice is the employee’s only notice to provide proof of dependency.
ADDITIONAL INFORMATION

Plan Sponsor 117
Plan Administrator 117
ERP Plan Trustee 117
Agent for Service of Legal Process 117
Plan Numbers, Funding, Years and Type 118
Plan Documents Control 119
When Benefits Are Not Paid 119
The Future of the Plans 121
Insuring ERP Benefits 121
If the Retirement Plans Become Top Heavy 122
Leaves of Absence 122
Your Rights Under ERISA 123
Your Employment 124
Additional Information

This document contains summary plan descriptions of the retirement benefit plans for the University of Miami. The benefits under these plans are provided for the exclusive benefit of participants and their beneficiaries.

Plan Sponsor
The plan sponsor is the University of Miami:

University of Miami, HR-Benefits
1320 S. Dixie Hwy.
Suite 100
Coral Gables, Florida 33146
305-284-3004

Plan Administrator
The UM Retirement Plans Review Committee of the University of Miami is the Plan Administrator under ERISA (the Employee Retirement Income Security Act of 1974) for the Employees' Retirement Plan, Faculty Retirement Plan, Retirement Savings Plan and Supplemental Retirement Annuity Plan.

HR-Benefits is charged with benefit determinations and day-to-day plan operation. Benefit applications and appeals for denied claims may all be made to:

University of Miami, HR-Benefits
1320 S. Dixie Hwy.
Suite 100
Coral Gables, Florida 33146
305-284-3004

ERP Plan Trustee
The name and address of the trustee for the Employees' Retirement Plan are:

Wells Fargo Institutional Retirement and Trust
MAC Z0307-092
100 South Ashley Drive, Suite 980
Tampa, FL 33602

Agent for Service of Legal Process
The registered agent to accept service of legal process for the University of Miami is:

Administrator for Risk Management
1320 S. Dixie Hwy.
Suite 1200
Coral Gables, Florida 33146
Plan Numbers, Funding, Years and Type
The University of Miami’s identification number for government reports is EIN 59-0624458.

<table>
<thead>
<tr>
<th>Plan Name and Number</th>
<th>Funding</th>
<th>Plan Year</th>
<th>Type</th>
<th>Plan Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care (501)</td>
<td>University and employee contributions</td>
<td>June 1 – May 31</td>
<td>Welfare</td>
<td>Self-Insured Third Party Administrator</td>
</tr>
<tr>
<td>Disability Income (502)</td>
<td>University contributions</td>
<td>January 1 – December 31</td>
<td>Welfare</td>
<td>Self-Insured Third Party Administrator</td>
</tr>
<tr>
<td>Dental Care (503)</td>
<td>University and employee contributions</td>
<td>June 1 – May 31</td>
<td>Welfare</td>
<td>Insurer</td>
</tr>
<tr>
<td>Flexible Spending Account Plan (504)</td>
<td>Employee contributions</td>
<td>January 1 – December 31</td>
<td>Welfare</td>
<td>Third Party Administrator</td>
</tr>
<tr>
<td>Business Travel Accident (505)</td>
<td>University contributions</td>
<td>June 1 – May 31</td>
<td>Welfare</td>
<td>Insurer</td>
</tr>
<tr>
<td>Group Life Insurance and Accident (506)</td>
<td>University contributions</td>
<td>June 1 – May 31</td>
<td>Welfare</td>
<td>Self-Insured Third Party Administrator</td>
</tr>
<tr>
<td>Medical Faculty LTD Plan (507)</td>
<td>University contributions</td>
<td>June 1 – May 31</td>
<td>Welfare</td>
<td>Insurer</td>
</tr>
<tr>
<td>Short Term Disability (508)</td>
<td>Employee contributions</td>
<td>June 1 – May 31</td>
<td>Welfare</td>
<td>Employer</td>
</tr>
<tr>
<td>Supplemental Life Insurance (509)</td>
<td>Employee contributions</td>
<td>January 1 – December 31</td>
<td>Welfare</td>
<td>Insurer</td>
</tr>
<tr>
<td>Medical Faculty Life Insurance and AD&amp;D (510)</td>
<td>University contributions</td>
<td>November 1 – October 31</td>
<td>Welfare</td>
<td>Insurer</td>
</tr>
<tr>
<td>Employees’ Retirement Plan (001)</td>
<td>University contributions</td>
<td>June 1 – May 31</td>
<td>Defined Benefit Cash Balance Pension</td>
<td>Third Party Administrator</td>
</tr>
<tr>
<td>Supplemental Retirement Annuity Program (002)</td>
<td>Employee contributions</td>
<td>January 1 – December 31</td>
<td>403(b)</td>
<td>Third Party Administrator</td>
</tr>
<tr>
<td>Faculty Retirement Plan (003)</td>
<td>University contributions</td>
<td>January 1 – December 31</td>
<td>403(b) Defined Contribution</td>
<td>Third Party Administrator</td>
</tr>
<tr>
<td>Retirement Savings Plan (005)</td>
<td>University contributions and voluntary employee contributions</td>
<td>January 1 – December 31</td>
<td>403(b) Defined Contribution</td>
<td>Third Party Administrator</td>
</tr>
</tbody>
</table>

For Self-Insured Plans: The plan is self-insured and unfunded. In other words, current employee contributions and the University of Miami’s contributions will pay only current benefit claims and will not fund future benefit claims. Although Aetna pays claims under the plan on behalf of the University of Miami, Aetna does not insure or guarantee that claims will be paid. Rather, Aetna relies on the University of Miami to provide it with enough money to pay the claims. Aetna cannot pay the claims if the University of Miami does not provide the money to Aetna.
For Insured Plans: The plan's benefits are financed through a group insurance contract with the following insurance companies: CIGNA (dental), Delta Dental (dental), MetLife (supplemental life), Unum (Medical Faculty Life and LTD). The insurers are responsible for investing the premiums and paying benefit claims. The insurers guarantee the payment of claims incurred before the group insurance contract terminates.

Plan Documents Control
The plan documents govern the operation of the plans described in these summary plan descriptions. If there is any conflict with these non-technical summaries, the plan documents will control. These summary plan descriptions are intended to help you understand the main features of the University’s retirement benefit plans. It should not be considered as a substitute for the plan documents which govern the operation of the plans. Those official plan documents set forth all of the details and provisions concerning the plans and are subject to amendment. If any questions arise that are not covered in these summary plan descriptions, or if these summary plan descriptions appear to conflict with the legal plan documents, the text of the legal plan documents will determine how questions will be resolved. You are welcome to request inspection of the official plan documents at HR-Benefits or request copies of your own, for a small fee to cover printing costs.

When Benefits Are Not Paid
These summary plan descriptions outline and the official plan documents describe in detail, plan benefits and how you or your spouse or other beneficiary can qualify for them. As long as the plans are in force, if you or a beneficiary becomes eligible for benefits and makes proper application for them, they should begin promptly – usually within 30 days. There are a few circumstances which might result in disqualification, non-eligibility, denial, loss, forfeiture, suspension or reduction of benefits to an eligible employee, spouse or other beneficiary. They include:

For the Faculty Retirement Plan and the Retirement Savings Plan
• Because the amount of any distribution from the plan(s) is based on your account balance at the time you terminate or retire, that amount may be more or less than the amount shown on your last statement of your account balance

For the Employees’ Retirement Plan
• Not accruing the required 1,000 hours in a plan year to earn a year’s credit for vesting or benefits
• Dying before you could commence benefits – but your beneficiary could receive a death benefit regardless of your service if you are an active plan member at the time of your death
• Re-employment by the University while receiving retirement payments and which requires a suspension of benefits during the period while again working (When you again retire, your benefit will be re-calculated and cannot be less than when you originally retired).

For the Employees’ Retirement Plan, the Faculty Retirement Plan and the Retirement Savings Plan
• Leaving the University before earning a vested right to your plan benefit – but your beneficiary could receive a death benefit regardless of your service if you are an active plan participant at the time of death. (Note that if you separate from service on or after January 1, 2009, you are automatically 100% vested in your benefit from the Employees’ Retirement Plan.)
• Failure to make timely and proper application for benefits, or to supply information, such as proof of age or death, as required by the UM Retirement Plans Review Committee.
• If your employment status changes such that you are no longer eligible under the plan or work enough to earn a benefit, you may stop accruing benefits or receiving credits to your plan account.
• If a court order concerning child support, alimony or marital property rights so decrees, part of your benefit may be payable to someone other than you or your designated beneficiary.
• If you work past your normal retirement date. If your normal retirement date occurs before June 1, 2014, and you continue working for the University, or if your normal retirement date occurs on or after June 1, 2014, and you do not elect to immediately commence your benefits, you will continue to accrue benefits, but your benefits accrued through your normal retirement date will not be paid to you
at your normal retirement date. That benefit, plus benefits earned after your normal retirement date, will be paid to you when you actually retire.

- Federal law limits the amount of benefits that may be received from a qualified pension plan. In particular, for 2014, no more than $260,000 ($265,000 in 2015) of annual compensation may be taken into account in determining your benefit. Also, in 2014 and 2015, your annual benefit will be limited to the lesser of $210,000 or 100% of your average compensation during your highest three years. These limits may be adjusted periodically for changes in the cost of living, and may be adjusted depending on the form of benefit you select and your benefit commencement date.
- By law, certain restrictions apply to the Employees’ Retirement Plan if the funded status decreases below a certain threshold. These restrictions would result in a limitation of the amount that could be paid under any lump sum option. In the event that benefit restrictions apply to the Employees’ Retirement Plan, the Plan Administrator will separately notify participants and beneficiaries.
- These plans also contain certain limitations on the amount of benefits that can be distributed to the 25 highest paid employees of the University, under certain circumstances. These restrictions may, among other things, limit the value of lump sums that may be paid to these affected employees. If you are subject to this limitation, you will be notified.

Under the Faculty Retirement Plan, the Retirement Savings Plan, and the Supplemental Retirement Annuity Program, all benefits are provided for from the individual annuity contracts or custodial accounts selected by and issued to plan participants under its provisions. Neither the Board of Trustees, the University, nor any officer or employee of the University has any liability or responsibility for those member-owned contracts or benefits. The University, therefore, makes no warranty against any loss or diminution in the value of any annuity contract or custodial account, except to make the plan’s required contributions to the provider company of your choice.

**Qualified Domestic Relations Order (QDRO)**

A qualified domestic relations order (QDRO) is a legal judgment, decree or order that recognizes the rights of an alternate payee under the retirement plans with respect to a child’s or other dependent’s support, alimony or marital property rights. The University is legally required to recognize a QDRO.

If you become legally separated or divorced, a portion or all of your benefit under your retirement plan may be assigned to someone else to satisfy a legal obligation you may have to a spouse, former spouse, child or other dependent.

There are specific requirements the court order must meet to be recognized by the Plan Administrator and specific procedures regarding the amount and timing of payments.

Participants and beneficiaries may obtain, without charge, a copy of the procedures governing QDRO determinations under the plan from the Plan Administrator by contacting HR-Benefits at 305-284-3004.

**Benefit Assignment**

To protect you and your dependents, your interest in a plan cannot be assigned, sold, transferred or pledged by you and, to the extent permitted by law, benefits are not subject to garnishment or attachment. However, current law allows a court to assign a portion of a participant’s benefits to another person under the terms of a qualified domestic relations order (QDRO), usually issued as part of a divorce proceeding.

**Receiving Advice**

The University cannot advise you with regard to legal, tax or investment considerations relative to any plan. Therefore, if you have questions pertaining to benefit planning in these areas, you should seek advice from a personal tax advisor or financial planner.

**Plan Interpretation**

To the fullest extent permitted by law, the Plan Administrator will have the exclusive discretion to determine all matters relating to eligibility, coverage and benefits under the plan. The Plan Administrator
will also have the exclusive discretion to determine all matters relating to interpretation and operation of the plan. Decisions by the Plan Administrator will be conclusive and binding.

**Withholding**

Unless you elect otherwise for the Faculty Retirement Plan, the Employees’ Retirement Plan and the Retirement Savings Plan, benefit payments from these plans will be subject to federal income taxes and may be subject to state and local income taxes as well. If you elect a lump sum payment, the University of Miami is required to withhold federal income taxes equal to 20% of the taxable portion of your payment, unless you roll over your distribution directly into an IRA (including a Roth IRA, but not to a SIMPLE IRA or Education IRA) or eligible employer plan. Unless you are at least age 55 at the time you leave the University, you are at least age 59½ at the time payment is made to you or another exception applies, your distribution may be subject to a 10% early payment penalty tax in addition to regular income taxes if it is not rolled over to an eligible retirement plan. Your distribution may be rolled over to the extent that it is an “eligible rollover distribution.” Generally, a distribution is an eligible rollover distribution if it is paid in the form of a single lump sum payment, or in the form of installment payments made over a period of less than 10 years. For more information on the additional 10% tax, please see IRS Form 5329.

You are responsible for paying any applicable federal, state and local taxes when you receive the distribution. You will receive more information about the applicable rules when you request payment of your benefits. Because taxes are complicated and subject to change, you may wish to consult a tax advisor before receiving benefits from the plan.

**The Future of the Plans**

It is the University’s intent that the Employees’ Retirement Plan, the Faculty Retirement Plan and the Retirement Savings Plan will continue indefinitely. However, the University reserves the right to amend, modify, suspend or terminate these plans, in whole or in part, in accordance with plan provisions. Plan amendment, modification, suspension or termination may be made for any reason, and at any time, and may, in certain circumstances, result in the reduction or elimination of benefits or other features of the plans to the extent allowed by law.

If any of the plans are completely or partially terminated, affected participants will become fully vested in the benefits they have accrued to that point (to the extent such benefits are funded). In the event of a complete plan termination, benefits will be distributed in any manner permitted by the plans as soon as practicable and any excess funds will then revert to the University.

**Insuring ERP Benefits**

The University of Miami pays annual premiums for all employees to a governmental insuring agency set up under ERISA. If the Employees’ Retirement Plan should terminate, benefits are insured, up to certain limits, by the Pension Benefit Guaranty Corporation (PBGC). Generally, it guarantees most vested normal and early retirement benefits, and certain survivor pensions. The PBGC does not guarantee all types of benefits under all plans, and the amount of protection has limits. For example, it covers vested benefits as of the date a plan terminates. In addition, if a plan has been adopted or benefits increased within five years, the whole amount may not be guaranteed. There is a ceiling on the monthly benefit the PBGC guarantees, which is adjusted periodically. For more information contact HR-Benefits at 305-284-3004 or contact the PBGC’s Technical Assistance Division, 1200 K. Street, N.W., Suite 930, Washington, DC 20005-4026, or call (202) 326-4000 (not a toll-free number). TTY/TDD users may call the federal relay service toll-free number at 1-800-877-8339 and ask to be connected to (202) 326-4000. Additional information about the PBGC’s pension insurance program is available through the PBGC’s website on the Internet at http://www.pbgc.gov.

You may direct requests for information about eligibility, membership, contributions, or other aspects of plan operation in writing to the Plan Administrator.
Defined contribution retirement plans such as the Faculty Retirement Plan, the Retirement Savings Plan or other University benefit plans are not insured by the PBGC.

If the Retirement Plans Become Top Heavy
Under a complicated set of IRS rules set out in the plan documents, the plans may become “top heavy.” A top heavy plan is one where more than 60% of the contributions or benefits have been allocated to “key employees.” Key employees are generally certain officers of the University. The Plan Administrator is responsible for determining whether a plan is a top heavy plan each year. In the unlikely event that a plan becomes top heavy in any year, non-key employees may be entitled to certain minimum benefits and special rules will apply. If the plan becomes top heavy, the Plan Administrator will advise you of your rights under the top heavy rules.

Leaves of Absence
You may be able to continue your participation during leaves of absence under the retirement plans under certain circumstances.

Continuation of Participation While on Approved Leaves of Absence
Special rules apply if you take an approved paid leave of absence (or are eligible for long-term disability) under your retirement plan (the Employees’ Retirement Plan, the Faculty Retirement Plan or the Retirement Savings Plan) for purposes of vesting and earning benefits or pay credits under the plan. Please see the applicable SPD for more details or contact HR-Benefits. You cannot receive a benefit payment from your plan account during a leave.

If you take an approved unpaid leave of absence, you will not continue to accrue service for purposes of vesting, benefit accrual or pay credits. You cannot receive benefit payments from your retirement plan until you are considered to have terminated your employment.

Continuation of Participation for Employees in the Uniformed Services (USERRA)
The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to eligible participants of retirement plans who enter military service. The terms “uniformed services” or “military service” mean the Armed Forces (i.e., Army, Navy, Air Force, Marines Corp., Coast Guard), the reserve components of the Armed Services, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency. Upon reinstatement, you are entitled to the seniority, rights and benefits associated with the position held at the time employment was interrupted, plus additional seniority, rights and benefits that you would have earned if employment had not been interrupted. These rights include receiving vesting service and benefit accrual or pay credits under your retirement plan. Such leave will not constitute a break in service.

If you think you may be eligible for these special rights under USERRA, please contact HR-Benefits at 305-284-3004.

Continuation of Participation While on a Family and Medical Leave (FMLA)
Under the federal Family and Medical Leave Act (FMLA), if you meet eligible service requirements, you are entitled to take up to 12 weeks of leave for certain family and medical situations. An absence under the Family and Medical Leave Act will not constitute a break in service for purposes of your retirement plan. In general, your FMLA leave is treated like any other paid or unpaid leave under your plan. If your FMLA leave is paid, your leave will be treated like other paid leaves; if your FMLA leave is unpaid, it will be treated like other unpaid leaves.
Your Rights Under ERISA

As a participant in any of these retirement plans (the Employees' Retirement Plan, the Faculty Retirement Plan, the Retirement Savings Plan, or the Supplemental Retirement Annuity Program), you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- **Examine**, in HR-Benefits without charge, copies of all documents governing the plans including a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- **Obtain**, on written request to the Plan Administrator and for a reasonable charge to cover printing, copies of documents governing the operation of the plan including copies of the latest annual report (Form 5500 Series) and updated summary plan description.
- **Receive** each year a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report. If you participate in the Employees' Retirement Plan, in lieu of a summary annual report, you will receive an annual funding notice providing basic information about the funding status and financial condition of the Plan, including the Plan's funding percentage, assets and liabilities, and a description of the benefits guaranteed by the PBGC. The Retirement Plan Administrator is required by law to furnish each participant and Plan beneficiary with a copy of this annual funding notice.
- **Obtain** a statement telling you whether you have a right to receive a benefit at your normal retirement age (age 65) and if so, what your pension benefits would be at normal retirement age under the plan if you stop working now. If you do not have a right to a benefit, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The plan must provide the statement free of charge.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a pension benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a suit in state or federal court, but only after you have exhausted your retirement plan's claims and appeals procedures as described in the next section, “Appeals Procedures.” In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the
court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

**Assistance with Your Questions**
If you have any questions about your plan, you should contact the Plan Administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

**Your Employment**
These summary plan descriptions provide detailed information about the University of Miami’s retirement benefit plans and how they work. These summary plan descriptions do not constitute an implied or express contract or guarantee of employment. Similarly, your eligibility or your right to benefits under these plans should not be interpreted as an implied or express contract or guarantee of employment. The University’s employment practices are made without regard to the benefits it offers as part of your total compensation.

*If any discrepancies exist between the summary plan description and the plan documents or master contracts, the plan documents or master contracts will override.*

For questions about the plans or your benefits under them, contact HR-Benefits. For questions about your ERISA rights, you may contact the Labor Management Services Administration of the U.S. Department of Labor (Look under “U.S. Government” in the telephone directory).
APPEALS PROCEDURES

Claims Procedures 126
External Review Policy 129
Sample Form 131
Medical Insurance 133
Dental Insurance 133
Concordia Behavioral Health 134
Voluntary Excess Life 134
Voluntary Accidental Death & Dismemberment 134
Life Insurance and Accidental Death & Dismemberment 135
Long Term Disability Insurance 135
Long Term Care Insurance 136
Flexible Spending Accounts 136
Retirement Claim/Appeal Procedures 137
Appeals Procedures

Claims Procedures

Coverage. All claims for benefits under the plan are processed by Aetna under an ASO contract.

Claims procedures. You must file claims for benefits under the plan with Aetna. The booklet describes the procedure for filing claims and the procedure for requesting a review of denied claims. As part of the claims administration process, Aetna will:

- pay claims for benefits due under the plan;
- provide written explanations of the reasons for denied claims;
- handle claimant requests for reviews of denied claims; and
- make the final decision on denied claims.

Under the Employee Retirement Income Security Act (ERISA) of 1974, you have the right to appeal a denied claim.

See the following claims review charts:

<table>
<thead>
<tr>
<th>Claims Review Chart: Effective [January 1, 2003]</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of Claim</strong></td>
</tr>
<tr>
<td>-------------------</td>
</tr>
<tr>
<td>Urgent Health Care Claim</td>
</tr>
<tr>
<td>Claims for conditions that could jeopardize life, health, or ability to regain maximum function, or would subject you to severe pain. The reasonable layperson standard is used for these claims, except that if a physician determines the condition is urgent, the Plan must accept the physician’s determination.</td>
</tr>
<tr>
<td>Step 1:</td>
</tr>
<tr>
<td>Step 2:</td>
</tr>
<tr>
<td>Step 3:</td>
</tr>
<tr>
<td><strong>IF YOUR CLAIM IS IMPROPER OR INCOMPLETE</strong></td>
</tr>
<tr>
<td>Step 1:</td>
</tr>
<tr>
<td>Step 2:</td>
</tr>
<tr>
<td>Step 3:</td>
</tr>
<tr>
<td>Step 4:</td>
</tr>
<tr>
<td>Pre-Service Health Claim</td>
</tr>
<tr>
<td>Group health claims where treatment must be pre-certified before it is performed.</td>
</tr>
<tr>
<td>Step 1:</td>
</tr>
<tr>
<td>Step 2:</td>
</tr>
<tr>
<td>Step 3:</td>
</tr>
</tbody>
</table>
### Claims Review Chart: Effective [January 1, 2003]

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Steps to Take</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IF YOUR CLAIM IS IMPROPER OR INCOMPLETE</strong></td>
<td></td>
</tr>
<tr>
<td>Step 1:</td>
<td>The Plan has <strong>5 days</strong> after receiving your initial claim to notify you that your claim is an improper claim.</td>
</tr>
<tr>
<td>Step 2:</td>
<td>The Plan has <strong>15 days</strong> after receiving your claim to notify you of its decision to approve or deny the claim. If the Plan needs more information and provides an extension notice during the initial 15-day period, the Plan has <strong>30 days</strong> after receiving the claim to notify you of its decision. (The time the plan waits for claimant information is not counted in totals.)</td>
</tr>
<tr>
<td>Step 3:</td>
<td>You have <strong>45 days</strong> after receiving the extension notice to provide additional information or complete the claim.</td>
</tr>
<tr>
<td>Step 4:</td>
<td>If your claim is denied, you have <strong>180 days</strong> after receiving the claim denial to appeal the Plan's decision.</td>
</tr>
<tr>
<td>Step 5:</td>
<td>The Plan has <strong>30 days</strong> after receiving your appeal (<strong>15 days</strong> if the Plan allows two levels of appeal) to notify you of the appeal decision. Both levels of appeal must be completed within the 30-day deadline.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Post-Service Health Claim</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Group health claims where you request reimbursement after treatment has been performed.</td>
<td></td>
</tr>
<tr>
<td>Step 1:</td>
<td>The Plan has <strong>30 days</strong> after receiving your initial claim to notify you if your claim is denied.</td>
</tr>
<tr>
<td>Step 2:</td>
<td>If your claim is denied, you have <strong>180 days</strong> after receiving the claim denial to appeal the Plan’s decision.</td>
</tr>
<tr>
<td>Step 3:</td>
<td>The Plan has <strong>60 days</strong> after receiving your appeal (<strong>30 days</strong> if the Plan allows two levels of appeal) to notify you of the appeal decision. Both levels of appeal must be completed within the 60-day deadline.</td>
</tr>
</tbody>
</table>

**Claim Denials.** If your claim for benefits is wholly or partially denied, any notice of adverse benefit determination under the plan will:

- state the specific reasons for the determination;
- reference specific plan provisions on which the determination is based;
- describe additional material or information necessary to complete the claim and why such information is necessary;
describe plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to sue in federal court under ERISA section 502(a) after an adverse benefit determination is rendered on appeal;

furnish information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable);

describe the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request);

disclose the availability of and contact information for any applicable office or health insurance consumer assistance or ombudsman, if any, established by the Department of Health and Human Services to assist with the internal claims and appeals and external review processes;

if the denial is based on medical necessity or experimental treatment, provide an explanation of the scientific or clinical judgment for the determination, applying plan terms to your medical condition (or state that such information will be provided free of charge upon request);

for urgent care claims, the denial notice will include a description of the expedited review process applicable to such claims. This denial may be given orally, provided that a written or electronic notification is furnished to you no later than 3 days after the oral notification.

Appeals. If you believe your claim was denied in error, you may appeal this decision to the plan. You have 180 days after receiving the claim denial to appeal the plan’s decision. You may submit written comments, documents, or other information in support of your appeal and have access, upon request, to all relevant documents free of charge. The review of the claim denial will take into account all new information, whether or not presented or available at the initial claim review, and will not be influenced by the initial claim decision.

A rescission of coverage under the health plan will be considered an adverse benefit determination and you will be able to appeal the rescission under these procedures. A rescission is a discontinuance of coverage with retroactive effect. Coverage may be rescinded if an individual or person seeking coverage on behalf of the individual commits fraud or makes an intentional misrepresentation of material fact, as prohibited by the terms of this Plan. However, a retroactive cancellation of coverage is not considered to be a rescission if it is due to failure to pay required premiums or contributions toward the cost of coverage on time. If your coverage is going to be rescinded, you will receive written notice at least 30 days before the coverage will be cancelled.

A different person than the one who made the initial claim determination will conduct the appeal review and such person will not work under the original decision maker’s authority. If your claim was denied on the grounds of medical judgment, the plan will consult with a health professional with appropriate training and experience. This health care professional will not be the individual who was consulted during the initial determination or work under their authority. If the advice of a medical or vocational expert was obtained by the plan in connection with the denial of your claim, we will provide you with the names of each such expert, regardless of whether the advice was relied upon.

If new or additional evidence is considered, relied upon, or generated by the Plan in connection with your claim, you will be provided free of charge with such evidence as soon as possible and sufficiently in advance of the date of which the notice of final internal adverse benefit determination is required to be provided to you as specified in the chart above. If new or additional rationale is relied upon in denying your claim on review, you will be provided with the new or additional rationale as soon as possible and with enough time before the final determination is required to be provided to you so that you will have a reasonable opportunity to respond. You may also review the claim file and present evidence and testimony.

If your claim involves urgent care, a request for an expedited appeal may be submitted orally or in writing and all necessary information shall be transmitted between the plan and you by telephone, fax, or other similar method.
If your appeal is denied, the denial notice will contain the following information:

- the specific reasons for the appeal determination;
- a reference to the specific plan provisions on which the determination was based;
- a statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all document, records, or other information relevant to the determination;
- a statement describing any voluntary appeal procedures offered by the plan and your right to obtain information about these procedures;
- a statement describing your right to bring a civil lawsuit under ERISA section 502(a); furnish information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable);
- the denial code and its corresponding meaning, as well as a description of the standard, if any, that was used in denying the claim, including a discussion of the decision;
- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);
- if the denial is based on medical necessity or experimental treatment, an explanation of the scientific or clinical judgment for the determination, applying plan terms to your medical condition (or state that such information will be provided free of charge upon request);
- a statement that “You or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency.”

The appeal determination notice may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

If the claims administrator fails to adhere, except for de minimis violations, to all of the time frames and requirements for processing claims as described above, then you are deemed to have exhausted the internal claims and appeals process and may initiate this external review process, if applicable, or pursue any other remedies available to you, including filing suit, under ERISA section 502(a). A violation is considered to be de minimis if it was non-prejudicial, attributable to good cause or due to matters beyond the control of the claims administrator, occurred in the context of an ongoing, good faith exchange of information between you and the claims administrator, and is not reflective of a pattern or practice of non-compliance. You may request a written explanation of the violation from the claims administrator, and such explanation must be provided within 10 days, including a specific description of the basis, if any, for asserting that the violation is de minimis.

**External Review Policy**

The University of Miami wishes to establish a policy on external, independent reviews of coverage denials based upon lack of medical necessity, or experimental or investigational nature of the proposed or rendered service or treatment and also the external review process applies to rescissions of health coverage. Giving members the right to seek external review of coverage denials by independent physician reviewers fosters confidence and trust among physicians, members, employers and managed care plans. Members with the right to external review know they can get an independent review of a claim denial when they need it, not years later after costly litigation.

External review not only reaches out to protect the interest of members involved in specific cases, but also gives the plan the input of independent experts, thereby helping the plan gain greater understanding about how managed care can work best for consumers.

**Policy**

- All members of the University of Miami’s health benefit plans administered by Aetna will have the option to obtain External Review of coverage denials based upon a lack of medical necessity, or the experimental or investigational nature of the proposed or rendered services or treatment from an
ERO ("ERO") approved by Aetna, provided the member's responsibility for the benefit in question is $500.00 or more.

- External Review will be conducted by an independent physician with appropriate expertise in the area at issue as determined by the ERO.
- The ERO is responsible for choosing the appropriate physician reviewer. The physician reviewer must be board certified by the appropriate American medical specialty board in a clinical specialty/area at issue in the external review.
- Conflict of interest: The ERO and the physician reviewers each certify that they have no professional, familial, financial, or research affiliation with Aetna (including the officers, directors and managers of the plan), the member in questions, or the provider (and provider's group) who recommended the service or treatment under review. There must also be certification of no professional, familial, or financial interest with the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of External Review. Each review determination must include these certifications.
- The professional fee for the review will be paid by the named fiduciary. Members will be responsible for the cost of compiling and sending the submission from the member to Aetna. Members may send any information they choose to support their review requests, but must include the External Review Request Form (except under expedited circumstances as described below), the denial of coverage letter, and any medical records in support of their request.
- Due to the expense of external review, in order for this policy to apply, the cost of the service or treatment at issue for which the member is financially responsible must exceed $500.00, unless an exception to this threshold is requested and granted by Aetna.
- Except in the case of a request for expedited review, members shall request external reviews using the Aetna External Review Request Form. This form includes a consent to disclosure of member's medical and claims information to the external reviewer. This form will be transmitted to members by the claim fiduciary along with the coverage denial, or experimental or investigational nature of the proposed or rendered service or treatment. This form also will be available on the Aetna website. Members also may request this form by calling writing, or emailing Aetna Member Services. (See standard below for expedited review).
- Where Aetna is the claim fiduciary, member will be notified of their right to external review once the member has exhausted the applicable appeal process.
- Where Customer is claim fiduciary, and Customer upholds denial of coverage at final level of appeal, Customer will notify members of their right to External Review and will enclose the Aetna External Review Request Forms (standard and expedited) with the denial of coverage notice that Customer sends to members.
- Members must submit the External Review Request Form, a copy of the denial of coverage letter, and all other information they wish to be reviewed. These materials must be submitted to Aetna within 60 calendar days of the date the member receives the final determination letter.
- The external review determination generally will be made within 30 calendar days of Aetna's receipt of (i) a properly completed External Review Request Form and (ii) when Customer is claim fiduciary, applicable plan documents and criteria relied upon in reaching the final determination. This time period includes the time within which Aetna submits the appropriate documentation to the ERO.
- A dedicated Aetna External Review unit(s), including dedicated fax numbers/address, will facilitate prompt transmission of document to ERO.
- At all times the confidentiality of member medical information is safeguarded.
- The ERO will notify the member that it has received the External Review request, and indicate the date that Aetna received such request.
- The ERO will submit the reviewer determination in writing to Aetna and the member (or the member's representative, if applicable), and specify whether the determination is upheld or reversed, and briefly specify the basis for such determination in accordance with plan documents and criteria (including, without limitation, Aetna Coverage Policy Bulletins).
- Expedited reviews are available when the member's physician certifies, on a separate Request For Expedited External Review form (or by telephone with prompt written follow-up), the clinical urgency of the member's situation. "Clinical urgency" means that a delay (waiting the full 30 calendar day period) in receipt of the service at issue would jeopardize the health of the member.
Expedited reviews generally will be decided by the ERO/physician reviewer within 5 calendar days of receipt of such request by Aetna. Telephonic notice of the ERO determination must be followed immediately by written notice (submitted by expedited mail or fax) to the member (or the member’s representative, if applicable) and Aetna.

The external reviewer may consider any appropriate credible information submitted by the member with the External Review request Form, but must follow the plan’s contractual documents and plan criteria (including, without limitation, Aetna Coverage Policy Bulletins) governing the member’s benefit in reaching a decision.

The decision of the external reviewer will be binding on Aetna and the plan, except where Aetna or the Plan can show reviewer conflict of interest (see standard above), bias, or fraud. In such cases, notice will be given to the member and the matter will be promptly resubmitted for consideration by a different reviewer.

Any person may request an External Review on behalf of the member, provided that the member has consented to such representation on the External Review Request Form.

Any provider or other person, including an attorney, may apprise a member of the member’s right to request External Review and may also assist a member in preparing or pursuing the member’s request for an External Review.

Members and providers will not be penalized for exercising their right to request an External Review or assisting a member in pursuing an External Review.

Procedures:

- The claim fiduciary will include, in the final denial of coverage letter, information describing the process to be undertaken by the member to request an External Review, and will include both of Aetna’s External Review Request Forms (standard and expedited). The letter will also include a statement that the member’s decision whether or not to request External Review will have no effect on the member’s rights to any other benefit under the plan, the member’s rights to representation, the process for selecting the External Review Organization or the impartiality of the physician reviewer.
- The applicable Aetna External Review Request Form must be completed by the member, or their treating physician, and submitted to the Aetna Review Unit with all requested documentation within 60 calendar days of receipt of the final denial.
- The Aetna External Review Unit will contact one of the ERO vendors to initiate the review process.
- When Customer is claim fiduciary and the member has submitted an Aetna External Review Request Form, Customer will transmit to Aetna External Review Unit copies of the applicable plan documents and criteria relied upon in reaching the final determination.
- The Aetna External Review Unit will transmit to the ERO vendor by overnight mail, all of the information provided by the member and customer, including copies of (i) the applicable plan documents and criteria and (ii) all of the information forwarded to Aetna by the claim fiduciary, reviewed or relied upon in making its determination.
- A final determination will be made and sent to Aetna, the member, and the treating physician by the ERO.
- For cases where the ERO reverses claims denials made by the claim fiduciary, Aetna will process claims for payment pursuant to the ERO decision and in accordance with the terms of the Plan.

Sample Form

Any Plan Participant may file a claim requesting a Plan benefit to which the participant believes that he or she is entitled. If the claim is denied in whole or in part, the Participant is afforded the following rights.

I. Request For Claims Review

A. __________________________ will assist the claimant in assembly of the necessary information.

   The claim review request should include the following:

   1. 
   2. 
   3. 

University of Miami Medical Group - 2015
4.

B. The request for review should be sent to _________ at the following address:

C. The request will be reviewed by ______________ within ninety (90) days of receipt. If additional time is required, written notice will be sent to the claimant. The extension of time will not exceed another ninety (90) days.

II. Notification to Claimant of Claim Review Decision

A. If the claim is wholly or partially denied, written notice of the decision by _________ shall be furnished to the claimant within ninety (90) days after receipt of the claim.

B. Content of notice:
   1. The specific reason or reasons for the denial;
   2. Specific reference to pertinent Plan provisions on which the denial is based;
   3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and
   4. Appropriate information as to the steps to be taken if the participant or beneficiary wishes to appeal the decision.

C. If notice of the denial of claim is not furnished within ninety (90) days, the claim is deemed denied and the claimant is permitted to proceed to the appeal stage described in Section III.

D. If special circumstances require an extension of time for processing the review, written notice of the extension shall be furnished to the claimant prior to the determination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to decide.

III. Appeal Procedure

A. A claimant, or his or her duly authorized representative, has an opportunity to appeal a denied claim. The claimant, or his or her duly authorized representative, may:
   1. Request review upon written application to the plan;
   2. Review pertinent documents; and
   3. Submit issues and comments in writing.

B. The claimant must file a request of review of a denied claim within sixty (60) days after receipt by the claimant of written notification of denial of a claim. The request for review should be sent to the following address:

C. A decision on the review shall be made promptly, no later than sixty (60) days after the plan's receipt of a request for review. If special circumstances require an extension of time for processing, a decision shall be rendered no later than 120 days after receipt of a request for review.

D. If the extension of time for review is required because of special circumstances, written notice of the extension shall be furnished to the claimant prior to the commencement of the extension.

E. The decision shall be in writing and shall include specific reasons for the decision, as well as specific references to the pertinent plan provisions on which the decision is based.

F. If a decision on appeal is not made within the time frame, the appeal is considered denied.
HEALTH INSURANCE - AETNA
SECTION I – Employee calls Aetna Member Services at 1-800-824-6411.
   A. Member Services
      1. Copy of claim
      2. Reason member feels claim should be paid
      3. Any supporting documentation
   B. Aetna
      Attn: National Account CRT
      PO Box 14463
      Lexington, KY 40512
   C. The Claims Review Department

SECTION II
   A. The Claims Department

SECTION III
   B. Aetna
      Attn: National Account CRT
      PO Box 14463
      Lexington, KY 40512

DENTAL INSURANCE - CIGNA DENTAL CARE (HMO)
SECTION I
   A. Member Services Department
      1. Reason member feels claim should be paid.
      2. Any supporting Documents
   B. CIGNA Dental Appeals
      PO BOX 188047
      Chattanooga, TN  37422-8047
   C. CIGNA Dental within 30 days of receipt

SECTION II
   A. CIGNA Dental within 30 days unless extension is needed.

DENTAL INSURANCE – DELTA DENTAL PPO
SECTION I
   A. Delta Dental Insurance Company
      1. Any supporting documents
      2. Reason member feels claim should be paid
   B. Delta Dental Insurance Company
      Attn: Professional Services
      1130 Sanctuary Parkway, 5th Floor
      M/S 5B
      Alpharetta, GA  30009
   C. Delta Dental Insurance Company

SECTION II
   A. Delta Dental Insurance Company within 30 days unless extension needed.
CONCORDIA BEHAVIORAL HEALTH - CBH
SECTION I
A. Member Services
   1. Copy of claim
   2. Reasons member feels claim should be paid
   3. Any supporting documentation
B. Concordia Behavioral Health
   Member Services
   PO Box 016960 (LC 2940)
   Miami, FL 33101
C. The Claims Review Department

SECTION II
A. The Claims Department

SECTION III
A. Concordia Behavioral Health
   Member Services
   PO Box 016960 (LC 2940)
   Miami, FL 33101

VOLUNTARY EXCESS LIFE – METLIFE
SECTION I
A. University of Miami HR-Benefits
   1. Certified Death Certificate
   2. Beneficiary Designations
   3. Enrollment Forms
   4. Signed Claimant and Employer Statements
B. Supervisor
   MetLife
   PO Box 6100
   Scranton, PA 18505-6100
C. A MetLife Claim Reviewer

SECTION II
A. A MetLife Claim Reviewer

SECTION III
B. Supervisor
   MetLife
   PO Box 6100
   Scranton, PA 18505-6100

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT – CHARTIS
SECTION I
A. University of Miami HR-Benefits
   1. Statement of claimant and attending physician
   2. Police accident/incident report
   3. Copy of enrollment/beneficiary designation form
   4. Payroll stub or other confirmation that premium payment was current
B. Chartis  
Accident and Health Claims Department  
PO Box 15701  
Wilmington, DE 19850-5701

C. Chartis

SECTION II
A. Chartis

SECTION III
A. Chartis  
Accident and Health Claims Department  
PO Box 15701  
Wilmington, DE 19850-5701

LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT - AETNA

SECTION I
A. University of Miami HR-Benefits  
1. Certified Death Certificate  
2. Beneficiary Designations  
3. Enrollment Forms  
4. Signed Claimant and Employer Statements

B. AETNA Life Insurance Company  
151 Farmington Avenue  
Hartford, CT 06156

C. AETNA

SECTION II
A. AETNA

SECTION III
A. AETNA Life Insurance Company  
151 Farmington Avenue  
Hartford, CT 06156

LONG TERM DISABILITY INSURANCE – UNUM

SECTION I
A. Unum Life Insurance Company  
1. Any supporting documents  
2. Reason member feels claim should be paid

B. Unum Life Insurance Company  
2211 Congress Street  
Portland, ME 04102-9997

C. Unum Life Insurance Company

SECTION II
A. Unum Life Insurance Company
LONG TERM CARE INSURANCE – UNUM
SECTION I
A. Quality Review Section
   1. Request must be received within 60 days of receipt of denial letter.
   2. Claim number
   3. Policy number

B. UNUM Quality Review Section
   PO Box 9064
   Portland, ME 04104-5064

C. Quality Review Section

FLEXIBLE SPENDING ACCOUNTS - WAGEWORKS
SECTION I
A. University of Miami HR-Benefits
   1. Documentation from the Provider(s) of Medical services indicating the nature of the expense(s), the date(s) and amount(s) so incurred, and the name of the patient and relationship to the Plan Participant, if the basis of the denial was the omission of any one of these items of information.
   2. A written statement by the patient’s physician indicating the medical necessity of the treatment/service if the basis of the denial relates to the medical necessity of the treatment/service.
   3. A written “Explanation of Benefits” from all available sources of insurance reimbursement indicating the insurance reimbursement of the expense(s), or a portion thereof, if the basis of the denial relates to insurance reimbursement.
   4. Documentation from the Provider(s) of Dependent Care services indicating the date(s) and amount(s) so incurred, the name, address and Employer identification number or Social Security number of the provider(s) of service(s), and the relationship to the Plan Participant if the nature of the denial was the omission of any one of these items of information.

B. WageWorks
   PO Box 991
   Mequon, WI 53092

C. HR-Benefits

SECTION II
A. HR-Benefits

SECTION III
A. University of Miami, HR-Benefits
   PO Box 248106
   Coral Gables, FL 33124-2902
Retirement Claim/Appeal Procedures

This section sets out the procedures pertaining to claims by participants and beneficiaries (claimants) for retirement benefits, consideration of such claims and review of claim denials. In the aggregate, the steps are referred to as claims procedures. A claim is a request for a plan benefit by a participant or beneficiary.

If a claim is wholly or partially denied (i.e., any denial, reduction or termination of a benefit, or a failure to provide or make a payment), notice of this decision must be furnished by the Plan Administrator to the claimant within 90 days of receipt of the claim by the plan. If notice of denial is not furnished in 90 days, the claim shall be considered as denied. This 90-day period may be extended for up to an additional 90 days, if the Plan Administrator both determines that special circumstances require an extension of time and the date by which the plan expects to render a determination.

In the event an extension is necessary due to your failure to submit necessary information, the plan’s timeframe for making a benefit determination on review is stopped from the date the Plan Administrator sends you an extension notification until the date you respond to the request for additional information.

If You Receive an Adverse Benefit Determination

The claim denial shall set forth in writing:
- The specific reason or reasons for the denial
- Specific reference to pertinent plan provisions on which the denial is based
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary and
- Appropriate information as to the steps to be taken under the rules of the plan if the participant or beneficiary wishes to submit his or her claim for review, including a statement of your right to bring a civil action under ERISA after an adverse determination on appeal.

Procedures for Appealing an Adverse Benefit Determination

If you receive an adverse benefit determination, you may ask for a review. A claimant or the claimant’s duly authorized representative has 60 days following the receipt of a notification of an adverse benefit determination within which to appeal a denied claim. You have the right to:
- Submit written comments, documents, records and other information relating to the claim for benefits
- Request, free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record, or other information is treated as “relevant” to your claim if it:
  o Was relied upon in making the benefit determination
  o Was submitted, considered or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination
  o Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination
- A review that takes into account all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination.

The Plan Administrator will notify you of the plan’s benefit determination on review within a reasonable period of time, but no later than 60 days after the plan’s receipt of your request for review. This 60-day period may be extended for up to an additional 60 days, if the Plan Administrator both determines that special circumstances require an extension of time for processing the claim, and notifies you, before the initial 60-day period expires, of the special circumstances requiring the extension of time and the date by which the Plan Administrator expects to render a determination on review.

In the event an extension is necessary due to your failure to submit necessary information, the plan’s timeframe for making a benefit determination on review is stopped from the date the Plan Administrator sends you notification of the extension until the date you respond to the request for additional information.
The Plan Administrator’s notice of an adverse benefit determination on appeal will contain all of the following information:

- The specific reason(s) for the adverse benefit determination
- References to the specific plan provisions on which the benefit determination is based
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim
- A statement describing any voluntary appeal procedures offered by the plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA.

Note: You must use and exhaust your plan’s administrative claims and appeals procedure before bringing suit in either state or federal court. Similarly, failure to follow the plan’s prescribed procedures in a timely manner will cause you to lose your right to sue regarding an adverse benefit determination.