For your protection, federal laws govern employee benefit plans. The following sections highlight several important legal issues. Please refer to the individual plan documents, certificates of insurance, summary of benefits and coverages, and/or summary plan descriptions at www.miami.edu/benefits (SPDs) for specific information.

**When Your Coverage Ends**
Your insurance will end on the last day of the month during which your employment ends or if a qualifying event takes place that makes you ineligible for coverage. You will be eligible to continue your coverage, as required by the federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). Continuing coverage under COBRA is available only for health care coverage.

**COBRA**
If you, your spouse, or eligible dependent lose coverage under our group medical and dental plans because of a COBRA-qualifying event, then you may have the right to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

If your coverage ends due to a COBRA qualifying event, you must notify Benefits Administration immediately. You will receive notice of your continuation rights. At that time you will have up to 60 days from the date of your event or the date you received your notice to decide whether you want to continue your health coverage.

**HIPAA — Continuation of Coverage**
The Health Insurance Portability and Accountability Act (HIPAA) helps protect your rights to medical coverage during events such as changing or losing jobs, pregnancy and childbirth, or divorce. Depending on your group health plan limitations, HIPAA may make it possible for you to get and keep health coverage even if you have past or present (pre-existing) medical conditions. If you were covered under a medical plan, you will receive a certificate of credible coverage upon termination. You can request a certificate of credible coverage for yourself or a qualified dependent from your insurance carrier.

**The Genetic Information Nondiscrimination Act of 2008**
The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits group health plans and group health insurance issuers from discriminating in health coverage based on genetic information. Plans and issuers may not use genetic information to adjust premium or contribution amounts for the group covered under the plan, 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.

**The Mental Health Parity Act of 1996**
Under MHPA, group health plans, insurance companies and HMOs offering mental health benefits will no longer be allowed to set annual or lifetime limits on mental health benefits that are lower than any such limits for medical and surgical benefits. A plan that does not impose an annual or lifetime limit on medical and surgical benefits may not impose such a limit on mental health benefits. MHPA’s provisions, however, do not apply to benefits for substance abuse or chemical dependency.

**The Mental Health Parity and Addiction Equity Act of 2008**
The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) expanded the protections of MHPA to financial requirements (e.g., copayments or deductibles) or treatment limitations (e.g., visit limits). Any financial requirements or treatment limitations imposed on mental health or substance use disorder benefits can be no more restrictive than the predominant requirements or limitations applied to substantially all medical and surgical benefits covered by a plan.

**Women’s Health and Cancer Rights Act of 1998**
Beginning in 1999, Federal law requires a group health plan to provide coverage for the following services to an individual receiving plan benefits in connection with a mastectomy:
- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).
Newborns’ and Mothers’ Protection Act of 1996 (Newborn’s Act)
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 caesarean section. However, Federal law 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).

ERISA
As a participant in our benefits program, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). If you would like more information about ERISA, or if you have any questions, you can contact Benefits Administration or the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory.

Complete details about each benefit plan are set forth in the individual plan document and/or Summary Plan Description. If there is any conflict between the material in this packet and a plan document, the plan document will prevail. The University of Miami reserves the right, at its discretion, to amend, revise, or terminate any benefit program at any time.

The Children’s Health Insurance Program Reauthorization Act of 2009
The Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) requires group health plans and group health insurance issuers to permit an employee or dependent that is eligible for but not enrolled in the plan to enroll when the employee or dependent is covered under Medicaid or CHIP and loses that coverage as a result of loss of eligibility or when the employee or dependent becomes eligible for Medicaid or CHIP assistance with respect to coverage under the group health plan. CHIPRA also created new notice requirements related to these special enrollment rights.

Summary Plan Description
The Employee Retirement Income Security Act (ERISA) requires plan administrators to provide plan participants with a written Summary Plan Description (SPD). The SPD is an important document that tells participants what the plan provides and how it operates. It provides information on when an employee can begin to participate in the plan, how service and benefits are calculated, when benefits become vested, when and in what form benefits are paid, and how to file a claim for benefits. You can view the SPD online at www.miami.edu/index.php/benefits_administration/legal_details. To request a paper copy, please contact HR-Benefits at 305-284-3004 or online at www.miami.edu/benefits/ask.

Summary of Benefits & Coverage
As of September 23, 2012, health insurance issuers and group health plans are required to provide you with an easy-to-understand summary about a health plan’s benefits and coverage. The new regulation is designed to help you better understand and evaluate your health insurance choices. The new forms include a short, plain-language Summary of Benefits and Coverage and a uniform glossary of terms commonly used in health insurance coverage. The SBC form also includes details, called “coverage examples,” which are comparison tools that allow you to see what the plan would generally cover in two common medical situations. You can view the University of Miami SBC forms for each medical plan online at www.miami.edu/index.php/benefits_administration/legal_details. To request a paper copy, please contact HR-Benefits at 305-284-3004 or online at www.miami.edu/benefits/ask.

New Health Insurance Marketplace Coverage Options and Your Health Coverage
As required by the Department of Labor, the University of Miami has posted the New Health Insurance Marketplace Coverage Options and Your Health Coverage notice online at www.miami.edu/index.php/benefits_administration/legal_details. Faculty and staff who are eligible for the UM/Aetna medical plan already have access to coverage that meets the requirements of the Affordable Care Act and do not need to take any action. However, if you are not eligible for the UM/Aetna medical plan, or you simply wish to learn more about the marketplaces, please read the notice to review what options may best suit your needs. For more information about UM/Aetna medical plans and health care reform, please visit www.miami.edu/benefits and go to the “Health Care Reform and UM” web page . To request a paper copy, please contact HR-Benefits at 305-284-3004 or online at www.miami.edu/benefits/ask.