2024 SUMMARY PLAN DESCRIPTION

UNIVERSITY OF MIAMI PREVENTIVE CARE MEDICAL PLAN

Table of Contents

This contains only a summary of preventive care plan benefits offered to anyone who is not eligible to enroll in the UM/Aetna health plan.

Foreign Language Statement

This SPD contains a summary in English of your plan rights and benefits under this employer's group health plan. If you have difficulty understanding any part of this document, contact HR-Total Rewards at 305-284-3004.

Este documento contiene un resumen en inglés de los derechos y beneficios bajo el plan de salud de este Empleador. Si tiene dificultades entendiendo cualquier parte de este documento, comuníquese con HR-Total Rewards al 305-284-3004.

Preventive Care Medical Plan

What the Plan Can Do For You

The University of Miami's Preventive Care Medical Plan is offered to anyone who is not eligible to enroll in the UM/Aetna health plan. 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.

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 Preventive Care Medical 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.

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.

After declining health coverage. If you are declining enrollment in the Preventive 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 affecting insurance coverage including:
    1. Termination of spouse's or dependent's employment
    2. 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-Total Rewards 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-Total Rewards 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 or child who no longer qualifies for coverage, you are required to notify HR-Total Rewards 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 UnitedHealthcare plan conforms to the standards for protection of individual private health information (PHI). Neither the University of Miami nor UnitedHealthcare 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 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.

Glossary of Common Terms

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

Coinsurance

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

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.

Out-Of-Pocket Limit
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 limit, UnitedHealthcare will pay 100% of covered expenses for the remainder of the calendar year.

What is Covered

Health Care Benefits will be paid for:

- Annual wellness exam
- Well women exams
- Measurements of your weight, blood pressure, glucose (blood sugar) and cholesterol
- Immunization vaccines, such as flu shots
- Well-baby and well-child visits
- Cancer screenings, such as mammograms and colonoscopies
- Preventive Lab, X-Ray or Preventive test
- Mandated over the counter drugs
- Women's health contraceptives

What is Not Covered

Health Care Benefits will not be paid for:

- Routine dental services and supplies
- Sick visits
- Outpatient surgery
- Hospitalization
- Doctor visits for anything other than annual preventive care

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. For a complete list, visit healthcare.gov/coverage/preventive-care-benefits.

UnitedHealthcare

The preventive care medical plan is administered by UnitedHealthcare on behalf of the University of Miami.

Monthly health care premium amounts for the current calendar year can be found on the HR-Total Rewards website located at benefits.miami.edu.

This plan allows you and your covered dependents a full range of preventive care benefits when using UnitedHealthcare In-Network providers.

Service	In Network Provider	Out of Network Provider
PRIMARY CARE (PCP):		
Preventive Care Visit	Covered 100%	Not Covered
IMMUNIZATIONS:		
Preventive Care	Covered 100%	Not Covered
LABS, X-RAY, TESTING:		
Preventive Care	Covered 100%	Not Covered
PHARMACY:		
Mandated over the counter drugs	Covered 100%	Not Covered
Women's health contraceptives	Covered 100%	Not Covered

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

Pharmacy

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 UnitedHealthcare.com for a complete list.

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