UNIVERSITY OF MIAMI HOSPITAL
2017 SUMMARY PLAN DESCRIPTION

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HEALTH CARE INSURANCE

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. You are eligible for coverage as of your start date.

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:
  a) 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);
  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 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.

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 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.*

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.

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.

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, option 1, option 1 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**.

Coverage Period: 01/01/2017 - 12/31/2017
Plan Type: Open Access HMO
Coverage for: Employee, Employee + Child(ren), Employee + Spouse/Partner, Family

Question	Answer	Why this Matters
What is the overall deductible?	$0	There is no deductible to meet before this plan begins to pay for covered services you use.
Are there other deductibles for specific services?	No. There are no other deductibles in this plan.	With no deductible to meet, your plan begins to pay for covered services right away.
Is there an out-of-pocket limit on my medical expenses?	Yes. For participating providers $3,000 per person/ $9,000 per family	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.
What is not included in the out-of-pocket limit?	Premiums, and health care services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services.
Does this plan use a network of providers?	Yes. See **www.aetna.com** for a list of participating providers. *Network: Aetna Select (Open Access)*	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.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the in-network specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes. Visit **www.aetna.com** to learn more.	See your plan document or **www.aetna.com** for additional information about excluded services.

If you aren't clear about any of the underlined terms used in this form, see the Glossary on pages 7 and 8.

UNIVERSITY OF MIAMI

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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.

Medical Event	Services you may need	Aetna Select 1		Limitations & Exceptions
		UM Providers	In-network	
If you wish to visit a health care provider's office	Primary care visit to treat injury or illness	$15 copay	$20 copay	Visit www.aetna.com
	Specialist visit	$25 copay	$50 copay	Visit www.aetna.com
	Preventive care (see list at **www.miami.edu/benefits**)	No charge	No charge (Skin Cancer Screening covered only at UHealth)	Visit www.aetna.com
If you have a test	Diagnostic Testing (Quest or UHealth labs)	$0 copay	$0 copay	Visit www.aetna.com
	High-End Imaging (CT/PET scans, MRI)	$150 copay	Not covered	Visit www.aetna.com
If you need immediate medical attention	Emergency room services	$100 copay	$100 copay	Visit www.aetna.com
	Emergency medical transportation	N/A	$0 copay	Visit www.aetna.com
	Urgent care	$50 copay	$50 copay	Visit www.aetna.com
If you are pregnant	Prenatal and postnatal care (office-based)	$25 copay for first visit, then all office visits covered at 100%	$50 copay for first visit, then all office visits covered at 100%	Visit www.aetna.com
	Delivery and all inpatient services	$150 copay per day ($750 max per admission)	$250 copay per day ($1,250 max per admission)	Visit www.aetna.com
If you need drugs to treat your illness or condition *(Administered by OptumRx)*	Generic, preferred brand, non-preferred brand and specialty drugs	Prescription drug costs are determined by the four-tier structure at miami.edu/benefits. Copays range from $10 to $100.		Covers up to a 30-day supply (retail prescription); 31-90 day supply (OptumRx mail order or Walgreens)

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Coverage for: Employee, Employee + Child(ren), Employee + Spouse/Partner, Family

Medical Event	Services you may need	Aetna Select 1		Limitations & Exceptions
		UM Providers	In-network	
If you have outpatient surgery	Facility fee (ambulatory surgery center)	$100 copay	$150 copay	Visit **www.aetna.com**
	Physician/surgeon fees	No charge	No charge	Visit **www.aetna.com**
If you have mental health, behavioral health, or substance abuse needs	Mental health services are offered through Concordia Behavioral Health. For more information, please visit **concordiabh.com** or call 1-800-294-8642, option 2			
If you need help recovering or have other special health needs	Home health care	No charge	No charge	Visit **www.aetna.com**
	Rehabilitation services	$15 copay	$20 copay	Visit **www.aetna.com**
	Durable medical equipment	No charge	No charge	Visit **www.aetna.com**
	Hospice service	No charge	No charge	Visit **www.aetna.com**
If you or your child needs dental or eye care	Routine eye exam (glasses only)	No charge	No charge	One exam per year
	Glasses	Discount offered through Aetna/ EyeMed	Discount offered through Aetna/ EyeMed	Discount offered on glasses, frames and contacts. **www.aetna.com**
	Dental check-up	Not covered	Not covered	Visit **www.aetna.com**

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.
- Food items
- Routine foot care
- 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 1

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Coverage Period: 01/01/2017 - 12/31/2017
Plan Type: Open Access HMO
Coverage for: Employee, Employee + Child(ren), Employee + Spouse/Partner, Family

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:	
Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (mother)	$ 900
Anesthesia	$ 900
Laboratory Tests	$ 500
Prescriptions	$ 200
Radiology	$ 200
Vaccines, other preventive	$ 40
Total	**$7,540**
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:	
Prescriptions	$2,900
Medical Equipment & Supplies	$1,300
Office Visits & Procedures	$ 700
Education	$ 300
Laboratory Tests	$ 100
Vaccines, other preventive	$ 100
Total	**$5,400**
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.

If you aren't clear about any of the underlined terms used in this form, see the Glossary on pages 7 and 8.

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 a 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.

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.

Aetna Select 2

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Coverage Period: 01/01/2017 - 12/31/2017
Plan Type: Open Access HMO
Coverage for: Employee, Employee + Child(ren), Employee + Spouse/Partner, Family

Question	Answer	Why this Matters
What is the overall deductible?	$250 per person $750 per family	There is a deductible to meet before this plan begins to pay for covered medical services you use.
Are there other deductibles for specific services?	No. There are no other deductibles in this plan.	There is a deductible to meet before this plan begins to pay for covered medical services you use.
Is there an out-of-pocket limit on my medical expenses?	Yes. For participating providers, $4,000 per person/ $12,000 per family.	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.
What is not included in the out-of-pocket limit?	Premiums, and health care services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services.
Does this plan use a network of providers?	Yes. See **www.aetna.com** for a list of participating providers. *Network: Aetna Select (Open Access)*	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.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the in-network specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes. Visit **www.aetna.com** to learn more.	See your plan document or **www.aetna.com** for additional information about excluded services.

If you aren't clear about any of the underlined terms used in this form, see the Glossary on pages 7 and 8.

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Aetna Select 2

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**.

Coverage Period: 01/01/2016 - 12/31/2016
Plan Type: Open Access HMO
Coverage for: Employee, Employee + Child(ren), Employee + Spouse/Partner, Family

- 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.

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

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Aetna Select 2

Summary of Benefits and Coverages (SBC): What this plan covers and what it costs.
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Coverage Period: 01/01/2017 - 12/31/2017
Plan Type: Open Access HMO
Coverage for: Employee, Employee + Child(ren), Employee + Spouse/Partner, Family

Medical Event	Services you may need	Aetna Select 2		Limitations & Exceptions
		UM Providers	In-network	
If you need drugs to treat your illness or condition *(Administered by OptumRx)*	Generic, preferred brand, non-preferred brand and specialty drugs	Prescription drug costs are determined by the four-tier structure found at **miami.edu/benefits**. Copays range from $10 to $100.		Covers up to a 30-day supply (retail prescription); 31-90 day supply (OptumRx mail order or Walgreens)
If you have outpatient surgery	Facility fee (ambulatory surgery center)	Deductible, then $100 copay	Deductible, then $250 copay	Visit **www.aetna.com**
	Physician/surgeon fees	Deductible, then $0 copay	Deductible, then $0 copay	Visit **www.aetna.com**
If you have mental health, behavioral health, or substance abuse needs	Mental health services are offered through Concordia Behavioral Health. For more information, please visit **concordiabh.com** or call 1-800-294-8642, option 2			
If you need help recovering or have other special health needs	Home health care	Deductible, then $0 copay	Deductible, then $0 copay	Visit **www.aetna.com**
	Rehabilitation services	Deductible, then $20 copay	Deductible, then $25 copay	Visit **www.aetna.com**
	Durable medical equipment	Deductible, then $0 copay	Deductible, then $0 copay	Visit **www.aetna.com**
	Hospice service	Deductible, then $0 copay	Deductible, then $0 copay	Visit **www.aetna.com**

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.
- Food items
- Routine foot care
- 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.**

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:	
Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (mother)	$ 900
Anesthesia	$ 900
Laboratory Tests	$ 500
Prescriptions	$ 200
Radiology	$ 200
Vaccines, other preventive	$ 40
Total	**$7,540**
Patient pays:	
Deductibles	$ 250
Copays	$1,030
Limits or exclusions	$ 0
Total	**$1,280**

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:	
Prescriptions	$2,900
Medical Equipment & Supplies	$1,300
Office Visits & Procedures	$ 700
Education	$ 300
Laboratory Tests	$ 100
Vaccines, other preventive	$ 100
Total	**$5,400**
Patient pays:	
Deductibles	$ 250
Copays	$ 660
Limits or exclusions	$ 0
Total	**$ 910**

**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 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.

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.

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**.

Coverage Period: 01/01/2017 - 12/31/2017
Plan Type: Aetna Choice POS II Open Access
Coverage for: Employee, Employee + Child(ren), Employee+ Spouse/Partner, Family

Question	Answer	Why this Matters
What is the overall deductible?	In-Network: $1,500 per person ($4,500 per family) Out-of-Network: $3,000 per person ($9,000 per family) The University of Miami HRA fund, administered by WageWorks, will pay for or reimburse you for certain, qualified medical expenses (including co-pays and coinsurance) up to the balance available in your HRA.	There is a deductible to meet before this plan begins to pay for covered medical services you use.
Are there other deductibles for specific services?	No. There are no other deductibles in this plan.	There is a deductible to meet before this plan begins to pay for covered medical services you use.
Is there an out-of-pocket limit on my medical expenses?	Yes. In-Network Providers: $4,000 per person ($12,000 per family). Out-of-Network Providers: $8,000 per person ($24,000 per family)	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.
What is not included in the out-of-pocket limit?	Premiums, balance billing, and health care services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services.
Does this plan use a network of providers?	Yes. See **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-nework 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** to learn more.	See your plan document or **www.aetna.com** for additional information about excluded services.

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Aetna Health Reimbursement Account (HRA)

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Coverage for: Employee, Employee + Child(ren), Employee+ Spouse/Partner, Family

- 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	Services you may need	Aetna HRA			Limitations & Exceptions
		UM Providers	In-network	Out-of-network	
If you wish to visit a health care provider's office	Primary care visit to treat injury or illness	Deductible, then $15 copay	Deductible, then $20 copay	Deductible, then 30% coinsurance	Visit **www.aetna.com**
	Specialist visit	Deductible, then $25 copay	Deductible, then $50 copay	Deductible, then 30% coinsurance	Visit **www.aetna.com**
	Preventive care (see list at **www.miami.edu/benefits**)	No charge	No charge (Skin Cancer Screening covered only at UHealth)	Not covered	Visit **www.aetna.com**
If you have a test	Diagnostic Testing (Quest or UHealth labs)	Deductible, then $0 copay	Deductible, then $0 copay	Deductible, then 30% coinsurance	Visit **www.aetna.com**
	High-End Imaging (CT/PET scans, MRI)	Deductible, then $100 copay	Not covered	Not covered	Visit **www.aetna.com**
If you need immediate medical attention	Emergency room services	Deductible, then $100 copay	Deductible, then $100 copay	Deductible, then $100 copay	Visit **www.aetna.com**
	Emergency medical transportation	N/A	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Visit **www.aetna.com**
	Urgent care	Deductible, then $35 copay	Deductible, then $35 copay	Deductible, then 30% coinsurance	Visit **www.aetna.com**
If you are pregnant	Prenatal and postnatal care *(office-based)*	Deductible, then $25 copay for first visit, then all office visits covered at 100%	Deductible, then $50 copay for first visit, then all office visits covered at 100%	Deductible, then 30% coinsurance	Visit **www.aetna.com**
	Delivery and all inpatient services	Deductible, then $100 copay per day ($500 max per admission)	Deductible, then $200 copay per day ($1,000 max per admission)	Deductible, then 30% coinsurance	Visit **www.aetna.com**

Aetna Health Reimbursement Account (HRA)

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Coverage Period: 01/01/2017 - 12/31/2017
Plan Type: Aetna Choice POS II Open Access
Coverage for: Employee, Employee + Child(ren), Employee+ Spouse/Partner, Family

Medical Event	Services you may need	Aetna HRA			Limitations & Exceptions
		UM Providers	In-network	Out-of-network	
If you need drugs to treat your illness or condition *(Administered by OptumRx)*	Generic, preferred brand, non-preferred brand and specialty drugs	Deductible, then copay based on the drug tier. Prescription drug costs are determined by the four-tier structure at **miami.edu/benefits**. Copays range from $10-$100.			Covers up to a 30-day supply (retail prescription); 31-90 day supply (OptumRx mail order or Walgreens)
If you have outpatient surgery	Facility fee (ambulatory surgery center)	Deductible, then $50 copay	Deductible, then $150 copay	Deductible, then 30% coinsurance	Visit **www.aetna.com**
	Physician/surgeon fees	Deductible, then $0 copay	Deductible, then $0 copay	Deductible, then $0 coinsurance	Visit **www.aetna.com**
If you have mental health, behavioral health, or substance abuse needs	Mental health services are offered through Concordia Behavioral Health. For more information, please visit **concordiabh.com** or call 1-800-294-8642, option 2				
If you need help recovering or have other special health needs	Home health care	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance	Visit **www.aetna.com**
	Rehabilitation services	Deductible, then $15 copay	Deductible, then $20 copay	Deductible, then 30% coinsurance	Visit **www.aetna.com**
	Durable medical equipment	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance	Visit **www.aetna.com**
	Hospice service	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance	Visit **www.aetna.com**
If you or your child needs dental or eye care	Routine eye exam	No charge	No charge	Not covered	One exam per year
	Glasses	Discount offered through Aetna/ EyeMed	Discount offered through Aetna/ EyeMed	Not covered	Discount offered on glasses, frames and contacts. **www.aetna.com**
	Dental check-up	Covered under dental plan	Covered under dental plan	Covered under dental plan	Visit **www.aetna.com**

If you aren't clear about any of the underlined terms used in this form, see the Glossary on pages 7 and 8.

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.
- Food items
- Routine foot care
- 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, 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)

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**.

Coverage Period: 01/01/2017 - 12/31/2017
Plan Type: Aetna Choice POS II Open Access
Coverage for: Employee, Employee + Child(ren), Employee+ Spouse/Partner, Family

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:	
Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (mother)	$ 900
Anesthesia	$ 900
Laboratory Tests	$ 500
Prescriptions	$ 200
Radiology	$ 200
Vaccines, other preventive	$ 40
Total	**$7,540**
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:	
Prescriptions	$2,900
Medical Equipment & Supplies	$1,300
Office Visits & Procedures	$ 700
Education	$ 300
Laboratory Tests	$ 100
Vaccines, other preventive	$ 100
Total	**$5,400**
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.*

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 the University of Miami HRA fund cover?

The University of Miami HRA fund will pay for or reimburse you for certain, qualified medical expenses (including co-pays and coinsurance) for amount under the deductible, up to the balance available in your HRA. Your HRA has an overall limit of $600 per person (max $1,800 for family) per plan year, even if your need is greater. You're responsible for all expenses above this limit.

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.

Aetna Health Reimbursement Account (HRA)

Summary of Benefits and Coverages (SBC): What this plan covers and what it costs.
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Coverage Period: 01/01/2017 - 12/31/2017
Plan Type: Aetna Choice POS II Open Access
Coverage for: Employee, Employee + Child(ren), Employee+ Spouse/Partner, Family

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.

If you aren't clear about any of the underlined terms used in this form, see the Glossary on pages 7 and 8.

Aetna Health Reimbursement Account (HRA)

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Plan Type: Aetna Choice POS II Open Access
Coverage for: Employee, Employee + Child(ren), Employee+ Spouse/Partner, Family

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.

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Aetna Health Reimbursement Account (HRA) Out of Area

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Coverage Period: 01/01/2017 - 12/31/2017
Plan Type: Aetna Choice POS II Open Access
Coverage for: Employee, Employee + Child(ren), Employee + Spouse/Partner, Family

Question	Answer	Why this Matters
What is the overall deductible?	In-Network: $1,500 per person ($4,500 per family) Out-of-Network: $3,000 per person ($9,000 per family) The University of Miami HRA fund, administered by WageWorks, will pay for or reimburse you for certain, qualified medical expenses (including co-pays and coinsurance) up to the balance available in your HRA.	There is a deductible to meet before this plan begins to pay for covered medical services you use.
Are there other deductibles for specific services?	No. There are no other deductibles in this plan.	There is a deductible to meet before this plan begins to pay for covered medical services you use.
Is there an out-of-pocket limit on my medical expenses?	Yes. In-Network Providers: $4,000 per person ($12,000 per family). Out-of-Network Providers: $8,000 per person ($24,000 per family)	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.
What is not included in the out-of-pocket limit?	Premiums, balance billing, and health care services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services.
Does this plan use a network of providers?	Yes. See **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-nework 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** to learn more.	See your plan document or **www.aetna.com** for additional information about excluded services.

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Aetna Health Reimbursement Account (HRA) Out of Area

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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	Services you may need	Aetna HRA (Out-of-Area)		Limitations & Exceptions
		In-network	Out-of-network	
If you wish to visit a health care provider's office	Primary care visit to treat injury or illness	Deductible, then $15 copay	Deductible, then 30% coinsurance	Visit **www.aetna.com**
	Specialist visit	Deductible, then $25 copay	Deductible, then 30% coinsurance	Visit **www.aetna.com**
	Preventive care (see list at **www.miami.edu/benefits**)	No charge	No charge (Skin Cancer Screening covered only at UHealth)	Visit **www.aetna.com**
If you have a test	Diagnostic Testing (Quest or UHealth labs)	Deductible, then $0 copay	Deductible, then 30% coinsurance	Visit **www.aetna.com**
	High-End Imaging (CT/PET scans, MRI)	Deductible, then $100 copay	Not covered	Visit **www.aetna.com**
If you need immediate medical attention	Emergency room services	Deductible, then $100 copay	Deductible, then $100 copay	Visit **www.aetna.com**
	Emergency medical transportation	N/A	Deductible, then 20% coinsurance	Visit **www.aetna.com**
	Urgent care	Deductible, then $35 copay	Deductible, then 30% coinsurance	Visit **www.aetna.com**
If you are pregnant	Prenatal and postnatal care (office-based)	Deductible, then $25 copay for first visit, then all office visits covered at 100%	Deductible, then 30% coinsurance	Visit **www.aetna.com**
	Delivery and all inpatient services	Deductible, then $100 copay per day ($500 max per admission)	Deductible, then 30% coinsurance	Visit **www.aetna.com**

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Medical Event	Services you may need	Aetna HRA (Out-of-Area)		Limitations & Exceptions
		In-network	Out-of-network	
If you need drugs to treat your illness or condition *(Administered by OptumRx)*	Generic, preferred brand, non-preferred brand and specialty drugs	Deductible, then copay based on drug tier. Prescriptions drug costs are determined by the four-tier structure at **miami.edu/benefits**. Copays range from $10-$100.		Covers up to a 30-day supply (retail prescription); 31-90 day supply (OptumRx mail order or Walgreens)
If you have outpatient surgery	Facility fee (ambulatory surgery center)	Deductible, then $50 copay	Deductible, then $100 copay	Visit **www.aetna.com**
	Physician/surgeon fees	Deductible, then $0 copay	Deductible, then 30% coinsurance	Visit **www.aetna.com**
If you have mental health, behavioral health, or substance abuse needs	Mental health services are offered through Concordia Behavioral Health. For more information, please visit **concordiabh.com** or call 1-800-294-8642, option 2.			
If you need help recovering or have other special health needs	Home health care	Deductible, then then 20% coinsurance	Deductible, then then 30% coinsurance	Visit **www.aetna.com**
	Rehabilitation services	Deductible, then $15 copay	Deductible, then $20 copay	Visit **www.aetna.com**
	Durable medical equipment	Deductible, then then 20% coinsurance	Deductible, then then 30% coinsurance	Visit **www.aetna.com**
	Hospice service	Deductible, then then 20% coinsurance	Deductible, then then 30% coinsurance	Visit **www.aetna.com**
If you or your child needs dental or eye care	Routine eye exam (glasses only)	No charge	Not covered	One exam per year
	Glasses	Discount offered through Aetna/ EyeMed	Not covered	Discount offered on glasses, frames and contacts. **www.aetna.com**
	Dental check-up	Covered under dental plan	Covered under dental plan	Visit **www.aetna.com**

If you aren't clear about any of the underlined terms used in this form, see the Glossary on pages 7 and 8.

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.
- Food items
- Routine foot care
- 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.**

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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:	
Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (mother)	$ 900
Anesthesia	$ 900
Laboratory Tests	$ 500
Prescriptions	$ 200
Radiology	$ 200
Vaccines, other preventive	$ 40
Total	**$7,540**
Patient pays:	
Deductibles	$ 900
Copays	$ 0
Coinsurance	$ 395
Limits or exclusions	$ 0
Total	**$1,295**

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:	
Prescriptions	$2,900
Medical Equipment & Supplies	$1,300
Office Visits & Procedures	$ 700
Education	$ 300
Laboratory Tests	$ 100
Vaccines, other preventive	$ 100
Total	**$5,400**
Patient pays:	
Deductibles	$ 900
Copays	$ 520
Coinsurance	$ 0
Limits or exclusions	$ 0
Total	**$1,420**

**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 the University of Miami HRA fund cover?

The University of Miami HRA fund will pay for or reimburse you for certain, qualified medical expenses (including co-pays and coinsurance) for amount under the deductible, up to the balance available in your HRA. Your HRA has an overall limit of $600 per person (max $1,800 for family) per plan year, even if your need is greater. You're responsible for all expenses above this limit.

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.

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.

If you aren't clear about any of the underlined terms used in this form, see the Glossary on pages 7 and 8.

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 for medical, behavioral health and Rx 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, the plan will pay 100% of covered expenses for the remainder of the calendar year.

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 heath 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, ultrasound 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
- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet
  Transgender services including hormone therapy, gender reassignment surgery and psychological support services (psychological services covered under Concordia Behavioral Health)

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
- 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 at www.miami.edu/hr.

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.

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

** 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.

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

** 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 a WageWorks HRA fund of $600 per individual (maximum of $1,800 per family) to help offset the deductible.

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

** 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 a WageWorks HRA fund of $600 per individual (maximum of $1,800 per family) to help offset the deductible.

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

** 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 Administered by OptumRx

The Pharmacy Plan available to members who are enrolled in health care is called a Four Tier Open Formulary administered by OptumRx. 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 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.optumrx.com for a complete list.

Maintenance Medications

Maintenance medications are medications taken over long periods of time. If you are taking a maintenance medication, you may use OptumRx 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 a retail option, you may purchase your maintenance medication at any Walgreens retail location and obtain a 3 month supply 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, your monthly copay will increase to 2.5x the typical copay after you've purchased two 30-day supplies at retail.

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/OptumRx pharmacy 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 OptumRx 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 OptumRx to request an authorization to fill the original medication at the standard copay.

WageWorks HRA Fund

When you enroll in Aetna Choice POSII HRA or Aetna Choice POSII HRA Out of Area medical plan, the University provides a $600 fund per person (max $1,800 per family) to help you pay for medical and pharmacy expenses. The fund is Visa accessible through a WageWorks HRA account on the effective date of coverage, typically January 1st for the calendar year. For those who enroll mid-year, the entire annual fund is deposited when coverage takes effect. HRA Funds can only be spent on medical claims covered under the UM/Aetna plan as well as prescription drugs covered under the OptumRx plan for you, your spouse, and eligible dependents who are covered under the plan. Vision and dental expenses, along with over the counter pharmacy expenses, are not eligible HRA expenses. All covered family members may share the fund. All unused fund dollars are rolled over to the following calendar year if the HRA plan is selected again. For those enrolled in both HRA and Health Care FSA, expenses eligible under both HRA and FSA are deducted from the HRA first (except during the annual grace period for FSA).

Using your WageWorks HRA Fund Visa Card

You will receive a WageWorks HRA Fund Visa card in the mail. You can use this card only to pay for eligible healthcare and pharmacy 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 HRA Fund. 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 may be asked to submit receipts.

Once your HRA funds are depleted the WageWorks Visa card will decline and you pay the negotiated rates for your medical and pharmacy expenses out of pocket until your deductible is met. If you participate in a Health Care Flexible Spending Account and have additional FSA funds available, you may continue to use your Visa card to pay for eligible FSA expenses after your HRA funds are depleted. If you are going to reenroll in an HRA medical plan the following calendar year, keep your WageWorks Visa card since HRA funds will be applied each January 1st.

For more information, review the WageWorks HRA QuickStart Guide at www.miami.edu/hr.

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 member may be recovered by the plan if not used.

If UM/Aetna coverage is terminated all members have until June 30th of the following calendar year to submit a WageWorks HRA claim. Services for that claim must have been incurred before the last day of coverage under the UM/Aetna plan.

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. Deductibles are not prorated during the year. These are the deductibles for each plan:

Deductibles (Participating Providers)

	AETNA SELECT 1	AETNA SELECT 2	AETNA CHOICE POSII HRA	AETNA CHOICE POSII HRA OUT OF AREA
Individual	$0	$250	$1,500	$1,500
EE+1 Dep	$0	$500	$3,000	$3,000
Family	$0	$750	$4,500	$4,500

Deductibles (Non-Participating Providers)

	AETNA SELECT 1	AETNA SELECT 2	AETNA CHOICE POSII HRA	AETNA CHOICE POSII HRA OUT OF AREA
Individual	N/A	N/A	$3,000	$3,000
EE+1 Dep	N/A	N/A	$6,000	$6,000
Family	N/A	N/A	$9,000	$9,000

Annual Out-of-Pocket Maximums

Deductibles, medical copayments (except Concordia), and prescription drug 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)

	AETNA SELECT 1	AETNA SELECT 2	AETNA CHOICE POSII HRA	AETNA CHOICE POSII HRA OUT OF AREA
Individual	$3,000	$4,000	$4,000	$4,000
EE+1	$6,000	$8,000	$8,000	$8,000
Family	$9,000	$12,000	$12,000	$12,000

Out of Pocket Maximums (Non-Participating Providers)

	AETNA SELECT 1	AETNA SELECT 2	AETNA CHOICE POSII HRA	AETNA CHOICE POSII HRA OUT OF AREA
Individual	N/A	N/A	$8,000	$8,000
EE+1	N/A	N/A	$16,000	$16,000
Family	N/A	N/A	$24,000	$24,000

Concordia Behavioral Health

Concordia Behavioral Health is a licensed managed behavioral health organization which manages a full spectrum of mental health and substance abuse services to employees and family members enrolled in one of the medical plans offered by the University of Miami. These services are authorized based on medical necessity criteria. Covered services for adults, adolescents and children include individual and group outpatient therapy, acute psychiatric hospitalization, substance abuse detox and treatment, intensive outpatient and partial hospitalization treatment for mental health and substance abuse, family counseling and 24-hour emergency care services. The network for Concordia is primarily in the state of Florida. If you or your covered dependent requires care outside of 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 contact Concordia Behavioral Health Member Services at 1-800-294-8642, option 2, prior to accessing services to confirm network status of the provider you wish to see.

The following services are not covered by Concordia:

- Neuropsychological Evaluations
- Psycho-Educational Testing
- Court Ordered Involuntary Placement to State Hospital or other Facilities
- Court Ordered Services unless deemed medically necessary
- Court Ordered Admissions under Marchman Act
- Prescription Medications
- Laboratory Services
- Medical Services that are not set forth in the most current version of the DSM
- Medical Consultations during an inpatient psychiatric admission
- Custodial Care
- Anesthesia related to Electroconvulsive Therapy (ECT) – Inpatient/Outpatient Services Concordia

		Aetna Select 1 & 2	Aetna Choice POSII HRA and Out of Area HRA	
Type of Service	**Pre-Authorization Requirements**	**In-Network Provider Copays**	**In-Network Provider Copays**	**Out-of-Network Providers** ***Pre-Authorization Required***
Outpatient Individual, Group and Family Counseling	Required for additional visits after initial assessment and 24 follow-up visits.	$20/visit	$20/visit	30% coinsurance
Outpatient Psychiatric/Med management Services	Required for additional visits after initial assessment and 12 follow-up visits.	$20/visit	$20/visit	30% coinsurance
ABA (for members 22 years if age or younger)	Requires Pre-Authorization, script, and clinical records	$20/visit	$20/visit	30% coinsurance
Intensive Outpatient Program (IOP)	Requires Pre-Authorization	$20/visit	$20/visit	30% coinsurance
Partial Hospitalization Program (PHP)	Requires Pre-Authorization	$50/day max of $250 per admission	$50/day max of $250 per admission	30% coinsurance
Inpatient Psychiatric Admission (24 hour Emergency Care Services)	Requires Pre-Authorization	$100/day max of $500 per admission	$100/day max of $500 per admission	30% coinsurance
Inpatient Substance Abuse Treatment (Detox)	Requires Pre-Authorization	$100/day max of $500 per admission	$100/day max of $500 per admission	30% coinsurance
Residential Services	Requires Pre-Authorization	$100/day max of $500 per admission	$100/day max of $500 per admission	30% coinsurance
Inpatient Psychiatric Consultations	Requires Pre-Authorization	No Copay	No Copay	30% coinsurance
Outpatient Behavioral Health (Psychiatric) Consultations	Requires Pre-Authorization	No Copay	No Copay	30% coinsurance

UM/Aetna medical plan deductibles do not apply to Concordia Behavioral Health services.

Autism and other Pervasive Developmental Disorders

The services that will be eligible for coverage will include applied behavioral analysis (ABA) for individuals 22 years of age or younger. Speech therapy, occupational therapy and physical therapy may also be available through Aetna or Special Employee Benefits (SEB).

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. A prescription showing diagnosis and ordering of ABA services is also required.

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 include diagnostic testing, neuropsychological testing, and treatment related to mental retardation or deficiency, learning disability, 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" includes several conditions that use to be diagnosed separately. These include:

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

Autism

Autism is a complex developmental disability that is typically diagnosed by age 4; 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.

In 2012, the Centers for Disease Control and Prevention estimate that 1 in 68 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

Special Employee Benefits for Rehabilitation

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. Benefits are for enrollees age 22 or younger.

Benefits require pre-approval from Concordia Behavioral Health. For more information, please 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 22 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 Concordia Behavioral Health must be obtained prior to the UM ASAC initial assessment.

Aetna Benefits	**Concordia Benefits**	**Special Employee Benefits for Rehabilitation**
• 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, Texas 79998-1106	• Applied Behavioral Analysis (ABA) Prior authorization is required for all services (in and out of network). 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. Claims should be submitted to: Concordia Behavioral Health P.O. Box 211277 Eagan, Minnesota 55121	• Coverage for evaluation by Psychiatrist and/or Psychologist, including assessment by UM Autism Spectrum Assessment Clinic • Coverage of other non-experimental, peer reviewed interventions will be considered and reviewed for medical necessity Claims are paid on a reimbursement basis. CONCORDIA/Aetna network usage is not required. Claims should be submitted to: Concordia Behavioral Health Special Employee Benefits Liaison 10685 North Kendall Drive Miami, Florida 33176

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 post-marked, 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, Kentucky 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, option 1.

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.

University of Miami
HR-Benefits
P.O. Box 248106
Coral Gables, Florida 33124-2902
305-284-3004, option 1

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/hr/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
P.O. Box 981106
El Paso, Texas 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 eligible 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 your coverage until your turn 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. Contact HR-Benefits for more information on early retirement.

Employees over 65

If you are still working for the University after age 65 when you become eligible for Medicare, you and your eligible dependents may continue to be covered under the Plan as any other active employee. Your UM medical plan will be your primary benefit source before Medicare, should you wish to enroll in Medicare while employed.

Long Term Disability

If you are receiving long term disability benefits through the University, your medical plan coverage and coverage for your covered eligible dependents may be continued at the time you are approved for disability or the entitlement is lost. 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.

Employee Assistance Program

Employee Assistance Program (EAP) is a free, confidential service available as a basic benefit of employment. EAP serves as an assessment and referral service and covers three sessions annually. EAP 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 CIGNA's Life Assistance program at (800) 538-3543 or for more information, log on to www.cignabehavioral.com/cgi.

Routine Vision Benefit

UM/Aetna medical plan participants receive one free annual routine vision exam through Aetna EyeMed. Aetna EyeMed also offers discounts on materials such as contacts, frames and lenses. Please visit www.miami.edu/hr for additional information.

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DENTAL INSURANCE

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.

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. You are eligible for coverage as of your start date.

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:
            A) the child is no longer disabled; or
            B) the child is capable of supporting him or herself; or
            C) the child no longer receives more than 50% of his/her support from the subscriber; or
            D) 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.

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.

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.

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. Benefits are maximized when using participating dentists.

2017 FEATURES (Total for In-Network and Out-of-Network)	
Calendar Year Benefit	$2,500 In-Network (Includes $1,500 Out of Network)
Annual Deductible	$50 per member/$150 per family
Lifetime Orthodontic Maximum (child)	$1,500
Lifetime Orthodontic Maximum (adult)	$1,500

Delta Dental BENEFITS	Delta Dental In Network	Delta Dental Out of Network*
Type A Preventive		
Oral Exams (twice per calendar year)	100%	80%
X-rays (full mouth/panorex) (1) every 3 years	100%	80%
X-rays (bitewing) (1) per calendar year; (1) in 6 consecutive months for children	100%	80%
Prophylaxis/Cleaning twice per calendar year	100%	80%
Fluoride Treatments (1) in 12 consecutive months (child to age 19)	100%	80%
Space Maintainers (child to age 16)	100%	80%
Type B Basic		
Sealants/Fillings	80% after deductible	60% after deductible
Endodontics/Root Canal	80% after deductible	60% after deductible
Periodontal Surgery		
General Anesthesia		
Periodontal Maintenance		
Simple Extractions	80% after deductible	60% after deductible
Surgical Extractions/Oral Surgery	80% after deductible	60% after deductible
Type C Major		
Rebases/Relines	50% after deductible	40% after deductible
Crown Build-ups	50% after deductible	40% after deductible
Dentures	50% after deductible	40% after deductible
Bridges	50% after deductible	40% after deductible
Inlays/Onlays	50% after deductible	40% after deductible
Type D Orthodontia		
Orthodontia	50%	40%

** 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.

VISION INSURANCE

Vision Insurance

What the Plan Can Do For You

The University of Miami Hospital offers optional vision coverage through the Vision Service Plan. You are eligible to join the University of Miami Hospital vision plan 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.

The amount of your premium will depend on 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 any time during the year, 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:

    f. 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);
    g. 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:
            A) the child is no longer disabled; or
            B) the child is capable of supporting him or herself; or
            C) the child no longer receives more than 50% of his/her support from the subscriber; or
            D) 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.
    h. Coverage will be extended where the subscriber has agreed to regularly provide medical care for the child by court order regardless of adoption.
    i. Coverage will be extended where a Qualified Medical Child Support Order (QMSCO) exists; Whether or not said child resides with the employee.
    j. 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.

Vision Plan Summary

Benefit	General Description	
Eye Examination	VSP offers a thorough eye exam covered in full every calendar year, less $10 copayment, when services are obtained from a VSP network doctor.	
Materials	Lenses: VSP's standard lenses are covered in full (less any applicable plan copayment), including glass or plastic single vision, bifocal, trifocal or other more complex lenses necessary for the patient's visual welfare. Frames: VSP provides a frame allowance of $150 for regular frames or $170 for featured frame brands every calendar year. If the patient selects a frame that exceeds the plan allowance, VSP offers a 20% discount off the amount over the retail allowance. Contact lenses: 15% savings on a contact lens exam (fitting and evaluation) and up to $150 allowance, applied to the contact lens exam (fitting and evaluation) and lenses.	
Lens Options	VSP provides a 20% discount on lens enhancements. It is important to note that VSP fully covers Polycarbonate lenses for children.	
Valuable Discounts	As an added benefit VSP provides: 20% off additional pairs of prescription glasses and non-prescription glasses, including sunglasses 15% off (average) laser vision correction through contracted laser centers or 5% off the promotional price	
Low Vision	Members with severe visual problems are eligible for this benefit, which can include supplemental testing, low vision prescription services, evaluations, optical and non-optical aids and training. If low vision supplemental testing is approved, VSP will pay up to a maximum of $125 every two years. If low vision aids are approved, VSP will pay 75% of the approved amount up to a maximum of $1,000 per covered individual (less any amount paid for supplemental testing) every two years.	
Exclusions	The following items are excluded under this plan: 1. plano lenses (non-prescription) 2. two pairs of glasses instead of bifocals 3. replacement of lenses, frames or contacts 4. medical or surgical treatment 5. orthoptics, vision training or supplemental testing	Items not covered under the contact lens coverage: 1. corneal refractive therapy or orthokeratology 2. insurance policies or service agreements 3. artistically painted lenses 4. additional office visits for contact lens pathology 5. contact lens modification, polishing or cleaning

Out-of-Network Schedule of Allowances	Although more than 95% of our patients see VSP network doctors, we believe that choice is essential when it comes to health care. That's why VSP provides the following reimbursement schedule for patients choosing a non-VSP provider.

Eye examination	up to $45	Trifocal lenses	up to $65
Single vision lenses	up to $30	Frame	up to $70
Bifocal lenses	up to $50	Contact lenses	up to $105
Progressive lenses	up to $50		

For more information contact Vision Service Plan Customer Service at 1-800-877-7195 or visit VSP at www.vsp.com. Benefits are maximized when using participating vision care provider.

LONG TERM DISABILITY INSURANCE

Long Term Disability Insurance

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 Hospitals Long Term Disability Insurance Plan provides protection for you and your family when an illness or injury keeps you away from work. This Plan is a voluntary benefit and you must enroll in the Plan and pay a premium to be eligible for the coverage.

- Coverage is available in two options, 50% or 60% of your monthly Covered Earnings rounded to the nearest dollar.
- Long Term Disability (LTD) benefits, which begin after 150 days of continuous disability and provide 50% or 60% of your salary (to a maximum benefit of $10,000 per month) for as long as the disability lasts, except for limitations noted later. Your disability insurance will continue if your active service ends because of a disability for which benefits under the policy are or may become payable. Your premiums will be waived while disability benefits are payable. If you do not return to active service, this insurance ends when your disability ends or when benefits are no longer payable, whichever occurs first.

Here are definitions of certain terms used in this section:

Active Service
A day which is one of the Employer's scheduled work days and the employee is performing their regular occupation for the Employer on a full time basis.

Appropriate Care
The determination of an accurate and medically supported diagnosis of the Employee's Disability by a Physician, or a plan established by a Physician of ongoing medical treatment and care of the Disability that conforms to generally accepted medical standards, including frequency of treatment and care.

Covered Earnings
Your wage or salary as reported by the Employer for work performed for the Employer as in effect just prior to the date of Disability begins. It does not include amounts received as bonus, commissions, overtime pay or other extra compensation.

Disability
Because of an injury or illness, you are either unable to perform any or all of the material and substantial duties of your regular occupation; or unable to earn 70% or more of your Indexed Earnings from working in your regular occupation.

Indexed Earnings
For the first 12 months Monthly Benefits are payable, Indexed Earnings will be equal to Covered Earnings. After 12 Monthly Benefits are payable, Indexed Earnings will be an Employee's Covered Earnings plus an increase applied on each anniversary of the date Monthly Benefits became payable. The amount of each increase will be the lesser of:

- 10% of the Employee's Indexed Earnings during the preceding year of Disability; or
- The rate of increase in the Consumer Price Index (CPI-W) during the preceding calendar year.

Other Income Benefits
Include Social Security, Workers' Compensation or any benefits from an occupational disease law, other state or federal disability benefits you qualify for, other University-sponsored disability benefits you may
receive and any other group disability plans. For a complete listing of Other Income Benefits, please see the Long Term Disability policy through CIGNA.

Pre-Existing Condition
Any Injury or Sickness for which the Employee incurred expenses, received medical treatment, care or services including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within 3 months before his or her most recent effective date of insurance.

Totally Disabled
After Disability Benefits have been payable for 24 months, you are considered Disabled if you are:

- Unable to perform any or all of the material and substantial duties of any occupation for which you are or may reasonably become qualified based on education, training, or experience; or
- Unable to earn 70% or more of your Indexed Earnings

Long Term Disability Benefits

When You Qualify For Coverage
Hospital full-time employees working a minimum of 32 hours per week are eligible for coverage on the first day of the month following two (2) months of employment and elect to enroll in the voluntary benefit.

What Is Your Coverage Payable At?
If your total disability continues for 150 days and longer, you may be eligible to receive a monthly Long Term Disability (LTD) benefit equal to 50% or 60% of your monthly salary, including any other income benefits you may receive. LTD payments will be offset by any severance pay from the University. The maximum payment you may receive from all sources is $10,000 a month.

Length of LTD Payments
The maximum period for which LTD benefits will be paid is based on your age when your disability begins. The maximum benefit period is listed in the chart below:

Age 62 or under	The employee's 65th birthday or the date the 42nd monthly benefit is payable, if later.
Age 63	The date the 36th Monthly Benefit is payable
Age 64	The date the 30th Monthly Benefit is payable
Age 65	The date the 24th Monthly Benefit is payable
Age 66	The date the 21st Monthly Benefit is payable
Age 67	The date the 18th Monthly Benefit is payable
Age 68	The date the 15th Monthly Benefit is payable
Age 69 or older	The date the 12th Monthly Benefit is payable

Group and Excess Life Insurance Benefit while on Long Term Disability
If you become totally disabled before you reach age 60 and are approved for benefits under the CIGNA Long Term Disability Plan, you will be covered under the Group Life Insurance during the period that you are covered under the Long Term Disability plan provided that:

- ✓ You file for continued coverage within the first 8 months of disability
- ✓ You furnish evidence of continued disability each year.
- ✓ Under age 65

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 five 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.

Payment Limitations
Benefits you receive due to mental or nervous disorders, alcoholism, drug addiction or the use of any hallucinogen, will be paid for no more than 24 months unless you are then confined in an approved hospital and have been confined for more than 14 days. In this case, that period of confinement will not count against your lifetime limit.

Benefits for Other Conditions:
After the Elimination Period is satisfied: benefits will be limited to a total of 24 months in your lifetime for all Disability resulting from or caused by Self-Reported Conditions.

Self-Reported Conditions means those conditions which when reported by your Physician cannot be verified and measured using generally accepted standard medical/chiropractic procedures and practices. Examples of such conditions include, but are not limited to; headaches, dizziness, fatigue, loss of energy, pain, and upper extremity cumulative trauma disorder.

Disability Not Covered

This coverage does not include disabilities caused by:

- Suicide, attempted suicide, or self-inflicted injuries while sane or insane.
- Commission of a felony
- War or any act of war whether declared or undeclared
- Active anticipation in a riot
- Any period of disability during which you are incarcerated in a penal or corrections institution.
- The revocation, restriction or non-renewal of your license, permit, or certification necessary to perform the duties of your occupation unless due solely to Injury or Sickness otherwise covered by the Policy.

Rehabilitation During a Period of Disability

If CIGNA determines that you are a suitable candidate for rehabilitation, the insurance company may require you to participate in a rehabilitation plan and assessment at the plans expense. The insurance company has the sole discretion to approve your participation in a rehabilitation plan and to approve a program as a rehabilitation plan. The insurance company will work with you, the hospital, your physician and others, as appropriate, to perform the assessment, develop a rehabilitation plan, and discuss return to work opportunities.

If You Become Disabled Again
If you become totally disabled within six months after you return to work from the same or related disability for which you have received Long Term Disability payments, LTD benefits will be paid without a new 150 day waiting period. If you return to work after receiving benefits from the Plan and become totally disabled from a different cause, your disability will be considered new, and the 150 day waiting period will again be required before LTD benefits will be paid.

When Disability Benefits End

Benefits will end on the earliest of the following dates:

- The date you earn more than the percentage of earnings that would still qualify you to meet the definition of Disability/Disabled;
- The date the insurance company determines you are not Disabled;
- The end of the maximum benefit period;
- The date the you die;
- The date you refuse, without good cause, to fully cooperate in all required phases of the rehabilitation plan and assessment;
- The date you are no longer receiving appropriate care;
- The date you fail to cooperate with the insurance company in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

  Benefits may be resumed if you begin to cooperate fully in the rehabilitation plan within 30 days of the date benefits terminate.

When Coverage Ends

Your LTD coverage continues as long as you are actively at work and working on a full-time regular basis at the University of Miami Hospital and pay the monthly premiums. Your coverage will end on the earliest of the following dates:

- The date the Employee is eligible for coverage under a plan intended to replace this coverage;
- The date the Policy is terminated;
- The date the Employee is no longer in a eligible class (full time);
- The day after the end of the period for which premiums are paid;
- The date the Employee is no long in Active Service;
- The date benefits end for failure to comply with the terms and conditions of the Policy.

Actively at Work

You will be considered to be active at work on any of your employer's scheduled work days if, on that day, you are performing the regular duties of your job on a full time basis for the number of yours you are normally scheduled to work. In addition, you will be considered to be actively at work on the following days:

1. Any day which is not one of your employer's scheduled work days if you were actively at work on the preceding scheduled work day or;
2. A normal vacation day.

Disability benefits will be payable to an employee who is entitled to receive disability benefits when the policy terminates, if he or she remains disabled and meets the requirements of the Policy.

LTD Employee Status and Benefits

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 are not continued.

Anyone hired after 6/1/2013 will not receive retirement contributions while on LTD.

Long Term Care Benefit while on Long Term Disability
You may continue your Long Term Care coverage while you are disabled by paying the required premiums.

To Claim Benefits

You must file a claim with CIGNA to apply for LTD benefits. If you make a claim for Plan benefits, and all or part of it is denied, CIGNA will notify you of the reasons for denial and refer you to pertinent Plan provisions within 45 days of receiving your claim (90 days if special circumstances apply). They will also inform you on how you can appeal this decision.

LTD Plan Fiduciary

The University of Miami Hospital designates CIGNA as the fiduciary for the Long Term Disability plan pursuant to ERISA and grants CIGNA the authority to make determinations on behalf of UMH as to whether and to what extent participants and beneficiaries are entitled to benefits, and to construe disputed or doubtful Plan terms.

This is a summary only and not intended as a complete description of covered services. Please refer to the Voluntary Long Term Disability Plan Document for more information. If any discrepancy exists between this document and the Voluntary Long Term Disability Plan Document, the language in the Voluntary Long Term Disability Plan Document will apply

SHORT TERM DISABILITY INSURANCE

Short Term Disability Insurance

What the Plan Can Do For You

In case of an employee's extended illness or injury, you may be eligible for continued income on a short-term basis if you elected to enroll in the Voluntary Short Term Disability plan through CIGNA.

The Hospital's Short Term Disability Insurance Plan (STD) provides a percentage of your income for you when you are on an approved Medical Leave of Absence due to an illness or injury.

Eligibility

You are eligible for coverage from the first day that all of the following requirements are met:

- Employed by the University of Miami Hospital, as a regular full time employee working a minimum of 32 hours per week.
- Classified as a full-time regular non-exempt (biweekly paid) employee by the University of Miami.
- Satisfied the eligibility waiting period of first of the month following 2 months of Active Service
- Completed the online enrollment process within thirty (30) days of original effective date and enroll in the Voluntary Short Term Disability plan.

Payments

Benefits will be paid to you while you are on an approved Medical Leave of Absence due to injury or illness after you have completed an elimination period 14 days. You will receive the income benefit of 60% of your pay to a maximum of $2,500 per week.

Benefit payments will stop when your attending physician states that you are capable of returning to work. Benefit payments will not be extended beyond the maximum period payable which is when the 20th disability benefit is payable.

Reoccurring Injury or Illness for the Same Illness or Injury That Occurred On The Prior Claim

An uninterrupted period of 14 calendar days of regular full-time hours at work must be accrued prior to filing a new STD claim in order to start a new claim.

Reoccurrence of Injury or Illness Within Less Than 14 Calendar Days

The same claim will be reactivated and the remainder of the initial 20 week pay period will be paid as long as you are on an approved Medical Leave of Absence.

Termination of Coverage

- The date the Policy is terminated;
- The date you are eligible for coverage under a plan intended to replace this coverage;
- The date you are no longer in an eligible class (full time);
- The date after the end of the period for which premiums are paid;
- The date you are no longer in Active Service;
- The date benefits end because you did not comply with the terms and conditions of the insurance coverage.

You must file an Initial Claim with CIGNA to begin receiving STD benefits. Your initial claim should be filed with CIGNA no later than 31 days after the covered loss occurs or begins or as soon as reasonably possible.

Your disability insurance will continue if your active status ends because of a disability for which benefits under the policy are or may become payable. If you do not return to active status, this insurance ends when your disability ends or when benefits are no longer payable, whichever occurs first.

Pre-Existing Condition Limitation

CIGNA will not pay benefits for any period of disability caused or contributed to by, or resulting from, a pre-existing condition. A "Pre-existing Condition" means any injury or sickness for which you incurred expenses, received medical treatment, care or services including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a physician within 3 months before your most recent effective date of insurance.

The pre-existing condition limitation will apply to any added benefits or increases in benefits. This limitation will not apply to a period of disability that begins after you are covered for at least 12 months after your most recent effective date of insurance, or the effective date of any added or increased benefit.

Disability Not Covered

This coverage does not include disabilities caused by:

- Suicide, attempted suicide, or self-inflicted injuries while sane or insane.
- Commission of a felony
- War or any act of war whether declared or undeclared
- Active anticipation in a riot
- Any period of disability during which you are incarcerated in a penal or corrections institution.
- The revocation, restriction or non-renewal of your license, permit, or certification necessary to perform the duties of your occupation unless due solely to Injury or Sickness otherwise covered by the Policy.

Rehabilitation During a Period of Disability

If CIGNA determines that you are a suitable candidate for rehabilitation, the insurance company may require you to participate in a rehabilitation plan and assessment at the plans expense. The insurance company has the sole discretion to approve your participation in a rehabilitation plan and to approve a program as a rehabilitation plan. The insurance company will work with you, the hospital, your physician and others, as appropriate, to perform the assessment, develop a rehabilitation plan, and discuss return to work opportunities.

This is a summary only and not intended as a complete description of covered services. Please refer to the Voluntary Short Term Disability Plan Document for more information. If any discrepancy exists between this document and the Voluntary Short Term Disability Plan Document, the language in the Voluntary Short Term Disability Plan Document will apply.

LONG TERM CARE INSURANCE

Long Term Care Insurance

Plan Summary

Plan 1 Base	Plan 2 Base Plan with Inflation Protection Plan
Long Term Care/Nursing Home Facility, Assisted Living Facility and Professional Home Care Services	Long Term Care/Nursing Home Facility, Assisted Living Facility, Professional Home Care Services and Simple Growth Capped Inflation Protection

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, 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 30 days from your date of hire if you are a full time faculty or staff member, anytime after 30 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, option 1.

LIFE INSURANCE AND ACCIDENT INSURANCE

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 employees, University of Miami Hospital offers a broad range of life and accident insurance coverage's. By selecting the combination of plans and coverage amounts best suited to your needs, you can customize this protection to meet your personal circumstances.

Plan	Who Pays	Benefit
Basic Group Life	Hospital	One times salary up to $700,000 (rounded to nearest $1,000).
Voluntary Excess Life	You, with after-tax earnings	**Full Time** - 1,2,3,4 or 5 times salary to $1,000,000 or the lesser of 5 times salary (rounded to nearest $1,000). **Part Time** – The lesser of 1 times annual salary (rounded to nearest $1,000) or $15,000
Basic AD&D	Hospital	One time salary up to $700,000 (rounded to the nearest $1,000) (full or partial benefit for dismemberment).
Voluntary AD&D	You, with after-tax earnings	**Full Time** - 1,2,3,4 or 5 times salary to $1,000,000 (rounded to nearest $1,000).
One Month Death Benefit	University	One times base salary

Who May Participate

You may participate in the University of Miami Hospital's survivor protection plans described in this section if you are a regular full-time or part-time regular member of the University of Miami Hospital.

For plans that the University of Miami Hospital provides at no cost to full time employees – Basic Group Life and Basic AD&D – your coverage begins automatically for full-time employees on the first day of the month following two (2) months 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.

Basic Group Life Insurance

Group Life Insurance is provided at no cost to you by the University of Miami Hospital and you are automatically enrolled. UMH 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.

If you die while insured by the plan, benefits will be paid to your beneficiary. Group Life Insurance provides one times your basic annual earnings rounded to the nearest $1,000 up to a maximum of $700,000 or 1 times salary, whichever is less.

For Example:

Basic annual earnings	$28,300
1 times basic annual earnings	$28,300
Group Life Insurance benefits	$29,000

Basic annual earnings for bi-weekly paid employees is defined as an employee's annual wage or salary as reported by the Employer for work performed for the Employer as of the date the covered

loss occurs. It does not include amounts received as bonuses, commissions, overtime pay or other extra compensation.

Life insurance is paid in addition to any death benefits from a University retirement plan for which your survivor may qualify.

Voluntary Excess Life Insurance

Voluntary Excess Life Insurance lets you supplement the Hospital-provided survivor protection plans if you want additional life insurance coverage. Your first opportunity to purchase this insurance, with coverage up to five times your annual salary to a max of $1,000,000 falls within 30 days of your first day of employment. The insurer guarantees a level of three times your annual salary to a max of $300,000 in coverage. Coverage in excess of three times your salary or $300, 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 five 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

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

For Example:	
Your base salary	$35,600
Your base salary rounded to the nearest $1,000	$36,000
Your elect 3 times your base salary of Voluntary Excess Life Insurance	$108,000

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

- The level of coverage you select
- Your age

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.

Life Insurance Coverage Age Based Reductions

When you are age 65 or older, your Life Insurance coverage will reduce to:

Age	Reduction Percent
65	65%
70	40%
75	25%
80	20%

Spousal Coverage
The Voluntary Excess Life Insurance Plan also allows insurance coverage for a spouse in units of $5,000 to a maximum of $100,000. Spousal coverage is limited to 50% of the employee's coverage, or $100,000 (whichever is less). The insurer guarantees a level of $25,000 in coverage. Coverage in excess of three times your salary or $25,000 requires review and acceptance by the insurer of a completed health questionnaire. 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 biweekly 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 guaranteed insurance coverage for dependent children. Dependent coverage is limited to $5,000 or $10,000 per dependent. The maximum benefit for a dependent child who is less than 6 months old is $1,000. The dependent coverage cannot exceed 50% of the employee's salary. Dependents are required to be non-confined and performing normal duties. A dependent child can be insured from life birth to age 26, or longer if primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Eligible children are born to or legally adopted by you. It includes a child during any waiting period prior to the finalization of the child's adoption. It also means a stepchild living with and financially dependent upon you. 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 eight 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 Accidental Death and Dismemberment

Basic Accidental Death and Dismemberment (AD&D) coverage is provided to full time employees at no cost to you by the University of Miami Hospital, and you are automatically enrolled. This coverage pays your beneficiary the full benefit amount if your death results from an accident, or pays you a full or partial benefit for accidental dismemberment. The full benefit amount equals your base annual salary, rounded to the nearest thousand, up to a maximum benefit of $700,000.

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:

Loss	**Benefit**
Two or more	Full benefit amount
Single loss	One-half amount
Thumb and index finger on the same hand	One-quarter amount

Voluntary Accidental Death & Dismemberment

Full-time employees, 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 an amount up to five times your annual salary (rounded to the next $1,000) to $1,000,000.

If you are covered under the Plan, you may also purchase coverage for your spouse from $5,000 to $50,000, in increments of $5,000.

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.

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

Age on date of death	Percentage of Benefit Amount
65 but less than 70	65%
70 but less than 75	40%
75 but less than 80	25%
80 or over	20%

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.

For Loss of:	Percentage of Principal Sum
Both hands or both feet	100%
Sight of both eyes	100%
One hand and one foot	100%
One hand and entire sight of one eye	100%
One foot and entire sight of one eye	100%
One hand or one foot	50%
Sight of one eye	50%
Speech of hearing in both ears	50%
Thumb and index finger of same hand	25%

"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 of the same hand.

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.

Seatbelt and Airbag Benefit
An additional benefit will be paid if you die directly and independently of all other causes from an accident while wearing a seatbelt and operating or riding as a passenger in an automobile. An additional benefit is provided if you were also positioned in a set protected by a properly-functioning and properly deployed airbag.

If a police report is not available or it is unclear if you were wearing a seatbelt or positioned in a seat with a properly functioning airbag, CIGNA will pay the default benefit amount shown.

Seatbelt Benefit	10% of the Principal Sum; maximum benefit $25,000
Airbag Benefit	5% of the Principal Sum; maximum benefit $5,000
Default Benefit	$1,000

Common Exclusions
Benefits are paid from your Basic AD&D and Voluntary AD&D coverage for all losses except those resulting from certain specific exclusions. Some examples of the exclusions are:

- Suicide or intentionally self-inflicted injury
- Physical or mental disease
- War or an act of war, declared or not
- Your commission or attempt to commit a felony or an assault
- 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 biweekly. 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:

Social Security

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

Workers' Compensation

Florida'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 name a beneficiary, you must complete the Designation of Beneficiary section in the online enrollment process at Workday. You may name anyone you wish, selecting the same beneficiary for all your coverage's, 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, by going online at Workday.

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 your base salary. Bonuses, commissions, 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 contributions 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 contributions.

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 arranged if requested by you or your beneficiary. For more information, contact HR-Benefits.

When Coverage Ends

Coverage from these Hospital-sponsored survivor protection plans will continue until the last day of the month in which the earliest of the HR-Benefits following occurs (unless you convert your coverage to an individual policy):

- You leave the hospital or retire
- You are no longer working the minimum hours required for coverage under the plan
- You stop making any required contributions toward the coverage's cost
- The applicable plan terminates

Converting to an Individual Policy

If your coverage ends because your employment with the Hospital terminates, you may convert all or part of your Group Life Insurance, Voluntary Excess Life Insurance, Group AD&D, and Voluntary AD&D coverage to individual policies available from the insurance company for that Plan subject to medical evidence of insurability, if applicable.

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 Group AD&D and Voluntary AD&D Insurance coverage (if applicable), 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

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.

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.

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.

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 $2,600 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 are enrolled in the UM/Aetna HRA medical plan HRA fund dollars are used for medical and pharmacy expenses first before any Health Care Flexible Spending monies, except during the grace period**.** 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 may be asked to submit receipts.

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

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/hr.

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 2017 Health Care and/or Dependent Care FSA plan may incur expenses (receive treatment, purchase supplies or receive child care services) from 1/01/17 through March 15, 2018 and use 2017 plan year funds for reimbursement of eligible health care and/or dependent care expenses. Participants will continue to have a three month run-out period to file for reimbursement of claims incurred during January 1, 2017 through March 15, 2018. The run-out period will end June 15, 2018.

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/hr. 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, 2017 through February 20, 2017) - 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:

- 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.

RETIREMENT SAVINGS PLAN II (RSPII)

Retirement Savings Plan II (RSPII)

What the Plan Can Do for You

With the Retirement Savings Plan II, 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 of Miami Hospital 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 of Miami Hospital 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 the matching contributions (and rollover contributions, if any). You have several investment funds 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. 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 II if you are an Eligible Employee of the University of Miami Hospital or you are covered by a collective bargaining agreement between Employee representatives and the University indicating that you are an Eligible Employee for this plan.

When You Can Participate

You can begin making voluntary contributions immediately upon hire If you have not made an election after two months of service you will be automatically enrolled in the Plan and there will be an automatic deduction of 3% of pay every pay period. The automatic deduction will increase by 1% to a maximum of 15% of pay unless you elect to contribute a different amount. The University of Miami Hospital will begin matching your voluntary contributions after you complete two months of service. A month of service is a 30 day period of employment.

University of Miami Hospital core contributions will begin as of the January 1st following your date of employment if you were an Eligible Employee on January 1st and December 31st of the previous Plan Year and you were credited with at least 1,000 hours of service for that plan year.

Enrolling in the Plan

Core contributions begin automatically once you meet the eligibility requirements.

Your voluntary contribution percentage is automatically set at 3% after two months of service and your contributions will be invested in the Fidelity Investments Freedom Index Fund matched to your date of birth unless you elect otherwise. You have the opportunity to elect to contribute a different

amount (or not at all) or elect a different investment company by visiting plan.fidelity.com/um and making your election on-line.

You may increase, decrease or stop your contributions at any time by visiting plan.fidelity.com/um and making a new election.
Rollover Contributions. You may roll over to 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 are Invested" section for more information.

Designating a Beneficiary

You should also name a beneficiary as soon as you become eligible for the Retirement Savings Plan II by visiting plan.fidelity.com/um and completing the beneficiary information on-line. 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 shall make a core contribution after the end of each Plan Year based on years of vesting service (years in which you have worked at least 1,000 hours of service) as follows:

Years of Vesting Service (as of end of Plan Year)	**Core Contribution % (As Percentage of Compensation*)**	
	% of Compensation up to Maximum Social Security Wage Base	% of Compensation above Maximum Social Security Wage Base
0-4	2.25%	4.50%
5-9	3.0% (prior to 2015) 3.5% effective January 1, 2015 4.0% effective January 1, 2016 4.5% effective January 1, 2017	6.0%
10-14	4.0% (prior to 2015) 4.5% effective January 1, 2015 5.0% effective January 1, 2016	8.0%
15 or more	5.0%	10.0%
20 or more and currently receiving 5.5% (as of January 1, 2015)	5.5%	11.0%

**Subject to Federal limits*

Example: Core Contribution
Let's assume that you are a plan participant and that your annual compensation is $30,000 and you have 11 years of service. In this example, your automatic core contribution – for the 2017 year – will equal $1,500:

$30,000 x 5% = $1,500 (for 2017 plan year)

Your Voluntary Contributions
When you become eligible, you are automatically set up to save 3% 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. If you are employed on a per diem basis, you will not be automatically enrolled. You may increase, decrease or stop contributing at any time by visiting plan.fidelity.com/um and making an on-line election. 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 50%, 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 II 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).

Matching Contributions
The University will match your voluntary contributions dollar-for-dollar up to 5% of your compensation. Your compensation includes the total paid to you by the University as shown on your W-2 form 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.

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 2017, 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 Retirement Savings Plan II. If you are over age 50 or will reach age 50 during the year, you may contribute up to an additional $6,000 in 2017 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.

The IRS also adjusts the total annual contributions that can be made to the Retirement Savings Plan II. Total annual contributions include automatic core contributions, your voluntary contributions

and matching contributions. Catch-up contributions are not included in this limit. For 2017, the limit on total annual contributions is $54,000.

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 2017, this limit is $270,000.

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

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 RSPII 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 www.miami.edu/hr.

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 please visit the investment company's website where you have your retirement account, netbenefits.com/um or www.tiaa-cref.org/uofmiami.

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 Fidelity Investments.

Protection Under ERISA Section 404(c)
The Retirement Savings Plan II 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 non-forfeitable right to the value of your account. You are always 100% vested in the value of your voluntary contributions and rollover contributions. You are 100% vested in the matching contributions that you receive from the University after three years of vesting service.

You become vested in the value of the automatic core contributions made to your account and any investment earnings of that account according to the below vesting schedule.

Years of Vesting Service	Vested Percentage
0-1	0%
2	20%
3	40%
4	60%
5	80%
6 or more	100%

You also become vested, regardless of your years of vesting service, if you reach age 65, become disabled or die while you are employed by the University. For purposes of the plan,being disabled means “permanent and total disability” which qualifies you for Social Security disability benefits as determined by the Social Security Administration

You earn a year of vesting service for each plan year in which you work at least 1,000 hours of service 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 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.

Entitlement to Distribution

If you separate from service or incur a disability, you may elect to receive:

- Your employee voluntary contributions, rollover contributions and your vested employer matching contribution, and
- Your vested employer core contribution.

Effective June 1, 2013, you have the option to elect a 100 percent lump sum distribution.

Distribution Options
When you are eligible to receive payments from the plan, you may elect to take the value of your vested account as a full lump sum or under any of the other distribution options offered by the investment company.

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.
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. If you obtain your spouse's notarized written consent, you may 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 distribution options available through the investment companies referenced in the section "Where the Contributions Are Invested."

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

Loans

Although the Retirement Savings Plan II 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 one loan outstanding at any time. In general, the maximum amount of the loan 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, you must transfer enough funds from TIAA-CREF 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 (including room and board, but excluding 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 Retirement Savings Plan II 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 About the RSPII

Please refer to the sections "Additional Retirement Information" and "Retirement Appeal Procedures" for information including how the Retirement Savings Plan II is administered and your rights under the Employee Retirement Income Security Act of 1974 (ERISA) as amended.

TUITION BENEFIT POLICY

Tuition Benefit Policy

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 natural, 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 – A former employee who is eligible to receive benefits under the Group Retirement Plan. Employees who are retiring and meet the rule of 70. (A former employee who is vested in the Group Retirement Plan, but not eligible to receive benefits under the early retirement provision is not eligible for tuition remission). An employee who qualifies for retirement and is involuntarily terminated is not eligible to retain tuition remission benefits.

Employee Coverage

Policy

UMH, as a part of its philosophy to providing exceptionally high quality patient care services, is committed to attracting and retaining qualified employees at all levels, by ensuring the effective development and utilization of its Human Resources. To achieve this goal, the Hospital offers tuition assistance benefits to eligible employees enrolled in accredited degree or certificate programs. When coordinated with internal Management and Staff Development programs and services; including career counseling, the Tuition Assistance Program will be utilized to the benefit of the individual employee and UMH as a whole. The Tuition Assistance Program and budget are reviewed annually and subject to change, reduction or elimination, as is determined in the best interest of UMH.

Guidelines

Tuition assistance eligibility requirements and degree reimbursement limitations have been established to ensure the expenditure of budgeted monies will achieve the previously described institutional goals.

I. ELIGIBILITY

A. All regular full-time employees classified for pay purposes as 32 hours or more, with more than six months of service and a satisfactory work/attendance record as documented by a

performance evaluation who enroll in accredited degree or certificate programs, are eligible to request tuition reimbursement.

Employees classified as Pool, Per Diem, Part-time, Agency or Temporary, and employees receiving premium pay in lieu of benefits, are not eligible for tuition reimbursement, regardless of scheduled hours per week.

If an otherwise eligible employee has not completed six months of service, an exception may be granted with prior approval of the Area Administrative Leader, when such approval is in the best interest of the hospital.

B. Degree/Certificate Program Limitations:

1. All eligible personnel
   - Certificate programs within departmental specialty area
   - Bachelors Degree within departmental specialty area

2. Assistant Department Leaders/Supervisory Personnel
   - Certificate programs within departmental specialty area
   - Bachelors Degree – Business
   - Bachelors Degree – Management
   - Bachelors Degree within departmental specialty area
   - Masters Degree within Departmental specialty area
   - Masters Business Administration (MBA) (provided the person is considered by the Department Leader and Area Administrative Leader to be highly promotable and it is highly likely an appropriate Department Leader level position will be available upon completion of the degree program)
   - Doctorate within departmental specialty area

3. Department Leaders/Administrative Personnel
   - Certificate Program within departmental specialty area
   - Bachelors Degree – Business
   - Bachelors Degree – Management
   - Bachelors Degree within departmental specialty area
   - Masters Degree within departmental specialty area
   - Masters Business Administration (MBA or MHA)
   - Doctorate within specialty area

C. In addition to the specific degree approval limitations, the following guidelines will also be used in evaluating tuition assistance requests:
   1. Programs which improve the individual's skills on their present job.
   2. Programs which update employees in the technology of their occupations.
   3. Programs which relate to the next job in the logical development of an employee's career.
   4. Programs which prepare an employee for openings that are expected to occur in the future and for which a sufficient number of qualified employees are not available.

D. Degree/Certificate programs applicable to assignments in another department
   1. Tuition Assistance may be granted to employees pursuing degrees/certificate programs in another department, provided openings are expected to occur in the future, and for which a sufficient number of qualified employees are not available. These requests are coordinated by the Human Resources Department and require the approval of the appropriate Department Leader and Area Administrative Leader.
   2. Those employees who have received approval based on eligibility requirements in D (1) will be required to participate in an internship component. The internship will involve interviews with the Department Leader of the new area, as well as observation time

(8-10 hours) at the time of initial application and a minimum of 20 hours performing tasks for that position within the last two semesters of the degree program. These internship hours would be on the employee's personal time. If an employee's degree program has a built-in internship component, the 20 hours of performing tasks will be waived.

II. TUITION REIMBURSEMENT

A. Eligible employees who request Tuition Assistance must obtain required approvals from Department Leader, appropriate Area Administrative Leader, and the Human Resources Department prior to course registration. Requests for Tuition Assistance at the Masters and Doctorate level also require CEO approval prior to registration.

Applicants will receive written notification of approval status from the Human Resources Department. Employees approved for Tuition Reimbursement may receive pre-class, or post-class payment. Employees will not receive tuition reimbursement if this procedure is not followed.

B. Types of Reimbursement

1. Eligible employees approved for Tuition Reimbursement may receive 100% of tuition up to $3,000 for undergraduate and certificate courses, per calendar year (August 1st to July 31st) in accredited institutions.
2. Eligible employees in bargaining positions approved for Tuition Reimbursement may receive 100% of tuition up to $3,000 for undergraduate and certificate courses per calendar year (August 1st to July 31st) in accredited institutions.
3. RNs and Medical Professionals taking certificate exams or pursuing certificate programs sponsored by an accredited professional association to increase clinical expertise may also receive a maximum of $1,000 per calendar year (August 1st to July 31st) towards certification examination fees, program and travel expenses (i.e., CCRN, CNOR, CPAN, etc.).
4. Eligible employees pursuing BSN/MSN degrees through Barry University will be reimbursed for tuition fees which reflect the 30% discount offered to students working full-time in a health care setting.
5. Employees receiving Tuition Reimbursement will be required to refund full tuition reimbursement received if they fail to remain an eligible employee at UMH for one (1) year from their course completion date.

C. Grade Requirements

To receive Tuition Reimbursement, eligible employees must receive a grade of "C" or better in undergraduate or certificate courses, or "B" or better in graduate course, or receive a passing grade on a certification examination from an accredited professional association.

D. Exceptions

Request for exceptions to Tuition Reimbursement limits as outlined in Section B above, require advance approval of the Department Leader, appropriate Area Administrative Leader and Chief Executive Officer.

E. Tuition Reimbursement Repayment Agreement

1. Employees requesting Tuition Assistance will sign a Tuition Reimbursement Repayment Agreement, indicating that they will comply with the grade, reporting and employment status requirements for the required periods or repay the full tuition reimbursement through payroll deduction.
2. <u>Repayment of Tuition Reimbursement</u>
   a. Automatic payroll deductions of the full amount of tuition reimbursement will result under the following conditions:

1. Failure to submit grades to the Human Resources Department within four weeks after course completion.
2. Failure to meet grade requirements of "B" or better in graduate courses, or "C" or better for undergraduate and certificate courses.

3. Failure to successfully complete a course or to pass a certification examination after receiving tuition prepayment.
4. Failure to follow-through on internship commitment.
5. Failure to submit proof of registration to the Human Resources Department within three weeks of receiving tuition pre-payment.

b. The full amount of Tuition Reimbursement received during the preceding 12 months, will be taken through payroll deduction from the final paycheck as a regular full-time employee under the below listed conditions:

1. Employees who tender a voluntary resignation before completion of one year of service after receiving Tuition Reimbursement.
2. Employees who are discharged because they cannot meet the requirements of the job or have exhibited extreme misconduct.
3. Employees who are reclassified to an ineligible category.

If there is insufficient money left in the final paycheck to repay the full amount of the tuition reimbursement received, the employee will be required to repay the full amount of the balance due on the final day of full-time employment or contact the Human Resources Department to arrange to pay the remaining amount according to a schedule mutually agreeable to the employee and the University of Miami Hospital.

3. Tuition Reimbursement Repayment Exceptions
   a. Exceptions for repayment of failure to achieve the requirements listed in items E (2) (a) (1-5) require approval in advance from the Area Administrative Leader.

   b. Other exceptions for repayment of tuition funds require advance approval of the Chief Executive Officer.

III. HUMAN RESOURCES' RESPONSIBILITY

A. Assist UMH employees and managers with career counseling and the development of career plans involving tuition assistance.
B. Act as a liaison for situations requiring input, statistics, etc., between departments and Administrative Team.
C. Review Requests for Tuition Assistance for completeness and appropriateness. Return Requests for Tuition Assistance that do not meet policy guidelines with appropriate explanation to the employee.
D. Coordinate Requests for Tuition Assistance and Internships requiring input from a second Department Leader.
E. Process check requests for tuition prepayment prior to course registration in the name of the institution and forward to Accounts Payable for disbursement; distribute check to employee.
F. Process check requests for tuition prepayment after course registration in the employee's name and forward to Accounts Payable for processing; distribute check to employee.
G. Notify Payroll of automatic and final paycheck tuition reimbursement deductions when appropriate.
H. Review Tuition Assistance Program on an annual basis with respect to organizational goals and provide recommendations for program changes and enhancements to Administrative Team for approval.
I. Prepare tuition reimbursement budget annually and recommend to Management Council for inclusion in the budget process.

IV. EMPLOYEE'S RESPONSIBILITY

A. Prior to registration, each term/semester, obtain appropriate "Request for Tuition Assistance" form from the Human Resources Department. Complete Employee, School and Course Information sections of the application. Sign Tuition Reimbursement Repayment Agreement and submit completed application to appropriate Department Leader and Administrative Leader for approval.
   1. All new tuition assistance applicants and on-going users who are pursuing a new degree should complete Form A.
   2. All applicants pursuing certification programs and continuing with previously approved programs should complete Form B.

B. Contact the Human Resources Department to coordinate internship when applicable.

C. Obtain Internship Evaluation Form from the Human Resources Department. Submit to Department Leader of new area and return to the Human Resources Department at the end of both the 10 hours of observation and 20 hours of task sections of the Internship.

D. Ensure Request for Tuition Assistance is approved by Department Leader and Area Administrative Leader (and CEO, if applicable), and is received by the Human Resources Department 10 working days (Monday through Friday) prior to registration.

E. After receiving approval for tuition assistance from Human Resources, register for class(es) and submit registration receipt to the Human Resources Department within three weeks of receiving funds.

F. Complete approved courses and attain a grade of "B" or better in graduate courses or "C" or better for undergraduate and certificate courses.

G. Submit grades to the Human Resources Department within four weeks after course completion, or in the case of certification/licensure, within one week of written notification of passing.

H. Repay full amount of Tuition Reimbursement received during the preceding 12 month period through payroll deduction or from final check as a regular, full-time employee under the following conditions:
   1. Failure to successfully complete a course or to pass a certificate examination after receiving pre-payment.
   2. Failure to obtain a grade of "B" or better in graduate courses or "C" or better for undergraduate and certificate courses.
   3. Voluntary resignation before completion of one year of service after receiving Tuition Reimbursement.
   4. Discharge for poor performance or gross misconduct.
   5. Failure to follow-through on internship commitment.
   6. Reclassification to an ineligible job category.

I. If there is insufficient money left in the final paycheck, pay the full amount of the balance of Tuition Reimbursement received or contact the Human Resources Department to arrange a payment schedule as stated in the Repayment Agreement signed at the time of application.

V. DEPARTMENT LEADER'S RESPONSIBILITIES

A. Department Leaders have responsibility for the initial approval or disapproval of Requests for Tuition Assistance submitted by their subordinates. In carrying out this responsibility, Department Leaders will:
   1. Meet with employees and discuss their educational goals in relation to improving skills on their present job or the next job in the logical development of an employee's career.
   2. Refer Requests for Tuition Assistance related to a career in another department to the Human Resources Department for processing.
   3. Evaluate the proposed course load to ensure it will not interfere with the Medical Center's functions or diminish the employee's ability to do his/her job.
   4. Review employee's status, records (attendance, dependability, performance evaluations, etc.) prior to approving Requests for Tuition Assistance.

5. Complete Department Leader section of the Request for Tuition Assistance Form and, if approved, forward to appropriate Area Administrative Leader. If Request for Tuition Assistance is disapproved, convey this information to the employee in person, explaining the reasons for disapproving the Request for Tuition Assistance. Once this has been completed, forward the Request for Tuition Assistance Form to the Human Resources Department for review. If appropriate, the employee should be referred to the Human Resources Department for further counseling regarding his/her educational goals.

B. Upon employee termination or reclassification to an ineligible job category, the Department Manager should refer the employee to the Human Resources Department for clearance before final check as an eligible employee is issued.

VI. ADMINISTRATIVE RESPONSIBILITIES

A. Review Requests for Tuition Assistance and ensure the requests are in line with departmental and hospital goals prior to approval.

1. If request for Tuition Assistance is for Masters or Doctorate level courses, obtain CEO approval.
2. If Request for Tuition Assistance is approved, forward form to the Human Resources Department for processing.
3. If Request for Tuition Assistance is disapproved, refer to Department Leader for discussion with employee.

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 attempted 128 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.

Credit Counting

Coursework that is begun or attempted but not successfully 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

A dependent of an employee 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. Dependent/spouse employee is not entitled to use tuition remission as a dependent.

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 that plan to use tuition remission are required to apply for the William L. Boyd, IV, and Florida Resident Access Grant (BFRAG). All dependents that qualify for 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% tuition remission. This BFRAG policy does not affect dependents receiving less than 100% 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 Hospital. 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. Then 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.

Changes 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 is involuntary terminated is eligible for the tuition remission benefit for him/herself and dependents through the end of the semester or summer session that is in progress.

Layoff
An employee who is placed on layoff is eligible for the tuition remission benefit for him/herself and dependents through the end of the semester or summer session that is in progress.
An employee who is laid off 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.

Returning to Employment
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 of Miami Hospital 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. Employees on an Education Leave are not permitted to use the tuition remission benefit while on the leave.

Graduate Taxation

Graduate Taxation for Spouse, Dependent Child, and Domestic Partner
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.

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. The amount of

taxes deducted from the employees' paycheck is based on the dollar value of tuition received and the employee's tax bracket when tuition value is added to paycheck. The value of tuition remission is treated as ordinary income per the Internal Revenue Service.

If a 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 programs. Note, this is not an exhaustive list and other programs or courses may be excluded:

- School of Law or School of Medicine
- Special programs including the Executive MBA, Working Professional MBA, (unless awarded a scholarship)
- UOnline courses
- 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

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 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.

METLAW LEGAL PLAN

MetLaw Legal Plan

What the Plan Can Do For You

MetLaw® was established to provide personal legal services for eligible Company employees, their spouses and dependent children. Hyatt Legal Plans, Inc. has been selected to provide for legal plan benefits. The services will be provided through a panel of carefully selected Participating Law Firms.

Office Consultation and Telephone Advice

This service provides the opportunity to discuss with an attorney any personal legal problems that are not specifically excluded. The Plan Attorney will explain the Participant's rights, point out his or her options and recommend a course of action. The Plan Attorney will identify any further coverage available under the Plan, and will undertake representation if the Participant so requests. If representation is covered by the Plan, the Participant will not be charged for the Plan Attorney's services. If representation is recommended, but is not covered by the Plan, the Plan Attorney will provide a written fee statement in advance. The Participant may choose whether to retain the Plan Attorney at his or her own expense, seek outside counsel, or do nothing. There are no restrictions on the number of times per year a Participant may use this service; however, for a non-covered matter, this service is not intended to provide the Participant with continuing access to a Plan Attorney in order to seek advice that would allow the Participant to undertake his or her own representation.

Consumer Protection

Consumer Protection Matters

This service covers the Participant as a plaintiff, for representation, including trial, in disputes over consumer goods and services where the amount being contested exceeds the small claims court limit in that jurisdiction and is documented in writing. This service does not include disputes over real estate, construction, insurance or collection activities after a judgment.

Small Claims Assistance

This service covers counseling the Participant on prosecuting a small claims action; helping the Participant prepare documents; advising the Participant on evidence, documentation and witnesses; and preparing the Participant for trial. The service does not include the Plan Attorney's attendance or representation at the small claims trial, collection activities after a judgment or any services relating to post-judgment actions.

Personal Property Protection

This service covers counseling the Participant over the phone or in the office on any personal property issue such as consumer credit reports, contracts for the purchase of personal property, consumer credit agreements or installment sales agreements. Counseling on pursuing or defending small claims actions is also included. The service also includes reviewing any personal legal documents and preparing promissory notes, affidavits and demand letters.

Debt Matters

Debt Collection Defense

This service provides Participants with an attorney's services for negotiation with creditors for a repayment schedule and to limit creditor harassment, and representation in defense of any action for personal debt collection, tax agency debt collection, foreclosure, repossession or garnishment, up to and including trial if necessary. It includes a motion to vacate a default judgment. It does not include counter, cross or third party claims; bankruptcy; any action arising out of family law matters,

including support and post-decree issues; or any matter where the creditor is affiliated with the Sponsor or Employer.

Identity Theft Defense
This service provides the Participant with consultations with an attorney regarding potential creditor actions resulting from identity theft and attorney services as needed to contact creditors, credit bureaus and financial institutions. It also provides defense services for specific creditor actions over disputed accounts. The defense services include limiting creditor harassment and representation in defense of any action that arises out of the identity theft such as foreclosure, repossession or garnishment, up to and including trial if necessary. The service also provides the Participant with online help and information about identity theft and prevention. It does not include counter, cross or third party claims; bankruptcy; any action arising out of family law matters, including support and post-decree issues; or any matter where the creditor is affiliated with the Sponsor or Employer

Personal Bankruptcy or Wage Earner Plan
This service covers the Employee and spouse in pre-bankruptcy planning, the preparation and filing of a personal bankruptcy or Wage Earner petition, and representation at all court hearings and trials. This service is not available if a creditor is affiliated with the Employer, even if the Employee or spouse chooses to reaffirm that specific debt.

Tax Audits
This service covers reviewing tax returns and answering questions the IRS or a state or local taxing authority has concerning the Participant's tax return; negotiating with the agency; advising the Participant on necessary documentation; and attending an IRS or a state or local taxing authority audit. The service does not include prosecuting a claim for the return of overpaid taxes or the preparation of any tax returns.

Defense of Civil Lawsuits

Administrative Hearing Representation
This service covers Participants in defense of civil proceedings before a municipal, county, state or federal administrative board, agency or commission. It includes the hearing before an administrative board or agency over an adverse governmental action. It does not apply where services are available or are being provided by virtue of an insurance policy. It does not include family law matters, post judgment matters or litigation of a job-related incident.

Civil Litigation Defense
This service covers the Participant in defense of arbitration proceeding or civil proceeding before a municipal, county, state or federal administrative board, agency or commission, or in a trial court of general jurisdiction. It does not apply where services are available or are being provided by virtue of an insurance policy. It does not include family law matters, post judgment matters, matters with criminal penalties or litigation of a job-related incident. Services do not include bringing counterclaims, third party or cross claims.

Incompetency Defense
This service covers the Participant in the defense of any incompetency action, including court hearings when there is a proceeding to find the Participant incompetent.

Document Preparation

Affidavits
This service covers preparation of any affidavit in which the Participant is the person making the statement

Deeds
This service covers the preparation of any deed for which the Participant is either the grantor or grantee.

Demand Letters
This service covers the preparation of letters that demand money, property or some other property interest of the Participant, except an interest that is an excluded service. It also covers mailing them to the addressee and forwarding and explaining any response to the Participant. Negotiations and representation in litigation are not included.

Mortgages
This service covers the preparation of any mortgage or deed of trust for which the Participant is the mortgagor. This service does not include documents pertaining to business, commercial or rental property.

Promissory Notes
This service covers the preparation of any promissory note for which the Participant is the payor or payee.

Document Review
This service covers the review of any personal legal document of the Participant, such as letters, leases or purchase agreements.

Elder Law Matters
This service covers counseling the Participant over the phone or in the office on any personal issues relating to the Participant's parents as they affect the Participant. The service includes reviewing documents of the parents to advise the Participant on the effect on the Participant. The documents include Medicare or Medicaid materials, prescription plans, leases, nursing home agreements, powers of attorney, living wills and wills. The service also includes preparing deeds involving the parents when the Participant is either the grantor or grantee; and preparing promissory notes involving the parents when the Participant is the payor or payee.

Family Law

Name Change
This service covers the Participant for all necessary pleadings and court hearings for a legal name change.

Prenuptial Agreement
This service covers representation of the Employee and includes the negotiation, preparation, review and execution of a prenuptial agreement between the Employee and his or her fiancé/partner prior to their marriage or legal union (where allowed by law), outlining how property is to be divided in the event of separation, divorce or death of a spouse. Representation is provided only to the Employee. The fiancé/partner must have separate counsel or must waive his/her right to representation. It does not include subsequent litigation arising out of a prenuptial agreement.

Protection from Domestic Violence
This service covers the Employee only, not the spouse or dependents, as the victim of domestic violence. It provides the Employee with representation to obtain a protective order, including all required paperwork and attendance at all court appearances. The service does not include representation in suits for damages, defense of any action, or representation for the offender.

Adoption and Legitimization (Contested and Uncontested)
This service covers all legal services and court work in a state or federal court for an adoption for the Plan Member and spouse. Legitimization of a child for the Plan Member and spouse, including reformation of a birth certificate, is also covered.

Uncontested Guardianship or Conservatorship
This service covers establishing an uncontested guardianship or conservatorship over a person and his or her estate when the Plan Member or spouse is appointed guardian or conservator. It includes obtaining a permanent and/or temporary guardianship or conservatorship, gathering any necessary medical evidence, preparing the paperwork, attending the hearing and preparing the initial accounting. If the proceeding becomes contested, the Plan Member or spouse must pay all additional legal fees. This service does not include representation of the person over whom guardianship or conservatorship is sought, or any annual accountings after the initial accounting or terminating the guardianship or conservatorship once it has been established.

Immigration

Immigration Assistance
This service covers advice and consultation, preparation
of affidavits and powers of attorney, review of any immigration documents and helping the Participant prepare for hearings.

Personal Injury

Personal Injury (25% Network Maximum)
Subject to applicable law and court rules, Plan Attorneys will handle personal injury matters (where the Participant is the plaintiff) at a maximum fee of 25% of the gross award. It is the Participant's responsibility to pay this fee and all costs.

Real Estate Matters

Boundary or Title Disputes (Primary Residence)
This service covers negotiations and litigation arising from boundary or real property title disputes involving a Participant's primary residence, where coverage is not available under the Participant's homeowner or title insurance policies.

Eviction and Tenant Problems (Primary Residence – Tenant Only)
This service covers the Participant as a tenant for matters involving leases, security deposits or disputes with a residential landlord. The service includes eviction defense, up to and including trial. It does not include representation in disputes with other tenants or as a plaintiff in a lawsuit against the landlord, including an action for return of a security deposit.

Security Deposit Assistance (Primary Residence – Tenant Only)
This service covers counseling the Participant as a tenant in recovering a security deposit from the Participant’s residential landlord for the Participant’s primary residence; reviewing the lease and other relevant documents; and preparing a demand letter to the landlord for the return of the deposit. It also covers assisting the Participant in prosecuting a small claims action; helping prepare documents; advising on evidence, documentation and witnesses; and preparing the Participant for the small claims trial. The service does not include the Plan Attorney’s attendance or representation at small claims trial, collection activities after a judgment or any services relating to post-judgment actions.

Home Equity Loans (Primary Residence)
This service covers the review or preparation of a home equity loan on the Participant’s primary residence.

Home Equity Loans (Second or Vacation Home)
This service covers the review or preparation of a home equity loan on the Participant's second or vacation home.

Property Tax Assessment (Primary Residence)
This service covers the Participant for review and advice on a property tax assessment on the Participant's primary residence. It also includes filing the paperwork; gathering the evidence; negotiating a settlement; and attending the hearing necessary to seek a reduction of the assessment.

Refinancing of Home (Primary Residence)
This service covers the review or preparation, by an attorney representing the Participant, of all relevant documents (including the mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in refinancing of or in obtaining a home equity loan on a Participant's primary residence. This benefit includes obtaining a permanent mortgage on a newly constructed home. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the refinancing of a second home, vacation property, rental property or property held for business or investment.

Refinancing of Home (Second or Vacation Home)
This service covers the review or preparation, by an attorney representing the Participant, of all relevant documents (including the refinance agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the refinancing of or obtaining a home equity loan on a Participant's second home or vacation home. The benefit also includes attendance of an attorney at closing. This benefit includes obtaining a permanent mortgage on a newly constructed home. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the refinancing of a second home, vacation property or property that is held for any rental, business, investment or income purpose

Sale or Purchase of Home (Primary Residence)
This service covers the review or preparation, by an attorney representing the Participant, of all relevant documents (including the construction documents for a new home, the purchase agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the purchase or sale of a Participant's primary residence or of a vacant property to be used for building a primary residence. The benefit also includes attendance of an attorney at closing. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the sale or purchase of a second home, vacation property, rental property, property held for business or investment or leases with an option to buy.

Sale or Purchase of Home (Second or Vacation Home)
This service covers the review or preparation, by an attorney representing the Participant, of all relevant documents (including the construction documents for a new second home or vacation home, the purchase agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the purchase or sale of a Participant's second home, vacation home or of a vacant property to be used for building a second home or vacation home. The benefit also includes attendance of an attorney at closing. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the sale or purchase of a second home or vacation home held for rental purpose, business, investment or income or leases with an option to buy.

Zoning Applications
This service provides the Participant with the services of a lawyer to help get a zoning change or variance for the Participant’s primary residence. Services include reviewing the law, reviewing the surveys, advising the Participant, preparing applications, and preparing for and attending the hearing to change zoning.

Traffic and Criminal Matters

Juvenile Court Defense
This service covers the defense of an Employee and Employee's dependent child in any juvenile court matter, provided there is no conflict of interest between the Employee and child. When a conflict exists, or where the court requires separate counsel for the child, this service provides an attorney for the Employee only including service for Parental Responsibility.

Traffic Ticket Defense (No DUI)
This service covers representation of the Participant in defense of any traffic ticket including traffic misdemeanor offenses, except driving under influence or vehicular homicide, including court hearings, negotiation with the prosecutor and trial.

Restoration of Driving Privileges
This service covers the Participant with representation in proceedings to restore the Participant's driving license.

Wills and Estate Planning

Trusts
This service covers the preparation of revocable and irrevocable living trusts for the Participant. It does not include tax planning or services associated with funding the trust after it is created.

Living Wills
This service covers the preparation of a living will for the Participant.

Powers of Attorney
This service covers the preparation of any power of attorney when the Participant is granting the power.

Probate (10% Network Discount)
Subject to applicable law and court rules, Plan Attorneys will handle probate matters at a fee 10% less than the Plan Attorney's normal fee. It is the Participant's responsibility to pay this reduced fee and all costs.

Wills and Codicils
This service covers the preparation of a simple or complex will for the Participant. The creation of any testamentary trust is covered. The benefit includes the preparation of codicils and will amendments. It does not include tax planning.

Exclusions

Excluded services are those legal services that are not provided under the plan. No services, not even a consultation, can be provided for the following matters:

- Employment-related matters, including company or statutory benefits
- Matters involving the company, MetLife and affiliates, and Plan Attorneys
- Matters in which there is a conflict of interest between the employee and spouse or dependents in which case services are excluded for the spouse and dependents
- Appeals and class actions
- Farm matters, business or investment matters, matters involving property held for investment or rental, or issues when the Participant is the landlord
- Patent, trademark and copyright matters
- Costs or fines - Frivolous or unethical matters
- Matters for which an attorney-client relationship exists prior to the Participant becoming eligible for plan benefits

Eligibility

To be eligible for legal services under The Legal Service Plan, you must have included the Plan in your benefits selection. You are eligible to enroll in the Plan for yourself and, for some cases, your eligible dependents. Eligible dependents include your lawful spouse and your unmarried child (or children) up to the age of 21 provided he or she depends on you for support.

Enrollment

During your employer's annual enrollment period, you can change or update your benefits selection. An eligible employee may choose to join or drop out of the Plan at that time. If you become an eligible employee after the annual enrollment period, you can elect to participate in the Legal Plan by completing your election form within 30 days of employment. The Plan has a minimum participation period of one year, and you must maintain the coverage for the entire year.

When Coverage Begins

Generally, plan coverage becomes effective on the date of the following:

- The first day of the month in which your employer has agreed to provide the Plan, (typically January 1), for the elections you made during the previous enrollment period; or
- If you were hired after an enrollment period, the first day of the month after you submitted a properly completed Enrollment Form.

When Coverage Ends

Your ability to receive legal services under the Plan ends if you are no longer an eligible employee or if you choose not to enroll during future annual enrollment periods.

If you cease to be eligible to participate in the plan or your employment with the Company ends, the Plan will cover the legal fees for those covered services that were opened and pending during the period you were enrolled in the plan. Of course, no new matters may be started after you become ineligible.

Amendment or Termination

While your employer expects to continue to offer participation in the Legal Service Plan, it reserves the right to amend, or terminate the Plan at any time. If the Plan is terminated, all covered services then in process will be handled to their conclusion under the Plan.

Administration and Funding

The Legal Service Plan is provided for and administered through a contract with Hyatt Legal Plans, Inc. Hyatt Legal Plans makes all determinations regarding attorneys' fees and what constitutes covered services. All contributions collected from employees electing this coverage are paid to Hyatt Legal Plans, Inc.

Cost of the Plan

You pay the cost of the Plan through after-tax payroll deductions, based on your enrollment choice.

Plan Confidentiality, Ethics and Independent Judgment

Your use of the Plan and the legal services is confidential. The Plan Attorney will maintain strict confidentiality of the traditional lawyer-client relationship. Your employer will know nothing about

your legal problems or the services you use under the Plan. Plan administrators will have access only to limited statistical information needed for orderly administration of the Plan.

No one will interfere with your Plan Attorney's independent exercise of professional judgment when representing you. All attorneys' services provided under the Plan are subject to ethical rules established by the courts for lawyers. The attorney will adhere to the rules of the Plan and he or she will not receive any further instructions, direction or interference from anyone else connected with the Plan. The attorney's obligations are exclusively to you. The attorney's relationship is exclusively with you. Hyatt Legal Plans, Inc., or the law firm providing services under the Plan is responsible for all services provided by their attorneys.

You should understand that the Plan has no liability for the conduct of any Plan Attorney. You have the right to file a complaint with the state bar concerning attorney conduct pursuant to the Plan. You have the right to retain at your own expense any attorney authorized to practice law in this state.

Plan attorneys will refuse to provide services if the matter is clearly without merit, frivolous or for the purpose of harassing another person. If you have a complaint about the legal services you have received or the conduct of an attorney, call Hyatt Legal Plans at **1-800-821-6400**. Your complaint will be reviewed and you will receive a response within two business days of your call.

You have the right to retain at your own expense any attorney authorized to practice law in the state. You have the right to file a complaint with the state bar concerning attorney conduct pursuant to the plan.

Other Special Rules

In addition to the coverage's and exclusions listed, there are certain rules for special situations. Please read this section carefully.

What if other coverage is available to you? If you are entitled to receive legal representation provided by any other organization such as an insurance company or a government agency, or if you are entitled to legal services under any other legal plan, coverage will not be provided under this Plan. However, if you are eligible for legal aid or Public Defender services, you will still be eligible for benefits under this Plan, so long as you meet the eligibility requirements.

What if you are involved in a legal dispute with your dependents? You may need legal help with a problem involving your spouse or your children. In some cases, both you and your child may need an attorney. If it would be improper for one attorney to represent both you and your dependent, only you will be entitled to representation by the plan attorney. Your dependent will not be covered under the Plan.

What if you are involved in a legal dispute with another employee? If you or your dependents are involved in a dispute with another eligible employee or that employee's dependents, Hyatt Legal Plans will arrange for legal representation with independent and separate counsel for both parties.

What if the court awards attorneys' fees as part of a settlement? If you are awarded attorneys' fees as a part of a court settlement, the Plan must be repaid from this award to the extent that it paid the fee for your attorney.

Denial of Benefits and Appeal Procedures

Denials of Eligibility

Hyatt verifies eligibility using information provided by **University of Miami Hospital**. When you call for services, you will be advised if you are ineligible and Hyatt Legal Plans will contact

University of Miami Hospital for assistance. If you are not satisfied with the final determination of eligibility, you have the right to a formal review and appeal. Send a letter within 60 days explaining why you believe you are eligible to:

University of Miami Hospital
Human Resources
1400 NW 12 Avenue
Suite 307
Miami, FL 33136

Within 30 days, you will be provided with a written explanation.

Denials of Coverage
If you are denied coverage by Hyatt Legal Plans or by any Plan Attorney, you may appeal by sending a letter to:

Hyatt Legal Plans, Inc.
Director of Administration
Eaton Center 1111 Superior Avenue
Cleveland, Ohio 44114-2507
(For Florida plans contact Hyatt Legal Plans of Florida, Inc. at the above address.)

The Director will issue Hyatt Legal Plans' final determination within 60 days of receiving your letter. This determination will include the reasons for the denial with reference to the specific Plan provisions on which the denial is based and a description of any additional information that might cause Hyatt Legal Plans to reconsider the decision, an explanation of the review procedure and notice of the right to bring a civil action under Section 502(a) of ERISA.

Your ERISA Rights

Congress enacted the Employee Retirement Income Security Act (ERISA) to safeguard your interests and those of your beneficiaries under your employee benefit plans. As a participant in the Hyatt Legal Plan, 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:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents, including collective bargaining agreements and copies of all documents filed by the Plan with U.S. Department of Labor; such as detailed annual reports and Plan descriptions;
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies;
- Receive a summary of the Plan's annual financial report from the Plan Administrator who is required by law to furnish this to you.

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 welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and consider your claim. Under ERISA, there are steps you can take to enforce the above rights. If you request materials 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 that is denied or ignored, in whole or in part, you may file suit in a state or 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 lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous. If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or at 200 Constitution Avenue, NW, Washington, DC. 20210 or you can call the publications hotline of the Employee Benefits Security Administration.

ADDITIONAL INFORMATION

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:

HR-Benefits
1320 South Dixie Highway
Suite 100
Coral Gables, FL 33146
305-284-3004, option 1

Plan Administrator

The following committees of the University of Miami are the Plan Administrators under ERISA (the Employee Retirement Income Security Act of 1974):

RSP II: RSP II Committee

Each committee delegates benefit determinations and day-to-day plan operation to HR-Benefits. Benefit applications and appeals for denied claims may all be made to:

HR-Benefits
1320 South Dixie Highway
Suite 100
Coral Gables, Florida 33146
305-284-3004, option 1

Agent for Service of Legal Process

The registered agent to accept service of legal process for the University of Miami Hospital is:

Administrator for Risk Management
1320 South Dixie Highway
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.

Health Care (501)	University and employee contributions	June 1 – May 31	Welfare	Third Party Administrator
Disability Income (502)	University contributions	January 1 – December 31	Welfare	Insurer
Dental Care (503)	University and employee contributions	June 1 – May 31	Welfare	Insurer
Flexible Spending Account Plan (504)	Employee contributions	January 1 – December 31	Welfare	Third Party Administrator
Business Travel Accident (505)	University contributions	June 1 – May 31	Welfare	Insurer
Group Life Insurance and Accident (506)	University contributions	June 1 – May 31	Welfare	Third Party Administrator
Short Term Disability (508)	Employee contributions	June 1 – May 31	Welfare	Insurer
Supplemental Life Insurance (509)	Employee contributions	January 1 – December 31	Welfare	Insurer
Retirement Savings Plan II (006)	University contributions and voluntary employee contributions	June 1 – May 31	403(b) Defined Contribution	Third Party Administrator

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, Delta Dental and VSP. 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.

The 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 the Human Resources Office 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 Retirement Savings Plan II

- Leaving the University of Miami Hospital before earning a vested right to your plan benefit – but your beneficiary could receive a lifetime pension regardless of your service if you are an active plan participant at the time of death
- Failure to make timely and proper application for benefits, or to supply information, such as proof of age or death, as required by the Retirement 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, 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 2017, no more than $270,000 of annual compensation may be taken into account in determining your benefit. Also, in 2017, your annual benefit will be limited to the lesser of $215,000 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
- 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 Retirement Savings Plan II 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 of Miami Hospital, 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, option 1.

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 the Retirement Savings Plan II, 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 a traditional 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 of Miami Hospital's intent that the Employees' Retirement Savings Plan II 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 Benefits

The University of Miami Hospital pays annual premiums for all employees to a governmental insuring agency set up under ERISA. If the Retirement Savings Plan II 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, option 1, option 1 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

If you take an approved paid leave of absence (or are eligible for long-term disability), you will continue to participate in your retirement plan Retirement Savings Plan II as if you were an active employee for purposes of vesting and earning benefits or pay credits under the plan. 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, option 1.

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:

Breast Reconstruction Following Mastectomy Notice
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; and
- Prosthesis and treatment of physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

The group health plan must determine the manner of coverage in consultation with the attending physician and patient. Coverage for breast reconstruction and related services will be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

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.
- **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 prevail. .

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

Appeals Procedures

Claims Procedures and Sample Form

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:

Claims Review Chart: *Effective [January 1, 2003]*		
Type of Claim	Steps to Take	
Urgent Health Care Claim		
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.	**Step 1:**	The Plan will respond as soon as possible but no later than **72 hours** after receiving your initial claim to approve or deny the claim.
	Step 2:	If denied, you have **180 days** after receiving the claim denial to appeal the Plan's decision.
	Step 3:	The Plan will respond as soon as possible but not than **72 hours** after receiving your appeal to notify you of its appeal decision.
	IF YOUR CLAIM IS IMPROPER OR INCOMPLETE	
	Step 1:	The Plan has **24 hours** after receiving your initial claim to notify you that your claim is improper or incomplete.
	Step 2:	You have **48 hours** after receiving notice from the Plan to correct or complete your claim.
	Step 3:	The Plan has **48 hours** to notify you if your claim is approved or denied. The Plan must do so within the earlier of 48 hours of: Receiving your completed claim, or Your deadline to complete the claim.
	Step 4:	If denied, you have **180 days** after receiving the claim denial to appeal the Plan's decision.
Pre-Service Health Claim		
Group health claims where treatment must be pre-certified before it is performed.	**Step 1:**	The Plan has **15 days** after receiving your initial claim to notify you if your claim is approved or denied.
	Step 2:	You have **180 days** after receiving the claim denial to appeal the Plan's decision.

Claims Review Chart: *Effective [January 1, 2003]*		
Type of Claim	Steps to Take	
	Step 3:	The Plan has **30 days** after receiving your appeal to notify you of the appeal decision. If the Plan allows two levels of appeal, it has **15 days** after receiving your appeal to notify you of its decision. Both levels of appeal must be completed within the 30-day deadline.
	IF YOUR CLAIM IS IMPROPER OR INCOMPLETE	
	Step 1:	The Plan has **5 days** after receiving your initial claim to notify you that your claim is an improper claim.
	Step 2:	The Plan has **15 days** 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 30 days after receiving the claim to notify you of its decision. (The time the plan waits for claimant information is not counted in totals.)
	Step 3:	You have **45 days** after receiving the extension notice to provide additional information or complete the claim.
	Step 4:	If your claim is denied, you have **180 days** after receiving the claim denial to appeal the Plan's decision.
	Step 5:	The Plan has **30 days** after receiving your appeal (**15 days** 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.
Post-Service Health Claim		
Group health claims where you request reimbursement after treatment has been performed.	**Step 1:**	The Plan has **30 days** after receiving your initial claim to notify you if your claim is denied.
	Step 2:	If your claim is denied, you have **180 days** after receiving the claim denial to appeal the Plan's decision.
	Step 3:	The Plan has **60 days** after receiving your appeal (**30 days** 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.
	IF THE PLAN NEEDS FURTHER INFORMATION OR AN EXTENSION	
	Step 1:	The Plan has **30 days** after receiving the initial claim to notify you if your claim is denied. If the Plan needs more information and provides an extension notice during the initial 30-day period, the Plan has **45 days** after receiving the claim to notify you if your claim is denied. (The time the plan waits for claimant information is not counted in totals.)
	Step 2:	You have **45 days** after receiving the extension notice to provide additional information or complete your claim.

Claims Review Chart: *Effective [January 1, 2003]*		
Type of Claim	Steps to Take	
	Step 3:	If your claim is denied, you have **180 days** after receiving the claim denial to appeal the Plan's decision.
	Step 4:	The Plan has **60 days** after receiving your appeal (**30 days** 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.

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);
- 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);
- 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:
- 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 you 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 federal law; 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 based on medical necessity, 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 is 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.
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.

MEDICAL 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
   P.O. Box 14463
   Lexington, KY 40512

C. The Claims Review Department

SECTION II

A. The Claims Department

SECTION III
B. Aetna
Attn: National Account CRT
P.O. Box 14463
Lexington, KY 40512

PHARMACY PLAN – OPTUMRX

Prescription Drug Benefit Claims

If you receive covered health services from a network pharmacy, the pharmacy plan pays network pharmacies directly for your covered health services. If a network pharmacy bills you for any covered health service, contact OptumRx. However, you are responsible for meeting any applicable deductible and for paying any required copayments and coinsurance to a network pharmacy at the time of service, or when you receive a bill from the network pharmacy.

Prescription Drug Products which Require Prior Authorization

In most cases, network providers are responsible for obtaining prior authorization from OptumRx before they provide these services to you. Contacting OptumRx is easy. Simply call the number on your ID card.

If You Receive Prescription Drug Products from a Non-Network Pharmacy

When you receive prescription drug products from a non-network pharmacy, you are responsible for requesting payment from the pharmacy plan. You must file the claim in a format that contains all of the information required, as described below.

You should submit a request for payment of benefits within 90 days after the date of service. If you don't provide this information within one year of the date of service, Benefits for that health service will be denied or reduced, in OptumRx's discretion. This time limit does not apply if you are legally incapacitated.

Required Information

When you request payment of benefits from the pharmacy plan, you must provide OptumRx with all of the following information:

1. The participant's name and address.
2. The patient's name and age.
3. The number stated on your ID card.
4. The name and address of the provider of the service(s).
5. The name and address of the Pharmacy.
6. An itemized bill from your provider that includes the following:
    - Pharmacy name and address.
    - Date of service.
    - Physician name or ID number.
    - NDC number (drug number).
    - Name of drug and strength.
    - Quantity and days' supply.
    - Prescription number.
    - Dispense-as-written instructions.
    - Amount paid.
    - The date the injury or sickness began.

A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with your claim to OptumRx, at the following address:

OptumRx, Inc.
P.O. Box 29044
Hot Springs, Arkansas 71903

DENTAL INSURANCE - CIGNA DENTAL CARE (DHMO)

SECTION I

A. Member Services Department
   1. Reason member feels claim should be paid.
   2. Any supporting Documents

B. CIGNA Dental Appeals
   P.O. BOX 188047
   Chattanooga, Tennessee 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, Georgia 30009

C. Delta Dental Insurance Company

SECTION II

A. Delta Dental Insurance Company within 30 days unless extension needed.

CONCORDIA BEHAVIORAL HEALTH

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
   Special Employee Benefits Liaison
   10685 North Kendall Drive
   Miami, Florida 33176

C. The Claims Review Department

SECTION II
A. The Claims Department

SECTION III
A. Concordia Behavioral Health
Special Employee Benefits Liaison
10685 North Kendall Drive
Miami, Florida 33176

VOLUNTARY EXCESS LIFE – CIGNA

SECTION I
A. University of Miami Hospital HR-Benefits
1. Certified Death Certificate
2. Beneficiary Designations
3. Enrollment Forms
4. Signed Claimant and Employer Statements

B. CIGNA Group Insurance
Pittsburgh Claims Office
1600 West Carson Street
Suite 300
Pittsburgh, Pennsylvania 15219

C. A CIGNA Case Manager

SECTION II
A. CIGNA Case Manager

SECTION III
B. CIGNA Group Insurance
Pittsburgh Claims Office
1600 West Carson Street
Suite 300
Pittsburgh, Pennsylvania 15219

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE – CIGNA

SECTION I
A. University of Miami Hospital 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. CIGNA Group Insurance
Pittsburgh Claims Office
1600 West Carson Street
Suite 300
Pittsburgh, Pennsylvania 15219

C. A CIGNA Case Manager

SECTION II
A. A CIGNA Case Manager

SECTION III

A. CIGNA Group Insurance
Pittsburgh Claims Office
1600 West Carson Street
Suite 300
Pittsburgh, Pennsylvania 15219

LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT - CIGNA

SECTION I

A. University of Miami Hospital HR-Benefits
   1. Certified Death Certificate
   2. Beneficiary Designations
   3. Enrollment Forms
   4. Signed Claimant and Employer Statements

B. CIGNA Group Insurance
Pittsburgh Claims Office
1600 West Carson Street
Suite 300
Pittsburgh, Pennsylvania 15219

C. A CIGNA Case Manager

SECTION II

A. A CIGNA Case Manager

SECTION III

B. CIGNA Group Insurance
Pittsburgh Claims Office
1600 West Carson Street
Suite 300
Pittsburgh, Pennsylvania 15219

LONG TERM DISABILITY INSURANCE – CIGNA

SECTION I

A. University of Miami Hospital HR-Benefits
   1. Initial claim form (or call 1-800-362-4462.
   2. Attending Physician's Statement

B. CIGNA Group Insurance
Paper Intake Team
12225 Greenville Avenue
Suite 100
Dallas, Texas 75243

C. A CIGNA Case Manager

SECTION II

A. CIGNA

SECTION III

A. CIGNA Group Insurance
   Paper Intake Team
   12225 Greenville Avenue
   Suite 100
   Dallas, Texas 75243

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
   P.O. Box 9064
   Portland, Maine 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
   P.O. Box 991
   Mequon, Wisconsin 53092

C. UMH HR-Benefits

SECTION II

A. UMH HR-Benefits

SECTION III

A. University of Miami
   HR-Benefits
   P.O. Box 248106
   Coral Gables, Florida 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:
  - Was relied upon in making the benefit determination
  - 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
  - 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.

Discrimination is Against the Law

The University of Miami complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The University does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The University of Miami:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact **Workplace Equity and Performance** at wep@miami.edu or 305-284-3064.

If you believe that the University has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, by fax, or by email with:

University of Miami
Workplace Equity and Performance
1320 South Dixie Highway
Suite 100R
Coral Gables, Florida 33146
Email: wep@miami.edu
Fax: 305-284-6211

If you need help filing a grievance, Workplace Equity and Performance is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1–800–868–1019, 800–537–7697 (TDD). Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-305-284-3064.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-305-284-3064.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-305-284-3064.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-305-284-3064.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-305-284-3064

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-305-284-3064.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-305-284-3064.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-305-284-3064.

ملحوظة: إذا تـنكـ تتحدث اذكر ،اللغة فإن خدمات المساعدة اللغوية تتوافر لكلـ بالمجان. اتصل مقربـ (رقم 3064 - 284 - 305 - 1)
x هاتف الصم والبكم:

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-305-284-3064.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-305-284-3064.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-305-2843064 번으로 전화해 주십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-305-284-3064.

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เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-305-284-3064.