2023 SUMMARY PLAN DESCRIPTION

UNIVERSITY OF MIAMI FACULTY AND STAFF*

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This contains only a summary of plan benefits for faculty and staff under the eligibility companies UNIV, MSOM, UHCorp,* UMHC,* or ABLEH.*

The University of Miami reserves the right, at its discretion, to amend, revise, or terminate any benefit program at any time.

** Hired prior to December 16, 2019*

HEALTH CARE INSURANCE

Foreign Language Statement

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

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

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 five plan options cover the same medical services but differ primarily in the design of their provider networks and out of pocket expense options.

You are eligible to join the University of Miami health care plans if you are a regular full-time or part-time faculty, staff or members of affiliates working at least 50% full-time effort. Coverage will begin on your date of hire. Faculty members who are members of the Associated Faculty (visiting and voluntary faculty) without the title of lecturer and temporary employees are not eligible.

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 employees permanently residing outside of Miami-Dade or Broward counties are eligible to elect the HRA Out of Area plan, and only BPEI Naples employees are eligible for the Select 2 Naples plan. Eligibility is determined by HR-Total Rewards. Election for these plans may only be made upon first enrollment into the health plan or during Open Enrollment.

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

Dependent Coverage

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

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

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

iv. the child receives less than 50% of his/her support from the subscriber and the subscriber is no longer obligated to provide medical care for said child by court order.

3. Coverage will be extended where the subscriber has agreed to regularly provide medical care for the child by court order regardless of adoption.
4. Coverage will be extended where a Qualified Medical Child Support Order (QMSCO) exists; Whether or not said child resides with the employee.
5. A newborn child of a covered dependent child is ineligible for medical coverage after delivery

- Your legally recognized spouse.

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. A smoker is defined as having used tobacco products within the past 12 months. 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. If it is medically unadvisable for the employee to complete the smoking-cessation program or to quit smoking, please contact HR-Total Rewards to request an alternative to have the surcharge waived.

A $350 monthly spousal surcharge will apply to spouses 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 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 becomes eligible for or loses coverage during the plan year, HR-Total Rewards 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 State Children's Health Insurance Program (SCHIP) or new enrollment in Medicaid or other SCHIP
- Change in employment status of employee, spouse, or dependent that affects insurance coverage 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-Total Rewards via Workday and requesting the corresponding change to benefits.

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

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 or child who no longer qualifies for coverage, you are required to notify HR-Total Rewards via Workday within 30 days of the event in order to remove the individual from coverage.

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

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 protected 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.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, 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, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. Contact your state for more information on eligibility.

ALABAMA Medicaid	**ALASKA Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS Medicaid	**CALIFORNIA Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA Medicaid	**INDIANA Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health- insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization- act-2009-chipra Phone: (678) 564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA Medicaid and CHIP (Hawki)	**KANSAS Medicaid**

Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid- a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012
KENTUCKY Medicaid	**LOUISIANA Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE Medicaid	**MASSACHUSETTS Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=e n_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
MINNESOTA Medicaid	**MISSOURI Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and- services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA Medicaid	**NEBRASKA Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA Medicaid	**NEW HAMPSHIRE Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY Medicaid and CHIP	**NEW YORK Medicaid**

Medicaid Website: http://www.state.nj.us/humanservices / dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA Medicaid	**NORTH DAKOTA Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

OKLAHOMA Medicaid and CHIP	**OREGON Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA Medicaid and CHIP	**RHODE ISLAND Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/ HIPP- Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA Medicaid	**SOUTH DAKOTA Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS Medicaid	**UTAH Medicaid and CHIP**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT Medicaid	**VIRGINIA Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON Medicaid	**WEST VIRGINIA Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN Medicaid and CHIP	**WYOMING Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and- eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137 (expires 1/31/2026).

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 the above periods.

No Surprise Act

The No Surprise Act was effective January 1, 2022. The following changes have been made to the emergency services benefit.

For those plans that use a network of providers, the following Emergency services benefit replaces the current Emergency services benefit now appearing in this booklet.

Emergency Services
When you experience an emergency medical condition, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and ambulance help.

Your coverage for emergency services will continue until your condition is stabilized and:

Your attending physician determines that you are medically able to travel or to be transported, by non-medical or non-emergency medical transportation, to another provider if you need more care
You are in a condition to be able to receive from the out-of-network provider delivering services the notice and consent criteria with respect to the services
Your out-of-network provider delivering the services meets the notice and consent criteria with respect to the services.

If your physician decides you need to stay in the hospital (emergency admission) or receive follow-up care, these are not emergency services. Different benefits and requirements apply. Please refer to the How your plan works – Medical necessity and precertification requirements section and the Coverage and exclusions section that fits your situation (for example, Hospital care or Physician services). You can also contact us or your network physician or primary care physician (PCP).

Non-Emergency Services
If you go to an emergency room for what is not an emergency medical condition, the plan may not cover your expenses. See the schedule of benefits for more information.

For those plans that use a network of providers, the following is added to the Emergency Services Important Note now appearing in your Schedule of Benefits.

In the case of a surprise bill from an out-of-network provider, where you had no control of their participation in your covered services, you will pay the same cost share you would have if the covered services were received from a network provider. The cost share will be based on the median contracted rate. Contact us immediately if you receive such a bill.

For those plans that provide out-of-network coverage, the following information on involuntary services revises the involuntary services information now appearing in the Recognized charge section of your booklet.

The out-of-network plan rate does not apply to involuntary services. Involuntary services are services or supplies that are one of the following:
Performed at a network facility by certain **out-of-network providers**
Not available from a **network provider**
Emergency services

We will calculate your cost share for involuntary services in the same way as we would if you received the services from a **network provider**. If you receive a surprise bill, your cost share will be calculated at the median contracted rate.

Important Note:
In the case of a surprise bill from an out-of-network provider, where you had no control of their participation in your **covered services,** you will pay the same cost share you would have if the **covered services** were received from a **network provider.** The cost share will be based on the median contracted rate. Contact us immediately if you receive such a bill.

For those plans that use a network of providers, the following sentence has been removed from the **Keeping a provider you go to now (continuity of care)** section of your booklet.

We will authorize coverage only if the **provider** agrees to our usual terms and conditions for contracting **providers**.

Women's Health and Cancer Rights

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") requires that health plans offering medical and surgical benefits in connection with a mastectomy also provide coverage in a manner determined in consultation with the attending physician and the patient for (1) all stages of reconstruction of the breast on which the mastectomy was performed; (2) surgery and reconstruction of the other breast to provide symmetrical appearance; (3) prostheses; and (4) treatment of physical complications of the mastectomy, including lymphedema. Where this law applies, these benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the applicable Component Benefit Plan identified. Contact HR-Total Rewards at 305-284-3004 for more information.

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.

Copayment (Copay)
The fixed dollar amount you pay for in-network provider services or medical supplies.

Deductible
The dollar amount you must pay for covered health care services before your insurance plan starts to pay. 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 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.

For detailed information regarding coordination of benefits, contact HR-Total Rewards at 305-284-3004 or visit aetna.com.

Hospital Services Covered

The following benefits are available under the plans. This is a summary only and not intended as a complete description of covered services:

- 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

These benefits may require preauthorization, please contact Aetna for details 1-800-824-6411 or visit aetna.com

Other Covered Benefits

This is a summary only and not intended as a complete description of covered services. 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 and 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 (covered at UHealth, employee coverage only)
- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet
- Transgender services including hormone therapy, gender confirmation surgery and psychological support services (psychological services covered under Behavioral Health benefits).

- Fertility services (medical coverage up to $9,000 per lifetime at UHealth, Rx coverage up to $5,000 per lifetime)

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/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

For detailed information regarding health care benefits not covered under your health plan, please contact Aetna 1-800-824-6411 or visit aetna.com.

Medical Necessity

Your plan pays for its share of the expense for eligible health services only if the general requirements are met. They are:

- The eligible health service is medically necessary.
- You or your provider precertifies the eligible health service when required.

Medically necessary health care services are ones that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease
- Not primarily for the convenience of the patient, physician, or other health care provider
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease

Generally accepted standards of medical practice means:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community.
- Consistent with the standards set forth in policy issues involving clinical judgment.

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 in-network services considered preventive and therefore covered at 100% under the Patient Protection and Affordable Care Act are covered as such under all medical plans. For a complete list, please visit healthcare.gov/coverage/preventive-care-benefits.

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:

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 International SOS 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 an employee covered by the University of Miami health plan
    b. The patient is a former employee on UM/Aetna COBRA/Retiree coverage.
2. Provider requirement
    a. Surgical procedure is performed at UHealth Tower 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, 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 aged 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 Medical Plans

There are five health plan options available within the University of Miami Group Health Plan: two HMO-type plans, a Select 2 option for BPEI Naples employees, 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 benefits.miami.edu.

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 UHealth physicians and facilities, your costs may be lower.

Service	UHealth Providers	Select Open Access
DEDUCTIBLE (maximum of three deductibles per family):		
	$200 per person	
PRIMARY CARE (PCP):		
Office Visit	Deductible, then $15 copay	Deductible, then $20 copay
SPECIALTY CARE (SPEC):		
Office Visit	Deductible, then $20 copay	Deductible, then $55 copay
Mental and Behavioral Health	$20 copay	$20 copay
MATERNITY CARE:		
First OB Prenatal Visit	Deductible, then $20 copay	Deductible, then $55 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 $150/day x five days per admission	Deductible, then $250/day x five days per admission
Inpatient Mental Health	$100/day, maximum of $500 per admission	$100/day, maximum of $500 per admission
EMERGENCY SERVICES:		
Emergency Room (waived if admitted)	Deductible, then $200 copay	Deductible, then $200 copay
Urgent Care Facility	Deductible, then $100 copay	Deductible, then $100 copay
OUTPATIENT SURGERY:		
Facility	Deductible, then $100 copay	Deductible, then $150 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 $15 copay	Deductible, then $20 copay
OUTPATIENT CHEMOTHERAPY AND RADIATION:		
	Deductible, then $0 copay	Deductible, then $40 copay

** This is a summary only and not intended as a complete description of covered services.*
*** Continued care authorization required for additional visits after initial assessment and 24 follow-up visits.*

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 UHealth physicians and facilities, your costs may be lower.

Service	UHealth Providers	Select Open Access
DEDUCTIBLE (maximum of three deductibles per family):		
	$300 per person	
PRIMARY CARE (PCP):		
Office Visit	Deductible, then $20 copay	Deductible, then $25 copay
SPECIALTY CARE (SPEC):		
Office Visit	Deductible, then $30 copay	Deductible, then $65 copay
Mental and Behavioral Health	$20 copay	$20 copay
MATERNITY CARE:		
First OB Prenatal Visit	Deductible, then $30 copay	Deductible, then $65 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 five days per admission	Deductible, then $300/day x five days per admission
Inpatient Mental Health	$100/day, maximum of $500 per admission	$100/day maximum, of $500 per admission
EMERGENCY SERVICES:		
Emergency Room (waived if admitted)	Deductible, then $250 copay	Deductible, then $250 copay
Urgent Care Facility	Deductible, then $100 copay	Deductible, then $100 copay
OUTPATIENT SURGERY:		
Facility	Deductible, then $150 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 $50 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 $40 copay

** This is a summary only and not intended as a complete description of covered services.*
*** Continued care authorization required for additional visits after initial assessment and 24 follow-up visits.*

Aetna Select 2 Naples*

This option allows BPEI Naples employees and 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.

Service	Select Open Access
DEDUCTIBLE (maximum of three deductibles per family):	
	$300 per person
PRIMARY CARE (PCP):	
Office Visit	Deductible, then $20 copay
SPECIALTY CARE (SPEC):	
Office Visit	Deductible, then $30 copay
Mental and Behavioral Health	$20 copay
MATERNITY CARE:	
First OB Prenatal Visit	Deductible, then $30 copay
All Other Prenatal Visits	Deductible, then $0 copay
Hospital Inpatient	(refer to hospital services below)
HOSPITAL SERVICES:	
Facility	Deductible, then $200/day x five days per admission
Inpatient Mental Health	$100/day, maximum of $500 per admission
EMERGENCY SERVICES:	
Emergency Room (waived if admitted)	Deductible, then $250 copay
Urgent Care Facility	Deductible, then $100 copay
OUTPATIENT SURGERY:	
Facility	Deductible, then $150 copay
Physician	Deductible, then $0 copay
OUTPATIENT DIAGNOSTIC HIGH END (including MRI, MRA, CT, PET):	
	Deductible, then $150 copay
OUTPATIENT DIAGNOSTIC LOW END:	
	Deductible, then $0 copay
PHYSICAL, SPEECH AND OCCUPATIONAL THERAPY SERVICES:**	
	Deductible, then $20 copay
OUTPATIENT CHEMOTHERAPY AND RADIATION:	
	Deductible, then $0 copay

** This is a summary only and not intended as a complete description of covered services.*
*** Continued care authorization required for additional visits after initial assessment and 24 follow-up visits.*

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 UHealth physicians and facilities, your costs may be lower. Members in this plan receive a HealthEquity/WageWorks HRA fund of $400 per individual (maximum of $1,200 per family) to help offset the deductible.

Service	UM Providers	CPII Open Access	Out of Network **
DEDUCTIBLE (maximum of three deductibles per family):			
	$1,500 per person		$3,000 per person
PRIMARY CARE (PCP):			
Office Visit	Deductible, then $15 copay	Deductible, then $20 copay	Deductible, then 30% coinsurance
SPECIALTY CARE (SPEC):			
Office Visit	Deductible, then $20 copay	Deductible, then $55 copay	Deductible, then 30% coinsurance
Mental and Behavioral Health	$20 copay	$20 copay	30% coinsurance
MATERNITY CARE:			
First OB Prenatal Visit	Deductible, then $20 copay	Deductible, then $55 copay	Deductible, then 30% coinsurance
All Other Prenatal Visits	Deductible, then $0 copay	Deductible, then $0 copay	Deductible, then 30% coinsurance
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 five days per admission	Deductible, then $200/day x five days per admission	Deductible, then 30% coinsurance
Inpatient Mental Health	$100/day, maximum of $500 per admission	$100/day, maximum of $500 per admission	30% coinsurance
Physician	Deductible, then $0 copay	Deductible, then $0 copay	Deductible, then 30% coinsurance
EMERGENCY SERVICES:			
Emergency Room (waived if admitted)	Deductible, then $250 copay	Deductible, then $250 copay	Deductible, then $250 copay
Urgent Care Facility	Deductible, then $100 copay	Deductible, then $100 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 $100 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 $40 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.*

**** Continued care authorization required for additional visits after initial assessment and 24 follow-up visits.*

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-Total Rewards. 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 HealthEquity/WageWorks HRA fund Visa of $400 per individual (maximum of $1,200 per family) to help offset the deductible.

Service	CPII Open Access	Out of Network **
DEDUCTIBLE (maximum of three deductibles per family):		
	$1,500 per person	$3,000 per person
PRIMARY CARE (PCP):		
Office Visit	Deductible, then $15 copay	Deductible, then 30% coinsurance
SPECIALTY CARE (SPEC):		
Office Visit	Deductible, then $20 copay	Deductible, then 30% coinsurance
Mental and Behavioral Health	$20 copay	30% coinsurance
MATERNITY CARE:		
First OB Prenatal Visit	Deductible, then $20 copay	Deductible, then 30% coinsurance
All Other Prenatal Visits	Deductible, then $0 copay	Deductible, then 30% coinsurance
Hospital Inpatient	(refer to hospital services below)	(refer to hospital services below)
HOSPITAL SERVICES:		
Facility	Deductible, then $100/day x five days per admission	Deductible, then 30% coinsurance
Inpatient Mental Health	$100/day, maximum of $500 per admission	30% coinsurance
EMERGENCY SERVICES:		
Emergency Room (waived if admitted)	Deductible, then $250 copay	Deductible, then $250 copay
Urgent Care Facility	Deductible, then $100 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	Deductible, then 30% coinsurance
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.*
**** Continued care authorization required for additional visits after initial assessment and 24 follow-up visits.*

Pharmacy Plan Administered by Aetna

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

Tier	Cost	Description
Tier 1	$10	Covered preferred generic medications (not self-injectable).
Tier 2	$45	Covered preferred brand name medications (not self-injectable).
Tier 3	$75	Covered non-preferred generic and brand-name medications (not self-injectable).
Tier 4	$100	Preferred and non-preferred self-injectable drugs covered by prescription benefits. Insulin is covered under Tiers 1, 2, and 3 (tier depends on type).

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 log in to your Aetna account, 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 CVS Caremark mail service to obtain a three-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 network pharmacy, including Walgreens, and obtain a three-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/Aetna 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 Aetna to let them know and you may be able to use the more expensive medication at its regular copay.

If you use the more expensive prescription without first trying one of the lower cost alternatives, you will be required to pay the full cost of the medication.

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

PrudentRx Copay Program for Specialty Medications

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications - in particular, specialty medications. The PrudentRx Copay Program will assist members in obtaining copay assistance from drug manufacturers to reduce a member's cost share for eligible specialty medications thereby reducing out-of-pocket expenses.

If you or a covered family member are currently taking a specialty medication or may start a new specialty medication, you can reach out to PrudentRx at 1-800-578-4403 to inquire about the program.

HealthEquity/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 $400 fund per person (max $1,200 per family) to help you pay for medical and pharmacy expenses. The fund is Visa accessible through a HealthEquity/WageWorks HRA account on the effective date of coverage. 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 Aetna 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 and there is no annual maximum rollover. For those enrolled in both HRA and Health Care FSA, expenses eligible under both HRA and FSA are deducted from the HRA first. Expenses which are eligible under FSA only are deducted from FSA first at any time during the year.

Using Your HealthEquity/WageWorks HRA Fund Visa Card

You will receive a HealthEquity/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 Health Equity/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, HealthEquity/WageWorks will not be able to automatically substantiate your claim. Therefore, you may be asked to submit receipts.

Once your HRA funds are depleted /HealthEquity/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 HealthEquity/WageWorks Visa card since HRA funds will be applied each January 1st.

If a dependent leaves the plan during the year but other family members remain on the same subscriber's coverage, the funds assigned to that dependent may be recovered by the plan if not used.

If your UM/Aetna HRA coverage ends, your HealthEquity/WageWorks HRA Fund Visa Card will stop working. You can submit HRA eligible claims through the last day of the month in which you are covered under the UM/Aetna HRA medical plan. You will need to submit claims directly to HealthEquity as your Visa would be closed. You can choose to continue your UM/Aetna HRA coverage through COBRA which will allow you to access your HRA funds after active medical coverage has ended with UM. A HealthEquity/WageWorks Visa card will not be issued if you continue your coverage through COBRA. Claims will have to be submitted to HealthEquity and reimbursed using your HRA funds

For more information, review the HealthEquity/WageWorks HRA QuickStart Guide at benefits.miami.edu.

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 & Select 2 Naples	Aetna Choice POSII HRA	Aetna Choice POSII HRA Out of Area
Individual	$200	$300	$1,500	$1,500
Employee+1	$400	$600	$3,000	$3,000
Family	$600	$900	$4,500	$4,500

Deductibles (Non-Participating Providers)

	Aetna Select 1	Aetna Select 2 & SELECT 2 NAPLES	Aetna Choice POSII HRA	Aetna Choice POSII HRA Out of area
Individual	N/A	N/A	$3,000	$3,000
Employee+1	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, behavioral health copayments, and prescription drug copayments count towards the out of pocket maximum in all plans. 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 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 & SELECT 2 NAPLES	Aetna Choice POSII HRA	Aetna Choice POSII HRA out of area
Individual	$3,000	$4,000	$4,000	$4,000
Employee+1	$6,000	$8,000	$8,000	$8,000
Family	$9,000	$12,000	$12,000	$12,000

	Aetna Select 1	Aetna Select 2 & SELECT 2 NAPLES	Aetna Choice POSII HRA	Aetna Choice POSII HRA out of area
Individual	N/A	N/A	$8,000	$8,000
Employee+1	N/A	N/A	$16,000	$16,000
Family	N/A	N/A	$24,000	$24,000

Out of Pocket Maximums (Non-Participating Providers)

Mental and Behavioral Health

For calendar year 2023, the University of Miami medical plan has designated Aetna as its primary behavioral health administrator and Carisk Behavioral Health (Carisk) as a secondary administrator, as part of a pilot program designed to improve access to mental and behavioral health services for employees and their dependents.

Aetna and Carisk manage 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. Note that individual and group outpatient therapy may be accessed without authorization until the 25th visit (initial visit plus 24 follow up visits), at which time a continued care authorization must be obtained.
Members are required to contact Aetna for their services. If a specialized service or provider is not available through the Aetna network, the member may be referred to Carisk for additional assistance.

Please contact Aetna at 1-800-824-6411, prior to accessing services to confirm network status of the provider you wish to see. If a referral is needed, you will be directed to contact Carisk for other options. For approved services provided by a non-network provider, you will need to submit a claim for reimbursement within 12 months of the date of service.

Aetna Mental Health services cover a variety of issues including:

- Depression
- Anxiety
- Panic
- Childhood behavioral disorders
- Drug problems
- Compulsive disorders
- Stress
- Eating Disorders
- Alcohol problems
- Schizophrenia

		Aetna Select 1 & 2 Select 2 Naples	Aetna Choice POSII HRA and Out of Area HRA	
Type of Service	**Requirements**	**In-Network Provider Copays**	**In-Network Provider Copays**	**Out-of-Network Providers *Pre-Authorization Required***
Outpatient Individual, Group and Family Counseling	Continued care authorization required for additional visits after initial assessment and 24 follow-	$20/visit	$20/visit	30% coinsurance
Outpatient Psychiatric/Med management Services	Continued care authorization required for additional visits after initial assessment and 24 follow-	$20/visit	$20/visit	30% coinsurance
Applied Behavioral Analysis (ABA) – for members 22 years of 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
Inpatient Psychiatric Admission (24-hour Emergency)	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 (Hospital Medical Floor)	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 Behavioral Health services.

Autism and other Pervasive Developmental Disorders

The services that will be eligible for coverage will include applied behavioral analysis (ABA). 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 used to be diagnosed separately. These include:

- Autistic disorder
- Asperger's syndrome
- 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 2018, the Centers for Disease Control and Prevention estimate that 1 in 59 children are affected by this disorder. The latest reports are estimating that the prevalence is higher. Autism affects boys almost four 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 Aetna.

Authorization from Aetna must be obtained prior to the UM ASAC initial assessment.

University of Miami Autism Coverage

An outline of the University's autism coverage is listed below. Medical copayments and deductibles apply according to plan. Benefits are based on medical necessity and are only for enrollees in a UM/Aetna plan.

If you visit the University of Miami Center for Autism and Related Disabilities (CARD) for your initial assessment, coverage is available through the Special Employee Benefits noted at the right.

Authorization from Aetna must be obtained prior to the University of Miami Autism Spectrum Assessment Clinic (ASAC) initial assessment.

Aetna Benefits	**Special Employee Benefits for Rehabilitation**
• Habilitative Speech, Occupational and Physical Therapy • Neurological Evaluation • Applied Behavioral Analysis (ABA) – Prior authorization required. • For the Aetna Select 1 & 2 Plans, members are required to use Aetna Providers. • For the HRA Plan, members are encouraged to use Aetna providers. • Members will be responsible for the member cost share for both in and out of network providers according to plan.	• Coverage for evaluation by Psychiatrist and/or Psychologist, including assessment by ASAC. • Coverage of other non-experimental, peer reviewed interventions will be considered and reviewed for medical necessity Claims are paid on a reimbursement basis. Aetna network usage is not required. Claims should be submitted to: Aetna P.O. Box 981106 El Paso, TX 79998-1106

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.

This SPD contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. Pease refer to the "Additional Information" section of the SPD. **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.**

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. Review the provider invoice to determine if an insurance payment was applied and review your Aetna Explanation of Benefits for the date of service
2. Contact your provider if an insurance payment was not applied or if the insurance payment applied does not match your Aetna Explanation of Benefits the date of service; your provider may need your Aetna ID card information

Out-of-Network

1. Utilize the claim form located at hr.miami.edu/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-Total Rewards.

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, 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-Total Rewards 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 approved for 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. Health, dental, and vision coverage may continue as long as you continue to pay for your portion of the premium and continue to be approved for long-term disability. If you have health, dental, and/or vision coverage on a spouse or dependent and wish to continue those benefits, you must pay for the full cost of their coverage, their cost will not be subsidized by the University.

Active coverage will end on the last day of the month of your approved disability, HR-Total Rewards will automatically send your eligibility to continue medical coverage for you and your covered eligible dependents upon approval of long-term disability. If you do not wish to continue coverage for yourself and/or eligible dependents, please notify HR-Total Rewards and you will be offered COBRA.

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. When claims are submitted to Aetna as a secondary insurance, Aetna will calculate the allowed amount it would have paid had Medicare not been primary and will then make payment of the lesser of Medicare remaining balance or Aetna allowed amount. The University of Miami will reimburse your Part B premiums while you are covered by the UM medical. Form SSA-1099 must be submitted to HR-Total Rewards for reimbursement.

Faculty/Staff Assistance Program

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

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 benefits.miami.edu for additional information.

To request detailed Aetna documents, please contact HR-Total Rewards at 305-284-3004.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact HR-Total Rewards at 305-284-3004. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at http://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-final.pdf or call 305-284-3004 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network providers: $1,500 / person, $4,500 / family Out-of-network providers: $3,000 / person, $9,000 / family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. The UM HRA fund, administered by WageWorks, will pay for or reimburse you for certain expenses (including copays and coinsurance) up to the balance in your HRA.
Are there services covered before you meet your deductible?	Yes. Preventive care and mental health	This plan covers some items and services even if you haven't yet met the deductible amount. However, a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network providers: $4,000 / person, $12,000 / family Out-of-network providers: $8,000 / person, $24,000 / family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See the Aetna website or call 1-800-824-6411 for a list of network providers. Network: Aetna Choice POS II	This plan uses a provider network. You pay the least if you use a provider in the UM network. You pay more if you use a provider in the Aetna network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		UM Providers (You will pay the least)	In-Network (You will pay more)	Out-of-Network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible, then $15 copay/visit	Deductible, then $20 copay/visit	Deductible, then 30% coinsurance	None
	Specialist visit	Deductible, then $20 copay/visit	Deductible, then $55 copay/visit	Deductible, then 30% coinsurance	Chiropractic care is $15 copay at UHealth & $20 copay in-network. Limited to 40 visits of chiropractic services per calendar year.
	Preventive care/screening/ immunization	No charge	No charge (Skin Cancer Screening covered only at UHealth)	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Skin cancer screening covered only at UHealth.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, then $0 copay/visit	Deductible, then $0 copay/visit for lab Deductible, then $40 copay/visit for low end diagnostics	Deductible, then 30% coinsurance	Lab work is only covered at UHealth labs, Quest Diagnostics or LabCorp
	Imaging (CT/PET scans, MRIs)	Deductible, then $100 copay/visit	Not covered	Not covered	Covered only at UHealth
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.aetna.com** or by calling 1-800-824-6411.	Generic drugs (Tier 1)	Deductible, then $10 copay/Rx - Retail Deductible, then $25 copay/Rx – CVS/Caremark Mail order or other retail pharmacies in the network including Walgreens and CVS			Prescription drug coverage is provided through Aetna. Covers up to a 30-day supply (retail); 31-90 day supply (CVS/Caremark Mail order or other retail pharmacies in the network including Walgreens and CVS). Maintenance medications that aren't filled in 90 day supplies through Aetna's network will have a copay of 2.5x the retail copay for a 30 day supply after two retail fills. Certain drugs may have a Pre-Notification requirement. If you choose a tier brand drug when a generic is available, you may also pay the cost difference between the generic & brand drug. You may be required to use a
	Preferred drugs (Tier 2)	Deductible, then $45 copay/Rx - Retail Deductible, then $112.50 copay/Rx – CVS/Caremark Mail order or other retail pharmacies in the network including Walgreens and CVS			
	Non-preferred brand drugs (Tier 3)	Deductible, then $75 copay/Rx - Retail Deductible, then $187.50 copay/Rx – CVS/Caremark Mail order or other retail pharmacies in the network including Walgreens and CVS			
	Specialty drugs (Tier 4)	Deductible, then $100 copay/Rx -University of Miami Specialty Pharmacy, CVS Specialty, Walgreens or other pharmacies in the network			

					lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See Aetna's website for information on drugs covered by your plan.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then $50 copay/procedure	Deductible, then $150 copay/procedure	Deductible, then 30% coinsurance	None
	Physician/surgeon fees	Deductible, then $0 copay	Deductible, then $0 copay	Deductible, then 30% coinsurance	None
If you need immediate medical attention	Emergency room care	Deductible, then $250 copay/visit	Same as network	Same as network	Emergency room copay is waived if you are admitted for Inpatient stay directly from the Emergency Room. Notify Aetna if confined in a non-network Hospital.
	Emergency medical transportation	N/A	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	
	Urgent care	Deductible, then $100 copay/visit	Deductible, then $100 copay/visit	Deductible, then 30% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then $100 copay per day up to a max of $500 copay per admission	Deductible, then $200 copay per day up to a max of $1,000 copay per admission	Deductible, then 30% coinsurance	None
	Physician/surgeon fees	Deductible, then $0 copay	Deductible, then $0 copay	Deductible, then 30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services – Administered by Aetna. For more information visit Aetna.com	Outpatient services	$20 copay/visit		30% coinsurance	Please contact Aetna Member Services at 1-800-824-6411.- prior to accessing services to confirm network status of the provider you wish to see.
	Inpatient services	$100 copay per day up to a max of $500 per admission		30% coinsurance	

If you are pregnant	Office visits	Deductible, then $20 copay - 1st office visit, then all office visits covered at 100%	Deductible, then $55 copay - 1st office visit, then all office visits covered at 100%	Deductible, then 30% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, a copay may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	Deductible, then $0 copay	Deductible, then $0 copay	Deductible, then 30% coinsurance	
	Childbirth/delivery facility services	Deductible, then $100 copay per day up to a max of $500 per admission	Deductible, then $200 copay per day up to a max of $1,000 per admission	Deductible, then 30% coinsurance	
If you need help recovering or have other special health needs (no limits with a mental health diagnosis)	Home health care	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance	60 visits/year
	Rehabilitation services	Deductible, then $15 copay /visit	Deductible, then $20 copay/visit	Deductible, then 30% coinsurance	Combination of outpatient rehabilitation /habilitation services is limited to 60 visits per calendar year. Habilitation services for autism related therapies are unlimited.
	Habilitation services	Deductible, then $15 copay/visit	Deductible, then $20 copay/visit	Not covered	
	Skilled nursing care	N/A	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance	100 days/ year
	Durable medical equipment	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance	None
	Hospice services	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Not covered	Refractive eye exams are limited to one exam/year.
	Children's glasses	Discount offered through Aetna/EyeMed	Discount offered through Aetna/EyeMed	Not covered	Discount offered on glasses, frames and contacts
	Children's dental check-up	Not covered	Not covered	Not covered	No coverage for dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

• Cosmetic surgery • Dental care (Adult/Child)	• Hearing aids • Long-term care	• Non-emergency care when traveling outside the US • Private-duty nursing	• Routine foot care • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Bariatric Surgery	• Chiropractic Care • Fertility treatment (limitations apply)	• Routine Eye Care (Child and Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/agencies/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x-61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Member Service number listed on the back of your ID card, aetna.com or optumrx.com. For plans subject to ERISA, you may also contact the U.S. Department of Labor's Employee Benefits Security Administration at the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/agencies/ebsa.

Additionally, a consumer assistance program may help you file your appeal. Contact www.dol.gov/agencies/ebsa.

Does this plan provide Minimum Essential Coverage? **Yes**.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **Yes**.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-624-6411
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-624-6411.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-624-6411.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-624-6411.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$1,500**
- **Specialist copayment** **$55**
- **Hospital (facility) copayment** **$200/day**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$1,930
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,430**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$1,500**
- **Specialist copayment** **$55**
- **Hospital (facility) copayment** **$200/day**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$1,500
Copayments	$1,155
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,655**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$1,500**
- **Specialist copayment** **$55**
- **Hospital (facility) copayment** **$200/day**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,500
Copayments	$380
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,880**

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. If you aren't clear about any of the underlined terms used in this form see www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-final.pdf for the glossary of terms.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact HR-Total Rewards at 305-284-3004. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at http://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-final.pdf or call 305-284-3004 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network providers: $1,500 / person, $4,500 / family Out-of-network providers: $3,000 / person, $9,000 / family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. The UM HRA fund, administered by WageWorks, will pay for or reimburse you for certain expenses (including copays and coinsurance) up to the balance in your HRA.
Are there services covered before you meet your deductible?	Yes. Preventive care and mental health	This plan covers some items and services even if you haven't yet met the deductible amount. However, a copayment or coinsurance may apply. For example, this plan covers certain in-network preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network providers: $4,000 / person, $12,000 / family Out-of-network providers: $8,000 / person, $24,000 / family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See Aetna website or call 1-800-824-6411 for a list of network providers. Network: Aetna Choice POS II	This plan uses a provider network. You pay the least if you use a provider in the UM network. You pay more if you use a provider in the Aetna network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
Released on April 6, 2016

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-Network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible, then $15 copay/visit	Deductible, then 30% coinsurance	None
	Specialist visit	Deductible, then $20 copay/visit	Deductible, then 30% coinsurance	Chiropractic care - $15 copay. Limited to 40 visits of chiropractic services per calendar year.
	Preventive care/screening /immunization	No charge	Not covered Note, skin cancer screening covered only at UHealth	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Skin cancer screening covered only at UHealth.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, then $0 copay/visit	Deductible, then 30% coinsurance	Lab work is only covered at UHealth labs, Quest Diagnostics or LabCorp
	Imaging (CT/PET scans, MRIs)	Deductible, then $100 copay/visit	Not covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.aetna.com** or by calling 1-800-824-6411.	Generic drugs (Tier 1)	Deductible, then $10 copay/Rx - Retail Deductible, then $25 copay/Rx – CVS/Caremark Mail order or other retail pharmacies in the network including Walgreens and CVS		Prescription drug coverage is provided through Aetna. Covers up to a 30-day supply (retail); 31-90 day supply (CVS/Caremark Mail order or other retail pharmacies in the network including Walgreens and CVS). Maintenance medications that aren't filled in 90 day supplies through Aetna's network will have a copay of 2.5X the retail copay for a 30 day supply after two retail fills. Certain drugs may have a Pre-Authorization requirement. If you choose a tier brand drug when a generic is available, you may also pay the cost difference between the generic and brand drug. You may be required to use a lower cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See Aetna's website for information on drugs covered by your plan.
	Preferred drugs (Tier 2)	Deductible, then $45 copay/Rx - Retail Deductible, then $112.50 copay/Rx – CVS/Caremark Mail order or other retail pharmacies in the network including Walgreens and CVS		
	Non-preferred brand drugs of 2.5x th retail copay for a 30 day supply after two retail fills. (Tier 3)	Deductible, then $75 copay/Rx - Retail Deductible, then $187.50 copay/Rx – CVS/Caremark Mail order or other retail pharmacies in the network including Walgreens and CVS		
	Specialty drugs (Tier 4)	Deductible, then $100 copay/University of Miami Specialty Pharmacy, CVS Specialty, Walgreens or other pharmacies in the network		

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then $50 copay/procedure	Deductible, then 30% coinsurance	None
	Physician/surgeon fees	Deductible, then $0 copay	Deductible, then 30% coinsurance	None
If you need immediate medical attention	Emergency room care	Deductible, then $250 copay/visit	Same as network	Emergency room copay is waived if you are admitted for inpatient stay directly from the emergency room. Notify Aetna if confined in a non-network hospital.
	Emergency medical transportation	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	
	Urgent care	Deductible, then $100 copay/visit	Deductible, then 30% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then $100 copay per day up to a max of $500 copay per admission	Deductible, then 30% coinsurance	None
	Physician/surgeon fees	Deductible, then $0 copay	Deductible, then 30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services – Administered by Aetna. For more information visit Aetna.com	Outpatient services	$20 copay/visit	30% coinsurance	Please contact Aetna Member Services at 1-800-824-6411- prior to accessing services to confirm network status of the provider you wish to see.
	Inpatient services	$100 copay per day up to a max of $500 per admission	30% coinsurance	
If you are pregnant	Office visits	Deductible, then $20 copay - 1st office visit, then all office visits covered at 100%	Deductible, then 30% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, a copay may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	Deductible, then $0 copay	Deductible, then 30% coinsurance	None
	Childbirth/delivery facility services	Deductible, then $100 copay per day up to a max of $500 per admission	Deductible, then 30% coinsurance	

If you need help recovering or have other special health needs (no limits with a mental health diagnosis)	Home health care	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance	60 visits/year
	Rehabilitation services	Deductible, then $15 copay/visit	Deductible, then 30% coinsurance	Combination of outpatient rehabilitation /habilitation services is limited to 60 visits per calendar year. Habilitation services for autism related therapies are unlimited.
	Habilitation services	Deductible, then $15 copay/visit	Not covered	
	Skilled nursing care	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance	100 days/ year
	Durable medical equipment	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance	None
	Hospice services	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Refractive eye exams are limited to one exam/year
	Children's glasses	Discount offered through Aetna/EyeMed	Not covered	Discount offered on glasses, frames and contacts
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)			
• Cosmetic surgery • Dental care (Adult/Child)	• Hearing aids • Long-term care	• Non-emergency care when traveling outside the US • Private-duty nursing	• Routine foot care • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Bariatric Surgery	• Chiropractic Care • Fertility treatment (limitations apply)	• Routine Eye Care (Child and Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/agencies/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x-61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Member Service number listed on the back of your ID card, aetna.com or optumrx.com. For plans subject to ERISA, you may also contact the U.S. Department of Labor's Employee Benefits Security Administration at the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/agencies/ebsa.

Additionally, a consumer assistance program may help you file your appeal. Contact www.dol.gov/agencies/ebsa.

Does this plan provide Minimum Essential Coverage? **Yes**.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **Yes**.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-624-6411
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-624-6411.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-624-6411.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-624-6411.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,500
Specialist copayment	$20
Hospital (facility) copayment	$100/day
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$1,590
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,090**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,500
Specialist copayment	$20
Hospital (facility) copayment	$100/day
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$1,500
Copayments	$1,065
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,565**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,500
Specialist copayment	$20
Hospital (facility) copayment	$100/day
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,500
Copayments	$185
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,685**

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. If you aren't clear about any of the underlined terms used in this form see www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-final.pdf for the glossary of terms.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact HR-Total Rewards at 305-284-3004. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at http://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-final.pdf or call 305-284-3004 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$200 per person $600 per family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes, preventive care, mental health and prescription drugs	This plan covers some items and services even if you haven't yet met the deductible amount. However, a copayment may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $3,000 individual / $9,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See the Aetna site or call 1-800-824-6411 for a list of network providers. Network: Aetna Select (Open Access)	This plan uses a provider network. You pay the least if you use a provider in the UM network. You pay more if you use a provider in the Aetna network. Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
Released on April 6, 2016

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		UM Providers (You will pay the least)	In-Network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible, then $15 copay/visit	Deductible, then $20 copay/visit	No out-of-network coverage
	Specialist visit	Deductible, then $20 copay/visit	Deductible, then $55 copay/visit	No out-of-network coverage. Chiropractic care is $15 copay at UHealth & $20 copay in-network. Limited to 40 visits of chiropractic services per calendar year.
	Preventive care/screening/ immunization	No charge	No charge Note, skin cancer screening covered only at UHealth	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Skin cancer screening covered only at UHealth. No out-of-network coverage
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, then $0 copay/visit	Deductible, then $0 copay/visit for lab Deductible, then $30 copay/visit for low end diagnostics	Lab work is only covered at UHealth labs, Quest Diagnostics or LabCorp
	Imaging (CT/PET scans, MRIs)	Deductible, then $150 copay/visit	Not Covered	Covered only at UHealth
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetna.com or by calling 1-800-824-6411	Generic drugs (Tier 1)	$10 copay/Rx - Retail $25 copay/Rx – CVS/Caremark Mail order or other retail pharmacies in the network including Walgreens and CVS		Prescription drug coverage is provided through Aetna. Covers up to a 30-day supply (retail); 31-90 day supply (CVS/Caremark Mail order or other retail pharmacies in the network including Walgreens and CVS). Maintenance medications that aren't filled in 90 day supplies through Aetna's network will have a copay of
	Preferred drugs (Tier 2)	$45 copay/Rx - Retail $112.50 copay/ Rx – CVS/Caremark Mail order or other retail pharmacies in the network including Walgreens and CVS		
	Non-preferred brand drugs (Tier 3)	$75 copay/Rx - Retail		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		UM Providers (You will pay the least)	In-Network (You will pay the most)	
		$187.50 copay/ Rx – CVS/Caremark Mail order or other retail pharmacies in the network including Walgreens and CVS		2.5x the retail copay for a 30 day supply after two retail fills. Certain drugs may have a pre-notification requirement. If you choose a tier brand drug when a generic is available, you may also pay the cost difference between the generic & brand drug. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See Aetna's website for information on drugs covered by your plan.
	Specialty drugs (Tier 4)	$100 copay/University of Miami Specialty Pharmacy, CVS Specialty, Walgreens or other pharmacies in the network		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then $100 copay/procedure	Deductible, then $150 copay/procedure	None
	Physician/surgeon fees	No charge	No charge	None
If you need immediate medical attention	Emergency room care	Deductible, then $200 copay/visit		Emergency room copay is waived if you are admitted for inpatient stay directly from the emergency room. Notify Aetna if confined in a non-network hospital.
	Emergency medical transportation	N/A	$0 copay	
	Urgent care	Deductible, then $100 copay/visit		
If you have a hospital stay (Inpatient)	Facility fee (e.g., hospital room)	Deductible, then $150 copay per day up to a max of $750 per admission	Deductible, then $250 copay per day up to a max of $1,250 per admission	No out-of-network coverage
	Physician/surgeon fees	No charge		None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		UM Providers (You will pay the least)	In-Network (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services – Administered by Aetna. For more information visit Aetna.com	Outpatient services	$20 copay/visit		Please contact Aetna Member Services at 1-800-824-6411.- prior to accessing services to confirm network status of the provider you wish to see
	Inpatient services	$100 copay per day up to a max of $500 per admission		
If you are pregnant	Office visits	Deductible, then $20 copay - 1st office visit, then all office visits covered at 100%	Deductible, then $55 copay - 1st office visit, then all office visits covered at 100%	Cost sharing does not apply to certain preventive services. Depending on the type of services, a copay may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). No coverage out-of-network
	Childbirth/delivery professional services	No charge	No charge	
	Childbirth/delivery facility services	Deductible, then $150 copay per day up to a max of $750 per admission	Deductible, then $250 copay per day up to a max of $1,250 per admission	
If you need help recovering or have other special health needs (no limits with a mental health diagnosis)	Home health care	No charge	No charge	60 visits/year. No out-of-network coverage
	Rehabilitation services	Deductible, then $15 copay/visit	Deductible, then $20 copay/visit	Combination of outpatient rehabilitation / habilitation services is limited to 60 visits per calendar year. Habilitation services for autism related therapies are unlimited with out-of-network coverage available.
	Habilitation services	Deductible, then $15 copay/visit	Deductible, then $20 copay/visit	
	Skilled nursing care	N/A	No charge	100 days/year. No out-of-network coverage
	Durable medical equipment	No charge	No charge	No out-of-network coverage
	Hospice services	No charge	No charge	No out-of-network coverage
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Refractive eye exams are limited to one exam/year
	Children's glasses	Discount offered through Aetna/EyeMed	Discount offered through Aetna/EyeMed	Discount offered on glasses, frames and contacts
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)			
• Cosmetic surgery • Dental care (Adult/Child)	• Hearing aids • Long-term care	• Non-emergency care when traveling outside the US • Private-duty nursing	• Routine foot care • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Bariatric Surgery	• Chiropractic Care • Fertility treatment (limitations apply)	• Routine Eye Care (Child and Adult)

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/agencies/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x-61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Member Service number listed on the back of your ID card, aetna.com or optumrx.com. For plans subject to ERISA, you may also contact the U.S. Department of Labor's Employee Benefits Security Administration at the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/agencies/ebsa.

Additionally, a consumer assistance program may help you file your appeal. Contact www.dol.gov/agencies/ebsa.

Does this plan provide Minimum Essential Coverage? **Yes**.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **Yes**.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-624-6411

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-624-6411.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-624-6411.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-624-6411.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	$200
■ Specialist copayment	$55
■ Hospital (facility) copay	$250/day
■ Other coinsurance	N/A

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$200
Copayments	$750
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$950**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	$200
■ Specialist copayment	$55
■ Hospital (facility) copay	$250/day
■ Other coinsurance	N/A

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$200
Copayments	$1,155
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,355**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

■ The plan's overall deductible	$200
■ Specialist copayment	$55
■ Hospital (facility) copay	$250/day
■ Other coinsurance	N/A

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$200
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**

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. If you aren't clear about any of the underlined terms used in this form see www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-final.pdf for the glossary of terms.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact HR-Total Rewards at 305-284-3004. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at http://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-final.pdf or call 305-284-3004 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	$300 per person $900 per family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay
Are there services covered before you meet your deductible?	Yes. Preventive care, mental health and prescription drugs.	This plan covers some items and services even if you haven't yet met the deductible amount. However, a copayment may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $4,000 individual / $12,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See Aetna website or call 1-800-824-6411 for a list of network providers. Network: Aetna Select (Open Access)	This plan uses a provider network. You pay the least if you use a provider in the UM network. You pay more if you use a provider in the Aetna network. Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
Released on April 6, 2016

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		UM Providers (You will pay the least)	In-Network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible, then $20 copay/visit	Deductible, then $25 copay/visit	No out-of-network coverage
	Specialist visit	Deductible, then $30 copay/visit	Deductible, then $65 copay/visit	No out-of-network coverage. Chiropractic care is $20 copay at UHealth & $25 copay in-network. Limited to 40 visits of chiropractic services per calendar year.
	Preventive care/screening/ immunization	No charge	No charge Note, skin cancer screening covered only at UHealth	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Skin cancer screening covered only at UHealth. No out-of-network coverage
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, then $0 copay/visit	$0 copay/visit for lab $50 copay/visit for low end diagnostics	Labwork is only covered at UHealth labs, Quest Diagnostics or LabCorp
	Imaging (CT/PET scans, MRIs)	Deductible, then $150 copay/visit	Not Covered	Covered only at UHealth
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.aetna.com** or by calling 1-800-824-6411.	Generic drugs (Tier 1)	$10 copay/Rx - Retail $25 copay/Rx – CVS/Caremark Mail order or other retail pharmacies in the network including Walgreens and CVS		Prescription drug coverage is provided through Aetna. Covers up to a 30-day supply (retail); 31-90 day supply (CVS/Caremark Mail order or other retail pharmacies in the network including Walgreens and CVS). Maintenance medications that aren't filled in 90 day supplies through Aetna's network will have a copay of 2.5x the retail copay for a 30 day supply after two retail fills. Certain drugs may have a pre-notification requirement. If you choose a tier brand drug when a generic is available, you may also pay the cost difference between the generic &
	Preferred drugs (Tier 2)	$45 copay/Rx - Retail $112.50 copay/Rx – CVS/Caremark Mail order or other retail pharmacies in the network including Walgreens and CVS		
	Non-preferred brand drugs (Tier 3)	$75 copay/Rx - Retail $187.50 copay/Rx – CVS/Caremark Mail order or other retail pharmacies in the network including Walgreens and CVS		
	Specialty drugs (Tier 4)	$100 copay/Rx - University of Miami Specialty Pharmacy, CVS Specialty, Walgreens or other pharmacies in the network		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		UM Providers (You will pay the least)	In-Network (You will pay the most)	
				brand drug. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See Aetna's website for information on drugs covered by your plan.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then $100 copay/procedure	Deductible, then $250 copay/procedure	None
	Physician/surgeon fees	Deductible, then $0 copay		None
If you need immediate medical attention	Emergency room care	Deductible, then $250 copay/visit		Emergency room copay is waived if you are admitted for Inpatient stay directly from the Emergency Room. Notify Aetna if confined in a non-network hospital.
	Emergency medical transportation	N/A	Deductible, then $0 copay	
	Urgent care	Deductible, then $100 copay/visit		
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then $200 copay per day up to a max of $1,000 per admission	Deductible, then $300 copay per day up to a max of $1,500 per admission	No out-of-network coverage
	Physician/surgeon fee	Deductible, then $0 copay		None
If you need mental health, behavioral health, or substance abuse services – Administered by Aetna. . For more information visit Aetna.com.	Outpatient services	$20 copay/visit		Please contact Aetna Member Services at 1-800-824-6411.- prior to accessing services to confirm network status of the provider you wish to see.
	Inpatient services	$100 copay per day up to a max of $500 per admission		

If you are pregnant	Office visits	Deductible, then $30 copay - 1st office visit, then all office visits covered at 100%	Deductible, then $65 copay - 1st office visit, then all office visits covered at 100%	Cost sharing does not apply to certain preventive services. Depending on the type of services, a copay may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). No out-of-network coverage
	Childbirth/delivery professional services	Deductible, then $0 copay	Deductible, then $0 copay	
	Childbirth/delivery facility services	Deductible, then $200 copay per day up to a max of $1,000 copay per admission	Deductible, then $300 copay per day up to a max of $1,500 copay per admission	
If you need help recovering or have other special health needs (no limits with a mental health diagnosis)	Home health care	Deductible, then $0 copay	Deductible, then $0 copay	60 visits/year. No out-of-network coverage
	Rehabilitation services	Deductible, then $20 copay/visit	Deductible, then $25 copay/visit	Combination of outpatient rehabilitation /habilitation services is limited to 60 visits per calendar year. Habilitation services for autism related therapies are unlimited with out-of-network coverage available.
	Habilitation services	Deductible, then $20 copay/visit	Deductible, then $25 copay/visit	
	Skilled nursing care	N/A	Deductible, then $0 copay	100 days/ year. No out-of-network coverage
	Durable medical equipment	Deductible, then $0 copay	Deductible, then $0 copay	No out-of-network coverage
	Hospice services	Deductible, then $0 copay	Deductible, then $0 copay	No out-of-network coverage
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Refractive eye exams are limited to one exam/year
	Children's glasses	Discount offered through Aetna/EyeMed	Discount offered through Aetna/EyeMed	Discount offered on glasses, frames and contacts
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult/Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the US
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Fertility treatment (limitations apply)
- Routine Eye Care (Child and Adult)

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/agencies/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x-61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Member Service number listed on the back of your ID card, aetna.com or optumrx.com. For plans subject to ERISA, you may also contact the U.S. Department of Labor's Employee Benefits Security Administration at the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/agencies/ebsa.

Additionally, a consumer assistance program may help you file your appeal. Contact www.dol.gov/agencies/ebsa.

Does this plan provide Minimum Essential Coverage? **Yes**.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **Yes**.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-624-6411

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-624-6411.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-624-6411.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-624-6411.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	$300
■ Specialist copayment	$65
■ Hospital (facility) copayment	$300/day
■ Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$2,610
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,910**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	$300
■ Specialist copayment	$65
■ Hospital (facility) copayment	$300/day
■ Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$300
Copayments	$1,215
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,515**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

■ The plan's overall deductible	$300
■ Specialist copayment	$65
■ Hospital (facility) copayment	$300/day
■ Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$300
Copayments	$530
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$830**

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. If you aren't clear about any of the underlined terms used in this form see www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-final.pdf for the glossary of terms.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact HR-Total Rewards at 305-284-3004. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at http://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-final.pdf or call 305-284-3004 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$300 per person $900 per family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care, mental health and prescription drugs.	This plan covers some items and services even if you haven't yet met the deductible amount. However, a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $4,000 individual / $12,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See the Aetna website or call 1-800-824-6411 for a list of network providers. Network: Aetna Select (Open Access)	This plan uses a provider network. You pay the least if you use a provider in the UM network. You pay more if you use a provider in the Aetna network. Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
Released on April 6, 2016

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay In-Network	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible, then $20 copay/visit	No out-of-network coverage
	Specialist visit	Deductible, then $30 copay/visit	No out-of-network coverage. Chiropractic care is $20 copay. Limited to 40 visits of chiropractic services per calendar year.
	Preventive care/screening/ immunization	No charge	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. No out-of-network coverage
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, then $0 copay/visit	Lab work is only covered at UHealth labs, Quest Diagnostics or LabCorp
	Imaging (CT/PET scans, MRIs)	Deductible, then $150 copay/visit	Covered only at UHealth
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.aetna.com** or by calling 1-800-824-6411.	Generic drugs (Tier 1)	$10 copay/Rx - Retail $25 copay/Rx – CVS/Caremark Mail order or other retail pharmacies in the network including Walgreens and CVS	Prescription drug coverage is provided through Aetna. Covers up to a 30-day supply (retail); 31-90 day supply (CVS/Caremark Mail order or other retail pharmacies in the network including Walgreens and CVS). Maintenance medications that aren't filled in 90 day supplies through Aetna's network will have a copay of 2.5x the retail copay for a 30 day supply after two retail fills. Certain drugs may have a pre-notification requirement. If you choose a tier brand drug when a generic is available, you may also pay the cost difference between the generic & brand drug. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. See Aetna's website for information on drugs covered by your plan.
	Preferred drugs (Tier 2)	$45 copay/Rx - Retail $112.50 copay/Rx – CVS/Caremark Mail order or other retail pharmacies in the network including Walgreens and CVS	
	Non-preferred brand drugs (Tier 3)	$75 copay/Rx - Retail $187.50 copay/Rx – CVS/Caremark Mail order or other retail pharmacies in the network including Walgreens and CVS	
	Specialty drugs (Tier 4)	$100 copay/Rx- University of Miami Specialty Pharmacy, CVS Specialty, Walgreens or other pharmacies in the network	

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then $100 copay/procedure	None
	Physician/surgeon fees	Deductible, then $0 copay	None
If you need immediate medical attention	Emergency room care	Deductible, then $250 copay/visit	Emergency room copay is waived if you are admitted for inpatient stay directly from the emergency room. Notify Aetna if confined in a non-network hospital.
	Emergency medical transportation	No charge	
	Urgent care	Deductible, then $100 copay/visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then $200 copay per day up to a max of $1,000 per admission	No out-of-network coverage
	Physician/surgeon fees	Deductible, then $0 copay	None
If you need mental health, behavioral health, or substance abuse services – Administered by Aetna. For more information visit Aetna.com	Outpatient services	$20 copay/visit	Please contact Aetna Member Services at 1-800-824-6411.- prior to accessing services to confirm network status of the provider you wish to see.
	Inpatient services	$100 copay per day up to a max of $500 per admission	
If you are pregnant	Office visits	Deductible, then $30 copay - 1st office visit, then all office visits covered at 100%	Cost sharing does not apply to certain preventive services. Depending on the type of services, a copay may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). No out-of-network coverage
	Childbirth/delivery professional services	Deductible, then $0 copay	
	Childbirth/delivery facility services	Deductible, then $200 copay per day up to a max of $1,000 per admission	
If you need help recovering or have other special health needs (no limits with a mental health diagnosis)	Home health care	Deductible, then $0 copay	60 visits/year. No out-of-network coverage
	Rehabilitation services	Deductible, then $20 copay/visit	Combination of outpatient rehabilitation /habilitation services is limited to 60 visits per calendar year. Habilitation services for autism related therapies are unlimited with out-of-network coverage available.
	Habilitation services	Deductible, then $20 copay/visit	
	Skilled nursing care	No charge	100 days/year. No out-of-network coverage
	Durable medical equipment	Deductible, then $0 copay	No out-of-network coverage

	Hospice services	Deductible, then $0 copay	No out-of-network coverage
If your child needs dental or eye care	Children's eye exam	No charge	Refractive eye exams are limited to one exam/year
	Children's glasses	Discount offered through Aetna/EyeMed	Discount offered on glasses, frames and contacts
	Children's dental check-up	Not covered	No coverage for dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult/Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the US
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Fertility treatment (limitations apply)
- Routine Eye Care (Child and Adult)

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/agencies/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x-61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Member Service number listed on the back of your ID card, aetna.com or optumrx.com. For plans subject to ERISA, you may also contact the U.S. Department of Labor's Employee Benefits Security Administration at the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/agencies/ebsa.

Additionally, a consumer assistance program may help you file your appeal. Contact www.dol.gov/agencies/ebsa.

Does this plan provide Minimum Essential Coverage? **Yes**.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **Yes**.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-624-6411
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-624-6411.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-624-6411. Navajo (Dine):

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-624-6411.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$300**
- **Specialist copayment** **$30**
- **Hospital (facility) copayment** **$200/day**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$1,610
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,910**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$300**
- **Specialist copayment** **$30**
- **Hospital (facility) copayment** **$200/day**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$300
Copayments	$1,215
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,515**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$300**
- **Specialist copayment** **$30**
- **Hospital (facility) copayment** **$200/day**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$300
Copayments	$530
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$830**

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. If you aren't clear about any of the underlined terms used in this form see www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-final.pdf for the glossary of terms.

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. Faculty members who are members of the Associated Faculty (visiting and voluntary faculty) without the title of lecturer and temporary employees are not eligible. Coverage will begin on your date of hire.

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

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

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

Dependent Coverage

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

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

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

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 State Children's Health Insurance Program (SCHIP) or new enrollment in Medicaid or other SCHIP
- Change in employment status of employee, spouse, or dependent that affects insurance coverage 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-Total Rewards via Workday and requesting the corresponding change to benefits.
2. Provide required supporting documentation (e.g. government issued marriage certificate, government issued birth certificate, divorce decree, etc.). QSCs cannot be processed without the corresponding required supporting documentation.
3. HR-Total Rewards must receive the request via Workday and related documentation within 30 days of the QSC event or the request for change(s) will be denied and cannot be made until the next annual open enrollment period. NOTE: The enrollee should report the event immediately if supporting documentation is not readily available; a period of 60 days may be allowed to provide the necessary documentation. For Medicaid or other SCHIP events, a period of 60 days is allowed to make a change.

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 or child who no longer qualifies for coverage, you are required to notify HR-Total Rewards via Workday within 30 days of the event in order to remove the individual from coverage.

Non Compliance
Falsifying information/documentation in order to obtain/continue insurance coverage is considered a dishonest act and could lead to 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 CIGNA.com. You can change dentists at any time of the year by contacting CIGNA at 1-800-367-1037 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 CIGNA.com.

Delta Dental PPO Plan

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 deltadentalins.com. Benefits are maximized when using participating dentists.

2023 FEATURES (Total for In-Network and Out-of-Network)		
Calendar Year Benefit	$2,500 PPO Providers $1,500 Premier or Non-Contracted Providers	
Annual Deductible	$50 per member/$150 per family	
Lifetime Orthodontic Maximum (child)	$1,500	
Lifetime Orthodontic Maximum (adult)	$1,500	
Benefits	**Delta Dental PPO Providers**	**Delta Dental Premier and Non-Contracted Providers***
Type A Preventive		
Oral Exams (twice per calendar year)	100%	80%
X-rays (full mouth/panorex) (1) every three years	100%	80%
X-rays (bitewing) (1) per calendar year; (1) in six 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%
Sealants	100%	80%
Type B Basic		
Fillings Endodontics/Root Canal Periodontal Surgery General Anesthesia	80% after deductible	60% after deductible
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
Implants	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 protected 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.

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.

This SPD contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. Pease refer to the "Additional Information" section of the SPD. **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.**

To request detailed Cigna or Delta Dental documents, please contact HR-Total Rewards at 305-284-3004.

VISION INSURANCE

Vision Insurance

What the Plan Can Do For You

The University of Miami offers optional vision coverage through the Vision Service Plan (VSP). You are eligible to join the University of Miami vision plan if you are a regular full-time or part-time faculty, staff or members of affiliates working at least 50% effort. Faculty members who are members of the Associated Faculty (visiting and voluntary faculty) without the title of lecturer and temporary employees are not eligible. Coverage will begin on your date of hire. The amount of your premium will depend on whether you elect to cover eligible family members.

Enrollment must be completed via benefits enrollment in Workday.

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:
    a. The child has not reached the Limiting Age which is defined in this Section as the last day of the month in which he or she turns age 26 (except for paragraph b) below);
    b. Coverage will be extended where the child is either physically incapacitated or mentally challenged, is not capable of supporting him or herself and regularly receives over 50% of his/her support from the subscriber, provided that the dependent was covered under the University's Group Health Plan prior to reaching age 26.
        i. Proof of incapacitation or mental challenge (e.g. written documentation from the child's physician) is required for coverage after the child has reached age 26.
        ii. Coverage for dependent child who is physically incapacitated or mentally challenged may be discontinued at the end of the calendar month in which the child reaches age 26 and:
            1. the child is no longer disabled; or
            2. the child is capable of supporting him or herself; or
            3. the child no longer receives more than 50% of his/her support from the subscriber; or
            4. the child receives less than 50% of his/her support from the subscriber and the subscriber is no longer obligated to provide care for said child by court order.
    c. Coverage will be extended where the subscriber has agreed to regularly provide 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 coverage after delivery.
- Your legally recognized spouse.

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

amount of time when requested, we reserve the right to terminate coverage for the applicable dependent.

Qualifying Status Changes

IRS Section 125 rules regarding pre-tax premium plans do not allow for enrollment, additions, changes, or cancellations except with the occurrence of a Qualifying Status Change (QSC) event, followed by written application for a change within 30 days or during the annual open enrollment period. The federal government determines the events that qualify as QSCs, and this list is subject to periodic change. 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 that affects insurance coverage 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-Total Rewards via Workday and requesting the corresponding change to benefits.
2. Provide required supporting documentation (e.g. government issued marriage certificate, government issued birth certificate, divorce decree, etc.). QSCs cannot be processed without the corresponding required supporting documentation.
3. HR-Total Rewards must receive the request via Workday and related documentation within 30 days of the QSC event or the request for change(s) will be denied and cannot be made until the next annual open enrollment period. NOTE: The enrollee should report the event immediately if supporting documentation is not readily available; a period of 60 days may be allowed to provide the necessary documentation. For Medicaid or other SCHIP events, a period of 60 days is allowed to make a change.

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 or child who no longer qualifies for coverage, you are required to notify HR-Total Rewards via Workday within 30 days of the event in order to remove the individual from coverage.

Non Compliance

Falsifying information/documentation in order to obtain/continue insurance coverage is considered a dishonest act and could lead to 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.

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 is 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, please contact VSP Customer Service at 1-800-877-7195 or visit VSP at vsp.com. Benefits are maximized when using participating vision care providers.

HIPAA Privacy

The VSP plan conforms to new standards for protection of individual protected health information (PHI). Neither the University of Miami nor VSP condition enrollment in the plan based on an individual's health status. Vision 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.

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.

This SPD contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. Pease refer to the "Additional Information" section of the SPD. **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.**

To request detailed VSP documents, please contact HR-Total Rewards at 305-284-3004.

SHORT TERM DISABILITY INSURANCE

Short Term Disability Insurance

What the Plan Can Do For You

New York Life Group Benefits Solution's Short Term Disability plan (STD) provides a percentage of continued income for you if you are on an approved Medical Leave of Absence due to your own extended illness or injury. The two coverage options are:

Option 1 – 60%, up to $5,000 per week, for a maximum of 26 weeks from the date of disability.
Option 2 – 66.66%, up to $5,000 per week, for a maximum of 26 weeks from the date of disability.

Eligibility Waiting Period

You are eligible for coverage from the first of the month following your date of hire if the following requirements are met:

- Employed by the University of Miami as a regular full-time or part-time regular employee working at least 50% effort.
- Classified as a full-time regular non-exempt (bi-weekly paid) or exempt (monthly paid) employee by the University of Miami. Faculty members who are members of the Associated Faculty (visiting and voluntary faculty) without the title of lecturer and temporary employees are not eligible.
- Enrollment must be completed via benefits enrollment in Workday. If enrollment is not completed within thirty (30) days of start date, you will not be eligible to enroll until the annual Open Enrollment period. If you enroll during Open Enrollment your Short Term Disability benefit begins on January 1.

The Eligibility Waiting Period does not apply if you are a former employee rehired within 31 days after your termination date and you had satisfied the Eligibility Waiting Period prior to your termination date.

If you did not fully satisfy the Eligibility Waiting Period prior to your termination date, credit will be given for any time that was satisfied.

Elimination Period

The Elimination Period is the period of time you must be continuously disabled before disability benefits are payable. There is an elimination period of 14 days for both options elected.

A period of Disability is not continuous if separate periods of Disability result from unrelated causes.

Disability Benefits

New York Life Group Benefit Solutions (NYLGBS) will pay Disability Benefits if you become disabled while covered under the plan. You must satisfy the Elimination Period, be under the Appropriate Care of a Physician, and meet all the other terms and conditions of the Policy.

You must provide to New York Life Group Benefit Solutions, at your own expense, satisfactory proof of Disability before benefits will be paid. New York Life Group Benefit Solutions will require continued proof of your Disability for benefits to continue.

Disability Benefit Calculation

The Weekly Benefit payable to you for any week you are Disabled is the Gross Disability Benefit minus Other Income Benefits. "Other Income Benefits" means any benefits listed in the Other Income Benefits provision that you receive on your own behalf or for your dependents, or which your dependents receive because of your entitlement to Other Income Benefits.

Weekly disability benefits are based on the number of days in a normally scheduled work week for you immediately before the onset of disability. They will be prorated if payable for any period less than a week.

Other Income Benefits

If Disability Benefits are payable to you under this Policy, you may be eligible for benefits from Other Income Benefits. If so, we may reduce the Disability Benefits by the amount of such Other Income Benefits.
Other Income Benefits include:

1. any amounts received (or assumed to be received*) by you or your dependents under:
   - the Canada and Quebec Pension Plans;
   - the Railroad Retirement Act;
   - any local, state, provincial or federal government disability or retirement plan or law payable for Injury or Sickness provided as a result of employment with the Employer;
   - salary continuation plan of the Employer;
   - any work loss provision in mandatory "No-Fault" auto insurance.
2. any Social Security disability or retirement benefits you or any third party receive (or are assumed to receive*) on your own behalf or for your dependents; or which your dependents receive (or are assumed to receive*) because of your entitlement to such benefits.
3. any Retirement Plan benefits funded by the Employer. "Retirement Plan" means any defined benefit or defined contribution plan sponsored or funded by the Employer. It does not include an individual deferred compensation agreement; a profit sharing or any other retirement or savings plan maintained in addition to a defined benefit or other defined contribution pension plan, or any employee savings plan including a thrift, stock option or stock bonus plan, individual retirement account or 401(k) plan.
4. any proceeds payable under any franchise or group insurance or similar plan. If other insurance applies to the same claim for Disability, and contains the same or similar provision for reduction because of other insurance, we will pay for our pro rata share of the total claim. "Pro rata share" means the proportion of the total benefit that the amount payable under one policy, without other insurance, bears to the total benefits under all such policies.
5. any amounts paid because of loss of earnings or earning capacity through settlement, judgment, arbitration or otherwise, where a third party may be liable, regardless of whether liability is determined.

Dependents include any person who receives (or is assumed to receive*) benefits under any applicable law because of your entitlement to benefits.

Increases in Other Income Benefits
Any increase in Other Income Benefits during a period of Disability due to a cost of living adjustment will not be considered in calculating your Disability Benefits after the first reduction is made for any Other Income Benefits. This section does not apply to any cost of living adjustment for Disability Earnings.

Lump Sum Payments
Other Income Benefits or earnings paid in a lump sum will be prorated over the period for which the sum is given. If no time is stated, the lump sum will be prorated over five years.

If no specific allocation of a lump sum payment is made, then the total payment will be an Other Income Benefit.

Assumed Receipt of Benefits
We will assume you (and your dependents, if applicable) are receiving benefits for which you are eligible from Other Income Benefits. We will reduce your Disability Benefits by the amount from Other Income Benefits we estimate are payable to you and your dependents. We will waive Assumed Receipt of Benefits, except for Disability Earnings for work you perform while Disability Benefits are payable, if you:

1. provide satisfactory proof of application for Other Income Benefits;
2. sign a Reimbursement Agreement;
3. provide satisfactory proof that all appeals for Other Income Benefits have been made unless we determine that further appeals are not likely to succeed; and
4. submit satisfactory proof that Other Income Benefits were denied.

We will not assume receipt of any pension or retirement benefits that are actuarially reduced according to applicable law, until you actually receive them.

Recovery of Overpayment
We have the right to recover any benefits we have overpaid. We may use any or all of the following to recover an overpayment:

1. request a lump sum payment of the overpaid amount;
2. reduce any amounts payable under this Policy; and/or
3. take any appropriate collection activity available to us.

The Minimum Benefit amount will not apply when Disability Benefits are reduced in order to recover any overpayment. If an overpayment is due when you die, any benefits payable under the Policy will be reduced to recover the overpayment.

Successive Periods of Disability
A separate period of Disability will be considered continuous:

1. if it results from the same or related causes as a prior Disability for which benefits were payable; and
2. if, after receiving Disability Benefits, you return to work in your Regular Occupation for less than 14 days; and
3. if you earn less than the percentage of Covered Earnings that would still qualify you to meet the definition of Disability/Disabled during at least one week.

Any later period of Disability, regardless of cause, that begins when you are eligible for coverage under another group disability plan provided by any employer will not be considered a continuous period of Disability.

For any separate period of disability which is not considered continuous, you must satisfy a new Elimination Period.

Pre-Existing Condition Limitation*

New York Life Group Benefit Solutions will not pay benefits for any period of Disability caused or contributed to by, or resulting from, a Preexisting 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 three 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 benefits.

** does not apply if you elected coverage during your initial enrollment period as a new hire*

What Is Not Covered?

New York Life Group Benefit Solutions will not pay any Disability Benefits for a Disability that results, directly or indirectly, from:

1. suicide, attempted suicide, or self-inflicted injury while sane or insane.
2. war or any act of war, whether or not declared.
3. active participation in a riot.
4. commission of a felony.
5. 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.
6. any cosmetic surgery or surgical procedure that is not Medically Necessary; "Medically Necessary" means the surgical procedure is: (a) prescribed by a Physician as required treatment of the Injury or Sickness; and (b) appropriate according to conventional medical practice for the Injury or Sickness in the locality in which the surgery is performed. (We will pay benefits if your disability is caused by your donating an organ in a non-experimental organ transplant procedure.)
7. Injury or Sickness for which benefits are paid or payable to you from Workers' Compensation or occupational disease law.

In addition, New York Life Group Benefit Solutions will not pay Disability Benefits for any period of Disability during which you are incarcerated in a penal or corrections institution**.**

Notice of Claim

Written notice of claim, or notice by any other electronic/telephonic means authorized by New York Life Group Benefit Solutions , must be given to New York Life Group Benefit Solutions within 31 days after a covered loss occurs or begins or as soon as reasonably possible. If written notice, or notice by any other electronic/telephonic means authorized by New York Life Group Benefit Solutions, is not given in that time, the claim will not be invalidated or reduced if it is shown that notice was given as soon as was reasonably possible. Notice should include the Employer's name, the Policy Number and the claimant's name and address.

Claim Forms

When New York Life Group Benefit Solutions receives notice of claim, they will send claim forms for filing proof of loss. If New York Life Group Benefit Solutions does not send claim forms within 15 days after notice is received by New York Life Group Benefit Solutions, the proof requirements will be met by submitting, within the time required under the "Proof of Loss" section, written proof, or proof by any other electronic/telephonic means authorized by New York Life Group Benefit Solutions, of the nature and extent of the loss.

Claimant Cooperation Provision

If you fail to cooperate with New York Life Group Benefit Solutions in their administration of your claim, New York Life Group Benefit Solutions may terminate 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.

Proof of Loss

You must provide written proof of loss to us, or proof by any other electronic/telephonic means authorized by us, within 90 days after the date of the loss for which a claim is made. If written proof of loss, or proof by any other electronic/telephonic means authorized by us, is not given in that 90 day period, the claim will not be invalidated nor reduced if it is shown that it was given as soon as was reasonably possible. In any case, written proof of loss, or proof by any other electronic/telephonic means authorized by us, must be given not more than one year after the 90 day period. If written proof of loss, or proof by any other electronic/telephonic means authorized by us, is provided outside of these time limits, the claim will be denied. These time limits will not apply due to lack of legal capacity.

Written proof that the loss continues, or proof by any other electronic/telephonic means authorized by us, must be furnished to us at intervals we require. Within 30 days of a request, written proof of continued Disability and Appropriate Care by a Physician must be given to New York Life Group Benefit Solutions.

Time of Payment

Disability Benefits will be paid at regular weekly intervals. Any balance, unpaid at the end of any period for which we are liable, will be paid at that time.

Termination of Coverage

Benefits will end on the earliest of the following dates:

1. the date you earn more than the percentage of earnings that would still qualify you to meet the definition of Disability/Disabled;
2. the date we determine you are not Disabled;
3. the end of the Maximum Benefit Period;
4. the date you die;
5. the date you are no longer receiving Appropriate Care;
6. the date you fail to cooperate with us 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.

Coverage will terminate when your employment terminates, you enter the Armed Forces, you die or when the master contract terminates. Coverage will end the last day of the month in which you are no longer a full-time regular or part-time employee.

To request detailed New York Life Group Benefit Solutions documents, please contact HR-Total Rewards at 305-284-3004.

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.

New York Life Group Benefits Solution's Long Term Disability Plan provides protection for you and your family when an illness or injury keeps you away from work. This Plan can continue as part of your salary through:

- Salary Continuation for up to six months, upon approval of long-term disability benefit
- Long Term Disability (LTD) benefits, which begin after six months and provide 66 2/3% of your salary (to a maximum benefit of $10,000 per month) including any other income benefits you may receive for as long as the disability lasts, except for limitations noted later. The maximum payment you may receive from all sources is $10,000 a month.

An Example

John Doe became totally disabled and was approved for LTD making him eligible to receive six months of Salary Continuation; after six months, his LTD benefits began. Assume he was to receive $1,200 disability benefit as 66 2/3% of his regular salary.

If he also received a payment of $500 from Social Security, his LTD benefit from the Plan would be reduced to $700 ($1,200 - $500 = $700). His total income from all sources would be equal to 66 2/3% of pay or $1,200 per month.

LTD benefits begin after you have received six months of benefits under the Salary Continuation Plan. Medical evidence documenting your inability to work is required.

Eligibility Waiting Period

Faculty and key administrators are eligible for coverage as of date of hire if the following requirements are met:

Staff are eligible for coverage after one year of service if the following requirements are met:

- Employed by the University of Miami, as a regular full-time or part-time regular employee working at least 50% effort
- Faculty members who are members of the Associated Faculty (visiting and voluntary faculty) without the title of lecturer and temporary employees are not eligible.

Elimination Period

The Elimination Period is the period of time you must be continuously disabled before disability benefits are payable. There is an elimination period of 180 days.

A period of Disability is not continuous if separate periods of Disability result from unrelated causes.

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 three 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 benefits.

Definition of Disability

You are disabled when New York Life Group Benefit Solutions determines that:

1. You are unable to perform the material duties of your regular occupation due to your sickness/injury, and
2. You have a 20% or more loss in your covered earnings due to the same sickness/injury

How Long Benefits Are Payable

New York Life Group Benefit Solutions will send you a payment each month up to the maximum period of payment. The maximum period of payment is based on your age at disability as follows:

Age at Disability	Maximum Period of Payment
Age 62 or under	Your 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.

New York Life Group Benefit Solutions will stop sending you payments and your claim will end on the earliest of the following:

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

The lifetime cumulative maximum benefit period for all disabilities due to Mental or Nervous Disorders is 24 months.

When Benefits Are Paid

You must be continuously disabled through your elimination period (180 days) before disability benefits are payable.

The disability benefit payable to you is figured using 66 2/3%% of your monthly covered earnings and other income benefits. Monthly Benefits are based on a 30-day month. The disability benefit will be prorated if payable for any period less than a month.

Benefits will not be less than the greater of $100 or 10% of your monthly benefit prior to any reductions for other income benefits.

Continuous Periods of Disability
A separate period of disability will be considered continuous:

- If it results from the same or related causes as a prior disability for which benefits were payable; and
- After receiving disability benefits, you return to work in your regular job for less than six consecutive months; and
- If you earn less than 80% of indexed earnings that would still qualify you to meet the definition of disability/Disabled during at least one month.

Disabilities Not Covered

This coverage does not include disabilities resulting, directly or indirectly, from:

- suicide, attempted suicide, or self-inflicted injury while sane or insane.
- war or any act of war, whether or not declared.
- active participation in a riot.
- commission of a felony.
- 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.

In addition, disability Benefits are not payable for any period of disability during which you are incarcerated in a penal or corrections institution.

LTD Employee Status and Benefits

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

If you qualified for such disability benefits prior to June 1, 2014, you will continue to earn service for retirement benefit accruals if you were a participant in the Employees' Retirement Plan. If you commence disability benefits under the University's Long-Term Disability Plan on or after June 1, 2014, you will no longer earn service for benefit accruals under the Employees' Retirement Plan if you were a participant in that plan. However, you may qualify for ongoing disability benefits in the form of contributions under the University of Miami Retirement Savings Plan. Contributions into the Faculty Retirement Plan continue while on LTD not to exceed the end of the plan year in which you turn 65.

If you are receiving long term disability benefits through the University, your medical plan coverage for yourself and your eligible covered dependents may be continued at the time you are approved for disability or the entitlement is lost. Your health and dental coverage will continue as long as you continue to pay for your portion of the premium. If you have health and/or dental coverage on a spouse/partner or dependent and wish to continue those benefits, you must pay for the full cost of their coverage. Coverage ends on the last day of the month in which you are approved for disability if your health and/or dental coverage is not continued.

Additionally, as part of the long term disability program, you are required to apply for Social Security disability benefits. New York Life Group Benefit Solutions will assist you with the application process. If you are approved for Social Security disability benefits, your New York Life Group Benefit Solutions disability payment may be offset by the new Social Security disability payments.

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. Form SSA-1099 must be submitted to HR-Total Rewards for reimbursement.

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

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

Group and Excess Life Insurance Benefit while on Long Term Disability
If you become totally disabled and are approved for benefits under the New York Life Group Benefit Solutions Long Term Disability Plan, you will be covered under the Group Life Insurance during the period that you are covered under New York Life Group Benefit Solutions Long Term Disability until the date you are no longer disabled.

If you continue to be totally disabled after nine months, you may apply for a waiver of premium for your voluntary excess life insurance policy up to Social Security Normal Retirement Age. 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.

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.

Salary Continuation

Full-time or part-time regular member of the faculty and key administrator are eligible for Salary Continuation as of their first day of employment. Other full-time or part-time regular employees become eligible after working for the University of Miami for one year.

When Benefits Begin
Salary Continuation payments are calculated starting with the first day of medically documented disability or the first day after you stop receiving your regular salary, whichever is later. Sick pay, vacation pay, Social Security, Workers' Compensation and Short Term Disability benefits are not considered as part of your salary, but will be used as a 100% offset to your Salary Continuation benefit payments.

Medical evidence documenting inability to perform the employee's job duties for a minimum of six continuous months is required before benefits begin. An LTD application must be filed through HR-Total Rewards. The provision of Salary Continuation payments for the six months prior to commencement of LTD Benefits and for benefits under the LTD Plan is contingent upon approval by New York Life Group Benefit Solutions.

The Salary Continuation Benefit provides salary coverage during the initial six-month LTD elimination period, provided the disability is certified under provisions of the Group LTD Insurance Plan. New York Life Group Benefit Solutions must first make a determination of LTD before any benefit payment can be made under either plan.

Employees with Three or More Years of Service

Receive full monthly salary for entire six-month period (offset by accrued sick and vacation pay, Short Term Disability, Social Security and Worker's Compensation).

Employees with One to Three Years of Service
Receive 66 2/3 percent of regular salary for entire six-month waiting period (offset by accrued sick and vacation pay, Social Security, Short-Term Disability and Worker's Compensation).

Employees with Less Than One Year of Service
Receive accrued sick and vacation time only. No Salary Continuation Plan.

Cost of Your Benefits
The University of Miami pays the full cost of your Salary Continuation benefits.

When Your Coverage Ends

While you remain employed with the university as a regular full-time or part-time faculty or staff member working at least 50% effort. Faculty members who are members of the Associated Faculty (visiting and voluntary faculty) without the title of lecturer and temporary employees are not eligible.

Coverage will terminate when your employment terminates, you enter the Armed Forces, you die or when the master contract terminates. Coverage will end the last day of the month in which you are no longer a full-time regular or part-time employee.

To request detailed New York Life Group Benefit Solutions documents, please contact HR-Total Rewards at 305-284-3004.

LONG TERM CARE INSURANCE

Long Term Care Insurance

What the Plan Can Do For You

The University of Miami offers optional Long Term Care Insurance through Unum. Long Term Care Insurance can help provide the financial resources necessary to receive care at home or in a facility; and insurance is available for you, your legally recognized spouse and you or your spouse's parents and grandparents. You are eligible to enroll in University of Miami long term care insurance if you are a regular full-time or part-time faculty, staff or members of affiliates working at least 50% effort. Faculty members who are members of the Associated Faculty (visiting and voluntary faculty) without the title of lecturer and temporary employees are not eligible. Coverage will begin first of the month following the date of hire.

Enrollment must be completed via benefits enrollment in Workday and a Long Term Care application must be submitted to HR-Total Rewards for you, your legal spouse, and/or eligible family members. Application can be found at benefits.miami.edu.

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:	Six Years
Elimination Period:	90 Days per Lifetime

Level of Care

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

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

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

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

Benefits

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

Benefit Duration: This is the length of time benefits would be paid as long as you continue to have a covered disability. You may move between facility and home care – depending on your need – and still receive benefits. Your benefit duration is six 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, any time after 30 days, you may apply for coverage by providing an evidence of insurability form.

Medical Underwriting: Legally recognized spouse, retirees and their legally recognized spouses and eligible family members must provide evidence of insurability to qualify for any level of coverage.

Eligible Family Members: Employee's legally recognized spouse, parents & grandparents; spouse's parents & grandparents; retirees, retiree's legally recognized spouse.

For spouse coverage, proof of relationship is required in the applicable form of a government issued marriage license. 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.

What Is Not Covered?

Unum will not make long term care payments to you for:

- chronic illness caused by war (whether declared or not) or any act of war,
- chronic illness caused by attempted suicide (while sane or insane) or self-destruction,
- chronic illness caused by a commission of a crime for which you have been convicted under state or federal law or attempting to commit a crime under state or federal law,
- chronic illness or confinements during which you are outside the United States, its territories or possessions for longer than 30 days,
- any days over fifteen days in each calendar year during which you are confined in any facility for acute care (acute care is medical care obtained as a result of an injury or a sickness requiring immediate medical intervention),
- chronic illness caused by alcoholism and drug addiction,
- chronic illness caused by voluntary use of any controlled substance unless the controlled substance is prescribed for you by a physician. ("Controlled substance" is defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and all amendments.),
- chronic illness caused by psychological or psychiatric conditions which include:
    - depression,
    - generalized anxiety disorders,
    - personality disorders,
    - schizophrenia, or

- manic depressive disorders

whether treated by drugs, counseling or other forms of therapy.
However, Unum will make payments to you for conditions that are not psychological or psychiatric in nature, including Alzheimer's disease, multi-infarct dementia, or Parkinson's disease.

Preexisting Conditions

Unum will not make any payments to you for any chronic illness that:

- is caused by, contributed to by, or results from a preexisting condition, and
- begins during the first six months after your coverage begins.

A preexisting condition is any condition that exists for which you:

- received medical treatment, consultation, care, or services, including diagnostic measures for the condition
- took drugs or medicines that were prescribed for the condition, during the six-month period right before your coverage began.

Unum calls this a preexisting condition. This preexisting conditions exclusion will apply to all insurance that does not require evidence of insurability.

Note: A pre-existing condition is not the same as a loss of Activities of Daily Living (ADLs) or severe cognitive impairment that existed before your effective date of coverage.

If you have a loss of ADLs or severe cognitive impairment before your effective date of coverage, that loss or impairment will never be covered.

If you have a condition that exists prior to your effective date of coverage and has not resulted in a loss of ADL or impairment, that condition may be a pre-existing condition. If it is a pre-existing condition and you have a loss of 2 or more ADLs or severe cognitive impairment caused by, contributed to by, or resulting from that pre-existing condition during the first six months after your effective date of coverage, these losses or impairment will not be covered.

Termination of Coverage

Coverage for you and your eligible family members will terminate when your employment terminates, you enter the Armed Forces, you die or when the master contract terminates. Insurance for eligible family members will also terminate when your coverage terminates or when they are no longer eligible family members 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.

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 or to request detailed Unum documents, contact HR-Total Rewards at 305-284-3004.

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 faculty and staff, the University of Miami offers a broad range of life and accident insurance coverages. 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	University	Two times your annual salary up to $100,000 (rounded to nearest $1,000).*
Voluntary Excess Life	You, with after-tax earnings	One to six times your annual salary (rounded to nearest $1,000) to a maximum of $1.5 million dollars.
Basic AD&D	University	One times your annual salary to $100,000 (rounded to the nearest $1,000) (full or partial benefit for dismemberment).
Voluntary AD&D	You, with pre-tax earnings	One to six times your annual salary (rounded to nearest $1,000) to a maximum of $1.5 million dollars.
One Month Death Benefit	University	One month's base salary.

**If your life insurance amount on May 31, 2010 (May 15, 2010, if a 9 month faculty), was greater than $100,000, your life insurance equals two times salary up to $200,000, but not more than the amount in force on May 31, 2010 (May 15, 2010, if a 9 month faculty). If you had a reduction in salary after May 31, 2010 your life insurance coverage will be reduced to two times your new salary up to $200,000. If you separated from the University after May 31, 2010 and return your life insurance coverage will equal two times your annual salary up to $100,000 (rounded to nearest $1,000).*

Who May Participate

You may participate in any of the University'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 faculty or staff working at least 50% effort. Faculty members who are members of the Associated Faculty (visiting and voluntary faculty) without the title of lecturer and temporary employees are not eligible.

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

For extra protection you may purchase – Voluntary AD&D and Voluntary Excess Life Insurance. You must enroll to participate. On Workday, you designate your beneficiary and authorize the University to withhold premiums for the coverage from your paycheck. Your first opportunity to enroll will be

during your first 30 days of employment. Your coverage then begins on the first of the month following the approval of your application. You may also enroll any time after 30 days of employment for Voluntary Excess Life Insurance but you will be asked to provide evidence of good health. Your coverage will begin on the first day of the month following approval of your application.

One Month Salary Benefit

If you die while employed by the University, your legally recognized spouse, named beneficiary or estate will receive a death benefit of one times one month's base salary in a single lump sum payment.

Basic Group Life Insurance

Group Life Insurance is provided at no cost to you by the University of Miami and you are automatically enrolled. The University pays the full cost of your Group Life Insurance, but there are certain income tax consequences on amounts exceeding $50,000. Please contact HR-Total Rewards for further details.

If you die while insured by the plan, benefits will be paid to your beneficiary. Group Life Insurance provides two times your basic annual earnings rounded to the nearest $1,000 up to a maximum of $100,000.

For Example:	
Basic annual earnings	$37,440
2 times basic annual earnings	$74,880
Group Life Insurance benefits	$75,000

Basic annual earnings for bi-weekly paid employees is defined as regular bi-weekly work hours (without regard to overtime) times hourly rate at last day worked times 26.1 (number of bi-weekly pay periods per year).

Basic annual earnings for administrative and research personnel is defined as base monthly salary at last day worked times number of pay periods per year (generally 12).

Basic annual earnings for faculty members is defined as contract salary plus administrative supplement(s) in effect at last day worked. If the faculty member is on a 9-month contract and death occurs during the summer months not covered by the contract, then contract salary plus administrative supplement(s) for the following academic year will be used to calculate life insurance. If the faculty member is on a sabbatical leave, basic annual earnings will be based on full contract salary.

If death occurs during a University approved leave of absence, the basic annual earnings shall be determined using earnings information at the time the leave of absence commenced.

Continuation for Medical Leave of Absence, Military Leave of Absence or Family Medical Leave

If you are an employee and your Active Service ends due to an employer approved medical leave of absence, military leave of absence or family medical leave, your insurance will continue if the required premium is paid.

1. For an employer approved medical leave of absence - 90 days
2. For military leave of absence - 30 days
3. For an employer approved family medical leave, up to the later of the period of the approved FMLA leave or the leave period required by the laws of the state in which the Employee is employed.

Continuation for Disability for Employees over Age 60
If you become Disabled and are age 60 or over, the Basic Life Insurance Benefits shown in the Schedule of Benefits will be continued, provided premiums are paid, until the earlier of the following dates:
1. The date you are no longer disabled.
2. The date coinciding with the end of the last period for which premiums are paid.
3. The date the Policy is terminated by us.

Continuation for Disability for Employees Age 60 and under
If you become disabled, the Basic Life Insurance Benefits shown in the Schedule of Benefits will be continued, provided premiums are paid, until the earlier of the following dates:
1. The date you are no longer disability.
2. The date coinciding with the end of the last period for which premiums are paid.
3. The date the Policy is terminated by us.

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 University-provided survivor protection plans if you want additional life insurance coverage. The insurer guarantees a level of the lesser of three times your annual salary to a max of $1,000,000 in coverage for faculty and staff enrolling in the Plan during the first thirty days of employment. Coverage in excess of three times your salary or $1,000,000 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 choose from one to six times your base salary, up to a maximum of $1.5 million dollars.

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	$37,800
You select 2x base salary	$38,000 x 2
(Rounded to the nearest $1,000)	
Your Voluntary Excess Life Insurance	$76,000

Your premium for Voluntary Excess Life Insurance is deducted automatically from your paycheck each month. You pay a group rate, based on:
- The level of coverage you select
- Your age
- Whether or not you are a smoker

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

Extended Death Benefit with Waiver of Premium
If you become disability and are less than age 60, the Voluntary Life Insurance Benefits will be extended without premium payment until the earlier of the following dates:
1. The date you are no longer disability; or

2. 12 months after the end of your Active Service.

Waiver of Premium
If you submit satisfactory proof that you have been continuously disability for nine months, coverage will be extended up to Social Security Normal Retirement Age.

Such proof must be submitted to New York Life Group Benefit Solutions no later than three months after the date the Waiver Waiting Period ends.

Premiums will be waived from the date we agree in writing to waive premiums for you.
After premiums have been waived for 12 months, they will be waived for future periods of 12 months, if you remain disability and submit satisfactory proof that disability continues. Satisfactory proof must be submitted to New York Life Group Benefit Solutions three months before the end of the 12-month period.

Termination of Waiver
Your insurance will end on the earliest of the following dates.
1. The date you are no longer disability;
2. The date you refuse to submit to any physical examination required by us;
3. The last day of the 12-month period of disability during which you fail to submit satisfactory proof of continued disability;
4. To Social Security Normal Retirement Age.

Continuation for Disability for Employees over Age 60
If you become disability and are age 60 or over, the Voluntary Life Insurance Benefits shown in the Schedule of Benefits will be continued, provided premiums are paid, until the earlier of the following dates:
1. The date you are no longer disability.
2. The date you are disability for 12 consecutive months.
3. The date coinciding with the end of the last period for which premiums are paid.
4. The date the Policy is terminated by us.

Spousal Coverage
The Voluntary Excess Life Insurance Plan also allows insurance coverage for a legally recognized spouse, without the completion of a health statement within the first 30 days of employment. Coverage purchased for a legal spouse after the first 30 days of employment will require review and acceptance by the insurer of a completed health questionnaire. Spousal coverage is available in units of $10,000 to a maximum of $50,000 and cannot exceed 100% of the employee's coverage until the age of 70, at which time coverage will end. Spouses are required to be non-confined and performing normal duties. Spousal coverage cost will be added to employee cost and deducted from the employee's payroll check. The monthly cost of the spouse's coverage is based on the amount of protection selected and the spouse's age.

An Employee who is the Spouse of another Employee may not be insured for Voluntary Life Insurance as both an Employee and as a Spouse at the same time.

Dependent Coverage
The Voluntary Excess Life Insurance Plan also allows insurance coverage for dependent children. Dependent coverage is limited to $5,000, $10,000 or $15,000 per dependent. The insurer guarantees a level of $15,000 in coverage for a dependent. Dependents are required to be non-confined and performing normal duties. Eligible children must meet the following requirements for coverage: dependent children – including stepchildren, foster children and legally adopted children – who are not self-supporting and are under 26 years old.(or 26 or more years old if primarily supported by the employee and incapable of self-sustaining employment by reason of mental or physical handicap). Dependent coverage cost will be added to employee cost and deducted from the employee's payroll check.

Any employee, who is eligible for Voluntary Life Insurance, will not be eligible to be insured as a Dependent Child of another employee.

Voluntary Excess Life Insurance pays a benefit if you die for any reason (except as a result of suicide anytime during the first two years of your coverage). If the benefit amount payable to a beneficiary is $5,000 or more, New York Life Group Benefit Solutions will automatically open a free, interest-bearing account in their name. A supply of personalized drafts (checks) will be mailed to the beneficiary once the claim has been approved. Personalized drafts are provided free of charge, and there are no per-draft fees, maintenance charges or penalties for withdrawal. Both the principal and any interest earned are guaranteed by New York Life Group Benefit Solutions. Any interest earned on the account may be taxable. Your beneficiary may withdraw the entire amount of the benefit payment immediately if he or she wishes. This account is not insured by the Federal Deposit Insurance Corporation or any federal agency, but is guaranteed by the state guarantee association.

To request detailed New York Life Group Benefit Solutions documents, please contact HR-Total Rewards at 305-284-3004.

Basic Accidental Death & Dismemberment

Basic Accidental Death and Dismemberment (AD&D) coverage is provided at no cost to you by the University of Miami, 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 annual salary, rounded to the nearest thousand, up to a maximum benefit of $100,000.

The schedule of covered losses is below:

Loss	**Benefit**
Loss of Life	100% of the Principal Sum
Loss of Two or More Hands or Feet	100% of the Principal Sum
Loss of Sight of Both Eyes	100% of the Principal Sum
Loss of One Hand or One Foot and Sight in One Eye	100% of the Principal Sum
Loss of Speech and Hearing (in both ears)	100% of the Principal Sum
Quadriplegia	100% of the Principal Sum
Paraplegia	75% of the Principal Sum
Hemiplegia	50% of the Principal Sum
Uniplegia	25% of the Principal Sum
Coma	
Monthly Benefit	1% of the Principal Sum
Number of Monthly Benefits	11
When Payable	At the end of each month during which the Covered Person remains comatose
Lump Sum Benefit	100% of the Principal Sum
When Payable	Beginning of the 12th month
Loss of One Hand or Foot	50% of the Principal Sum
Loss of Sight in One Eye	50% of the Principal Sum
Loss of Speech	50% of the Principal Sum
Loss of Hearing (in both ears)	50% of the Principal Sum
Loss of all Four Fingers of the Same Hand	25% of the Principal Sum
Loss of Thumb and Index Finger of the Same Hand	25% of the Principal Sum
Loss of all the Toes of the Same Foot	20% of the Principal Sum

Voluntary Accidental Death & Dismemberment

Full-time and part-time regular faculty and staff may purchase Voluntary Accidental Death and Dismemberment (AD&D) coverage. Faculty members who are members of the Associated Faculty (visiting and voluntary faculty) without the title of lecturer and temporary employees are not eligible. 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 choose from one to six times your base salary, up to a maximum of $1.5 million dollars. The Plan also offers a total disability benefit, and a special education benefit to provide for your children's schooling if you die before they finish college.

If you are covered under the Plan, you may also purchase coverage for your legally recognized spouse and dependent children – including stepchildren, foster children and legally adopted children – who are not self-supporting and are under 26 years old.(or 26 or more years old if primarily supported by the employee and incapable of self-sustaining employment by reason of mental or physical handicap).

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

Your spouse will be covered for 50% of your benefit amount, or 40% if you have eligible children. Each of your eligible children will be insured for 15% of your benefit amount, or 10% if a spouse is insured.

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	Selected principal sum
65 but less than 70	65%
70 but less than 75	45%
75 but less than 80	30%
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 and 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.

If more than one loss is sustained by an Insured Person as a result of the same accident, only one amount, the largest, will be paid.

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

1. Education Benefit for each of your dependent children who, on the date of the accident, are enrolled as a full-time student,
   a. In a school for higher learning or
   b. In the 12th grade but enrolls as full-time student in a school for higher learning within one year after your death.
2. If there are no dependent children who qualify under 1.a) or 1.b), payment of $1000 will be paid to your beneficiary

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

Permanent Total Disability
If you are permanently and totally disabled within 180 days of a covered accident occurrence, New York Life Group Benefit Solutions will pay 100% of your Principal Sum as long as you remain disabled for 12 consecutive months and after the 12 months are met, a Certified Physician must confirm that you will continue to be permanently disabled for the rest of your life. The total amount payable is reduced by any amount paid or payable under the Accidental Death and Dismemberment Benefit for the same accident. If you die before the end of the maximum benefit period, the unpaid benefits will be paid in one lump sum to your beneficiary.

Emergency Evacuation Benefit
If the Insured Person suffers an Injury or Emergency Sickness that warrants his or her Emergency Evacuation while he or she is outside a 100 mile radius from his or her current place of primary residence, the policy will pay for Covered Emergency Evacuation Expenses reasonably incurred, with no maximum limits for all Emergency Evacuations due to all Injuries from the same accident or all Emergency Sicknesses from the same or related causes.

Repatriation of Remains Benefit
If the Insured Person dies as a result of a Covered Medical Emergency, or during a Medical Evacuation covered by this Policy, the following expenses will be covered:

- Embalming;
- Cremation in the locality where death occurred and urn for return ashes;
- A container appropriate for transportation of remains;
- Autopsy if required by law;
- Expenses of securing documentation necessary for return of remains;
- Transportation of the body or remains to the Covered Person’s place of permanent residence.

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

- Suicide or intentionally self-inflicted injury
- Physical or mental disease
- War or an act of war, declared or not
- Your commission of a felony
- Travel or flight in an aircraft not intended for passengers
- Performing and/or training to become a flight crew member
- Riding in an aircraft owned, leased or operated by the Policyholder or by the Insured Person’s employer

- The Insured person being under the influence of drugs or intoxicants, unless taken under the advice of a Physician.
- Sickness, disease or infections of any kind; except bacterial infections due to an accidental cut or wound, botulism or ptomaine poisoning.

This is a summary. For a complete description of exclusions contact HR-Total Rewards at 305-284-3004.

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

Conversion Privilege
You and your insured family members may apply for a conversion policy of Accidental Death and Dismemberment insurance if insurance under the policy terminates for any reason except:
- Non-payment of premium
- When the terminated coverage is replaced within 31 days by similar coverage sponsored or arranged by your employer

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

University Retirement Plans

There are pre- and post-retirement benefits under the Employees' Retirement Plan. Also, if you are vested, your death benefit from the Employees' Retirement Plan will equal the greater of your benefit based on the value of your cash balance account or your benefit calculated under the standard formula benefit. Refer to the Employees' Retirement Plan section for more information.

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 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 designate a beneficiary, you must do so on workday.miami.edu. You may name anyone you wish, selecting the same beneficiary for all your coverages, or different beneficiaries for each. You may also name more than one beneficiary.

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

If you do not name a beneficiary or your named beneficiary is not living when benefits become payable, the death benefit will be paid in accordance with the plan document or policy governing each benefit.

Your Salary

Some of the coverage described in this section is based on your salary. For these plans, your salary is either your annual contract earnings or your base salary, depending on your job category. Overtime and overload pay or any other extraordinary compensation is not considered to be part of your salary for the purpose of these plans. As your salary and your age change, the amount of your coverage or your contributions for certain plans may need to be adjusted to reflect these changes. These adjustments will be made each January 1st 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-Total Rewards.

When Coverage Ends

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

- You leave the University or retire
- You are no longer working the minimum 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 University terminates, you may convert all or part of your Basic 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-Total Rewards 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. To convert your Voluntary Excess Life Insurance please call Life Insurance Company of North America at 1-800-423-1282. Your application and first monthly premium must be received within 30 days of the date your insurance terminates. If you die within 30 days following the date your insurance ends, your beneficiary will receive the full amount of your Voluntary AD&D (if applicable), Basic Group Life and Voluntary Excess Life Insurance coverage (if applicable) whether or not you decided to convert to an individual policy.

Claim for Benefits

Your beneficiary should notify HR-Total Rewards of your death and provide a death certificate. HR-Total Rewards will calculate the amount of benefit payable to your beneficiary and notify your beneficiary in writing. HR-Total Rewards 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-Total Rewards to obtain the necessary forms and for an explanation of the claim procedure.

To request detailed New York Life Group Benefit Solutions documents, please contact HR-Total Rewards at 305-284-3004.

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 working at least 50% effort. Faculty members who are members of the Associated Faculty (visiting and voluntary faculty) without the title of lecturer and temporary employees are not eligible. 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 1st. 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 affecting insurance coverage 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-Total Rewards 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-Total Rewards 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 legal spouse or child who no longer qualifies for coverage, you are required to notify HR-Total Rewards via Workday within 30 days of the event in order to remove the individual from coverage.

Non Compliance
Falsifying information/documentation in order to obtain/continue insurance coverage is considered a dishonest act and could lead to 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

In 2023, an FSA allows you to pay up to $3,050 a year in eligible healthcare 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).

HealthEquity/WageWorks Visa Card

When you enroll in a Health Care Flexible Spending Account, you will receive the HealthEquity/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 HealthEquity/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, HealthEquity/WageWorks will not be able to automatically substantiate your claim. Therefore, you may be asked to submit receipts.

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

Examples of Eligible Health Care Expenses

- 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
- Menstrual care products
- Certain over-the-counter (OTC) medicines and drugs

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.

Examples of Ineligible Health Care Expenses

- 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 $135,000 per year, your maximum Dependent Care contribution through UM is $1,500 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:

Examples of Eligible Dependent Care Expenses

- 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

Examples of Ineligible Dependent Care Expenses

- 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-Total Rewards 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 2023 Health Care and/or Dependent Care FSA plan may incur expenses (receive treatment, purchase supplies or receive child care services) from January 1, 2023 through March 15, 2024 and use 2023 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, 2023 through March 15, 2024. The run-out period will end on June 15, 2024.

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 benefits.miami.edu. 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 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 6, 2023 through February 17, 2023) - 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.

This SPD contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. Please refer to the "Additional Information" section of the SPD. 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.

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

FACULTY RETIREMENT PLAN (FRP)

Faculty Retirement Plan (FRP)

What the Plan Can Do for You

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

This summary plan description describes the Faculty Retirement Plan in effect as of January 1, 2023.

Who Is Eligible to Participate

You are eligible to participate in the Faculty Retirement Plan if you:

- Are a member of the University Faculty hired before June 1, 2007, or
- Are a member of the Associated Faculty with the title Lecturer, Instructor, or with a professional title prefixed by Adjunct (except for visiting or voluntary faculty) hired prior to June 1, 2007, or
- You are a former Participant who terminated service after June 1, 2007 and you were rehired within 30 days of termination.

If you are a Faculty Member who elected to participate in the Retirement Plan for Employees of the University of Miami (ERP), you are not eligible to participate in the FRP.

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

When You Can Participate

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

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

A “contract year of service” means employment as a faculty member for two regular academic semesters (excluding the summer session) in a 12-month period ending on December 31. A “month of service” is a calendar month of employment as a faculty member, plus any period of full-time or part-time regular employment at the University immediately preceding appointment as a faculty member.

Designating a Beneficiary

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

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

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

If there is no valid beneficiary form on file when you die, your spouse (if you are married) or the individual(s) provided under Florida intestate succession law (if you are single) will automatically become your beneficiary.

What the University Contributes

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

- If you were hired on or after October 1, 1984, the University will contribute 7% of your salary* until the June 1 after:
  1. You complete seven years of contract service or
  2. You complete 84 months of service or
  3. Your tenure is approved.

- If you were hired before October 1, 1984, the University will contribute 7% of your salary* until the June 1 after:
  1. You reach age 40 or
  2. You complete five years of contract service or
  3. You complete 60 months of service or
  4. Your tenure is approved.

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

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

* The Internal Revenue Service sets a limit on the amount of salary that can be taken into account for purposes of determining University contributions to the plan. For 2023, this limit is $330,000 and may change annually as determined by the Internal Revenue Service.

Sabbatical And Other Leaves of Absence

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

Where the Contributions Are Invested

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

Tier One – Fidelity Freedom Index Funds

The funds in this tier are monitored by the University of Miami Retirement Plans Review Committee.

Tier Two – Passive and Active Mutual Funds

The funds in this tier are monitored by the University of Miami Retirement Plans Review Committee.

Tier Three – TIAA Annuities

The funds in this tier are monitored by the University of Miami Retirement Plans Review Committee.

Tier Four – Fidelity BrokerageLink

The funds in this tier are NOT monitored by the University of Miami Retirement Plans Review Committee.

For detailed information about the funds offered through the plan, please visit benefits.miami.edu.

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

Protection Under ERISA Section 404(c)

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

What You Can Expect at Termination or Retirement

You may elect to receive your account from the Faculty Retirement Plan upon your separation from service. You may also elect to defer the payment of your distribution. In general, under the tax law, distributions must begin no later than April 1 of the year following attainment of age 72 and must satisfy certain "minimum distribution" rules. Your distribution options are described below.

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

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

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

First 7 years @ 7%	$ $38,700
Next 28 years @ 11%	+ 506,300
Combined contributions =	**$545,000**

Total Accumulation
These contribution amounts will accumulate over the years with compounding tax-deferred investment return credited to the chosen investment. To illustrate how the faculty member's total accumulation could vary depending on what these contributions earn, here are just two of many possibilities. The first illustration is based on a 4% annual rate of growth; the second illustration is based on a 8% annual rate of growth.

Total at 65, 4% return:	$948,000
Total at 65, 8% return:	$1,846,000

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

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

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

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

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

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

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

Death and Disability

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

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

If You Become Disabled
Should you become totally and permanently disabled and qualify for Social Security Disability benefits and for benefits under the University of Miami Long Term Disability Plan, the University will continue its contributions for you under the Faculty Retirement Plan. Contributions will be based on your University compensation during the 12 months before your regular salary stops. Contributions will continue as long as you remain eligible for disability benefits up to the end of the plan year that you attain age 65.

If You Have a Frozen ERP Benefit

Faculty members who were employed at the University by June 1, 1979 may receive their University-funded retirement income from both a defined benefit pension from the Employees' Retirement Plan trust and from contributions made under the Faculty Retirement Plan.

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

Additional Information

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

EMPLOYEES' RETIREMENT PLAN (ERP)

Employees' Retirement Plan (ERP)

What the Plan Can Do for You

The Employees' Retirement Plan will pay you a monthly benefit for your lifetime,* with payments guaranteed to a beneficiary during the first 10 years,* starting at your normal retirement date. If you separated from service prior to June 1, 2008 and if you had completed five years of vesting service, you were eligible for a Plan benefit. (In general, this would be plan years in which you had at least 1,000 hours of service.) If you separated from service on or after June 1, 2008 but before January 1, 2009, you became eligible for a Plan benefit after completing three years of vesting service. If you separate from service on or after January 1, 2009, you are automatically 100% vested regardless of your years of vesting service.

The Employees' Retirement Plan is funded entirely by the University of Miami and provides a monthly benefit to you at retirement. Along with Social Security, prior retirement plan benefits and your own retirement savings and investments, this plan can help you prepare for a financially secure retirement.

This summary plan description describes the Employees' Retirement Plan in effect as of January 1, 2023.

** if these options are elected at time of distribution*

Who Is Eligible to Participate

You are eligible to participate in the ERP if you were hired on or before May 31, 2007 and you made an election to participate in the ERP. If eligible, you became a Participant after completing at least 1,000 hours of service during a 12-consecutive-month period beginning with your date of employment or during any plan year following your date of employment.

If you leave the University and are re-hired more than 30 days after your termination date, or you are on layoff status for more than a 13-consecutive-month period, you will not be eligible to re-enter this plan. Instead, you will immediately participate in the 403(b) retirement plan if you satisfy the eligibility criteria for that plan.

Additionally, if you are a Participant in the ERP with 15 or more Years of Service and you transferred to become a member of the University faculty, you may make a one-time election to remain in the ERP.

IMPORTANT NOTE: If you elected to participate in the Retirement Savings Plan, you will not lose the benefits you have already earned under the Employees' Retirement Plan, provided you are vested when you retire or terminate your employment with the University. The benefit you have earned under the Employees' Retirement Plan will be paid to you at retirement. This summary plan description describes the benefits you have earned through your date of transfer from the Employees' Retirement Plan. Refer to the summary plan description for the Retirement Savings Plan for information about the benefit you earn for your service with the University of Miami on and after your transfer date.

When You Qualify for Benefits

The Employees' Retirement Plan (ERP) provides flexibility as to when benefits are payable. This section briefly describes when you qualify for benefits.

Normal Retirement Date (NRD)
You may retire and begin receiving your monthly benefit at your normal retirement date. Your normal retirement date is the June 1st coincident with or next following your attainment of your normal retirement age. If you were hired before age 60 and before October 1, 1987, your normal retirement age is your 65th birthday, and your normal retirement date is the coincidental or next following June 1st. If you were hired on or after October 1, 1987, your normal retirement age is the later of your 65th birthday or the fifth anniversary of the date you began participation in the Employees' Retirement Plan, and your normal retirement date is the coincidental or next following June 1st.

Early Retirement Date (ERD)
You may retire and begin receiving your monthly benefit before your normal retirement date if you have completed 10 years of service and reached age 55 or if you meet the Rule of 70 (age at separation from service plus years of service equals at least 70). If you elected to participate in the Retirement Savings Plan, your service under the Retirement Saving Plan will count towards your eligibility for early retirement under the Employees' Retirement Plan.

Late Retirement Date (LRD)
You may retire and begin receiving your monthly benefit at any time after your normal retirement date but not later than the April 1st following the year in which you turn 70½ or the April 1st following the year you separate from service, if later.

If You Leave with a Vested Benefit
If you leave the University before you are eligible for retirement but after you are vested, you will be eligible for a monthly benefit at your normal retirement date. "Vested" means that you have a non-forfeitable right to your retirement plan benefit. If you separated from service prior to June 1, 2008, you must have had at least five years of service to be vested. If you separated from service between June 1, 2008 and December 31, 2008, you must have had at least 3 years of service to be vested. If you separate from service on or after January 1, 2009, you are automatically 100% vested.

If you separated from service prior to May 1, 2013, and you have completed at least 10 years of service, you may begin receiving a reduced benefit after you reach age 55, or later, regardless of your age at the time you leave the University.

If you separated from service on or after May 1, 2013, you may elect to commence your vested benefit at any time before your normal retirement date even if you are under age 55 ("early retirement").

You may also elect to defer commencement of your benefit to the April 1st following the calendar year in which you reach age 70½.

Determining Service

The calculation of credited service, eligibility for membership and determination of vesting are all based on plan years. Prior to October 1, 1990, the plan year was the 12-consecutive-month period beginning October 1 and ending September 30. There was a short plan year from October 1, 1990 to May 31, 1991 and, as of June 1, 1991, the plan year coincides with the University's fiscal year – June 1 through May 31.

Credited service prior to October 1, 1976 is based on completed months of service. Effective October 1, 1976, one year of service is credited for each plan year in which you complete at least 1,000 hours of service. A partial year of service is credited during your first and last plan years of participation if you accumulated less than 1,000 hours.

Service Rules While Eligible for Long-Term Disability Benefits

If you qualified for such disability benefits prior to June 1, 2014, you will continue to earn service for benefit accruals. If you commence disability benefits under the University's Long-Term Disability Plan on or after June 1, 2014, you will no longer earn service for benefit accruals under the Employees' Retirement Plan. However, you may qualify for ongoing disability benefits in the form of contributions under the University of Miami Retirement Savings Plan.

You have a "break-in-service" if you earn less than 501 hours of service in any plan year. Once you incur a break-in-service, you will no longer be an active participant. If you incur a break-in-service without being vested and subsequently re-enter plan participation, your prior credited service will be restored if you work 1,000 hours in a plan year and you have less than five break-in-service years. If you are vested when your break occurs, your prior service will be automatically reinstated after you accrue 1,000 hours of service in a plan year. If you re-enter participation after October 1, 1977, the service you accumulate will be used to calculate your benefit under the revised plan formula for participants hired on or after October 1, 1977.

How the ERP Works

Your benefit is calculated using two different formulas known as the Standard Formula and the Cash Balance Formula. At retirement, you will receive the larger of the two benefits, not to exceed the IRS Section 415 limit. The IRS Section 415 limit is the lesser of:

- 100% of the highest consecutive three year average compensation or
- $330,000 per year based on a straight life annuity for plan year beginning January 1, 2023 (the limit is adjusted annually for cost of living increases).

The following sections describe how your benefit is calculated under the Standard Formula, based on your date of hire and under the Cash Balance Formula.

The Standard Formula Benefit
FOR EMPLOYEES HIRED BEFORE OCTOBER 1, 1977

The Standard Formula used to determine your annual benefit at your normal retirement date is:

7/8% of final average compensation up to $4,800
\+ 1 3/8% of final average compensation over $4,800
x Years of credited service

Your **final average compensation** is the average of your annual compensation during your highest paid five consecutive years ending May 31, including any pre-tax contributions you make to your benefit plans, and overtime and overload earnings as of June 1, 1989. If you worked less than 1,000 hours during the plan year, compensation for that year is not included.

Example 1: Normal Retirement (Hired Before October 1, 1977)

James retired at age 65 from the University of Miami after 38 years of service. His final average compensation was $80,000, and his Standard Formula benefit was figured as follows:

a.	7/8% of $4,800	=	$ 42.00
b.	1 3/8% of $75,200	=	1,034.00
c.	Sum of a) and b)	=	1,076.00
d.	$1,076 x 38	=	40,888.00

James' Standard Formula benefit is $40,888.00 per year based on a 10-year certain and continuous annuity. This amount will be compared to the amount provided under the Cash Balance Formula and he will receive the larger of the two benefits.

Example 2: Early Retirement (Hired Before October 1, 1977)
Eleanor elected early retirement at age 62 after 35 years of service. Her final average compensation was $60,000 and her benefit – payable once she reaches her normal retirement date – was computed as follows:

a.	7/8% of $4,800	=	$42.00
b.	1 3/8% of $55,200	=	759.00
c.	Sum of a. and b.	=	801.00
d.	$801.00 x 35	=	28,035.00

Eleanor's Standard Formula benefit is $28,035 per year based on a 10-year certain and continuous annuity. This amount will be compared to the amount provided under the Cash Balance Formula and she will receive the larger of the two benefits.

The Standard Formula Benefit
FOR EMPLOYEES HIRED ON OR AFTER OCTOBER 1, 1977
The Standard Formula used to determine your annual benefit at your normal retirement date if you have 35 years of service is:

	32.5% of final average compensation up to covered compensation*
+	50% of final average compensation over covered compensation*

*Covered compensation is the average Social Security wage base during the last 35 years before your Social Security retirement age.

(NOTE: If you have less than 35 years of credited service, your Standard Formula benefit will be proportionately reduced).

Example 3: Normal Retirement (Hired on or after October 1, 1977)
When Jane retired from the University of Miami at age 65 after 15 years of service, her final average compensation was $75,000 and covered compensation was $67,308. Her benefit was computed as follows:

a.	32.5% of $67,308	=	$21,875.10
b.	50% of $7,692	=	3,846.00
c.	Sum of a) and b)	=	25,721.10
d.	$25,721.10 x 15/35	=	11,023.33

Jane's Standard Formula benefit is $11,023.33 per year based on a 10-year certain and continuous annuity. This amount will be compared to the amount provided under the Cash Balance Formula and she will receive the larger of the two benefits.

Example 4: Termination of Employment Prior to Eligibility for a Retirement Benefit (Hired on or after October 1, 1977)
George left the University of Miami after nine years of service at age 48 and with final average compensation of $50,000. His covered compensation was $102,780. The annual accrued retirement income under the Standard Formula was computed as follows:

a.	32.5% of $50,000	=	$16,250.00
b.	50% of covered compensation over $102,780	=	0.00
c.	Sum of a) and b)	=	16,250.00
d.	$16,250.00 x 9/35	=	4,178.57

George's annual accrued retirement income at his normal retirement date is $4,178.57 under the Standard Formula. This amount will be compared to the amount provided under the Cash Balance Formula and his monthly benefit will be based on the larger of the two amounts.

The Cash Balance Formula
Each year that you are a participant in the Employees' Retirement Plan, you may earn cash balance credits. When you retire, you will receive a lifetime income based on your cash balance account or the Standard Formula benefit, whichever is larger.

Your cash balance benefit can include three kinds of credits:

- Pay Credits, based on your pay and years of service after October 1, 1988
- Investment Credits, based on the total value of your cash balance account each year and
- An Opening Account Balance, for service completed before October 1, 1988, if applicable.

Pay Credits
At the end of each plan year, your cash balance account will receive a credit which will be a percentage of your pay ending each May 31, according to the following table: (The percentage will depend on the years of service you have completed as of the beginning of the plan year).

Completed Service at Beginning of Year:	Credit to your Cash Balance Account
Less than 1 year*	3.25% of pay
1 through 2 years	3.25% of pay
3 through 4 years	4% of pay
5 through 9 years	5% of pay
10 through 14 years**	7% of pay
15 through 19 years	8% of pay
20 or more years	11% of pay

*For your first year of participation, you would receive a pro-rated credit based on your completed months of participation as of the end of the first plan year.

**For plan years beginning prior to June 1, 2017, the pay credit was 6% of pay.

Example 5: Full Year of Service
If you have completed 10 years of service and your annual pay for the plan year ending May 31 is $50,000, the pay credit assigned to your cash balance account as of May 31 would be $3,500 (7% of $50,000).

Investment Credits
The University assigns your cash balance account an investment credit on an annual basis.
For plan years starting on or after June 1, 2017, investment credits are determined using a formula based on the 24 month average yield on U.S. long-term corporate bonds, reported by the IRS as the "Third Segment Rate" for the month of February prior to the beginning of the plan year. The minimum investment credit is 4% for a full plan year.

For plan years beginning prior to June 1, 2017, investment credits was determined using a formula based on the average rate of six-month Treasury Bills and the actual investment return earned by the Employees' Retirement Plan Trust Fund. The minimum investment credit was 5.5% for a full plan year. The maximum investment credit was 9%.

Opening Account Balance
A cash balance account was created for each participant in the Employees' Retirement Plan as of October 1, 1988, reflecting each participant's years of service before this date.
The beginning balance was figured using the larger of (a) or (b) below:

a. The amount in the cash balance account as if it had been in effect when plan participation began, using the final average compensation through May 31, 1988 and the following assumptions:
   - Pay had increased 6% annually during University employment and
   - The cash balance account was credited with an investment return of 8% annually since October 1, 1985 and 6% for each year before that date

OR

b. The single-sum value of the Standard Formula benefit as of October 1, 1988.

Upon retirement, the total amount of your cash balance account is converted to a lifetime monthly benefit. That amount is then compared to the monthly amount which can be provided by the Standard Formula. You will receive whichever monthly benefit is larger.

If you leave the University before your normal retirement date but after you are vested, investment credits will continue to be added annually to your cash balance account, until you actually begin receiving your retirement benefit.

Example 6: Adding in Investment Credits
Here, we assume that you have a beginning account balance of $10,000, receive an investment credit (5%) and a 7% pay credit on a salary of $30,000:

Beginning balance - as of beginning of plan year (June 1)	$ 10,000
Investment credit (5% of $10,000)	$ 500
Pay credit (7% of $30,000)	$ 2,100
Ending balance - at end of plan year (May 31)	$ 12,600

Investment credits continue to be credited to your cash balance account annually until you begin receiving benefits. Your benefit will be based on the larger of the Standard Formula or the benefit provided by the accumulations in the cash balance account (the Cash Balance Formula).

Early Retirement Benefits

When you have reached age 55 and have completed at least 10 years of credited service, or if you leave the University on or after January 1, 2001 and your age at separation from service plus credited service is at least 70, you are eligible for early retirement benefits.

If you elect to retire from the University after reaching age 45 but before age 65, your Standard Formula benefit will be reduced according to the following table:

Age When Benefit Begins	Reduction In Benefit	Age When Benefit Begins	Reduction In Benefit *
45	77.75%	55	50.00%
46	75.96%	56	46.67%
47	74.00%	57	43.33%
48	71.87%	58	40.00%
49	69.54%	59	36.67%
50	67.00%	60	33.33%
51	64.20%	61	26.67%
52	61.36%	62	20.00%
53	57.77%	63	13.33%
54	54.08%	64	6.67%

*Reduction does not apply if you elect to receive your benefit upon retirement from the University after reaching age 62.

If you elect early retirement, your Standard Formula benefit will still be compared to the Cash Balance Formula benefit. You will receive whichever benefit is larger, not to exceed the IRS Section 415 limit.

When you are ready to retire or leave the University, you should request a Retirement Kit by contacting the ERP Pension Service Center at 855-662-0118 (or 678-981-2775 for international callers). You should request a Retirement Kit at least 30 days, but not more than 180 days, in advance of your anticipated termination date.

Late Retirement Benefits

Normal Retirement Date before June 1, 2014

If you reached your normal retirement date before June 1, 2014 and you continue working at the University past your normal retirement date, you will receive a lifetime benefit at actual retirement based on the largest of the following, not to exceed the IRS Section 415 limit:

- Your cash balance account, including pay credits and investment credits up to your late retirement date
- The Standard Formula benefit, using final average compensation and credited service as of your late retirement date or
- The monthly benefit provided by the single-sum value, using the Standard Formula benefit at your normal retirement date increased with interest up to your late retirement date.

Normal Retirement Date on or After June 1, 2014

If you reach your normal retirement date on or after June 1, 2014 and you continue working at the University past your normal retirement date, you will receive a lifetime benefit at actual retirement based on the largest of the following, not to exceed the IRS Section 415 limit:

- Your cash balance account, including pay credits and investment credits up to your late retirement date
- The Standard Formula benefit, using final average compensation and credited service as of your late retirement date.
- If you work beyond age 70 ½ your benefit will be adjusted to reflect actuarial increases from age 70 ½ to your late retirement date

In addition, you have the option to commence your retirement benefit in the normal form of payment (see “Benefit Payment Options” below) while still actively employed but you must do so within six months of your normal retirement date. If you elect this option, your final benefit at actual retirement will be reduced by the actuarial value of benefits that you have already received. However, your benefit at actual retirement will not be less than the actuarial value of your benefit paid at the time your benefit initially commenced.

Suspension of Benefits

If you reach your normal retirement date on or after June 1, 2014 and continue in active employment, you will be provided with a special notice that describes the suspension of your benefit and the impact on your benefit in more detail, including the applicable Department of Labor regulations. Special rules regarding the notice and your benefits also apply if you defer commencement of your retirement benefit but work less than 40 hours in a calendar month. In addition, the notice will inform you how to request a review of the suspension of your benefits. Such requests will be considered under the Plan’s claims procedures.

Early Payment of Vested Benefit

***If you separated from service prior to May 1, 2013*:** Early retirement benefits are payable as a reduced benefit as described in the "Early Retirement Benefits" section above if you commence your benefit at or after age 55.

***If you separated from service on or after May 1, 2013*:** Early retirement benefits are payable as a reduced benefit as described in the "Early Retirement Benefits" section above if you commence your benefit at or after age 55. For early commencement before age 55, the Plan's early retirement factors as described above will be used to determine the reduction to age 55, and then a further reduction based on the Plan's actuarial basis will be applied for your age at benefit commencement that is below age 55. You will be eligible to commence your benefit as a lump sum or in the normal form of payment.

Death and Disability

If you should die while actively working for the University and before your benefit begins, your named beneficiary will receive a benefit based on the larger of the Standard Formula or the Cash Balance Formula, not to exceed the IRS Section 415 limit. Your beneficiary will receive a lump-sum distribution, and if you were married, your spouse will also have the option to elect a monthly benefit for life, beginning on the first of the month following your date of death. Availability of the lump sum distribution option is subject to restrictions imposed by federal law in effect at the time of the distribution.

If you die before your benefit begins but after you have left the University (assuming you are 100% vested), your beneficiary will be eligible for a distribution beginning on the first of the month following your date of death.

If you were hired before October 1, 1977 and should die while actively employed at the University, the death benefit will not be less than the benefit which could be provided by an amount equal to one times your annual salary, limited to 100 times the benefit you would have earned if you continued working at the University until age 65, with no change in annual salary.

In the event of your death after retirement, there may be a monthly benefit continued to your named beneficiary, depending upon the option you selected when you retired.

If you qualified for disability (i.e., you commenced LTD benefits prior to June 1, 2014), you may commence your benefits at any time, however, you will be deemed to have terminated employment when you commence benefits. Also, you cannot receive benefits at the same time from this Plan and the University's LTD Plan.

Benefit Payment Options

Regardless of whether your monthly benefit is based on the Standard Formula or the Cash Balance Formula, you can choose from several forms of payment. You will need to complete certain forms to specify how benefits should be paid and the date that benefit payments should commence.

When you are ready to retire or leave the University, you should request a Retirement Kit by contacting the Pension Service Center at 855-662-0118 (or 678-981-2775 for international callers). The Retirement Kit will include the payment options available to you, the forms you need to complete, and information to guide you through the election process. You should request a Retirement Kit at least 30 days, but not more than 180 days, in advance of your anticipated termination date. If you request the Retirement Kit at least 30 days in advance of your anticipated

termination date, your pension benefit will be calculated as of the day immediately following your date of termination.

If you are married when your benefit begins, you will need to elect one of the contingent annuitant options with your spouse as your joint annuitant. If you elect an option which does not provide your spouse with at least 100% of the benefit you were receiving for his or her lifetime, you must provide a notarized spousal consent form.

The following are the forms of payment available, subject to the eligibility conditions and restrictions described below:

Generally Available Distribution Options

- **Full Lump Sum Distribution.** You can elect to receive your retirement benefit in the form of a lump sum distribution. There will be no further payments due to you from the Plan. Availability of this option is subject to restrictions imposed by federal law in effect at the time of distribution.
- **Mandatory Lump Sum Distribution**. If the full lump sum value of a retirement or death benefit is $5,000 or less, you will receive the distribution as an immediate lump sum payment.
- **10-Year Certain and Continuous Annuity**. The monthly benefit figured using the larger of the Standard Formula or the Cash Balance Formula is a 10-year certain and continuous annuity and is the normal form of payment for single individuals. It guarantees a lifetime income to you and, in the event of your death any time during the first 10 years, provides the same monthly benefit to your beneficiary for the balance of the 10-year period, if any. If your beneficiary does not survive to receive the balance of the 120 payments, payments will be made to the contingent beneficiary you have named. If you have not named a contingent beneficiary, payments will be made to your beneficiary's beneficiary or, if one has not been named, to your beneficiary's estate.
- **Life Annuity**. A monthly benefit is paid to you for your lifetime, with **no** provision to continue benefits to a beneficiary in the event of your death. Because no benefits are payable in the event of your death, the monthly benefit is larger than the normal form, described above.
- **Contingent Annuitant Options**. Your monthly benefit is adjusted to provide a lifetime benefit to you, and a continuing benefit to your beneficiary after your death for his or her lifetime. The percentage will depend upon the option you elect: a 50%, 66 2/3% or 100% contingent annuitant option. It will also depend upon your age and that of your beneficiary. If your beneficiary predeceases you, your benefit will continue for your lifetime and ceases upon your death. The 100% contingent annuitant option with your spouse as the named beneficiary is the normal form of payment for married individuals.

Special Distribution Options

- **Partial Lump Sum Distribution.** If you meet the Rule of 70 (age at separation from service plus years of service must equal at least 70), you can elect to receive a portion (up to 60% of the total lump sum value) of your retirement benefit as a partial lump sum distribution with the remainder of the benefit paid to you in one of the benefit payment options listed above
- **Hardship Distribution**. If a participant who has terminated employment faces a financial hardship, he or she may address a request for a hardship distribution to the UM Retirement Plans Review Committee prior to his or her pension starting date. A notarized Spousal Consent Form must accompany the request if the participant is married. If the request is approved, the Plan may pay the vested benefit, or any portion thereof, in a lump sum not to exceed $3,000 per event causing the hardship. For these purposes, a financial hardship means an immediate and heavy financial need where other resources are not available including:
    - A sickness or disability condition affecting you or a member of your immediate family
    - The need to provide for education or adequate housing for you or for any of your children or dependents
    - Layoff or

- Divorce.

Availability of this option is subject to restrictions imposed by federal law in effect at the time of distribution.

Benefits accrued under the International Oceanographic Foundation (IOF) Pension Plan were "frozen" as of October 31, 1989 when that plan was merged into the Employees' Retirement Plan. Upon retirement, participants in the IOF Plan will receive a "frozen" benefit, plus any benefit which has accrued under the Employees' Retirement Plan, based on participation as of November 1, 1989, or upon their date of transfer to University employment on or after July 1, 1986, if earlier.

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.

Transfers Out of the ERP

Eligible faculty members who were employed at the University before June 1, 1979 and transferred to the Faculty Retirement Plan may qualify for a benefit from the Employees' Retirement Plan, as well as a benefit from contributions made to the Faculty Retirement Plan.

Eligible non-faculty members who participated in the Employees' Retirement Plan and transferred to the Retirement Savings Plan may qualify for a benefit from the Employees' Retirement Plan as well as a benefit from contributions made to the Retirement Savings Plan.

Any benefit from the Employees' Retirement Plan for which a participant is eligible will be based on service and salaries earned prior to participation in the Faculty Retirement Plan or Retirement Savings Plan, as applicable. The "frozen" ERP benefit will be held in trust for future payments to be provided under either the Standard Formula or the Cash Balance Formula, whichever is larger. The Cash Balance Formula is based on service and final average compensation at the time of transfer to the Faculty Retirement Plan or Retirement Savings Plan, as applicable, and investment credits are applied to the account each year until retirement.

Additional Information

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

RETIREMENT SAVINGS PLAN (RSP)

Retirement Savings Plan (RSP)

What the Plan Can Do for You

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

- **An automatic core contribution**. If you are eligible, the University will make a contribution to your retirement account, based on your earnings.
- **Voluntary and matching contributions**. You may also contribute to your retirement account. If you do, you have the option to contribute on a pre-tax basis and benefit from current tax savings or you may contribute through the Roth option which is on an after-tax basis and save on taxes at retirement. If you are eligible, the University will also match a percentage of your contributions.
- **Rollover Contributions**. You may roll over to the Plan distributions that you receive from certain other retirement arrangements, such as other Section 403(b) plans, individual retirement accounts ("IRAs"), tax-qualified plans (including 401(k) or other 401(a) plans)..
- **Investment earnings**. You decide how to invest your account balance – including the core contributions, your voluntary contributions (and rollover contributions, if any) and the matching contributions. You have several investment 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 (see Loans and Withdrawal sections below). When you separate from service, you decide how and when to receive payment. Along with Social Security, any supplemental retirement annuities you purchase, prior retirement plan benefits and your own investments, this plan can help you prepare for a financially secure retirement.

This summary plan description describes the Retirement Savings Plan in effect as of January 1, 2023.

Who Is Eligible to Participate

You are eligible to participate in the Retirement Savings Plan if you are an employee of the University or an Affiliate, and you are not:

- A leased employee
- Covered by a collective bargaining agreement, unless the agreement expressly provides for the inclusion of your employment classification as an eligible employee in the RSP
- A student at the University
- A faculty member who is a member of the Associated Faculty (voluntary or visiting faculty) without the title of Lecturer (instructors or lecturers who are categorized as regular full-time are eligible and not excluded)
- An employee who is an active participant in the Retirement Plan for Employees of the University of Miami (ERP), the Defined Contribution Plan for Faculty of the University of Miami (FRP), the University of Miami Retirement Savings Plan II (RSPII), or the UHealth Retirement Savings Plan (RSPIII),
- An employee assigned to eligibility company "UMH," "UHCorp*," "UMHC*," or "ABLEH*," and who is or may become eligible to participate in the RSPII or UHealth RSP
- A former employee who works less than twenty hours a week and whose benefits under the Plan have been paid or have commenced
- A resident of the University's Medical School

** hired on or after December 16, 2019*

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

If you are an active participant in the Retirement Plan for Employees of the University of Miami (ERP) and you first commence disability benefits on or after June 1, 2014 under the University of Miami Long-Term Disability Plan (LTD Plan), you are eligible to participate in the RSP as of the date you first commence disability benefits under the LTD Plan.

When You Can Participate

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

Enrolling in the Plan

Employee Contributions

Affirmative Election Contributions. You are eligible to make employee pre-tax or after-tax (Roth) contributions on the first day of any payroll period following the date you become eligible to participate in the Plan. You can make contributions to the Plan by visiting netbenefits.com/um and making your online election or by contacting Fidelity Investments at 1-800-642-7131. Your employee contributions for a payroll period will be made as soon as reasonably practical following the end of the payroll period.

Automatic Employee Contributions

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

You may increase, decrease, change between pre-tax or the Roth option, or stop your contributions at any time by visiting netbenefits.com/um or by contacting Fidelity Investments at 1-800-642-7131.

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, or change between pre-tax and post-tax contributions at any time. See the "Where the Contributions are Invested" section for more information.

Employer Contributions

You become eligible for matching and core contributions after you complete one year of service and worked 1,000 hours within the anniversary year.

Designating a Beneficiary

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

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

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

If there is no valid beneficiary form on file when you die, your spouse (if you are married) or the individual(s) provided under Florida intestate succession law (if you are single) will automatically become your beneficiary.

How Your Account Can Grow

The Automatic Core Contribution

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

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

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

Example: Core Contribution

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

$48,000 x 5% = $2,400

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

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

Your Voluntary Contributions
When you become eligible, you may contribute any percentage of your compensation from 1% to 90% to the plan, up to federal limits. Your voluntary contributions may be deducted from your paycheck before federal taxes are withheld or through the Roth option which is after federal taxes are withheld. Contributions made on a pre-tax basis means you pay federal taxes on contributions and earnings when you withdraw the funds in retirement. With the Roth option, you pay taxes on your contributions now, and then withdraw your contributions and any qualified earnings tax-free in retirement.

If you elect not to contribute during your first year of service, you will automatically be set up to save 1.5% of your compensation in the plan as your voluntary pre-tax contributions – unless you elect to contribute at a different level before you complete your first year of service. You may increase, decrease, change between pre-tax and Roth contributions, or stop contributing at any time. The change will become effective as of the next applicable pay period or as soon as administratively feasible.

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

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

Catch-Up Contributions
In order to give those who are closest to retirement an additional opportunity to put away more money on a tax-favored basis for retirement, an additional savings option ("catch-up contributions") is available under the Retirement Savings Plan. If you are over age 50 or will reach age 50 during the year, you may contribute up to an additional $7,500 in 2023 as a catch-up contribution to the plan. You must save the maximum allowed under the plan in order to make catch-up contributions. The maximum allowed catch-up contribution may change as determined by the Internal Revenue Service.

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

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

Internal Revenue Code Limits
Your total voluntary contributions to the Retirement Savings Plan – not including any catch-up contributions – may not exceed the annual dollar limit for pre-tax deferrals as specified under the Internal Revenue Code (IRC) and adjusted by the Internal Revenue Service (IRS) each calendar year. For 2023, the dollar limit for pre-tax contributions is $22,500. If you are at least age 50, you may contribute more – up to $30,000 in 2023.

The IRS also adjusts the total annual contributions that can be made to the Retirement Savings Plan. Total annual contributions include automatic core contributions, your voluntary contributions and matching contributions. Catch-up contributions are not included in this limit. For 2023, the limit on total annual contributions is $66,000.

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 2023, this limit is $330,000.

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

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

Where the Contributions are Invested

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

Tier One – Fidelity Freedom Index Funds
The funds in this tier are monitored by the University of Miami Retirement Plans Review Committee.

Tier Two – Passive and Active Mutual Funds
The funds in this tier are monitored by the University of Miami Retirement Plans Review Committee.

Tier Three – TIAA Annuities
The funds in this tier are monitored by the University of Miami Retirement Plans Review Committee.

Tier Four – Fidelity BrokerageLink
The funds in this tier are NOT monitored by the University of Miami Retirement Plans Review Committee.

For detailed information about the funds offered through the plan please visit benefits.miami.edu. It is important to thoroughly review and carefully consider the investments available on a regular basis and to make changes as needed. It is also vital that you keep your beneficiary designation current. If you wish to change your beneficiary, you must request the form directly from Fidelity Investments or TIAA.

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

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

Vesting

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

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

You earn a year of vesting service for each plan year in which you work at least 1,000 hours from your date of hire to your date of termination, subject to the plan's break in service rules. Generally, hours are counted based on the actual hours you work and in certain cases may be based on periods you work if hours are not actually tracked.

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

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

If you are not vested in your core contribution account balance when you separate from service and you are reemployed before incurring five consecutive one-year breaks in service, your account balance will be restored.

What You Can Expect at Termination or Retirement

You may elect to receive the vested portion of your account from the Retirement Savings Plan upon your separation from service. You may also elect to defer the payment of your distribution.

In general, under the tax law, distributions must begin no later than April 1 of the year following attainment of age 72 and must satisfy certain “minimum distribution” rules. Your distribution options are described below.

Example: How Your Account Grows
It is important to understand what the value of the automatic core contribution means for your retirement years – and how you may want to save on a voluntary basis to ensure a financially secure retirement. We will assume that you become eligible for the Retirement Savings Plan at age 30, when earning $50,000 a year. We will assume that your pay grows by 3% per year and that you contribute 5% of your compensation to the plan and receive a 5% matching contribution.

Your contributions and the University’s contributions will accumulate over the years with compounding tax-deferred investment returns. To illustrate how your total accumulation could vary depending on what these contributions earn, here are just two of many possibilities. The first illustration is based on a 4% annual investment return; the second illustration is based on an 8% annual investment return.

Total at 65, 4% return:	$566,000
Total at 65, 8% return:	$1,197,000

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

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

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

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

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

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

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

Death and Disability

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

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

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

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

Loans

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

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

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

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

The period of repayment must be agreed upon by you and Fidelity Investments. The maximum period of repayment is five years (10 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 voluntary contributions in the case of "financial hardship" as defined by the IRS. The University's automatic core and matching contributions and any investment earnings cannot be withdrawn while you are employed. A financial hardship withdrawal must be approved by the University in advance.

Financial hardships currently include the following:

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

You must have taken any other available 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.

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

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

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

Additional Information

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

SUPPLEMENTAL RETIREMENT ANNUITIES (SRA)

Supplemental Retirement Annuities (SRA)

What the Plan Can Do for You

If you are an eligible employee, you have the option to save and invest your own money on a pre-tax basis and benefit from current tax savings or you may contribute through the Roth option which is on an after-tax basis and save on taxes at retirement or Roth (post-tax) basis to build additional assets for the future through the Supplemental Retirement Annuity Program. The amount you can save annually in the Supplemental Retirement Annuity Program is based on your taxable compensation and provisions in the law. Contact HR-Benefits for information on individual limits.

This summary plan description describes the SRA Plan in effect as of January 1, 2023.

Who is Eligible to Participate

You are eligible to participate in the SRA if you are:

- A participant in the Retirement Plan for Employees of the University of Miami (ERP) or
- A participant in the Defined Contribution Plan for Faculty of the University of Miami (FRP);

In order to be an eligible employee, you must not be considered a non-resident alien.

If you are an eligible employee you may enroll in the Supplemental Retirement Annuity Program at any time after you are employed. You can make contributions to the Plan by visiting netbenefits.com/um and making your on-line election or by contacting Fidelity Investments at 1-800-642-7131. Your employee contributions for a payroll period will be made as soon as reasonably practical following the end of the payroll period.

Other employees of the University, including students and employees who are eligible for the Retirement Savings Plan, are generally not eligible to participate in the Supplemental Retirement Annuity Plan.

Designating a Beneficiary

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

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

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

If there is no valid beneficiary form on file when you die, your spouse (if you are married) or the individual(s) provided under Florida intestate succession law (if you are single) will automatically become your beneficiary.

The Tax Advantages

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

The funds in your account, including any earnings on your investment, will not be taxed until you receive them. Access to your account is limited except as allowed by law. Loans and withdrawals may also be offered through this program.

Roth (post-tax):
Unlike the pre-tax contribution, your designated Roth contribution will be included in your gross income for tax purposes. Your net pay may be less than it would be if you made a traditional pre-tax contribution. With a Roth contribution, you pay the taxes now on the contributions you elect to defer. Upon withdrawal, Roth contributions and associated earnings are tax-free, provided the five-year aging requirement has been satisfied and one of the following conditions is met – age 59½, disability, or death.

For example*:
If your annual income is $80,000 and you elect to designate 6% of your salary to Roth contributions instead of your current 6% of your salary to traditional pre-tax contributions, your net pay will be reduced as shown in the chart below:

	Pre-tax	Roth
Your monthly contribution into each account	$400	$400
Your reduction in take-home pay	$400	$300

**This hypothetical example is based solely on an assumed federal income tax rate of 25%. No other payroll deductions are taken into account. Your own results will be based on your individual tax situation.*

Internal Revenue Code Limits
Your voluntary contributions to the Supplemental Retirement Annuity Program – not including any catch-up contributions – may not exceed the annual dollar limit for pre-tax contributions as specified under the Internal Revenue Code (IRC) and adjusted by the Internal Revenue Service (IRS) each calendar year. For 2023, the dollar limit for pre-tax contributions is $22,500. This includes both pre-tax and Roth contributions.

In order to give those who are closest to retirement an additional opportunity to put away more money on a tax-favored basis for retirement, an additional savings option ("catch-up contributions") is available under the Supplemental Retirement Annuity Program. If you are over age 50 or will reach age 50 during the year, you may contribute up to an additional $7,500 in 2023 on a pre-tax basis as a catch-up contribution to the plan. You must save the maximum allowed under the plan on a pre-tax basis in order to make catch-up contributions. In future years, these limits may change as determined by the Internal Revenue Service.

Investment Options

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

Tier One – Fidelity Freedom Index Funds
The funds in this tier are monitored by the University of Miami Retirement Plans Review Committee.

Tier Two – Passive and Active Mutual Funds
The funds in this tier are monitored by the University of Miami Retirement Plans Review Committee.

Tier Three – TIAA Annuities
The funds in this tier are monitored by the University of Miami Retirement Plans Review Committee.

Tier Four – Fidelity BrokerageLink
The funds in this tier are NOT monitored by the University of Miami Retirement Plans Review Committee.

For detailed information about the funds offered through the plan, please visit benefits.miami.edu.

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

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

Loans

Although this program was set up to encourage you to save for your retirement, it does offer you the option to take loans while you are actively employed, according to specific IRS rules.
You may have multiple outstanding loans at any time. In general, the maximum amount of all loans cannot exceed 50% of the value of your contributions or $50,000, whichever is less. Any loan from another plan sponsored by the University is included in this maximum. 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 or any prior investment provider, you must transfer enough funds from your investment provider to Fidelity to support the loan amount and then request a loan from your Fidelity account. Please contact Fidelity Investments for assistance.

The period of repayment must be agreed upon by you and Fidelity Investments. The maximum period of repayment is five years (20 years for loans used to purchase your principal residence). You may prepay your loan in full at any time without penalty.
If you are married, you must obtain your spouse's notarized consent to be able to take a loan from the plan.

To apply for a loan, please contact Fidelity Investments.

Withdrawals

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

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

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

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

You must have taken any other available 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.

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

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

When Benefits are Paid

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

Benefit Payment Options

Distribution Options

When you are eligible to receive payments from the plan, the value of your vested account may be rolled over into an IRA or paid as a full lump sum. Other distribution options, including annuity options, are also available under the annuity or custodial contract under the plan.

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

If you are not married when benefit payments begin, you may select from the wide range of annuity options available through the investment companies referenced in the section "Investment Options."

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

Employment after Retirement

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

Personal Statements

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

Information for Participants Who Joined the RSP

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

Additional Information

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

TUITION REMISSION POLICY

Tuition Remission 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 marriage license is proof of dependency for spouse.

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

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

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

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

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

1. An employee who separates from service on or after age 65 with a minimum of five years of fully benefits eligible years of service
2. An employee who separates from service on or after age 55 with a minimum of 10 years of fully benefits eligible years of service
3. An employee who meets the Rule of 70 (age at separation from service plus fully benefits eligible years of service is at least 70)

Employee Coverage

Employee

The University will grant tuition remission to all full-time or part-time regular employees who have completed 90 calendar days of continuous employment at the University prior to the first scheduled day of class as published in the University Bulletin. Faculty members who are members of the Associated Faculty (visiting and voluntary faculty) without the title of lecturer and temporary employees are not eligible. If the completion of the 90 days falls after the first scheduled day of class, eligibility shall commence at the next successive regular registration.

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

Accountability:

Employees who do not successfully complete a course (i.e. do not receive credit for the course within the semester in which it was taken) will be responsible for all or a portion of the tuition cost

for the course. The charge to the employee will be based on the amount actually charged to tuition remission for the unsuccessful course based on the Student Accounts Tuition Drop Schedule. The charge will be applied to the employee's student account.

Full-time Employees Attending Class
Full-Time employees may attend class during assigned regular working hours with the prior approval from the supervisor and appropriate vice president/dean.

Part-Time Regular Employee
Part-Time regular employees are eligible for prorated tuition remission for up to two courses per semester with a maximum of 15 credits per calendar year.

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

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

Summer Scholars Program
The three week credited program is covered for dependent children at the appropriate rate per the employee's years of service. The credits used during this program will count against the dependent child's 128 attempted credit maximum. The two week non-credited program is **NOT** covered.

Dependent/Spouse Coverage

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

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

Faculty members who are members of the Associated Faculty (visiting and voluntary faculty) without the title of lecturer and temporary employees are not eligible.

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

Years of Employment	Benefit[(1)]
< 1	0%
1-4 years	70%
5-9 years	85%
10+ years	100%

[(1)] The benefit for spouses and eligible unmarried dependents of part-time employees is prorated.

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-Total Rewards for information regarding dependent tuition remission for part-time regular employees.

Financial Aid Requirements (100% dependent tuition remission recipients only)

EASE REQUIREMENTS - All full-time undergraduate students who plan to use tuition remission are required to apply for the Effective Access to Student Education Program (EASE). New students and their parent/claimant must complete a Certificate of FL Residency application or a FAFSA to apply. All dependents who are certified as Florida residents and qualify for the EASE will have the amount of the EASE subtracted from their charges for tuition and fees; tuition remission may cover the remaining entitled costs up to the employee's benefit rate. If a dependent does not complete the certification requirements, tuition remission will not be increased to cover costs that the EASE funds would have covered. This EASE policy affects only dependents who are full-time undergraduate students eligible for 100% tuition remission. This EASE policy does not affect dependents receiving less than 100% 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-Total Rewards who will consider each request on a case-by-case basis.

Normal Progress after graduation from Undergraduate Program

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

Dependent Eligibility Requirements

Proof of Dependency

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

Change in Employee Status

Termination of an Employee

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

Involuntary Termination

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

Employees Placed on Layoff

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

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

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

Returning to Employment

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

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

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

Disability of an Employee
Employees approved for Long Term Disability are eligible for tuition remission for themselves and eligible dependents as set forth in this policy at the same rate eligible when approved for long-term disability.

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

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

Graduate Taxation

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

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

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

Estimated Graduate Taxation
It is advised to complete a Graduate Tuition Remission Taxation 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-Total Rewards 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 an employee or dependent drops taxable graduate courses after the course withdrawal date, the course remains taxable to the employee.

What Is Not Covered

Tuition Remission is not available in the following programs:

- School of Law or School of Medicine
- Special programs including the Executive MBA, Working Professional MBA
- UOnline programs, Frost Online and other exclusively online programs
- Doctoral level study
- 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
- Test Prep Courses (GRE, GMAT, LSAT, SAT, etc.) are not eligible for tuition remission.

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

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-Total Rewards 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 will be attending the University of Miami and using tuition remission, the employee must provide proof of dependency or marriage if the dependent is not currently covered on the employee's medical and/or dental plan. Proof must be uploaded and approved in Workday.

If proof of dependency is not received by HR-Total Rewards, 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. MetLife Legal Plans, Inc. has been selected to provide legal plan benefits. The services will be provided through a panel of carefully selected participating law firms. Lawyers in this network are called Plan Attorneys. These arrangements are described in detail in this summary.

Advice and Consultation

Office Consultation

This service enables the Covered Person to talk with a Plan Attorney about any personal legal problems not specifically excluded. The attorney will:

- explain the Covered Person's rights;
- point out his or her options; and,
- if needed, suggest a course of action.

The Plan Attorney will describe any further coverage under the Plan and will represent the Covered Person if requested. If representation is covered as outlined in this Schedule, the Covered Person will not be charged for the Plan Attorney's services. For non-covered matters where this is the only service provided. You may obtain consultations with a Plan Attorney for an unlimited number of matters. If representation is suggested but is not covered, the Plan Attorney will give a written fee estimate. The Covered Person may then choose to:

- retain the Plan Attorney at his or her own expense;
- seek other counsel; or,
- do nothing.

This service is not intended to provide the Covered Person with continuing access to a Plan Attorney in order to seek advice that would allow the Covered Person to undertake his or her own representation. For non-covered matters that are not otherwise excluded, this benefit provides four hours of attorney time and services per year. The Covered Person is responsible to pay fees beyond the four hours. No more than a combined maximum total of four hours of attorney time and service are provided for the member, spouse and qualified dependents annually.

Telephone Advice

This service enables the Covered Person to talk with a Plan Attorney about any personal legal problems not specifically excluded. The attorney will:

- explain the Covered Person's rights;
- point out his or her options; and,
- if needed, suggest a course of action.

The Plan Attorney will describe any further coverage under the Plan and will represent the Covered Person if requested. If representation is covered as outlined in this Schedule, the Covered Person will not be charged for the Plan Attorney's services. For non-covered matters where this is the only service provided. You may obtain consultations with a Plan Attorney for an unlimited number of matters. If representation is suggested but is not covered, the Plan Attorney will give a written fee estimate. The Covered Person may then choose to:

- retain the Plan Attorney at his or her own expense;
- seek other counsel; or,
- do nothing.

This service is not intended to provide the Covered Person with continuing access to a Plan Attorney in order to seek advice that would allow the Covered Person to undertake his or her own representation. For non-covered matters that are not otherwise excluded, this benefit provides four hours of attorney time and services per year. The Covered Person is responsible to pay fees beyond the four hours. No more than a combined maximum total of four hours of attorney time and service are provided for the member, spouse and qualified dependents annually.

Consumer Protection

Consumer Protection Matters

This service provides the Covered Person with representation as a plaintiff in consumer protection matters and includes representation at trial. It covers disputes over consumer goods and services where:

- the amount being contested exceeds the small claims court limit; and
- the controversy is evidenced by a written document such a sales slip, contract, note or warranty.

Small Claims Assistance

This service provides the Covered Person with:

- counseling on prosecuting a small claims action;
- help in preparing documents;
- advice on evidence, documentation, and witnesses; and
- help in preparing for trial.

This service does not cover the Plan Attorney's attendance or representation at a small claims trial, collection activities after a judgment, or any services relating to post-judgment actions.

Personal Property Protection

This service provides the Covered Person with:

- Counseling on any personal property issue. Examples are consumer credit reports, contracts for purchase of personal property, consumer credit agreements or installment sales agreements;
- Counseling on pursuing or defending a small claims action;
- Reviewing personal legal documents; and
- Preparing promissory notes, affidavits and demand letters.

Debt Matters

Debt Collection Defense

This benefit provides Covered Persons with an attorney's services for negotiation with creditors for a repayment schedule, 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 Covered Person 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

Covered Person with online help and information about identity theft and prevention. It does not include counter claims, cross claims, bankruptcy, any action arising out of divorce or post decree matters, 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 provides the Covered Person with an attorney to:

- review tax returns;
- review questions from the IRS or other state or local taxing authority concerning the Covered Person's tax return;
- negotiate with the taxing authority;
- advise the Covered Person on necessary documentation; and
- attend an IRS or a state or local taxing authority audit, if necessary.

This service does not include prosecuting a claim for the return of overpaid taxes, costs of hiring an accountant, or the preparation of any tax returns.

Defense of Civil Lawsuits

Administrative Hearing Representation
This service provides the Covered Person with defense in civil proceedings. It includes 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 legal representation is available or being provided by virtue of a homeowner or vehicle insurance policy. It does not include:

- family matters;
- post judgment matters; or
- litigation of a job-related incident.

Civil Litigation Defense
This service provides the Covered Person with defense in civil proceedings. It includes proceedings in a trial court of general jurisdiction or before an administrative agency or a local, state, or federal agency. It does not apply where legal representation is available or being provided by virtue of another insurance policy. It does not include:

- family matters;
- post judgment matters; or
- litigation of a job-related incident.

This service does not include bringing counterclaims, cross claims, or third-party claims.

Incompetency Defense
This service provides the Covered Person with defense in any incompetency action. It includes representation at court hearings when there is a proceeding to find the Covered Person incompetent.

Document Preparation

Affidavits
This service covers preparation of any affidavit in which the Covered Person is the person making the statement.

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

Demand Letters
This service provides for:

- the preparation of letters which demand money, property or some other property interest of the Covered Person;
- mailing them to the addressee; and
- forwarding and explaining any response to the Covered Person.

Negotiations and representation in litigation are not included.

Mortgages
This service provides for the preparation of any mortgage for which the Covered Person is the mortgagor. This service does not include documents pertaining to business, commercial, or rental property.

Promissory Notes
This service provides for the preparation of any promissory note for which the Covered Person is the payor or payee.

Document Review
This service provides for the review of any personal legal document of the Covered Person, such as letters, leases, or purchase agreements.

Elder Law Matters
This service provides the Covered Person with:
Counseling on any personal issues relating to the Covered Person's parents as they effect the Covered Person;

- Reviewing documents of the parents as they effect the Covered Person, including Medicare or Medicaid materials, prescription plans, leases, nursing home agreements, powers of attorney, living wills and wills;
- Preparing deeds involving the parents when the Covered Person is the grantor or the grantee; and
- Preparing promissory notes involving the parents when the Covered Person is either the payor or payee.

Family Law

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

Prenuptial Agreement
Where allowed by law, this service provides for the negotiation, preparation, review, and execution of an agreement by the Contractholder and his or her fiancé(e)/partner prior to marriage or legal union outlining how property is to be divided in the event of:
separation; divorce; or death of either.

Representation is provided only to the Contractholder. The fiancé(e)/partner must have separate counsel or waive 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 provides for all legal services and court work in a state or federal court for an adoption for the Contractholder and spouse. Legitimization of a child for the Contractholder and spouse, including reformation of a birth certificate, is also covered.

Guardianship or Conservatorship (Contested or Uncontested)
This service covers establishing a guardianship or conservatorship over a person and his or her estate when the Employee or spouse is appointed as 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. This service does not include representation of the person over whom guardianship or conservatorship is sought, 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 Covered Person 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 Covered Person is the plaintiff at a maximum fee of 25% of the gross award. It is the Covered Person's responsibility to pay the attorney's fee and all costs.

Real Estate Matters

Boundary or Title Disputes (Primary Residence)
This service provides representation for the Covered Person in disputes concerning boundary or real property title disputes involving his or her residence. It does not apply where legal representation is available or being provided by virtue of homeowner or title insurance policies.

Eviction and Tenant Problems (Tenant Only)
This service covers the Covered Person 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 (Tenant Only)
This service covers counseling the Covered Person in recovering a security deposit from the Covered Person's residential landlord; 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 Covered Person in prosecuting a small claims action;
- helping prepare documents;
- advising on evidence, documentation and witnesses; and
- preparing the Participant for the small claims trial.

This 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.

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 Covered Person's second or vacation home.

Refinancing of Home (Primary and Secondary Residence)
This service provides the Covered Person with counsel in the refinancing of or obtaining a home equity loan on the Covered Person's primary or secondary residence. It includes the review or preparation of all relevant documents, including the mortgage, deed, and documents pertaining to title, insurance, recordation and taxation.

It does not include:

- services provided by an attorney representing a lending institution or title company;
- the sale or purchase of a home; or
- the refinancing of or obtaining a home equity loan on:
    1. rental property; or
    2. property held for business or investment.

Sale or Purchase of Home (Primary and Secondary Residence)
This service provides the Covered Person with counsel for the purchase and sale of the Covered Person's primary or secondary residence or of vacant property to be used for building a primary or secondary residence. It includes the review or preparation of all relevant documents, including the construction documents for a new home, purchase agreement, mortgage, deed and documents pertaining to title, insurance, recordation, and taxation. The service also includes attendance of a Plan Attorney at closing in cities where it is the custom to do so. It does not include:

- services provided by an attorney representing a lending institution or title company;
- refinancing a home;
- home equity loans; or
- the sale or purchase of:
    1. rental property; or
    2. property held for business or investment.

Property Tax Assessment
This service provides the Covered Person with coverage for review and advice on a property tax assessment on his or her residence. The service includes:

- filing the paperwork,
- gathering the evidence,
- negotiating a settlement and attending the hearing necessary to seek a reduction of the assessment.

Zoning Applications
This service provides the Covered Person with counsel to help get a zoning change or variance for his or her residence. This service includes:

- reviewing the law;
- reviewing the surveys;
- advising the Covered Person;
- preparing applications for the zoning hearings;
- preparing for the hearing; and
- attending the hearing, if necessary, to change the zoning

Traffic and Criminal Matters

Juvenile Court Defense
This service provides representation of a Contractholder and Contractholder's Dependent Child in any juvenile court matter, provided there is no conflict of interest between the Contractholder and Child. In that event, or where the court requires separate counsel for the Child, this service provides an attorney for the Contractholder only, including services for parental responsibility.

Traffic Ticket Defense (No DUI)
This service provides the Covered Person with representation in defense of any traffic ticket including traffic misdemeanor offenses. However, no service is provided where the ticket was the result of any driving under the influence or related charge or vehicular homicide. This service includes representation for:

- court hearings;
- negotiation with the prosecutor; and
- trial.

Restoration of Driving Privileges
This service covers the Covered Person with representation in proceedings to restore the Covered Person's driver's license.

Wills and Estate Planning

Trusts
This service includes the preparation of revocable or irrevocable living trusts for the Covered Person. It does not include tax planning.

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

Powers of Attorney
This service includes the preparation of any power of attorney when the Covered Person 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 usual fee. The Covered Person must pay the reduced fee and all costs.

Wills and Codicils
This service covers the preparation of simple or complex wills or codicils for the Covered Person. The creation of a testamentary trust is covered. The service 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:

- Employment-related matters, including company or statutory benefits
- Matters involving your employer, MetLife or its affiliates, or 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, business, and investment matters and 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

You are eligible to join the University of Miami legal plan if you are a regular full-time or part-time faculty, staff or member of affiliates working at least 50% effort. If elected, coverage will begin on your start date. Otherwise, you are able to enroll during the University's annual open enrollment period. Enrollment must be completed via benefits enrollment in Workday.

Faculty members who are members of the Associated Faculty (visiting and voluntary faculty) without the title of lecturer and temporary employees are not eligible.

The Plan has a minimum participation period of one year, and you must maintain the coverage for the entire calendar year.

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 services 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 terms of the plan.

Administration and Funding

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

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 provided are confidential. The Plan Attorney will maintain strict confidentiality of the traditional lawyer-client relationship. Your employer will know nothing about your legal issue 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. MetLife Legal Plans or the law firm providing services under the Plan is responsible for all services provided by the 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 your state.

Plan attorneys will refuse to provide services if a 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 MetLife Legal Plans at 1-800-821-6400. We will review your complaint and respond 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 coverages 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 another 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 under the plan. In these situations, 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, MetLife 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

MetLife Legal Plans verifies eligibility using information provided by University of Miami. When you call for services, you will be advised if you are ineligible and MetLife Legal Plans will contact University of Miami 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, HR-Total Rewards
1320 South Dixie Highway
Suite 100
Coral Gables, Florida 33146
305-284-3004

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

Denials of Coverage

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

MetLife Legal Plans, Inc.
Director of Administration
1111 Superior Avenue
Suite 800
Cleveland, Ohio 44114-2507

For Florida plans contact MetLife Legal Plans of Florida, Inc. at the above address.

The Director will issue MetLife 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, a description of any additional information that might cause MetLife 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.

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:

University of Miami, HR-Total Rewards
1320 South Dixie Highway
Suite 100
Coral Gables, Florida 33146
305-284-3004

Plan Administrator

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

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

University of Miami, HR-Total Rewards
1320 South Dixie Highway
Suite 100
Coral Gables, Florida 33146
305-284-3004

ERP Plan Trustee

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

Northern Trust
801 South Canal Street C2N
Chicago, Illinois 60607
312-557-9629

Agent for Service of Legal Process

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

Administrator for Risk Management
1320 South Dixie Highway
Suite 1230
Coral Gables, Florida 33146

Plan Numbers, Funding, Years and Type

The University of Miami's identification number for government reports is EIN 59-0624458.

Plan Name and Number	Funding	Plan Year	Type	Plan Administration
Group Health Plan for Faculty and Staff of the University of Miami (501)	University and Employee pre-tax contributions	June 1 – May 31	Welfare	Self-Insured
Group Dental Plan for the Faculty and Staff of the University of Miami (503)	University and Employee pre-tax contributions	June 1 – May 31	Welfare	Fully-insured
Flexible Benefits for Employees of the University of Miami (504)	Employee contributions	January 1 – December 31	Welfare	Fully-insured
University of Miami Long Term Care Insurance (514)	Employee post-tax contributions	January 1 – December 31	Welfare	Fully-insured
University of Miami Life, AD&D and Disability Plan (515)	University and Employee pre-tax and/or post-tax contributions	January 1 – December 31	Welfare	Fully-insured
Employees' Retirement Plan (001)	University contributions	June 1 – May 31	Defined Benefit Cash Balance Pension	Fully-insured
Supplemental Retirement Annuity Program (002)	Employee pre-tax contributions	January 1 – December 31	403(b)	Fully-insured
Faculty Retirement Plan (003)	University contributions	January 1 – December 31	403(b) Defined Contribution	Fully-insured
Retirement Savings Plan (005)	University contributions and voluntary employee pre-tax contributions	January 1 – December 31	403(b) Defined Contribution	Fully-insured

For Self-Insured Plans: The plan is self-insured and unfunded. In other words, current employee contributions and the University of Miami's contributions will pay only current benefit claims and will not fund future benefit claims. Although Aetna pays claims under the plan on behalf of the University of Miami, Aetna does not insure or guarantee that claims will be paid. Rather, Aetna relies on the University of Miami to provide it with enough money to pay the claims. Aetna cannot pay the claims if the University of Miami does not provide the money to Aetna.

For Insured Plans: The plan's benefits are financed through a group insurance contract with the following insurance companies: Cigna (dental), Delta Dental (dental), New York Life Group Benefit Solutions (Medical Faculty Life, LTD, STD, supplemental life). The insurers are responsible for investing the premiums and paying benefit claims. The insurers guarantee the payment of claims incurred before the group insurance contract terminates.

Plan Documents Control

The plan documents govern the operation of the plans described in these summary plan descriptions. If there is any conflict with these non-technical summaries, the plan documents will

control. These summary plan descriptions are intended to help you understand the main features of the University's retirement benefit plans. It should not be considered as a substitute for the plan documents which govern the operation of the plans. Those official plan documents set forth all of the details and provisions concerning the plans and are subject to amendment. If any questions arise that are not covered in these summary plan descriptions, or if these summary plan descriptions appear to conflict with the legal plan documents, the text of the legal plan documents will determine how questions will be resolved. You are welcome to request inspection of the official plan documents at HR-Total Rewards or request copies of your own, for a small fee to cover printing costs.

When Benefits Are Not Paid

These summary plan descriptions outline and the official plan documents describe in detail, plan benefits and how you or your spouse or other beneficiary can qualify for them. As long as the plans are in force, if you or a beneficiary becomes eligible for benefits and makes proper application for them, they should begin promptly – usually within 30 days. There are a few circumstances which might result in disqualification, non-eligibility, denial, loss, forfeiture, suspension or reduction of benefits to an eligible employee, spouse or other beneficiary. They include:

For the Faculty Retirement Plan and the Retirement Savings Plan

- Because the amount of any distribution from the plan(s) is based on your account balance at the time you terminate or retire, that amount may be more or less than the amount shown on your last statement of your account balance

For the Employees' Retirement Plan

- Not accruing the required 1,000 hours in a plan year to earn a year's credit for vesting or benefits
- Dying before you could commence benefits – but your beneficiary could receive a death benefit regardless of your service if you are an active plan member at the time of your death
- Re-employment by the University while receiving retirement payments and which requires a suspension of benefits during the period while again working (when you again retire, your benefit will be re-calculated and cannot be less than when you originally retired).

For the Employees' Retirement Plan, the Faculty Retirement Plan and the Retirement Savings Plan

- Leaving the University before earning a vested right to your plan benefit – but your beneficiary could receive a death benefit regardless of your service if you are an active plan participant at the time of death. (Note that if you separate from service on or after January 1, 2009, you are automatically 100% vested in your benefit from the Employees' Retirement Plan)
- Failure to make timely and proper application for benefits, or to supply information, such as proof of age or death, as required by the UM Retirement Plans Review Committee.
- If your employment status changes such that you are no longer eligible under the plan or work enough to earn a benefit, you may stop accruing benefits or receiving credits to your plan account.
- If a court order concerning child support, alimony or marital property rights so decrees, part of your benefit may be payable to someone other than you or your designated beneficiary.
- If you work past your normal retirement date. If your normal retirement date occurs before June 1, 2019, and you continue working for the University, or if your normal retirement date occurs on or after June 1, 2019, and you do not elect to immediately commence your benefits, you will continue to accrue benefits, but your benefits accrued through your normal retirement date will not be paid to you at your normal retirement date. That benefit, plus benefits earned after your normal retirement date, will be paid to you when you actually retire.

- Federal law limits the amount of benefits that may be received from a qualified pension plan. In particular, for 2023, no more than $330,000 ($305,000 in 2022) of annual compensation may be taken into account in determining your benefit. Also, in 2023 your annual benefit will be limited to the lesser of $265,000 ($245,000 in 2022 and $230,000 in 2021) or 100% of your average compensation during your highest three years. These limits may be adjusted periodically for changes in the cost of living, and may be adjusted depending on the form of benefit you select and your benefit commencement date.
- By law, certain restrictions apply to the Employees' Retirement Plan if the funded status decreases below a certain threshold. These restrictions would result in a limitation of the amount that could be paid under any lump sum option. In the event that benefit restrictions apply to the Employees' Retirement Plan, the Plan Administrator will separately notify participants and beneficiaries.
- These plans also contain certain limitations on the amount of benefits that can be distributed to the 25 highest paid employees of the University, under certain circumstances. These restrictions may, among other things, limit the value of lump sums that may be paid to these affected employees. If you are subject to this limitation, you will be notified.

Under the Faculty Retirement Plan, the Retirement Savings Plan, and the Supplemental Retirement Annuity Program, all benefits are provided for from the individual annuity contracts or custodial accounts selected by and issued to plan participants under its provisions. Neither the Board of Trustees, the University, nor any officer or employee of the University has any liability or responsibility for those member-owned contracts or benefits. The University, therefore, makes no warranty against any loss or diminution in the value of any annuity contract or custodial account, except to make the plan's required contributions to the provider company of your choice.

Qualified Domestic Relations Order (QDRO)
A qualified domestic relations order (QDRO) is a legal judgment, decree or order that recognizes the rights of an alternate payee under the retirement plans with respect to a child's or other dependent's support, alimony or marital property rights. The University is legally required to recognize a QDRO.

If you become legally separated or divorced, a portion or all of your benefit under your retirement plan may be assigned to someone else to satisfy a legal obligation you may have to a spouse, former spouse, child or other dependent.

There are specific requirements the court order must meet to be recognized by the Plan Administrator and specific procedures regarding the amount and timing of payments.

Participants and beneficiaries may obtain, without charge, a copy of the procedures governing QDRO determinations under the plan from the Plan Administrator by contacting HR-Total Rewards at 305-284-3004.

Benefit Assignment
To protect you and your dependents, your interest in a plan cannot be assigned, sold, transferred or pledged by you and, to the extent permitted by law, benefits are not subject to garnishment or attachment. However, current law allows a court to assign a portion of a participant's benefits to another person under the terms of a qualified domestic relations order (QDRO), usually issued as part of a divorce proceeding.

Receiving Advice
The University cannot advise you with regard to legal, tax or investment considerations relative to any plan. Therefore, if you have questions pertaining to benefit planning in these areas, you should seek advice from a personal tax advisor or financial planner.

Plan Interpretation

To the fullest extent permitted by law, the Plan Administrator will have the exclusive discretion to determine all matters relating to eligibility, coverage and benefits under the plan. The Plan Administrator will also have the exclusive discretion to determine all matters relating to interpretation and operation of the plan. Decisions by the Plan Administrator will be conclusive and binding.

Withholding
Unless you elect otherwise for the Faculty Retirement Plan, the Employees' Retirement Plan and the Retirement Savings Plan, benefit payments from these plans will be subject to federal income taxes (with the exception of employee voluntary Roth contributions) and may be subject to state and local income taxes as well. If you elect a lump sum payment, the University of Miami is required to withhold federal income taxes equal to 20% of the taxable portion of your payment, unless you roll over your distribution directly into an IRA (including a Roth IRA, but not to a SIMPLE IRA or Education IRA) or eligible employer plan. Unless you are at least age 55 at the time you leave the University, you are at least age 59½ at the time payment is made to you or another exception applies, your distribution may be subject to a 10% early payment penalty tax in addition to regular income taxes if it is not rolled over to an eligible retirement plan. Your distribution may be rolled over to the extent that it is an "eligible rollover distribution." Generally, a distribution is an eligible rollover distribution if it is paid in the form of a single lump sum payment, or in the form of installment payments made over a period of less than 10 years. For more information on the additional 10% tax, please see IRS Form 5329.

You are responsible for paying any applicable federal, state and local taxes when you receive the distribution. You will receive more information about the applicable rules when you request payment of your benefits. Because taxes are complicated and subject to change, you may wish to consult a tax advisor before receiving benefits from the plan.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

What's COBRA continuation coverage?
COBRA continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries who are not getting continuation coverage. Each "qualified beneficiary" (described below) who elects COBRA continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan.

Who are the qualified beneficiaries?
Each person ("qualified beneficiary") in the category(ies) checked below can elect COBRA continuation coverage:

- Employee or former employee
- Spouse or former spouse
- Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage
- Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may

pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it is important that you choose carefully between COBRA continuation coverage and other coverage options, because once you have made your choice, it can be difficult or impossible to switch to another coverage option.

If I elect COBRA continuation coverage, when will my coverage begin and how long will the coverage last?
If elected, COBRA continuation coverage will begin on the first day of the month following termination of employment or other qualifying event. COBRA requires that continuation coverage extend from the date of the qualifying event for a limited period of time of 18 or 36 months. The length of time for which continuation coverage must be made available (the "maximum period" of continuation coverage) depends on the type of qualifying event that gave rise to the COBRA rights. A plan, however, may provide longer periods of coverage beyond the maximum period required by law. When the qualifying event is the covered employee's termination of employment (for reasons other than gross misconduct) or reduction in hours of work, qualified beneficiaries must be provided 18 months of continuation coverage. When the qualifying event is the end of employment or reduction of the employee's hours, and the employee became entitled to Medicare less than 18 months before the qualifying event, COBRA coverage for the employee's spouse and dependents can last until 36 months after the date the employee becomes entitled to Medicare. For example, if a covered employee becomes entitled to Medicare 8 months before the date his/her employment ends (termination of employment is the COBRA qualifying event), COBRA coverage for his/her spouse and children would last 28 months (36 months minus 8 months). For all other qualifying events, qualified beneficiaries must be provided 36 months of continuation coverage.

Continuation coverage may end before the date noted above in certain circumstances, like failure to pay premiums, fraud, or the individual becomes covered under another group health plan.

Can I extend the length of COBRA continuation coverage?
If you elect continuation coverage, you may be able to extend the length of continuation coverage if a qualified beneficiary is disabled, or if a second qualifying event occurs. You must notify HR-Total Rewards of a disability or a second qualifying event within a certain time period to extend the period of continuation coverage. If you do not provide notice of a disability or second qualifying event within the required time period, it will affect your right to extend the period of continuation coverage.

For more information about extending the length of COBRA continuation coverage, visit dol.gov/general/topic/health-plans/cobra

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.

Other coverage options may cost less. If you choose to elect continuation coverage, you do not have to send any payment with the Election Form. Additional information about payment will be provided to you after the election form is received by the Plan. Important information about paying your premium can be found below.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. You can learn more about the Marketplace below.

Important Information About Payment

First payment for continuation coverage

You must make your first payment for continuation coverage no later than 45 days after the date of your election (this is the date the Election Notice is postmarked). If you do not make your first payment in full no 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 HR-Total Rewards at 305-284-3004 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 have to make periodic payments for each coverage period that follows. 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. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. 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. You will get continuation coverage for each coverage period as long as payment for that coverage period is postmarked before the end of the grace period.

If you do not 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 periodic payments for continuation coverage should be sent to:

Health Equity/WageWorks, Inc.
P.O. Box 14055
Lexington, Kentucky 40512-4055

What is the Health Insurance Marketplace?

The Marketplace offers “one-stop shopping” to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you’ll also learn if you qualify for free or low-cost coverage from Medicaid or the Children’s Health Insurance Program (CHIP). You can access the Marketplace for your state at HealthCare.gov

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage will not limit your eligibility for coverage or for a tax credit through the Marketplace.

When can I enroll in Marketplace coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a “special enrollment” event. After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away. In addition, during what is called an “open enrollment” period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit HealthCare.gov.

If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?
If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you will have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you have exhausted your COBRA continuation coverage and the coverage expires, you will be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

Can I enroll in another group health plan?
You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you are eligible, you will have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

What factors should I consider when choosing coverage options?
When considering your options for health coverage, you may want to think about:

- Premiums: Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- Provider Networks: If you are currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- Drug Formularies: If you are currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- Severance payments: If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.
- Service Areas: Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- Other Cost-Sharing: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

For more information
This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator.

If you have questions about the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, contact HR-Total Rewards at 305-284-3004.

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit healthcare.gov.

Keep Your Plan Informed of Address Changes
To protect your and your family's rights, keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy of any notices you send to the Plan Administrator.

HIPAA Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

Note: The 60-day period for requesting enrollment applies only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, a 30-day period applies to most special enrollments.

To request special enrollment or obtain more information, contact HR-Total Rewards at 305-284-3004.

The Future of the Plans

It is the University's intent that all welfare and retirement benefits included in this Summary Plan Description 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 the Employees' Retirement Plan, the Faculty Retirement Plan, and/or the Retirement Savings Plan are completely or partially terminated, affected participants will become fully vested in the benefits they have accrued to that point (to the extent such benefits are funded). In the event of a complete plan termination, benefits will be distributed in any manner permitted by the plans as soon as practicable, and any excess funds will then revert to the University.

Insuring ERP Benefits

The University of Miami pays annual premiums for all employees to a governmental insuring agency set up under ERISA. If the Employees' Retirement Plan should terminate, benefits are insured, up to certain limits, by the Pension Benefit Guaranty Corporation (PBGC). Generally, it guarantees most vested normal and early retirement benefits, and certain survivor pensions. The PBGC does not guarantee all types of benefits under all plans, and the amount of protection has limits. For example, it covers vested benefits as of the date a plan terminates. In addition, if a plan has been adopted or benefits increased within five years, the whole amount may not be guaranteed. There is a ceiling on the monthly benefit the PBGC guarantees, which is adjusted periodically. For more information contact HR-Total Rewards at 305-284-3004 or contact the PBGC's Technical Assistance Division, 1200 K. Street, N.W., Suite 930, Washington, DC 20005-4026, or call 202-326-4000 (not a toll-free number). TTY/TDD users may call the federal relay service toll-free number at 1-800-877-8339 and ask to be connected to 202-326-4000. Additional information about the PBGC's pension insurance program is available through the PBGC's website on the Internet at pbgc.gov.

You may direct requests for information about eligibility, membership, contributions, or other aspects of plan operation in writing to the Plan Administrator.

Defined contribution retirement plans such as the Faculty Retirement Plan, the Retirement Savings Plan or other University benefit plans are not insured by the PBGC.

If the Retirement Plans Become Top Heavy

Under a complicated set of IRS rules set out in the plan documents, the plans may become "top heavy." A top heavy plan is one where more than 60% of the contributions or benefits have been allocated to "key employees." Key employees are generally certain officers of the University. The Plan Administrator is responsible for determining whether a plan is a top heavy plan each year. In the unlikely event that a plan becomes top heavy in any year, non-key employees may be entitled to certain minimum benefits and special rules will apply. If the plan becomes top heavy, the Plan Administrator will advise you of your rights under the top heavy rules.

Leaves of Absence

You may be able to continue your participation during leaves of absence under the retirement plans under certain circumstances.

Continuation of Participation While on Approved Leaves of Absence
Special rules apply if you take an approved paid leave of absence (or are eligible for long-term disability) under your retirement plan (the Employees' Retirement Plan, the Faculty Retirement Plan or the Retirement Savings Plan) for purposes of vesting and earning benefits or pay credits under the plan. Please see the applicable SPD for more details or contact HR-Total Rewards. 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 the University welfare and 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-Total Rewards at 305-284-3004.

Continuation of Participation While on a Family and Medical Leave (FMLA)
Under the federal Family and Medical Leave Act (FMLA), if you meet eligible service requirements, you are entitled to take up to 12 weeks of leave for certain family and medical situations. An absence under the Family and Medical Leave Act will not constitute a break in service for purposes of your welfare and retirement plan benefits. 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.

Visit hr.miami.edu to access the University's Family and Medical Leave policy for more information.

Your Rights Under ERISA

As a participant in any of these welfare benefits and/or retirement plans (the Employees' Retirement Plan, the Faculty Retirement Plan, the Retirement Savings Plan, or the Supplemental Retirement Annuity Program), you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- **Examine**, in HR-Total Rewards without charge, copies of all documents governing the plans including a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- **Obtain**, on written request to the Plan Administrator and for a reasonable charge to cover printing, copies of documents governing the operation of the plan including copies of the latest annual report (Form 5500 Series) and updated summary plan description.
- **Receive** each year a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report. If you participate in the Employees' Retirement Plan, in lieu of a summary annual report, you will receive an annual funding notice providing basic information about the funding status and financial condition of the Plan, including the Plan's funding percentage, assets and liabilities, and a description of the benefits guaranteed by the PBGC. The Retirement Plan

Administrator is required by law to furnish each participant and Plan beneficiary with a copy of this annual funding notice.

- **Obtain** a statement telling you whether you have a right to receive a benefit at your normal retirement age (age 65) and if so, what your pension benefits would be at normal retirement age under the plan if you stop working now. If you do not have a right to a benefit, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The plan must provide the statement free of charge.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a pension benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a suit in state or federal court, but only after you have exhausted your retirement plan's claims and appeals procedures as described in the next section, "Appeals Procedures." In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions
If you have any questions about your plan, you should contact the Plan Administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Your Employment

These summary plan descriptions provide detailed information about the University of Miami's welfare benefits and retirement benefit plans and how they work. These summary plan descriptions do not constitute an implied or express contract or guarantee of employment. Similarly, your eligibility or your right to benefits under these plans should not be interpreted as an implied or express contract or guarantee of employment. The University's employment practices are made without regard to the benefits it offers as part of your total compensation.
If any discrepancies exist between the summary plan description and the plan documents or master contracts, the plan documents or master contracts will override.

For questions about the plans or your benefits under them, contact HR-Total Rewards. 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

Coverage. All claims for medical 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 no later 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.
	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	

Claims Review Chart: *Effective [January 1, 2003]*		
Type of Claim	Steps to Take	
	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.
	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);
- disclose the availability of and contact information for any applicable office or health insurance consumer assistance or ombudsman, if any, established by the Department of Health and Human Services to assist with the internal claims and appeals and external review processes:
- if the denial is based on medical necessity or experimental treatment, provide an explanation of the scientific or clinical judgment for the determination, applying plan terms to your medical condition (or state that such information will be provided free of charge upon request);
- for urgent care claims, the denial notice will include a description of the expedited review process applicable to such claims. This denial may be given orally, provided that a written or electronic notification is furnished to you no later than 3 days after the oral notification.

Appeals

If you believe your claim was denied in error, you may appeal this decision to the plan. You have 180 days after receiving the claim denial to appeal the plan's decision. You may submit written comments, documents, or other information in support of your appeal and have access, upon request, to all relevant documents free of charge. The review of the claim denial will take into account all new information, whether or not presented or available at the initial claim review, and will not be influenced by the initial claim decision.

A rescission of coverage under the health plan will be considered an adverse benefit determination and you will be able to appeal the rescission under these procedures. A rescission is a discontinuance of coverage with retroactive effect. Coverage may be rescinded if an individual or person seeking coverage on behalf of the individual commits fraud or makes an intentional misrepresentation of material fact, as prohibited by the terms of this Plan. However, a retroactive cancellation of coverage is not considered to be a rescission if it is due to failure to pay required premiums or contributions toward the cost of coverage on time. If 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 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. 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.

Important Administrative Information: ERISA

This section includes information on the administration of the medical Plan, as well as information required of all Summary Plan Descriptions by ERISA. While you may not need this information for your day-to-day participation, it is information you may find important.

Plan Sponsor and Administrator

University of Miami is the Plan Sponsor and Plan Administrator of the Group Health Plan for Faculty and Staff of University of Miami and has the discretionary authority to interpret the Plan.

You may contact the Plan Administrator at:
Plan Administrator
University of Miami, HR-Total Rewards
P.O. Box 248106
Coral Gables, Florida 33124-2902
305-284-3004

Claims Administrator

Aetna is the Plan's Claims Administrator for the medical benefit and pharmacy benefit. The role of the Claims Administrator is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator, through an administrative agreement with the Company. The

Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

You may contact the Claims Administrator by phone at the number on your ID card or in writing at:
Aetna Claims Center
P.O. Box 981106
El Paso, Texas 79998-1106

Agent for Service of Legal Process

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's Agent of Service is:

Administrator for Risk Management
1320 South Dixie Highway
Suite 1230
Coral Gables, Florida 33146

Legal process may also be served on the Plan Administrator.

Other Administrative Information

This section of your SPD contains information about how the Plan is administered as required by ERISA.

Type of Administration

The Plan is a self-funded welfare Plan and the administration is provided through one or more third party administrators.

Plan Name:	Group Health Plan for Faculty and Staff of University of Miami
Plan Number:	501
Employer ID:	59-0624458
Plan Type:	Welfare benefits plan
Plan Year:	June 1 – May 31
Plan Administration:	Self-Insured
Source of Plan Contributions:	Employee and Company
Source of Benefits:	Assets of the Company

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be permitted to:

- receive information about Plan Benefits;
- examine, without charge, at the Plan Administrator's office and at other specified worksites, all plan documents – including pertinent insurance contracts, collective bargaining agreements (if applicable),a copy of the latest annual report (Form 5500 Series) filed by the plan and other documents available at the Public Disclosure Room of the Employee Benefits Security Administration; and
- obtain copies of all Plan documents and other Plan information, including insurance contracts and collective bargaining agreements (if applicable), a copy of the latest annual report (Form 5500 Series) and updated Summary Plan Descriptions, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies.

The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.

You can continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the Plan documents to understand the rules governing your COBRA continuation coverage rights.

In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the Plan. The people who operate your Plan, who are 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, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan Benefit or exercising your rights under ERISA.

If your claim for a Plan Benefit is denied or ignored, in whole or in part, you have a 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 the plan document from the Plan, and do not receive it 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 for reasons beyond the control of the Plan Administrator.

If you have a claim for benefits, which is denied or ignored, in whole or in part, and you have exhausted the administrative remedies available under the Plan, you may file suit in a state or federal court. 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 federal court. If it should happen that the Plan's 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.

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, 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 write to 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 at 866-444-3272.

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, Kentucky 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, Kentucky 40512

PHARMACY PLAN – AETNA

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 Aetna. 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 Aetna before they provide these services to you. Contacting Aetna 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 do not provide this information within one year of the date of service, Benefits for that health service will be denied or reduced, in Aetna'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 Aetna 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 Aetna, at the following address:

Aetna
Attn: National Account CRT
P.O. Box 14463
Lexington, Kentucky 40512

MENTAL AND BEHAVIORAL HEALTH - AETNA

SECTION I

A. Member Services
   1. Copy of claim
   2. Reasons member feels claim should be paid
   3. Any supporting documentation

B. Aetna
   Attn: National Account CRT
   P.O. Box 14463
   Lexington, Kentucky 40512

C. The Claims Review Department

SECTION II

A. The Claims Department

SECTION III

A. Aetna
   Attn: National Account CRT
   P.O. Box 14463
   Lexington, Kentucky

DENTAL INSURANCE - CIGNA DENTAL CARE (HMO)

SECTION I

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

B. CIGNA Dental Appeals
   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.

VISION INSURANCE – VISION SERVICE PLAN (VSP)

SECTION I
A. Member Services Department
   1. VSP Member Name and Date of Birth
   2. VSP Member Identification Number
   3. Provider Name
   4. Claim Number

B. VSP
   ATTN: Claim Appeals
   PO Box 2350
   Rancho Cordova, CA 95741

C. VSP within 30 days of receipt

SECTION II
A. VSP within 30 days unless extension is needed.

VOLUNTARY EXCESS LIFE & VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT – NEW YORK LIFE GROUP BENEFIT SOLUTIONS

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

B. New York Life Group Benefit Solutions Life & Accident Claim Services
   P.O. Box 22328
   Pittsburgh, PA 15222-0328

C. New York Life Group Benefit Solutions Case Manager

SECTION II
A. New York Life Group Benefit Solutions Case Manager

SECTION III
A. New York Life Group Benefit Solutions Life & Accident Claim Services
   P.O. Box 22328

Pittsburgh, PA 15222-0328

LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT

SECTION I

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

B. New York Life Group Benefit Solutions Life & Accident Claim Services
   P.O. Box 22328
   Pittsburgh, PA 15222-0328

C. New York Life Group Benefit Solutions Claim Reviewer

SECTION II

A. New York Life Group Benefit Solutions Claim Reviewer

SECTION III

A. New York Life Group Benefits Solutions Life & Accident Claim Services
   P.O. Box 22328
   Pittsburgh, PA 15222-0328

SHORT-TERM DISABILITY INSURANCE – NEW YORK LIFE GROUP BENEFIT SOLUTIONS

SECTION I

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

B. New York Life Group Benefit Solutions Disability Management Solutions
   Paper Intake Team
   P.O. Box 709015
   Dallas, TX 709015

C. A New York Life Group Benefit Solutions Case Manager

SECTION II

A. New York Life Group Benefit Solutions Case Manager

SECTION III

A. New York Life Group Benefit Solutions Disability Management Solutions
   Paper Intake Team
   P.O. Box 709015
   Dallas, TX 709015

LONG TERM DISABILITY INSURANCE - NEW YORK LIFE GROUP BENEFIT SOLUTIONS

SECTION I

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

B. New York Life Group Benefit Solutions Disability Management Solutions
Paper Intake Team
P.O. Box 709015
Dallas, TX 709015

C. New York Life Group Benefit Solutions Case Manager

SECTION II
A. New York Life Group Benefit Solutions Case Manager

SECTION III
A. New York Life Group Benefit Solutions Disability Management Solutions
Paper Intake Team
P.O. Box 709015
Dallas, TX 709015

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 – HEALTH EQUITY/WAGEWORKS

SECTION I
A. University of Miami, HR-Total Rewards
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. HealthEquity/WageWorks
P.O. Box 991
Mequon, Wisconsin 53092

C. University of Miami, HR-Total Rewards

SECTION II
A. University of Miami, HR-Total Rewards

SECTION III
A. University of Miami
HR-Total Rewards
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 Inclusion at wei@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 Inclusion
1320 South Dixie Highway
Suite 355
Coral Gables, Florida 33146
Fax: 305-284-6211
Email: wei@miami.edu

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 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 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.

مصلا امكبلوا: (مقر ة 1 - 305 - 284 - 3064ظوحلم: إذا تنك تثرك دحتتة، اذةغللن اإف تامدخ قدعاسملا اقيوغللا ارفاكلا ونتد نلصتة .اجملاب امقرب
x فـتاه

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.

ચના : % ત ગuજરાતી બોલતા હો, તો ંન:શuક ભાષા સહાય વાઓ તમારા મા= ઉપલ@ધ B. ફોન કરો 1-305-284-3064.

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