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 al 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 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 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.

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 LabCorp or Quest
	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.optumrx.com or by calling 1-855-438-4509	Generic drugs (Tier 1)	$10 copay/Rx - Retail $25 copay/Rx – Optum Rx Mail or Walgreens		Prescription drug coverage is provided through Optum Rx. Covers up to a 30-day supply (retail); 31-90 day supply (OptumRx mail order or Walgreens). Maintenance medications that aren't filled in 90 day supplies through OptumRx or Walgreens will have a copay of 2.5x the retail copay for a 30 day supply after two retail fills.
	Preferred drugs (Tier 2)	$45 copay/Rx - Retail $112.50 copay/Rx – Optum Rx Mail or Walgreens		
	Non-preferred brand drugs (Tier 3)	$75 copay/Rx - Retail $187.50 copay/Rx – Optum Rx Mail or Walgreens		
	Specialty drugs (Tier 4)	$100 copay/Rx BriovaRx or Walgreens		

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)	
				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 Optum 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 $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
If you need mental health, behavioral health, or substance abuse services – Administered by Carisk Behavioral Health. For more information visit concordiabh.com	Outpatient services	$20 copay/visit		Please contact Carisk Behavioral Health Member Services at 1-800-294-8642, option 2, prior to accessing services to confirm network status of the provider you wish to see. No out-of-network coverage in service area, but is available outside the service area.
	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	Deductible, then $55 copay - 1st office visit, then all office visits covered at	Cost sharing does not apply to certain preventive services. Depending on the type of services, a copay may apply. Maternity care

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)	
		covered at 100%	100%	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 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 https://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.

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	Lab work is only covered at LabCorp or Quest.
	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 the Optum website or by calling 1-855-438-4509	Generic drugs (Tier 1)	$10 copay/Rx - Retail $25 copay/Rx – Optum Rx Mail or Walgreens		Prescription drug coverage is provided through Optum Rx. Covers up to a 30-day supply (retail); 31-90 day supply (Optum Rx mail order or Walgreens). Maintenance medications that aren't filled in 90 day supplies through Optum Rx or Walgreens 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 – Optum Rx Mail or Walgreens		
	Non-preferred brand drugs (Tier 3)	$75 copay/Rx - Retail $187.50 copay/Rx – Optum Rx Mail or Walgreens		
	Specialty drugs (Tier 4)	$100 copay/Rx BriovaRx or Walgreens		

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 the Optum 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 Carisk Behavioral Health. For more information visit the Carisk site	Outpatient services	$20 copay/visit		Please contact Carisk Behavioral Health Member Services at 1-800-294-8642, option 2, prior to accessing services to confirm network status of the provider you wish to see. No out-of-network coverage in the service area, but is available for care outside the service area.
	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 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 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.

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 LabCorp or Quest
	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 the Optum website or by calling 1-855-438-4509	Generic drugs (Tier 1)	$10 copay/Rx - Retail $25 copay/Rx – Optum Rx Mail or Walgreens	Prescription drug coverage is provided through Optum Rx. Covers up to a 30-day supply (retail); 31-90 day supply (Optum Rx mail order or Walgreens). Maintenance medications that aren't filled in 90 day supplies through Optum Rx or Walgreens 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 Optum website for information on drugs covered by your plan.
	Preferred drugs (Tier 2)	$45 copay/Rx - Retail $112.50 copay/Rx – Optum Rx Mail or Walgreens	
	Non-preferred brand drugs (Tier 3)	$75 copay/Rx - Retail $187.50 copay/Rx – Optum Rx Mail or Walgreens	
	Specialty drugs (Tier 4)	$100 copay/Rx BriovaRx or Walgreens	

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 Carisk Behavioral Health. For more information visit the Carisk website.	Outpatient services	$20 copay/visit	Please contact Carisk Behavioral Health Member Services at 1-800-294-8642, option 2, prior to accessing services to confirm network status of the provider you wish to see. No out-of-network coverage
	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.

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 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 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.

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	In-network lab work is covered at LabCorp or Quest labs only
	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 the Optum website or by calling 1-855-438-4509	Generic drugs (Tier 1)	Deductible, then $10 copay/Rx - Retail Deductible, then $25 copay/Rx – Optum Rx Mail or Walgreens			Prescription drug coverage is provided through Optum Rx. Covers up to a 30-day supply (retail); 31-90 day supply (Optum Rx mail order or Walgreens). Maintenance medications that aren't filled in 90 day supplies through Optum Rx or Walgreens 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
	Preferred drugs (Tier 2)	Deductible, then $45 copay/Rx - Retail Deductible, then $112.50 copay/Rx – Optum Rx Mail or Walgreens			
	Non-preferred brand drugs (Tier 3)	Deductible, then $75 copay/Rx - Retail Deductible, then $187.50 copay/Rx – Optum Rx Mail or Walgreens			
	Specialty drugs (Tier 4)	Deductible, then $100 copay/Rx BriovaRx or Walgreens			

					your policy being available for certain prescribed drugs. See Optum 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 Carisk Behavioral Health. For more information visit the Carisk website	Outpatient services	$20 copay/visit		30% coinsurance	Please contact Carisk Behavioral Health Member Services at 1-800-294-8642, option 2, prior to accessing services to confirm network status of the provider you wish to see.
	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 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 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.

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 covered only at LabCorp or Quest
	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 the Optum website or by calling 1-855-438-4509	Generic drugs (Tier 1)	Deductible, then $10 copay/Rx - Retail Deductible, then $25 copay/Rx – Optum Rx Mail or Walgreens		Prescription drug coverage is provided through Optum Rx. Covers up to a 30-day supply (retail); 31-90 day supply (Optum Rx mail order or Walgreens). Maintenance medications that aren't filled in 90 day supplies through Optum Rx or Walgreens 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 the Optum 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 – Optum Rx Mail or Walgreens		
	Non-preferred brand drugs (Tier 3)	Deductible, then $75 copay/Rx - Retail Deductible, then $187.50 copay/Rx – Optum Rx Mail or Walgreens		
	Specialty drugs (Tier 4)	Deductible, then $100 copay/Rx BriovaRx or Walgreens		

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 Concordia Behavioral Health. For more information visit the Carisk website.	Outpatient services	$20 copay/visit	30% coinsurance	Please contact Carisk Behavioral Health Member Services at 1-800-294-8642, option 2, prior to accessing services to confirm network status of the provider you wish to see.
	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.

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

<u>After declining health coverage</u>. 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 July 31, 2018. Contact your state for more information on eligibility.

ALABAMA – Medicaid myalhipp.com 1-855-692-5447	NEW HAMPSHIRE – Medicaid dhhs.nh.gov/ombp/nhhpp 603-271-5218 NH Medicaid Service Center: 1-888-901-4999
ALASKA – Medicaid The AK Health Insurance Premium Payment Program myakhipp.com 1-866-251-4861 CustomerService@MyAKHIPP.com Medicaid: dhss.alaska.gov/dpa/Pages/medicaid	NEW JERSEY – Medicaid and CHIP Medicaid: state.nj.us/humanservices/dmahs/clients/medicaid 609-631-2392 CHIP: njfamilycare.org/index.html CHIP: 1-800-701-0710
ARKANSAS – Medicaid myarhipp.com 1-855-MyARHIPP (855-692-7447)	NEW YORK – Medicaid health.ny.gov/health_care/medicaid 1-800-541-2831

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+) Health First Colorado healthfirstcolorado.com Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/State Relay 711	NORTH CAROLINA – Medicaid dma.ncdhhs.gov 919-855-4100
FLORIDA – Medicaid flmedicaidtplrecovery.com/hipp 1-877-357-3268	NORTH DAKOTA – Medicaid nd.gov/dhs/services/medicalserv/medicaid 1-844-854-4825
GEORGIA – Medicaid dch.georgia.gov/medicaid Click on Health Insurance Premium Payment (HIPP) 404-656-4507	OKLAHOMA – Medicaid and CHIP insureoklahoma.org 1-888-365-3742
INDIANA – Medicaid Healthy Indiana Plan for low-income adults 19-64 in.gov/fssa/hip 1-877-438-4479 All other Medicaid: indianamedicaid.com 1-800-403-0864	PENNSYLVANIA – Medicaid dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm 1-800-692-7462
IOWA – Medicaid dhs.iowa.gov/hawk-i 1-800-257-8563	RHODE ISLAND – Medicaid eohhs.ri.gov 855-697-4347
KANSAS – Medicaid kdheks.gov/hcf 1-785-296-3512	SOUTH CAROLINA – Medicaid scdhhs.gov 1-888-549-0820
KENTUCKY – Medicaid chfs.ky.gov 1-800-635-2570	SOUTH DAKOTA - Medicaid dss.sd.gov 1-888-828-0059
LOUISIANA – Medicaid dhh.louisiana.gov/index.cfm/subhome/1/n/331 1-888-695-2447	TEXAS – Medicaid gethipptexas.com 1-800-440-0493
MAINE – Medicaid maine.gov/dhhs/ofi/public-assistance/index.html 1-800-442-6003 TTY: Maine relay 711	UTAH – Medicaid and CHIP Medicaid: medicaid.utah.gov CHIP: health.utah.gov/chip 1-877-543-7669
MASSACHUSETTS – Medicaid and CHIP mass.gov/eohhs/gov/departments/masshealth 1-800-862-4840	VERMONT– Medicaid greenmountaincare.org 1-800-250-8427
MINNESOTA – Medicaid mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp 1-800-657-3739	VIRGINIA – Medicaid and CHIP Medicaid: coverva.org/programs_premium_assistance.cfm 1-800-432-5924 CHIP: coverva.org/programs_premium_assistance.cfm 1-855-242-8282
MISSOURI – Medicaid dss.mo.gov/mhd/participants/pages/hipp.htm 573-751-2005	WASHINGTON – Medicaid hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program 1-800-562-3022, ext. 15473
MONTANA – Medicaid dphhs.mt.gov/MontanaHealthcarePrograms/HIPP 1-800-694-3084	WEST VIRGINIA – Medicaid mywvhipp.com 1-855-MyWVHIPP (1-855-699-8447)

NEBRASKA – Medicaid ACCESSNebraska.ne.gov 855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	WISCONSIN – Medicaid and CHIP dhs.wisconsin.gov/publications/p1/p10095.pdf 1-800-362-3002
NEVADA – Medicaid dhcfp.nv.gov 1-800-992-0900	WYOMING – Medicaid wyequalitycare.acs-inc.com 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov
1-877-267-2323, 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.

Newborns' Act Disclosure

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

Women's Health and Cancer Rights

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from

a mastectomy, including lymphedema? Contact HR-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 Carisk Behavioral Health)
- Fertility services (medical coverage up to $9,000 per lifetime at UHealth, Rx coverage up to $5,000 per lifetime through OptumRx)

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 services considered preventive and therefore covered at 100% under the Patient Protection and Affordable Care Act are covered as such under all four medical plans. For a complete list, please visit 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 age 13 or under
2. Service is performed outside of Miami-Dade or Broward counties
3. Service is performed concurrent with daily radiation therapy
4. Service required is an open or standing MRI, or other procedure not available within UHealth
5. Service is received in an emergency room or inpatient setting

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

Aetna 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
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
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
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
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 deductible per family):	
	$300 per person
PRIMARY CARE (PCP):	
Office Visit	Deductible, then $20 copay
SPECIALTY CARE (SPEC):	
Office Visit	Deductible, then $30 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
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 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 deductible 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
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
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 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 deductible 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
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
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 OptumRx

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

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 visit optumrx.com for a complete list.

Maintenance Medications

Maintenance medications are medications taken over long periods of time. If you are taking a maintenance medication, you may use OptumRx Home Delivery to obtain a 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 Walgreens retail location 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 have 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 OptumRx to request an authorization to fill the brand name medication without the additional cost.

Step Therapy

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

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

Try It and Don't Like It: If you choose to try the lower cost alternative, but it does not work as well for you, your doctor can call OptumRx to let them know and you may be able to use the more expensive medication at its regular copay.

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

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

WageWorks HRA Fund

When you enroll in Aetna Choice POSII HRA or Aetna Choice POSII HRA Out of Area medical plan, the University provides a $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 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 OptumRx plan for you, your spouse, and eligible dependents who are covered under the plan. Vision and dental expenses, along with over the counter pharmacy expenses, are not eligible HRA expenses. All covered family members may share the fund. All unused fund dollars are rolled over to the following calendar year if the HRA plan is selected again 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 WageWorks HRA Fund Visa Card

You will receive a WageWorks HRA Fund Visa card in the mail. You can use this card only to pay for eligible healthcare and pharmacy expenses wherever Visa debit cards are accepted, including in-network pharmacies, doctor's offices, and hospitals.

When you present the card for payment, you need to select "Credit," not "Debit," when paying for eligible expenses with your WageWorks Visa card. Be sure to sign for the payment to ensure funds are deducted from your HRA Fund. If you receive a medical bill with a "Patient Balance Due," write the card number on the bill and return it to the provider (doctor, pharmacy, or hospital). Having the card typically means you do not need to submit a paper claim form and wait for reimbursement. However, in certain circumstances, WageWorks will not be able to automatically substantiate your claim. Therefore, you may be asked to submit receipts.

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

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 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 WageWorks 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 WageWorks Visa card will not be issued if you continue your coverage through COBRA. Claims will have be submitted to WageWorks and reimbursed using your HRA funds

For more information, review the 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

Out of Pocket Maximums (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	$8,000	$8,000
Employee+1	N/A	N/A	$16,000	$16,000
Family	N/A	N/A	$24,000	$24,000

Carisk Behavioral Health

Carisk Behavioral Health is a licensed managed behavioral health organization which manages a full spectrum of mental health and substance abuse services to employees and family members enrolled in one of the medical plans offered by the University of Miami. These services are authorized based on medical necessity criteria. Covered services for adults, adolescents and children include individual and group outpatient therapy, acute psychiatric hospitalization, substance abuse detox and treatment, intensive outpatient and partial hospitalization treatment for mental health and substance abuse, family counseling and 24-hour emergency care services. 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. The network for Carisk is primarily in the state of Florida. If you or your covered dependent requires care outside of Florida, please contact Carisk to arrange for coverage in your area at the in-network coverage level.

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

Please contact Carisk Behavioral Health Member Services at 1-800-294-8642, option 2, prior to accessing services to confirm network status of the provider you wish to see. If you need to file a claim for a non-network provider, the claim must be submitted timely to Carisk, which means it must be filed within 12 months of the date of service.

The following services are not covered by Carisk:

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

		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	$20/visit	$20/visit	30% coinsurance
Outpatient Psychiatric/Med management Services	Continued care authorization required for additional visits after initial assessment and 24	$20/visit	$20/visit	30% coinsurance
ABA	Requires Pre-Authorization, script, and clinical records	$20/visit	$20/visit	30% coinsurance
Intensive Outpatient Program (IOP)	Requires Pre-Authorization	$20/visit	$20/visit	30% coinsurance
Partial Hospitalization Program (PHP)	Requires Pre-Authorization	$50/day max of $250 per admission	$50/day max of $250 per admission	30% coinsurance
Inpatient Psychiatric Admission	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
Psychiatric Consultations (Hospital Medical Floor)	Requires Pre-Authorization	No Copay	No Copay	30% coinsurance
Psychiatric Consultations (Skilled Nursing Facility, Assisted Living Facility or Nursing Home)	Requires Pre-Authorization	No Copay	No Copay	30% coinsurance

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

Benefits require pre-approval from Carisk Behavioral Health. For more information, please contact 1-800-294-8642.

Autism coverage is unlimited and will include all benefits used through Aetna, Carisk Behavioral Health and Special Employee Benefits except for ABA. Medical copayments and deductibles apply according to plan. Enrollment in UM/Aetna coverage is required. If you visit UM CARD for your initial assessment, coverage is available through the Special Employee Benefits.

Authorization from Carisk Behavioral Health must be obtained prior to the UM ASAC initial assessment.

Aetna Benefits	**Carisk Benefits**	**Special Employee Benefits for Rehabilitation**
• Speech Therapy • Occupational Therapy • Physical Therapy • Neurological Evaluation Use of the Aetna network is encouraged. Out of network providers may also be used for this benefit. Members will be responsible for their Aetna network copay for both in and out of network providers. Claims should be submitted timely to: Aetna P.O. Box 981106 El Paso, Texas 79998-1106	• Applied Behavioral Analysis (ABA) Prior authorization is required for all services (in and out of network). Use of the Carisk network is encouraged. Out of network providers may also be used for this benefit. Members will be responsible for their Carisk network copay for both in and out of network providers. Claims should be submitted timely to: Carisk Behavioral Health P.O. Box 211277 Eagan, Minnesota 55121	• Coverage for evaluation by Psychiatrist and/or Psychologist, including assessment by UM Autism Spectrum Assessment Clinic • Coverage of other non-experimental, peer reviewed interventions will be considered and reviewed for medical necessity Claims are paid on a reimbursement basis. Carisk/Aetna network usage is not required. Claims should be submitted timely to: Carisk Behavioral Health Special Employee Benefits Liaison 10685 North Kendall Drive Miami, Florida 33176

Termination and Continuation of Coverage

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

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 Carisk 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.