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**HEALTH CARE INSURANCE**

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Health Care Insurance

What the Plan Can Do For You

The University of Miami group health insurance offers you important protection against the cost of health care. There are four health options to choose from which cover a broad range of medical services and supplies, both in and out of a hospital. The four options cover a wide range of medical benefits 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% effort. Coverage will begin on the first of the month following 60 calendar days after date of hire (or date of acceptance if you provide documentation from your hiring department).

When you first become eligible, you will be asked to complete a health care coverage enrollment form. To make sure you receive the coverage you want, you must return the completed form within 30 days of your initial date of employment. If the form is not received at Benefits Administration within that time period, coverage cannot begin until the next Open Enrollment unless a Qualified Status Change occurs.

Employees who request to have their health care premiums taken on a pre-tax basis agree to a 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. The employee accepts that this salary reduction agreement cannot be revoked during the Plan year unless there is a Qualified Status Change in family or employment. In addition, except for changes in family or employment status, elections for group health insurance may not be changed during the Plan year.

The amount of your premium will depend on the type of coverage you choose and whether you elect family or individual coverage.

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 natural child or stepchild of the subscriber or legally adopted child (from the moment of placement in compliance with Florida law) in the custody of the subscriber; written evidence of adoption must be furnished to the Plan Administrator upon request. Except as specifically noted, the child must meet all requirements for eligibility listed herein:
  
  a) The child resides with the subscriber (except for paragraphs e), f), g), and h) below);
  b) The child has not reached the Limiting Age which is defined in this Section as the last day of the month in which he or she turns age 19 (except for paragraphs e) and f) below);
  c) The child regularly receives over 50% of his/her support from the subscriber (except for paragraphs g) below); and
  d) The child is not married. Note: A child will lose dependent status on the date of marriage, regardless of age.
  e) Coverage will be extended until the last day of the calendar year in which the child turns age 26 provided that he or she has been continuously enrolled as a full-time student at a college, university, vocational or secondary school accredited by a state board of education.
    i) Full-time undergraduate student status is defined for the purposes of continued coverage under the plan as enrollment of 12 credits during Fall and Spring semesters.
    ii) Full-time graduate student status is defined for the purposes of continued coverage under the plan as enrollment of 9 credits during Fall and Spring semesters.
    iii) Member is responsible for notifying Plan Administrator when full-time student status ends. Coverage shall terminate as of the last day of the calendar month in which full-time status...
ends, e.g. a student graduating in May will have his or her coverage terminated on May 31st of that year. Termination of coverage will be retroactively applied if Plan Administrator is not notified.

iv) Member agrees to provide documentation of full-time status upon request of Plan Administrator

v) Dependents who go back to school after age 19, must submit proof of paid school enrollment for coverage to begin on education start date.

f) Coverage will be extended where the child is either physically incapacitated or mentally retarded, 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 Limiting Age or age 26 if a full-time student, as defined in this section.

i) Proof of incapacitated or retardation (e.g. written documentation from the child’s physician) is required for coverage after the child has reached the Limiting Age or age 26 if a full-time student under the plan.

ii) Coverage for dependent child who is physically incapacitated or mentally retarded may be discontinued at the end of the calendar month in which the child is over the Limiting Age or age 26 if a full-time student and:

A) the child is no longer disabled; or

B) the child is capable of supporting him or herself; or

C) the child no longer receives more than 50% of his/her support from the subscriber; or

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

E) the child has a full-time job with benefits

g) Coverage will be extended where the subscriber has agreed to regularly provide medical care for the child by court order regardless of adoption.

h) Coverage will be extended where a Qualified Medical Child Support Order (QMSCO) exists; Whether or not said dependent resides with the employee.

i) A newborn child of a covered dependent child who is a member is ineligible for medical coverage after delivery.

• Your legally recognized (under Florida law) spouse (unless legally separated).

• Same sex domestic partner provided the relationship has existed for at least 12 consecutive months, the domestic partner shares living arrangements and a state of financial co-dependency exists. Neither partner may be married to anyone. Coverage is available for eligible dependent children of a same sex domestic partner as well. Contact Benefits Administration prior to enrolling a same sex domestic partner for information. Eligible requirements, documentation and tax consequences must be reviewed with potential enrollees.

• If your child is a University of Miami full time regular employee, he/she must enroll as an employee and cannot be covered as a child under the parent’s University of Miami coverage.

Surcharges
If you are a smoker, your monthly premium will be increased by $20, and if your spouse/same sex domestic partner is a smoker, your monthly premium will be increased by an additional $20. Therefore, if both you and your spouse/same sex domestic partner are smokers, your monthly premium will be increased by $40. To waive this surcharge, the NonSmoking Certification Form at www.miami.edu/benefits must be completed.

A $20 monthly spousal surcharge will apply to spouses/same sex domestic partners who are eligible to participate in their employer sponsored medical plan but choose to participate in the University’s group medical plan. The surcharge will be waived if the spouse/same sex domestic partner does not have
access to medical coverage through his/her employer. To waive this surcharge, the No Access to Employer Sponsored Medical Insurance Certification Form at [www.miami.edu/benefits](http://www.miami.edu/benefits) must be completed.

**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 a prescribed time frame or during the annual open enrollment period. The federal government determines the events that qualify as QSCs, and this list is subject to periodic change. The following events are some, but not necessarily all, valid QSC events:

- Marriage or divorce
- Death of a spouse or dependent
- Birth or adoption
- Change in dependent eligibility
- Change in employment status of employee, spouse, or dependent including:
  1) Termination of spouse’s or dependent’s employment
  2) Unpaid leave of absence over 31 calendar days
  3) Change from part-time to full-time status or vice versa

An enrollee wishing to change a benefit election on the basis of a QSC must complete the following steps:

1) Contact Benefits Administration to report the QSC event and date.
2) Complete all required forms authorizing the desired change.
3) Provide supporting documentation (e.g. marriage certificate, birth certificate, divorce decree, etc.)

*NOTE: The enrollee should report the event immediately if documentation is not readily available; a period of 60 days is allowed to provide the necessary documentation.*

4) Benefits Administration must receive the required enrollment forms within 31 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.

To make an enrollment change based on a QSC, the QSC must result in a gain or loss of eligibility for coverage, and general consistency rules must be met. For example, if an enrollee with family health insurance coverage is divorced and no longer has dependents, that enrollee may change from family to individual coverage but cannot cancel enrollment in health insurance because the QSC merely changes the level of coverage eligibility. Cancellation would not be consistent with the nature of the QSC event.

**Health Insurance Portability and Accountability Act (HIPAA)**

**Protected Health Information (PHI)**

The Aetna plan conforms to the standards for protection of individual private health information (PHI). Neither the University of Miami nor Aetna condition enrollment in the plan based on an individual’s health status. Medical claims are submitted according to electronic data standards required by the act. The University of Miami subscribes to the use of the minimum necessary standard when it comes to an individual’s PHI. Access to PHI must be authorized in writing by the individual employee or representative.

**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
The percentage of covered expenses based on the contracted Aetna reimbursement rate you pay for services after your deductible is met.

CO-PAYMENT (CO-PAY)
The fixed amount you pay for in-network provider services.

DEDUCTIBLE
The dollar amount you must pay before the plan will pay for certain services. Co-payments do not apply to the deductible.

MAXIMUM ALLOWABLE FEE
An amount determined by Aetna to be the prevailing charge for the service. This amount is based on a national database, complexity of services, range of services and prevailing charge in the geographic area.

OUT-OF-POCKET MAXIMUM
When the amount of combined covered expenses paid by you and/or all your covered dependents (family) satisfies the out-of-pocket maximums, Aetna will pay 100% of covered expenses for the remainder of the calendar year. Under Aetna Select 1, Aetna Select 2 and Choice POSII 600, copayments for Rx, mental health and BPECN do not apply to the out of pocket maximum. Under the Health Reimbursement Account plan, copayments for mental health and BPECN do not apply to the out of pocket maximum.

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 health care plan coordinates benefits with any other group plan that provides health insurance for you or your dependents. “Other Plans”, include without limitation, policies and organizations that provide medical, hospitalization, surgical and disability benefits, government programs, group insurance programs and no fault automobile insurance. This provision limits the total benefits payable under your University of Miami Plan and other group plans to the total of all allowable expenses. Allowable expenses are any necessary, customary and reasonable expenses covered at least in part by this or another group insurance plan.

When you or an insured member of your family is covered under two or more plans, one is the primary plan (for example, if covered as an employee rather than as a dependent), and all other plans are secondary plans. The primary plan pays its benefits first, without regard to the other plans. The secondary plan then makes up the difference, up to 100% of allowable expenses. The deductibles under both plans will apply. For dependent coverage, the plan of the parent whose birthday comes first in the year is the primary plan.

Hospital Services Covered
The following benefits are available under the plans:

♦ Semi-private hospital room and board, for an unlimited number of days
♦ Use of operating and recovery rooms, including outpatient surgery
♦ Prescribed drugs and medicines while hospitalized
♦ Intravenous solutions
♦ Dressings, including ordinary casts
Anesthetics and their administration
- Transfusion supplies and equipment, including whole blood or blood plasma
- Diagnostic x-rays, ultrasound and computerized tomography
- Laboratory and pathology services
- Electrocardiogram (EKG) tests to monitor heartbeat, and EEGs for brain waves
- Physical, respiratory and radiation therapy

Other Covered Benefits
The Plan will also consider coverage for the following types of care and treatment:

- Maternity benefits, including delivery, pre and post-natal care, false labor, toxemia and certain other complications of pregnancy, (If you have family coverage, the plan covers newborn baby from birth.) Federal Law requires coverage for 48 hours in hospital after vaginal delivery and at least 96 hours following cesarean section.
- Diagnostic x-rays and lab tests, including pathology services, radiation therapy, EKGs and EEGs.
- Ambulance service to or from your home or a hospital (including emergency air transportation), if medically necessary
- Services & supplies, including prescribed drugs and medicines and prosthetics (such as artificial limbs and braces)
- Emergency/accident care
- Prescription drug coverage
- Outpatient surgery

What is Not Covered
Health Care Benefits will not be paid for:

- Routine dental services and supplies
- Cosmetic surgery
- Transportation services (except for approved ambulance service)
- Treatment resulting from war or an act of war
- Charges resulting and illness or injury that occurs while at work
- Care or treatment in any governmental institution for military-service related disabilities, except inpatient hospital care provided by a government-owned facility will be covered for military dependents, military retirees and their dependents, and veterans with non-service disabilities
- Services you receive from a relative
- Prescription drugs for weight control
- Non-medically necessary services and supplies

Well Child Care
Well child care benefits are provided on an outpatient basis for a covered dependent child and include periodic examination (which may include a history, physical examinations, developmental assessment and anticipated guidance) necessary to monitor the normal growth and development of an infant, limited to oral and/or intramuscular injection for the purpose of immunization; and laboratory tests.

Hospice Care
Hospice Care facilities provide care in a home-like atmosphere for terminally ill patients. For this benefit to be paid the 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 copay.

**Aetna**

There are four health plan options available within the University of Miami Group Health Plan: two HMO-type plans and two PPO-type plans, one of which is the Health Reimbursement Account. Covered benefits are similar under each option. 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 on the Benefits Administration website located at [www.miami.edu/benefits](http://www.miami.edu/benefits).
Aetna Select 1
This option allows you and your covered dependents a full range of health care benefits when using Aetna Select Open Access Network providers. Referrals for office visits to specialists are not required. Should you choose to use UM physicians and UM facilities, your costs may be lower.

<table>
<thead>
<tr>
<th>Service</th>
<th>UM Providers</th>
<th>Aetna Select Open Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRIMARY CARE (PCP):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>$15 copay</td>
<td>$20 copay</td>
</tr>
<tr>
<td>SPECIALTY CARE (SPEC):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>$30 copay</td>
<td>$40 copay</td>
</tr>
<tr>
<td>EMERGENCY SERVICES:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room (waived if admitted)</td>
<td>$100 copay</td>
<td>$100 copay</td>
</tr>
<tr>
<td>Urgent Care Facility</td>
<td>$50 copay</td>
<td>$50 copay</td>
</tr>
<tr>
<td>MATERNITY CARE:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First OB Prenatal Visit</td>
<td>$30 copay</td>
<td>$40 copay</td>
</tr>
<tr>
<td>All Other Prenatal Visits</td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Hospital Inpatient</td>
<td>(refer to hospital services below)</td>
<td>(refer to hospital services below)</td>
</tr>
<tr>
<td>OUTPATIENT SURGERY:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td>$100 copay</td>
<td>$150 copay</td>
</tr>
<tr>
<td>Physician</td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td>OUTPATIENT CHEMOTHERAPY AND RADIATION:</td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td>OUTPATIENT DIAGNOSTIC HIGH END (including MRI, MRA, CT, PET):</td>
<td>$150 copay</td>
<td>$200 copay</td>
</tr>
<tr>
<td>OUTPATIENT DIAGNOSTIC LOW END:</td>
<td>$0 copay</td>
<td>$30 copay</td>
</tr>
<tr>
<td>REHABILITATION SERVICES</td>
<td>$40 copay</td>
<td>$40 copay</td>
</tr>
<tr>
<td>HOSPITAL SERVICES:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td>$150/day x 5 days per admission</td>
<td>$250/day x 5 days per admission</td>
</tr>
<tr>
<td>Physician</td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
</tbody>
</table>

** This is a summary only and not intended as a complete description of covered services.
Aetna Select 2

This option allows you and your covered dependents a full range of health care benefits when using Aetna Select Open Access Network providers. Referrals for office visits to specialists are not required. Should you choose to use UM physicians and UM facilities, your costs may be lower.

<table>
<thead>
<tr>
<th>Service</th>
<th>UM Providers</th>
<th>Aetna Select Open Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRIMARY CARE (PCP):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>$20 copay</td>
<td>$25 copay</td>
</tr>
<tr>
<td>SPECIALTY CARE (SPEC):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>$40 copay</td>
<td>$50 copay</td>
</tr>
<tr>
<td>EMERGENCY SERVICES:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room (waived if admitted)</td>
<td>$150 copay after deductible</td>
<td>$150 copay after deductible</td>
</tr>
<tr>
<td>Urgent Care Facility</td>
<td>$75 copay after deductible</td>
<td>$75 copay after deductible</td>
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<tr>
<td>MATERNITY CARE:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First OB Prenatal Visit</td>
<td>$40 copay</td>
<td>$50 copay</td>
</tr>
<tr>
<td>All Other Prenatal Visits</td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Hospital Inpatient</td>
<td>(refer to hospital services)</td>
<td>(refer to hospital services)</td>
</tr>
<tr>
<td>OUTPATIENT SURGERY:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td>$100 copay after deductible</td>
<td>$250 copay after deductible</td>
</tr>
<tr>
<td>Physician</td>
<td>$0 copay after deductible</td>
<td>$0 copay after deductible</td>
</tr>
<tr>
<td>OUTPATIENT CHEMOTHERAPY AND RADIATION:</td>
<td>$0 copay after deductible</td>
<td>$0 copay after deductible</td>
</tr>
<tr>
<td>OUTPATIENT DIAGNOSTIC HIGH END (including MRI, MRA, CT, PET):</td>
<td>$150 copay after deductible</td>
<td>$300 copay after deductible</td>
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<tr>
<td>OUTPATIENT DIAGNOSTIC LOW END:</td>
<td>$0 copay</td>
<td>$50 copay after deductible</td>
</tr>
<tr>
<td>REHABILITATION SERVICES</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$50 copay</td>
<td>$50 copay</td>
</tr>
<tr>
<td>HOSPITAL SERVICES:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td>$200/day x 5 days per admission after deductible</td>
<td>$300/day x 5 days per admission after deductible</td>
</tr>
<tr>
<td>Physician</td>
<td>$0 copay after deductible</td>
<td>$0 copay after deductible</td>
</tr>
</tbody>
</table>

* This is a summary only and not intended as a complete description of covered services.
Aetna Choice POSII Open Access

This option provides you and your covered dependents with the choice of using services from Aetna Choice POSII Open Access Network providers as well as from non-participating providers. Should you choose to use UM physicians and UM facilities, your costs may be lower.

<table>
<thead>
<tr>
<th>Service</th>
<th>UM Providers</th>
<th>Aetna CPII Open Access</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRIMARY CARE (PCP):</td>
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<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>$15 copay</td>
<td>$20 copay</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>SPECIALTY CARE (SPEC):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>$30 copay</td>
<td>$40 copay</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>EMERGENCY SERVICES:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room (waived if admitted)</td>
<td>$100 copay after deductible</td>
<td>$100 copay after deductible</td>
<td>$100 copay after deductible</td>
</tr>
<tr>
<td>Urgent Care Facility</td>
<td>$40 copay after deductible</td>
<td>$40 copay after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>MATERNITY CARE:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First OB Prenatal Visit</td>
<td>$30 copay</td>
<td>$40 copay</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>All Other Prenatal Visits</td>
<td>$0 copay</td>
<td>$0 copay</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Hospital Inpatient</td>
<td>(refer to hospital services)</td>
<td>(refer to hospital services)</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>OUTPATIENT SURGERY:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td>$50 copay after deductible</td>
<td>$100 copay after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Physician</td>
<td>10% after deductible</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
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<tr>
<td>OUTPATIENT CHEMOTHERAPY AND RADIATION:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility/Physician</td>
<td>$0 copay after deductible</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>OUTPATIENT DIAGNOSTIC HIGH END (including MRI, MRA, CT, PET):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10% after deductible</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>OUTPATIENT DIAGNOSTIC LOW END:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$0 copay</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>REHABILITATION SERVICES:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>20% after deductible</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>HOSPITAL SERVICES:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td>$150/day x 5 days per admission after deductible</td>
<td>$250/day x 5 days per admission after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Physician</td>
<td>$0 copay after deductible</td>
<td>$0 copay after deductible</td>
<td>40% after deductible</td>
</tr>
</tbody>
</table>

* Subject to balance billing up to maximum allowable fee.

** This is a summary only and not intended as a complete description of covered services.
Aetna Choice POSII Health Reimbursement Account (HRA)

This option provides you and your covered dependents with the choice of using services from Aetna Choice POSII Open Access Network providers as well as from non-participating providers. Should you choose to use UM physicians and UM facilities, your costs may be lower. Members in this plan receive an HRA fund of $600 per individual (maximum of $1800 per family).

<table>
<thead>
<tr>
<th>Service</th>
<th>UM Providers</th>
<th>Aetna CPII Open Access</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRIMARY CARE (PCP):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>$15 copay after deductible</td>
<td>$20 copay after deductible</td>
<td>30% after deductible</td>
</tr>
<tr>
<td>SPECIALTY CARE (SPEC):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>$30 copay after deductible</td>
<td>$40 copay after deductible</td>
<td>30% after deductible</td>
</tr>
<tr>
<td>EMERGENCY SERVICES:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room (waived if admitted)</td>
<td>deductible</td>
<td>$100 copay after deductible</td>
<td>deductible</td>
</tr>
<tr>
<td>Urgent Care Facility</td>
<td>$35 copay after deductible</td>
<td>$35 copay after deductible</td>
<td>30% after deductible</td>
</tr>
<tr>
<td>MATERNITY CARE:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First OB Prenatal Visit</td>
<td>$30 copay after deductible</td>
<td>$40 copay after deductible</td>
<td>30% after deductible</td>
</tr>
<tr>
<td>All Other Prenatal Visits</td>
<td>$0 copay after deductible</td>
<td>$0 copay after deductible</td>
<td>30% after deductible</td>
</tr>
<tr>
<td>Hospital Inpatient</td>
<td>(refer to hospital services)</td>
<td>(refer to hospital services)</td>
<td>30% after deductible</td>
</tr>
<tr>
<td>OUTPATIENT SURGERY:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td>$50 copay after deductible</td>
<td>$100 copay after deductible</td>
<td>30% after deductible</td>
</tr>
<tr>
<td>Physician</td>
<td>$0 copay after deductible</td>
<td>$0 copay after deductible</td>
<td>30% after deductible</td>
</tr>
<tr>
<td>OUTPATIENT CHEMOTHERAPY AND RADIATION:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility/Physician</td>
<td>$0 copay after deductible</td>
<td>20% after deductible</td>
<td>30% after deductible</td>
</tr>
<tr>
<td>OUTPATIENT DIAGNOSTIC HIGH END</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(including MRI, MRA, CT, PET):</td>
<td>$50 copay after deductible</td>
<td>$100 copay after deductible</td>
<td>30% after deductible</td>
</tr>
<tr>
<td>OUTPATIENT DIAGNOSTIC LOW END</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$0 copay after deductible</td>
<td>$40 copay after deductible</td>
<td>30% after deductible</td>
</tr>
<tr>
<td>REHABILITATION SERVICES:</td>
<td></td>
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<td></td>
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<td></td>
<td>20% after deductible</td>
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</tr>
<tr>
<td>HOSPITAL SERVICES:</td>
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<td></td>
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<tr>
<td>Facility</td>
<td>$100/day x 5 days per admission after deductible</td>
<td>$200/day x 5 days per admission after deductible</td>
<td>30% after deductible</td>
</tr>
<tr>
<td>Physician</td>
<td>$0 copay after deductible</td>
<td>$0 copay after deductible</td>
<td>30% after deductible</td>
</tr>
</tbody>
</table>

* Subject to balance billing up to maximum allowable fee.

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

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

- Level 1 = $10
- Level 2 = $35
- Level 3 = $55
- Level 4 = $100

Please note that in the HRA plan, the copayments above do not apply until after the fund has been exhausted and the deductible has been met. The pharmacy plan monthly premiums are already included in the medical plan premiums.

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. Family members medical expenses can be combined to satisfy the family deductible. These are the deductibles for each plan:

### Deductibles (Participating Providers)

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>AETNA SELECT 1</th>
<th>AETNA SELECT 2</th>
<th>AETNA CHOICE POSII 600</th>
<th>AETNA CHOICE POSII HRA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$0</td>
<td>$300</td>
<td>$600</td>
<td>$1,500</td>
</tr>
<tr>
<td>Family</td>
<td>$0</td>
<td>$750</td>
<td>$1,800</td>
<td>$4,500</td>
</tr>
</tbody>
</table>

### Deductibles (Non-Participating Providers)

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>AETNA SELECT 1</th>
<th>AETNA SELECT 2</th>
<th>AETNA CHOICE POSII 600</th>
<th>AETNA CHOICE POSII HRA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>N/A</td>
<td>N/A</td>
<td>$1,200</td>
<td>$3,000</td>
</tr>
<tr>
<td>Family</td>
<td>N/A</td>
<td>N/A</td>
<td>$3,300</td>
<td>$9,000</td>
</tr>
</tbody>
</table>

**Annual Out-of-Pocket Maximums**

Deductibles, medical copays and coinsurance count towards the out of pocket maximum in Aetna Select 1, Aetna Select 1 and CPII 600. The prescription drug, UMBH and BPECN copays, do not count towards the out of pocket maximum. After the out of pocket maximum is met, all medical copays and coinsurance will be paid at 100% by the plan. Deductibles, medical/prescription copays and coinsurance count towards the out of pocket maximum in CPII HRA. UMBH and BPECN copays do not count towards the out of pocket maximum in CPII HRA. In CPII HRA, after the out of pocket maximum is met, all medical/Rx copays and coinsurance will be paid at 100% by the plan.
### Out of Pocket Maximums (Participating Providers)

<table>
<thead>
<tr>
<th></th>
<th>AETNA SELECT 1</th>
<th>AETNA SELECT 2</th>
<th>AETNA CHOICE POSII 600</th>
<th>AETNA CHOICE POSII HRA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$3,000</td>
<td>$4,000</td>
<td>$4,100</td>
<td>$3,500</td>
</tr>
<tr>
<td>Family</td>
<td>$9,000</td>
<td>$12,000</td>
<td>$12,300</td>
<td>$10,500</td>
</tr>
</tbody>
</table>

### Out of Pocket Maximums (Non-Participating Providers)

<table>
<thead>
<tr>
<th></th>
<th>AETNA SELECT 1</th>
<th>AETNA SELECT 2</th>
<th>AETNA CHOICE POSII 600</th>
<th>AETNA CHOICE POSII HRA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>N/A</td>
<td>N/A</td>
<td>$8,200</td>
<td>$7,000</td>
</tr>
<tr>
<td>Family</td>
<td>N/A</td>
<td>N/A</td>
<td>$24,600</td>
<td>$21,000</td>
</tr>
</tbody>
</table>

### Enhanced Benefits For Learning Disabled Children

Children who are developmentally delayed may be eligible for two additional benefits from the University of Miami: the Learning Disability benefit and the Rehabilitative Services benefit. These benefits are offered directly through the University and are not part of the Aetna health plan.

The Learning Disability benefit provides coverage for a maximum of 4 years for the intensive educational therapy required by dependent children who are handicapped with learning disabilities (including autism), subject to the following limitations and qualifications:

- The educational facility or clinic must be recognized by the Internal Revenue Service as eligible for a medical deduction
- The maximum coverage will be 50% of the eligible charges to a maximum of $5,000 per calendar year, after payment by other sponsored programs have been made
- This benefit ends at the end of the calendar year in which the dependent child turns 17 regardless of whether or not the benefit has been used for 4 full years
- The dependent must be enrolled in other local, state or federal programs for which the dependent child is eligible (i.e., governmental early intervention programs or the Fidler’s program)
- Benefit includes evaluation

The Rehabilitative Services program provides physical, speech, ABA and occupational therapy services 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 also includes evaluation. This benefit is limited to a maximum per member benefit of $3,500 per calendar year. All treatment plans must be pre-approved by University of Miami Behavioral Health (UMBH). This benefit ends at the end of the calendar year in which the dependent child turns 17.

Both benefits require pre-authorization from University of Miami Behavioral Health (UMBH) and have lifetime limits. For more information contact 1-800-294-8642.

### 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.
You may elect to continue your health or dental plan coverage’s for yourself or your dependents for up to 18 months if coverage ends because:

- You terminate employment with the University for any reasons other than gross misconduct or
- You are no longer eligible for coverage due to a reduction in your work hours

At the time you experience any of the above qualifying events, you and your department must notify Benefits Administration immediately.

If you are disabled at the time of termination or reduction in hours, you may be entitled to continue coverage for up to a total of 29 months. University coverage may also be continued for a covered dependent for up to 36 months if coverage ends because:

- You die
- You divorce or become legally separated
- The child ceases to qualify for dependent coverage under the terms of your plan (see dependent eligibility for more information)

If you choose to continue your coverage, you and/or your covered dependent must pay the entire cost plus 2% for the continued coverage. Other provisions apply if you qualify for benefits under the Long Term Disability Plan. If you terminate employment or your work hours are reduced, the cost of continued coverage cannot be paid with money set aside to pay for health care expenses in your Flexible Spending Plan account.

If you do not elect continued coverage, your coverage will end on the last day of the month that you are still actively employed. You must elect in writing, on the appropriate form to continue your University coverage within 60 days after coverage would otherwise end. If you elect coverage it will retroactively start on the first of the month following termination and coverage will be continuous. You will have an additional 45-day period to pay the back premium necessary to avoid a gap in coverage. It is up to you or your covered dependent to contact Benefits Administration within 30 days of the date you are legally separated or divorced, or your child ceases to qualify for dependent coverage, to be eligible to continue your University coverage.

Your coverage will be canceled before the end of the indicated time period if:

- The Plan is terminated
- You or your dependent becomes covered under any other group health plan or entitled to Medicare (unless the new plan has pre-existing conditions that will restrict the benefits you receive)
- The required premiums are not paid on the first of each month. If the payment is not made by the end of the grace period (30 days) coverage will be canceled retroactive to the last month

**Claims**

Aetna is the claims administrator for the University of Miami Health Plan. A claim which has not been timely filed 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 a Aetna provider should do the following:

**In-Network**

1. Make a copy of your Aetna ID card (front and back) and a copy of the bill. Send a copy of both to the provider who is sending you the bill. This will alert the provider to bill the insurance company. Provide an explanation of the issue.

2. Follow the same procedures as in step 1, but mail the information to the Aetna claims address on the back of your Aetna ID card. Provide an explanation of the issue.

**Out-of-Network**

1. Utilize the claim form located at www.miami.edu/benefits/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
PO Box 981106
El Paso, TX 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 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 Benefits Administration.

Early Retirement

You 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)]. You must pay the full premium at the University’s group rate. Registration is required within 30 days of your retirement or the entitlement is lost. At age 65, you are no longer entitled to the University health care plan. Contact Benefits Administration for more information on early retirement.

Retirees over 65

If you are still working for the University after age 65 when you become eligible for Medicare, you may continue to be covered under the Plan and it will be your primary benefit source before Medicare. There is no employer administered plan for a retired person over age 65.
Employee Assistance Program

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

University of Miami Behavioral Health

University of Miami Behavioral Health (UMBH) is a managed mental health program which provides outpatient, inpatient and partial hospitalization behavioral health and substance abuse services to any employee and family member enrolled in one of the medical plans. UMBH offers a full spectrum of mental health services that are essential and medically necessary. All services offered through UMBH are designed to help you and your family with everyday problems as well as more serious ones. Covered services for adults, adolescents and children include: in-network individual and group outpatient services; inpatient psychiatric and substance abuse treatment at an in-network facility; intensive outpatient and partial hospitalization at an in-network facility; family counseling and 24 hour emergency care services from an in-network provider.

Please note that before accessing services, you MUST gain prior authorization by calling UMBH Member Services at 1-800-294-8642.

<table>
<thead>
<tr>
<th>Outpatient</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Therapy</td>
<td>$20/visit</td>
</tr>
<tr>
<td>Group Therapy</td>
<td>No co-payment</td>
</tr>
<tr>
<td>Benefit Payment</td>
<td>100% of negotiated fee</td>
</tr>
<tr>
<td>Maximum Calendar Year Benefit</td>
<td>Based on medical necessity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inpatient</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible per admission</td>
<td>$0</td>
</tr>
<tr>
<td>Benefit payment</td>
<td>100% of allowable charges</td>
</tr>
<tr>
<td>Maximum Days</td>
<td>Based on medical necessity</td>
</tr>
<tr>
<td>Pre-Certification</td>
<td>Required</td>
</tr>
</tbody>
</table>

Remember: To receive benefit coverage, you must contact UMBH to receive pre-authorization and a referral to a network provider or facility. There is no Out-of-Network Provider benefit.

University of Miami Vision Benefit

Routine vision care for University of Miami faculty, staff, and dependents will be provided by the Bascom Palmer Eye Care Network (BPECN). The BPECN is part of the University of Miami Medical Group (UMMG) and closely affiliated with the Bascom Palmer Eye Institute. The BPECN Routine Vision Benefit also includes optometrists from the South Florida community. The University of Miami vision care benefit consists of an annual eye exam with a participating BPECN optometrist. There is a $20 copay required. A directory of BPECN optometrists is located at [http://www.miami.edu/benefits/pdf/Optometrists.pdf](http://www.miami.edu/benefits/pdf/Optometrists.pdf). A referral is not required to see a BPECN optometrist. You may call the BPECN optometrist directly to schedule a visit. Please note that eye wear (contacts, glasses) is not covered under this benefit. In order to see an ophthalmologist please review your health care plan. For more information on the vision care benefit, contact the BPECN at 305-243-9999.

University of Miami Medical Group

For the purposes of benefits discrimination testing only, the plan options offered to members of the University of Miami Medical Group and the plan options offered to everyone else shall be treated as separate plans. For all other purposes, including IRC Section 105(h)(3), the plans shall be treated as a single plan.
DENTAL INSURANCE

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Dependent Coverage 19
Qualifying Status Changes 20
CIGNA Dental Care Plan (DHMO) 21
Delta Dental PPO Plan 22
Dental Insurance

What the Plan Can Do For You

The University of Miami offers optional dental coverage through the Dental Plan. There are two options available, a DHMO administered by CIGNA and a PPO administered by Delta Dental. To join this Plan, you will need to authorize monthly payroll deductions for your coverage on the enrollment form.

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% effort. Coverage will begin on the first of the month following 60 calendar days after date of hire (or date of acceptance if you provide documentation from your hiring department).

When you first become eligible, you will be asked to complete a health care coverage enrollment form. To make sure you receive the coverage you want, you must return the completed form within 30 days of your initial date of employment. If the form is not received at Benefits Administration within that time period, coverage cannot begin until the next Open Enrollment unless a Qualified Status Change occurs.

Employees who request to have their health care premiums taken on a pre-tax basis agree to a 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. The employee accepts that this salary reduction agreement cannot be revoked during the Plan year unless there is a substantial change in family or employment status. In addition, except for changes in family or employment status, elections for group health insurance may not be changed during the Plan year.

The amount of your premium will depend on the type of coverage you choose and whether you elect family or individual coverage.

Dental plan monthly premiums for the current calendar year can be found on the Benefits Administration website located at http://www.miami.edu/benefits.

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 natural child or stepchild of the subscriber or legally adopted child (from the moment of placement in compliance with Florida law) in the custody of the subscriber; written evidence of adoption must be furnished to the Plan Administrator upon request. Except as specifically noted, the child must meet all requirements for eligibility listed herein:
  
  a) The child resides with the subscriber (except for paragraphs e), f), g), and h) below);
  b) The child has not reached the Limiting Age which is defined in this Section as the last day of the month in which he or she turns age 19 (except for paragraphs e) and f) below);
  c) The child regularly receives over 50% of his/her support from the subscriber (except for paragraphs g) below); and
  d) The child is not married. Note: A child will lose dependent status on the date of marriage, regardless of age.
  e) Coverage will be extended until the last day of the calendar year in which the child turns age 25 provided that he or she has been continuously enrolled as a full-time or part time student at a college, university, vocational or secondary school accredited by a state board of education.
  
  f) Coverage will be extended where the child is either physically incapacitated or mentally retarded, 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 Limiting Age or age 25 if a full-time or part-time student, as defined in this section.

i) Proof of incapacitated or retardation (e.g. written documentation from the child’s physician) is required for coverage after the child has reached the Limiting Age or age 25 if a full-time or part-time student under the plan.

ii) Coverage for dependent child who is physically incapacitated or mentally retarded may be discontinued at the end of the calendar month in which the child is over the Limiting Age or age 25 if a full-time or part-time student and:
   A) the child is no longer disabled; or
   B) the child is capable of supporting him or herself; or
   C) the child no longer receives more than 50% of his/her support from the subscriber; or
   D) the child receives less than 50% of his/her support from the subscriber and the subscriber is no longer obligated to provide medical care for said child by court order.
   E) the child has a full-time job with benefits

g) Coverage will be extended where the subscriber has agreed to regularly provide medical care for the child by court order regardless of adoption.

h) Coverage will be extended where a Qualified Medical Child Support Order (QMSCO) exists; Whether or not said dependent resides with the employee.

i) A newborn child of a covered dependent child who is a member is ineligible for medical coverage after delivery.

- Your legally recognized (under Florida law) spouse (unless legally separated).
- Same sex domestic partner provided the relationship has existed for at least 12 consecutive months, the domestic partner shares living arrangements and a state of financial co-dependency exists. Neither partner may be married to anyone. Coverage is available for eligible dependent children of a same sex domestic partner as well. Contact Benefits Administration prior to enrolling a same sex domestic partner for information. Eligible requirements, documentation and tax consequences must be reviewed with potential enrollees.
- If your child is a University of Miami full time regular employee, he/she must enroll as an employee and cannot be covered as a child under the parent’s University of Miami coverage.

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 a prescribed time frame or during the annual open enrollment period. The federal government determines the events that qualify as QSCs, and this list is subject to periodic change. The following events are some, but not necessarily all, valid QSC events:

- Marriage or divorce
- Death of a spouse or dependent
- Birth or adoption
- Change in dependent eligibility
- Change in employment status of employee, spouse, or dependent including:
  - Termination of spouse’s or dependent’s employment
  - Unpaid leave of absence over 31 calendar days
  - Change from part-time to full-time status or vice versa

An enrollee wishing to change a benefit election on the basis of a QSC must complete the following steps:
1. Contact Benefits Administration to report the QSC event and date.
2. Complete all required forms authorizing the desired change.
3. Provide supporting documentation (e.g. marriage certificate, birth certificate, divorce decree, etc.)

**NOTE:** The enrollee should report the event immediately if documentation is not readily available; a period of 60 days is allowed to provide the necessary documentation.

4. Benefits Administration must receive the required enrollment forms within 31 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.

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 dental coverage is divorced and no longer has dependents, that enrollee may change from family to individual coverage but cannot cancel enrollment in dental insurance because the QSC merely changes the level of coverage eligibility. Cancellation would not be consistent with the nature of the QSC event.

**Cigna Dental Care Plan (DHMO)**

Under the CIGNA Dental Care Plan you select the facility that best meets your family’s needs from a list of licensed private dental practices located throughout South Florida. You must elect a primary care dental provider from a list of participating providers. Information on participating providers is available at [http://www.CIGNA.com](http://www.CIGNA.com). You can change dentists at any time of the years by contacting CIGNA at 800-367-1037, to be effective the first of the following month. This plan covers the cost of most dental care expenses.

The Dental Plan is designed to correct and prevent dental problems before they become serious. Therefore, under the Plan there is no charge for:

- Diagnostic examinations (every six months)
- Fillings
- Space maintenance
- X-rays
- Cleanings (maximum of two per year)
- Certain types of emergency care

The following services are also available at fees below the dentist’s usual and customary charge:

- Crowns
- Bridges
- Gum treatment
- Oral surgery
- Orthodontics (children and adults)

For more information visit [www.CIGNA.com](http://www.CIGNA.com).

**Delta Dental PPO**

The PPO Plan offers the use of any dentist you choose. If your dental provider is in the Delta Dental PPO network, your claim will be filed electronically. If your dental provider is not in the network, you must complete a Delta Dental Expense Claim Form and submit it to Delta Dental for reimbursement. For more information contact Delta Dental Customer Service at 1-800-521-2651 or visit MetLife at [www.deltadentalins.com](http://www.deltadentalins.com).
Benefits are maximized when using participating dentists. A $50 annual deductible with a $2,000 benefit maximum per patient per calendar year applies.

<table>
<thead>
<tr>
<th>Benefits (usual, customary and reasonable fee concept):</th>
<th>Participating Dentist</th>
<th>Non Participating Dentist*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic and preventive services</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Restorative and denture repairs</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Other basic services</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Crowns and prosthodontics</td>
<td>50%</td>
<td>40%</td>
</tr>
<tr>
<td>Orthodontic services (for eligible dependent children up to age 19)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Based on usual, customary and reasonable fee schedule.

### 2009 FEATURES (Total for In-Network and Out-of-Network)

<table>
<thead>
<tr>
<th>Feature</th>
<th>In Network</th>
<th>Out of Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Benefit</td>
<td>$2,000</td>
<td>($1,500)</td>
</tr>
<tr>
<td>Annual Deductible</td>
<td>$50 per member/$150 per family</td>
<td></td>
</tr>
<tr>
<td>Lifetime Orthodontic Maximum (child)</td>
<td>$1,000</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Lifetime Orthodontic Maximum (adult)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Delta Dental BENEFITS

<table>
<thead>
<tr>
<th>Type A Preventive</th>
<th>Delta Dental In Network</th>
<th>Delta Dental Out of Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Exams (twice per calendar year)</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>X-rays (full mouth/panorex) (1) every 3 years</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>X-rays (bitewing) (1) per calendar year; (1) in 6 consecutive months for children</td>
<td>100%</td>
<td>90%</td>
</tr>
<tr>
<td>Prophylaxis/Cleaning (1) in 6 consecutive months</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Fluoride Treatments (1) in 12 consecutive months (child to age 19)</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Space Maintainers (child to age 16)</td>
<td>100%</td>
<td>80%</td>
</tr>
</tbody>
</table>

### Type B Basic

<table>
<thead>
<tr>
<th>Type B Basic</th>
<th>80% after deductible</th>
<th>60% after deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sealants/Fillings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endodontics/Root Canal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periodontal Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Anesthesia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periodontal Maintenance</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Simple Extractions</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Surgical Extractions/Oral Surgery</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Inlays/Onlay</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Type C Major</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------</td>
<td>--------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Rebases/Relines</td>
<td>50% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Crown Build-ups</td>
<td>50% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Dentures</td>
<td>50% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Bridges</td>
<td>50% after deductible</td>
<td>40% after deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type D Orthodontia</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthodontia</td>
<td>50%</td>
<td>40%</td>
</tr>
</tbody>
</table>

* Delta Dental reimbursement is based on 90th percentile of Maximum Plan Allowance.

**HIPAA Privacy**

The CIGNA and Delta Dental plans conform to new standards for protection of individual private health information (PHI). Neither the University of Miami nor CIGNA/Delta Dental condition enrollment in the plan based on an individual’s health status. Dental claims are submitted according to electronic data standards required by the act. The University of Miami subscribes to the use of the minimum necessary standard when it comes to an individual’s PHI. Access to PHI must be authorized in writing by the individual employee or representative.
LONG TERM DISABILITY INSURANCE

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Right of Reimbursement 29
Long Term Disability Insurance

What the Plan Can Do For You
In case of an extended illness or injury, you may be eligible for continued income on a long-term basis. Income protection during these times is vital to many aspects of your life and the lives of your family members - particularly if the disability extends over several months or years.

The University's Long Term Disability Insurance Plan provides protection for you and your family when an illness or injury keeps you away from work. This Plan can continue as part of your salary through:

- Salary Continuation for up to six months, upon approval of Long Term Disability benefit
- Long Term Disability (LTD) benefits, which begin after six months and provide 66 2/3% of your salary (to a maximum benefit of $10,000 per month) for as long as the disability lasts, except for limitations noted later

Here are definitions of certain terms used in this section:

Approved Hospital
An “Approved Hospital” is primarily engaged in providing for the surgical and medical diagnosis, treatment and care of injured and sick persons under the facilities supervision of a staff of physicians. An Approved Hospital provides care on an inpatient basis in exchange for compensation. An Approved Hospital does not (other than incidentally) serve as a place for rest, for caring for the aged, for drug addicts, alcoholics or as a nursing home.

Disability
The complete inability to perform any and every duty of your occupation or of a similar occupation for which you are reasonably capable due to education and training, as a result of Injury or Illness.

Other Income Benefits
Social Security, Workers' Compensation or any benefits from an occupational disease law, other state or federal disability benefits you qualify for, other University-sponsored disability benefits you may receive and any other group disability plans.

Pre-Existing Condition
A health condition you received treatment for within 12 months prior to being eligible to participate in the LTD Plan.

Totally Disabled
A disease or accidental bodily injury that prevents you from performing the duties of:

- Your own occupation during the first 60 months you are receiving Long Term Disability payments
- Any occupation, after that 60-month period, for which you are reasonably qualified by training, education or experience

Long Term Disability Benefits
When You Qualify For Coverage
Full-time and part-time regular members of the faculty and key administrators are eligible for coverage as of their first day of employment. Other full-time and part-time regular employees become eligible after working at the University of Miami for one year on a full-time or part-time regular basis.

What Is Your Coverage Payable At?
If your total disability continues for six months and longer, you may be eligible to receive a monthly Long Term Disability (LTD) benefit equal to 66 2/3% of your monthly salary, including any other income benefits you may receive. The maximum payment you may receive from all sources is $10,000 a month (not including any personal policies you have).
An Example
John Doe became totally disabled and was approved for LTD making him eligible to receive six months of Salary Continuation; after six months, his LTD benefits began. Assume he was to receive $1,200 disability benefit as 66 2/3% of his regular salary.

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

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

Length of LTD Payments
The maximum period for which LTD benefits will be paid is based on your age when your disability begins. Benefits are payable to the end of the calendar month in which Social Security Normal Retirement Age is attained. If disabled after Social Security Normal Retirement Age:

- If you are age 62 but less than 65 when the period of total disability starts, your payment maximum is 36 months
- If you are age 65 but less than 68 when the period of total disability starts, your payment maximum is 24 months
- If you are age 68 or over when the period of total disability starts, your payment maximum is 12 months

Group and Excess Life Insurance Benefit while on Long Term Disability
If you become totally disabled before you reach age 65 and are approved for benefits under the University’s Long Term Disability Plan, you will be covered under the Group Life Insurance during the period that you are covered under the University’s Long Term Disability plan provided that:

- You file for continued coverage within the first 12 months of disability
- You furnish evidence of continued disability each year.

You may continue your Voluntary Excess Life Insurance while you are disabled by paying the required premiums. If you continue to be totally disabled after six months, you may apply for a waiver of premium. The same amount of coverage you had when you became disabled will continue at no cost to you if you are approved for a waiver of premium.

Payment Limitations
Benefits you receive due to mental or nervous disorders, alcoholism, drug addiction or the use of any hallucinogen, will be paid for no more than 24 months unless you are then confined in an approved hospital and have been confined for more than 30 days. In this case, benefits will continue until you have been out of the hospital for that condition for a total of 90 days during any 12-month period or until you reach the end of the maximum benefit period described in the preceding section.

Disability Not Covered
This coverage does not include disabilities caused by:

- Intentionally self-inflicted injuries
- Commission or attempted commission of an assault, battery or felony
- War or any act of war whether declared or undeclared, insurrection or rebellion
- Participating in a riot or civil disturbance
- An illness, injury or pregnancy-related condition for which you have received medical treatment during the 12-month period before your University LTD coverage began; if a disability begins
during the 24 months after this LTD coverage begins and is in any way related to a pre-existing condition, you will not receive benefits for that disability from the Plan.

Rehabilitative Employment
The Plan offers an incentive for you to return to work when possible through rehabilitative benefits that will increase your overall level of income. If you return to part-time work (less than 75% of full-time), your LTD benefit will be based on the ratio of your part-time earnings to your pre-disability earnings.

To be eligible for rehabilitative disability benefits, you must obtain employment within one year of becoming disabled. Rehabilitative disability benefits can continue for a maximum of three years of part-time employment.

An Example
Susan Jones was earning $1,200 per month when she became eligible for LTD benefits, resulting in a LTD income of $800 ($1,200 x 66 2/3% = $800). She was, however, able to obtain part-time employment earning $600 per month. Since her disability benefit was prorated by the ratio of part-time income to pre-disability earnings ($600/$1,200 = 50%), her $800 LTD benefit was reduced by $400 ($800 x 50%) to $400. Her total income increased, however, from $800 to $1,000 ($400 + $600 = $1,000).

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

When Coverage Ends
Your LTD coverage continues as long as you are working full-time or on a part-time regular basis at the University of Miami. Your coverage will end if you leave the University for any reason, including retirement. Coverage also ends if the Plan is terminated.

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

You will continue to accrue time credit toward retirement.

Your health and dental coverage will continue as long as you continue to pay for your portion of the premium. If you have health and/or dental coverage on a spouse/partner or dependent and wish to continue those benefits, you must pay for the full cost of their coverage.

If you completed five years or more of full-time or part-time regular employment at the University of Miami, tuition remission for yourself, spouse and dependents will continue. If you have fewer than five years of full-time regular service then tuition remission will not continue for yourself and/or your spouse/partner and dependents unless you or they are already enrolled in a program and receiving tuition remission. If you become totally disabled before you reach age 65 and are approved for benefits under the University’s Long Term Disability Plan, you will be covered under the Group Life Insurance during the period that you are covered under the University’s Long Term Disability plan provided that:

-You file for continued coverage within the first 12 months of disability
-You furnish evidence of continued disability each year.
Salary Continuation

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

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

Medical evidence documenting inability to perform the employee's job duties for a minimum of six continuous months is required before benefits begin. An LTD application must be filed through Benefits Administration. The provision of Salary Continuation payments for the six months prior to commencement of LTD Benefits and for benefits under the LTD Plan is contingent upon approval by the Third Party Plan Administrator.

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

Employees With Three Or More Years Of Service
Receive full monthly salary for entire six-month period (offset by accrued sick and vacation pay, Short Term Disability, Social Security and Worker's Compensation).

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

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

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

To Claim Benefits
You must file a claim with Benefits Administration to apply for LTD benefits. If you make a written claim for Plan benefits, and all or part of it is denied, Aetna, the third party administrator, will notify you of the reasons for denial and refer you to pertinent Plan provisions within 90 days of receiving your claim (180 days if special circumstances apply). They will also inform you on how you can appeal this decision.
ARTICLE VIII

Right of Reimbursement. By accepting payment for, or receiving the benefit of, long term disability or other expenses covered by the Plan, any Eligible Employee who has a claim against any other person or entity which would entitle the Eligible Employee to recover hereby agrees that the Plan immediately acquires a right of recovery from any recovery or is due which the Eligible Employee receives, directly or indirectly, from the other person or entity, to the extent of any monies allocated to loss of wages, inability to be employed in the current or any other position or other payments received by the Employee from the Plan. The right of the Plan to obtain reimbursement shall constitute a first lien against any recovery by the Eligible Employee to the extent of any payments by the Plan, and shall also constitute a set-off against future benefits due to the Eligible Employee under the Plan. The Plan’s right to reimbursement for its payments shall not be subject to reduction for attorney's fees (often referred to as the “attorney fund doctrine”) or other expenses of recovery, and shall apply to the entire amount of any recovery by the Eligible Employee, whether by judgment, settlement, arbitration award or otherwise. The Plan’s right of recovery shall not be limited by any characterization of the nature or purpose of the amount(s) recovered by the Eligible Employee, or by the nature or purpose of the payments received by Eligible Employee under the Plan. The Plan’s right to recover shall not be subject to any reduction because the Eligible Employee has not been made whole, nor shall it be subject to any limitation as a recovery for a particular type or kind of expense.

By accepting payment for, or receiving the benefit of, disability or other expenses covered by the Plan, the Eligible Employee also agrees that the Plan thereby immediately acquires a first superior equitable right, title and interest in the proceeds of any recovery the Eligible Employee may secure on any claim which he or she may have against any other person or entity which would entitle him or her to recover that such equitable right, title and interest shall give the Plan a first priority of payment over the Eligible Employee or any other party; that such equitable right, title or interest is in the nature of an ownership interest; and that, in order to protect said equitable right, title and interest, the Plan shall have the right to seek and obtain the imposition of a constructive trust upon the proceeds, to the extent of the disability or other payments made to or on behalf of the Eligible Employee by the Plan, regardless of whether said proceeds are in the actual or constructive possession of said Eligible Employee and regardless of whether said proceeds are payable directly to the Eligible Employee or to a third person or entity on his or her behalf or for his or her benefit or credit.

By accepting payment for, or receiving the benefit of, disability or other expenses covered by the Plan, the Eligible Employee also agrees that when the Eligible Employee has recovered any monies on any claim which he or she may have against any other person or entity he or she shall remit the monies to the Plan, up to the amount expended by the Plan on disability or other expenses paid by the Plan or on behalf of the Eligible Employee. The Eligible Employee further agrees that if he or she has recovered funds and does not repay the Plan within fourteen (14) days after the actual or constructive receipt thereof, the Plan shall have the right to bring cause of action against him or her for the return of the same. If the Plan brings a cause of action in State Court, federal law shall apply as it relates to ERISA Plans.

As a precondition to any payment by the Plan, the Eligible Employee shall:

(1) Execute an Agreement acknowledging the Plan's right to a constructive trust as well as any other rights of recovery, agreeing to repay any claims paid by the Plan, pledging amounts recovered by the Eligible Employee from any other source as security for repayment of any claims paid by the Plan, and to the extent provided below, assigning the Eligible Employee’s cause of action or other right of recovery to the Plan;

(2) Provide such information as the Plan Administrator may request;

(3) Notify the Plan Administrator in writing by copy of the complaint or other pleading of the commencement of any action by the Eligible Employee to recover monies; and

(4) Agree to notify the Plan Administrator of any recovery.
The Eligible Employee shall cooperate fully with the Plan in asserting claims against any entity and such cooperation shall include, where requested, the filing of a suit by the Eligible Employee against any entity and the giving of testimony in any action filed by the Plan. If an Eligible Employee fails or refuses to cooperate in connection with the assertion of claims against a party, the Plan Administrator may deny payment of claims and treat prior claims as overpayments recoverable by offset against future Plan benefits or by other action of the Plan Administrator. The Eligible Employee shall not take any action which prejudices the Plan’s right to reimbursement, or clouds or contravenes its equitable right, title and interest in the proceeds of any recovery which the Eligible Employee may secure on any claim against any other person or entity which would entitle him or her to recover for some or all of the disability or other expenses paid or payable by the Plan.

The Eligible Employee further agrees that if he or she breaches any of the foregoing agreements, the Plan shall have the right to bring a cause of action against the Eligible Employee to enforce any or all of its rights. Should the Plan bring a cause of action in State Court, federal law shall apply as it relates to ERISA Plans. Should the Eligible Employee fail to repay the Plan from the proceeds of any recovery, the Plan Administrator shall also have the right to satisfy the lien by deducting the amount from future claims otherwise payable under the Plan.

Subrogation and Assignment. Should the Eligible Employee fail to take action to recover within eight (8) months or within thirty (30) days of a request by the Plan, the Plan shall be deemed to have acquired, by assignment or subrogation, a portion of the Eligible Employee’s claim equal to its payments. The Plan may thereafter commence proceedings directly against any appropriate party. The Plan shall not be deemed to waive its rights to commence action against a party if it fails to act after the expiration of eight (8) months nor shall the Plan’s failure to act be deemed a waiver or discharge of the lien described above.

Release of Information. The execution of a claim form shall constitute authorization by an Eligible Employee of the Plan to request and obtain from, or release to, any party any information deemed necessary by the Plan Administrator or Claims Administrator to process or verify an Eligible Employee’s claims.
SHORT TERM DISABILITY INSURANCE

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Short Term Disability Insurance

What the Plan Can Do For You:
In case of an employee's extended illness or injury, you may be eligible for continued income on a short-term basis.

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

Eligibility:
You are eligible for coverage from the first day that all of the following requirements are met:
- Employed by the University of Miami, as a regular full time or part-time regular employee
- Classified as a full-time regular non-exempt (bi-weekly paid) or exempt (monthly paid) employee by the University of Miami
- Completed the enrollment form and forwarded it to Benefits Administration within thirty (30) days of original hire date or enroll online during the annual Open Enrollment period
- Have been enrolled in the Short Term Disability Plan for one year prior to the onset of the Medical Leave of Absence in which you wish to collect Short Term Disability (for example, your Leave of Absence must not begin prior to your being effective for one full calendar year)

Cost of the Plan:

<table>
<thead>
<tr>
<th>University of Miami</th>
<th>Short Term Disability Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Rates Based on Gross Salary</td>
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</tr>
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</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>New Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 and &lt;</td>
<td>1.1%</td>
</tr>
<tr>
<td>25-29</td>
<td>1.1%</td>
</tr>
<tr>
<td>30-34</td>
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<tr>
<td>60-64</td>
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<tr>
<td>65-69</td>
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</tr>
<tr>
<td>70 and &gt;</td>
<td>1.2%</td>
</tr>
</tbody>
</table>

STD Payments:
Benefits will be paid to you while you are on an approved Medical Leave of Absence due to injury, illness, or pregnancy. You will receive the income benefit of 66 2/3% of your pay.

Benefit payments will be processed according to the standard pay schedule.

Benefit payments will stop when your approved Medical Leave of Absence ceases or the attending physician states that you are capable of returning to work. Benefit payments will not be extended beyond the maximum period payable.

Benefits will NOT be paid until an approved Medical Leave of Absence has been entered into the system by Human Resources.
Benefits are Payable:
- Benefits are payable for your own injury, illness and pregnancy
- A Medical Leave of Absence must be activated prior to receiving STD income
- Employees and their attending physician must complete an Initial Claim Form and return it to Benefits Administration prior to receiving STD income.
- The first 15 working days of the approved Medical Leave of Absence will not be paid by STD
- STD Income will begin to accrue on the 16th working day of the Medical Leave of Absence
- The maximum payable period is 24 weeks

Follow-Up Claim Forms:
Follow-Up Claim Forms must be completed by your attending physician and submitted to Benefits Administration every four weeks to receive benefit payments. The follow-up claim form is located at www.miami.edu/benefits/forms. This form must be returned to Benefits Administration to prevent an interruption of STD benefit payments. Benefits Administration reserves the right to hold STD check(s) if the Follow-Up Claim Form has not been returned within the stated time frame or if the form is lacking continuity from the previously completed Initial Claim Form or Follow-Up Claim Form.

Reoccurring injury or illness for the same illness or injury that occurred on the prior claim:
An uninterrupted period of sixty (60) calendar days of regular full-time or part-time regular hours at work must be accrued prior to filing a new STD claim in order to start a new claim. (Meeting this criteria would designate a new maximum payable period of 24 weeks.) The sixty (60) days must begin on the first regular paid day returning from the prior approved Medical Leave of Absence and continue through the first day of the next approved Medical Leave of Absence.

Reoccurrence of injury or illness within less than 60 calendar days:
The same claim will be reactivated and the remainder of the initial 24 week pay period will be paid as long as you are on an approved Medical Leave of Absence.

New injury or illness:
If an injury or illness is sustained then there must be 60 calendar days of full-time or part-time regular hours in between the two approved Medical Leave of Absences.

Your STD Coverage will terminate on the earliest of these days:
- The date Plan is terminated
- The date you cease to contribute to the cost of the Plan
- The date you cease to meet any of the above mentioned requirements

You must file an Initial Claim Form with Benefits Administration to begin receiving STD benefits. Your initial claim form should be filed with Benefits Administration no later than 15 days of the onset of your medical leave. Benefits Administration reserves the right to deny any Short Term Disability Claim if any of the above mentioned requirements are not met or if any mandated terms of the approved Medical Leave of Absence are not met. Appeals will be accepted and considered on a case-by-case basis.
LONG TERM CARE INSURANCE

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Benefits 35
Long Term Care Insurance

Plan Summary

Plan 1 Base
Long Term Care/Nursing Home Facility, Assisted Living Facility and Professional Home Care Services

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

Daily Benefit: $70, $100, $130, $150, or $200 per Day, paid monthly
Benefit Duration: 6-Years
Elimination Period: 90 Days per Lifetime

Level of Care

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

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

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

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

Benefits

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

Benefit Duration: This is the length of time benefits would be paid as long as you continue to have a covered disability. You may move between facility and home care – depending on your need – and still receive benefits. Your benefit duration is 6 years, for LTC/Nursing Home Facility Care.

Lifetime Maximum: The Lifetime Maximum is the maximum benefit dollar amount UNUM will pay over the life of your coverage. This dollar amount is based on the Long Term Care/Nursing Home Facility Benefit Amount and the Benefit Duration you choose.

For example: If you choose the Base Plan of $100 per day Long Term Care/Nursing Home Facility Benefit Amount with 6 Year Duration, your Lifetime Maximum is as follows: $100 / day X 365 days X 6 years = $219,000.

Elimination Period: A period of 90 consecutive days of continuous disability that occurs after the effective date of coverage and during which you are receiving care. This 90-day period must be satisfied before benefits would begin. This 90-day Elimination Period must be satisfied only once during your lifetime.

Guaranteed Issue: You are eligible for guaranteed enrollment within 90 days from your date of hire if you are a full time faculty or staff member, with the exception of the $200 per day benefit amount, which requires an evidence of insurability form. The $200 per day election requires an evidence of insurability form. Anytime after 90 days, you may apply for coverage by providing an evidence of insurability form.
Medical Underwriting: Spouses, retirees and their spouses and eligible family members must provide evidence of insurability to qualify for any level of coverage.

Eligible Family Members: Employee’s spouse, parents & grandparents; spouse’s parents & grandparents; retirees, retiree’s spouse and certified domestic partners.

Converting to and Individual Policy: If your coverage ends because your employment with the University terminates you may convert your LTC to an individual policy paying the same rate. You must request conversion within 30 days of termination to continue coverage. To convert your LTC plan to an individual policy, contact Benefits Administration at (305) 284-2973.
LIFE INSURANCE AND ACCIDENT INSURANCE

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Life Insurance and Accident Insurance

What the Plans Can Do For You
Your life insurance needs depend on your family status, your financial situation and other individual considerations. To accommodate the diverse needs of faculty and staff, the University of Miami offers a broad range of life and accident insurance coverages. By selecting the combination of plans and coverage amounts best suited to your needs, you can customize this protection to meet your personal circumstances.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Who Pays</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Group Life</td>
<td>University</td>
<td>Two times salary up to $200,000 (rounded to nearest $1,000).*</td>
</tr>
<tr>
<td>Voluntary Excess Life</td>
<td>You, with after-tax earnings</td>
<td>One time salary to $100,000 or two times salary to $200,000 (rounded to nearest $1,000).</td>
</tr>
<tr>
<td>Basic AD&amp;D</td>
<td>University</td>
<td>One time salary to $100,000 (rounded to the nearest $1,000) (full or partial benefit for dismemberment).</td>
</tr>
<tr>
<td>Voluntary AD&amp;D</td>
<td>You, with either pre- or after-tax earnings</td>
<td>From $10,000 - $500,000. If you choose more than $150,000 your benefit amount must not be more than ten times your salary.</td>
</tr>
<tr>
<td>One Month Death Benefit</td>
<td>University</td>
<td>One times base salary</td>
</tr>
</tbody>
</table>

*If you participate in the Employees Retirement Plan and you were employed before October 1, 1977, this benefit may be different depending on the amount of your accrued pension benefit under that Plan.

Who May Participate
You may participate in any of the University’s survivor protection plans described in this section if you are a regular full-time or part-time regular member of the University of Miami faculty or staff.

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

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

Basic Group Life Insurance
Group Life Insurance is provided at no cost to you by the University of Miami and you are automatically enrolled. The University pays the full cost of your Group Life Insurance, but there are certain income tax consequences on amounts exceeding $50,000. Please contact Benefits Administration for further details.
If you die while insured by the plan, benefits will be paid to your beneficiary. Group Life Insurance provides two times your basic annual earnings rounded to the nearest $1,000 up to a maximum of $200,000.

**For Example:**
- Basic annual earnings: $28,300
- 2 times basic annual earnings: $56,600
- Group Life Insurance benefits: $57,000

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

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

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

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

If you become totally disabled before you reach age 65 and are approved for benefits under the University’s Long Term Disability Plan, you will be covered under the Group Life Insurance during the period that you are covered under the University’s Long Term Disability plan provided that:

- You file for continued coverage within the first 12 months of disability
- You furnish evidence of continued disability each year.

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

**Voluntary Excess Life Insurance**

Voluntary Excess Life Insurance lets you supplement the University-provided survivor protection plans if you want additional life insurance coverage. Your first opportunity to purchase this insurance, with coverage up to $50,000 falls within 90 days of your first day of employment. The insurer guarantees a level of $50,000 in coverage for faculty and staff enrolling in the Plan during the first ninety days of employment. Coverage in excess of $50,000 requires review and acceptance by the insurer of a completed health questionnaire. If you decide to purchase coverage after you are first eligible, evidence of insurability is required. The benefit paid upon your death will depend on the level of coverage you choose. You may select from two levels of coverage:

- One times your salary (maximum benefit $100,000)
- Two times your salary (maximum benefit $200,000)

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

**For Example:**
- Your base salary: $35,600
- You select 1x base salary: $36,000
  (Rounded to the nearest $1,000)
- Your Voluntary Excess Life Insurance: $36,000
Your premium for Voluntary Excess Life Insurance is deducted automatically from your paycheck each month. You pay a group rate, based on:

♦ The level of coverage you select
♦ Your age
♦ Whether or not you are a smoker

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

**Spousal Coverage**

The Voluntary Excess Life Insurance Plan also allows insurance coverage for a spouse completion of health statement, with acceptance by insurer. Spousal coverage is limited to 50% of the employee's coverage, or $50,000 (whichever is less). The minimum spousal coverage is $5,000. Spouses are required to be performing normal duties and not be confined in an institution during the ninety days prior to enrollment. Spousal coverage cost will be added to employee cost and deducted from the employee’s payroll check. The monthly cost of the spouse’s coverage is based on the amount of protection selected and the spouse’s age.

**Dependent Coverage**

The Voluntary Excess Life Insurance Plan also allows insurance coverage for dependent children. Dependent coverage is limited to $5,000, $10,000 or $15,000 per dependent. The dependent coverage cannot exceed 50% of the employee’s salary. Dependents are required to be non-confined and performing normal duties. Eligible children must be 14 days to 19 years of age, or up to age 26 if full-time students. Dependent coverage cost will be added to employee cost and deducted from the employee’s payroll check.

You may continue your Voluntary Excess Life Insurance while you are disabled by paying the required premiums. If you continue to be totally disabled after six months, you may apply for a waiver of premium. The same amount of coverage you had when you became disabled will continue at no cost to you if you are approved for a waiver of premium.

Voluntary Excess Life Insurance pays a benefit if you die for any reason (except as a result of suicide any time during the first two years of your coverage).

Please refer to the Voluntary Excess Life Insurance Plan Document for more information.

**Basic Accidental Death and Dismemberment Insurance**

Basic Accidental Death and Dismemberment (AD&D) coverage is provided at no cost to you by the University of Miami, and you are automatically enrolled. This coverage pays your beneficiary the full benefit amount if your death results from an accident, or pays you a full or partial benefit for accidental dismemberment. The full benefit amount equals your annual salary, rounded to the nearest thousand, up to a maximum benefit of $100,000.

If you accidentally suffer the loss of a hand, foot or sight in an eye, or a combination of these, you will receive the following benefits:

<table>
<thead>
<tr>
<th>Loss</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two or more</td>
<td>Full benefit amount</td>
</tr>
<tr>
<td>Single loss</td>
<td>One-half amount</td>
</tr>
<tr>
<td>Thumb and index finger on the same hand</td>
<td>One-quarter amount</td>
</tr>
</tbody>
</table>
Voluntary Accidental Death & Dismemberment

Full-time and part-time regular faculty and staff, who are under 70 years of age, may purchase Voluntary Accidental Death and Dismemberment (AD&D) coverage. Voluntary AD&D offers additional insurance protection if you or an enrolled dependent dies as the result of an accident. Voluntary AD&D also pays a benefit for your accidental dismemberment. You may purchase this coverage in amounts ranging from $10,000 to $500,000, but no more than ten times your salary (if coverage is greater than $150,000). The Plan also offers a total disability benefit, and a special education benefit to provide for your children’s schooling if you die before they finish college.

If you are covered under the Plan, you may also purchase coverage for your spouse and dependent children – including stepchildren, foster children and legally adopted children – who are not self-supporting and who are between the ages of 14 days and 19 years old, (or 25 years old if attending an institution of higher learning on a full-time or part-time basis).

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

Your spouse will be covered for 50% of your benefit amount, or 40% if you have eligible children. Each of your eligible children will be insured for 15% of your benefit amount for loss of life and 50% of your benefit amount for determining dismemberment benefit if there is no insured spouse at the time of the accident; or 10% of your benefit amount for loss of life benefit and 50% of your benefit amount for determining dismemberment benefit if your spouse is eligible for coverage.

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

<table>
<thead>
<tr>
<th>Age on date of death</th>
<th>Selected principal sum</th>
</tr>
</thead>
<tbody>
<tr>
<td>69 or younger</td>
<td>100%</td>
</tr>
<tr>
<td>70-74</td>
<td>87.5%</td>
</tr>
<tr>
<td>75-79</td>
<td>57.5%</td>
</tr>
<tr>
<td>80-84</td>
<td>37.5%</td>
</tr>
<tr>
<td>85 and older</td>
<td>20%</td>
</tr>
</tbody>
</table>

When a covered injury results in any of the following losses to an insured person within 365 days after the date of the accident, payment of the indicated percent of the Principal Sum will be made:

<table>
<thead>
<tr>
<th>For Loss of:</th>
<th>Percentage of Principal Sum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both hands or both feet</td>
<td>100%</td>
</tr>
<tr>
<td>Sight of both eyes</td>
<td>100%</td>
</tr>
<tr>
<td>One hand and one foot</td>
<td>100%</td>
</tr>
<tr>
<td>One hand and entire sight of one eye</td>
<td>100%</td>
</tr>
<tr>
<td>One foot and entire sight of one eye</td>
<td>100%</td>
</tr>
<tr>
<td>One hand or one foot</td>
<td>50%</td>
</tr>
<tr>
<td>Sight of one eye</td>
<td>50%</td>
</tr>
<tr>
<td>Speech of hearing in both ears</td>
<td>50%</td>
</tr>
<tr>
<td>Thumb and index finger of same hand</td>
<td>25%</td>
</tr>
</tbody>
</table>

“Loss” as used above with reference to hand or foot means the actual and complete severance through or above the wrist or ankle joint; as used with reference to eye means irrecoverable loss of entire sight; as used with reference to speech means complete and irrecoverable loss of entire ability to speak; as used with the reference to hearing in an ear means complete and irrecoverable loss of the entire ability to hear.
in that ear; and as used with respect to thumb and index finger means the actual and complete severance through or above the metacarpophalangeal joint of both digits.

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

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

1. Education Benefit for each of your dependent children who, on the date of the accident, are enrolled as a full-time student,
   a) In a school for higher learning or
   b) In the 12th grade but enrolls as full-time student in a school for higher learning within one year after your death.

2. If there are no dependent children who qualify under 1.a) or 1.b), payment of 2% of your Principal Sum will be distributed to your beneficiary.

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

Permanent Total Disability
If you are permanently and totally disabled within 100 days of a covered accident occurrence, 2% of your Principal Sum each month after 12 consecutive months of permanent total disability will be paid for as long as the permanent total disability continues, up to a maximum of 50 consecutive months. The total amount payable is reduced by any amount paid or payable under the Accidental Death and Dismemberment Benefit for the same accident. If you die before the end of the maximum benefit period, the unpaid benefits will be paid in one lump sum to your beneficiary.

The Permanent Total Disability benefit does not cover your family member and this benefit is not available if you are age 70 or older.

Emergency Evacuation Benefit
If the Insured Person suffers an Injury or Emergency Sickness that warrants his or her Emergency Evacuation while he or she is outside a 100 mile radius from his or her current place of primary residence, the policy will pay for Covered Emergency Evacuation Expenses reasonably incurred, up to a maximum of $30,000 for all Emergency Evacuations due to all Injuries from the same accident or all Emergency Sicknesses from the same or related causes.

Repatriation of Remains Benefit
If an Insured Person suffers loss of life due to Injury or Emergency Sickness while outside a 100 mile radius from his or her current place of primary residence, the policy will pay for covered expenses reasonably incurred to return his or her body to his or her current place of primary residence, up to a maximum of $3,000.

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

- Suicide or intentionally self-inflicted injury
- Physical or mental disease
- War or an act of war, declared or not
- Your commission of a felony
- Travel or flight in an aircraft not intended for passengers

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Performing and/or training to become a flight crew member
• Riding in an aircraft owned, leased or operated by the Policyholder or by the Insured Person’s employer
• The Insured person being under the influence of drugs or intoxicants, unless taken under the advice of a Physician.
• Sickness, disease or infections of any kind; except bacterial infections due to an accidental cut or wound, botulism or ptomaine poisoning.

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

Conversion Privilege
You and your insured family members may apply for a conversion policy of Accidental Death and Dismemberment insurance if insurance under the policy terminates for any reason except:

• Non-payment of premium
• When the terminated coverage is replaced within 31 days by similar coverage sponsored or arranged by your employer

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

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

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

Workers’ Compensation
Florida’s Workers’ Compensation, which is paid for by the University, provides continuing monthly income for your surviving spouse and eligible children if you die as a result of an on-the-job illness or injury.

Naming Your Beneficiary
You designate who will receive benefits from each of your survivor protection plans by naming a beneficiary for each plan. In order to name a beneficiary, you must complete a Designation of Beneficiary form. The form may be obtained from Benefits Administration. You may name anyone you wish, selecting the same beneficiary for all your coverages, or different beneficiaries for each. You may also name more than one beneficiary.
Generally, you name your beneficiary when you enroll in a plan. You may also change your beneficiary designation at anytime, in writing, by contacting Benefits Administration.

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

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

How Benefits are Paid
Death benefits from each of the other plans are generally paid in a single lump sum, but installment payments may be arranged if requested by you or your beneficiary. For more information, contact Benefits Administration.

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

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

Converting to an Individual Policy
If your coverage ends because your employment with the University terminates, you may convert all or part of your Group Life Insurance, Voluntary Excess Life Insurance and Voluntary AD&D coverage to individual policies available from the insurance company for that Plan subject to medical evidence of insurability, if applicable. Your Basic AD&D may not be converted.

Benefits Administration will provide you with specific details and the necessary applications for conversion. Rates and terms of coverage will depend on the policies available at the time you convert. Your application and first monthly premium must be received within 30 days of the date your insurance terminates.

If you die within 30 days following the date your insurance ends, your beneficiary will receive the full amount of your Voluntary AD&D (if applicable), Group Life and Voluntary Excess Life Insurance coverage (if applicable) whether or not you decided to convert to an individual policy.

Claims for Benefits
Your beneficiary should notify Benefits Administration of your death and provide a death certificate. Benefits Administration will calculate the amount of benefit payable to your beneficiary and notify your beneficiary in writing. Benefits Administration will complete applicable claim forms and obtain your beneficiary’s signature on the forms as required. Written claim forms must be filed before benefits can be processed and paid from any of these plans.

If you have a claim for dismemberment benefits, contact Benefits Administration to obtain the necessary forms and for an explanation of the claim procedure.
FLEXIBLE SPENDING ACCOUNT PLAN

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Flexible Spending Account Plan

What the Plan Can Do For You

The University of Miami Flexible Spending Account Plan (FSA) helps you save on your annual taxes by allowing you to pay eligible out-of-pocket health and dependent care expenses with a portion of your earnings that are tax-free. When you contribute to an FSA, you reduce your federal income and Social Security taxes and thereby increase the level of your spendable income for the year. An FSA designed to meet current federal laws is just another part of the flexibility the University of Miami provides in your benefit program.

Who May Participate

You may participate in an FSA if you are a regular, full-time or part-time regular member of the University of Miami faculty or staff. To participate, you must enroll during your initial benefits eligibility period. You must re-enroll each year during the annual "Open Enrollment Period" for participation beginning the next January 1. FSA deductions stop automatically at the end of each calendar year. You must make an election each year if you wish to participate.

If your spouse works for the University and is eligible to participate in an FSA, each of you can join the Plan individually. An eligible expense may be reimbursed through one account or the other, but not both.

Changing Your Coverage

Generally, federal law prohibits you from stopping or changing your contributions to an FSA until the next annual Open Enrollment period. This includes the contributions you make to pay for health and dependent care expenses, as well as your election to pay for other University benefits with pre-tax dollars. You may stop or change your contributions or open a new account mid year only under limited circumstances as provided by the University's plan document and established IRS guidelines. Election changes must be consistent with the event. Examples of a Qualified Status Change:

- Marriage
- Divorce
- Death of your spouse or other dependent
- Birth or adoption of a child
- Change in your spouse’s employment status

If you want to change your pre-tax contribution election during the year, you will need to complete and submit a Qualifying Status Change (Life Event) Form, along with supporting documentation such as a marriage license, divorce decree, birth certificate, adoption papers or a death certificate to Benefits Administration within 30 days of the event.

Electing Annual Amount

When you enroll, you designate how much you will contribute to a flexible spending reimbursement account to pay for health and/or dependent care expenses. You may choose to contribute to the Plan to pay only dependent care expenses, or health care expenses or both types. Throughout the year, you may draw money out of the account to reimburse health or dependent care expenses. You cannot use the portion of your contribution designated for health care expenses to pay for dependent care expenses or vice versa.

Examples

Here are two examples of how the Flexible Spending Account Plan can save you taxes. These two examples illustrate the effect of an FSA for someone earning $15,000 a year with a contribution of $2,000, and another person earning $45,000 a year and contributing $4,500 to the Plan.
<table>
<thead>
<tr>
<th></th>
<th>With FSA</th>
<th>Without FSA</th>
<th>With FSA</th>
<th>Without FSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross Annual Pay</td>
<td>$15,000</td>
<td>$15,000</td>
<td>$45,000</td>
<td>$45,000</td>
</tr>
<tr>
<td>Plan Contribution</td>
<td>-$2,000</td>
<td>$0</td>
<td>-$4,500</td>
<td>$0</td>
</tr>
<tr>
<td>Taxable Pay</td>
<td>$13,000</td>
<td>$15,000</td>
<td>$40,500</td>
<td>$45,000</td>
</tr>
<tr>
<td>Estimated Tax (Federal/Social Security)</td>
<td>-$2,945</td>
<td>-$3,398</td>
<td>-$9,173</td>
<td>-$10,193</td>
</tr>
<tr>
<td>Bills for qualified expenses</td>
<td>$0</td>
<td>-$2,000</td>
<td>$0</td>
<td>-$4,500</td>
</tr>
<tr>
<td>Spendable Income</td>
<td>$10,055</td>
<td>$9,602</td>
<td>$31,327</td>
<td>$30,307</td>
</tr>
<tr>
<td>TAX SAVINGS</td>
<td>$453</td>
<td>$1,020</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Health Care Reimbursement Account

FSA allows you to pay up to $8,400 a year in eligible health care expenses for you and your dependents with tax-free dollars contributed to the Plan. Dependents for purposes of this Plan include anyone you can claim an exemption for on your federal income tax return. Eligible expenses will be reimbursed as long as:

- You incur the expense during the same calendar year for which you make the contribution, or during the grace period of the following year
- The expense is not eligible for payment by your University Health Care Plan, other insurance coverage or another source

Generally, any health care expense you could claim as a deduction on your federal income tax return can be reimbursed through the Plan (although once reimbursed through FSA, the same expenses cannot be claimed as a federal income tax deduction). Here are some examples of eligible health care expenses:

WageWorks Visa Card

When you enroll in a Health Care Spending Account, you will receive the WageWorks Visa card in the mail. You can use this card only to pay for eligible health care expenses wherever Visa debit cards are accepted, including in-network pharmacies, doctor’s offices, and hospitals.

When you present the card for payment, you need to select “Credit,” not “Debit,” when paying for eligible expenses with your WageWorks Visa card. Be sure to sign for the payment to ensure funds are deducted from your Health Care FSA. You cannot use the card to pay for dependent care expenses. Eligible charges are automatically deducted from your FSA. If you 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 will have to submit receipts.

For more information, review the WageWorks User's Guide at [www.miami.edu/benefits](http://www.miami.edu/benefits).

Eligible Health Care Expense Examples

- Copayments, deductibles and coinsurance for Health Care coverage
- Expenses exceeding reasonable and customary charges or scheduled amounts as determined under your health care coverage
- Out-of-pocket dental expenses - including orthodontia (a letter of medical necessity is required for orthodontia to be reimbursed)
- Vision care expenses - including eye exams, frames, lenses and contact lenses
- Hearing exams and hearing aids
- Certain over-the-counter (OTC) medicines and drugs – For more information on the requirements to be reimbursed for OTC medicines visit [www.wageworks.com](http://www.wageworks.com) or [www.miami.edu/benefits](http://www.miami.edu/benefits).

A sample list of deductible health care expenses can be found in IRS Publication 502, “Medical and Dental Expenses,” which is available from the IRS. Note: not all health care expenses deducted by the IRS for taxation purposes are eligible FSA health care expenses.
Ineligible Health Care Expense Examples
• Insurance premiums
• Vision warranties and service contracts
• Health or fitness club membership fees
• Cosmetic surgery not deemed medically necessary to alleviate, mitigate or prevent a medical condition

Dependent Care Reimbursement Account
You may contribute up to $5,000 - per family - to an FSA each year to pay for eligible dependent care expenses. The care must be for an eligible dependent and be necessary to enable you and, if you are married, your spouse to work, look for work or attend school full-time. IRS guidelines define dependents as:

• Children under age 13 who live with you
• Any dependent for whom you claim federal tax exemption, including your spouse or elderly parents who are physically or mentally incapable of caring for themselves, provided the dependent spends at least eight hours a day in your home

Generally, any dependent care expenses for which you could receive a credit on your federal income tax return are considered eligible for reimbursement through an FSA. Examples of eligible dependent care expenses include:

Eligible Dependent Care Expense Examples
• Babysitters - in or outside your home (care cannot be provided by you, your spouse or other tax dependent)
• Licensed day care centers and nursery schools caring
• Local day camp fees
• Disabled dependent care centers that comply with state and local laws and regulations

Ineligible Dependent Care Expense Examples
• Child support payments or child care if you are a non-custodial parent
• Dependents who could be cared for by your employed spouse whose work hours do not coincide with yours
• Payments for dependent care services provided by your dependent, your spouse’s dependent or your child who is under age 19
• Healthcare costs or educational tuition
• Overnight care for your dependent (unless it allows you and your spouse to work during that time)
• Nursing home fees
• Diaper services
• Kindergarten expenses
• Services which are paid for by another organization or provided without cost
• Transportation to or from the dependent care location
• Care provided in full-time residential institutions, such as nursing homes and homes for the mentally disabled
• Expenses you plan to take as a credit on your income tax return
• Clothing, entertainment or food
• Housekeeping unless part of those services are for the care of an eligible dependent

If you are married, your spouse unless disabled must also work, be looking for work or attend school full-time for expenses to be eligible under the Plan. Your reimbursement is then limited by the following conditions:

• If your spouse works, your dependent care reimbursement cannot exceed your income or your spouse’s, whichever is less
If your spouse attends school full-time or is disabled, you may be reimbursed a maximum of $3,000 annually for the care of one dependent and up to $5,000 annually for two dependents.

**Dependent Care FSA vs. Dependent Care Tax Credit**

Whether it is better for you to use the FSA instead of the tax credit depends on your household income, marital status and the amount of your eligible expenses. As a rule of thumb, using the FSA is better if your adjusted gross family income is $40,000 or more. If it is less than $40,000, taking the income tax credit generally provides greater, but not immediate, tax savings. Again, whether or not you should claim credits or participate in FSA’s depends on your individual tax situation.

The expenses eligible for reimbursement through your dependent care FSA are the same as those that qualify for a federal tax credit. However, the maximum you can claim as a tax credit at the end of the year will be reduced by any amount that has been reimbursed through your dependent care FSA during the year.

For most families earning over $40,000 a year, using the dependent care FSA will result in a greater tax reduction than claiming a tax credit on their federal tax return. For specific guidance on which method would be best for your particular circumstances, you should consult your tax advisor.

**Caution when Setting Aside Funds**

Before you enroll in Health Care or Dependent Care Flexible Spending Account, you should be aware of the risk involved in setting aside tax-free earnings in the Plan. In exchange for the tax advantage provided by the Plan, the IRS restricts the use of your money to the reimbursement of eligible expenses incurred in that calendar year only. If you are unable to use your entire account balance for eligible expenses you incur during the year, you will forfeit the unused portion. You cannot receive cash back or carry unused amounts forward to pay for the next year’s expenses. You also cannot use amounts deposited for health care expenses to pay dependent care expenses and vice versa. To be sure you do not forfeit any of your contribution, estimate your anticipated expenses carefully.

**Claim Procedures**

Dependent Care participants have until each March 31 to submit claims for expenses incurred in the previous year. On April 1, any unused portion of your account will be forfeited as required by law. The University uses all forfeitures to help offset the cost of administering the Plan.

Health Care participants enrolled in a Health Care Flexible Spending Account (FSA) have an additional 2 ½ month period (following the end of the plan year) in which to incur expenses (in the subsequent year) and make claim for reimbursement against any funds remaining from the prior plan year’s account.

**Example:** Participants enrolled in the 2009 Health Care FSA plan may incur expenses (receive treatment or purchase supplies) from 1/01/09 through 3/15/10 and use 2009 plan year funds for reimbursement of eligible health care expenses. Participants will continue to have a 3 month run-out period to file for reimbursement of claims incurred during 1/01/09 through 3/15/10. The new run-out period will be June 15th.

You should submit a claim for reimbursement anytime you have eligible expenses.

- If a health care expense exceeds the amount in your account, you will be advanced the balance, provided your total health care contributions for the year will be sufficient to cover the expense; the outstanding claim amount will be charged to your account as additional deposits are made during the year.

- Dependent care expenses will be reimbursed only up to the amount that can be paid out for the contributions already in your account; if a dependent care expense exceeds this amount, you will be reimbursed the balance as additional contributions are credited to your account.

Dependent care and health care expenses may be filed on the same FSA Reimbursement Request Claim Form available at [www.benefits.miami.edu](http://www.benefits.miami.edu). After you have completed the appropriate form, you must...
mail or fax a correctly completed FSA Reimbursement Request Form along with one or more of the following:

**For Health Care Reimbursement**
- A receipt, invoice or bill listing the name of the provider, the date the service was received, the cost of the service, the specific type of service and the person for whom the service was provided.
- An Explanation of Benefits (EOB) from your health insurance provider that shows the specific type of service you received, the date and cost of the service and any uninsured portion of the cost.
- A written statement from your healthcare provider indicating that service was medically necessary if those services could be deemed cosmetic in nature, accompanied by the receipt, invoice or bill for the service.

**For Dependent Care Reimbursement**
Be sure to obtain and mail or fax the information below when requesting reimbursement from your Dependent Care FSA. This information is required with each request for reimbursement.

- The name, address and telephone number of the dependent care provider or
- The name, address and signature of the individual providing the dependent care service
- The date your dependent received the care (for example, February 9, 2009 through February 20, 2009) - not the date you paid for the service.
- The amount of the expense
- The Social Security number or tax identification number of the provider

**If Your Employment Status Changes**
If you retire, die or leave the University while you are participating in the Plan, your FSA contribution will stop as of your last paycheck from the University. Claims for qualified expenses incurred may only be submitted for expenses incurred to the date of separation from the University.

**Effect on Other Benefits**

**Social Security**
You do not pay Social Security (FICA) taxes on the earnings you place in FSA if your taxable wages, after pre-tax deposits to the Plan, are less than the Social Security wage base. As a result, your Social Security benefit - when you retire or if you become disabled - may be reduced. The reduction, based in part on the number of years you participate in FSA prior to retirement, is usually more than compensated for by current tax savings.

**Paying for Other Benefits Pre-Tax**

**Other Benefits**
Although your contributions to the Plan reduce your reported W-2 earnings, they will not affect the value of your other benefits including University-provided life insurance and your benefit or contributions made on your behalf under University retirement plans. These plans will continue to be based on your full base salary, before your FSA contribution is deducted.

Under the pre-tax provisions, you may also elect to pay your part of the cost for the following University benefits with tax-free earnings:

- University Health Care
- Dental Care
- Voluntary Accidental Death & Dismemberment Insurance

At your direction, contributions for any of these plans may be deducted from your paycheck just as though they are FSA contributions - before federal income and Social Security taxes are withheld. You will have a chance to make this election during the annual benefit open enrollment period, at the same time you choose your Health Care Plan coverage for the year. New hires make this election on your benefit enrollment form. Full-time and part-time regular employees make their elections using the on-line Open
Enrollment system "myUM." Pre-tax deductions for any required plan contributions are not included in the annual maximum FSA contribution for health care expenses.

HIPAA Privacy
The University of Miami follows the same rules of access to Protected Health Information (PHI) for the flexible spending account as outlined on page 5 of this summary plan description.
FACULTY RETIREMENT PLAN (FRP)

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Faculty Retirement Plan (FRP)

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

Who Is Eligible to Participate
You are eligible to participate in the Faculty Retirement Plan if you were hired before June 1, 2007 and:

- You are a full professor, associate professor, assistant professor or an instructor or lecturer (except for visiting faculty) and
- You hold a regular tenure earning appointment or receive an annual contract from the University as a full-time or part-time regular faculty member
- You did not elect to end your participation in this plan and begin participating in the Retirement Savings Plan.

This summary plan description describes the Faculty Retirement Plan in effect as of June 1, 2007.

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

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

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

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

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

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

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

If there is no valid beneficiary form on file when you die, your spouse (if you are married) or your estate (if you are single) will automatically become your beneficiary. For purposes of this plan, your spouse is your opposite-sex spouse as defined by the federal Defense of Marriage Act.

What the University Contributes

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

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

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

After you satisfy the above requirements, the University contribution will increase to 11% of your salary. Note: Before June 1, 1987, contributions were not made for participants past the normal retirement age of 65.

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

IMPORTANT NOTE: During the first year of your appointment as a professor, associate professor or assistant professor, you are not eligible to receive contributions for the Faculty Retirement Plan. However, so that you do not lose retirement income, the University will make contributions of 7% of your eligible pay (11% for tenured faculty) to either a pre-tax account or a post-tax account as you elect for that first year. Once you satisfy the eligibility requirements noted above, the University’s regular contributions will go into the Faculty Retirement Plan.

Where the Contributions Go

For the investment of the contributions made on your behalf, you can choose from five companies which offer a variety of investment funds and annuities. Your investment decision will impact the final value of your benefit from this plan, so it is important to obtain financial advice and to plan carefully. You may change the direction of future contributions at anytime by contacting Benefits Administration, but transfer of funds from one company to another may be restricted so you should carefully select your investments.
The following are the investment companies currently approved for the investment of contributions:

- Fidelity Investments
- T. Rowe Price
- TIAA-CREF
- Lincoln Life Insurance Company
- AIG VALIC

Here are some facts about each company. You may request more information from Benefits Administration or the investment company.

- **FIDELITY INVESTMENTS AND T. ROWE PRICE** Separate families of mutual funds have been selected to give you a non-insurance investment alternative. They offer several growth (equity) funds, income (stock) funds and a money market fund of short-term government and corporate notes and debt obligations. You can invest in one or more funds to match your own investment objectives and transfer from one fund to another. There are no guarantees of principal or income in a mutual fund as are usually available through an insurance company.

- **TIAA (Teachers Insurance & Annuity Association)** provides insured annuities for employees of participating colleges, universities and research institutions. It invests plan contributions in fixed-income securities such as government or corporate bonds and mortgages, crediting your annuity contract with a stated rate of return (“interest”), which can change from year to year. TIAA “fixed” annuities have increased from year to year as investment interest exceeded the guaranteed minimum rate.

- **CREF (College Retirement Equity Fund)** is TIAA’s companion corporation which invests designated plan contributions in a diversified portfolio of equity securities, such as common stocks of selected companies. The value of your accumulated contributions fluctuates, depending on dividends paid and stock market performance. CREF pays variable annuities which change in amount with the value of their underlying investments.

At retirement, both TIAA and CREF offer a choice of annuity payment methods ranging from a life income for you alone to ones that are guaranteed for certain periods or which continue to your surviving spouse or other beneficiary.

- **LINCOLN LIFE INSURANCE COMPANY** offers you a product with the flexibility to meet your retirement goals. The product is appropriately named “GVA” (Group Variable Annuity). GVA offers a wide range of choices for your contributions, including several variable options and a fixed account. The fixed account provides a competitive interest rate that translates into the highest possible return with the lowest level of risk. The fixed account is attractive to the investor seeking a stable source of earnings and protection from market fluctuations. The fixed account is invested in government and corporate bonds. The interest rate is credited using a “portfolio” method, meaning that all monies receive the same rate. You may transfer among the variable accounts as often as you like.

- **AIG VALIC** offers both fixed and variable annuities. Fixed annuities offer a monthly amount for life. Variable annuities offer payments that vary with the current value of underlying equity (common stock) investments. There are transfer privileges between funds, no initial sales charges, no administration fee and a range of payment options for both the fixed and variable annuities. You may transfer annuity assets between the mutual funds and the fixed account; however, some restrictions apply.

It is important to thoroughly review and carefully consider the options available under the various insurance and investment companies on a regular basis and to make changes as needed. It is also vital that you keep your beneficiary designation current. If you wish to change your beneficiary, you must request the form directly from your investment company.
Protection Under ERISA Section 404(c)
The Faculty Retirement Plan is intended to meet the requirements of ERISA Section 404(c). This means that it provides participants with diversified investment options plus information on those options. It also refers you to the appropriate investment managers whose responsibility it is to provide you with additional investment information to carry out your investment elections. Under 404(c), plan fiduciaries are relieved of liability for any losses which result from a participant’s investment decisions.

What You Can Expect at Retirement
You can begin receiving payments from the Faculty Retirement Plan if you separate from service and are at least age 65 or if you are at least age 55 and have completed 10 or more years of service. In addition, if you separate from service on or after January 1, 2001, you are eligible to begin payments if you meet the “Rule of 70” (age at separation from service plus years of service equals or exceeds 70).

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

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

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

- First 7 years @ 7% $38,700
- Next 28 years @ 11% +506,300

Combined contributions = $545,000

Total Accumulation
These contribution amounts will accumulate over the years with compounding tax-deferred investment return credited to the chosen investment. To illustrate how the faculty member’s total accumulation could vary depending on what these contributions earn, here are just two of many possibilities. The first illustration is based on a 5% annual rate of growth; the second illustration is based on a 10% annual rate of growth.

- Total at 65, 5% return: $1,110,000
- Total at 65, 10% return: $2,674,000

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

Distribution Options
Participants whose employment with the University terminates on or after January 1, 2001 and who meet the “Rule of 70” may make a one-time election to receive a partial lump sum distribution of up to 60% of the amount accumulated in the Faculty Retirement Plan subject to spousal consent rules (if married). The balance in the account may be taken as an annuity at any time.

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

If you are married when benefit payments begin, the normal form of payment is a joint and survivor annuity with at least one-half of your benefit paid to your spouse after your death. If you obtain your
spouse’s notarized written consent, you may select a different form of payment and/or beneficiary. The amount of the benefit you receive will depend on the total accumulation in your account, the type of benefit payment you select, annuity rates based your age and, if applicable, the age of your beneficiary at the time you begin drawing your pension.

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

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

**Death, Disability and Termination**
Retirement is not the only circumstance in which the Faculty Retirement Plan may provide benefits.

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

**If You Become Disabled**
Should you become totally and permanently disabled and qualify for Social Security Disability benefits and for benefits under the University of Miami Long Term Disability Plan, the University will continue its contributions for you under the Faculty Retirement Plan. Contributions will be based on your University compensation during the 12 months before your regular salary stops. Contributions will continue as long as you remain eligible for disability benefits up to the June 1st following age 65.

**If You Should Terminate**
Should you leave the University, you are fully vested in your account balance in the Faculty Retirement Plan and have a right to receive a benefit from the plan once you meet the retirement rules described in the “What You Can Expect at Retirement” section.

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

**If You Have an ERP Frozen Benefit**
Faculty members who were employed at the University by June 1, 1979 may receive their University-funded retirement income from both a defined benefit pension from the Employees’ Retirement Plan trust and from contributions made under the Faculty Retirement Plan.

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

**Additional Information About the FRP**
Please refer to the sections “Additional Retirement Information” and “Retirement Appeal Procedures” for information including how the Faculty Retirement Plan is administered and your rights under the Employee Retirement Income Security Act of 1974 (ERISA) as amended.
EMPLOYEES’ RETIREMENT PLAN

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Employees’ Retirement Plan (ERP)

What the Plan Can Do for You
The Employees’ Retirement Plan will pay you a monthly benefit for your lifetime, with payments
 guaranteed to a beneficiary during the first 10 years, starting at your normal retirement date, if you have
 completed five years of vesting service. (In general, this would be plan years in which you have at least
 1,000 hours of service.)

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

Who Is Eligible to Participate
Participation is limited to Employees’ Retirement Plan participants who were hired prior to June 1, 2007
 and did not elect to participate in the Retirement Savings Plan. You are automatically a participant once
 you have met the eligibility requirements. Prior to October 1, 1976, participation was limited to full-time
 employees. Effective October 1, 1976, you became a participant if you completed at least 1,000 hours of
 service during a 12-consecutive-month period beginning with your date of employment or with any plan
 year following your date of employment. If you leave the university and are re-hired after 30 days of your
 termination date, you will not be eligible to re-enter this plan. You will automatically participate in the
 Retirement Savings Plan (RSP).

This summary plan description describes the Employees’ Retirement Plan in effect as of January 1, 2009.

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

When You Qualify for Benefits
The Employees’ Retirement Plan (ERP) provides flexibility as to when benefits are payable. This section
 briefly describes when you qualify for benefits.

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

Early Retirement Date (ERD)
You may retire and begin receiving your monthly benefit before your normal retirement date if you have
 completed 10 years of service and reached age 55 or if you meet the Rule of 70 (age at separation from
 service plus years of service equals at least 70).

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

If You Leave
If you leave the University before you are eligible for retirement but after you are vested, you will be
 eligible for a monthly benefit at your normal retirement date. “Vested” means that you have a non-
forfeitable right to your retirement plan benefit. If you separate from service prior to June 1, 2008, you must have at least five years of service to be vested. If you separate from service between June 1, 2008 and December 31, 2008, you must have at least 3 years of service to be vested. If you separate from service on or after January 1, 2009, you are automatically 100% vested. You may defer commencement of your benefit to the April 1st following the calendar year in which you reach age 70½. If you have completed at least 10 years of service, you may begin receiving a reduced benefit after you reach age 55, or later, regardless of your age at the time you leave the University.

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

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

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

How the ERP Works
Your benefit is calculated using two different formulas known as the Standard Formula and the Cash Balance Formula. At retirement, you will receive the larger of the two benefits. The following sections describe how your benefit is calculated under the Standard Formula, based on your date of hire and under the Cash Balance Formula.

The Standard Formula Benefit
FOR EMPLOYEES HIRED BEFORE OCTOBER 1, 1977
The Standard Formula used to determine your annual benefit at your normal retirement date is:

\[
\frac{7}{8}\% \times \text{final average compensation up to } 4,800 \\
+ \frac{13}{8}\% \times \text{final average compensation over } 4,800 \\
\times \text{Years of credited service}
\]

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

Example 1: Normal Retirement (Hired Before October 1, 1977)
James retired at age 65 from the University of Miami after 38 years of service. His final average compensation was $34,500, and his Standard Formula benefit was figured as follows:

\begin{align*}
\text{a)} & \quad \frac{7}{8}\% \times 4,800 = 42.00 \\
\text{b)} & \quad 1 \frac{3}{8}\% \times 29,700 = 408.38 \\
\text{c)} & \quad \text{Sum of a) and b)} = 450.38 \\
\text{d)} & \quad \$450.38 \times 38 = 17,114.44
\end{align*}
James’ Standard Formula benefit is $17,114.44 per year based on a 10-year certain and continuous annuity. This amount will be compared to the amount provided under the Cash Balance Formula and he will receive the larger of the two benefits.

**Example 2: Early Retirement (Hired Before October 1, 1977)**

Eleanor elected early retirement at age 62 after 30 years of service. Her final average compensation was $50,000 and her benefit – payable once she reaches her normal retirement age – was computed as follows:

- a) 7/8% of $4,800 = $42.00
- b) 1 3/8% of $45,200 = 621.50
- c) Sum of a) and b) = 663.50
- d) $663.50 x 30 = 19,905.00

Eleanor’s Standard Formula benefit is $19,905 per year based on a 10-year certain and continuous annuity. This amount will be compared to the amount provided under the Cash Balance Formula and she will receive the larger of the two benefits.

**The Standard Formula Benefit**

**FOR EMPLOYEES HIRED ON OR AFTER OCTOBER 1, 1977**

The Standard Formula used to determine your annual benefit at your normal retirement date if you have 35 years of service is:

\[
\text{32.5\% of final average compensation up to covered compensation} \times \frac{50\%}{2} \times \text{final average compensation over covered compensation}
\]

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

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

**Example 3: Normal Retirement (Hired on or after October 1, 1977)**

When Jane retired from the University of Miami at age 65 after 15 years of service, her final average compensation was $43,000 and covered compensation was $37,608. Her benefit was computed as follows:

- a) 32.5% of $37,608 = $12,222.60
- b) 50% of $5,392 = 2,696.00
- c) Sum of a) and b) = 14,918.60
- d) $14,918.60 x 15/35 = 6,393.69

Jane’s Standard Formula benefit is $6,393.69 per year based on a 10-year certain and continuous annuity. This amount will be compared to the amount provided under the Cash Balance Formula and she will receive the larger of the two benefits.

**Example 4: Termination of Employment Prior to Eligibility for a Retirement Benefit (Hired on or after October 1, 1977)**

George left the University of Miami after nine years of service at age 48 and with final average compensation of $23,100. His covered compensation was $42,600. The annual accrued retirement income under the Standard Formula was computed as follows:

- a) 32.5% of $23,100 = $7,507.50
- b) 50% of covered compensation over $42,600 = 0.00
- c) Sum of a) and b) = 7,507.50
- d) $7,507.50 x 9/35 = 1,930.50
George’s annual accrued retirement income at his normal retirement date is $1,930.50 under the Standard Formula. This amount will be compared to the amount provided under the Cash Balance Formula and his monthly benefit will be based on the larger of the two amounts.

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

Your cash balance benefit can include three kinds of credits:

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

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

<table>
<thead>
<tr>
<th>Completed service at beginning of year:</th>
<th>The credit to your Cash Balance Account:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 year</td>
<td>3.25% of pay (pro-rated for the number of completed months between your one-year anniversary date and the end of the plan year)</td>
</tr>
<tr>
<td>1 thru 2 years</td>
<td>3.25% of pay</td>
</tr>
<tr>
<td>3 thru 4 years</td>
<td>4% of pay</td>
</tr>
<tr>
<td>5 thru 9 years</td>
<td>5% of pay</td>
</tr>
<tr>
<td>10 thru 14 years</td>
<td>6% of pay</td>
</tr>
<tr>
<td>15 thru 19 years</td>
<td>8% of pay</td>
</tr>
<tr>
<td>20 and more years</td>
<td>11% of pay</td>
</tr>
</tbody>
</table>

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

**Example 5: Full Year of Service**
If you have completed three years of service and your annual pay for the plan year ending May 31 is $22,000, the pay credit assigned to your cash balance account as of May 31 would be $880 (4% of $22,000).

**Investment Credits**
The University assigns your cash balance account an investment credit on an annual basis. Investment credits are figured using a formula based on the average rate of six-month Treasury Bills and the actual investment return earned by the Employees’ Retirement Plan Trust Fund. The minimum investment credit is 5.5% for a full plan year.

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

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

OR

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

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

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

Example 6: Adding in Investment Credits
Here, we assume that you have a beginning account balance of $10,000, receive an investment credit (6.95%) and a 6% pay credit on a salary of $30,000:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beginning balance (as of June 1, 2006)</td>
<td>$ 10,000</td>
</tr>
<tr>
<td>Investment credit (6.95% of $10,000)</td>
<td>$ 695</td>
</tr>
<tr>
<td>Pay credit (6% of $30,000)</td>
<td>$ 1,800</td>
</tr>
</tbody>
</table>

ENDING CASH BALANCE ACCOUNT (as of May 31, 2007) $ 12,495

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

Early Retirement Benefits
When you have reached age 55 and have completed at least 10 years of credited service, or if you leave the University on or after January 1, 2001 and your age plus credited service as of your termination date is at least 70, you are eligible for early retirement under the following provisions:

- If you elect to retire from the University after reaching age 55 but before age 65, your Standard Formula benefit will be reduced according to the following table:

<table>
<thead>
<tr>
<th>Age When Benefit Begins</th>
<th>Reduction In Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>55</td>
<td>50.00 %</td>
</tr>
<tr>
<td>56</td>
<td>46.67 %</td>
</tr>
<tr>
<td>57</td>
<td>43.33 %</td>
</tr>
<tr>
<td>58</td>
<td>40.00 %</td>
</tr>
<tr>
<td>59</td>
<td>36.67 %</td>
</tr>
<tr>
<td>60</td>
<td>33.33 %</td>
</tr>
<tr>
<td>61</td>
<td>26.67 %</td>
</tr>
<tr>
<td>62</td>
<td>20.00 %*</td>
</tr>
<tr>
<td>63</td>
<td>13.33 %</td>
</tr>
<tr>
<td>64</td>
<td>6.67 %</td>
</tr>
</tbody>
</table>

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

If you elect early retirement, your Standard Formula benefit will still be compared to the Cash Balance Formula benefit. You will receive whichever benefit is larger.
You should contact Benefits Administration three months in advance if you plan to retire early. Your benefit will be calculated and a Benefits Administration counselor will explain the distribution options.

**Late Retirement Benefits**

If you continue working at the University past your normal retirement date, you will receive a lifetime benefit based on the largest of the following:

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

**Death Benefits**

If you should die while actively working for the University and before your benefit begins, your named beneficiary will receive a benefit based on the larger of the Standard Formula or the Cash Balance Formula. Your beneficiary will have the option of receiving either a lump-sum distribution or a monthly benefit for life, beginning on the first of the month following your date of death.

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

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

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

**Benefit Payment Options**

Regardless of whether your monthly benefit is based on the Standard Formula or the Cash Balance Formula, you can choose from several forms of payment. However, if you are married when your benefit begins, you will need to elect one of the joint and survivor options with your spouse as your joint annuitant. If you elect an option which does not provide your spouse with at least 50% of the benefit you were receiving for his or her lifetime, you **must** provide a notarized spousal consent form. The following are the forms of payment available:

- **10-Year Certain and Continuous Annuity.** The monthly benefit figured using the larger of the Standard Formula or the Cash Balance Formula is a 10-year certain and continuous annuity and is the normal form of payment for single individuals. It guarantees a lifetime income to you and, in the event of your death any time during the first 10 years, provides the same monthly benefit to your beneficiary for the balance of the 10-year period, if any. If your beneficiary does not survive to receive the balance of the 120 payments, payments will be made to the contingent beneficiary you have named. If you have not named a contingent beneficiary, payments will be made to your beneficiary’s beneficiary or, if one has not been named, to your beneficiary’s estate.
- **Life Annuity.** A monthly benefit is paid to you for your lifetime, with no provision to continue benefits to a beneficiary in the event of your death. Because no benefits are payable in the event of your death, the monthly benefit is larger than the normal form, described above.
Joint and Survivor Annuity Options. Your monthly benefit is adjusted to provide a lifetime benefit for you and, in the event of your death or the death of your joint annuitant, a monthly benefit is paid to the survivor for his/her lifetime. The amount of the monthly benefit is based on your age and that of your joint annuitant, and which option you choose. You may choose from a 50%, 66 2/3% or 100% joint and survivor annuity.

Contingent Annuitant Options. Your monthly benefit is adjusted to provide a lifetime benefit to you, and a continuing benefit to your beneficiary after your death for his or her lifetime. The percentage will depend upon the option you elect: a 50%, 66 2/3% or 100% contingent annuitant option. It will also depend upon your age and that of your beneficiary. If your beneficiary predeceases you, your benefit will continue for your lifetime and ceases upon your death.

Joint and Survivor Annuity with 10-Year Guarantee Options. Your monthly benefit is adjusted to provide a lifetime benefit to you and, in the event of your death, or the death of your joint annuitant, a monthly benefit is paid to the survivor for his or her lifetime with the provision that if, at the death of the survivor, 120 monthly payments have not been made in combination to you and the survivor, the remainder of the 120 payments will be paid to the survivor’s beneficiary.

Increasing Annuity Option. This option reduces your initial monthly benefit by approximately 20%, but your benefit will increase by 3% each year, after the initial year. This increasing option may be applied to any of the options described above.

Partial Lump-sum Distribution. If you meet the Rule of 70 (age at separation from service plus years of service must equal at least 70), you may be eligible to receive a portion of your benefit as a partial lump sum distribution with the remainder of the benefit paid to you in one of the Benefit Payment Options listed above. Availability of this option is subject to restrictions imposed by federal law in effect at the time of distribution.

Mandatory Lump-Sum Distribution. If the full lump sum value of a retirement or death benefit is $1,000 or less, you will receive the distribution as an immediate lump-sum payment.

Hardship Distribution. If a participant who has terminated employment faces a financial hardship, he or she may address a request for a hardship distribution to the Retirement Committee prior to his or her pension starting date. A notarized spousal consent form must accompany the request if the participant is married. If the request is approved, the plan may pay the vested benefit, or any portion thereof, in a lump-sum not to exceed $3,000 per event causing the hardship. For these purposes, a financial hardship means an immediate and heavy financial need where other resources are not available including:

- A sickness or disability condition affecting you or a member of your immediate family
- The need to provide for education or adequate housing for you or for any of your children or dependents
- Layoff or Divorce.

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

Transfers Out of the ERP

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

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

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

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

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Retirement Savings Plan (RSP)

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

- **An automatic core contribution.** If you are eligible, the University will make a contribution to your retirement account, based on your earnings.
- **Voluntary and matching contributions.** You may also contribute to your retirement account. If you do, you will benefit from current tax savings. The University will also match a percentage of your contributions.
- **Investment earnings.** You decide how to invest your account balance – including the core contributions, your voluntary contributions and the matching contributions. You have several investment companies from which to choose.

Under this plan, you have access to the value of your voluntary contributions while you are employed through loans and withdrawals (see p. 68). When you separate from service, you decide how and when to receive payment. Along with Social Security, any supplemental retirement annuities you purchase, prior retirement plan benefits and your own investments, this plan can help you prepare for a financially secure retirement.

Who Is Eligible to Participate
You are eligible to participate in the Retirement Savings Plan if you were hired prior to June 1, 2007 and elected to participate in the Retirement Savings Plan or if you were hired on or after June 1, 2007 and:

- You are a full professor, associate professor, assistant professor or an instructor or lecturer (except for visiting faculty) and you hold a regular tenure earning appointment or receive an annual contract from the University as a full-time or part-time regular faculty member, or
- You are a non-faculty employee of the University unless you are in one of the excluded job classifications noted below.

Note that University of Miami Hospital employees, leased employees, residents, interns and students are not eligible for this plan.

This summary plan description describes the Retirement Savings Plan in effect as of June 1, 2007.

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

When You Can Participate
Your participation in this plan will begin after you complete one year of service. For employees other than faculty members, you will earn a year of service if you complete 1,000 hours during the 12-month period immediately following your date of hire. If you do not complete 1,000 hours during your initial employment year, you will be credited with a year of service if you complete 1,000 hours of service during any plan year (June 1 to May 31). For faculty members, you will earn a year of service for each 12-month period of employment between your date of hire and the date you separate from service.
Enrolling in the Plan
Core contributions begin automatically once you meet the eligibility requirements.

Your voluntary contribution percentage is automatically set at 1.5% of pay and your contributions will be invested in the Fidelity Investments Freedom Fund matched to your date of birth once you meet the one year of service eligibility waiting period. Benefits Administration will notify you of your eligibility and you will have the opportunity to elect to contribute a different amount (or not at all) or elect a different investment company.

You may increase, decrease or stop your contributions once per calendar quarter by completing a new salary reduction agreement. Contact Benefits Administration for information on how to change your contribution amount.

You may change your investment company and/or your investment funds at any time. See the “Where the Contributions Go” section for more information.

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

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

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

If there is no valid beneficiary form on file when you die, your spouse (if you are married) or your estate (if you are single) will automatically become your beneficiary. For purposes of this plan, your spouse is your opposite-sex spouse as defined by the federal Defense of Marriage Act.

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

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

If you are on a paid sabbatical leave of absence, the University will continue making core contributions to your plan account.

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

\[ \text{\$48,000} \times 5\% = \text{\$2,400} \]

Remember, though, that core contributions are actually contributed to your account each pay period throughout the year.
Your Voluntary Contributions
When you become eligible, you are automatically set up to save 1.5% of your compensation in the plan as your voluntary contributions – unless you elect not to contribute or elect to contribute at a different level at that time. You may increase, decrease or stop contributing at any time. The change will become effective as of the next applicable pay period or as soon as administratively feasible.

You may contribute any percentage of your compensation from 1% to 100% or any flat dollar amount to the plan, up to federal limits. Your voluntary contributions are deducted from your paycheck before federal taxes are withheld. Because your contributions are made on a pre-tax basis, you do not pay current federal (or state, as applicable) taxes on the amount you save.

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

Catch-Up Contributions
In order to give those who are closest to retirement an additional opportunity to put away more money on a tax-favored basis for retirement, an additional savings option (“catch-up contributions”) is available under the Retirement Savings Plan. If you are over age 50 or will reach age 50 during the year, you may contribute up to an additional $5,000 in 2007 on a before-tax basis as a catch-up contribution to the plan. You must save the maximum allowed under the plan on a pre-tax basis in order to make catch-up contributions. The maximum allowed catch-up contribution may change as determined by the Internal Revenue Service.

An additional catch-up contribution may be available to participants who have 15 or more years of service at the University. Contact Benefits Administration to determine if you qualify.

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

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

Internal Revenue Code Limits
Your total voluntary contributions to the Retirement Savings Plan – not including any catch-up contributions – may not exceed the annual dollar limit for pre-tax deferrals as specified under the Internal Revenue Code (IRC) and adjusted by the Internal Revenue Service (IRS) each calendar year. For 2007, the dollar limit for pre-tax contributions is $15,500 in 2007. If you are at least age 50, you may contribute more – up to $20,500 in 2007.

The IRS also adjusts the total annual contributions that can be made to the Retirement Savings Plan. Total annual contributions include automatic core contributions, your voluntary contributions and matching contributions. Catch-up contributions are not included in this limit. For 2007, the limit on total annual contributions is $45,000.
An additional limit specified under the IRC and adjusted by the IRS is the amount of compensation that can be taken into account for purposes of determining University core and matching contributions. For 2007, this limit is $225,000.

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

**Excess Contributions**

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

**Where the Contributions Go**

For the investment of the contributions you and the University make on your behalf, you can choose from five companies which offer a variety of investment funds and annuities. Your investment decision will impact the final value of your benefit from this plan, so it is important to obtain financial advice and to plan carefully. You may change the direction of future contributions at anytime by contacting Benefits Administration, but transfer of funds from one company to another may be restricted so you should carefully select your investments.

The following are the investment companies currently approved for the investment of contributions:

- Fidelity Investments
- T. Rowe Price
- TIAA-CREF
- Lincoln Life Insurance Company
- AIG VALIC

Here are some facts about each investment company. You may request more information from Benefits Administration or the investment company.

- **FIDELITY INVESTMENTS AND T. ROWE PRICE** Separate families of mutual funds have been selected to give you a non-insurance investment alternative. They offer several growth (equity) funds, income (stock) funds and a money market fund of short-term government and corporate notes and debt obligations. You can invest in one or more funds to match your own investment objectives and transfer from one fund to another. There are no guarantees of principal or income in a mutual fund as are usually available through an insurance company.

- **TIAA (Teachers Insurance & Annuity Association)** provides insured annuities for employees of participating colleges, universities and research institutions. It invests plan contributions in fixed-income securities such as government or corporate bonds and mortgages, crediting your annuity contract with a stated rate of return (“interest”), which can change from year to year. TIAA “fixed” annuities have increased from year to year as investment interest exceeded the guaranteed minimum rate.

- **CREF (College Retirement Equity Fund)** is TIAA’s companion corporation which invests designated plan contributions in a diversified portfolio of equity securities, such as common stocks of selected companies. The value of your accumulated contributions fluctuates, depending on dividends paid and stock market performance. CREF pays variable annuities which change in amount with the value of their underlying investments.

  ✓ At retirement, both TIAA and CREF offer a choice of annuity payment methods ranging from a life income for you alone to ones that are guaranteed for certain periods or which continue to your surviving spouse or other beneficiary.
Lincoln Life Insurance Company offers you a product with the flexibility to meet your retirement goals. The product is appropriately named “GVA” (Group Variable Annuity). GVA offers a wide range of choices for your contributions, including several variable options and a fixed account. The fixed account provides a competitive interest rate that translates into the highest possible return with the lowest level of risk. The fixed account is attractive to the investor seeking a stable source of earnings and protection from market fluctuations. The fixed account is invested in government and corporate bonds. The interest rate is credited using a “portfolio” method, meaning that all monies receive the same rate. You may transfer among the variable accounts as often as you like.

AIG VALIC offers both fixed and variable annuities. Fixed annuities offer a monthly amount for life. Variable annuities offer payments that vary with the current value of underlying equity (common stock) investments. There are transfer privileges between funds, no initial sales charges, no administration fee and a range of payment options for both the fixed and variable annuities. You may transfer annuity assets between the mutual funds and the fixed account; however, some restrictions apply.

It is important to thoroughly review and carefully consider the options available under the various insurance and investment companies when you enroll and then, on a regular basis and to make changes as needed. It is also vital that you keep your beneficiary designation current. If you wish to change your beneficiary, you must request the form directly from your investment company.

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

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

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

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

You earn a year of vesting service for each plan year in which you work at least 1,000 hrs. from your date of hire to your date of termination, subject to the plan’s break in service rules.

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

If you are not vested in your core contribution account balance and you incur five or more consecutive one-year breaks in service, your account balance will be forfeited.

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

**What You Can Expect at Retirement**

You can begin receiving payments from the Retirement Savings Plan before age 65 if your age at separation from service plus your years of vesting service equals or exceeds 70 (“Rule of 70”) or if you are at least age 55 and have completed 10 or more years of vesting service. If neither of these criteria are met, you may retire on or after reaching age 65.

**Example: How Your Account Grows**

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

Your contributions and the University’s contributions will accumulate over the years with compounding tax-deferred investment returns. To illustrate how your total accumulation could vary depending on what these contributions earn, here are just two of many possibilities. The first illustration is based on a 5% annual investment return; the second illustration is based on a 10% annual investment return.

<table>
<thead>
<tr>
<th>Total at 65, 5% return:</th>
<th>$415,000</th>
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<tbody>
<tr>
<td>Total at 65, 10% return:</td>
<td>$1,138,000</td>
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</table>

**Investment Company Selection**

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

**Distribution Options**

When you are eligible to receive payments from the plan, the value of your account attributable to your voluntary contributions may be rolled over into an IRA or paid as a full lump sum. Annuity options are also available.

If the current value of the matching contributions and automatic core contributions that the University has made on your behalf is $12,500 or less, you may elect to receive a lump sum payment when you become eligible to receive payment, subject to spousal consent rules. Otherwise, you will have a choice of annuity options, based on the investment company you elected.

If you have met the “Rule of 70” when you terminate employment, you may elect a partial lump sum payment of your account balance. You may receive up to 60% of your then current account value as a lump sum payment. If you are married, your spouse will need to consent to this payment. The balance in the account may be taken as an annuity at any time.

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

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

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

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

Death, Disability and Termination
Retirement is not the only circumstance in which the Retirement Savings Plan may provide benefits.

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

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

If You Should Terminate
Should you leave the University with a vested right to your account value, you have a right to receive a benefit from the plan once you meet the retirement rules.

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

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

Only the value of your own voluntary contributions and any rollover contributions are available for a loan. You may have one loan outstanding at any time. In general, the maximum amount of the loan cannot exceed 50% of the value of your voluntary contributions or $50,000, whichever is less. The minimum amount you may borrow is $1,000.

If you take a loan, you will pay a set-up fee and a loan maintenance fee in accordance with the terms established by the investment provider. Loan payments will be repaid to your account. You will pay interest on your loan, which will be set at the prime rate of interest as published in the “money rate” section of the “Wall Street Journal” plus 1% as of the first business day of the month before the loan originated. All loan repayments, including the interest you pay to yourself, will be credited directly back to your own account, according to your current investment elections.
The period of repayment must be agreed upon by you and the investment company. The maximum period of repayment is five years (20 years for loans used to purchase your principal residence). You may prepay your loan in full at any time without penalty.

If you are married, you must obtain your spouse's notarized consent to be able to take a loan from the plan.

If you terminate employment with the University, retire or die with an outstanding loan balance, you (or your beneficiary) have up to 90 days to repay the remaining balance. If you do not repay the loan within 90 days, any distributions paid to you or your beneficiary from the plan will be reduced by the outstanding balance. In addition, your loan balance will be subject to regular income tax and potentially a 10% penalty tax. (Note that you may have up to 12 months to repay the loan if you become disabled or have a military leave of absence.)

To apply for a loan, please contact your investment company.

Withdrawals

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

Withdrawals After Age 59½

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

Before Reaching Age 59½

Before reaching age 59½, you may withdraw the current value of your pre-tax voluntary contributions in the case of “financial hardship” as defined by the IRS. The University's automatic core and matching contributions and any investment earnings cannot be withdrawn while you are employed. A financial hardship withdrawal must be approved by the University in advance.

Financial hardships currently include the following:

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

You must have taken any other available loans or withdrawals before you request a financial hardship withdrawal. Only one hardship withdrawal is available for each type of hardship event. A financial hardship withdrawal cannot be for more than is required to meet your need, but can be increased to take into account the income taxes and penalties you will pay on a withdrawal. You will need to provide documentation confirming the cause of your financial need. When you take a financial hardship withdrawal, you will not be allowed to contribute to the Retirement Savings Plan for a six-month period following the date of the withdrawal. You may reenter the plan as of the next available payroll period following the six-month suspension period.
If you are married, you must obtain your spouse's notarized consent before you can make a withdrawal from the plan.

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

**Additional Information About the RSP**

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

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Supplemental Retirement Annuity (SRA) Program

What the Plan Can Do for You
If you participate in the Faculty Retirement Plan or the Employees’ Retirement Plan, you may also save and invest your own money on a pre-tax basis to build additional assets for the future through the Supplemental Retirement Annuity Program. The amount you can save annually in the Supplemental Retirement Annuity Program is based on your taxable compensation and provisions in the law. Contact Benefits Administration for information on individual limits.

When You Can Participate
If you are participating in the Faculty Retirement Plan or the Employees’ Retirement Plan, you may enroll in the Supplemental Retirement Annuity Program at any time. When you enroll, you sign a salary reduction agreement authorizing the University to reduce a portion of your salary and remit it to the investment company you choose. You also complete an investment company application indicating your fund elections. Contact Benefits Administration to obtain enrollment applications.

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

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

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

If there is no valid beneficiary form on file when you die, your spouse (if you are married) or your estate (if you are single) will automatically become your beneficiary. For purposes of this plan, your spouse is your opposite-sex spouse as defined by the federal Defense of Marriage Act.

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

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

An Example:
If you earn $40,000 a year and elect to invest 10% or $4,000 a year in the Supplemental Retirement Annuity Program (assuming this amount is within IRC limitations), you need to declare as taxable income only the remaining $36,000.
Internal Revenue Code Limits
Your voluntary contributions to the Supplemental Retirement Annuity Program – not including any catch-up contributions – may not exceed the annual dollar limit for pre-tax contributions as specified under the Internal Revenue Code (IRC) and adjusted by the Internal Revenue Service (IRS) each calendar year. For 2009, the dollar limit for pre-tax contributions is $16,500.

Catch-Up Contributions
In order to give those who are closest to retirement an additional opportunity to put away more money on a tax-favored basis for retirement, an additional savings option (“catch-up contributions”) is available under the Supplemental Retirement Annuity Program. If you are over age 50 or will reach age 50 during the year, you may contribute up to an additional $6,000 in 2009 on a pre-tax basis as a catch-up contribution to the plan. You must save the maximum allowed under the plan on a pre-tax basis in order to make catch-up contributions. In future years, these limits may change as determined by the Internal Revenue Service.

An additional catch-up contribution may be available to participants who have 15 or more years of service at the University. Contact Benefits Administration to determine if you qualify.

Investment Options
You choose where your contributions are invested from the companies approved by the Supplemental Retirement Committee. Your investment decision will impact the final value of your benefit from this plan, so it is important to obtain financial advice and to plan carefully. You may change the direction of future contributions at any time by contacting Benefits Administration, but transfer of funds from one investment company to another may be restricted so you should carefully make your investment choices.

Currently, the Supplemental Retirement Committee has approved the following investment companies for this program:

- Fidelity Investments
- T. Rowe Price
- TIAA-CREF
- Lincoln Life Insurance Company
- AIG VALIC

The terms, rates, provisions and available options differ from one investment company to another, so be sure to carefully read the information provided by each investment company. Printed material from these investment companies is available through Benefits Administration.

- FIDELITY INVESTMENTS AND T. ROWE PRICE  Separate families of mutual funds have been selected to give you a non-insurance investment alternative. They offer several growth (equity) funds, income (stock) funds, and a money market fund of short-term government and corporate notes and debt obligations. You can invest in one or more funds to match your own investment objectives, transfer from one fund to another and select an installment or lump sum payment option when it’s time to retire. There are no guarantees of principal or income in a mutual fund as are usually available through an insurance company.

- TIAA  (Teachers Insurance & Annuity Association) provides insured annuities for employees of participating colleges, universities and research institutions. It invests your contributions in fixed-income securities such as government or corporate bonds and mortgages, crediting your annuity contract with a stated rate of return (“interest”), which can change from year to year. TIAA “fixed” annuities have increased from year to year as investment interest exceeded the guaranteed minimum rate.

- CREF  (College Retirement Equity Fund) is TIAA’s companion corporation which invests your contributions in a diversified portfolio of equity securities, such as common stocks of selected companies. The value of your accumulated contributions fluctuates, depending on dividends paid and stock market performance. CREF pays variable annuities, which change in amount with the value of their underlying investments.
**LINCOLN LIFE INSURANCE COMPANY** offers you a product with the flexibility to meet your retirement goals. The product is appropriately named “GVA” (Group Variable Annuity). GVA offers a wide range of choices for your contributions, including several variable options and a fixed account. The fixed account provides a competitive interest rate that translates into the highest possible return with the lowest level of risk. The fixed account is attractive to the investor seeking a stable source of earnings and protection from market fluctuations. The fixed account is invested in government and corporate bonds. The interest rate is credited using a “portfolio” method, meaning that all monies receive the same rate. You may transfer among the variable accounts as often as you like.

**AIG VALIC** offers both fixed and variable annuities. Fixed annuities offer a monthly amount for life. Variable annuities offer payments that vary with the current value of underlying equity (common stock) investments. There are transfer privileges between funds, no initial sales charges, no administration fee and a range of payment options for both the fixed and variable annuities. You may transfer annuity assets between the mutual funds and the fixed account; however, some restrictions apply.

**Protection Under ERISA Section 404(c)**

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

**Plan Loans and Withdrawals**

Although this program was set up to encourage you to save for your retirement, there are certain circumstances under which you may take a loan or withdrawal while you are still working. Please contact the investment company in which your contributions are invested for details on loans that may be available to you.

**When Benefits Are Paid**

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

**Benefit Payment Options**

Please contact the investment company in which your contributions are invested for information about your payment options.

**Information for Participants Who Joined the RSP**

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

**Additional Information About the SRA Program**

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

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What the Plan Can Do For You
To provide financial assistance regarding tuition as an incentive for self-improvement and a means of encouraging higher education for current and retired employees, as well as their dependents.

Glossary of Common Terms
Continuous Employment—Uninterrupted and working regularly scheduled hours including time away from work for vacation and sick leave, based on the date of acceptance of the position or date of hire.

Dependent—A spouse recognized under Florida Law, a University certified domestic partner or dependent child as defined below. A marriage license is proof of dependency for spouse.

Dependent Child—A natural, adopted or stepchild receiving 50% or more support from the University employee.

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

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

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

Retired Employee—A former employee who is eligible to receive benefits under the Group Retirement Plan. Employees who are retiring and meet the rule of 70. (A former employee who is vested in the Group Retirement Plan, but not eligible to receive benefits under the early retirement provision is not eligible for tuition remission.)

Employee Coverage

Employee
The University will grant tuition remission to all full-time or part-time regular employees who have completed 90 calendar days of continuous employment at the University prior to the first scheduled day of class as published in the University Bulletin. If the completion of the 90 days falls after the first scheduled day of class, eligibility shall commence at the next successive regular registration.

Full-Time Employees are eligible for 100% tuition remission for:
1. A maximum of 7 credits in the spring semester.
2. A maximum of 7 credits in the fall semester.
3. One intersession course during the spring semester.
4. Not more than 8 credits for all summer sessions during a calendar year.
   (The 8 credits during summer may be used in any combination.)

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

Part-Time Regular Employee
Part-Time regular employees are eligible for prorated tuition remission for:
1. A maximum of 7 credits in the Fall semester
2. A maximum of 7 credits in the Spring semester
3. Not more than 8 credits for the entire summer session during one calendar year (you may use the 8 credits in any combination).
4. One intersession course during the spring semester.
Example: A part-time regular working 60% FTE is eligible for 60% of up to 7 credits

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

Retired Employees
Retired employees are eligible for 100% tuition remission for themselves and their dependents that meet all requirements.

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

The Executive MBA & Working Professional Program is not eligible for tuition remission.

Doctoral Level Study
Doctoral Level Study is granted on case-by-case basis to full-time regular employees through a cost sharing arrangement. Doctoral level study requests must be received by the Provost and only that office may approve tuition remission for such requests. Doctoral level study is not available to dependents. The following is the cost sharing formula for the full-time regular employee doctoral level programs:

- No tuition remission during the first year of full-time regular employment
- After completion of twelve months of regular full-time employment, employee receives a 75% tuition discount.
- After completion of two full years of full-time regular employment, the University pays the difference between tuition charged at a Florida State System University and the University of Miami; employee pays the tuition amount charged by the applicable State University.

Non-Credit Courses
Only employees are eligible for approved non-credit classes.

Test Prep Courses
Preparatory classes (GRE, GMAT, LSAT, SAT, etc) are not eligible for tuition remission. CLEP exams will be reimbursed for up to three failed exams. There is no limit on passed exams for all tuition remission recipients.

Dependent/Spouse Coverage

Credit Limit
Dependents of full time regular employees are eligible for tuition remission at the University of Miami for a total of 10 semesters or 150 credits, whichever is greater, except in the School of Architecture where a maximum of 164 credits is permissible. There are restrictions as described in this policy.

Dependents of part-time regular employees are eligible for prorated tuition for a total of 10 semesters or 150 credits, whichever is greater, except the School of Architecture where a maximum of 164 credits is permissible. There are restrictions as described in this policy.

Credit Counting
Coursework that is begun or attempted but not completed for any reason will count against the 150 (164) credit maximum for dependents and spouses. Coursework that is failed will count against the 150 (164) credit maximum.

Level of Coverage
Dependents of employees hired before September 1, 2002 will receive 75% tuition remission during the employee’s first five years of full-time regular employment, and 100% thereafter. The five years must be
completed prior to the first day of class as advised in the University bulletin, otherwise 100% tuition remission will begin with the next semester.

A dependent of an employee hired on or after September 1, 2002 is eligible for tuition remission at the University of Miami after completion of one full year of full-time regular employment at the rate of 70% during years two through five, 85% during years six through ten and 100% thereafter. For the rate of tuition to be changed due to reaching successive years the time must be completed prior to the first day of classes as published by the University bulletin, otherwise the new rate of tuition would commence at the next semester.

Please contact Benefits Administration for information regarding dependent tuition remission for part-time regular employees.

Financial Aid Requirements

BFRAG Requirements
All full-time undergraduate dependents that plan to use tuition remission are required to apply for the William L. Boyd, IV, and Florida Resident Access Grant (BFRAG). All dependents that qualify for BFRAG will have the amount of the BFRAG subtracted from their charges for tuition and fees, and tuition remission will cover the remaining entitled costs. If a dependent qualifies for the BFRAG and does not apply as required, tuition remission will be reduced by the amount of the BFRAG. This BFRAG policy affects only dependents that are full-time undergraduate students eligible for 100% tuition remission. This BFRAG policy does not affect dependents receiving less than 100% tuition remission.

Admission & Normal Progress Requirements

Admission Requirements
Employees and dependents must meet the admissions requirements set forth by the University. This means that all grade point average and SAT requirements must be met as well as any other requirements for admission. An employee or dependent will not be admitted solely on the basis of employment. The application fee is waived for employees and dependents.

Age Requirements
Dependent children must be enrolled in a college degree-seeking program before they reach age of 23. Dependent children then must make normal progress as defined toward graduation or until the maximum benefit has been received per this policy. During the time that the dependent is receiving benefits they must continue to prove dependency on a yearly basis. The dependent child will not be eligible for tuition remission for any semester that begins after reaching age 27.

Break in Normal Progress
If a semester(s) is/are missed due to extenuating circumstances, documentation may be submitted to Benefits Administration who will consider each request on a case-by-case basis.

Normal Progress after graduation from Undergraduate Program
Normal progress towards graduation requirements is modified for dependents who obtain an undergraduate degree using the tuition remission and who wish to pursue a graduate course study at the University of Miami. Within a two-year period following the graduation date, a dependent may resume utilizing tuition remission for graduate study credits using the balance of the original 150 credits. To be eligible for resumption the dependent must submit certification of dependency. Then must continue to make normal progress toward the degree or expiring of benefit.

Dependent Eligibility Requirements

Proof of Dependency
Every dependent of a University of Miami employee enrolled in the University of Miami health care plan will be eligible for tuition remission, provided they meet all the other tuition remission requirements. Certification
of a dependent child normally requires a copy of the employees most recent IRS tax return (1040 US Individual Income Tax Return) showing the child as a dependent; exceptions will be made on a case-by-case basis for certain circumstances such as divorce. If the child is not covered under the University of Miami health care plan, then this proof must be provided on a yearly basis.

Changes in Employee Status

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

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

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

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

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

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

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

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

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

Away Tuition Remission Policy

Away Tuition Remission
Dependent children of employees (including children of retired or deceased employees) who established eligibility prior to June 1, 1972, and who have been in continuous full-time service are eligible for tuition up to 120 credits or eight semesters (whichever is greater) at either the University of Miami or at other accredited universities or colleges (undergraduate level dollars only.)
These above indicated individuals are also eligible for additional credits at the University of Miami only, up to a combined total not to exceed 14 semesters or 225 credits, whichever is greater. However, the institution each student is attending must certify that the student is making normal progress toward graduation. This tuition benefit is available to dependent children who begin a college program before age 23 and are making normal progress toward a degree. If the student attends elsewhere, tuition remission cannot exceed the current tuition cost the employee would receive at the University of Miami.

**Graduate Tuition Remission Taxation**

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

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

**Employee Graduate Tuition Taxation**

Employees enrolled in graduate level courses will be exempt from taxation for the first $5250 of graduate tuition remission per calendar year. The value of graduate tuition remission received by employees over $5250 per calendar year is taxable income to the employee. The value of graduate tuition remission received by employees over $5250 per calendar year will be allocated over the remaining pay periods in the semester for which the graduate tuition remission is received unless the employee has contacted Benefits Administration regarding the allocation of an estimate of the entire years graduate tuition remission and allocate the taxes over the entire calendar year.

**Dependent Graduate Tuition Taxation**

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

**Estimation of Taxation**

It is advised to complete a Graduate Tuition Taxation Estimate Form at the beginning of each calendar year. This will help to spread out the taxation costs over the year and avoid being heavily taxed at the end of the calendar year. This can be done for employee and dependent graduate taxation. Please notify Benefits Administration during the year of any changes to the estimate.

**Taxation Notification**

Employees are notified by mail or email of the amount of taxable income reported to the IRS for graduate tuition remission. If an employee or dependent drops taxable graduate courses after the course withdrawal date, the course remains taxable to the employee.

**What Is Not Covered**

Tuition Remission is not available in the following:

- School of Law or School of Medicine
- Special programs including the Executive MBA, Working Professional MBA, (unless awarded a scholarship) and the Master of International Business Programs in the Graduate School or Undergraduate School.
- Private music lessons
- All private lessons and hobby courses
- Auditing of courses
- In-service courses in Miami Dade County Schools
- Courses required for certification or licensure that are conducted in whole or in part by outside vendors
- Non-credit courses
- CME courses sponsored by the University of Miami or another educational institution

Exceptions to the above policy will be made for adult education courses through the School of Continuing Studies in the non-hobby, non-sports category, provided that the course offers job related training for University personnel, as certified by the department chair or supervisor, charges market rates.
for tuition, and has space available after all regular tuition paying enrollees are accommodated and has
no more than 20% of the enrollees eligible for tuition remission. Non-credit language courses will have
to meet the previous requirements for an exception to the non-credit course tuition remission policy;
however, no more than 30% of the enrollees in the non-credit language-training course will be eligible for
tuition remission.

Governing Policy: It is the responsibility of the employee to review and comply with the current University
of Miami policy. The Tuition Remission Policy is the governing policy on tuition remission. Any other
printed material is not binding on Benefits Administration and therefore, will not be considered as policy.

**Granting Procedure:**
The granting of tuition remission is an automatic process. Forms are not required to claim tuition
remission. If the employee anticipates that his/her dependent or domestic partner will be attending the
University of Miami and using tuition remission, the employee must provide proof of dependency or
marriage, or certification of domestic partnership, if the dependent is not currently covered on the
employee’s medical and/or dental plan.

If proof of dependency is not received Benefits Administration, the employee’s tuition remission for that
dependent will be delayed until proof is received. If there is such a delay and the dependent is dropped
from classes for non-payment, the employee will be responsible for any re-instatement fees incurred.
This notice is the employee’s only notice to provide proof of dependency.
### COLLEGE SAVINGS PLAN INTERNAL REVENUE CODE
### SECTION 529

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College Savings Plan Internal Revenue Code Section 529

What the Plan Can Do For You
A Section 529 College Savings Plan (529 Plan) is a new way to set aside money to pay for qualified college expenses. You deposit after tax dollars, via payroll deductions, into an account. Earnings grow free of federal income taxes. Distributions are tax-free provided they are used for qualified educational expenses such as college tuition, room and board. Your savings through a 529 Plan can be used at accredited institutions of higher learning. Enroll through Benefits Administration.

Eligibility
No Income Limits- Everyone is eligible to participate. There are no income limits.

Flexibility
Anywhere in the U.S.- Savings through a 529 Plan account can be used at accredited institutions of higher learning in the U.S., as well as at many foreign institutions.

Changing Beneficiaries- You may change the beneficiary of your account to another family member as addressed in administrative regulations.

Employee Payroll Direct Deposit Available

Investments
Professional Investment Management - With a 529 College Savings Plan, you benefit from the investment management experience of leading global investment managers. If you would like to discuss or meet with a 529 Plan representative, please contact the representative from the company of your choice.

- **Lincoln Life Insurance Company** - Delaware Investments Tuition Edge: 1-866-524-2443
- **AIG VALIC** - Putnam College Advantage: 1-800-892-5558, Ext. 87705
- **TIAA-CREF** - Georgia Higher Education Savings Plan: 1-877-424-4377
- **Fidelity Investments** - For further information contact 1-800-544-2270. (Please note that Fidelity does not have payroll deduction at this time. You may enroll in Fidelity's 529 Plan; however, you must make arrangements for 529 Plan contributions directly with Fidelity.)

Once you complete your enrollment forms, please forward to Benefits Administration, P.O. Box 248106, Coral Gables, Florida 33124-1415, or Interoffice Orvitz Bldg. Room 131, Locator Code 1415, Coral Gables Campus. Your enrollment material must be submitted to Benefits Administration for payroll deduction processing prior to submission to the 529 Plan company. Keep a copy of your enrollment forms for your records. For any other questions, please contact Sheri Virok at 305-284-2728, or email at sherri.lee@miami.edu
Additional Information

This document contains summary plan descriptions of the retirement benefit plans for the University of Miami. The benefits under these plans are provided for the exclusive benefit of participants and their beneficiaries.

Plan Sponsor
The plan sponsor is the University of Miami:
Benefits Administration
University of Miami
1507 Levante Avenue
Coral Gables, Florida 33146
(305) 284-3004

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

- ERP: Retirement Committee
- FRP: Faculty Retirement Committee
- RSP: RSP Committee
- SRA: Supplemental Retirement Committee

Each committee delegates benefit determinations and day-to-day plan operation to Benefits Administration. Benefit applications and appeals for denied claims may all be made to:
Benefits Administration
University of Miami
1507 Levante Avenue
Coral Gables, Florida 33146
(305) 284-3004

ERP Plan Trustee
The name and address of the trustee for the Employees' Retirement Plan are:
Wachovia Retirement Services
200 South Biscayne Boulevard, FL 6066
11th Floor
Miami, FL 33131

Agent for Service of Legal Process
The registered agent to accept service of legal process for the University of Miami is:

Administrator for Risk Management
Jackson Memorial Tower
1500 NW 12 Avenue
Suite 1112
Miami, Florida 33136
Plan Numbers, Funding, Years and Type

The University of Miami’s identification number for government reports is EIN 59-0624458.

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The Plan Documents Control

The plan documents govern the operation of the plans described in these summary plan descriptions. If there is any conflict with these non-technical summaries, the plan documents will control. These summary plan descriptions are intended to help you understand the main features of the University’s retirement benefit plans. It should not be considered as a substitute for the plan documents which govern the operation of the plans. Those official plan documents set forth all of the details and provisions concerning the plans and are subject to amendment. If any questions arise that are not covered in these summary plan descriptions, or if these summary plan descriptions appear to conflict with the legal plan documents, the text of the legal plan documents will determine how questions will be resolved. You are welcome to request inspection of the official plan documents at Benefits Administration or request copies of your own, for a small fee to cover printing costs.

When Benefits Are Not Paid

These summary plan descriptions outline, and the official plan documents describe in detail, plan benefits and how you or your spouse or other beneficiary can qualify for them. As long as the plans are in force, if you or a beneficiary becomes eligible for benefits and makes proper application for them, they should begin promptly – usually within 30 days. There are a few circumstances which might result in disqualification, non-eligibility, denial, loss, forfeiture, suspension or reduction of benefits to an eligible employee, spouse or other beneficiary. They include:
For the Faculty Retirement Plan and the Retirement Savings Plan

- Because the amount of any distribution from the plan(s) is based on your account balance at the time you terminate or retire, that amount may be more or less than the amount shown on your last statement of your account balance.

For the Employees’ Retirement Plan

- Not accruing the required 1,000 hours in a plan year to earn a year’s credit for vesting or benefits.
- Not living until the earliest date you qualify for benefits (example: age 55 with 10 years of credited service, or age 65 with five years of credited service) – but your beneficiary could receive a lifetime pension regardless of your service if you are an active plan member at the time of your death.
- Re-employment by the University while receiving retirement payments and which requires a suspension of benefits during the period while again working (When you again retire, your benefit will be re-calculated and cannot be less than when you originally retired.)

For the Employees’ Retirement Plan, the Faculty Retirement Plan and the Retirement Savings Plan

- Leaving the University before earning a vested right to your plan benefit – but your beneficiary could receive a lifetime pension regardless of your service if you are an active plan participant at the time of death.
- Failure to make timely and proper application for benefits, or to supply information, such as proof of age or death, as required by the Retirement Committee.
- If your employment status changes such that you are no longer eligible under the plan or work enough to earn a benefit, you may stop accruing benefits or receiving credits to your plan account.
- If a court order concerning child support, alimony or marital property rights so decrees, part of your benefit may be payable to someone other than you or your designated beneficiary.
- If you work past your normal retirement date, you will continue to accrue benefits, but your benefits accrued through your normal retirement date will not be paid to you at your normal retirement date. That benefit, plus benefits earned after your normal retirement date, will be paid to you when you actually retire.
- Federal law limits the amount of benefits that may be received from a qualified pension plan. In particular, for 2007, no more than $225,000 of annual compensation may be taken into account in determining your benefit. Also, in 2007, your annual benefit will be limited to the lesser of $180,000 or 100% of your average compensation during your highest three years. These limits may be adjusted periodically for changes in the cost of living, and may be adjusted depending on the form of benefit you select and your benefit commencement date.
- These plans also contain certain limitations on the amount of benefits that can be distributed to the 25 highest paid employees of the University, under certain circumstances. These restrictions may, among other things, limit the value of lump sums that may be paid to these affected employees. If you are subject to this limitation, you will be notified.

Under the Faculty Retirement Plan, the Retirement Savings Plan, and the Supplemental Retirement Annuity Program, all benefits are provided for from the individual annuity contracts or custodial accounts selected by and issued to plan participants under its provisions. Neither the Board of Trustees, the University, nor any officer or employee of the University has any liability or responsibility for those member-owned contracts or benefits. The University, therefore, makes no warranty against any loss or diminution in the value of any annuity contract or custodial account, except to make the plan’s required contributions to the provider company of your choice.

Qualified Domestic Relations Order (QDRO)

A qualified domestic relations order (QDRO) is a legal judgment, decree or order that recognizes the rights of an alternate payee under the retirement plans with respect to a child’s or other dependent’s support, alimony or marital property rights. The University is legally required to recognize a QDRO.
If you become legally separated or divorced, a portion or all of your benefit under your retirement plan may be assigned to someone else to satisfy a legal obligation you may have to a spouse, former spouse, child or other dependent.

There are specific requirements the court order must meet to be recognized by the Plan Administrator and specific procedures regarding the amount and timing of payments.

Participants and beneficiaries may obtain, without charge, a copy of the procedures governing QDRO determinations under the plan from the Plan Administrator by contacting Benefits Administration at (305) 284-2743.

Benefit Assignment
To protect you and your dependents, your interest in a plan cannot be assigned, sold, transferred or pledged by you and, to the extent permitted by law, benefits are not subject to garnishment or attachment. However, current law allows a court to assign a portion of a participant’s benefits to another person under the terms of a qualified domestic relations order (QDRO), usually issued as part of a divorce proceeding.

Receiving Advice
The University cannot advise you with regard to legal, tax or investment considerations relative to any plan. Therefore, if you have questions pertaining to benefit planning in these areas, you should seek advice from a personal tax advisor or financial planner.

Plan Interpretation
To the fullest extent permitted by law, the Plan Administrator will have the exclusive discretion to determine all matters relating to eligibility, coverage and benefits under the plan. The Plan Administrator will also have the exclusive discretion to determine all matters relating to interpretation and operation of the plan. Decisions by the Plan Administrator will be conclusive and binding.

Withholding
Unless you elect otherwise for the Faculty Retirement Plan, the Employees’ Retirement Plan and the Retirement Savings Plan, benefit payments from these plans will be subject to federal income taxes and may be subject to state and local income taxes as well. If you elect a lump sum payment, the University of Miami is required to withhold federal income taxes equal to 20% of the taxable portion of your payment, unless you roll over your distribution directly into a traditional IRA or eligible employer plan. Unless you are at least age 55 at the time you leave the University, you are at least age 59½ at the time payment is made to you or another exception applies, your distribution may be subject to a 10% early payment penalty tax in addition to regular income taxes if it is not rolled over to an eligible retirement plan. Your distribution may be rolled over to the extent that it is an “eligible rollover distribution.” Generally, a distribution is an eligible rollover distribution if it is paid in the form of a single lump sum payment, or in the form of installment payments made over a period of less than 10 years. For more information on the additional 10% tax, please see IRS Form 5329.

You are responsible for paying any applicable federal, state and local taxes when you receive the distribution. You will receive more information about the applicable rules when you request payment of your benefits. Because taxes are complicated and subject to change, you may wish to consult a tax advisor before receiving benefits from the plan.

The Future of the Plans
It is the University’s intent that the Employees’ Retirement Plan, the Faculty Retirement Plan and the Retirement Savings Plan will continue indefinitely. However, the University reserves the right to amend, modify, suspend or terminate these plans, in whole or in part, in accordance with plan provisions. Plan amendment, modification, suspension or termination may be made for any reason, and at any time, and may, in certain circumstances, result in the reduction or elimination of benefits or other features of the plans to the extent allowed by law.
If any of the plans are completely or partially terminated, affected participants will become fully vested in the benefits they have accrued to that point (to the extent such benefits are funded). In the event of a complete plan termination, benefits will be distributed in any manner permitted by the plans as soon as practicable, and any excess funds will then revert to the University.

**Insuring ERP Benefits**
The University of Miami pays annual premiums for all employees to a governmental insuring agency set up under ERISA. If the Employees’ Retirement Plan should terminate, benefits are insured, up to certain limits, by the Pension Benefit Guaranty Corporation (PBGC). Generally, it guarantees most vested normal and early retirement benefits, and certain survivor pensions. The PBGC does not guarantee all types of benefits under all plans, and the amount of protection has limits. For example, it covers vested benefits as of the date a plan terminates. In addition, if a plan has been adopted or benefits increased within five years, the whole amount may not be guaranteed. There is a ceiling on the monthly benefit the PBGC guarantees, which is adjusted periodically. For more information contact Benefits Administration at (305) 284-6834 or contact the PBGC’s Technical Assistance Division, 1200 K. Street, N.W., Suite 930, Washington, DC 20005-4026, or call (202) 326-4000 (not a toll-free number). TTY/TDD users may call the federal relay service toll-free number at 1-800-877-8339 and ask to be connected to (202) 326-4000. Additional information about the PBGC's pension insurance program is available through the PBGC’s website on the Internet at http://www.pbgc.gov.

You may direct requests for information about eligibility, membership, contributions, or other aspects of plan operation in writing to the Plan Administrator.

Defined contribution retirement plans such as the Faculty Retirement Plan, the Retirement Savings Plan or other University benefit plans are not insured by the PBGC.

**If the Retirement Plans Become Top Heavy**
Under a complicated set of IRS rules set out in the plan documents, the plans may become “top heavy.” A top heavy plan is one where more than 60% of the contributions or benefits have been allocated to "key employees." Key employees are generally certain officers of the University. The Plan Administrator is responsible for determining whether a plan is a top heavy plan each year. In the unlikely event that a plan becomes top heavy in any year, non-key employees may be entitled to certain minimum benefits and special rules will apply. If the plan becomes top heavy, the Plan Administrator will advise you of your rights under the top heavy rules.

**Leaves of Absence**
You may be able to continue your participation during leaves of absence under the retirement plans under certain circumstances.

**Continuation of Participation While on Approved Leaves of Absence**
If you take an approved paid leave of absence (or are eligible for long-term disability), you will continue to participate in your retirement plan (the Employees’ Retirement Plan, the Faculty Retirement Plan or the Retirement Savings Plan) as if you were an active employee for purposes of vesting and earning benefits or pay credits under the plan. You cannot receive a benefit payment from your plan account during a leave.

If you take an approved unpaid leave of absence, you will not continue to accrue service for purposes of vesting, benefit accrual or pay credits. You cannot receive benefit payments from your retirement plan until you are considered to have terminated your employment.

**Continuation of Participation for Employees in the Uniformed Services (USERRA)**
The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to eligible participants of retirement plans who enter military service. The terms “uniformed services” or “military service” mean the Armed Forces (i.e., Army, Navy, Air Force, Marines Corp., Coast Guard), the reserve components of the Armed Services, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the
commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

Upon reinstatement, you are entitled to the seniority, rights and benefits associated with the position held at the time employment was interrupted, plus additional seniority, rights and benefits that you would have earned if employment had not been interrupted. These rights include receiving vesting service and benefit accrual or pay credits under your retirement plan. Such leave will not constitute a break in service.

If you think you may be eligible for these special rights under USERRA, please contact Benefits Administration at (305) 284-6834.

Continuation of Participation While on a Family and Medical Leave (FMLA)
Under the federal Family and Medical Leave Act (FMLA), if you meet eligible service requirements, you are entitled to take up to 12 weeks of leave for certain family and medical situations. An absence under the Family and Medical Leave Act will not constitute a break in service for purposes of your retirement plan. In general, your FMLA leave is treated like any other paid or unpaid leave under your plan. If your FMLA leave is paid, your leave will be treated like other paid leaves; if your FMLA leave is unpaid, it will be treated like other unpaid leaves.

Your Rights Under ERISA
As a participant in any of these retirement plans (the Employees' Retirement Plan, the Faculty Retirement Plan, the Retirement Savings Plan, or the Supplemental Retirement Annuity Program), you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits
• **Examine**, in Benefits Administration without charge, copies of all documents governing the plans including a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
• **Obtain**, on written request to the Plan Administrator and for a reasonable charge to cover printing, copies of documents governing the operation of the plan including copies of the latest annual report (Form 5500 Series) and updated summary plan description.
• **Receive** each year a summary of the plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
• **Obtain** a statement telling you whether you have a right to receive a benefit at your normal retirement age (age 65) and if so, what your pension benefits would be at normal retirement age under the plan if you stop working now. If you do not have a right to a benefit, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The plan must provide the statement free of charge.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a pension benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days,
you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a suit in state or federal court, but only after you have exhausted your retirement plan’s claims and appeals procedures as described in the next section, “Appeals Procedures.” In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions
If you have any questions about your plan, you should contact the Plan Administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Your Employment
These summary plan descriptions provide detailed information about the University of Miami’s retirement benefit plans and how they work. These summary plan descriptions do not constitute an implied or express contract or guarantee of employment. Similarly, your eligibility or your right to benefits under these plans should not be interpreted as an implied or express contract or guarantee of employment. The University’s employment practices are made without regard to the benefits it offers as part of your total compensation.

If any discrepancies exist between the summary plan description and the plan documents or master contracts, the plan documents or master contracts will override.

For questions about the plans or your benefits under them, contact Benefits Administration. For questions about your ERISA rights, you may contact the Labor Management Services Administration of the U.S. Department of Labor. (Look under “U.S. Government” in the telephone directory.)
# APPEALS PROCEDURES

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Appeals Procedures

Claims Procedures and Sample Form

Claims Procedures

This section sets out the procedures pertaining to claims by participants and beneficiaries (claimants) for plan benefits, consideration of such claims and review of claim denials. In the aggregate, the steps are referred to as claims procedures.

A claim is a request for a plan benefit by a participant or beneficiary.

If a claim is wholly or partially denied, notice of this decision must be furnished to the claimant within ninety days of receipt of the claim by the plan. If notice of denial is not furnished in ninety days, the claim shall be considered as denied.

The claim denial shall set forth in writing:

1. The specific reason or reasons for the denial.
2. Specific reference to pertinent plan provisions on which the denial is based.
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and
4. Appropriate information as to the steps to be taken if the participant or beneficiary wishes to submit his or her claim for review.

A claimant or the claimant’s duly authorized representative has sixty days in which to appeal a denied claim. The review requests are to be made to an appropriate named fiduciary or to a person designated by such fiduciary. The claimant may:

1. Request a review upon written application to the plan;
2. Review pertinent documents; and
3. Submit issues and comments in writing.

Decision on review

A decision by an appropriate named fiduciary is to be made no later than 60 days after the plan’s receipt of a request for review, unless special circumstances (such as the need to hold a hearing, if the plan procedure provides for a hearing) require an extension of time for processing.

In the case of a plan with a committee or board of trustees designated as the appropriate named fiduciary, which holds regularly scheduled meetings at least quarterly, a decision on review shall be made by no later than the date of the meeting of the committee or board which immediately follows the plan’s receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a decision may be made by no later than the date of the second meeting following the plan’s receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the plan procedure provides for a hearing) require a further extension of time for processing, a decision shall be rendered no later than the third meeting of the committee or board following the plan’s receipt of the request for review.

If such an extension of time for review is required because of special circumstances, written notice of the extension shall be furnished to the claimant prior to the commencement of the extension.

The decision on review shall be in writing and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, as well as specific references to the pertinent plan provisions on which the decision is based.

The decision on review shall be furnished to the claimant within 60 days. If the decision on review is not furnished within such time, the claim shall be deemed denied on review.
The following is a general statement of the Claims Review and Appeals Process. Following the general statement below are the specific details by benefit and/or the providing company to complete the blanks of the general statement. In the specific detail sections, addresses and needed documentation are listed.

Sample Form

Any Plan Participant may file a claim requesting a Plan benefit to which the participant believes that he or she is entitled. If the claim is denied in whole or in part, the Participant is afforded the following rights.

I. Request For Claims Review

A. ____________________________ will assist the claimant in assembly of the necessary information.

   The claim review request should include the following:

   1. 
   2. 
   3. 
   4. 

B. The request for review should be sent to _________ at the following address:

C. The request will be reviewed by ________________ within ninety (90) days of receipt. If additional time is required, written notice will be sent to the claimant. The extension of time will not exceed another ninety (90) days.

II. Notification to Claimant of Claim Review Decision

A. If the claim is wholly or partially denied, written notice of the decision by ________ _______ shall be furnished to the claimant within ninety (90) days after receipt of the claim.

B. Content of notice:

   1. The specific reason or reasons for the denial;
   2. Specific reference to pertinent Plan provisions on which the denial is based;
   3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and
   4. Appropriate information as to the steps to be taken if the participant or beneficiary wishes to appeal the decision.

C. If notice of the denial of claim is not furnished within ninety (90) days, the claim is deemed denied and the claimant is permitted to proceed to the appeal stage described in Section III.

D. If special circumstances require an extension of time for processing the review, written notice of the extension shall be furnished to the claimant prior to the determination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to decide.

III. Appeal Procedure

A. A claimant, or his or her duly authorized representative, has an opportunity to appeal a denied claim. The claimant, or his or her duly authorized representative, may:

   1. Request review upon written application to the plan;
   2. Review pertinent documents; and
   3. Submit issues and comments in writing.
B. The claimant must file a request of review of a denied claim within sixty (60) days after receipt by the claimant of written notification of denial of a claim. The request for review should be sent to the following address:

C. A decision on the review shall be made promptly, no later than sixty (60) days after the plan's receipt of a request for review. If special circumstances require an extension of time for processing, a decision shall be rendered no later than 120 days after receipt of a request for review.

D. If the extension of time for review is required because of special circumstances, written notice of the extension shall be furnished to the claimant prior to the commencement of the extension.

E. The decision shall be in writing and shall include specific reasons for the decision, as well as specific references to the pertinent plan provisions on which the decision is based.

F. If a decision on appeal is not made within the time frame, the appeal is considered denied.

HEALTH INSURANCE - AETNA
SECTION I – Employee calls Aetna Member Services at 1-800-824-6411
A. Member Services
   1. Copy of claim
   2. Reason member feels claim should be paid
   3. Any supporting documentation

B. Aetna
   Attn: National Account CRT
   PO Box 14463
   Lexington, KY 40512

C. The Claims Review Department

SECTION II
A. The Claims Department

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

DENTAL INSURANCE - CIGNA DENTAL CARE (HMO)
SECTION I
A. Member Services Department
   1. Reason member feels claim should be paid.
   2. Any supporting Documents

B. CIGNA Dental Appeals
   PO BOX 188047
   Chattanooga, TN  37422-8047
C. CIGNA Dental within 30 days of receipt

SECTION II
A. CIGNA Dental within 30 days unless extension is needed.
DENTAL INSURANCE – DELTA DENTAL PPO
SECTION I
A. Delta Dental Insurance Company
   1. Any supporting documents
   2. Reason member feels claim should be paid

B. Delta Dental Insurance Company
   Attn: Professional Services
   1130 Sanctuary Parkway, 5th Floor
   M/S 5B
   Alpharetta, GA 30009

C. Delta Dental Insurance Company

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

UNIVERSITY OF MIAMI BEHAVIORAL HEALTH (UMBH)
SECTION I
A. Member Services
   1. Copy of claim
   2. Reasons member feels claim should be paid
   3. Any supporting documentation

B. University of Miami Behavioral Health
   Member Services
   PO Box 016960 (LC 2940)
   Miami, FL 33101

C. The Claims Review Department

SECTION II
A. The Claims Department

SECTION III
A. University of Miami Behavioral Health
   Member Services
   PO Box 016960 (LC 2940)
   Miami, FL 33101

VOLUNTARY EXCESS LIFE – METLIFE
SECTION I
A. University of Miami Benefits Administration
   1. Certified Death Certificate
   2. Beneficiary Designations
   3. Enrollment Forms
   4. Signed Claimant and Employer Statements

B. Supervisor
   MetLife
   PO Box 6122
   Utica, New York 13504

C. A MetLife Claim Reviewer
SECTION II
A. A MetLife Claim Reviewer

SECTION III
B. Supervisor
   MetLife
   PO Box 6122
   Utica, New York 13504

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE – AIG
SECTION I
A. University of Miami Benefits Administration
   1. Statement of claimant and attending physician
   2. Police accident/incident report
   3. Copy of enrollment/beneficiary designation form
   4. Payroll stub or other confirmation that premium payment was current

B. AIGCS
   Accident and Health Claims Department
   PO Box 15701
   Wilmington, DE 19850-5701

C. AIGCS

SECTION II
A. AIGCS

SECTION III
D. AIGCS
   Accident and Health Claims Department
   PO Box 15701
   Wilmington, DE 19850-5701

LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT - UNUM
SECTION I
A. University of Miami Benefits Administration
   1. Certified Death Certificate
   2. Beneficiary Designations
   3. Enrollment Forms
   4. Signed Claimant and Employer Statements

B. UNUM Life Insurance Company of America
   2211 Congress Street
   Portland, ME 04102-9997

C. UNUM

SECTION II
A. UNUM

SECTION III
B. UNUM Life Insurance Company of America
   2211 Congress Street
   Portland, ME 04102-9997
LONG TERM DISABILITY INSURANCE – UNUM
SECTION I
D. Capital Coordination
   1. Part I and II of the initial claim form.
   2. Attending Physician’s Statement

E. UNUM Life Insurance Company of America
   Individual Disability Benefits
   2211 Congress Street
   Portland, ME 04102-9997

F. UNUM

SECTION II
A. UNUM

SECTION III
G. UNUM Life Insurance Company of America
   Attn: Manager, Individual Disability Benefits
   2211 Congress Street
   Portland, ME 04102-9997

LONG TERM CARE INSURANCE – UNUM
SECTION I
A. Quality Review Section
   1. Request must be received within 60 days of receipt of denial letter.
   2. Claim number
   3. Policy number

B. UNUM
   Quality Review Section
   PO Box 9064
   Portland, ME 04104-5064

C. Quality Review Section

FLEXIBLE SPENDING ACCOUNTS - WAGEWORKS
SECTION I
A. University of Miami Benefits Administration

1. Documentation from the Provider(s) of Medical services indicating the nature of the expense(s), the date(s) and amount(s) so incurred, and the name of the patient and relationship to the Plan Participant, if the basis of the denial was the omission of any one of these items of information.
2. A written statement by the patient’s physician indicating the medical necessity of the treatment/service if the basis of the denial relates to the medical necessity of the treatment/service.
3. A written “Explanation of Benefits” from all available sources of insurance reimbursement indicating the insurance reimbursement of the expense(s), or a portion thereof, if the basis of the denial relates to insurance reimbursement.
4. Documentation from the Provider(s) of Dependent Care services indicating the date(s) and amount(s) so incurred, the name, address and Employer identification number or Social Security number of the provider(s) of service(s), and the relationship to the Plan Participant if the nature of the denial was the omission of any one of these items of information.

B. WageWorks
PO Box 991
Mequon, WI 53092

C. Benefits Administration

SECTION II
A. Benefits Administration

SECTION III
B. University of Miami
Benefits Administration
PO Box 248106
Coral Gables, Florida 33124-1415
Retirement

This section sets out the procedures pertaining to claims by participants and beneficiaries (claimants) for retirement benefits, consideration of such claims and review of claim denials. In the aggregate, the steps are referred to as claims procedures. A claim is a request for a plan benefit by a participant or beneficiary.

If a claim is wholly or partially denied (i.e., any denial, reduction or termination of a benefit, or a failure to provide or make a payment), notice of this decision must be furnished by the Plan Administrator to the claimant within 90 days of receipt of the claim by the plan. If notice of denial is not furnished in 90 days, the claim shall be considered as denied. This 90-day period may be extended for up to an additional 90 days, if the Plan Administrator both determines that special circumstances require an extension of time and the date by which the plan expects to render a determination.

In the event an extension is necessary due to your failure to submit necessary information, the plan's timeframe for making a benefit determination on review is stopped from the date the Plan Administrator sends you an extension notification until the date you respond to the request for additional information.

If You Receive an Adverse Benefit Determination

The claim denial shall set forth in writing:

- The specific reason or reasons for the denial
- Specific reference to pertinent plan provisions on which the denial is based
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary and
- Appropriate information as to the steps to be taken under the rules of the plan if the participant or beneficiary wishes to submit his or her claim for review, including a statement of your right to bring a civil action under ERISA after an adverse determination on appeal.

Procedures for Appealing an Adverse Benefit Determination

If you receive an adverse benefit determination, you may ask for a review. A claimant or the claimant’s duly authorized representative has 60 days following the receipt of a notification of an adverse benefit determination within which to appeal a denied claim. You have the right to:

- Submit written comments, documents, records and other information relating to the claim for benefits
- Request, free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record, or other information is treated as “relevant” to your claim if it:
  - Was relied upon in making the benefit determination
  - Was submitted, considered or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination
  - Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination
- A review that takes into account all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination.

The Plan Administrator will notify you of the plan’s benefit determination on review within a reasonable period of time, but no later than 60 days after the plan’s receipt of your request for review. This 60-day period may be extended for up to an additional 60 days, if the Plan Administrator both determines that special circumstances require an extension of time for processing the claim, and notifies you, before the initial 60-day period expires, of the special circumstances requiring the extension of time and the date by which the Plan Administrator expects to render a determination on review.
In the event an extension is necessary due to your failure to submit necessary information, the plan's timeframe for making a benefit determination on review is stopped from the date the Plan Administrator sends you notification of the extension until the date you respond to the request for additional information.

The Plan Administrator's notice of an adverse benefit determination on appeal will contain all of the following information:

- The specific reason(s) for the adverse benefit determination
- References to the specific plan provisions on which the benefit determination is based
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim
- A statement describing any voluntary appeal procedures offered by the plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA.

Note: You must use and exhaust your plan's administrative claims and appeals procedure before bringing suit in either state or federal court. Similarly, failure to follow the plan's prescribed procedures in a timely manner will cause you to lose your right to sue regarding an adverse benefit determination.