EMBRY RIDDLE
AERONAUTICAL UNIVERSITY
(Daytona Beach Campus)

Health Care Plan

______________________________
Plan Document
&
Summary Plan Description

______________________________
Revised and Restated:
August 1, 2008
INTRODUCTION

Embry-Riddle Aeronautical University is pleased to present this description of the Group Health (Medical, Dental & Vision) Benefit Plan. These plans have been specifically designed for our employees and their dependents. Please read this booklet carefully since it contains information concerning personal security for you and your family.

Embry-Riddle Aeronautical University, the “Plan Administrator,” has retained the services of an independent Claims Administrator, Fringe Benefits Management Company (hereinafter referred to as FBMC), experienced in claims processing, to handle health claims.

This booklet is the Summary Plan Description for the Embry-Riddle Aeronautical University Health Care Plan (the “Plan”), and has been prepared in compliance with Public Law 93-406, better known as the “Employee Retirement Income Security Act of 1974” (ERISA). This booklet (together with any amendments) also constitutes the Plan Document for the Plan. This Plan is maintained for the exclusive benefit of eligible employees and their eligible dependents, and their rights under this Plan are legally enforceable. The Employer has the right to amend this Plan at any time, and will make a “good faith” effort to communicate to you, on a timely basis, all such changes which affect benefit payment.

If you receive any information on this Plan and it is not consistent with the provisions in this document, the provisions of this document, as the governing document for this Plan, will prevail.

Included in this document are a description of the requirements for coverage under this Plan, the provisions concerning termination of coverage, a description of the Plan benefits (including any limitations and exclusions), and the procedures to be followed in presenting claims for benefits and remedies available for appeal of denied claims.

You are entitled to coverage under the Plan only if you are eligible in accordance with the provisions in this booklet. The benefits and other rights described in this booklet do not apply to you if you are not, or have ceased to be, eligible for coverage under the Plan. No clerical error will invalidate your coverage if otherwise validly in force. No clerical error will validate coverage that does not otherwise exist under this Plan.

Some of the terms used in the booklet begin with a capital letter. Many of these terms have a special meaning under this Plan and they are listed in the Definitions section. When reading the provisions of this Plan, it may be helpful to refer to this section. Becoming familiar with the terms defined there will give you a better understanding of the procedures and benefits described.

Please keep this information for future reference in accessing your benefits. You will be notified of any plan modifications in writing to be inserted in your binder.

Your continued cooperation and feedback concerning these benefits are welcome as we continue to refine our plan and respond to the changing health care industry.
INTRODUCTION (Continued)

Any questions you may have about your coverage should be directed to:

FBMC
PO Box 730561
Ormond Beach, FL 32173-0561

1-386-676-5760
1-800-323-4890
COST CONTAINMENT AND YOU

The cost of the nation's medical care delivery system continues to be inflationary and it has become imperative that efforts be made for the containment of these costs.

In an attempt to keep the cost of benefits under control and at the same time provide basic coverage for you and your dependents in times of need, we have taken a progressive approach to benefit plan design and administration. We encourage you to become a knowledgeable and responsible consumer of health care services in order to conserve our available resources so we may continue to provide quality health care benefits.

The responsibility for cost containment must be shared by all of us. Active participation in physical fitness programs can be a factor in avoiding some illnesses and in minimizing the seriousness of others. Should medical attention become necessary however, there are procedures that can be taken, and in some instances required, to avoid unnecessary expenses. Pre-admission certification is one of the cost containment measures outlined in this booklet.
BENEFIT CHOICE AND CONTRIBUTION INFORMATION

As an eligible employee of Embry-Riddle Aeronautical University you have the option to participate in the Embry-Riddle Health Care Plan (Plan) or the Florida Health Care Plan, a health maintenance organization (HMO) (Daytona Beach Campus), or you may decline to participate in either of these plans.

If you elect health coverage under the family coverage option, all members of the family must be under the same plan.

The University allows employees the choice of paying their health care premiums on either a pre-tax or after-tax basis. Once a decision is made, a Pre-Tax Election Form must be completed and returned to Human Resources. This election may be made one time per calendar year.

Should you elect to pay your health care premiums on a pre-tax basis, your gross salary will be reduced for Federal and FICA tax purposes. In other words, your health care premiums are deducted from your pay before federal and social security taxes are determined.

Should you elect to pay your health care premiums on an after-tax basis, your Federal and FICA taxes will be based on your full salary and your health care premiums will be deducted after all taxes have been determined.

It is possible that you will pay less income tax and social security tax if your payments are made with pre-tax and not after-tax dollars.

CHOICE OF PROVIDERS

The Plan Administrator has entered into a contractual agreement with Preferred Provider Organization(s) (PPO) so that certain providers of health care may offer their services through a Preferred Provider Organization. For directories, questions or information regarding the Preferred Provider Organization(s) or a Network Provider, please call the number that is on the back of your identification card.

♦ Covered Persons who reside within a PPO service area have a choice of obtaining health care services and supplies from providers participating in the Preferred Provider Organization (PPO providers) or any other covered provider of their choice (non-PPO providers).

PPO providers have agreed to provide services to Covered Persons at reduced rates. Therefore, your use of PPO providers will generally result in lower costs for you.
PREFERRED PROVIDERS

For the Daytona Beach Campus, call Volusia Health Network at 386-258-4801 or 1-800-741-2198 if you have any questions about a Physician, Hospital or other health care Practitioner within the PPO network.

It is necessary to present your medical identification card whenever seeking health care services with the appropriate Preferred Provider Network.

The Preferred Provider Network can assist you in determining an appropriate Physician to meet your particular medical needs, however, you and your covered Dependents may choose to seek medical treatment at any time from a PPO Provider or from any other provider who is qualified under the terms of the Plan.

You will be provided with a list of Participating Providers. Because changes to the network may occur, it is advisable to verify a provider's current status as participating prior to scheduling an appointment by either calling the appropriate Preferred Provider Network as listed above or inquiring with the provider.

All referrals to Physicians and Hospitals not listed in the appropriate Preferred Provider Network Provider Directory must be pre-approved by the campus' Preferred Provider Network prior to services being obtained, in order for In-Network benefits to apply.

If you reside outside of Volusia County or Flagler County, for the Daytona Beach campus, you will be given an opportunity to elect the network. Please note that if you should change your residence to Volusia County or Flagler County, you must notify the Human Resources Department and participate in the network at that time.

FLEXIBLE BENEFIT PLAN

IRS SECTION 125 - FLEXIBLE BENEFIT PLANS: Once you elect to participate in the Pre-Tax Premium Plan, you cannot add, drop or change your coverage until the next Annual Choice Period, which will be announced each year, unless there is a Change in Status as described below. In the case of a Change in Status, you have 31 days from the date of the event to make any changes.

Make your decision carefully. You will not be able to change your coverage or stop your contributions during the year unless one of the following changes in family status occurs:

1. The marriage, divorce or legal separation of an Employee.
2. The death of the Employee's Spouse or a tax Dependent.
3. The birth or adoption of a child of the Employee.
4. The termination or commencement of employment of Employee's Spouse, or the Employee’s tax Dependent.
5. Medicare/Medicaid and other government health programs.
FLEXIBLE BENEFIT PLANS (Continued)

6. A change from part-time to full-time employment status or from full-time to part-time status by the Employee, Employee's Spouse or tax Dependent.

7. The taking of an unpaid leave of absence by the Employee or Employee's Spouse.

8. The Employee’s tax Dependent is satisfying or ceasing to satisfy an eligibility requirement for a particular benefit.

9. A change in the place of residence or work by the Employee, spouse or tax Dependent.

10. A significant change occurs in the health coverage of the Employee or Spouse attributable to the Spouse’s employment or annual enrollment for the spouse’s health coverage.

11. “Life Event” may also be applicable to a participant’s former spouse, where the occurrence affects eligible dependents.

12. A change in the Employee’s health plan from the HMO plan to the self-funded plan if moving out of the HMO plan service area during the Plan Year.

Please refer to the Pre-Tax Election Form for further details and an example of how tax dollars may be saved by electing the pre-tax option. Pre-tax Election Forms are available in Human Resources.
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GENERAL INFORMATION

Name of the Plan: EMBRY-RIDDLE AERONAUTICAL UNIVERSITY HEALTH CARE PLAN

Type of Administration: The Plan is a self-funded health plan administered through a third party Claims Administrator.

Address of Plan: 600 S. Clyde Morris Blvd.
Daytona Beach, FL 32114

Plan No.: 501

Group No.: 0100

IRS Employer Identification No: 59-0936101

Restated Plan Effective Date: August 1, 2008

Plan Year: January 1 – December 31

Claims Administrator: FBMC
780 West Granada Blvd., Suite 200 (32174)
PO Box 730561
Ormond Beach, FL 32173-0561

Plan Sponsor: Embry-Riddle Aeronautical University

Plan Administrator: Embry-Riddle Aeronautical University

Agent for Service of Legal Process: Embry-Riddle Aeronautical University

Costs of the Plan: Both Employer(s) and Covered Employees contribute toward the cost of coverage under the Plan as determined by the Plan Administrator from time to time. Contributions by Covered Employees may either be deducted from pay on a pre-tax or a post-tax basis as authorized by the Employee on the enrollment form or other applicable form(s).

Plan Funding: Benefits under the Plan are self-funded from the general assets of the Employer(s) and are not guaranteed through an insurance contract.

Eligible Employees: Class A – All full-time staff employees or 9, 10 and 11 month work schedule employees who work at least 30 hours per week on an ongoing basis.

Class B – All full-time faculty, including 9, 10 and 11 month work schedule faculty as defined by the University.
GENERAL INFORMATION (Continued)

All eligible employees who retire while covered by this Plan are eligible for Retiree or COBRA coverage.

Effective Date of Coverage: First of month following waiting period
Waiting Period: 1 month period beginning with the first day of active employment
Termination Date of Coverage: On last day which the Covered Person ceases to satisfy the Plan’s eligibility requirements.
SUMMARY OF MEDICAL BENEFITS

LIFETIME MAXIMUM BENEFIT FOR ALL COVERED EXPENSES .............$2,000,000
Except as Otherwise Indicated Below
   Hospice Care (Inpatient/Outpatient Maximum Combined).................$10,000
   Hospice Care (Outpatient Maximum)..............................................$2,000
   Hospice Care (Bereavement Counseling Maximum)...........................$200
   Alcohol and Drug Abuse Treatment (inpatient/outpatient combined)....$10,000

All maximums under this Plan count towards the $2,000,000 total Lifetime Maximum.

CALENDAR YEAR DEDUCTIBLE
   Individual Maximum ..............................................................................$300
   Family Maximum .................................................................................$600

MAXIMUM OUT-OF-POCKET EXPENSE
The Maximum Out-of-Pocket Expense is the amount you must pay toward covered expenses during a calendar year before benefits are increased. It does not include any applicable Deductible(s). Benefits payable for Mental & Nervous, Alcohol and Drug Abuse, Chiropractic Care and Temporomandibular Joint Dysfunction are not credited toward the Out-of-Pocket amount and are not paid at 100%. If both In- and Out-of-Network Providers are used the combined amount accumulated In or Out of Network will track toward the maximum(s) per calendar year. Refer to the General Medical Provisions’ “Tracking Out-of-Pocket Expenses” section.

The Maximum Out-of-Pocket Expense, not including the Deductible(s) are:

MAXIMUM OUT-OF-POCKET EXPENSE   IN-NETWORK   OUT-OF-NETWORK
& PLAN B
   Individual Maximum Per Calendar Year.......$1,500 ..................................$3,000
   Family Maximum Per Calendar Year..........$3,000 ..................................$6,000

PRECERTIFICATION REQUIREMENTS
All Hospital Admissions require Precertification prior to scheduled admissions or within 48 hours following Emergency treatment -- this includes: Hospital Admissions, Inpatient Mental Health Disorders and Substance Abuse Treatment, Skilled Nursing Facility Admissions and Outpatient Surgery.

[Box: Failure to comply will result in a Non-Precertification Penalty
Non-Precertification Penalty.............................................$200 per event]

PLAN PERCENTAGES PAYABLE
The Plan percentage is the portion the Plan will pay for eligible Covered Expenses after you satisfy any required Deductible or Co-Payment.

Precertification Is Mandatory. Failure To Comply Will Result In A Reduction Of Benefits. See The Utilization Review Process Provision For Details.
All Out-of-Network benefit payments are limited to Usual, Reasonable and Customary Charges.
PRECERTIFICATION REQUIREMENTS THROUGH VHN (386-258-4801 or 1-800-741-2198)

The plan requires precertification of all emergency and non-emergency hospital admissions and all inpatient and outpatient surgery.

**Penalty For Failure To Precertify** ........................................Penalty Of $200 Per Event Applied

This Non-Precertification Penalty amount does not count toward the Out-of-Pocket maximum amount. Refer to the Precertification and Utilization Review provisions for complete details.

**CO-PAYMENT PERCENTAGES PAYABLE PLAN A** (PPO 85%  NON-PPO 65%)

The Co-Payment Percentage is the portion the Plan will pay for eligible covered expenses after you satisfy any applicable Deductibles. Employees that reside in Volusia, Flagler, Orange, Osceola, Seminole, Lake, Hardee and Highlands Counties are considered in the preferred Provider Network, Plan A.

All referrals to Physicians and Hospitals not listed in the Preferred Provider Directory must be pre-approved prior to services being obtained, in order for In-Network benefits to apply. If approved, all services, supplies, or treatment rendered by a Non-PPO Provider upon referral by a PPO Provider will be paid at the Co-Payment Percentage of 85%.

Non-PPO Providers of ancillary services, (assistant surgeons, lab. Radiology, anesthesia, durable medical equipment, and emergency room physicians) will be paid at the PPO level when rendered at a PPO facility and/or services performed were provided outside the patient’s control or election.

All services, supplies, or treatment incurred as a direct result of a Medical Emergency will be paid at the Co-Payment percentage of 85%.

**CO-PAYMENT PERCENTAGES PAYABLE PLAN B** (80%)

Employees participating in the Preferred Provider Network (Volusia, Flagler, Orange, Osceola, Seminole, Lake, Hardee and Highlands) are in Plan A. All other Employees are in Plan B.

Employees who reside outside the network service area are considered in Plan B – Paid at 80%.

All services, supplies, or treatment rendered to covered individuals outside of the network service area will be paid at the Co-Payment percentage of 80% - Plan B.

**Precertification Is Mandatory. Failure To Comply Will Result In A Reduction Of Benefits. See The Utilization Review Process Provision For Details.**

**All Out-of-Network benefit payments are limited to Usual, Reasonable and Customary Charges.**
### SUMMARY OF MEDICAL BENEFITS (Continued)

<table>
<thead>
<tr>
<th>CO-PAYMENT PERCENTAGES PAYABLE</th>
<th>PLAN A</th>
<th>PLAN B</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PLAN A</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>IN-NETWORK</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Co-Payment Percentage</td>
<td>85%</td>
<td>65%</td>
</tr>
<tr>
<td>Daily Maximum Room and Board Rate</td>
<td>Average Semi</td>
<td>Average Semi</td>
</tr>
<tr>
<td>Intensive Care</td>
<td>URC Charges</td>
<td>URC Charges</td>
</tr>
<tr>
<td>Misc. Services and Supplies</td>
<td>85%</td>
<td>65%</td>
</tr>
<tr>
<td>Calendar Year Applies</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>OUT-NETWORK</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Co-Payment Percentage</td>
<td>85%</td>
<td>65%</td>
</tr>
<tr>
<td>Calendar Year Applies</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>NOT AVAILABLE</strong></td>
<td></td>
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</tbody>
</table>

**INPATIENT HOSPITAL EXPENSES**

Co-Payment Percentage: 85% after Deductible, 65% after Deductible, 80% after Deductible

**AMBULANCE SERVICES**

Co-Payment Percentage: 85%, 85%, 80%

**OUTPATIENT SURGERY* AND OTHER OUTPATIENT EXPENSES**

Co-Payment Percentage: 85%, 65%, 80%

**AMBULATORY SURGICAL CENTER FEE**

Co-Payment Percentage: 85%, 65%, 80%

**SECOND SURGICAL OPINIONS**

Required by Utilization Review

Co-Payment Percentage: 100%, 100%, 100%

Calendar Year Deductible Applies: Yes, Yes, Yes

Not Required by Utilization Review

Co-Payment Percentage: 85%, 65%, 80%

Calendar Year Deductible Applies: Yes, Yes, Yes

**PRE-ADMISSION TESTING BENEFIT**

(When done in accordance with plan provisions)

Co-Payment Percentage: 100%, 100%, 100%

Calendar Year Deductible Applies: No, No, No

**PHYSICIAN’S OR SURGEON’S SERVICES**

Co-Payment Percentage: 85%, 65%, 80%

Calendar Year Deductible Applies: Yes, Yes, Yes

The Plan provides benefits for the services of an assistant surgeon provided the assistance is Medically

*Precertification Is Mandatory. Failure To Comply Will Result In A Reduction Of Benefits. See the Utilization Review Process Provision For Details.

All Out-Of-Network benefit payment are limited to Usual, Reasonable and Customary Charges.
### SUMMARY OF MEDICAL BENEFITS (Continued)

<table>
<thead>
<tr>
<th>CO-PAYMENT PERCENTAGES PAYABLE</th>
<th>PLAN A IN-NETWORK</th>
<th>PLAN A OUT-OF-NETWORK</th>
<th>PLAN B NOT AVAILABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Necessary and no intern, resident, or other staff Physician is available. The amount considered as eligible charges for an assistant surgeon is the lesser of the assistant surgeon’s fee or no more than 20% of the allowable charge for the surgical procedure.</td>
<td></td>
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</tr>
</tbody>
</table>

### SUPPLEMENTAL ACCIDENT BENEFIT
(Services & supplies furnished within 90 days of accident)

<table>
<thead>
<tr>
<th>First $300</th>
<th>100%</th>
<th>100%</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible Applies</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>OVER $300</td>
<td>85%</td>
<td>65%</td>
<td>80%</td>
</tr>
<tr>
<td>Calendar Year Deductible Applies</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### WELL CHILD CARE
(Scheduled from birth through age 6 - refer to provision for complete details)

<table>
<thead>
<tr>
<th>Co-Payment Percentage</th>
<th>85%</th>
<th>65%</th>
<th>80%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible Applies</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Maximum Number of Visits From Birth Through 6 ...</td>
<td>12</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>(Separate preventative benefit beginning at age 7 and up)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Co-Payment Percentage</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Calendar Year Deductible Applies</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Total Maximum Benefit Per Calendar Year</td>
<td>$150</td>
<td>$150</td>
<td>$150</td>
</tr>
</tbody>
</table>

### ANNUAL PHYSICAL EXAMINATION
(For covered employees and their spouses only - refer to provision for complete details)

<table>
<thead>
<tr>
<th>Co-Payment Percentage</th>
<th>100%</th>
<th>100%</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible Applies</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Total Maximum Benefit Per Calendar Year</td>
<td>$300</td>
<td>$300</td>
<td>$300</td>
</tr>
</tbody>
</table>

### COLONOSCOPY (refer to COVERED MEDICAL BENEFITS for complete details)
(NOT A YEARLY BENEFIT)

<table>
<thead>
<tr>
<th>Co-Payment Percentage</th>
<th>85%</th>
<th>65%</th>
<th>80%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible Applies</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### SKILLED NURSING/EXTENDED CARE/CONVALESCENT FACILITY*

| Co-Payment Percentage | 100% | 100% | 100% |
| Maximum Room and Board Allowance | Semi-Private | Semi-Private | Semi-Private |
| Maximum Allowable Time between Hospital Discharge and SNF Admission | 14 Days | 14 Days | 14 Days |
| Calendar Year Deductible Applies | Yes | Yes | No |
| Maximum Length of Stay Per Confinement | 90 Days | 90 Days | 90 Days |

*Precertification Is Mandatory. Failure To Comply Will Result In A Reduction Of Benefits. See the Utilization Review Process Provision For Details.

All Out-Of-Network benefit payment are limited to Usual, Reasonable and Customary Charges.
SUMMARY OF MEDICAL BENEFITS (Continued)

<table>
<thead>
<tr>
<th>CO-PAYMENT PERCENTAGES PAYABLE</th>
<th>PLAN A</th>
<th>PLAN B</th>
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<tbody>
<tr>
<td></td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
</tbody>
</table>

**BIRTHING CENTERS/MIDWIVES' SERVICES**

Co-Payment Percentage ........................................ 100% ................. 100% ................. 100%
Calendar Year Deductible Applies ................ No ................. No ................. No

**HOME HEALTH CARE***

Co-Payment Percentage ........................................ 100% ................. 100% ................. 100%
Maximum Number of Visits Per Calendar Year ...... 90 .................... 90 ................. 90
Calendar Year Deductible Applies ................ Yes ..................... Yes ................. Yes

**HOSPICE CARE***

**Inpatient**

Co-Payment Percentage ........................................ 100% ................. 100% ................. 100%
Calendar Year Deductible Applies ................ No ................. No ................. No
Maximum Daily Allowance ................................. $150/Day ........... $150/Day ........... $150/Day
for 6 Mths .......... for 6 Mths ........... for 6 Mths

**Outpatient**

Lifetime Maximum Benefit ................................. $2,000 ............. $2,000 ............. $2,000

**TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)**

Co-Payment Percentage ........................................ 50% .................... 50% ................. 50%
Calendar Year Deductible Applies ................ Yes ..................... Yes ................. Yes

**CHIROPRACTIC CARE**

Co-Payment Percentage ........................................ 50% .................... 50% ................. 50%
Calendar Year Deductible Applies ................ Yes ..................... Yes ................. Yes
Maximum Benefit Per Year ................................. $1,000 ............. $1,000 ............. $1,000

**MENTAL AND NERVOUS TREATMENT**

**Inpatient**

Co-Payment Percentage ........................................ 50% .................... 50% ................. 50%
Calendar Year Deductible Applies ................ Yes ..................... Yes ................. Yes
Maximum Days Per Calendar Year ................... 30 Days ............. 30 Days ............. 30 Days

**Outpatient**

Co-Payment Percentage ........................................ 50% .................... 50% ................. 50%
Calendar Year Deductible Applies ................ Yes ..................... Yes ................. Yes
Maximum Visits Per Calendar Year .................. 20 Visits .......... 20 Visits ........... 20 Visits

*Precertification Is Mandatory. Failure To Comply Will Result In A Reduction Of Benefits. See the Utilization Review Process Provision For Details.

All Out-Of-Network benefit payment are limited to Usual, Reasonable and Customary Charges.
### SUMMARY OF MEDICAL BENEFITS (Continued)

#### PLAN A

<table>
<thead>
<tr>
<th>Benefit</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
<th>NOT AVAILABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ALCOHOL AND DRUG ABUSE TREATMENT</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Co-Payment Percentage</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Calendar Year Deductible Applies</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Maximum Days Per Calendar Year</td>
<td>30 Days</td>
<td>30 Days</td>
<td>30 Days</td>
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<tr>
<td><strong>Outpatient</strong></td>
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<td></td>
<td></td>
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<tr>
<td>Co-Payment Percentage</td>
<td>50%</td>
<td>50%</td>
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<tr>
<td>Calendar Year Deductible Applies</td>
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<tr>
<td>Maximum Benefit Per Calendar Year</td>
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<td>$1,500</td>
<td>$1,500</td>
</tr>
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</table>

#### PRESCRIPTION DRUG EXPENSE BENEFIT

| Medco Mail Order Program (90 DAY SUPPLY)     |            |                |               |
| Co-Payment                                  | $20.00     | $60.00         | $110.00       |
| Calendar Year Deductible Applies            | No         | No             | No            |
| Birth Control Pills                          | Covered    | Covered        | Covered       |

| Medco/Prescription Drug Network Retail       |            |                |               |
| Co-Payment                                  | $10.00     | $30.00         | $55.00        |
| Calendar Year Deductible Applies            | No         | No             | No            |

**Non-Network Provider**

Non-Network Pharmacy will be paid at 50% through the medical plan and it does not track to Deductible or Co-insurance.

*Note:* The Inpatient and Outpatient charges for Mental Disorders and Substance Abuse will not be counted toward the Maximum Out-of-Pocket Expense, and 100% payment by the Plan is not available for these charges even upon satisfaction of the Maximum Out-of-Pocket Expense.

### Referral to Non-PPO Provider from PPO Provider

Covered services obtained from a Non-PPO Provider will be covered at PPO percentages and rates if the Covered Person was referred to a Non-PPO Provider by the treating PPO Provider, subject to receipt of a letter of Medical Necessity by the referring physician.

### Life-Threatening or Emergency Services

Covered services will also be considered at PPO levels if an accident, Injury or Illness occurs and immediate services are required inside or outside the PPO covered area.

### Services Not Available From a PPO Provider

Covered services not available from a PPO Provider will be payable on the same basis as if received at a PPO Provider.

### Non-PPO Ancillary Services

Non-PPO Providers of ancillary services, (assistant surgeons, lab, radiology, anesthesia, emergency room physicians) will be paid at the PPO level when rendered at a PPO facility and/or services performed were provided outside the patient’s control or election.
PRECERTIFICATION AND UTILIZATION REVIEW PROGRAM

Precertification (also referred to as Pre-Admission Review) is MANDATORY under the ERAU Health Care Plan for the following benefits in order for full benefits to be paid.

1. Emergency and non-emergency Inpatient Hospital Admissions, including Inpatient treatment of Mental and Nervous Disorders or Alcohol and Drug Abuse.

2. Scheduled In-patient and Outpatient surgery.

3. Admission to a skilled nursing, extended care or convalescent facility.

4. Home Health Care

5. Hospice Care

6. The following outpatient diagnostic/therapeutic services:
   - Acupuncture
   - Allergy Testing (RAST)
   - Arthroscopy
   - Bronchoscopy
   - Cardiac Catheterization
   - Cardiac Stress Test – (Chemical Test)
   - Chronic Villus Sampling (CVS)
   - Colonoscopy
   - Cystoscopy
   - Gastric Balloons
   - Gastric Shunts
   - Gastric, Stomach Bypass or Stapling
   - Home Health Care
   - Hospice Services
   - Intestinal Bypass
   - Hyperbaric Oxygen Therapy
   - Interventional Pain Management
   - Jaw Wiring
   - Jejunal Bypass
   - Laparoscopy
   - Laser Therapy
   - Lithotripsy
   - Myelogram
   - Nasal Endoscopy
   - Panendoscopy/Upper Endoscopy
   - Procedures designed to Restrict Assimilation of Food

The diagnostic/therapeutic services listed above are subject to all precertification procedures and penalties.

7. Repair or replacement of Durable Medical Equipment in excess of $250.00.

8. Services rendered at the Specialty Hospitals as defined by Volusia Health Network.

Please Note:
If you do not follow the Pre-Admission/Pre-Surgery certification procedure outlined below, a penalty of $200 per event will be applied.

If the Pre-Admission/Pre-Surgery certification procedure is followed, but certification is not approved by the utilization review agency, the benefit will be reduced by $200.
Pre-Certification is not a guarantee that benefits are payable. Benefit payments are subject to plan provisions.

All referrals to Physicians and Hospitals not listed in the Provider Directory must be pre-approved by the campus’ PPO provider network prior to services being obtained, in order for In-Network benefits to apply.

Precertification and Utilization Review will be performed by Volusia Health Network (VHN). VHN may be contacted 24 hours a day, 7 days a week at 1-800-741-2198 or 386-258-4801.

You or the Physician must notify the appropriate precertification provider by telephone prior to the scheduled Inpatient admission or the start of other care requiring Precertification.

If the admission is for a Medical Emergency, you or someone in your behalf should contact the appropriate precertification provider immediately or within 48 hours following the Emergency admission. See the Definitions section for what constitutes a Medical Emergency.

SPECIAL NOTE: All Precertification and Utilization Review requirements of the Plan will not apply to Surgical and treatment procedures associated with mastectomies of the Covered Employee or Covered Dependent as required pursuant to the Women’s Health and Cancer Rights Act of 1998. Nor shall they apply to Hospital admissions of expectant mothers and newborns that are for periods no longer than 48 hours following a normal vaginal delivery, or 96 hours following a cesarean section delivery as required by the Newborns’ and Mothers’ Health Protection Act of 1996, however, recommended stays longer than these periods will require you to follow the Precertification and Utilization Review Program of the Plan.

PRE-ADMISSION REVIEW. Pre-admission Review determines if a Hospital Admission or other care requiring Precertification is appropriate. The number of days of Hospital confinement necessary for the care and treatment of the Covered Person is certified at the time of Pre-admission Review. If the Hospital stay or the start of other care must be postponed past the stated date of service, a new Precertification request must be made.

After a completed Pre-admission Review request for non-urgent care has been appropriately submitted, and if no additional information is required, the pre-certification provider will generally complete its determination of the claim within a reasonable period of time, but no later than [15] calendar days from receipt of the request. If an extension of time to make a decision is necessary due to circumstances beyond the control of the pre-certification provider, the pre-certification provider will, within [15] calendar days from receipt of the Pre-admission Request, provide the Covered Person (or authorized representative) with a notice detailing the circumstances and the date by which the pre-certification provider expects to render a decision.

If the circumstances include a failure to submit necessary information, the notice will specifically describe the needed information. The Covered Person will have [45] calendar days to provide the information requested, and the pre-certification provider will complete its determination of the claim no later than [15] calendar days after receipt by the Plan of the requested information. Failure to respond in a timely and complete manner will result in a denial.

Please keep in mind that Precertification does not mean that all charges incurred will be covered nor does it guarantee payment of any benefits. All other terms, limits, and exclusions of the Plan still apply.
CONTINUED STAY REVIEW. Continued stay review is a process to assure that the length of stay in the Hospital is appropriate for your medical condition whether you are admitted for non-Emergency or Emergency treatment.

If your Physician believes that Hospitalization is required beyond the approved initial length of stay, he or she may request an extended length of stay by contacting the appropriate pre-certification provider. You, the attending Physician, the Hospital, and the Plan Administrator will be notified if such extended length of stay is authorized. Continued stay review requests that involve non-urgent care will be processed within [15] calendar days after the request was received. If such extended length of stay is not requested, or if requested, is not approved, the non-pre-certification penalty described above will apply.

If the pre-certification provider determines that the hospital stay or course of treatment should be shortened or terminated before the end of the fixed number of days and/or treatments, or the fixed time period that was previously approved, then the pre-certification provider will notify the Covered Person (or authorized representative) of the proposed change, and allow the Covered Person (or authorized representative) to file an appeal and obtain a decision, before the end of the fixed number of days and/or treatments, or the fixed time period that was previously approved.

NOTICE OF DENIAL; OPPORTUNITY TO APPEAL. If a Pre-admission Review or a continued stay review results in a denial, in whole or in part, the Plan Administrator or its designee will provide the Covered Person (or authorized representative) with a written notice of adverse determination. For the contents of the denial notice and the Covered Person’s right to appeal, see the Section below entitled, APPEALS PROCEDURES.

DISCHARGE PLANNING. When Hospitalization is no longer necessary, the appropriate pre-certification provider will work with you and your Physician to provide for your continued needs by assisting in arranging for home care services, skilled nursing care, or medical equipment that you will require. This process helps assure that every patient is provided with appropriate care after an Inpatient Hospital stay.

MEDICAL CASE MANAGEMENT. The primary objective of Medical Case Management is to identify and coordinate cost effective medical care alternatives to help manage the care of patients who have catastrophic or extended care Illnesses or Injuries.

Medical Case Management also monitors the care of the patient, offers emotional support to the family, and coordinates communications among health care providers, patients and others. Prior to any final determination, severity of condition and prognosis are taken into consideration.

The appropriate pre-certification provider assesses the need for alternative care and, when necessary, will refer the case for Medical Case Management.

The organization providing Medical Case Management services may arrange for review and/or medical case management services from a professional qualified to perform such services. The Plan Administrator has the right to alter or waive the normal provisions of this Plan when it is reasonable to expect a cost-effective result without a sacrifice to the quality of care.

In addition, the organization providing Medical Case Management services may recommend (or change) alternative methods of medical care or treatment, equipment or supplies that are either (i) not Covered
Expenses under the Plan or (ii) Covered Expenses under the Plan but on a basis that differs from the alternative recommended by the organization providing Medical Case Management services.

The recommended alternatives will be considered as Covered Expenses under the Plan; provided, that the expenses can be shown to be viable, Medically Necessary, and are included in a written case management report or treatment plan proposed by the organization providing Medical Case Management Services.

The Plan Administrator has the right to waive the normal provisions of The Plan if a proposed alternative meets accepted standards of medical practice and is shown to be cost effective without sacrifice to the quality of patient care.

The Utilization Management Program also includes services for the management of large or potentially large claims. On a case by case basis as selected by The Plan Sponsor, the Utilization Management Organization will provide an initial assessment of the patient, summarize the patient's continuing medical needs, assess the quality of current treatments, coordinate alternative care when appropriate and approved by the Physician and Plan Sponsor, review the progress of alternative treatment after implementation, and make appropriate recommendations to The Plan Sponsor.

In conjunction with these services, The Plan Sponsor reserves the right to monitor health care and modify Plan benefits to assure that high-quality medical care is provided in the most cost-effective settings.

SPECIAL NOTICES

It is the Employee's or Covered Person's responsibility to make certain that the compliance procedures of this program are completed. To minimize the risk of reduced benefits, an Employee should contact the review organization to make certain that the Hospital or attending Physician has initiated the necessary processes.

Also, prior authorization is not a guarantee of Coverage. The Utilization Review Program is designed ONLY to determine whether or not a proposed course of treatment is appropriate. Benefits under the Plan will depend upon the person's eligibility for Coverage and the Plan's limitations and exclusions.
YOUR ELIGIBILITY AND EFFECTIVE DATES

Employee Eligibility.

Who is Eligible

1. Class A – All full-time staff employees or 9, 10 and 11 month work schedule employees who work at least 30 hours per week on an ongoing basis.

2. Class B – All full-time faculty, including 9, 10 and 11 month work schedule faculty as defined by the University.

3. All eligible employees who retire while covered by this Plan are eligible for Retiree or COBRA coverage.

Full-time regular employees become eligible the first day of the month following one (1) month of employment.

Weekends and holidays (traditional and/or Company) that defer an employee's initial employment date will be applied to an employee's waiting period for coverage. This only applies if the first day of work is the beginning of the month.

The waiting period will have been satisfied for a “Regular” part-time employee (temporary employees excluded)” who has worked no less than three (3) months and converts to full-time status.

Benefit elections must be submitted to Human Resources Department before the employee's eligibility date.

Dependent Eligibility. Each Dependent is eligible to enroll only if such person satisfies the definition of Dependent as set forth in the Definitions section. If both spouses are eligible for Coverage under the Plan as an Employee, one may enroll as a Dependent or both may enroll as Employees. An Employee cannot be covered as both an Employee and as a Dependent under this Plan.

Eligible dependents include the following:

A. employee's wife or husband as evidenced by legal document;
B. employee’s “domestic partner” is an individual with whom the Employee has united in a serious, committed relationship. Such relationship is intended as a consideration of life partnership between the employee and his/her domestic partner.

The following criteria are required to establish the relationship:

a. the employee must file an Affidavit of Domestic Partnership with the Plan Administrator;
b. the two parties are each other's sole domestic partner and intend to remain so indefinitely;
c. they are of the same or opposite sex and neither one is married;
d. they are at least 18 years of age and mentally competent to consent to the contract;
e. they are not related by blood to a degree of closeness that would prohibit legal marriage in the state in which they legally reside;
f. they reside together in the same residence and intend to do so indefinitely;
YOUR ELIGIBILITY AND EFFECTIVE DATES (Continued)

g. they are jointly responsible for each other’s common welfare and financial obligations;

h. they understand that as domestic partners they are subject to the same enrollment period governing all other Employee’s spouses who are covered under or applying for coverage under Embry-Riddle Aeronautical University Health Care Plan; and

i. The domestic partners have been living together at the same residence and have been engaged in a committed, mutually exclusive relationship for a minimum of 12 months

If there is any change in the domestic partnership, the Plan Administrator must be notified within 31 days of such change by filing a "Statement of Termination of Domestic Partnership." A subsequent Affidavit of Domestic Partnership cannot be filed until twelve (12) months after a Statement of Termination of a previous partnership has been filed with the Plan Administrator.

The definition of "Employee’s Dependent Eligibility" will be expanded to include children of a non-employee domestic partner if the covered domestic partner who is the Employee has legally assumed principal support and maintenance for the child(ren) and live in a child/parent relationship.

C. employee's unmarried dependent children up to the end of the month of their 19th birthday, including natural children; children placed under legal guardianship through the court; and legally adopted children and stepchildren living in a parent and child relationship. Also, included are employee's children (or children of employee's spouse) for whom there is legal responsibility resulting from a qualified medical support order. These children may be covered up to the end of the month of their 26th birthday provided they are your dependents, are registered in an accredited school as a part-time or full-time student as defined in the regulations of the school which he is attending. For Coverage to continue during vacation periods, the child must be scheduled to enter school on the next Enrollment Date or, if not so enrolled, would have been eligible to enroll but were prevented from doing so due to illness or injury, are not employed on a full time basis and rely upon the employee for support and maintenance.

D. the term "children" also shall include pre-adopted children (i.e., children placed with a Covered Employee in anticipation of adoption.) Such children will be provided Coverage under the same terms and conditions that apply to Dependents who are an Eligible Employee's natural children, irrespective of whether the adoption has become final, and with no preexisting conditions limitations applied provided the Dependent is enrolled in a timely manner as stated within.

E. unmarried children who are mentally or physically disabled and totally dependent upon the employee for support may remain enrolled on your coverage regardless of age. Certification of the disability is required within 31 days of attainment of age 19. A form for such certification may be required periodically by the Plan.
YOUR ELIGIBILITY AND EFFECTIVE DATES

F. A newborn baby will be covered from birth (or the date adoptive child is placed in the custody of the Employee) if Employee has Dependent coverage in effect on other family members at the time of birth (or adoptive placement), however an enrollment form must be completed on the new dependent. If Dependent coverage is not in effect, the newborn (adoptive child) must be enrolled within 31 days of birth (adoptive placement) in order for coverage under the plan to be effective on the date of birth (adoptive placement). In order to enroll, the Human Resources Department must be notified and contributions at the family rate must begin the pay period following birth (adoptive placement) of the child. After 31 days, the Late Enrollee provision will apply, and an up to 18 month Pre-Existing Condition limitation will apply.

G. No one will be eligible as a dependent during active military service.

Eligibility Waiting Period. To be eligible to enroll in the Plan, you must first complete the Eligibility Waiting Period, which is 31 days of active Full-Time Work. If an Employee is hired as (i) temporary, (ii) an independent contractor, (iii) subject to an outsourcing agreement, or (iv) a leased employee, and subsequently becomes reclassified as a Full-Time Employee, the Eligibility Waiting Period will apply and begin from the date of reclassification as a Full-Time Employee.

Enrollment When Newly Hired or Newly Eligible. If you are a Full-Time Employee, you have 31 days beginning with your first day of Full-Time Work to enroll yourself and any eligible Dependent in the Plan by delivering a completed Enrollment Form to the Plan Administrator. If you fail to enroll during the initial 31-day period, you must wait until the next Annual Enrollment to enroll in the Plan (except as specified in the Changes in Status and Special Enrollment sections below).

Annual Enrollment and Late Applicants If you do not enroll yourself and your Dependents for the Coverage when first eligible, enrollment in the Plan will not be available until the next Annual Enrollment Period, unless there is a Mid-Year Change in Status or a Special Enrollment Period (see below). A Pre-Existing Condition Limitation of up to 18 months may also apply to Late Applicants.

The specific open enrollment dates are announced each year. The second is when an employee incurs a "Status Change", as defined under the Flexible Benefit Plan. The third is when an employee incurs a "Special Enrollment", as defined under the Special Enrollment Rules. During these three times, an employee may change their current enrollment status. For the Daytona Beach Campus only, currently covered employees and dependents may choose between the HMO and the ERAU Health Plan.

Employees who change to the ERAU Health Plan will be subject to the Plan's Pre-Existing Condition limitations based on their original coverage effective date. Refer to the section entitled Your Right To Demonstrate Creditable Coverage.
YOUR ELIGIBILITY AND EFFECTIVE DATES (Continued)

Employee Reinstatement

Employees and eligible Dependents who lost Coverage due to an approved leave of absence, layoff, or termination of employment with the Employer are eligible for reinstatement of Coverage as follows:

1. Reinstatement of Coverage is available to Employees and Dependents who were previously covered under the Plan.

2. Rehire or return to active service must occur within six (6) months of the last day worked.

3. The Employee must submit the completed application for enrollment to Human Resources within 31 days of rehire or return to work.

4. Coverage shall be effective the first of the month following the date of rehire or return to work subject to the pre-existing condition provision in the Plan. You will not receive credit for any amounts applied to your deductibles and out-of-pocket amounts.

If the provisions of (1) through (3) above are not met, the Plan's provisions for eligibility, application for enrollment and waiting period shall apply.

Except as otherwise required under this Plan or by law, an Employee who returns to work more than 24 months following an approved leave of absence, layoff, or termination of employment will be considered a new Employee for purposes of eligibility and will be subject to all eligibility requirements, including all requirements relating to the effective date of coverage and any pre-existing condition limitations.

Special Enrollment Due to Acquisition of New Dependent(s). In addition, a newly acquired Dependent may be enrolled within 31 days from the date:

1. You marry, for Spouse and stepchildren:

2. A child is born to you (see Newborn Enrollment Requirements);

3. You adopt a child or have a child placed for adoption ("placed" means that you have accepted legal responsibility for that child); or

4. A child for whom you become a foster parent.

The Employee is responsible for timely forwarding to Human Resources all enrollment materials for Dependents. If timely enrolled, Coverage for the newly acquired Dependent is the effective date of the birth, adoption, or placement for adoption, or assumption of legal responsibility as a foster parent, as applicable.

In addition, if you have a new Dependent or Dependents as a result of marriage and you are otherwise eligible for coverage under the Plan, you may enroll yourself and your new Dependent(s) provided that you request enrollment within 31 days after the marriage. If timely application is made, coverage will be effective on the first day of the month following receipt of the fully completed enrollment form.
Newborn Enrollment Requirements. Please enroll your newborn as soon as possible, but not later than 31 days after birth. Your newborn child is automatically covered at birth for 31 days. For Coverage to continue beyond 31 days, you must timely notify your Employer of the birth and pay any required contributions. If notification and contributions are not timely made, coverage will terminate at your child's date of birth. Note: Your claim for maternity expenses is not considered as notification to your Employer for Coverage to continue beyond 31 days.

Special Enrollment Due to Loss of Other Coverage However, if you declined enrollment in the Plan for yourself or your Dependents (including your Spouse) because of other health insurance coverage, you may in the future be eligible for Special Enrollment which would allow you to enroll yourself or your Dependents in the Plan, but only if both of the following occur:

(1) At the time you decline coverage, you give a written statement to the Plan Administrator that the reason you and/or your Dependents are declining enrollment is because of coverage under another group health plan or other health coverage; and

(2) You request enrollment in the Plan within 31 days after the other coverage ends.

If you meet these requirements, your Coverage will be effective on the first day of the month following receipt of the fully completed enrollment form and a Pre-Existing Condition Limitation of up to 12 months may apply.

To verify your eligibility for this Special Enrollment, the Plan Administrator may request and obtain information, such as the reasons your prior coverage terminated. Acceptable reasons are a loss of coverage due to (i) termination of the other coverage (including exhaustion of COBRA benefits), (ii) cessation of an employer's contribution towards the other coverage, or (iii) loss of eligibility for the other coverage (for example, due to legal separation, divorce, death, termination of employment, reduction in the number of hours worked, reaching a lifetime maximum for benefits, or no longer living or working in the service area and no other benefit package is available). Reasons that are not acceptable are failure to pay premiums on a timely basis or termination of other coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Plan).

Mid-Year Change in Status. In addition to the enrollment opportunities during an Annual Enrollment Period and the Special Enrollment periods described above, an Employee may change benefit options or modify enrollment if one of the following Change in Status events occurs, but only in a manner that is consistent with the Internal Revenue Service (IRS) requirements and restrictions on the types of benefit or enrollment changes that may be made on account of such Change in Status event. Changes in Status events include:

1. Change in family status. A change in family status shall include only:
   a. Change in Employee's legal marital status;
   b. Change in number of Dependents;
   c. Change in employment status of the Employee, Spouse or Dependent, including termination or commencement of employment;
   d. Dependent satisfies (or ceases to satisfy) Dependent eligibility requirements;
   e. Change in residence or worksite of Employee, Spouse or Dependent.

2. Significant change in coverage or the cost of coverage under the Employer's group medical plan.
YOUR ELIGIBILITY AND EFFECTIVE DATES (Continued)

3. Taking or returning from a leave of absence under the Family and Medical Leave Act of 1993.

4. Change in the coverage under another employer plan (including a plan of the Employer or another employer).

5. A Special Enrollment Period as mandated by the Health Insurance Portability and Accountability Act of 1996.

6. A court order, judgment or decree.

7. Entitlement to Medicare or Medicaid.

8. A COBRA qualifying event.

If, as a result of a Change in Status, you have the right to add additional Coverage, then you will have 31 days after the date of the event that constituted the Change in Status to notify the Plan of your new election. Coverage will be effective on the first day of the month after the date application for Coverage is made. If you fail to notify the Plan within this 31-day period, you would not be eligible to apply for the additional Coverage until the next Annual Enrollment period. A Pre-Existing Condition Limitation of up to 18 months may apply from the date application is made. Any election change made as a result of a Change in Status must be consistent with and on account of such Change in Status.

If, as a result of a Change in Status, you have the right to reduce Coverage, then you will have 30 days after the date of the Change in Status to notify the Plan of your election to reduce coverage.

If you notify the Plan within this 30-day period, the reduced Coverage will apply retroactively to the date acceptable proof of the Change in Status is supplied to the Plan Administrator. If, however, you notify the Plan after this 30-day period, you will not be entitled to a refund of any premiums you may have paid after the date of the "Change in Status."

**Statement of Non-Discrimination in Eligibility Requirements.** No individual, Employee or Dependent, otherwise eligible for coverage under the Plan, shall be denied enrollment into the Plan on the basis of a health factor. In addition, the following Plan eligibility restrictions shall not apply:

a. timely or late entrant evidence of good health;
b. individual hospital confinement and disability deferred effective dates;
c. hazardous occupations and recreational activities; and not being actively at work, if the reason for the absence is an Illness or Injury.
TERMINATION OF COVERAGE

Termination of Employee Coverage. Termination of an Employee’s Coverage occurs on the earliest to occur of the following events: (1) the Employee is no longer in an eligible class of Employees, (2) the Employee is no longer making required contributions, (3) the Employee elects to terminate Coverage as permitted during an Annual Enrollment period, (4) enters full-time military service, (5) termination of the Employee’s employment, or (6) termination of the Plan or amendment to the Plan to terminate that type of coverage.

Termination of Dependent Coverage. A Dependent's Coverage Will End the Earliest of When:

- The period ends for which the last required contribution is made for dependent coverage.
- Group coverage ends.
- The class of person to which the employee belongs is no longer eligible for dependent coverage.
- The employee's coverage ends.
- Divorce – Spouse Coverage will terminate the end of the month in which the divorce is final.

Plan Termination. The Plan (or any of its benefits) terminates on the earliest to occur of date on which your Employer: (1) terminates any or all benefits under the Plan, (2) discontinues or suspends active business operation, (3) is placed in bankruptcy (except Chapter 11) or receivership, or (4) loses its business by dissolution, merger or otherwise, unless other arrangements are made.

LEAVE OF ABSENCE

Should a covered employee be away from work on an approved, paid or unpaid leave of absence, they may elect to continue benefits at their expense for up to 24 months. Disability benefits are not applicable during a leave of absence.

If the covered employee has health coverage at the time of leave of absence and they elect to continue coverage, they must pay the full cost for health, life, and AD&D benefits. These benefits are provided as a package and may not be obtained separately. If the employee is not covered for health benefits they may continue the other coverages. This may be continued for up to 24 months.

Upon notification from a qualified beneficiary under Leave of Absence, FBMC will prepare and mail the initial notice to the qualified beneficiary indicating the contribution amount due for continued coverage; the grace period for payment of premiums; and the termination provisions for non-payment of premium. Coverage will be terminated if employee premiums are more than 30 days delinquent.

Should the employee choose not to continue coverage during the leave of absence, pre-existing conditions will be in effect for health and disability benefits upon their return. The waiting period and medical review will be waived provided the employee returns to work within 24 months.
RETIREE COVERAGE
As of January 1, 2001

As of January 1, 2001, ERAU offered coverage for its Retirees. In order to be eligible for coverage, the Retiree’s years of service with ERAU and their age combined must equal at least 70.

At the time of retirement, the Retiree must make their decision to take the Retiree Plan, COBRA or refuse coverage with ERAU. If the Retiree does not elect the Retiree Plan at the time of retirement, they may not enroll in it in the future.

When an employee becomes eligible for Retiree or COBRA benefits the employee must choose the same type coverage he or she had while being an active employee. For example, if the active employee has single coverage he or she must choose single coverage as a Retiree or COBRA participant.

If the Retiree elects the Retiree Plan at the time of retirement, they must stay with the Plan they have chosen for the duration of their coverage. For example, if the Retiree elects single coverage upon retirement, they may not at a later date add their spouse to their coverage.

A Retiree and his/her spouse will only be eligible for the Retiree Plan up to age 65 at which time they will be terminated from the Plan. If the Retiree turns 65 before their spouse, their spouse may remain on the Plan with single coverage without the Retiree. If the Retiree’s coverage ends due to turning age 65 or upon their death, their spouse may remain on the Plan with single coverage; however, the spouse’s coverage will end once they turn 65. The retiree (employee) must elect coverage for themselves to be eligible for coverage for their spouse. If the Retiree cancels their coverage voluntarily, they (including their spouse) are not eligible for COBRA.

If ERAU were to eliminate the Retiree Plan or if there was a significant change in premium and the Retiree and their spouse were on the plan they would be eligible for COBRA and may continue for 18 or 36 months.

Premiums for the Retiree Plan will be paid for by the Retiree. The premium rates are subject to change as determined by the Plan actuary. Premium payments should be made within 30 days of the due date, if not coverage will be terminated and can not be reinstated.
EXTENSION OF COVERAGE

In the circumstances identified below, Coverage may be continued beyond the date on which it would otherwise terminate. Unless expressly stated otherwise, however, Coverage for a Dependent will not extend beyond the date the Employee's Coverage ceases.

EXTENSION OF COVERAGE FOR HANDICAPPED DEPENDENT CHILDREN

If a Covered Dependent child attains the age which would otherwise terminate his status as a "Dependent" and:

1. if on the day immediately prior to the attainment of such age the child was a Covered Dependent under the Plan; and

2. at the time of attainment of such age the child is incapable of self-sustaining employment by reason of mental retardation or physical handicap or disability which commenced prior to the attainment of such age; and

3. such child is primarily dependent upon a parent for support and maintenance;

then such child's status as a "Dependent" will not terminate solely by reason of his having attained the specified age and he will continue to be considered a Covered Dependent under the Plan so long as he remains in such condition, and otherwise conforms to the definition of "Dependent."

The Employee must submit to the Contract Administrator proof of the child's incapacity within thirty-one (31) days of the child's attainment of such age, and thereafter as may be required, but not more frequently than once a year after the two-year period following the child's attainment of such age.

FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA)

Regardless of the Employer's established Leave of Absence policy, this Plan will at all times comply with the regulations under the Family and Medical Leave Act of 1993, as amended (FMLA) as set forth by the Department of Labor. An Employee who is eligible for unpaid leave and benefits under the terms of the FMLA has the right to continue coverage under this Plan for up to twelve (12) weeks during any twelve (12) month period.

If the Covered Employee fails to make the required contribution during a FMLA leave within thirty (30) days after the date the contribution was due, the Coverage will terminate effective on the date the contribution was due. If coverage under the Plan was terminated during an approved FMLA leave, and the Employee returns to active work immediately upon completion of that leave, Coverage will be reinstated on the date the Employee returns to active work, provided that the Employee makes any necessary contributions and re-enrolls within thirty (30) days of his return to active work.

If an Employee does not return to work from FMLA leave, Coverage under this Plan will terminate unless election is made to continue Coverage under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). The Qualifying Event for purposes of COBRA is the date the Employee's employment is formally terminated and not the date the Employee first took the FMLA leave.
EXTENSION OF COVERAGE (Continued)

It is the Plan's intent to comply with all requirements of the Family Medical Leave Act. If any Plan provision is incomplete or in conflict with the requirements of the law or its Amendments, the law will prevail.

EXTENSION OF COVERAGE DURING MILITARY SERVICE
Regardless of an Employer's established Leave of Absence policy, the Plan will at all times comply with the regulations of the Uniformed Services Employment and Reemployment Rights Act (USERRA) for an Employee or Dependent entering or returning from military service. If an Employee is called for active duty by the United States Armed Services (including the Coast Guard, the National Guard or the Public Health Service), the Employee and the Employee's Dependent may continue their health coverage pursuant to USERRA.

When the leave is less than thirty-one (31) days, the Employee and the Employee's Dependent may not be required to pay more than the Employee's share, if any, applicable to that coverage. If the leave is thirty-one (31) days or longer, then the Plan Administrator (or its designee) may require the Employee and the Employee's Dependent to pay no more than one hundred and two percent (102%) of the full contribution.

The maximum length of the continuation coverage required to be made available under USERRA is the lesser of:

1. Twenty-four (24) months beginning on the day that the leave commences, or
2. A period beginning on the day that the leave began and ending on the day after the Employee fails to return to employment within the time allowed.

The period of continuation coverage under USERRA will be counted toward any continuation coverage period concurrently available under COBRA. Upon return from active duty, the Employee and the Employee's Dependent will be reinstated without pre-existing conditions exclusions or a waiting period, regardless of their election of COBRA continuation coverage.

Plan exclusions and waiting periods may be imposed for any Sickness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

Additional information concerning the USERRA can be obtained from your Human Resources Department.

RESUMING COVERAGE UNDER THE PLAN AFTER BEING COVERED UNDER COBRA
Coverage under the Plan will resume for any former Employee who has [or had] Coverage under COBRA and returns to work with the Company. Coverage for the Employee and Covered Dependents will be the same as the Coverage that was in effect under COBRA Continuation Coverage.

The “Eligibility Waiting Period” and “Employee Reinstatement” provisions (under ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE) do apply to individuals returning to work after electing COBRA coverage.

Individuals will be credited with the amount of time they were covered under the Plan prior to and including any time covered under COBRA toward satisfying any Pre-Existing Conditions Limitations, Exclusions or similar provisions under the Plan.
GENERAL MEDICAL PROVISIONS

Benefits available under this Plan are subject to some basic conditions, including the following:

MEDICAL NECESSITY. The Plan provides benefits only for Covered Services and supplies that are Medically Necessary for the treatment of a covered Illness or Injury. The treatment must also be generally accepted by medical professionals in the United States and not be Experimental or educational in nature. The fact that a physician may prescribe, order, recommend, or approve a service or supply does not, in itself, make it Medically Necessary or make the charge an allowable expense, even though it is not specifically listed as an exclusion.

USUAL, REASONABLE AND CUSTOMARY CHARGES. The Plan provides benefits only for Covered Expenses that are equal to or less than the Usual, Reasonable and Customary Charge in the geographic area where services or supplies are provided. Any amounts that exceed the Usual, Reasonable and Customary are not recognized by the Plan for any purpose.

LIFETIME. The word Lifetime, as used in this document, means the total period of time a Covered Person participates in this Plan, including any one or more interrupted periods of Coverage in the Covered Person's lifetime.

DEDUCTIBLES. A Deductible is the amount that must be paid toward Covered Expenses before the Plan will start reimbursement.

CALENDAR YEAR DEDUCTIBLE. Once each Calendar Year each separate Covered Person must satisfy the Individual Calendar Year Deductible amount shown in the Summary of Medical Benefits. Benefits are based on the person's Covered Expenses that exceed the Deductible amount.

FAMILY DEDUCTIBLE. The Family Deductible can be satisfied by combining the amounts paid toward Covered Expenses for all covered family members. The Family Calendar Year Deductible amount is shown in the Summary of Medical Benefits.

One family member cannot satisfy more than one times the individual deductible amount. When the Family Deductible is satisfied, no further Deductible will be applied for any covered family member during the remainder of that year.

PLAN PERCENTAGES. The Plan Percentage is the portion the Plan will pay for eligible Covered Expenses, after you satisfy any applicable Deductible(s) or Co-payment(s). Your choice of Provider will determine the amount of the Plan Percentage. The Plan Percentages for Covered Expenses are shown in the Summary of Medical Benefits.

TRACKING OUT-OF-POCKET EXPENSES. Not all charges or amounts paid toward Covered Expenses track toward satisfying your Out-of-Pocket expenses, and the Plan Percentage for certain benefits may not be increased even when the Out-of-Pocket Maximum amount has been met.
GENERAL MEDICAL PROVISIONS (Continued)

The following items do not count toward the Out-of-Pocket Maximum amount [and will not be payable at 100% even after the Maximum Out-of-Pocket Expense limit has been satisfied]:

1. Any penalties imposed for failure to comply with any Precertification requirements.
2. Expenses incurred for treatment of Mental Health/Substance Abuse;
3. Expenses above Usual, Reasonable and Customary [or negotiated rate, if applicable].
4. Expenses above the Benefit Maximums stated in the Summary of Medical Benefits.
5. Co-Payments.
6. Expenses incurred as a result of failure to obtain pre-certification.
7. Any ineligible or excluded charges under this Plan.

MAXIMUM OUT-OF-POCKET EXPENSE. The Plan is responsible for paying any Covered Expenses at the Plan Percentage(s) shown in the Summary of Medical Benefits. The remaining portion of the charge, other than the excluded items above, is your Out-of-Pocket expense.

The Maximum Out-of-Pocket Expense is the total amount that must be paid toward Covered Expenses during a Calendar Year before the Plan Percentage automatically increases. However, the Plan Percentage for certain benefits does not increase even when the Out-of-Pocket Maximum amount has been met. Refer to "TRACKING OUT-OF-POCKET EXPENSES" above.

Individual Maximum Out-of-Pocket - When an individual incurs the applicable In-Network or Out-of-Network amounts of covered out-of-pocket expenses plus the deductibles in a calendar year, the benefit percentage during the remainder of that calendar year will be 100%. If both In- and Out-of-Network providers are used, the combined amount accumulated In and Out-of-Network will track toward the calendar year maximum, not to exceed the Out-of-Network maximum. This provision does not apply to mental and nervous conditions, treatment of alcohol and drug abuse, chiropractic treatment and treatment of temporomandibular joint dysfunction (TMJ).

Family Maximum Out-of-Pocket - After members of the same family incur the applicable In-Network or Out-of-Network amounts of covered out-of-pocket expenses, the benefit percentage for the entire family will be 100% for the balance of that calendar year. If both In and Out-of-Network providers are used, the combined amount accumulated In and Out-of-Network will track toward the calendar year maximum, not to exceed the Out-of-Network maximum. This provision does not apply to mental and nervous conditions or treatment of alcohol and drug abuse, chiropractic and TMJ.

BENEFIT MAXIMUMS. Total Plan payments for each Covered Person are limited to certain Benefit Maximums shown in the Summary of Medical Benefits. A Benefit Maximum can apply to a specific benefit or to all benefits. A Benefit Maximum can be a specific dollar limit; a specific limit on services, such as number of visits or days; a specific time period, such as Calendar Year or Lifetime; or any other specific limit imposed upon a benefit, or benefits, by the Plan.

If the Summary of Medical Benefits also contains a separate Lifetime Maximum for a specified condition, the separate Lifetime Maximum is part of, and not in addition to, the Plan Lifetime Maximum amount.

Any benefits paid on behalf of a Covered Person whether covered as an Employee or a Dependent will be combined for purposes of determining the Benefit Maximum.
PRE-ADMISSION TESTING BENEFIT. Covered medical charges made for pre-admission testing performed on an out-patient basis in a hospital, ambulatory surgical center, or physician's office will be payable at 100%. However, these tests must be (1) performed within 7 days prior to confinement as an in-patient for scheduled surgery; (2) related to the condition for which surgery will be performed; (3) ordered by a physician; and (4) followed by admission to the hospital. No benefits will be payable if duplicate testing is required after hospital admission.

MEDCO/PRESCRIPTION DRUG NETWORK RETAIL. The Medco/Prescription Drug Network applies to Employees of Embry-Riddle Aeronautical University covered under the Embry-Riddle Aeronautical University Health Care Plan.

NETWORK PREFERRED PHARMACY PROVIDERS. Benefits are payable for drugs or medications lawfully obtainable only upon the written Prescription of a qualified Physician and dispensed by a licensed Pharmacist.

The preferred pharmacy providers are Medco's Drug Stores and the independent pharmacies in the Network. Your Employer will provide you with a list of the pharmacies that have contracted with the Pharmacy Network to fill your Prescriptions.

For additional information please refer to the literature prepared and distributed to your Employer by the Medco/Pharmacy Network.
PRE-EXISTING CONDITIONS LIMITATION

This Plan contains a Pre-Existing Conditions Limitation. This means if you had a Pre-Existing Condition prior to your Enrollment Date, you may not be covered for this particular condition until you satisfy a Pre-Existing Conditions Limitation period. Once this period has elapsed, you will then have coverage for this condition. However, if you had prior health coverage and have a Certificate of Creditable Coverage from your prior employer, your Pre-Existing Condition Limitation period may be reduced or eliminated. The Certificate of Creditable Coverage shows the number of days that you were covered under your prior health plan and this time may be applied to satisfying your Pre-Existing Conditions Limitation period.

Pre-Existing Condition means a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, prescription drugs or treatment was recommended or received within the six-month period ending on the "Enrollment Date."

Enrollment Date, for these purposes, means the first day of coverage or, if Eligibility Waiting Period applies, the first day of the Eligibility Waiting Period. For Late Enrollees, Enrollment Date is their first day of coverage.

Pre-Existing Condition Limitation applies when:

♦ you do not have evidence of prior Creditable Coverage;
♦ you have evidence of prior Creditable Coverage showing less than twelve months of prior coverage; or
♦ there is a 63-day or more break in coverage immediately before your Enrollment Date.

When the Pre-Existing Conditions Limitation applies expenses relating to the Pre-Existing Condition are not covered under this Plan until the person has been covered under the Plan for 12 months (18 months for a Late Enrollee) after the Enrollment Date.

Pre-Existing Conditions Limitation does not apply:

♦ when you have evidence of prior coverage showing 12 months of prior coverage and there is less than a 63-day break in coverage immediately before your Enrollment Date;
♦ to Pregnancy;
♦ to a newborn child; or
♦ to a child adopted or placed for adoption before attaining age 18.

Note: However, the newborn child or child adopted or placed for adoption must be enrolled in a group health plan or other Creditable Coverage within 31 days after the birth, adoption or placement, and does not have a 63-day or more break in coverage.

Creditable Coverage includes coverage under a group health plan, individual or group health insurance, Medicare, Medicaid, military coverage and certain other medical coverage.

When applying Creditable Coverage the 12-month Pre-Existing Condition Limitation period is reduced by the number of days of Creditable Coverage the individual has as of their Enrollment Date, as shown on their Certificate of Creditable Coverage, but without regard to any period of coverage preceding a 63-day or longer break in coverage. No waiting period or HMO affiliation period is taken into account in determining if a break in coverage occurred. For example, if you have a Certificate of Creditable Coverage showing
you had 8 months of prior coverage without a 63-day or more break in coverage, your Pre-Existing Conditions Limitation period would be reduced by eight months, leaving a four-month Pre-Existing Conditions Limitation period. Your Pre-Existing Condition would then be eligible for coverage under this Plan after you have been enrolled for four months, counting from your Enrollment Date.

Special Note: If the accuracy of a certificate is contested or a certificate is unavailable, you may evidence prior Creditable Coverage by means of any other documentation that may be viewed as evidence of such by the Plan. Such documents must be presented to the Contract Administrator, who will then review them and issue the individual a determination explaining to what extent it will apply toward reducing the Plan’s pre-existing condition provision, and why it will not, if that is the case.

These pre-existing condition limitations are intended to comply with at least the minimum requirements of the Health Insurance Portability and Accountability Act of 1996 (H.R. 3103). If they are incomplete or in conflict with the Act in any way, the Act will prevail.

YOUR RIGHT TO DEMONSTRATE CREDITABLE COVERAGE

You are entitled to a certificate from your previous health care provider that will show evidence of your prior health coverage. A plan or issuer is required to furnish a certificate automatically and without charge at the time the individual loses coverage under the plan or would have lost coverage in the absence of COBRA or similar coverage. A plan or issuer is also required to issue a certificate automatically to an individual who has elected COBRA coverage when that coverage ceases. You or your authorized representative may also request a certificate from a prior plan or issuer within 24 months after the coverage ceases. The Plan will assist in obtaining a certificate from any prior plan or issuer, if necessary. Please contact the Human Resources Department if you need assistance.
COVERED MEDICAL EXPENSES

Unless otherwise specified, payment for the covered medical expenses listed below will be made at the Plan Percentages shown in the “Summary of Medical Benefits,” subject to any Deductible amounts, any limitations, the definitions, and all other provisions of this Plan. The Plan will not pay any benefit expenses that exceed the Usual, Reasonable and Customary charge amount.

An expense is considered to be incurred on the date the Covered Person receives the services and supplies for which a charge is made.

ALCOHOL AND DRUG DEPENDENCY. Benefits will be paid as shown in the “Summary of Medical Benefits,” subject to the benefit maximum(s) shown, for treatment of Alcoholism or Drug Abuse.

No benefits are provided for court-ordered treatment of mental or psychiatric disorders or Substance Abuse.

Treatment of Alcoholism or Drug Abuse must be given under the direction of a Physician and the treatment program must be accredited by the Joint Commission on the Accreditation of Health Care Organizations (JCAHCO) or by equal standards. This includes JCAHCO or state-approved Alcoholism rehabilitation programs or licensed Drug Abuse rehabilitation programs.

Expenses incurred for treatment of Alcoholism and Drug Abuse cannot be applied to the Out-of-Pocket Maximum.

- **Inpatient Treatment**
  The Plan will pay for eligible charges incurred for room, board, and other usual services while confined as an Inpatient in a Hospital, a Substance Abuse Treatment Facility, or a Residential Treatment Facility. Physician visits provided during such confinement are also covered.

- **Outpatient Treatment**
  The Plan will pay for eligible charges incurred for treatment or service on an Outpatient basis. Benefits include visits to a licensed Physician, psychologist, or a Substance Abuse health professional in an office, a Hospital or a Substance Abuse Treatment Facility.

- **Partial Hospitalization**
  If treatment involves Partial Hospitalization or a combination of Inpatient and Partial Hospitalization, not more than the benefit maximum shown on the “Summary of Medical Benefits,” including Physician fees, will be payable in each calendar year.

AMBULANCE CHARGES. Benefits are payable for the use of a local professional land or air Ambulance service to transport a Covered Person to the nearest facility appropriate for the Covered Person’s condition. Payment will be made for trips from the home of the Covered Person or the scene of an Accident to the nearest Hospital equipped to provide service or to a Skilled Nursing Facility.

ANESTHESIA CHARGES. Benefits are payable for eligible charges for anesthetics and the administration of Anesthesia by a licensed anesthesiologist or certified registered nurse (R.N.) anesthetist in connection with a covered Surgical Procedure when these are not covered as Hospital charges.
COVERED MEDICAL EXPENSES (Continued)

BLOOD. Benefits are payable for eligible charges for blood and/or blood plasma (if not replaced by or for
the patient), including blood processing, equipment, and administration services.

BIRTHING CENTERS. Benefits are payable for the eligible charges made by a licensed Birthing Center
(as defined in the “Definitions” section) for a Covered childbirth, and the associated normal services and
supplies.

No Room and Board Charges must be incurred, and recuperation must take place at home.

CARDIAC REHABILITATION THERAPY. Eligible expenses incurred are covered for cardiac rehabilitation therapy subject to the following:

- The Covered Person must be recovering from a myocardial infarction (heart attack), cardiovascular surgery or a diagnosis of angina pectoris but only when the diagnosis is established prior to the start date of the rehabilitation program as evidenced by a record of prior treatment.
- Cardiac rehabilitation therapy must be prescribed by a licensed medical physician who is receiving regular progress reports concerning the Covered Person’s progress.
- Cardiac rehabilitation therapy must be conducted at a medical facility. Proper monitoring equipment and qualified medical personnel must be present during therapy in order to effectively respond to any emergency situation.
- In order for charges for therapy which extend beyond 12 weeks following a myocardial infarction or coronary surgery (but not following a diagnosis of angina pectoris) to be considered as Covered Expenses, medical documentation is required to establish:
  - the patient is not on a maintenance exercise program
  - continuation of the monitored exercise program is necessary to enable the patient to reach an acceptable level of individual exercise tolerance consistent with the particular state of this person’s disease.
- Charges for cardiac rehabilitation therapy for angina pectoris extending beyond 12 weeks will be denied on the basis that a monitored exercise program is no longer considered Medically Necessary for the treatment of the disease involved.

The Plan specifically excludes dietary instruction, educational services, behavior modification, literature, membership in health clubs, exercise equipment, preventive programs and any other items specifically excluded under the “Medical Benefit Exclusions and Limitations” section of the Plan.

CHIROPRACTIC SERVICES/SPINAL MANIPULATION. Benefits will be paid as shown in the “Summary of Medical Benefits,” subject to the benefit maximum(s) shown, for Medically Necessary chiropractic treatment. Benefits will include the detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebra) column, and services rendered during general Anesthesia. Benefits also include the application of treatment modalities such as, but not limited to diathermy, ultrasound, and heat and cold to the skeletal system to restore proper articulation of joints, alignment of bones or nerve functions.
COVERED MEDICAL EXPENSES (Continued)

COLONOSCOPY BENEFIT. Benefits are payable according to the Summary of Benefits and using the following guidelines:

A. No symptoms/history at age 50 and above screening may be performed every five years; and
B. For symptoms and/or personal or family history, screening may be performed at any age every 24 months.

CONSULTATION SERVICES. This service is covered when the special skill and knowledge of a consulting physician is required for the diagnosis or treatment of an illness or injury. The program provides benefits for one consultation per hospital admission for each consulting physician. Required second surgical opinion consultations are covered and are payable at 100% UCR (Usual, Customary and Reasonable).

CONTRACEPTIVE DEVICES. Benefits are payable for mechanical contraceptive devices.

COSMETIC, RECONSTRUCTIVE OR CORRECTIVE SURGERY. Benefits are payable for eligible expenses incurred for reconstructive Surgery, only if such Surgery is (i) necessary to correct a deformity or to restore or provide normal bodily function lost as a result of an Injury or Illness; (ii) for reconstructive Surgery due to a congenital disease or anomaly which has resulted in a functional defect of a covered dependent child or (iii) as provided in the subsection below entitled Mastectomy Procedures.

DIAGNOSTIC X-RAY AND LABORATORY BENEFIT. The Plan will pay for eligible charges for diagnostic x-rays, electrocardiograms; electroencephalograms; ultrasound; amniocentesis; or other laboratory and pathology tests prescribed by a doctor and performed as the result of a covered Accident or Illness. Also covered is genetic testing if there is a family history of genetic disorders, and allergy testing, by any method, based on the type and number of tests performed by the same Physician. The services of a professional radiologist or pathologist are also covered.

DIALYSIS SERVICES. Dialysis services, including training, when provided and billed for by a Hospital, freestanding dialysis center or other appropriate covered provider.

DOCTOR'S VISITS - INPATIENT. The Plan will cover the eligible charges for Physician visits (including specialists), to the patient while in the Hospital or Special Care Facility.

DURABLE MEDICAL EQUIPMENT. Any repair and/or replacement of Durable Medical Equipment over $250 requires precertification. The Plan will pay for the rental of certain Hospital-type equipment, including, but not limited to, a wheelchair, a Hospital-type bed, or mechanical equipment for the treatment of respiratory paralysis.

Also covered are eligible charges for oxygen and the equipment for the administration of oxygen, for the personal and exclusive use of the patient.
COVERED MEDICAL EXPENSES (Continued)

The total Covered Expense for renting Durable Medical Equipment shall not exceed its purchase price. If the cost of renting the equipment is more than a Covered Person would pay to buy it, the cost of the purchase will be considered a Covered Expense. Excluded in this provision are equipment or devices not specifically designed and intended for the care and treatment of an Injury or Sickness.

ELECTIVE STERILIZATION PROCEDURES. Covered are eligible charges for vasectomies and tubal ligations, but not for the reversal of the same operations.

HOME HEALTH CARE BENEFIT. Eligible charges incurred for necessary Home Health Care will be paid as shown in the “Summary of Medical Benefits,” subject to the requirements and benefit maximum(s) shown.

Covered are charges for the following services: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); visits by persons who have completed a home health aide training course under the supervision of a registered nurse; Physical Therapy, Occupational Therapy, and Speech Therapy; medical supplies, drugs and medications prescribed by a Physician and, laboratory services, to the extent such items would have been covered under the Plan if the Covered Person had been hospitalized.

This benefit is available only if the patient requires the continuous care of a physician and/or 24-hour-a-day nursing care. The physician must re-certify the patient's continuing need for such care at least every 14 days.

This benefit is subject to the deductible and is paid as outlined on the Summary of Medical Benefits up to 90 visits in a Calendar Year for these services subject to usual and customary allowances:

- Home Health Care Agency services.
- Temporary or part-time nursing care by or supervised by a registered graduate nurse (R.N.).
- Temporary or part-time care by a home health aide.
- Physical therapy.
- Occupational therapy.

Four hours of home health aide care will count as one visit. Each visit by any other member of the home health team will count as one visit.

HOSPICE CARE BENEFIT. The Plan will pay for the eligible charges made by a formal Hospice Care program directed by a Physician to help care for Terminally Ill Person. Benefits will be paid as shown in the “Summary of Medical Benefits,” subject to the requirements and benefit maximum(s) shown.

The program must meet standards set by the National Hospice Organization and recognized as a Hospice Care program by the Plan Administrator. If such a program is required by the state to be licensed, certified or registered, it must also meet that requirement.

Hospice Care includes Inpatient care in a Hospice, a Hospital or a home care setting. Outpatient services provided by the hospice include drugs or medical supplies. Also included are instructions for care of the patient, counseling, and other supportive services for the family of the dying individual.
COVERED MEDICAL EXPENSES (Continued)

HOSPITAL SERVICES

- **Room and Board Charges**
  Benefits are payable for Room and Board Charges not to exceed the amount shown in the “Summary of Medical Benefits.” The room limit for each day of confinement in a private room is the daily Average Semi-Private Room Rate. However, if a private room is Medically Necessary due to contagious disease, the Hospital’s Usual, Reasonable and Customary charge for such room will be a Covered Expense.

- **Inpatient Hospital Special Charges**
  Eligible benefits are payable for the Hospital's special charges and for non-custodial services of a Nurse when rendered on an Inpatient basis.

- **Intensive Care**
  Payment will be made for eligible confinement in an Intensive Care Unit, cardiac care or neonatal unit up to the amount shown in the “Summary of Medical Benefits.”

  Intensive care must be: (a) ordered by a Physician; and (b) due to a condition that requires special medical and nursing treatment not generally provided to other Inpatients of the Hospital.

For determining the benefits payable, all care in a Hospital shall be considered related and to have occurred in one "Period of Confinement" (as defined in the “Definitions” section of this Plan).

MAMMOGRAPHY SCREENING. The Plan will pay for an eligible mammography as shown in the “Summary of Medical Benefits.” Refer to Annual Physical Examination benefit. This is not limited to, but will include the following:

1. Benefits will be paid for the baseline mammogram for a patient who is at least thirty-five (35) but less than forty (40) years of age.
2. Benefits will be paid for no more than one (1) mammogram every two years for a patient who is at least forty (40) but less than fifty (50) years of age.
3. Benefits will be paid for one (1) mammogram every year for a patient who is at least fifty (50) years of age.

However, additional mammographies may be covered if:

a. the patient's doctor recommends more frequent screening; or
b. the patient obtains a mammogram without a doctor's referral in an office, facility or health testing service that uses radiological equipment that is registered with the Department of Health and Rehabilitative Services for breast cancer screening.

MASTECTOMY PROCEDURES

The Plan shall cover the following procedures in the manner as determined in consultation between the attending Physician and the Covered Person:

1. Reconstruction of the breast on which a mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
COVERED MEDICAL EXPENSES (Continued)

3. Prostheses and physical complications of all stages of the mastectomy, including lymphedemas.

All Precertification and Utilization Review requirements of the Plan will not apply to Surgical and treatment procedures associated with mastectomies of the Covered Employee or covered dependent.

MATERNITY BENEFIT. Maternity benefits and benefits for Complications of Pregnancy are payable on the same basis as any other Illness for Covered Employees and Covered Dependent spouses only. Benefits for Complications of Pregnancy for Dependent children are covered.

All mothers and newborns may have a minimum of a 48 hour hospitalization after a normal birth and a hospitalization of a minimum of 96 hours after a cesarean delivery. Patients may make a decision to leave a Hospital sooner. This decision should be mutually agreed upon between the Physician and the mother.

MEDICAL SERVICES AND SUPPLIES Covered are eligible charges for: (a) casts, splints, cervical collars, head halters, traction apparatus, trusses, braces, crutches, catheters, colostomy bags, and surgical dressings; (b) the purchase of orthotic devices to be attached to or placed in shoes (but not the shoes themselves); (c) the initial purchase of eyeglasses or contact lenses due to cataract Surgery; (d) the initial purchase of a wig after chemotherapy, and (e) initial purchase of two mastectomy bras.

MENTAL OR NERVOUS DISORDERS. Benefits will be paid as shown in the “Summary of Medical Benefits,” subject to the benefit maximum(s) shown, for treatment of Mental/Nervous Disorders.

A Mental/Nervous Disorder must be classified in the International Classification of Diseases of the U.S. Department of Health and Human Services and must, according to generally accepted professional standards, be amenable to favorable modification. Treatment must not extend beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation. No benefits are provided for court-ordered treatment of Mental/Nervous Disorders or psychiatric disorders.

Treatment of Mental/Nervous Disorders must be given under the direction of a Physician and the treatment program must be accredited by the Joint Commission on the Accreditation of Health Care Organizations (JCAHCO) or by equal standards.

Expenses incurred for treatment of Mental/Nervous Disorders do not count toward the Out-of-Pocket Maximum.

- **Inpatient Treatment**
  The Plan will pay for eligible charges incurred for room, board, and other usual services while confined as an Inpatient in a Hospital, a Mental/Nervous Treatment Facility, or a Residential Treatment Facility. Physician visits provided during such confinement are also covered.

- **Outpatient Treatment**
  The Plan will pay for eligible charges incurred for treatment or service on an Outpatient basis. Benefits include visits to a licensed Physician, psychologist, or mental health professional in an office, a Hospital, a Mental/Nervous Disorder Treatment Facility or a Substance Abuse Treatment Facility.
• **Partial Hospitalization**
If treatment involves Partial Hospitalization or a combination of Inpatient and Partial Hospitalization, not more than the cost of the maximum number of Inpatient days shown on the “Summary of Medical Benefits,” including Physician fees, will be payable in each calendar year.

**NEWBORN WELL-BABY CARE.** Newborn Well-baby Care includes eligible charges made during the initial Hospital confinement for Hospital nursery room, board, miscellaneous services and supplies and Doctor charges for circumcision and routine exams of the child before release from the Hospital.

A covered newborn who is sick or injured is eligible for benefits to the same extent as any other Covered Person. This includes treatment of diagnosed birth defects, congenital anomalies, and abnormalities.

**OFFICE VISITS.** The Plan covers the services of Physicians (including surgeons) seen by the Covered Person for the diagnosis and treatment of an Illness or Injury as shown in the Summary of Medical Benefits.

**ORGAN TRANSPLANT OPERATIONS.** This Plan will pay up to the Benefits Maximum stated in the Summary of Medical Benefits for services and supplies required for all human organ or tissue transplants except those which are classified as Experimental and/or Investigational. Prior approval is mandatory. The Physician must submit a complete medical history and include a current diagnosis. The name of the surgeon who will perform the transplant must be included. The surgery must be performed at a recognized transplant center.

• **Special Transplant Program**
In addition to the standard transplant benefit stated in this booklet, the following benefits may be available when a covered person participates in our Special Transplant Program. This Special Transplant Program is an enhancement to the transplant benefit and participation in the program is voluntary.

• **Additional Covered Benefits**
1. Access to approximately 40 transplant Centers of Excellence across the United States, as well as outpatient peripheral stem cell facilities.
2. Reimbursement for travel and lodging expenses incurred during the transplant (immediately prior to and after the transplant) up to a $5,000 maximum for covered person and a companion. Travel and lodging discounts are also available with select airlines and hotels.
3. Waiver of covered person’s deductible and out-of-pocket expenses, up to a $1,500 maximum.
4. Services of a Transplant Facilitator, who will coordinate the entire process.

These benefits are available when a covered person participates in the Special Transplant Program and meets all of the following requirements:

1. Pre-notification of the upcoming transplant must be given by the covered person, their physician or Third Party Administrator as soon as the covered person is identified as a potential transplant candidate. Pre-notification must be made to 1-888-4ORGANS; and
2. Pre-certification must be obtained from Volusia Health Network (VHN). VHN may be contacted at 1-800-741-2198 or 386-258-4801; and
3. All transplant services must be rendered at a transplant Center of Excellence facility in the preferred transplant network. If these requirements are not met, Special Transplant Program benefits may be reduced.

- **General Provisions**
  Early precertification to 1-888-4ORGANS must be made as soon as the covered person is identified as a potential transplant candidate. Once enrolled in the program, a Transplant Facilitator will be assigned and will coordinate the entire process with the patient and physician from hospital selection to travel arrangements to prescription drug options. The Transplant Facilitator will contact FBMC for benefit information, as well as contact the covered person’s referring physician for additional information. Information on the program will be forwarded to the covered person and their physician regarding network hospitals and other relevant information. The Transplant Facilitator will work with the covered person, his/her physician, and FBMC to ensure quality and continuity of care throughout the process, pre-transplant to post-transplant, including organ harvest.

**OCCUPATIONAL THERAPY BENEFIT.** The Plan provides Coverage for the services of a registered occupational therapist, for therapy ordered by a Physician and deemed appropriate and Medically Necessary. The patient must demonstrate functional gains; Occupational Therapy for the sole reason of maintaining current level of functioning and to prevent deterioration is not a Covered Service.

The therapist must be under the direct supervision of a Physician in a home setting or a facility or institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing, duly-licensed Outpatient therapy facility.

**ORAL SURGERY.** Includes only the following:

- Fracture of facial bones;
- Excision of mandible joints, lesions of the mouth, lip or tongue, or roof and floor of the mouth;
- Incision of accessory sinuses, mouth salivary glands or ducts;
- Dislocation of the jaw, and
- Plastic reconstruction or repair of the mouth or lip necessary to correct or repair traumatic injury or congenital defect.

**OXYGEN.** The Plan will pay for eligible charges for: oxygen and rental of equipment required for its use, not to exceed the purchase price of such equipment. See Durable Medical Equipment.
OUTPATIENT SURGICAL FACILITY BENEFIT. If you have Surgery done at an Outpatient Surgical Facility, those charges are Covered Expenses. Coverage is provided for miscellaneous services and supplies rendered by the facility on its own behalf. This includes charges made by a Doctor for services rendered while you are at the facility, for x-rays and lab tests, and for radiology and pathology. These charges are covered whether billed directly by the facility or separately by the Doctor.

PHYSICAL THERAPY BENEFIT. The Plan will pay for the eligible charges made by a registered physical therapist, for therapy ordered by a Physician and deemed appropriate and Medically Necessary. The patient must demonstrate functional gains; Physical Therapy for the sole reason of maintaining current level of functioning and to prevent deterioration is not a Covered Service.

The therapist must be under the direct supervision of a Physician in a home setting or a facility or institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing, duly-licensed Outpatient therapy facility.

PHYSIOTHERAPIST. Services when ordered and supervised by a physician.

PREVENTIVE CARE/ROUTINE PHYSICAL EXAM BENEFITS. Covered Services includes preventive care/routine physical exam, which includes, but is not limited to, pap smears, prostate specific antigen tests, gynecological examinations, immunizations, routine physical examinations, mammography, x-rays and laboratory blood tests. If care is related to an illness or accident, charges will be considered under the terms of the Plan (subject to the deductible and coinsurance provisions).

PRIVATE DUTY NURSING. The Plan will pay for eligible charges made by a licensed nurse for nursing services. Here, “licensed nurse” means a registered graduate nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.). The term “private duty” refers to a session of four or more hours that continuous nursing care is furnished to the Covered Person alone.

PROSTHETICS. The Plan will pay for eligible charges for the initial purchase of artificial eyes and limbs for the initial replacement of natural eyes and limbs, or for the replacement of such prosthesis if it is determined to be necessary, by the Covered Person's Physician, because of growth or bodily change; purchase of a breast prosthesis for the initial replacement of a breast surgically removed;

Replacement of any such devices for other reasons is not covered.

PSYCHOLOGIST. Services within the lawful scope of practice and rendered by a psychologist (Ph.D.) or out-patient clinical mental and nervous treatment administered by any other Practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.
RESPIRATORY THERAPY. Professional services of a licensed respiratory therapist when specifically prescribed by a Physician or surgeon as to type and duration, but only to the extent that the therapy is for improvement of respiratory function.

R.N. OR L.P.N. - (not related to the patient). Services on an in-patient basis, but only when no intensive or cardiac care unit is available, and the care needed is beyond the capabilities of the hospital's floor nurses. Physician certification of medical necessity - on forms supplied by the Plan - is required.

R.N. OR L.P.N - (not related to the patient). Services on an out-of-hospital basis. Physician certification of medical necessity - on forms supplied by the Plan - is required.

SECOND SURGICAL OPINION BENEFIT. When surgery is recommended, a second opinion may be necessary to confirm the need for surgery. A call to the Review Agency is required to confirm the need for a second opinion. Covered Medical Charges incurred in obtaining a required second opinion will not be used to meet any Deductible. Benefits for the opinion and any related tests will be payable at 100%.

SKILLED NURSING FACILITY BENEFIT. This benefit is payable when you are confined to a Skilled Nursing Facility because of an Injury or Sickness covered by the Plan. Covered Expenses include room and board (limited to the average semi-private room rate in the facility), routine services, and skilled nursing care. Benefits for a Skilled Nursing Facility confinement will not be payable if the confinement is for Custodial Care.

The Physician must certify that confinement in a Skilled Nursing Facility is in lieu of Hospital confinement and must submit a written treatment plan which establishes the Medical Necessity for the service. The confinement must start within 14 days of a hospital confinement of at least 3 days. Benefits are provided for semi-private room charges, for up to 90 days of care per confinement. The benefit is subject to the deductible and is payable as outlined in the Summary Medical Benefits of the regular daily rate of the daily charge for a semi-private room in the hospital from which the patient was transferred.

A skilled nursing facility is:

- accredited by the Joint Commission on Accreditation of Hospitals, or
- recognized as a skilled nursing facility by the Secretary of Health and Human Services (HHS).

Confinement must be within 14 days after release from a general hospital.

Skilled care is that care required during a period of recovery with the following characteristics:

- a favorable prognosis;
- a reasonably predictable time of recovery, and requires an intensity or combination of services and/or facilities less than those of the acute general hospital but greater than those normally available at the residence of the patient.

SLEEP DISORDER/SLEEP APNEA. Benefits will be paid for the diagnosis and treatment of sleep disorders/sleep apnea based on medical necessity.

SPEECH THERAPY - RESTORATIVE OR REHABILITATIVE. The Plan will pay for the services of a legally qualified speech therapist for Speech Therapy ordered by a Physician and deemed appropriate and Medically Necessary. The patient must demonstrate functional gains; Speech Therapy for the sole reason of maintaining current level of functioning and to prevent deterioration is not a Covered Service. If the speech loss or impairment is due to a congenital anomaly, Surgery to correct the anomaly must have been performed prior to the therapy. If the Speech Therapy is performed as a result of a developmental disorder, no Coverage shall be extended.

The therapist must be under the direct supervision of a Physician in a home setting or a facility or institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing duly-licensed Outpatient therapy facility.

SUPPLEMENTAL ACCIDENT BENEFIT. Supplemental Accident Benefit pays a portion of eligible expenses in full as shown in the Summary of Medical Benefits. Treatment must commence within ninety (90) days of the Accidental Injury or the earliest date that is medically possible.

Supplemental Accident Benefit is to be used before other Coverage under the Plan is made available.

Treatment covered as Supplemental Accident Benefit must be completed within twelve (12) months following the date of the Accidental Injury or an earlier date that is medically possible.

Charges over the maximum shown in the Summary of Medical Benefits or incurred more than twelve (12) months after the date of the Accidental Injury will be paid at the Co-Payment Percentage shown in the Summary of Medical Benefits after satisfaction of the applicable Deductible.

SURGERY BENEFIT. The Plan will cover the charges made by a Physician for the performance of Surgical Procedures which are not covered under any other benefit provision of this Plan. Surgery fees are payable for Surgical Procedures and for correcting fractures and complete dislocations. Benefits payable under this Plan will be subject to satisfaction of applicable pre-certification requirements, if any.

The Plan provides benefits for the services of an assistant surgeon provided the assistance is Medically Necessary and no intern, resident, or other staff Physician is available. The amount considered as eligible charges for an assistant surgeon is the lesser of the assistant surgeon's fee or no more than 20% of the Usual, Reasonable and Customary Charge for the Surgical Procedure.

Sometimes the Physician may perform more than one Surgical Procedure in one operating period. Multiple Surgical Procedures can often be done through the same natural body opening, or through the Same Incision...
COVERED MEDICAL EXPENSES (Continued)

in the same Operative Field. In such a case, the maximum benefit will be allowed for the primary procedure. One-half of the Usual, Reasonable and Customary Charge will be paid for each of the next three (3) lesser procedures, provided that they are not Incidental Procedures. No additional amount will be allowed for an Incidental Procedure when performed in conjunction with other major Surgical Procedures.

If multiple Surgical Procedures are performed through separate body openings, or through Separate Incisions in Separate Operative Fields, the maximum benefit will be allowed for each Independent Procedure.

Sterile surgical supplies required after Surgery are also covered.

The Physician's fee for a procedure is deemed to include all post-operative care he or she gives for the same condition.

TEETH, GUMS AND ALVEOLAR PROCESS. This Plan covers the services of a Dentist or licensed dental surgeon for the care or treatment of the teeth, gums, or alveolar process but is limited to:

a. the excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when a lab exam is required;
b. external incision and drainage of cellulitis;
c. incision of salivary glands or ducts;
d. emergency repair for Accidental Injuries to natural teeth; and
e. surgery needed to correct Accidental Injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

When treatment is necessary as the direct result of an Accidental Injury, eligible Hospital expenses and expenses incurred for the services of a Dentist or licensed dental surgeon are also covered.

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ). Benefits will be paid as shown in the “Summary of Medical Benefits,” subject to the benefit maximum(s) shown for eligible charges incurred for surgical and non-surgical treatment of temporomandibular joint disorders and craniomandibular disorders on the same basis as for treatment to any other joint in the body, provided the treatment is administered by a Physician or Dentist.

THERAPEUTIC SERVICES. The materials, and the services of technicians to administer them, are considered to be covered for the following therapeutic services: X-ray, cobalt, radium, radioactive isotope and other acceptable forms of radiation therapy for treatment of proven malignant disease; intravenous and oral chemotherapy for the treatment of proven malignant disease when the drugs used are approved by the Federal Food and Drug Administration.

Allergy therapy for the treatment of allergies by the administration of antigens is considered to be a covered charge based on the type and number of antigen doses per vial.
WELL CHILD CARE. The Plan shall cover up to 12 visits for Well Child Care Benefits provided by a Physician from the moment of birth to age six. No deductible applies and benefits will be paid as shown in the Summary of Medical Benefits, subject to the limits that follow:

1. routine newborn nursery charges;
2. benefits will be limited to one amount payable to one provider for all of Covered Services provided at each visit;

A separate preventative benefit will apply beginning at age 7 and up as shown in the Summary of Medical Benefits.

For Injury or Sickness, Coverage will be payable on the same basis as for any other eligible expense not as Well Child Care, including care or treatment of congenital defects, birth abnormalities; or premature birth, provided Dependent Coverage is in force at the time eligible expenses are incurred.

"Covered Services" means the services which are covered at each visit in keeping with prevailing medical standards. They are:

a. a history;
b. physical examination;
c. developmental assessment;
d. anticipatory guidance; and
e. appropriate immunizations and laboratory tests.
MEDICAL BENEFIT EXCLUSIONS & LIMITATIONS

The Plan will not pay for, and Covered Expenses do not include:

1. **Abortion.** Non-therapeutic abortions, whether for the Covered Employee, Covered Spouse or Covered Dependent Child, unless: (1) the mother’s life would be endangered if the pregnancy were allowed to continue to term; (2) an amniocentesis and genetic testing of fetal chromosomes has shown one or more severe congenital abnormalities such as Down’s Syndrome, or; (3) the pregnancy resulted from an act of rape or incest.

2. **Abortion Complications.** Charges for complications arising from any non-covered surgery or treatment, except for complications from a non-covered abortion, will be covered;

3. **Adoption.** Charges for adoption expenses or services of a surrogate mother;

4. **Alternative Treatment.** Charges for holistic medicine, acupuncture (unless deemed medically necessary), hypnosis or biofeedback or other forms of self-care or self-help;

5. **Appointments.** Charges for broken appointments or telephone calls;

6. **Artificial Heart.** Expenses related to insertion or maintenance of an artificial heart;

7. **Autopsy.** Charges for services associated with autopsy or postmortem examination, including the autopsy;

8. **Contraceptives.** Charges for contraceptive devices or appliances whether or not prescribed (unless otherwise specified);

9. **Cosmetic Drugs.** Charges for Minoxidil (Rogaine) for the treatment of alopecia or any other drug used primarily for cosmetic purposes;

10. **Cosmetic Surgery.** Charges for Cosmetic Surgery except as specified under the "COSMETIC, RECONSTRUCTIVE OR CORRECTIVE SURGERY" provision of this Plan;

11. **Convalescent, Custodial or Sanitarium Care.** Charges for custodial care or confinement primarily for the purpose of meeting personal needs which could be rendered at home or by persons without professional skills or training. Any type of maintenance care which is not reasonably expected to improve the patient’s condition except as may be included as part of a Hospice Care program or Extended Care Coverage;

12. **Dental.** Charges for dental services and supplies, including teeth broken while chewing, except as specified under the “TEETH, GUMS AND ALVEOLAR PROCESS” provision of this Plan and as covered under the Dental Care Benefits Plan;

13. **Eye Examinations.** Charges for eye exams or eye refractions (to determine the correction of vision); charges for eye exercises or eyeglasses or contact lenses or their fitting, except as prescribed by an opthalmologist in connection with the treatment of cataracts; for orthoptics, vision therapy or supplies; for radial keratotomy or other refractive Surgery; surgical correction of nearsightedness and/or astigmatism except as specifically covered under "Vision Care Benefits";

**Note:** This exclusion will not apply to the initial purchase of glasses or contact lenses following cataract surgery.
MEDICAL BENEFIT EXCLUSIONS & LIMITATIONS (Continued)

14. **Equipment.** Charges for purchase or rental of motorized transportation equipment; wheelchair lifts; escalators or elevators; saunas or swimming pools; structural changes to a house or vehicle; professional medical equipment such as blood pressure kits; or supplies or attachments for any of these items;

15. **Experimental or Investigational.** Charges for any medical treatment, procedure, drug, biological product or device which meets the definition of Experimental or Investigational as defined in the Definitions section of the Plan;

16. **Family and Marriage Counseling.** Charges for family and marriage counseling;

17. **Foot Care.** Charges for routine, non-surgical treatment of the feet, treatment of corns, calluses, toenails, or other routine foot care unless the charges are for the removal of nail roots or for the treatment of a metabolic or peripheral-vascular disease except charges made by the hospital for necessary in-patient care. Only charges for hospitalization actually billed by the hospital will be covered;

18. **Government Facilities.** Charges for care, treatment, services, and supplies received in a Hospital or facility owned or operated by the United States Government or any of its agencies, except that charges incurred at either a Veterans Administration Hospital for non-service related disabilities, or a military Hospital for all disabilities, will be directly reimbursed to the Hospital upon demand and then only to the extent that the charges are eligible and payable under the Plan;

19. **Government Services, and Supplies.** Charges for care, treatment, services, and supplies provided or paid for by any government plan or law not restricted to its own civilian employees and their dependents (This will not apply to Medicaid or the Uniformed Services Employment and Reemployment Rights Act of 1994.);

20. **Group Contracts.** Services covered by any other group contract issued by Embry-Riddle Aeronautical University.

21. **Hair transplants.** Charges for hair transplants;

22. **Hearing Examinations.** Charges for hearing examinations, hearing aids or their fitting, or related supplies;

23. **Housekeeping, domestic assistance, and child care services.** Charges for housekeeping, domestic assistance, and child care services;

24. **Illegal.** Charges for insurrection, participation in a riot, or the commission of a crime unless due to a medical condition or as a result of domestic violence;

25. **Immunization Shots.** Charges for immunization shots except as covered under "Well Child Care Benefits" or "Preventive Maintenance Benefit";

26. **Implant Removal.** Charges for expenses related to the removal of breast or other prosthetic implants that were: (1) inserted in connection with Cosmetic Surgery, regardless of the reason for removal; or (2) not inserted in connection with Cosmetic Surgery, the removal of which is not currently Medically Necessary;
MEDICAL BENEFIT EXCLUSIONS & LIMITATIONS (Continued)

27. **Infertility.** Charges for all services and supplies for and/or related to treatment of infertility, artificial insemination, zygote intrafallopian transfer, in-vitro fertilization or embryo transfer procedures except for diagnostic testing to determine infertility;

28. **Learning Disorders.** Expenses for education, counseling, or job training or care for learning disorders or behavioral problems, whether or not services are rendered in a facility that also provides medical and/or mental/nervous treatment;

29. **Medically Necessary.** Charges for any medical treatment not generally accepted as Medically Necessary for diagnosis or treatment of a Covered Person's Sickness or Injury; for any care, treatment, services, and supplies not recognized throughout the medical profession as appropriate for treating the Covered Person's Sickness or Injury even if ordered by a Doctor; or for care, treatment, services and supplies not prescribed by or performed by or upon direction of a Physician or Practitioner;

30. **Massage Therapy.** Charges for massage therapy or rolfing;

31. **Medical Reports.** Expenses for preparing medical reports, itemized bills or claim forms, mailing and/or shipping and handling;

32. **Military Activities.** Charges incurred due to a declared or undeclared act of war, or any act due to war, arising from any other military activities including offensive, defensive, peace keeping or training activities;

33. **Outside of United States.** Charges for treatment or services rendered outside the United States of America or its territories except for an Accidental Injury or a Medical Emergency;

34. **Orthopedic Shoes.** Charges for orthopedic shoes except as an integral part of a brace or prosthetic device;

35. **Personal Hygiene and Convenience.** Charges for personal hygiene and convenience items such as, but not limited to haircuts; shampoo and sets; guest meals; radio/television rentals; air purifiers or air conditioners; room humidifiers; exercise cycles or other physical fitness equipment; water purifiers, hypo-allergenic pillows or mattresses; or waterbeds;

36. **Pre-Existing Conditions.** Charges for Pre-Existing Conditions, except as stated otherwise;

37. **Pregnancy (Dependent Child).** Pregnancy-related expenses of a Dependent child. Coverage will be provided, however, for “complications of pregnancy” as defined (see “Maternity Benefit” in the Covered Medical Expenses).

38. **Prescription Drug Co-Payments.** Charges for prescription drug Co-Payments or expenses used to satisfy Deductibles;

39. **Prescription Drugs.** Charges for prescription drugs, medicines and supplies (including prenatal vitamins), vitamins, mineral supplements, or fluoride drugs, whether or not a Physician's prescription is required;

40. **Rehabilitative Services.** Charges for rehabilitative services such as recreational therapy, or any similar services by whatever name, except as otherwise stated;
MEDICAL BENEFIT EXCLUSIONS & LIMITATIONS (Continued)

41. **Self-inflicted Injury or Sickness.** Expenses related to intentional self-inflicted Injury or Sickness, suicide or attempted suicide unless due to a medical condition or domestic violence;

42. **Sexual or Gender dysfunctions.** Charges for sex change Surgery; penile prosthetic implant; services, therapy or counseling for sexual or gender dysfunctions or inadequacies;

43. **Smoking Deterrent.** Charges for smoking deterrent medications containing nicotine or any other smoking cessation aids, all dosage forms (e.g. Nicorette, Nicoderm, etc.)

44. **Sterilization.** Charges for reversal of any sterilization procedure;

45. **Termination of Coverage.** Charges for any benefit or service provided after Coverage has been terminated for the individual (for reasons relating to individual eligibility or any other reason) or after Coverage has been canceled;

46. **Travel.** Charges for travel or accommodations, or rest cures, whether or not recommended by a Physician; or for travel time and related expenses by an eligible provider of services;

47. **Unauthorized Charges.** Charges for which you are not legally required to pay, including any charges that are discounted or rebated, or for professional services rendered by a family member; charges which you would not have to pay if you had no Coverage; any expenses incurred while you are not covered under this Plan;

48. **Unauthorized Hospitalization.** Charges for Hospital service for a Covered Person who remains in a Hospital after the attending Physician advises that further Hospital services are unnecessary;

49. **Usual, Reasonable and Customary.** Charges which are in excess of the [lesser of (i) any applicable network allowance and (ii)] Usual, Reasonable and Customary charge for the geographic area in which services are rendered;

50. **Vitamins.** Charges for Vitamins, whether or not prescribed by a physician;

51. **Vocational Testing or Training.** Charges for vocational testing, evaluation, counseling or training;

52. **Weekend Non-Emergency Hospital Admissions.** Charges for Weekend Non-Emergency Hospital Admissions as defined in the Definitions section of this Plan;

53. **Weight Control.** Charges for weight control services including any service to lose, gain or maintain weight loss. This exclusion includes, but is not limited to, weight control/loss programs; appetite suppressants and other medications; dietary regimens; food or food supplements; exercise programs; exercise or other equipment.

Gastric or stomach bypass or stapling, intestinal bypass, gastric balloons, jaw wiring, jejunal bypass, gastric shunts, and procedures designed to restrict the ability to assimilate food are excluded unless deemed medically necessary due to illness and is part of a treatment plan for a condition. Procedure needs to be pre-approved.

54. **Wigs and wig maintenance.** Charges for wigs and wig maintenance; or

55. **Workers' Compensation.** Charges for any Injury or Sickness arising out of any activity for wage or profit by the Covered Person. This includes self-employment or employment by others. It applies whether or not Workers' Compensation or similar law covers the expenses incurred.
# PRESCRIPTION DRUG EXPENSE BENEFIT

## SUMMARY OF PHARMACEUTICAL BENEFITS

### PRESCRIPTION DRUG EXPENSE BENEFIT

<table>
<thead>
<tr>
<th></th>
<th>Generic</th>
<th>Formulary Brand</th>
<th>Non-Formulary Brand</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medco Mail Order Program (90 DAY SUPPLY)</strong></td>
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</tr>
<tr>
<td>Co-Payment</td>
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<td>$60.00</td>
<td>$110.00</td>
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<tr>
<td>Calendar Year Deductible Applies</td>
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<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Birth Control Pills</td>
<td>Covered</td>
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<td>Covered</td>
</tr>
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<td><strong>Medco/Prescription Drug Network Retail</strong></td>
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<tr>
<td>Calendar Year Deductible Applies</td>
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</table>

### Non-Network Provider

Non-Network Pharmacy will be paid at 50% through the medical plan and it does not track to Deductible or Co-insurance.

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## PRESCRIPTION DRUG PROGRAM

A pharmacy network is available for the ERAU Health Care Plan. The pharmacy network includes retail pharmacies in the United States as well as a Mail Service Program for maintenance medications. For a list of pharmacies in the network throughout the United States, please refer to the Preferred Provider Directory.

Because pharmacies transmit claim information electronically, you must show your I.D. Card for eligibility determination when filling a prescription. You will pay $10 for a generic drug prescription, $30 for a Preferred brand name drug and $55.00 for a Non-Preferred brand drug.

Maintenance drugs should be purchased through the Mail Service Program. Maintenance drugs are covered for up to a 100-day supply per fulfillment. You will pay $10 for a generic drug prescription, $30 for a Preferred brand name drug and $55.00 for a Non-Preferred brand drug.

If the actual cost of a drug is less than the co-payment amount, you will only be charged the cost of the drug.

Mail Service Order Forms are available from your Human Resources Department.

If you need a replacement I.D. Card, please call FBMC at:

1-800-323-4890
COVERED MEDICATIONS

Medications covered by this Plan include all generic and brand drugs prescribed by a Physician unless specifically excluded elsewhere. Compound medications are covered if at least one ingredient is a legend drug. Insulin and disposable needles and syringes are covered when prescribed by a Physician. Disposable blood/urine glucose/acetone testing agents (e.g. Chemstrips, Acetest tablets, Clinitest tablets, Diastix Strips and Tes-Tape), and Lancets are also covered.

Also covered are:

- Impotency Treatment Drugs – 6 in 30 at Retail, 18 at mail
- Tretinoin, all dosage forms (e.g. Retin-A) for individuals through the age of 34
- Adderall/Dexedrine through the age of 18
- Injectable and non-injectable chemotherapeutic drugs
- Oral, implantable and injectable contraceptives

DISPENSING LIMITATIONS

This Plan covers the amount prescribed by a Physician, but not to exceed, for each fulfillment, a 30-day supply for drugs purchased from a retail pharmacy or a 90-day supply for drugs purchased from the Mail Service Program.
PRESCRIPTION DRUG EXPENSE BENEFIT LIMITATIONS

Expenses for the following are not payable as a Prescription Drug Expense Benefit:

1. Drugs lawfully obtained without a Doctor's prescription.

2. Devices or appliances, including hypodermic needles and syringes other than when used for insulin; support garments and other non-medicinal supplies, regardless of their intended use.

3. Immunization agents, biological sera, blood or blood plasma.

4. Smoking cessation aids, all dosage forms (e.g. Nicorette, Nicoderm, etc.) except Zyban, Chantix, Nicotrol covered with limitations – covered for 12 weeks per year for a maximum of two years.

5. Injectable drugs except insulin, non-legend drugs (except those listed in covered drugs), Minoxidil (Rogaine), Tretinoin, all dosage forms (e.g. Retin-A) for individuals 20 years of age and older (unless pre-approved), infertility medications, Levonorgestrel (norplant), health and beauty aids; charges for administration of any drug or medication.

6. Drugs labeled "Caution: limited by Federal law to investigational use" or Experimental drugs, even though a charge is made.

7. Drugs taken or given while at a Hospital, skilled nursing care facility, or similar institution.

8. Refilling of a prescription more than the number of times specified by the Doctor, or any refill dispensed after one year from the Physician's original order.

9. Any drug received without charges unless there is a requirement to pay whether or not there is insurance.

10. Expenses related to Accidental Injury or Sickness arising out of occupation or employment.

11. Expenses for treatment of or related to an overdose of drug or medication, unless due to a medical condition or domestic violence.
## DENTAL CARE BENEFIT

### SUMMARY OF DENTAL EXPENSE BENEFITS

**Calendar Year Maximum Benefit for Covered Dental Expenses**

Other Than Orthodontia: $1,300 maximum per calendar year per covered person. Benefits are based on UCR charges.

**Calendar Year Deductible**

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<thead>
<tr>
<th>Type</th>
<th>Deductible</th>
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<tbody>
<tr>
<td>Type I</td>
<td>None</td>
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<tr>
<td>Types II, III</td>
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<td>Individual</td>
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<td>Family</td>
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<tr>
<td>Type IV</td>
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**Plan Percentages Payable**

<table>
<thead>
<tr>
<th>Type</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Type I -- Preventive Services</td>
<td>80%</td>
</tr>
<tr>
<td>Type II -- Basic Services</td>
<td>80%</td>
</tr>
<tr>
<td>Type III -- Major Services</td>
<td>50%</td>
</tr>
<tr>
<td>Type IV -- Orthodontic Services</td>
<td>50%</td>
</tr>
</tbody>
</table>

**Lifetime Maximum Benefit**

For Orthodontia Services (Type IV): $500 per person

Benefits for dental services are handled separately from the comprehensive major medical program and are subject to deductibles as indicated above.

For details, refer to the plan provisions contained in this section.
GENERAL DENTAL PROVISIONS

Your benefits will be based on the Covered Expenses you incur. It is important to know what expenses are covered and the limitations that apply.

This Plan will pay a percentage of your Covered Expenses that exceed or are not subject to a Deductible amount. The Summary of Dental Expense Benefits shows what percentage will be paid for each type of dental service as well as the maximum benefit for this Coverage. Covered Charges are limited to Usual, Customary and Reasonable and you are responsible for charges exceeding UCR guidelines.

DEDUCTIBLES. A Deductible is the amount that must be paid toward Covered Expenses before the Plan will start reimbursement.

CALENDAR YEAR DEDUCTIBLE. Once each calendar year each separate Covered Person must satisfy the Individual Calendar Year Deductible amount shown in the Summary of Dental Benefits, except as provided for below. Benefits are based on the person's Covered Expenses that exceed the Deductible amount.

FAMILY DEDUCTIBLE. Only three members of your family must meet the Deductible per Calendar Year during any one year. Once the third family member meets that Deductible, no further Deductibles per Calendar Year must be met during the rest of that year for any charges incurred by any other members of your family.
PRE-DETERMINATION OF DENTAL BENEFITS

Covered Members contemplating dental work (i.e., where expenses will exceed $300), are strongly urged to submit a copy of the treatment plan (the “Treatment Plan”) to the Claims Administrator. The Treatment Plan should include a list of the services and procedures to be done; the itemized charges for each service and procedure; and the estimated length of treatment. Dental X-rays, study models and whatever else needed to evaluate the Treatment Plan should also be sent.

The Treatment Plan will be reviewed and the Plan will determine the benefits available and advise the patient and/or the Dentist of the benefits available before treatment commences.

If a Treatment Plan for pre-determination of benefits is not submitted, the Plan retains the right to pay the claim on the basis of the amount of benefits which would have been paid had a Treatment Plan been submitted for pre-determination of benefits.

Emergency treatment, oral examination, dental x-rays and teeth cleaning are part of a course of treatment, but may be done before the pre-determination review is made.

A Treatment Plan should always be submitted before orthodontic treatment starts. Orthodontia benefits will begin upon submission of proof that the orthodontia appliances have been installed. Payments will be divided into equal installments, based upon the estimated number of months of treatment, and will be paid over the remaining treatment period as proof of continuing treatment is submitted. The maximum benefit for orthodontia services is $500. This maximum applies to the entire period(s) a person is covered under the Plan.
COVERED DENTAL EXPENSES

Unless otherwise specified, payment for Covered Dental Expenses will be made at the Plan Percentages shown in the Summary of Dental Expense Benefits, subject to any Deductible amounts, any Limitations, the Definitions, and all other provisions of this Plan.

Type I -- Preventive Services

1. Diagnostic oral exams, cleanings, and x-rays limited to two (2) visits per calendar year. (Panoramic – 1 per 36 months; bitewings 2 per calendar year)

2. Topical application of fluoride, limited to children under the age of 19 and limited to one (1) application per calendar year.

3. Topical application of sealants on posterior teeth, limited to children under the age of 18.

4. Space Maintainers.

5. Diagnostic Casts.


Type II -- Basic Services

1. Fillings (non-precious, not gold fillings), extractions.

2. Anesthesia, general anesthesia when administered in connection with oral surgery.

3. Injection of antibiotics.

4. Periodontal treatment, including periodontal scaling and root planing.

5. Endodontic treatment, including root canal therapy (except for final restoration), pulpotomy, apicoectomy and retrograde filling.

6. Consultation by a dental specialist upon referral by the patient’s attending dentist.

7. Oral Surgery, surgical and adjunctive treatment of disease; procedures such as surgical extractions, alveoloplasty, surgical incisions, frenulectomy, cyst and lesion removal when the alveolar process is involved; injury and defects of the oral cavity and associated structures and excision of impacted teeth, subject to Medical Necessity and precertification requirements. All Hospital charges related to Oral Surgery should be covered under the Medical Plan, subject to normal deductible co-pays and co-insurance that the Plans would prescribe.


9. Pathology, diagnostic laboratory services performed to assist in the diagnosis of oral disease.

10. Recement crown, bridges and inlays.
COVERED DENTAL EXPENSES (Continued)

13. Osseous surgery, including flap entry and closure
14. Mucogingivoplastic surgery
15. Vestibuloplasty
16. Management of acute infection and oral lesions

Type III -- Major Services

1. Crowns, porcelain, gold or composite crown restorations. Replacement of an existing crown is covered only if the crown is at least five (5) years old.
2. Inlays and onlays.
3. Repair or recementing of crowns, inlays, bridgework or dentures. Also the relining of dentures.
4. Prosthetics, the initial placement of full and partial dentures, fixed and removable bridgework to replace one (1) or more natural teeth.
5. Replacement of an existing or partial denture or fixed bridgework or addition of teeth to an existing prosthetic, but only if:
   - the replacement or addition of teeth is required to replace one (1) or more teeth extracted after the existing denture or bridgework was installed;
   - the existing denture or bridgework cannot be made serviceable and is at least five (5) years old;
   - the existing denture is an immediate temporary denture installed within the past twelve months and must now be replaced by a permanent denture.
   - the replacement of an existing prosthesis is eligible if the person has been covered under this Plan for twenty-four (24) consecutive months

Type IV -- Orthodontic Services

Orthodontic treatment, such as braces, including correction of bite or malocclusion to include:

- initial consultation, models, x-rays and other diagnostic services;
- initial banding or placement of orthodontic appliance(s);
- periodic adjustment fees; and
- retainers.
Orthodontia services must be in accordance with a treatment plan that has been reviewed and approved by the Contract Administrator prior to the commencement of services (see Pre-Determination of Dental Benefits section).

Orthodontia benefits will begin upon submission of proof that the orthodontia appliances have been installed. Payments will be divided into equal installments, based upon the estimated number of months of treatment, and will be paid over the remaining treatment period as proof of continuing treatment is submitted. The maximum benefit for orthodontia services is $500. This maximum applies to the entire period(s) a person is covered under the Plan.

Orthodontic Benefits
Before a course of orthodontic treatment or services begins, You have the choice of obtaining a written treatment plan as outlined under the "Treatment Plan" provision.

Total benefits for the course or treatment will then be determined as follows:

1. **Single Charge for Diagnosis:** Payable at 50%.
2. **Itemized Charge for Treatment:** Initial Banding - Payable at 50%. Subsequent monthly benefits will then be the balance of the total benefit prorated over the number of months remaining in the treatment plan, payable at 50%, up to the Lifetime Maximum.

The remaining months of an orthodontic treatment plan which was covered by the Employee's prior plan shall be an allowable expense. The remaining benefit available will be calculated using 1. and 2. above. Monthly benefits shall then be payable for each month that the covered person's treatment continues while he or she remains covered under this Plan.

Expenses for orthodontic treatment which was started prior to an Employee's effective date of coverage under the plan shall not be covered.

Monthly benefits shall then be payable for each month that the covered person's treatment continues while he or she remains covered under this Plan or until the maximum benefit for Orthodontics has been paid.

**Treatment Plan** - Pre-authorization is not mandatory. However, obtaining a pre-authorization for treatment in excess of $300 will assist you in determining your out-of-pocket expense prior to treatment.
DENTAL LIMITATIONS AND EXCLUSIONS

This Plan will not pay for and covered dental expenses do not include charges for:

1. Appliances - Items intended for sport or home use, such as athletic mouthguards or habit-breaking appliances;

2. Cosmetic Dentistry - Treatment rendered for cosmetic purposes, except when necessitated by an Accidental Injury;

3. Crowns - Crowns placed for the purpose of periodontal splinting;

4. Customized Prosthetics - Precision or semi-precision attachments, overdentures, or customized prosthetics;

5. Discoloration Treatment - Any treatment to remove or lessen discoloration except in connection with endodontia;

6. Excess Care - Services which exceed those necessary to achieve an acceptable level of dental care. If the Plan Sponsor determines that alternative procedures, services, or courses of treatment could (could have been) performed to correct a dental condition, benefits will be provided for the least costly procedure(s) which would produce a professionally satisfactory result. Duplicate prosthetic devices or appliances;

7. Excess Charges - charges in excess of the Usual, Customary and Reasonable charge for dental services or supplies;

8. Experimental Procedures - Services which are considered experimental or which are not approved by the American Dental Association;

9. Grafting - Extra oral grafts (grafting of tissue from outside the mouth to oral tissues);

10. Hospital Expenses;

11. Lost or Stolen Prosthetics or Appliances - Replacement of a prosthetic or any other type of appliance which has been lost, misplaced, or stolen;

12. Medical Plan Coverages - Any dental services to the extent to which coverage is provided under the terms of the medical benefits sections of this Plan, a Participating Plan or any other carrier;

13. Myofunctional Therapy - Muscle training therapy or training to correct or control harmful habits;

14. Non-Professional Care - Services rendered by other than a dentist (DDS or D.M.D.) or a dental hygienist or x-ray technician under the supervision of a dentist;

15. Occlusal Restoration - Non-orthodontic procedures, appliances or restorations that are performed to alter, restore or maintain occlusion (i.e., the way the teeth mesh), including:
DENTAL LIMITATIONS AND EXCLUSIONS (Continued)

- increasing the vertical dimension;
- replacing or stabilizing tooth structure lost by attrition;
- realignment of teeth;
- gnathological recording or bite registration or bite analysis;
- occlusal equilibration.

16. Oral Hygiene Counseling, etc. - Education or training in and supplies used for dietary or nutritional counseling, personal oral hygiene instruction or plaque control. Charges for supplies normally used at home, including but not limited to toothpaste, toothbrushes, waterpiks and mouthwashes;

17. Personalization or Characterization of Dentures;

18. Prescription Drugs - see Prescription Drug Coverages section;

19. A dental Injury or Illness for which a Covered Person is entitled to benefits under any Workers’ Compensation law;

20. Prior to Effective Date - Charges for courses of treatment which were begun prior to the Covered Person’s effective date, including crowns, bridges or dentures which were ordered prior to the effective date;

21. Splinting - Appliances and restorations for splinting teeth;

22. Congenital Tooth Malformations. Charges for dental services with respect to congenital tooth malformations or primarily for cosmetic or aesthetic purposes unless due to accidental injury;

23. Gold Foil Restorations. Charges for gold foil restorations;

VISION BENEFITS

If the Employee or Dependent incurs expenses for Covered Vision Care Charges, benefits are payable provided such services and supplies are necessary and are recommended by a Physician, and the charges are usual and customary and do not exceed the maximum payments as shown below:

**Covered Vision Care Charges**

<table>
<thead>
<tr>
<th>For These Vision Care Expenses</th>
<th>These Vision Benefits Are Payable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision Exam.................................</td>
<td>Up to $50 for one examination per calendar year</td>
</tr>
<tr>
<td>Single Vision Lenses....................</td>
<td>Up to $40 per calendar year</td>
</tr>
<tr>
<td>Bifocal Lenses.............................</td>
<td>Up to $50 per calendar year</td>
</tr>
<tr>
<td>Trifocal Lenses......................... Up to $60 per calendar year</td>
<td></td>
</tr>
<tr>
<td>Contact Lenses and/or Disposable Contact Lenses .......................</td>
<td>Up to $60 per calendar year</td>
</tr>
<tr>
<td>Eyeglass Frames............................</td>
<td>Up to $60 per calendar year</td>
</tr>
</tbody>
</table>

**COVERED EXPENSES**

1. Eye examination
2. Complete case history
3. Examination of fundi, media, crystalline, lens, optic, disc and pupil reflex for pathological anomalies or Injury
4. Corneal curvature measurements
5. Retinoscopy
6. Muscle Balance
7. Refraction
8. Steropsis determination, distance and near
9. Color discrimination (testing for color blindness)
10. Amplitude of accommodation
11. Analysis of findings
12. Determining of prescription
13. Measuring and recording of visual acuity, distance and near, corrected and uncorrected, with new prescription if required
14. Glaucoma test
15. Visual field analysis
16. Slit lamp examination
17. Lenses and frames
18. Services required to fit, administer, or prepare subnormal vision aids including contact lenses, telescopic lenses, and other similar devices when Medically Necessary to improve vision to 20/70 in the better eye when vision cannot be corrected by convention lenses.
VISION BENEFITS (Continued)

EXCLUSIONS

1. Any services or supplies to the extent benefits are payable for such expenses under any other portion of the Plan
2. Expenses occurring as a result of occupational injuries and diseases
3. Expenses which are covered by workers' compensation or similar laws
4. Special procedures such as surgical or medical treatment of the eyes, orthoptics, or vision training
5. Replacement of lost, stolen or broken lenses and/or frames
6. Services and supplies not listed on the Summary of Medical Benefits
7. Services or supplies which neither the Covered Employee nor any of the Covered Dependents are required to pay
8. Services or supplies unless they are prescribed as necessary by a legally qualified ophthalmologist or optometrist
9. Duplicate or spare lenses or frames
10. Special supplies such as non-prescription sunglasses
11. Anti-reflective coatings or tinting
12. Any amount for prescription sunglasses or light sensitive lenses which is in excess of what would be covered for non-tinted lenses
13. Any eye examination which is required as a condition of employment by any applicable law
14. Expenses for services and supplies in excess of reasonable and customary charges
15. Vision training.
FILING A CLAIM FOR BENEFITS

Appropriate claim forms may be obtained directly from your Human Resources department. The following general steps are required in order to file a claim for benefits under this Plan. Detailed instructions are included on the claim forms.

1. Complete the Employee portion on the front of the claim form in full. Answer all questions, even if the answer is "none" or "N/A" (does not apply).

2. Complete a separate claim form for each Covered Person for whom benefits are being requested.

3. Attach all necessary original receipts to the claim form. Receipts for claims must include, at minimum: the diagnosis; the date(s) of service; the patient's name; the provider's name, address, phone number; and the federal tax identification number of the provider.

   If you do not have the actual itemized bills, the back of the claim form may be completed by the Doctor.

4. If another plan is the primary payor, a copy of the other plan's Explanation of Benefits (EOB) must accompany the claim form sent to this Plan.

5. If the provider is to be paid directly, sign the "AUTHORIZATION TO PAY BENEFITS TO PROVIDER(S)" portion of the claim form.

6. Sign and date the claim form.

7. Mail completed medical claim to:

   FBMC
   P.O. Box 730561
   Ormond Beach, FL 32173-0561

TIME FRAME FOR BENEFIT DETERMINATION. Unless further information is needed or an extension is required, the Claims Administrator, upon receipt of the completed claim, will inform you in writing as to their decision within:

♦ 30 days for Pre-Service Claims — a claim for health care where prior approval for any part of the care is a condition to receiving the care. For example, the Plan requires that you precertify hospital admissions;

♦ 60 days for Post-Service Claims — a claim for care that has already been received, any claim for which a Plan does not require pre-authorization;

♦ 72 hours for Urgent Care Claims — a Pre-Service or Concurrent Care Claim becomes an Urgent Care Claim when the normal time frame for making a determination would:

   • seriously jeopardize the life of the claimant (in the view of a prudent lay person acting on behalf of the Plan who possesses an average knowledge of health and medicine or a physician with knowledge of the claimant’s medical condition) or
FILING A CLAIM FOR BENEFITS (Continued)

- subject the claimant to severe pain that cannot be adequately managed without treatment (in the view of a physician with knowledge of the claimant’s condition).

A claim may take longer to review if additional information is necessary to complete the review, or if an extension is necessary due to circumstances beyond the Plan's control. If additional information is needed for determination of the claim, the Covered Person (or authorized representative) will be provided with a notice detailing the information needed. The notice will be provided in accordance with the time frames set forth in the chart below (notice for urgent care claims may be oral). If the reason for the extension is that you need to provide additional information, you will be given a certain amount of time in which to obtain the requested information (it will vary depending on the type of claim). The time period during which the Claims Administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the applicable information gathering period. If you fail to timely provide the additional information requested for determination of the claim, your claim will be denied and you will receive a notice of denial as described in the section below entitled, “Appeals Procedures.”

TIME LIMIT FOR SUBMITTING CLAIMS. All claims should be submitted as soon as possible after the charges are incurred. In any event, in order to be considered eligible for payment, all claims must be submitted within twelve (12) months of the date charges are incurred. A charge will be deemed to be incurred on the date services are actually rendered or supplies are actually received.

A claim is not deemed to be “filed” for purposes of these claims review procedures until it is filed in accordance with the “Filing a Claim” sections of this Plan document and Summary Plan Description and it is received by the Claims Administrator.

ASSIGNMENT OF BENEFITS. Generally, benefits are payable to you and can only be paid directly to another party upon authorization from you. All benefits payable by the Plan may be assigned to the provider of services or supplies at your option. Payments made in good faith and in reasonable reliance on a written notification of assignment will discharge the Plan's obligation to the extent of the payment.

If conditions exist under which a valid release or assignment cannot be obtained, the Plan may make payment to any individual or organization that, in the Plan’s sole determination, has assumed the care or principal support for you and is equitably entitled to payment. The Plan may also honor benefit assignments made prior to your death in relation to remaining benefits payable by the Plan. Any payment made by the Plan in accordance with this provision will fully release the Plan of any liability to you with regard to that payment.

RIGHT TO INVESTIGATE CLAIMS. The Plan Administrator (or its designee) retains the right to request any medical information from any provider of service or products it deems necessary to properly process a claim.

The Plan Administrator has the right and opportunity to examine, at its expense, any person whose Illness or Injury is the basis of any claim, when and as often as reasonably required and, in the event of death, to obtain an autopsy, unless prohibited by law.
FREE CHOICE OF PHYSICIAN. Nothing in this Plan is intended to restrict any Covered Person’s choice of Physician.
APPEALS PROCEDURES

Review your notice carefully. Once you have received your notice from the Claims Administrator, review it carefully. The notice will contain:

(a) the reason(s) for the denial and the Plan provisions on which the denial is based;
(b) a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
(c) a description of the Plan’s appeal procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action following a denial of your appeal;
(d) a statement indicating whether an internal rule, guideline or protocol was relied upon in making the denial and that a copy of that rule, guideline or protocol will be provided free of charge upon request;
(e) if the denial is based on a Medical Necessity, experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request; and
(f) if the claim was an Urgent Care Claim, a description of the expedited appeal process. The notice may be provided to you orally; however, a written or electronic notification will be sent to you not later than three days after the oral notification.

Appealing Denied Claims.

If you disagree with the decision, file a 1st Level Appeal with the Claims Administrator. If you do not agree with the decision of the Claims Administrator and you wish to appeal, you must file a written appeal with the Claims Administrator within 180 days of receipt of the Claims Administrator’s denial notice described above. Your appeal may be made orally to the extent it involves an Urgent Care Claim. In addition, you should submit all information necessary to perfect your claim and any other information that you believe will support your claim.

If the claim on appeal is again denied, you will be notified by the Claims Administrator within the time period described in the chart below, depending on the type of claim. Review your notice carefully. The notice will contain the same type of information that is provided in the first notice of denial provided by the Claims Administrator.

If you still do not agree with the Claims Administrator’s decision and you wish to appeal, you must file a written appeal to the Claims Fiduciary at the address listed in your denial notice within 60 days after receiving the 1st level appeal denial notice from the Claims Administrator. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe will support your claim.

If the Claims Fiduciary denies your 2nd level appeal, you will receive notice within the time period described in the chart below, depending on the type of claim. The notice will contain the same type of information that was referenced in the denial notice for your 1st level appeal.

Important Information. Other important information regarding appeals of denied claims:

- Each level of appeal will be independent from the previous level (i.e., the same person(s) or
APPEALS PROCEDURES (Continued)

- subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal).

- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information. In addition, you have a right to request documents or other records relevant (as defined by ERISA) to your claim.

- If a claim involves medical judgment, an independent health care professional with expertise in the specific area involving medical judgment will be consulted.

- If you wish to submit relevant documentation to be considered in reviewing your claim or appeal, you must submit it at the time you file your claim and/or appeal.

- You cannot file suit in federal court until you have exhausted these appeals procedures.

Limitation on Legal Action. Any legal action to receive benefits must be filed the earlier of:

- One year from the date a determination is made under the particular Plan or should have been made in accordance with the Plan’s claims review procedures, or

- Two years from the date the service or treatment was provided or the date the claim arose, whichever is earlier. Your failure to file suit within this time limit results in the loss/waiver of your right to file suit.

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**Summary Chart.** The chart below shows the time limit for you to submit appeals and for the Claims Administrator or Claims Fiduciary to respond to your claim or appeal. The chart is intended to be used in conjunction with the remainder of information in this section.

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Initial Claims</th>
<th>1st Level Appeal</th>
<th>2nd Level Appeal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Claimant notified of determination as soon as possible but no later than…</td>
<td>Extension for reasons beyond Claims Admin’s control…</td>
<td>Claimant must file appeal within…</td>
</tr>
<tr>
<td>Pre-Service Claim (but not Urgent Care Claim)</td>
<td>15 days from receipt of claim</td>
<td>One extension of 15 days</td>
<td>45 days of date of extension notice</td>
</tr>
<tr>
<td>Urgent Care Claim</td>
<td>72 hours (24 hours if additional information is needed from you)</td>
<td>None permitted</td>
<td>48 hours (Claims Administrator must notify you of determination within 48 hours of receipt of your information or the specified time period for providing information, whichever is earlier)</td>
</tr>
<tr>
<td>Concurrent Care Claim: Early termination or reduction of treatment</td>
<td>Notification to end or reduce treatment will allow time to finalize appeal before end of treatment</td>
<td>N/A</td>
<td>Denial letter will specify filing limit</td>
</tr>
<tr>
<td>Concurrent Care Claim: Request to extend treatment</td>
<td>Treat the same as any other pre-service or post-service claim</td>
<td>One extension of 15 days</td>
<td>45 days of date of extension notice</td>
</tr>
<tr>
<td>Concurrent Care Claim involving Urgent Care</td>
<td>24 hours, if your claim is submitted at least 24 hours before the scheduled end date of treatment. Otherwise, treated as Pre-Service Urgent Care</td>
<td>None</td>
<td>180 days of claim denial</td>
</tr>
<tr>
<td>Post-Service Claim</td>
<td>30 days from receipt of claim</td>
<td>One extension of 15 days</td>
<td>45 days of date of extension notice</td>
</tr>
</tbody>
</table>
COORDINATION OF BENEFITS

GENERAL PROVISION. The Plan has the following coordination of benefits provision, which is designed to prevent duplication of payments when you or a covered family member has medical coverage in addition to the coverage provided by the Plan. It allows the Plan to continue to provide quality benefits in a cost-effective manner.

Generally, if you or a covered family member is eligible for benefits under two or more plans, one plan is primary. Allowable expenses are paid by the primary plan before benefits from other plans are paid.

When coverage is provided by both the Plan and any “Other Plan(s)” (as defined below), the Plan will ensure that you receive up to the total benefit that would have been paid by the Plan, but no more than that. For this purpose, “Other Plan” means any plan, policy or coverage providing benefits or services for medical, dental or vision care. Such Other Plan(s) do not include flexible spending accounts (FSA), health reimbursement accounts (HRA), health savings accounts (HSA), or individual medical, dental or vision insurance policies. Other Plan(s) include:

- Group insurance or any other arrangement for coverage of persons in a group, whether on an insured or uninsured basis, including, but not limited to, hospital indemnity benefits and hospital reimbursement-type plans;
- Hospital or medical service organization on a group basis, group practice, and other group prepayment plans or on an individual basis having a provision similar in effect to this provision;
- A licensed Health Maintenance Organization (HMO);
- Any coverage for students which is sponsored by, or provided through, a school or other educational institution;
- Any coverage under a government program and any coverage required or provided by law;
- Group automobile insurance coverage;
- Individual automobile insurance coverage;
- Individual automobile insurance coverage based upon the principles of “no-fault” coverage;
- Any plan or policies funded in whole or in part by an employer or former employer, or deductions made by an employer from a person’s compensation or retirement benefits;
- Labor/management trustee, union welfare, employer organization, or employee benefit organization plan; and
- Other group health plans covering any individual covered by the Plan, whether as employee, retiree, spouse, dependent or COBRA Qualified Beneficiary.

For purposes of coordination, eligible expense means any Usual, Reasonable and Customary Charge considered in part or full by at least one of the plans. However, any expense denied by the primary carrier
because the participant did not comply with the rules governing the plan of benefits will not be considered as eligible under our Plan.

The Plan sets a ceiling on the total possible reimbursement from all plans. This means that when this Plan is a secondary payor, the Plan will limit benefits so that the total reimbursements received from all plans do not exceed the amount that this Plan would have paid as a primary payor. The Plan’s administrator on this matter has the sole discretion to determine the amount that the primary plan would have paid, taking into account the governing documents of the other plan. The total amounts paid will be considered benefits paid under this Plan and to the extent of such payments, the Plan will be fully released from any liability regarding the person for whom payment was made.

In order to receive all available benefits, file for benefits under the primary plan first. After primary benefits are paid, file for benefits under the secondary plan with a copy of the primary plan’s explanation of benefits (EOB). The two plans will coordinate benefit payments so that the combined payments of both plans will not exceed the benefits that would have been paid by the Plan if it was primary.

DETERMINING PRIMARY/SECONDARY COVERAGES. This Plan coordinates with other plans according to the following rules:

1. Any group health plan which does not contain a coordination of benefits provision will be primary.

2. A plan covering a person as an Employee will be primary over a plan covering the same person as a Dependent.

3. A plan covering a person as an Employee will be primary over a plan covering the same person as either a retiree or laid-off individual.

4. When a person is an Employee under more than one plan, the plan covering the individual for the longer period of time will be primary.

5. A plan covering a person as a Dependent child of non-divorced or non-separated parents will be primary according to which parent has the earlier birth date (month and day) in the year. If both parents have the same birth date, the plan covering the child for the longer period of time will be primary.

CHILDREN OF DIVORCED OR SEPARATED PARENTS. When all plans covering a person as a Dependent child of divorced or legally separated parents contain a coordination of benefits provision, this Plan coordinates with other plans according to the following rules:

1. If there is a court order establishing which parent has financial responsibility for the child's health care expenses, that parent's plan (assuming it covers the child as a Dependent), will be primary.

2. If there is no court order, and the parent with legal custody has not remarried, that parent's plan is primary (assuming it covers the child as a Dependent).

3. If there is no court order, and the parent with legal custody has remarried, the plans that cover the child as a Dependent will pay benefits in the following order:
   a. The plan of the parent with legal custody;
b. The plan of a step-parent who is the spouse of the natural parent having legal custody;

c. The plan of the parent without custody.

If none of the rules listed above establish an order of payment, the plan which has covered the person the longest will be primary.

NOTE: Notwithstanding any other provision in this Coordination of Benefits section, the following two rules always apply:

1. The Plan’s responsibility for expenses arising out of an automobile accident will always be secondary to any automobile insurance, irrespective of the type of automobile insurance law that is in effect in the relevant state. In no event will the Plan pay as primary any claim presented by or on behalf of an individual for medical benefits that would have been payable under an automobile insurance policy but for an election made by the named insured under the automobile policy that reduced covered levels and/or subsequent premium. This provision is expressly intended to avoid the possibility that this Plan will be determined to be primary to automobile insurance coverage, including any “no-fault” automobile insurance coverage.

2. Special rules apply for coordination with Medicare, as described below.

COORDINATION OF BENEFITS WITH MEDICARE. Medicare benefits will be primary to the extent permitted under applicable law. Covered Persons who are covered under the Plan based on criteria other than current employment status — e.g. COBRA continues — will have Medicare as their primary coverage. Individuals with End Stage Renal Disease (ESRD) may be subject to a coordination period during which the Plan is primary, after which Medicare will become primary.

As a general rule, if you or your Covered Dependent becomes eligible for Medicare benefits, there are rules that determine whether the Plan pays benefits first, or whether Medicare is primary.

- If you are an active employee covered by the Plan, the Plan would be primary for you and your Covered Dependent who is eligible for Medicare (for example, due to a disability or being age 65 or older).
- If you are disabled and not actively working, the Plan would be primary for you and any Covered Dependents who may be eligible for Medicare for the first six calendar months
- of your disability period. After the six-month period, if you are not actively working at the Company, Medicare pays benefits first for you and any Covered Dependents (if they are also eligible for Medicare).
- In the event a Covered Person is also eligible for Medicare due to end stage renal disease (ESRD), the Plan will be primary during the coordination period (currently the first 30 months of ESRD). Thereafter, Medicare will be primary.
COORDINATION OF BENEFITS (Continued)

Notwithstanding the foregoing, this Plan will coordinate against Medicare to the extent permitted under applicable law.

During the time the Plan pays benefits first, you may wish to submit a claim for any remaining expenses not covered by the Plan to Medicare. (Incidentally, you should apply for Social Security disability income benefits during the fifth month of disability to make sure you have no gaps in income protection.) During the time Medicare pays benefits first, you should first submit claims to Medicare for payment.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION. The Plan Administrator has right to give information to or obtain information from any insurance company, organization or person regarding any Covered Persons. As a condition for participation in this Plan, the Covered Person must supply the Plan Administrator with information necessary to enforce this provision.

RIGHT TO MAKE PAYMENT. The Plan Administrator reserves the right to pay any other organization as needed to properly carry out coordination of benefits. These payments that are made will be made in good faith and will be considered benefits paid under this Plan. Also, these payments discharge the Plan Administrator from further liability to the extent the payments are made.

RIGHT OF RECOVERY. If more benefits were paid than should have been, the right to recover the excess amount will be exercised. This can be from the person for whom the payments were made or from any other insurance company or organization. The Plan has the right to withhold payment on future benefits until the overpayment is recovered.

MEDICAID ELIGIBILITY AND ASSIGNMENT OF RIGHTS. The Plan will not take into account whether an individual is eligible for, or is currently receiving, medical assistance under a State plan for medical assistance as provided under Title XIX of the Social Security Act ("State Medicaid Plan") either in enrolling that individual as a participant or beneficiary or in determining or making any payment of benefits to that individual. The Plan will pay benefits with respect to such individual in accordance with any assignment of rights made by or on behalf of such individual as required under a State Medicaid Plan pursuant to §1912(a)(1)(A) of the Social Security Act. To the extent payment has been made to such individual under a State Medicaid Plan and this Plan has a legal liability to make payments for the same items or services, payment under the Plan will be made in accordance with any state law which provides that the State has acquired the rights with respect to such individual to payment for such items and services under this Plan.
This section describes the Plan's right to seek reimbursement of expenses that are paid by the Plan on behalf of you or your Covered Dependents if those expenses are related to the acts of a third party (for example, if you are involved in an automobile accident). The Plan may seek reimbursement of these expenses from any recovery you or your Covered Dependent may receive from the third party or another source, including from any insurance proceeds, settlement amounts or amounts recovered in a lawsuit. The terms of the Plan's reimbursement rights are described below:

If a Covered Person incurs expenses covered by the Plan as a result of the act of a third party (person or entity), the Covered Person may receive benefits pursuant to the terms of the Plan. However, the Covered Person is required to refund to the Plan all benefits paid if he recovers from any other party (such as proceeds from a settlement, judgment, lawsuit or otherwise as a result of the act). The Covered Person may be required to:

a) Execute an agreement provided by the Employer or the Claims Administrator acknowledging the Plan's right of recovery, agreeing to repay any claims paid by the Plan, pledging amounts recovered by the Covered Person from the third party as security for repayment of any claims paid by the Plan, and to the extent provided below, assigning the Covered Person's cause of action or other right of recovery to the Plan. If the Covered Person fails to execute such an agreement, the Covered Person, by filing claims (assigning benefits or having claims filed on his behalf) related to such act of a third party, shall be deemed to have agreed to the terms of this reimbursement provision;

b) Provide such information as the Employer, or the Claims Administrator may request;

c) Notify the Employer and/or the Claims Administrator in writing by copy of the complaint or other pleading of the commencement of any action by the Covered Person to recover damages from a third party;

d) Agree to notify the Employer and/or the Claims Administrator of any recovery.

The Plan's right to recover the benefits it has paid is subject to reduction for attorney's fees and other expenses of recovery. The reduction is limited to the lesser of actual attorney fees and other expenses or one-third of the Plan's lien. The Plan's right to recover benefits shall apply to the entire proceeds of any recovery by the Covered Person. This includes any recovery by judgment, settlement, arbitration award or otherwise. The Plan's right to recover shall not be limited by application of any statutory or common law "make whole" doctrine (i.e., the Plan has a right of first reimbursement out of any recovery, even if the Covered Person is not fully compensated) or the characterization of the nature or purpose of the amounts recovered or by the identity of the party from which recovery is obtained.

The Plan shall have a lien against the proceeds of any recovery by the Covered Person and against future benefits due under the Plan in the amount of any claims paid. The lien shall attach as soon as any person or entity agrees to pay any money to or on behalf of any Covered Person that could be subject to the Plan's right of recovery if and when received by the Covered Person. If the Covered Person fails to repay the Plan from the proceeds of any recovery, the Plan Administrator may satisfy the lien by deducting the amount from future claims otherwise payable under the Plan.
SUBROGATION, REIMBURSEMENT & THIRD PARTY RECOVERY PROVISION (Continued)

If the Covered Person fails to take action against a responsible third party to recover damages within one year or within 30 days after the Plan requests, the Plan shall be deemed to have acquired, by assignment or subrogation, a portion of the Covered Person's claim equal to the amounts the Plan has paid on the Covered Person's behalf. The Plan may thereafter commence proceedings directly against any responsible third party. The Plan shall not be deemed to have waived its rights to commence action against a third party if it fails to act after the expiration of one year nor shall the Plan's failure to act be deemed a waiver or discharge of the lien described above.

The Covered Person shall cooperate fully with the Plan in asserting claims against a responsible third party and such cooperation shall include, where requested, the filing of suit by the Covered Person against a responsible third party and the giving of testimony in any action filed by the Plan. If a Covered Person fails or refuses to cooperate in connection with the assertion of claims against a responsible third party, the Plan Administrator may deny payment of claims and treat prior claims paid as overpayments recoverable by offset against future Plan benefits or by other action of the Plan Administrator.

In addition, the Plan has a right to recover benefits that were paid in error (e.g., benefits paid to an ineligible person), or benefits that were obtained through fraudulence, as determined by the Plan Administrator. Benefits may be recovered by either direct payment to the Plan by you or a beneficiary (through voluntary payments or legal action) or by an offset of future benefits equal to the amount of the overpayment.
GENERAL PLAN PROVISIONS

WAIVER. The failure of the Plan Administrator to strictly enforce any provision of this Plan shall not be construed as a waiver of the provision. The Plan Administrator reserves the right to strictly enforce each and every provision of this Plan at any time regardless of the prior conduct of the Plan Administrator and regardless of the similarity of the circumstances or the number of prior occurrences.

EFFECTIVE DATE OF CHANGE IN AMOUNT OF COVERAGE. Except as specifically provided, any change in the amount of Coverage of a Covered Person by reason of a change in classification, change in benefits structure and/or schedule, or for any other reason, will become effective on the first day of the next month.

CONFORMITY WITH LAW. This Plan shall be deemed automatically amended to conform with minimum requirements of the Employee Retirement Income and Security Act ("ERISA") as may be amended from time to time. If any provision of this Plan conflicts with any other law to which it is subject, such provision shall be deemed automatically amended to conform with the minimum requirements of any such law. If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

WRITTEN NOTICE. Any written notice required under this Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

STATEMENTS NOT WARRANTIES. In the absence of fraud, all statements made by the Employer or by a Covered Employee are deemed representation and not warranties. No statement made by the Employer, Employee or Dependent for the purpose of obtaining Coverage will be used to avoid such Coverage or reduce benefits unless the statement is in writing and is signed by the Employer, Employee or Dependent and a copy is sent to the Employer, Employee, Dependent or their beneficiary.

USE OF STATEMENTS. No statement made by or on behalf of any person shall be used in any context unless a copy of the written instrument containing such statement has been or is furnished to such person or to any person claiming a right to receive benefits with respect to such person.

GENDER IN CONTEXT. Whenever a personal pronoun in the masculine gender is used, it will be deemed to include the feminine unless the context clearly indicates the contrary.

MISSTATEMENTS ON APPLICATION. If any relevant fact has been misstated by or on behalf of any person to obtain Coverage under this Plan, the true facts shall be used to determine whether Coverage is in force and the extent, if any, of such Coverage. Upon the discovery of any such misstatement, an equitable adjustment of any contributions will be made.

NOT A CONTRACT. This Plan shall not be construed as a contract, consideration, or inducement of employment, or as affecting in any manner or to any extent whatsoever the rights or obligations of the Employer or any Employee to continue or terminate employment at any time.

CLERICAL ERROR. If a clerical error is made, it will not affect the Coverage to which the Covered Person is entitled. A fair adjustment of premiums shall be made when a clerical error pertaining to the Coverage under the Plan is found in keeping the records of the Plan or a delay in making entries on the records pertaining to the Plan. Such an error or delay will neither void Coverage that is otherwise validly in

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force, nor continue Coverage beyond the date that Coverage would otherwise have been reduced or terminated.

UNDERPAYMENT OR OVERPAYMENT. The Plan will reimburse any plan that makes a payment that should have been made by this Plan. The Plan can make the recovery against any person, insurance company, or other organization if an overpayment is made. If an overpayment is made it is the employee's responsibility to promptly reimburse the Plan. If timely reimbursement is not made the Plan reserves the right to take whatever legal action is necessary for collection and may apply the overpayment against future claims.

CHANGES IN THE PLAN. This Plan or any rider may be changed at any time. Any change must be in writing and will not require the consent of any individual. Only the plan administrator can change the provisions of this Plan. The Plan will not be bound by any promise or representation made by any other person.

LEGAL PROCEEDING. In addition to any other requirement as may apply under this Plan, legal actions to recover any lost benefits under this Plan may not be brought unless and until the Plan's appeal procedure, including utilization of a professional/peer review committee, has been exhausted.

AUTHORITY AND DISCRETIONARY CONTROL OF THE PLAN. The Plan Administrator, and/or its designated administrative agents or representatives, shall have full power and authority and absolute discretion to determine all questions of eligibility for benefits of all claimants and to interpret and construe the terms of the Plan. Such determinations, subject to the appeal procedures as may be available under this Plan, shall be conclusive and binding upon all interested parties.

REPLACEMENT OF ANOTHER PLAN. If this Plan replaces the Employer's prior plan of group health benefits, and if an Employee or a Dependent (a) becomes covered by this Plan on its effective date, and (b) had been covered by the Employer's prior plan of group health benefits on the day before this Plan took effect:

1. credit will be given for any amounts applied to the prior plan's Calendar Year Deductible and Out-of-Pocket Amount(s) or for any time accumulated under the Pre-Existing Conditions Limitations of the prior plan toward satisfying the Deductible and Out-of-Pocket Amount(s) and Pre-Existing Conditions Limitations of this Plan;

2. payment for benefits under this Plan will be made for any Pre-Existing Conditions being paid under the prior plan. Benefits payable for the Pre-Existing Conditions will be based on the benefits payable under this Plan; and

3. benefits under this Plan will not be payable for any expenses being paid by the prior plan under an extension of benefits provision.

IN THE EVENT OF AN ACQUISITION OR MERGER. In the event of an acquisition or merger, the Plan Administrator shall have full power and authority and absolute discretion to waive the Waiting Period and any Pre-Existing Conditions Limitations of this Plan for Employees and Dependents.

If the Plan Administrator elects to extend Coverage under this Plan to a newly acquired affiliated and/or associated company; and if this Plan replaces the prior plan of group health coverage of the newly acquired affiliated and/or associated company; and if an Employee or a Dependent (a) becomes covered by this Plan
GENERAL PLAN PROVISIONS (Continued)

on the date this Plan replaces the prior plan, and (b) had been covered by the prior plan of group health benefits on the day before Coverage was assumed by this Plan:

1. credit will be given for any amounts applied to the prior plan's calendar year deductible and out-of-pocket amount(s) or for any time accumulated under the pre-existing conditions limitations of the prior plan toward satisfying the Deductible and Out-of-Pocket Amount(s) and Pre-Existing Conditions Limitations of the Plan;

2. payment for benefits under this Plan will be made for any pre-existing conditions that was covered under the prior plan. Benefits payable for the pre-existing conditions will be based on the benefits payable under this Plan; and

3. benefits under this Plan will not be payable for any expenses being paid by the prior plan under an extension of benefits provision.

AMENDING AND TERMINATING THE PLAN. The Employer currently intends to maintain the Plan indefinitely, but since future conditions affecting the Employer cannot be anticipated or foreseen, the Employer reserves the right to amend, modify, suspend or terminate the Plan in whole or in part at any time by formal written action. This includes, but is not limited to, amending the benefits, Deductibles, maximums, Co-Payments, exclusions, limitations, definitions or eligibility requirements under the Plan[ or the Trust Agreement (if any)]. If the Plan is terminated or amended to reduce or terminate certain benefits, the rights of the Covered Persons to benefits are limited to expenses incurred prior to such termination or amendment.
COBRA CONTINUATION COVERAGE

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Covered Employees and/or their Covered Dependents described below (called "Qualified Beneficiaries") are entitled to elect to purchase a temporary continuation of health Coverage (called "Continuation Coverage") at group rates in certain instances (called "qualifying events") when Coverage under the Plan would otherwise end.

An Employee covered by the Plan has a right to elect Continuation Coverage if Coverage is lost because of a termination of employment (for reasons other than gross misconduct) or a reduction in hours of employment.

The Covered Dependent who is the spouse of a Covered Employee has a right to elect Continuation Coverage (even if the Employee chooses to decline Continuation Coverage) if the Covered Dependent loses group health Coverage under the Plan for any of the following four reasons:

1. The death of the Employee;
2. A termination of the Employee's employment (for reasons other than gross misconduct) or reduction in the Employee's hours of employment;
3. The divorce or legal separation, where recognized, from the Employee; or
4. The Employee becomes entitled to benefits under Medicare.

In the case of a Covered Dependent who is a child of a Covered Employee, such child has the right to elect Continuation Coverage (or the Employee's spouse may elect Continuation Coverage on behalf of the child, even if the Employee chooses to decline Continuation Coverage) if group health Coverage under the Plan is lost for any of the following reasons:

1. The death of the Employee;
2. A termination of the Employee's employment (for reasons other than gross misconduct) or a reduction in the Employee's hours of employment;
3. The Employee's divorce or legal separation, where recognized;
4. The Employee becomes entitled to benefits under Medicare; or
5. The child ceases to be a "Dependent child" under the Plan.

Qualified Beneficiaries have the same rights as similarly situated active employees to change Coverage options and Coverage levels during Open Enrollment or if he experiences a Change in Status or Special Enrollment event.

ELECTING CONTINUATION COVERAGE. Provided you or your Covered Dependents have provided any required notice to the Plan Administrator (see below), you or your Covered Dependents will be notified of the right to continue Coverage and provided with the necessary information to complete an election. You and your Covered Dependents will have 60 days from the date the notice of the right to Continuation Coverage is received (or, if later, 60 days from the date coverage is lost) to complete an election of Continuation Coverage. If the election is not completed within the 60-day period, you will not have Continuation Coverage and will have no further rights to elect such coverage.
Each Qualified Beneficiary may purchase Continuation Coverage by completing and returning the appropriate election forms.

**ADDING NEW DEPENDENTS.** Children born to, adopted by, or placed for adoption with the Covered Employee during the period of Continuation Coverage will be considered Qualified Beneficiaries and may also receive Continuation Coverage provided they are added within the time required by the Plan after the birth, adoption or placement for adoption.

Other than a child born to, adopted by, or placed for adoption with a Covered Employee during the COBRA period, spouses and dependents added during the COBRA coverage period are not Qualified Beneficiaries, even though the new spouse or dependent may be eligible to be added to the Coverage for the balance of the COBRA coverage period. The Covered Employee must enroll the new spouse and/or dependent within 31 days after the marriage, birth, adoption, or placement for adoption. If COBRA coverage ceases for the Covered Employee before the end of the maximum COBRA coverage period, COBRA coverage also will end for a newly added spouse or dependent child. However, COBRA coverage can continue for a newly added newborn child, adopted child, or child placed with the Covered Employee for adoption until the end of the maximum COBRA coverage period.

If while the Covered Employee is enrolled in Continuation Coverage, his or her spouse or dependent loses coverage under another group health plan, the Covered Employee may add the spouse or dependent to his or her coverage for the balance of the Continuation Coverage period, provided the eligible dependent meets the requirements for special enrollment as described in the “SPECIAL ENROLLMENT” section of this Plan.

Continuation Coverage may also apply to certain covered retirees and their covered dependents in the event of the Employer's bankruptcy under Title 11 of the U.S. Code. Special rules apply for this event.

**COVERED PERSON’S NOTICE REQUIREMENTS.** Under COBRA and this Plan, Covered Persons, have the responsibility to notify the Plan Administrator at:

Director of Human Resources  
Embry-Riddle Aeronautical University  
600 South Clyde Morris Blvd.  
Daytona Beach, FL 32114  
386 226-6145

of a divorce, legal separation, where recognized, or a child losing dependent status under the Plan. To protect the Covered Person’s Continuation Coverage rights in these situations, this notification must be made within 60 day from whichever date is later, the date of the event or the date on which health plan coverage would be lost under the terms of the Plan because of the event.

**NOTICE PROCEDURES.** Procedures for making proper and timely notice are listed below.

1. Contact the Human Resources Department and request a Qualifying Event Notification Form;
2. Complete the Qualifying Event Notification Form;
3. Make a copy of the form for your records;
4. Attach the required documentation depending upon the qualifying event;
5. Hand deliver or mail the notification form to the address listed on the form and document your mailing; and
6. Call within 10 days to insure the notification form has been received.

If this notification is not completed according to the outlined procedures and within the required 60-day notification period, then rights to Continuation Coverage based on the occurrence of the event will be forfeited. In addition, failure to notify and thereby causing the Plan to continue coverage of an individual who has in fact become ineligible may be considered fraud on the part of the Employee.

The Covered Person must also notify the [Plan Administrator] of the current address of the individual losing coverage. This is the address where the COBRA notice will be sent. Once it is notified, the [Claims Administrator] will, in turn, notify the eligible COBRA participant that he or she has the right to elect Continuation Coverage.

EMPLOYER'S NOTICE REQUIREMENTS. If the qualifying event is a termination of employment, reduction in hours, death, enrollment in Medicare (Part A, Part B, or both) or a commencement of a bankruptcy proceeding, the Covered Person will be notified that he or she has the right to elect Continuation Coverage. The eligible COBRA participant has 60 days from the date of the COBRA notice (or, if later, 60 days from the date Coverage is lost because of one of the qualifying events described above) to elect Continuation Coverage.

TRADE ADJUSTMENT ASSISTANCE. An Employee may have the right to a second COBRA election period if the Employee was entitled to elect COBRA coverage and did not do so during the original COBRA election period. To qualify, the Employee must be receiving trade adjustment assistance (eligibility requires a government certification under the 1974 Trade Act) and must have lost his or her Coverage under the Plan because of a job loss that resulted in his or her eligibility for trade adjustment assistance. The Employee’s new 60-day COBRA election period will begin the first day of the month in which he or she begins receiving trade adjustment assistance, but it will not extend more than six months after his or her initial loss of Coverage under the Plan. If the Employee elects COBRA coverage during this second election period and after the end of the initial election period, his or her Continuation Coverage will begin on the first day of the second election period. The Employee’s Continuation Coverage will not be retroactive to the date of the initial loss of Coverage. The period of time between the Employee’s loss of Coverage that resulted in his or her eligibility for trade adjustment assistance and the date he or she began receiving trade adjustment assistance will not be counted in determining whether he or she has a 63-day break in Coverage for purposes of applying any Pre-existing Condition Limitation under the Plan.

TYPE OF COVERAGE. If timely and properly elected and paid, Continuation Coverage will be provided to Qualified Beneficiaries in a manner identical to Coverage provided under the Plan to similarly situated Covered Persons who are not Qualified Beneficiaries.

LENGTH OF CONTINUATION COVERAGE. The length of Continuation Coverage depends upon the type of qualifying event and who the Qualified Beneficiary is. If you are on an approved military leave that lasts longer than 30 days, your Continuation Coverage can last up to 24 months. In the case of a loss of coverage due to the end of employment or the reduction in hours of employment, Continuation Coverage can last up to 18 months. In the case of a loss of coverage due to the Covered Employee's death, divorce or legal separation, the Covered Employee's becoming entitled to Medicare or a dependent child ceasing to qualify as a Dependent under the terms of the Plan, Continuation Coverage may last for up to 36 months (provided that the Qualified Beneficiary submitted written notice of divorce, legal separation or dependent child ceasing to be a dependent within 60 days of the later of the date of the event or the date coverage is lost as a result of
**COBRA CONTINUATION COVERAGE (Continued)**

the event). When the qualifying event is the end of employment or reduction in hours of employment, and the Covered Employee became entitled to Medicare less than 18 months before the qualifying event, COBRA coverage for Qualified Beneficiaries (other than the Employee) who lose coverage as a result of the qualifying event can extend up to 36 months after the date of Medicare entitlement.

**SECOND QUALIFYING EVENTS.** The maximum duration of Continuation Coverage based on termination of employment or reduction in hours may be extended from 18 months to 36 months if a second event entitling a Covered Dependent to Continuation Coverage (such as a death, divorce, legal separation (where recognized), the Employee's Medicare entitlement or a child losing Dependent status under the Plan) occurs during that 18-month period (or the first 29 months of continuation coverage in the case of a disability extension). To qualify for this extension, the Employee or Covered Dependent must notify the Employer within 60 days after the second event. In providing this notice, you must follow the notice procedures specified above. You are entitled to an extension only if the event would have caused a spouse or dependent child of an active employee to lose coverage under the Plan. If the Employee or Covered Dependent does not notify the Employer within the 60-day period, the Covered Dependent will not be entitled to extend the maximum period from 18 months to 36 months.

**DISABILITY DETERMINATION.** For certain disabled Qualified Beneficiaries, Continuation Coverage may be available for up to a total of 29 months from the date of the qualifying event. If you or your Covered Dependent elect Continuation Coverage for reasons due to termination of employment or reduction of hours, and are deemed disabled by the Social Security Administration before, on, or within 60 days of the date the Continuation Coverage became effective, you and your Covered Dependents may be eligible for up to an additional 11 months of Continuation Coverage. You must notify the [Claims Administrator] within 60 days of the date of the Social Security disability determination and before the end of the initial 18-month COBRA period. You must also notify the [Claims Administrator] within 30 days of the Social Security Administration’s determination that you (or your Covered Dependent) are no longer disabled.

If the individual entitled to the disability extension (described in the preceding paragraph) has nondisabled family members who have Continuation Coverage due to the same qualifying event, those nondisabled family members will also be entitled to this 11-month disability extension. If a child is born to or adopted (or placed for adoption) by you while you are continuing coverage and the child is determined to be disabled within the first 60 days of Continuation Coverage, the child and all family members with Continuation Coverage arising from the same qualifying event may be eligible for a total of up to 29 months of Continuation Coverage.

**UNIFORMED SERVICES.** Pursuant to the Veterans Benefits Improvement Act 2004 (VBIA), Members of the Uniformed Services and their families are entitled to health coverage under TRICARE, the military health program. If a Covered Employee takes a leave of absence to perform services in the Uniformed Services that is expected to last 31 days or more (as addressed in the Uniformed Services Employment and Reemployment Act (USERRA)), employers must offer employees called to active service the right to continue their employer-provided health coverage for themselves and their dependents for a period of up to 24 months.

**TERMINATION BEFORE THE END OF MAXIMUM COVERAGE PERIOD.** In all cases, Continuation Coverage will end for any of the following reasons:

1. Employer no longer provides group health coverage for any of its Employees;
COBRA CONTINUATION COVERAGE (Continued)

2. Appropriate payment for Continuation Coverage is not made timely;

3. After the date of the COBRA election, the Employee or Dependent becomes covered under another group health plan that does not contain a pre-existing condition exclusion or limitation which affects them (under the HIPAA portability laws, the time the other health plan can exclude coverage for pre-existing conditions may be reduced by the period of time during which you had coverage for the condition under a previous health plan, including Continuation Coverage);

4. After the date of the COBRA election, the Employee or Dependent becomes entitled to Medicare;

5. The Employee and/or Dependents previously extended continuation coverage beyond 18 months due to a Social Security disability, and a final determination has been made that the Qualified Beneficiary is no longer disabled;

6. A Qualified Beneficiary notifies the Employer he wishes to cancel COBRA Continuation Coverage; or

7. Any other event that would cause a Covered Person who is not on Continuation Coverage to lose Coverage under the Plan.

Written health evidence is not required to elect Continuation Coverage.

PAYING FOR CONTINUATION COVERAGE. Initial payment for Continuation Coverage must be made within 45 days from the date of Continuation Coverage election. This initial payment must pay for all months of coverage from the date of the qualifying event up to and including the month in which the payment is made. Continuation Coverage will not become effective until the full and correct initial payment is made and received. Subsequent payments are due on the first day of each month of Coverage. Premiums are delinquent if not paid by 30 days following the due date, in which event Continuation Coverage will cease, without notice, retroactive to the first day of the month for which payment has not been made. A check that is dishonored for any reason will not be considered payment.

COST OF CONTINUATION COVERAGE. Qualified Beneficiaries must pay the entire cost of Continuation Coverage, including an additional 2% charge to cover administrative expenses. Required contribution for any part of the additional 11 months of Continuation Coverage due to disability may be increased up to 150% of the applicable premium if the disabled Qualified Beneficiary elects the extension. If only non-disabled Qualified Beneficiaries elect the extension, the applicable premium will remain at the 102% rate.

You and your Covered Dependents will receive written notice of the cost of Continuation Coverage at the time of eligibility. You may also request written verification of the cost of Continuation Coverage at any time during the Continuation Coverage period.

NOTIFICATION OF ADDRESS CHANGE. To ensure all Covered Persons receive information properly and efficiently, it is important that you notify FBMC at the address listed below of any address change for you or your Dependent as soon as possible. Failure on your part to do so may result in delayed COBRA notifications or the loss of Continuation Coverage options.

FBMC
PO Box 730561
Ormond Beach, FL 32173-0561

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DEFINITIONS

This section defines some of the specific terms used in this Plan. The following definitions should not be interpreted to extend Coverage and are defined for reference only. Not all of the definitions may apply to this Plan.

**Accident** means any unforeseen and unavoidable event resulting in an Injury.

**Accidental Injury** means a bodily Injury sustained in the course of an Accident and independently of all other causes by a traumatic event or due to exposure to the elements. The term does not include Injury which arises out of or in the course of any employment or occupation for compensation or profit. The term also does not include chewing injuries.

**Acute** means a condition having rapid onset, severe symptoms and a short course.

**Acute Care** means health care delivered to patients experiencing Acute Illness or trauma. Acute Care generally occurs in a Hospital or emergency room setting and is generally a short-term pattern of care in contrast to chronic care, which is long term.

**Age Discrimination** means a violation of the Social Security Act, which states that all active Employees and their Covered Dependents age 65 and over are entitled to the same and/or equal benefits they had prior to age 65.

**Alcohol or Drug Abuse Treatment Facility or Substance Abuse Treatment Facility** means a facility, licensed and operated according to the law, which provides a program for diagnosis, evaluation, and effective treatment of Alcoholism or Drug Dependency. The facility must be supervised by a staff of Physicians and must provide skilled nursing care by licensed Nurses who are directed by a full-time R.N.

**Alcoholism** means the chronic and habitual use of alcoholic beverages. This use must: (1) injure the person’s health; (2) interfere with the person’s ability to function normally; or (3) have reached the point where the person has lost his or her self control.

**Alternate Recipient** - see Dependent

**Ambulatory Surgical Center or Outpatient Surgical Facility** means a facility, licensed and operated according to the law, which does not provide services or accommodations for the patient to stay overnight. The facility must have an organized medical staff of Physicians; maintain permanent facilities equipped and operated primarily for the purpose of performing Surgical Procedures; and supply registered professional nursing services whenever a patient is in the facility.

The term does not include a facility for the primary purpose of performing terminations of Pregnancy or an office maintained by a Physician for the practice of medicine or an office maintained for the practice of Dentistry.

**Anesthesia** means the administration of a local or general anesthetic agent by a Physician, Anesthetist, Anesthesiologist, or Registered Nurse when rendered in connection with a covered Surgical Procedure. **Local** - administration of specific anesthetic agent(s) to achieve the loss of pain sensation in a specific location or area of the body. **General** - administration of specific anesthetic agent(s) to render the patient completely unconscious and without pain sensation.
DEFINITIONS (Continued)

At Work and Work means the time and energy you spend performing, in the customary manner, all of the essential functions of your regular job duties on a Full-Time basis, either at one of the Employer’s regular places of business or at some location to which the Employer’s business requires you to travel to perform your regular duties or other duties assigned by your Employer. You are also considered to be at Work on each day of a regular paid vacation or non-working day, but only if you were performing in the customary manner all of the regular duties of your occupation with your Employer on the immediately preceding regularly scheduled workday. For purposes of this Plan, you will also be considered to be at Work on a day that you are absent from work due to any health factor.

Average Semi-Private Room Rate means the rate that is charged by the Hospital for confinement in most of its semi-private rooms.

Birthing Center means a facility, which meets the free standing birthing center requirements of the State Department of Health (or its equivalent) in the state where the Covered Person receives the services.

Calendar Year means the twelve-month period beginning each January 1 and ending on the following December 31.

Certificate of Creditable Coverage has the meanings as described in the Pre-Existing Conditions Limitations section of this Plan.

Chemical Dependency - see Drug Abuse.

Chemical Dependency Treatment Facility - see Drug Abuse Treatment Facility.

COBRA Beneficiary means any Covered Person who is continuing participation under the Plan consistent with the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA).

Complications of Pregnancy means a condition or conditions (when the Pregnancy is not terminated) whose diagnosis is distinct from, but caused or affected by, Pregnancy. As applied to any Covered Person, the word “Illness” includes Complications of Pregnancy.

Complications of Pregnancy include: Acute nephritis or nephrosis; cardiac decomposition; missed abortion; or similar conditions as severe as these. Complications of Pregnancy also include a non-elective cesarean section, an ectopic Pregnancy which is terminated; and spontaneous termination of Pregnancy which occurs during a period of gestation when a live birth is not possible; and, pernicious vomiting (hyperemesis gravidarum) and toxemia with convulsions (eclampsia of Pregnancy).

Complications of Pregnancy do not include: false labor, occasional spotting, Doctor prescribed rest; morning sickness, or similar conditions which, although associated with the management of a difficult Pregnancy, are not medically classified as distinct Complications of Pregnancy.

Convalescent Care Facility - see Skilled Nursing Facility.

Co-Pay or Co-Payment means the amount payable by the Covered Person at the time of service for certain Covered Services.

Cosmetic Surgery means cosmetic surgery or the reversal or correction of cosmetic surgery except for treatment or surgery for reconstructive surgery, only if such surgery is necessary to correct a deformity or to
DEFINITIONS (Continued)

restore or provide normal bodily function lost as a result of an Injury or Illness; or for reconstructive surgery
due to a congenital disease or anomaly which has resulted in a functional defect of a Covered Dependent child.

Coverage means coverage under this Plan.

Covered Employee; Covered Dependent; Covered Person means any eligible participant whose Coverage
became effective and has not terminated, including those eligible participants who elected to continue
Coverage through the COBRA Continuation Coverage provision.

Covered Service or Covered Expense means a treatment or procedure given by, or under the direction of, a
licensed Physician or Practitioner and of an approved type usually provided for the condition being treated
and for which Coverage is provided under this Plan.

Creditable Coverage has the meanings as described in the Pre-Existing Conditions Limitations section of
this Plan.

Custodial Care means care which is designed essentially to help a person in the activities of daily living and
which does not require the continuous attention of trained medical or paramedical personnel. Such care may
involve preparation of special diets, supervision over medication that can be self-administered and assistance
in getting in or out of bed, walking, bathing, dressing, eating and using the toilet.

Deductible means the amount you pay before certain benefits are payable from the Plan.

Dentist means any dental or medical Practitioner the Plan is required by law to recognize who is properly
licensed or certified under the laws of the state where he practices and who provides services which are
within the scope of his license or certificate and covered by this Plan.

Dependent means the Covered Employee’s Spouse and children.

- The term “Spouse” means the spouse of the Covered Employee under a legally valid existing marriage.
The term shall exclude such spouse who has divorced the Employee or who is legally separated from the
Employee. “Spouse” shall include the domestic partner of a Covered Employee.

- The term “children” means unmarried children under age 19 (or older if described below) and
principally dependent upon either parent for support and maintenance. Children eligible for Dependent
Coverage include:

  - Covered Employees’ natural born or adopted children (or placed for adoption), step children, and
children for whom the Covered Employee is the court-appointed legal guardian;

  - The term children will be expanded to include children of a non-employee domestic partner if the
covered domestic partner who is the Employee has legally assumed principal support and maintenance
for the child(ren) and live in a child/parent relationship

  - A Covered Employee’s or Spouse’s child who is recognized under a Qualified Medical Child Support
Order (QMCSO) as having a right to Coverage under the Plan as an “alternate recipient.” The Plan
Administrator will communicate the procedures which have been established to determine whether a
Medical Child Support Order is qualified under ERISA Section 609, and within a reasonable time after
DEFINITIONS (Continued)

receiving an order will determine whether or not the order is qualified and whether or not the child has been determined to be an “alternate recipient.” The Covered Employee and each child who is the subject of the order will be notified of the determination. Such children may designate a representative to receive copies of all such notices. A child determined to be an “alternate recipient” will be provided Coverage under the same terms and conditions that apply to Dependents who are a Covered Employee’s natural children, with no pre-existing conditions limitations applied provided the Dependent is enrolled in a timely manner as stated herein.

- A Covered Employee’s unmarried child who has attained the age of 19 but who is a Full-Time student registered in an accredited school as a full-time student consistent with Internal Revenue Code requirement for purposes of determining eligible tax dependent status. For Coverage to continue during vacation periods, the child must be scheduled to enter school on the next Enrollment Date. In no event, however, is such child eligible or covered hereunder on or after the end of the month of the Dependent’s 26th birthday.

- A Covered Employee’s unmarried child while the child is physically or mentally handicapped and is incapable of earning his own living, and who is actually dependent on either parent for maintenance and support, and who is a covered individual on the date immediately preceding the date his Coverage would have terminated due to age. Proof of incapacity must be submitted to the [Plan Administrator] within 31 days of the date the child’s Coverage would have terminated due to age, and thereafter as may be required by the [Plan Administrator], but not more frequently than annually following the child’s attainment of the limiting age; otherwise the child’s Coverage will not be continued.

In the event both parents of an eligible Dependent child are Covered Employees, then for purposes of this Plan, such child is considered as a Dependent of either parent, but not both parents. No one can be a Covered Employee and a Covered Dependent at the same time.

Diagnostic Charges means the Usual, Reasonable and Customary charges for x-rays or laboratory examinations made or ordered by a Physician in order to detect a medical condition.

Drug Abuse means being physically and/or emotionally dependent on drugs, narcotics, alcohol or any other addictive substance that results in a chronic disorder affecting, to a debilitating degree, physical health and/or personal or social functioning. The term does not include dependence on tobacco and caffeine.

Drug Abuse Treatment Facility means a facility, licensed and operated according to the law, which provides a program for diagnosis, evaluation, and effective treatment of Drug Abuse including Alcoholism. The facility must be supervised by a staff of Physicians and must provide Skilled Nursing Care by Nurses who are directed by a full-time R.N.

Drug Dependency - see Drug Abuse.

Drug Dependency Treatment Facility - see Drug Abuse Treatment Facility.

Durable Medical Equipment means equipment able to withstand repeated use for the therapeutic treatment of an active Illness or Injury. Such equipment will not be covered under the Plan if it could be useful to a person in the absence of an Illness or Injury and could be purchased without a Physician’s prescription.
DEFINITIONS (Continued)

Effective Date means the effective date of the Plan is May 1, 1989. For the effective date of individual coverage, see that provision in the Plan entitled "Effective Date".

Elective Hospital Admission means any non-emergency Hospital admission which may be scheduled at the patient’s convenience without jeopardizing the patient’s life or causing serious impairment.

Elective Surgical Procedure means any non-emergency Surgical Procedure which may be scheduled at the patient’s convenience without jeopardizing the patient’s life or causing serious impairment.

Eligibility Waiting Period means the time beginning with the Employee’s most recent date of continuous employment with the Employer, and ending on the date he is eligible to enroll in this Plan.

Employee a person who is directly employed in the regular business of and compensated for services by the Employer or any subsidiary or affiliate, and who actively expends time and energy in the service of the Employer at the Employer’s usual place of business or some other location which is usual for the Employee’s particular duties, including the Employee’s home. An Employee will not include any of the following: an individual classified by the Employer as a temporary, casual or seasonal employee, or a contract worker or independent contractor.

Employer means Embry Riddle Aeronautical University[ and, if applicable, any of its authorized affiliates or subsidiaries that adopts the Plan as a participating employer and are listed in Exhibit A hereto.]

Enrollment Period means the period as designated by the Plan in which an Employee may change his election. Employees who fail to enroll during this period may be subject to Late Applicant requirements unless eligible to enroll pursuant to a Change in Status or Special Enrollment provision as described in the Section entitled, Eligibility, Enrollment and Effective Date.

Enrollment Date means the first day of Coverage or, if there is a waiting period, the first day of the Eligibility Waiting Period.

Experimental Investigational means treatment, procedure, drug, device, or technology as to which the Plan Administrator or its designee has determined that any of the following applies (at the time it makes a determination regarding Coverage):

1. It cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA), and approval for marketing has not been given at the time the treatment, procedure, drug, or device is furnished; or

2. It is subject to review and approval by the treating facility’s institutional review board, or other institutional review board; or

3. Reliable Evidence shows that to determine its maximum tolerated dose, toxicity, safety, or efficacy as compared with the standard means of treatment or diagnosis for the condition in question:
    a. It is undergoing phase I, II, or III clinical trials (as defined by FDA regulations, regardless of whether the trial is subject to FDA oversight), or is under study; or,
    b. Further clinical trials or studies are needed according to the experts’ consensus opinion.
DEFINITIONS (Continued)

“Reliable Evidence” means published reports and articles in authoritative medical and scientific literature; or the written protocol or protocols used by the treating facility, or by another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility, or by another facility studying substantially the same drug, device, medical treatment or procedure.

Extended Care Facility - see Skilled Nursing Facility.

Full-Time, Full-Time Employee, Full-Time Work, and like terms will mean a job with the Employer on a regular and active basis for pay and scheduled to work at least the number of hours as stated in the Section entitled Eligibility, Enrollment and Effective Date. Without limiting the above, these terms will not mean part-time or temporary work; or working in a place that is not the Employer’s usual place of business, unless employed in a job that requires you to travel.

Home Health Care means a program of medical care and treatment, provided by a public or private agency or organization, licensed and operated according to the law, that is provided in the home.

Home Health Care Agency means a public or private agency or organization, licensed and operated according to the law, that specializes in providing medical care and treatment in the home. The agency must have policies established by a professional group and at least one Physician and one registered graduate Nurse to supervise the services provided.

Hospice Care means a program approved by the attending Physician for care rendered in a Hospice Facility, a Hospital, or in the home to a Terminally Ill Covered Person with a medical prognosis that life expectancy is 6 months or less.

Hospice Facility means a public or private organization, licensed and operated according to the law, primarily engaged in providing palliative, supportive, and other related care for a Covered Person diagnosed as Terminally Ill with a medical prognosis that life expectancy is 6 months or less.

The facility must have an interdisciplinary medical team consisting of at least one Physician, one registered Nurse, one social worker, one volunteer and volunteer program. A Hospice facility is not a facility or part thereof which is primarily a place for rest, Custodial Care, the aged, drug addicts, alcoholics, or a hotel or similar institution.

Hospital means an institution constituted, licensed, and operated as set forth in the laws of applicable jurisdiction, if it: (1) provides room and board and nursing care for its patients; (2) has a staff with one or more Physicians available at all times; (3) provides 24-hour registered nursing service; (4) maintains on its premises all the facilities needed for the diagnosis and medical care and treatment of Sickness or Injury; and (5) provides organized facilities for major Surgery. A birthing home or center that has Certified Nurse-Midwives on its staff will be considered as a Hospital. This term does not include an institution, or that part of an institution, which is, other than by coincidence, used for: (1) rest care; (2) convalescent care; (3) care of the aged; or (4) Custodial Care.

The Hospital’s Most Common Semi-Private Room Rate means the rate that is charged by the Hospital for confinement in most of its semi-private rooms. If the Hospital has no semi-private rooms, this term will mean the lowest rate charged by the Hospital for confinement in a private room.

Illness means any bodily Sickness, disease, or disorder; Pregnancy; Complications of Pregnancy; or Mental and Nervous Disorders.
DEFINITIONS (Continued)

**Injury** means a condition which results independently of an Illness and all other causes and is a result of an externally violent force or Accident.

**Inpatient** means a person who is confined in an approved facility during the period when he is charged for room and board.

**Intensive Care Unit** means a section, ward or wing within a Hospital which is operated exclusively for critically ill patients and provides special supplies, equipment and constant observation and care by registered graduate Nurses or other highly trained personnel. This excludes, however, any Hospital facility maintained for the purpose of providing normal post-operative recovery treatment or service.

**Late Applicant/Entrant** means an Employee or Dependent who does not enroll when first eligible to enroll, or during the time specified during the Special Enrollment when there is a Change in Status or loss of coverage under another plan.

**Layoff** means that the Employer ceases to employ the Employee, but expects to recall the Employee to Full-Time Work after a limited period of time.

**Leave of Absence** means a period of time, of stated duration, during which the Employee does not work but after which time the Employee is expected to return to Full-Time Work.

**Mammography** means the x-ray examination of the breast using equipment dedicated specifically for such examination.

**Medicaid** means the state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965, as amended.

**Medical Emergency** means an Illness and/or Injury which occurs suddenly and unexpectedly with Acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention or use of the most accessible Hospital equipped to furnish care could reasonably be expected to result in the death or serious impairment of the Covered Person’s health or bodily functions.

Such conditions include, but are not limited to, actual or suspected heart attack, loss of consciousness, actual or suspected poisoning, Acute appendicitis, heat exhaustion, convulsions, major burns, spinal Injuries, shock, emergency medical care rendered to Accident cases and other Acute and potentially life-threatening conditions.

**Medically Necessary or Medical Necessity** means a specific medical, health care, or Hospital service that is required for the identification, treatment, or management of a medical symptom or condition. A service, care or supply is Medically Necessary if it is: 1) consistent with the symptom, diagnosis, and treatment of the condition; and 2) in accordance with standards of good medical practice; and 3) approved by the appropriate medical body or board for the condition in question; and 4) is not primarily for the convenience of the Covered Person, a Physician, or other Provider; and 5) is the most appropriate, efficient, and economical medical supply, service or level of care which can be safely provided.

**Medicare** means Title XVIII (Health Insurance for the aged) of the Social Security Act, as amended.
Mental/Nervous Disorder (or Illness) means a mental or emotional disease or disorder of any kind, including any neurosis, psychoneurosis, psychopathy, psychosis or personality disorder which requires regular care by a Physician.

Mental/Nervous Treatment Facility means a facility, licensed and operated according to the law, which provides a program for diagnosis, evaluation, and effective treatment of Mental/Nervous Disorders; infirmary-level medical services; supervision by a staff of Physicians; and skilled nursing care by Licensed Practical Nurses who are directed by a full-time R.N. The facility must also prepare and maintain a written plan of treatment for each patient. The plan must be based on medical, psychological and social needs.

Newborn Well-Baby Care has the meaning as described in the paragraph entitled, “Newborn Well-Baby Care” in the Covered Medical Expenses section of this Plan.

Non-PPO Physician or Non-PPO Provider (or Non-PPA Physician or Non-PPA Provider) means a Physician or other health care provider, such as a Hospital, a clinic, or a Pharmacy, who has chosen not to participate in the PPO. Since participation arrangements have not been established with these Physicians or other providers, payment will be made directly to you, unless you have assigned benefits to the Physician or other provider. If you receive services in a Non-PPO Hospital and assign benefits, the Hospital will be paid directly. You will be responsible for the difference between what was paid by the Plan and what was charged.

Non-Therapeutic Abortion means an elective termination of Pregnancy not caused by medical reasons. The Pregnancy must be terminated before a live birth is possible. It does not mean a miscarriage.

Normal Pregnancy; Pregnancy does not include any Complications of Pregnancy.

Nurse means a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), or a Licensed Vocational Nurse (L.V.N.).

Nurse Midwife or Certified Nurse Midwife means a person who has been certified as a Nurse Midwife by the American College of Nurse-Midwives and who is authorized to practice as a Nurse Midwife under the state regulations where the Covered Person receives the services.

Occupational Therapy means a program of self-care designed to restore, develop, and maintain a patient’s ability to perform functional daily tasks in order to achieve maximum independence.

Open Enrollment/Annual Enrollment Period/Choice Period means, the only period of time (usually, but not always, a one-month period each year) in which an Employee can enroll for Coverage, drop Coverage, or make any changes (unless there is a Change in Status or Special Enrollment).

Out-of-Area means outside of the network geographical Service Area.

Outpatient means a person who receives care for a Sickness or an Injury but who is not confined as an Inpatient and is not charged for room and board.

Outpatient Surgical Facility or Ambulatory Surgical Center means a facility, licensed and operated according to the law, which does not provide services or accommodations for the patient to stay overnight. The facility must have an organized medical staff of Physicians; maintain permanent facilities equipped and
DEFINITIONS (Continued)

operated primarily for the purpose of performing Surgical Procedures; and supply registered professional nursing services whenever a patient is in the facility.

**Palliative** - an alleviating measure. To relieve, but not cure.

**Partial Hospitalization** means care offered by a program accredited by the Joint Commission Accreditation of Healthcare Organizations or in compliance with equivalent standards. Such care must be provided as part of a formal Hospital Outpatient program. Such programs consist of one or more scheduled sessions conducted by members of the Hospital’s staff. The sessions are usually from 4 to 8 hours long. Licensed Drug Abuse rehabilitation programs and alcohol rehabilitation programs accredited by the Joint Commission on Accreditation of Healthcare Organizations or approved by the appropriate state are also considered to be Partial Hospitalization Services.

**Participating Physician** or **Participating Provider** means a Physician, Hospital, Skilled Nursing Facility, Home Health Care Agency or any other duly licensed institution of health Practitioner under contract with the PPO.

**Participating Provider Network** means the group of health care providers who has an agreement with your Employer to provide services through a PPO (Preferred Provider Organization) or PPA (Preferred Provider Arrangement).

**Period of Confinement** means that a Covered Person is discharged from a Convalescent/Skilled Nursing/Extended Care Facility and again becomes an Inpatient in such facility due to the same or related causes separated by less than 3 months in a row. In regards to Hospital stays, a Covered Person is discharged from the Hospital and again becomes an Inpatient in such facility due to the same or related cases and had not, with respect to a Covered Employee, returned to Active Work for at least one full day; or with respect to a Dependent, was not separated by a period of complete recovery.

**Pharmacist** means a person who is licensed to prepare, compound and dispense medication and who is practicing within the scope of his or her license.

**Pharmacy** means a licensed establishment where Prescription medications are dispensed by a Pharmacist.

**Physical Therapy** means a program of care, including exercises and movements to maximize the patient’s motor skills, provided by a registered physical therapist, designed to return a patient to the highest level of motor functioning possible.

**Physically or Mentally Handicapped** means the inability of a person to be self-sufficient as the result of a condition such as mental retardation, cerebral palsy or other neurological disorder and diagnosed by a Physician as a permanent and continuing condition.

**Physician/Doctor** means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Dental Medicine (D.M.D.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Psychologist (Ph.D.), Optometrist (O.D.), Licensed Professional Physical Therapist, Physiotherapist, Licensed Professional Counselor, Psychiatrist, Audiologist, Speech Language Pathologist, Midwife and any other Practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.
DEFINITIONS (Continued)

Plan will mean, whenever used herein without qualification, the Plan of benefits as described in this Plan Document and Summary Plan Description and any agreements, schedules and Amendments endorsed by the Employer.

Plan Administrator means the Embry Riddle Aeronautical University Director of Human Resources.

Plan Percentage has the meaning as described in the General Medical Provisions section of this Plan.

Podiatry means the diagnosis, treatment, and prevention of the conditions of the human feet.

PPA – see Preferred Provider Organization (PPO); or Preferred Provider Association (PPA)

PPO – see Preferred Provider Organization or Preferred Provider Association

PPO Physician or PPO Provider (or PPA Physician or PPA Provider) - a Physician or other health care provider, such as a Hospital, a clinic, or a Pharmacy, who has chosen to participate in the PPO or PPA. and has agreed to accept the pre-determined payment and bill you only for the Co-Payment, Deductible, and non-Covered Services.

Practitioner means a person who is licensed Practitioner of the healing arts who is regulated by a state or federal agency and is acting within the scope of his or her license.

Precertification or Pre-admission Review has the meaning as set forth in the section entitled, Precertification and Utilization Review Program.

Preferred Provider Organization (PPO); or Preferred Provider Association (PPA); means a network or group of health care providers who have entered into an agreement with your Employer to provide services at a pre-determined rate.

Pregnancy - see Normal Pregnancy.

Premature Birth means a birth occurring at 37 weeks or less before full term. It also includes congenital anomalies or any Injury or Illness existing at birth including any complications from these conditions.

Prescription means a direct order for the preparation and use of a drug, medicine or medication. This order may be given verbally or in writing by a Physician to a Pharmacist for the benefit of and use by a Covered Person. The drug, medicine or medication must be obtainable only by Prescription. The Prescription must include the name and address of the Covered Person for whom the Prescription is intended; the type and quantity of the drug; medicine or medication prescribed; and the directions for its use; the date the Prescription was prescribed; and the name, address and DEA number of the prescribing Physician.

Prescription Drug Plan means an arrangement made by an Employer with a preferred prescription drug provider (either a drug company or a specific Pharmacy or group of pharmacies) who have contracted with the ERAU, to fill Prescriptions for individuals Covered under the Plan. The preferred prescription drug provider agrees to accept only a percentage of the full cost of the Prescription from the Covered Person at the time the Prescription is filled, and bill the Plan for the balance of the cost of the Prescription.
DEFINITIONS (Continued)

Preexisting Condition or Preexisting Condition Limitation has the meanings as described in the Pre-Existing Conditions Limitations section of this Plan.

Psychiatric Disorder means neurosis, psychoneurosis, psychopathy or psychosis.

Psychiatric Treatment Program means licensed psychiatric treatment programs. These programs must be accredited by the Joint Commission on Accreditation of Healthcare Organizations or be in compliance with equivalent standards or be approved in the state where the program is run.

Qualified Beneficiary means covered Employee or Dependents of a covered Employee who were Covered Persons on the date preceding the date on which the Qualifying Event occurred.  

Note: Domestic Partners and their dependents are not considered Qualified Beneficiaries.

Qualifying Event means any one of the following which would result in the loss of coverage under the Plan:

- the death of the covered Employee;
- the termination of the Covered Employee's employment (other than by the Employee's gross misconduct);
- reduction in a covered Employee's hours of employment to an ineligible status.
- the divorce or legal separation of the covered Employee from the Employee's spouse;
- the covered Employee's becoming enrolled for Medicare coverage;
- the cessation of covered Dependent child coverage by operation of Plan provision.

Children born to, or placed for adoption with, the employee during the period of continuation coverage will be considered qualified beneficiaries and may also receive continuation coverage provided they are added within the time required by the Plan after the birth or placement for adoption.

While an individual may incur more than one Qualifying Event, the length of continued coverage will never exceed 36 months.

Rehabilitation Facility means a public or private facility, licensed and operated according to the law, which maintains permanent and full-time facilities to mainly provide Rehabilitative Services to correct functional defects which remain after a catastrophic Illness, crippling Injury, or Acute trauma.

Rehabilitative Services means the health care services rendered to correct functional defects which remain after a catastrophic Illness, crippling Injury, or Acute trauma.

Residential Treatment Facility means a facility, licensed and operated according to applicable law, which provides a program of treatment approved by a Physician. The facility must prepare and maintain a written, specific and detailed regimen requiring full-time residence and full-time participation by the Covered Person of treatment for each patient. The plan must be based on medical, psychological and social needs. The facility must also provide (i) room and board, (ii) evaluation and diagnosis, (iii) counseling and (iv) referral and orientation to specialized community resources. For this purpose, “room and board” includes room and meals, and general nursing services as may be required for the treatment regimen, but not personal items.
DEFINITIONS (Continued)

Retiree means that effective January 1st, 2001 at time of separation an employee who meets the following condition: their years of service plus their age equals at least 70.

Room and Board Charges means all charges made by a Hospital or a Skilled Nursing Facility on its own behalf for: (1) room and meals; and (2) all general nursing services required and provided to all individuals registered on an Inpatient basis. These Room and Board Charges must be made at a daily or weekly rate that is based on the type of room occupied.

Service Area means the geographical area within which the Covered Services are available through a Participating Provider.

Short Term Rehabilitation means Rehabilitative Services received on a limited basis.

Sickness means Illness or disease. It includes Pregnancy and the resulting childbirth, miscarriage, abortion, and any Complications of Pregnancy. For newborn children, the term includes: medically diagnosed congenital defects; birth abnormalities; or Premature Birth. Whether or not a birth is premature must be determined by a Physician.

Skilled Nursing Facility means a facility, licensed and operated according to the law, which maintains permanent and full-time facilities to mainly provide Inpatient care and treatment for persons who are convalescing from Injury or Sickness; and has a Registered Nurse or Physician on full-time duty in charge of patient care; has at least one Registered Nurse or Licensed Practical Nurse on duty at all times; maintains a daily medical record for each patient; and has transfer arrangements with a Hospital and a utilization review plan in effect.

The facility must be primarily engaged in providing continuous skilled nursing care for persons during the convalescent stage of their Illness or Injury, and is not, other than by coincidence, a rest home for Custodial Care or for the aged.

Special Care Facility means healthcare institution which meets all applicable state or local approval and licensure requirements, including Medicare, and provides, on an inpatient basis, professional nursing services, physical restoration services and/or other medical care services for persons convalescing from Illness or Injury. “Special Care Facility” does not include, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, a place for custodial or educational care, or a place for the care of mental and nervous disorders. This term shall also apply to expenses incurred in an institution referring to itself as a Skilled Nursing Facility, convalescent nursing facility, or any such other similar designation.

Special Charges means the charges made by a Hospital or a Convalescent Facility on its own behalf for the services and supplies that are required for the care and treatment of a Sickness or an Injury. It does not mean fees for professional services or the charges that are made for room, meals, and personal items.

Specialist means a health care provider who has advanced education and training in one clinical area of practice and limits his practice to a particular branch of medicine.

Speech Therapy means a program of care to improve the patient’s motor-speech skill, expressive and receptive language skills, and writing and reading skills.

Spouse—see Dependent.
DEFINITIONS (Continued)

**Status Change** means, a life event which qualifies an Employee to make a change in his or his eligible Dependent’s (if applicable) Coverage, outside of the “Open Enrollment Period,” “Annual Enrollment Period” or “Annual Choice Period.”

**Student** or **Full-time Student**—see Dependent

**Substance Abuse** - see Drug Abuse.

**Substance Abuse Treatment Facility** - see Alcohol or Drug Dependency Treatment Facility.

**Summary of Material Modification** means a formal document signed by the authorized representative of the Employer. The Modification changes the provisions of the Plan and applies to all Covered Persons, including those persons covered before the Modification becomes effective, unless otherwise specified.

**Surgery** or **Surgical Procedure** means any of the following procedures (excluding oral Surgical Procedures):

1. incision, excision or electrocauterization of any organ or body part;
2. reconstruction of any organ or body part or the suture repair of lacerations;
3. reduction of a fracture or dislocation by manipulation;
4. use of endoscopic procedure to explore for or to remove a stone or other object from the larynx, bronchus, trachea, esophagus, stomach, intestine, urinary bladder or ureter;
5. puncture for aspiration;
6. injection for contrast media testing; or
7. laser Surgery.

**Same Incision** means all surgeries performed using one (1) incision.

**Separate Incisions** means surgeries performed using two (2) or more incisions.

**Operative Field** means the exposed area of the body which has been scrubbed or sterilized.

**Separate Operative Fields** means two (2) or more separate areas of the body which have been surgically scrubbed or sterilized.

**Incidental Procedure** means a procedure for which an additional charge is not reasonable. These procedures include, but are not limited to, incidental appendectomy, incidental scar excisions, puncture of ovarian cysts, simple lysis of adhesions, simple repair of hiatal hernia, etc.

**Independent Procedure** means a procedure that is performed independently and is not immediately related to other services.

**Terminally Ill Person** means a covered individual whose life expectancy is 6 months or less as certified by a Physician.

**Uniformed Services** means the Armed Forces, 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 of the United States in time of war or emergency.
DEFINITIONS (Continued)

Usual, Reasonable and Customary Charge or Reasonable and Customary Charge means the charge customarily made to individuals with similar medical conditions by an individual Physician, Pharmacy, or supplier for a given procedure. The charge must be within the range most frequently used in the same or similar medical service area for the same or similar service or procedure, with consideration given to unusual circumstances involving medical complications requiring additional time, skill and experience. Determination of the Usual, Reasonable and Customary Charge will be made by the Claims Administrator based on nationally obtained and recognized survey data.

Work – see At Work.

Weekend Non-Emergency Hospital Admission means an admission to a Hospital on a Friday, Saturday or Sunday at the convenience of the Covered Person or his or her Physician when there is no cause for an emergency admission and the Covered Person receives no Surgery or therapeutic treatment until the following Monday or later.
STATEMENT OF ERISA RIGHTS

As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all documents governing the Plan, including any insurance contracts and collective bargaining agreements, and 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, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including any insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

- Receive 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.

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of an 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, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest summary 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 up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in 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.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits.
STATEMENT OF ERISA RIGHTS (Continued)

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, D.C. 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.
PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION (HIPAA)

This Section applies to the Plan solely to the extent it provides medical, dental, vision, and any other benefits that constitute group health plan benefits under 45 C.F.R. §160.103, and does not apply to any non-health benefits or benefits that provide or pay for the cost of excepted benefits that are listed in 42 U.S.C. §300gg 91(c)(1).

A. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

(1) The Plan will use PHI to the extent of, and in accordance with, the uses and disclosures permitted by HIPAA, including but not limited to health care treatment, payment for health care, health care operations and as required by law. The Privacy Notice will list the specific uses and disclosure of PHI that will be made by the Plan.

(2) Disclosure to the Plan Sponsor. The Plan will disclose PHI to the Plan Sponsor only upon receipt of written certification from the Plan Sponsor that:

   (a) The Plan document has been amended to incorporate the provisions in this Section; and

   (b) The Plan Sponsor agrees to implement the provisions in Subsection B below.

B. CONDITIONS IMPOSED ON PLAN SPONSOR. Notwithstanding any provision of the Plan to the contrary, the Plan Sponsor agrees:

(1) Not to use or disclose PHI other than as permitted or required by this Section or as required by law;

(2) To ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI received or created on behalf of the Plan and ensure that such individuals agree to implement reasonable and appropriate security measures to protect electronic PHI;

(3) Not to use or disclose an individual’s PHI for employment-related purposes (including hiring, firing, promotion, assignment or scheduling) unless authorized by the Individual. Notwithstanding this paragraph (3), the Plan Sponsor may use enrollment, disenrollment and eligibility information as permitted by 45 C.F.R. Parts 160-164 to perform enrollment and disenrollment functions.

(4) Not to use or disclose an Individual’s PHI in connection with any other non-health benefit program or employee benefit plan of the Plan Sponsor unless authorized by the Individual;

(5) To report to the Plan any use or disclosure of PHI that is inconsistent with this Section or any Security Incident, if it becomes aware of an inconsistent use or disclosure. Security Incident includes reporting for both attempted and successful unauthorized access, use, disclosure, modification, and destruction of information, or interference with system operations. As a result, the Plan Sponsor shall report the aggregate number of unsuccessful, unauthorized attempts to access, use disclose, modify or destroy electronic Protected Health Information or interfere with systems in operations in an information system containing electronic Protected Health Information. These reports will be provided only as frequently as the Plan and the Plan Sponsor mutually agree, but no more than once per month. For any successful unauthorized, attempts to access, use disclose, modify or destroy electronic Protected Health Information or interfere with systems in operations in an information system containing electronic Protected Health
PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION
(Continued)

Information, the Plan Sponsor shall report in writing any such use or disclosure to the Plan as soon as administratively possible;

(6) To provide Individuals with access to PHI in accordance with 45 C.F.R. §164.524;

(7) To make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. §164.526;

(8) To make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. §164.528;

(9) To make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining the Plan’s compliance with HIPAA;

(10) If feasible, to return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible;

(11) To ensure adequate separation supported by reasonable and appropriate security measures is implemented between the Plan and the Plan Sponsor as required by 45 C.F.R. §164.504(f)(2)(iii) and described in this Section; and

(12) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that the Plan Sponsor creates, receives, maintains or transmits on behalf of the Plan.

C. DESIGNATED EMPLOYEES WHO MAY RECEIVE PHI. In accordance with the Privacy Rules, only certain, designated Employees who perform Plan administrative functions may be given access to PHI. Those Employees or class of Employees who have access to PHI are as follows (or their equivalents and successors within the Plan Sponsor’s workforce):

(1) Benefits Department;

(2) Privacy Official;

(3) Members of the Corporate in-house legal staff who have limited access to Participant’s PHI for purposes of assisting with Plan interpretation; and

(4) Members of the Payroll and Information Technology Departments who have limited access to Participant’s PHI.

D. RESTRICTIONS ON EMPLOYEES WITH ACCESS TO PHI. The Employees who have access to PHI may only use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan, as set forth in the Privacy Notice, including but not limited to, quality assurance, claims processing, auditing, monitoring, and management of the Plan and coordination with other benefits.
E. **POLICIES AND PROCEDURES.** On or before the effective date of the Privacy Rules, the Plan Sponsor shall have implemented Policies and Procedures setting forth operating rules to implement the provisions hereof.

F. **ORGANIZED HEALTH CARE ARRANGEMENT.** It is intended that the Plan may form part of an Organized Health Care Arrangement.

G. **HYBRID ENTITY DESIGNATION.** The Plan Administrator intends the Plan to be a Hybrid Entity in accordance with 45 C.F.R. §164.504(b) and only those benefits that would be a covered health plan under 45 C.F.R. §160.103 (if set forth as a separate plan) will constitute the health care components of the Plan. Any benefit offered by the Plan that would not be a covered health plan under 45 C.F.R. §160.103 if provided through a separate plan is a non-health care component of the Hybrid Entity and is not subject to the Privacy Rules.

H. **PRIVACY OFFICIAL.** The Plan shall designate a Privacy Official, who will be responsible for the Plan’s compliance with the privacy provisions of HIPAA. The Privacy Official may contract with or otherwise utilize the services of attorneys, accountants, brokers, consultants, or other third party experts as the Privacy Official deems necessary or advisable. In addition, and notwithstanding any provision of this Plan to the contrary, the Privacy Official shall have the authority to and be responsible for:

   1. Accepting and verifying the accuracy and completeness of any certification provided by the Plan Sponsor under this Section;
   2. Transmitting the certification to any third parties as may be necessary to permit them to disclose PHI to the Plan Sponsor;
   3. Establishing and implementing policies and procedures with respect to PHI that are designed to ensure compliance by the Plan with the Privacy Rules;
   4. Establishing and overseeing proper training of the Plan, or the Plan Sponsor personnel who will have access to PHI; and
   5. Any other duty or responsibility that the Privacy Official, in his or her sole capacity, deems necessary or appropriate to comply with the Privacy Rules and the purposes of this Section.

I. **SECURITY OFFICIAL.** The Plan shall designate a Security Official, who will be responsible for the Plan’s compliance with the security provisions of HIPAA. The Security Official may contract with or otherwise utilize the services of attorneys, accountants, brokers, consultants, or other third party experts as the Security Official deems necessary or advisable. In addition, and notwithstanding any provision of this Plan to the contrary, the Security Official shall have the authority to and be responsible for:

   1. Accepting and verifying the accuracy and completeness of any certification provided by the Plan Sponsor under this Section;
   2. Transmitting the certification to any third parties as may be necessary to permit them to disclose electronic PHI to the Plan Sponsor;
   3. Establishing and implementing policies and procedures with respect to electronic PHI that are designed to ensure compliance by the Plan with the security requirements of HIPAA;
PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION  
(Continued)

(4) Establishing and overseeing proper training of the Plan, or Plan Sponsor personnel who will have access to electronic PHI; and

(5) Any other duty or responsibility that the Security Official, in his or her sole capacity, deems necessary or appropriate to comply with the security provisions of HIPAA and the purposes of this Section.

J. NONCOMPLIANCE. The Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions for personnel who do not comply with the provisions of this Section.

K. INTERPRETATION AND LIMITED APPLICABILITY. This Section serves the sole purpose of complying with the requirements of HIPAA and shall be interpreted and construed in a manner to effectuate this purpose. Neither this Section nor the duties, powers, responsibilities, and obligations listed herein shall be taken into account in determining the amount or nature of the benefits provided to any person covered under this Plan, nor shall they inure to the benefit of any third parties. To the extent that any of the provisions of this Section are no longer required by HIPAA, they shall be deemed deleted and shall have no further force or effect.

L. SERVICES PERFORMED FOR THE PLAN SPONSOR. Notwithstanding any other provision of this Plan to the contrary, all services performed by a business associate for the Plan in accordance with the applicable service agreement shall be deemed to be performed on behalf of the Plan and subject to the administrative simplification provisions of HIPAA contained in 45 C.F.R. parts 160 through 164, except services that relate to eligibility and enrollment in the Plan. If a business associate of the Plan performs any services that relate to eligibility and enrollment to the Plan, these services shall be deemed to be performed on behalf of the Plan Sponsor in its capacity as Plan sponsor and not on behalf of the Plan.

M. DEFINITIONS. As used in this Section, each of the following capitalized terms shall have the respective meaning given below:

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

Individual means the person who is the subject of the health information created, received or maintained by the Plan or the Plan Sponsor.

Organized Health Care Arrangement means the relationship of separate legal entities as defined in 45 C.F.R. §160.103.

Privacy Notice means the notice of the Plan’s privacy practices distributed to Plan participants in accordance with 45 C.F.R. §164.520, as amended from time to time.

Privacy Rules means the privacy provisions of HIPAA and the regulations in 45 C.F.R. Parts 160 and 164.

Protected Health Information (PHI) means individually identifiable health information as defined in 45 C.F.R. §160.103.

Security Incident means an incident as defined in 45 C.F.R. §164.304.
SUMMARY PLAN DESCRIPTION RECEIPT AND AGREEMENT(S)

I. RECEIPT

I hereby acknowledge receipt of the Embry-Riddle Aeronautical University Health Care Plan Document and Summary Plan Description given to me by my Employer and agree to abide by its terms and conditions.

II. COORDINATION OF BENEFITS AND SUBROGATION PROVISIONS

I further agree to promptly furnish and/or execute such information and/or forms as may be required from time to time by the Plan. I further agree to comply with the Plan’s Coordination of Benefits and Subrogation provisions which state that if I recover monies in the future for any claims previously paid by the Plan on my behalf, or my Dependent’s behalf, I will reimburse or cause to have the Plan reimbursed accordingly.

X__________________________________________

Employee’s Signature Date

THIS PAGE MUST BE SIGNED BY THE COVERED EMPLOYEE AND RETAINED BY THE EMPLOYER