PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR

FLORIDA MEMORIAL UNIVERSITY STUDENT ATHLETIC PLAN

EFFECTIVE AUGUST 1, 2017

TABLE OF CONTENTS

INTRODUCTION

This document is a description of Florida Memorial University Student Athletic Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for eligible Students and designated Dependents when the Student and such Dependents satisfy all eligibility requirements of the Plan.

The Plan Administrator fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, exclusions, limitations, definitions, eligibility and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Students and their Dependents and is divided into the following parts:

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Defined Terms. Defines those Plan terms that have a specific meaning.

Effective Date. August 1, 2017.

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Students. All Active Students.

Eligibility Requirements for Student Coverage. A person is eligible for Student coverage from the first day that he or she:

(1) is a Full-Time Student. A Full-Time Student is a degree-seeking student who has submitted "In Lieu of Credit Hours" documentation.

(2) Has submitted a completed application and payment.

(3) This plan document is effective on the Effective Date.

(4) Coverage begins when requirements have been met.

FUNDING

Cost of the Plan. The level of any Student premiums is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Student premiums.

ENROLLMENT

Enrollment Requirements. A Student must enroll for coverage by filling out and signing an enrollment application along with the appropriate premium payment.

Disclosure Requirements. Any person who, with intent to defraud or knowing that he is facilitating a fraud against the Plan, submits an application containing a false or deceptive statement is guilty of fraud.

EFFECTIVE DATE

Effective Date of Student Coverage. A Student will be covered under this Plan as of the date that the Student satisfies all of the following, but no earlier than the Effective Date:

(1) The Eligibility Requirement.

(2) The Active Student Requirement.

(3) The Enrollment Requirements of the Plan.

Active Student Requirement.

A Student must be an Active Student (as defined by this Plan) for this coverage to take effect.

TERMINATION OF COVERAGE

When Student Coverage Terminates. Student coverage will terminate on the earliest of these dates:

(1) The date the Plan is terminated.

(2) The date in which the covered Student ceases to be in one of the Eligible Classes. This includes death or termination of Active Enrollment of the covered Student.

(3) If a Student commits fraud, makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the plan Administrator or Plan may either void coverage for the Student and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

THE UNIVERSITY STUDENT ATHLETIC PLAN is designed to protect against unexpected medical expense and to meet most students' needs while on campus and throughout the Policy Year. Often a student covered by a Health Maintenance Organization (HMO) or a managed care policy at home, has limited or no benefits while at the University, in other parts of the U.S. or in a foreign country. When reviewing your current policy, check to ensure that it provides access to healthcare providers in the University area and provides comprehensive coverage, extending beyond emergency care to include hospitalization (including room and board, physicians' fees, surgical expenses), lab tests, x-rays, prescription drugs, mental health care, and sports injuries.

If you are covered under another health insurance plan as well, your other plan will be primary and your Student Athletic Plan will pay on an excess basis.
Plan means a plan, which provides benefits or services for, or by reason of, medical, or dental care or treatment through:

(1) Group, blanket, franchise, or subscriber insurance coverage;

(2) Pre-paid plans for:
- (a) group hospital service;
- (b) group medical service;
- (c) group practice;
- (d) individual practice; and
- (e) any other such plans for members of a group;

(3) Any plan provided by:
- (a) labor management trusts;
- (b) unions;
- (c) employer organizations;
- (d) professional organization; or
- (e) employee benefit organizations;

(4) A government program or statute, other than a state medical assistance plan that implements Title XIX of the Social Security Act of 1965;

(5) Any group or group type hospital indemnity of more than $100 per day;

(6) Medicare (Title XVII of the Social Security Act); and

(7) Any group, group-type and individual automobile "no fault" and traditional automobile "fault" type contracts.

SCHEDULE OF BENEFITS

Verification of Eligibility: Student Educational Benefit Trust (877) 233-5159

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

Deductibles and certain Copayments are payable by Plan Participants.

Copayments and Deductibles are dollar amounts that the Covered Person must pay before the Plan pays. See the Schedule of Benefits for details.

A deductible is an amount of money that is paid once a Plan Year per Covered Person. Typically, there is one deductible amount per Plan Year and it must be paid before any money is paid by the Plan for any Covered Charges. On the Effective Date for each plan year, a new deductible amount is required.

A copayment is the amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments. Copayments accrue toward the 100% maximum out-of-pocket payment.

Information and Records Disclaimer

At times the Plan may need additional information from the participants in order to furnish the Plan with all information and proofs that the Plan may reasonably require regarding any matters pertaining to the Policy. If the Participants do not provide this information when requested, it may delay or deny payment of their Benefits.

By accepting Benefits under this Plan, they authorize and direct any person or institution that has provided services to them to furnish the Plan with all information or copies of records relating to the services provided. The Plan has the right to request this information at any reasonable time. This applies to all Covered Participants, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. The Plan agrees that such information and records will be considered confidential.

MEDICAL BENEFITS SCHEDULE

BENEFIT PERIOD	Provided treatment begins within 90 days from the date of Injury, Benefits are payable for 104-weeks from the date of an Injury. The Injury must occur after the effective date and prior to the termination date and care must be Medically Necessary.
MAXIMUM BENEFIT AMOUNT	$25,000 per Accident
Benefits provided only for the following sport(s): Baseball, men's and women's basketball, men's and women's cross country, field hockey, football, men's and women's golf, men's and women's lacrosse, women's rowing, men's and women's soccer, men's and women's swim/dive, men's and women's tennis, men's and women's track anf field, women's volleyball, men's and women's water polo, wrestling, intercollegiate cheerleading, student managers and student trainers.	
DEDUCTIBLE, PER PLAN YEAR	
Per Covered Person	$5,000
MEDICAL EXPENSE BENEFIT	
Hospital Room and Board	100% of usual and customary after deductible
Intensive Care Room and Board	100% of usual and customary after deductible
Hospital Miscellaneous	100% of usual and customary after deductible
Outpatient Pre-Admission Testing	100% of usual and customary after deductible
Emergency Room	100% of usual and customary after deductible
Surgical Benefits: Primary surgeon, assistant surgeon, consultation, anesthesia, surgical facility	100% of usual and customary after deductible
Physician Inpatient Visits	100% of usual and customary after deductible
Physician Office Visits	100% of usual and customary after deductible
X-ray and Laboratory	100% of usual and customary after deductible
Nursing	100% of usual and customary after deductible
Physiotherapy: Limited to 30 treatments per Injury for Inpatient and Outpatient combined	100% of usual and customary after deductible
Ambulance	100% of usual and customary after deductible

Durable Medical Equipment Limited to once every 2 Plan Years, unless prescribed by a Physician as Medically Necessary. Limited to $7,000	100% of usual and customary after deductible
Medical Services and Supplies (Including blood, blood transfusions, oxygen)	100% of usual and customary after deductible
Dental Services – Injury only	100% of usual and customary after deductible
Outpatient Prescription Drugs	100% of usual and customary after deductible

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Plan Year a Covered Person must meet the deductible shown in the Schedule of Benefits.

BENEFIT PAYMENT

Each Plan Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible and any copayments. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan. The Plan Administrator maintains the discretion and authority to audit claims, or facilitate the auditing of claims, in order to fulfill its obligations as Plan Fiduciary, and to determine the amounts properly payable under this Plan as to all claims.

MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges incurred by a Covered Person during the Plan Year. The Maximum Benefit applies to all plans and benefit options offered under the Student Athletic Plan, including the ones described in this document.

COVERED CHARGES

Covered Charges are the Usual and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

(1) **Hazard (Sports Coverage).** Injuries sustained from covered athletic games or competition including:

(a) Taking part in a regularly scheduled athletic game or competition, or a practice session for an athletic team or club.

(b) Traveling to or from such a game, competition or practice session provided the Covered Person is traveling with the athletic team or club; and is under the direct and immediate supervision of the athletic team or club or an adult authorized by the athletic team or club.

(c) Traveling directly, without interruption between the Covered person's home and a scheduled game, competition or practice session; or in a vehicle which is designated or furnished by the athletic team or club, operated by a properly licensed adult driver, or under the direct supervision of the athletic team or club; or in a vehicle other than that already described when operated by a properly licensed driver and travel time does not exceed an hour each way.

Travel time includes the time to or from home, scheduled game, competition or practice session; before required attendance time; after the Covered person is dismissed; and after the Covered Person completes extra duties assigned by the School.

Benefit includes injuries which result over a period of time (such as blisters, tennis elbow, etc.), and which are a normal foreseeable result of the sport.

(2) **Accidental (Sports).** Treatment as a result of any one sports Injury and due to practice or play in any covered sport. Benefit is payable upon receipt of proof that the Covered Person has incurred such expenses for the treatment of Injury

(3) **Hospital Care.** The medical services and supplies furnished by a Hospital or Outpatient Surgical Center or a Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Room charges made by a Hospital having only private rooms will be paid at the facility's average private room rate.

Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

(4) **Physician Care.** The professional services of a Physician for surgical or medical services.

Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

(a) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Usual and Reasonable Charge that is allowed for the primary procedures; 50% of the Usual and Reasonable Charge will be allowed for each additional procedure performed through the same or separate incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(b) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Usual and Reasonable Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Usual and Reasonable percentage allowed for that procedure; and

(c) If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 20% of the surgeon's Usual and Reasonable allowance.

(5) **Nursing Care.** The nursing care by or under the supervision of a licensed graduated registered nurse (R.N). Covered Charges do not include routine Hospital care.

(6) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

(7) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

(a) Local Medically Necessary professional land or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.

(b) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(c) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase. Repairs may be considered if deemed Medically Necessary, if repairs do not exceed the fair market replacement value of the equipment at the time of repair. There is no coverage for repairs required due to mistreatment or misuse of equipment.

(d) **Expanded medical treatment** of the following conditions resulting from the play or practice of Intercollegiate sports: repetitive motion injuries, strains, sprains, hernia, tennis elbow, tendonitis, bursitis and muscle tears.

(e) Treatment of an acute onset of conditions relating to the **heart and/or circulatory system** that result from Injury during play, practice, or conditioning of Intercollegiate sports. These conditions include heart attack, stroke, brain circulatory malfunctions and heat exhaustion.

(f) **Laboratory studies.** Covered Charges for diagnostic and preventive lab testing and services.

(g) Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

Emergency repair due to Injury to sound natural teeth.

Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

(h) **Occupational therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

(i) The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.

(j) **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy.

(k) **C**harges for **Pre-Admission testing**. Confinement must occur within 7 days of the testing.

(l) **Prescription** Drugs (as defined).

(m) **Re-aggravation of a sports Injury** suffered prior to the Effective Date of a Covered person's coverage. Re-aggravation will be considered an Injury of the re-injury occurs under circumstances, which would have otherwise been covered under the Plan.

(n) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts, and replacement if there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

(o) **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow an Injury.

(p) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

(q) Diagnostic **x-rays**.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Accident is an occurrence which is unforeseen, not due to or contributed to by Sickness or disease of any kind, and causes Injury.

Ambulance is a licensed motor vehicle or rotary aircraft operated by licensed and certified personnel and used to provide transportation and life support services.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Benefit Period is the period of time from the date of Injury, as shown in the Schedule of Benefits.

Brand Name means a trade name medication.

Coinsurance is a policy provision under which the insurer and the insured share costs incurred after the deductible is met, according to a specific formula.

Cosmetic means to improve appearance or self-perception.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person is a Student or Dependent who is covered under this Plan.

Custodial Care is care (including Room and Board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Eligible Expenses are the Usual, Reasonable, and Customary charges for services or supplies which are incurred by the Covered Person for the Medically Necessary treatment of an Injury.

Emergency Services means a medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA)) within the capability of the Hospital emergency department, including routine ancillary services, to evaluate a Medical Emergency and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital and required under EMTALA to stabilize the patient.

Student means a person who is an Active, Enrolled Student of the Plan Sponsor.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

Experimental and/or Investigational means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

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

(2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

(3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, 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.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Injury means bodily harm which results, directly and independently of disease or bodily infirmity, from an Accident. All injuries to the same Covered Person sustained in one accident, including all related conditions and recurring symptoms of the Injuries will be considered one Injury.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medical Non-Emergency Care means care which can safely and adequately be provided other than in a Hospital.

Medically Necessary care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Never Event is a serious reportable adverse event that is reasonably preventable through application of evidence based guidelines. These errors include, but are not limited to the following: Surgery on wrong body part, foreign object left in patient after surgery, intravascular air embolism, blood incompatibility, stage 3 or 4 pressure ulcers, electric shock, burn, or fall while confined to facility.

Orthotic is a mechanical device applied externally to limit or assist the motion of any given body part.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Outpatient Surgical Center, or the patient's home.

Personal Health Information includes medical information (i.e. claims, health assessments, etc.) and other administrative data (i.e. names, addresses, social security numbers, etc) that are personally identifiable.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist 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.

Plan means Florida Memorial University Student Athletic Plan, which is a benefits plan for certain Students and is described in this document.

Plan Participant is any Student or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Prosthetic Device means a device that replaces all or part of an internal body organ or external body member, or that replaces all or a part of the function of a permanently inoperative or malfunctioning internal body organ or external body member.

Semi-Private Room means a room containing two (2) or more patient beds in an inpatient facility.

Sickness is: Illness, disease or Pregnancy.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Urgent Care is medical care for an unexpected illness or injury that does not require emergency services but which may need prompt medical attention to minimize severity and prevent complications.

Usual and Customary (Reasonable) Charge (UCR): The usual fee charged in a geographic area by a medical provider for a specific medical procedure or service. The fee is based upon a consensus of what other medical providers in the same geographic area are accepting as payment for similar procedures or service.

The Plan will reimburse the actual charge billed if it is less than the Usual and Customary (Reasonable) Charge, even if the Provider is in Network.

The Plan Reimbursement to a Medical Provider is, regardless of PPO Agreement, limited to the Reasonable Reimbursement for the treating Medical Provider. We define Reasonable Reimbursement to the dominant Commercial Payor Reimbursement at the treating Medical Provider.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Customary.

PLAN EXCLUSIONS

Note: Any treatment, charges, and/or medical provider reimbursement not covered by Reinsurance contract.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

(1) **Adverse audit.** Any amount determined by audit to not be payable.

(2) **After hour services.** Additional charges, billed by the physician, for after hour, extended hour, or holiday services.

(3) **Air Ambulance**. Charges for air transport services.

(4) **Alcohol.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion applies to the perpetrator of an act of domestic violence but does not apply to the victim if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(5) **Biofeedback.** Services, supplies, care or treatment in connection with biofeedback.

(6) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan, except complications from an abortion for a covered Student or Spouse.

(7) **Cosmetic.** Services, supplies, care or treatment, which is cosmetic in nature, except for reconstructive surgery on a diseased or injured part of the body.

(8) **Court ordered.** Any charges incurred as the result of court ordered treatment or testing.

(9) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.

(10) **Dental services**. Dental Services, dental appliances or treatment including hospitalization for dental service except as specifically mentioned in Covered Medical Expenses. Facility charges for dental services due to age or mental capacity are not covered.

(11) **Educational or vocational testing.** Services for educational or vocational testing or training.

(12) **Elective treatment.** Expenses incurred for elective treatment or elective surgery except as specifically provided elsewhere in the plan and performed while the plan is in effect.

(13) **Excess charges**. The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.

(14) **Exercise programs.** Health spa or similar facilities, strengthening programs, or exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

(15) **Experimental or not Medically Necessary**. Care and treatment that is either Experimental/Investigational or not Medically Necessary.

(16) **Eye care.** Radial keratotomy, lasik surgery or other eye surgery to correct vision problems that are alternately correctable by vision lenses. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting.

(17) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

(18) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

(19) **Hazardous hobby or activity.** Care and treatment of an Injury or Sickness that results from engaging in a Hazardous Hobby or Activity. A hobby or activity is hazardous if it is an unusual activity, which is characterized by a constant threat of danger or risk of bodily harm. Examples of hazardous hobbies or activities are, but not limited to, skydiving, auto racing, hang gliding, jet ski operating, snowmobiling, scuba diving, mountain climbing, cave exploration or bungee jumping.

(20) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting.

(21) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

(22) **Hypnosis.** Charges in connection with hypnosis.

(23) **Illegal acts.** Charges for services received as a result of Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance. This exclusion applies to the perpetrator of an act of domestic violence but does not apply to the victims if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(24) **Illegal drugs or medications.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(25) **Incremental nursing.** Any charges for incremental nursing.

(26) **Late submission.** Charges for care, treatment, services or supplies which were incurred more than 12 months prior to the date the charges were submitted to the Plan for payment.

(27) **Maintenance therapy.** Treatment given when no additional progress is apparent, or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning but which does not result in any additional improvement to the condition.

(28) **Motor vehicle injury.** Charges incurred for the care or treatment of any injury sustained as a result of or related to any motor vehicle accident to the extent that such care or treatment for that injury is covered by any plan, program, policy or other arrangement providing insurance coverage for vehicles. Injury resulting from motor vehicle accident if the Covered person is not properly licensed to operate the motor vehicle in the jurisdiction in which the accident takes place (except in a Driver's Education program).

(29) **Never event.** Care, treatment, services, or supplies for Never Events- any adverse event that is reasonably preventable, is potentially excluded from coverage under the Plan. Possible non-reimbursement from the Plan includes, but is not limited to the following errors: Surgery on wrong body part, foreign object left in patient after surgery, intravascular air embolism, blood incompatibility, stage 3 or 4 pressure ulcers, electric shock, burn, or fall while confined to facility.

(30) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

(31) **Non-compliance.** All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.

(32) **Non-emergency Hospital admissions. Care and treatment billed by a Hospital for** non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

(33) **Non-school activity**. Care and treatment for an Injury resulting from participation for non-school sponsored skiing, ice hockey, lacrosse, soccer or football

(34) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

(35) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(36) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

(37) **Nutritional supplements.** Charges for nutritional supplies or supplements, vitamins/mineral supplements.

(38) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.

(39) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.

(40) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.

(41) **Podiatric orthotics/orthopedic appliances.** Over the counter or custom made shoes, shoe inserts, arch supports and other foot orthotics to control foot function; and orthopedic appliances which are used mainly to protect an Injury so that a Covered person can take part in interscholastic or intercollegiate sports.

(42) **Private duty nursing.** Charges in connection with care, treatment or services of a private duty nurse.

(43) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(44) **Replacement braces**. Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

(45) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventative medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits.

(46) **Safety devices**. For drivers and all passengers: charges for the treatment for injuries incurred when not wearing appropriate safety restraints and/or motorcycle helmets, when applicable.

(47) **Self-inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply to the victim if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition. This exclusion does apply to the perpetrator of an act of domestic violence.

(48) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was Covered under this Plan or after coverage ceased under this Plan.

(49) **Sickness**. Care, treatment or supplies for Sickness, except infection which occurs directly from an Accidental cut or wound or diagnostic test or treatment

(50) **Structural change.** Charges for structural changes to a house or vehicle.

(51) **Subrogation.** Charges for illnesses or injuries suffered by a covered person due to the action or inaction of any party if the covered person fails to provide information as requested by the Claims Administrator.

(52) **Substance abuse.** Services, supplies, care or treatment to a covered person for injury or sickness resulting from voluntary taking of or being under the influence of legal or illegal substance, drug, hallucinogen or narcotic not administered on the advice of a physician

(53) **Telephone.** Charges for telephone or email consultations, completion of claim forms, or any charges associated with missed appointments.

(54) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a covered expense.

(55) **War.** Any loss that is due to a declared or undeclared act of war, civil insurrection or act of terrorism.

(56) **Weekend admission.** Charges relating to services or supplies provided during the Friday, Saturday and Sunday coincident with an admission beginning on any of those days, unless the admission is due to an accident or medical emergency, or surgery is scheduled for the day of or the day following the admission.

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

When a Covered Person has a Claim to submit for payment that person must:

(1) Obtain a Claim form from the Student Educational Benefit Trust or the Plan Administrator.

(2) Complete the Student portion of the form. ALL QUESTIONS MUST BE ANSWERED.

(3) Have the Physician complete the provider's portion of the form.

(4) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:

- Student ID number
- Student's name
- Name of patient
- Name, address, telephone number of the provider of care
- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Date of services
- Charges

(5) Send the above to the Claims Administrator at this address:

Continential Benefits
P.O. Box 3610
Brandon, FL 33509-3610

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 180 days of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

(a) it's not reasonably possible to submit the claim in that time; and

(b) the claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

CLAIMS APPEALS PROCEDURE

Following is a description of how the Plan processes claims for benefits and reviews the appeal of any claim that is denied. The terms used in this section are defined below.

A "Claim" is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, which complies with the Plan's reasonable procedure for filing claims and making benefit claims determinations.

A "Claim" does not include a request for a determination of an individual's eligibility to participate in the Plan.

If a Claim is denied, in whole or in part, the denial is known as an "Adverse Benefit Determination."

A claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal." If the Claim is denied at the end of the Appeal process, as described below, the Plan's final decision is known as a "Final Adverse Benefit Determination."

Both the Claims and the Appeal procedures are intended to provide a full and fair review.

Any of the authority and responsibilities of the Plan Administrator under the Claims and Appeal Procedures, including the discretionary authority to interpret the terms of the Plan, may be delegated to a third party. If you have any questions regarding these procedures, please contact the Plan Administrator.

Internal Appeals

When a claimant receives notification of an Adverse Benefit Determination, the claimant has 6 months following receipt of the notification in which to file a written request for an Appeal of the decision.

If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

A document, record, or other information shall be considered relevant to a Claim if it:

(1) was relied upon in making the benefit determination;

(2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The period of time within which a benefit determination on Appeal is required to be made shall begin at the time an Appeal is filed in writing in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

If the Appeal of a Claim is denied, in whole or in part, the Plan Administrator shall provide written notification of the Adverse benefit Determination on Appeal within 60 days after receipt of the notice of Appeal.

External Appeals

If the Covered Person is not satisfied with the Internal Appeals determination, an External Appeal for an Adverse benefit Determination may be requested. You may request an external review if you or your provider disagrees with HealthSmart Benefit Solutions' decision. An external review by an Independent Review Organization/External Review Organization (ERO) made up of physicians or other appropriate health care providers. The ERO must have expertise in the problem or question involved.

To request an external review, the following requirements must be met:

(1) You have received notice of the denial of the claim.

(2) Your claim was denied because it was determined that the care was not necessary or was experimental or investigational.

(3) You have exhausted the applicable internal appeal processes or you qualify for a faster review.

The claim denial letter you receive from HealthSmart Benefit Solutions will describe the process to follow if you wish to pursue an external review, including a copy of the Request for External Review Form.

You must submit the Request for External Review Form to HealthSmart Benefit Solutions within 4 months after you received the final claim denial letter. You also must include a copy of the final claim denial letter and all other pertinent information that supports your request.

For more information about the External Review process, call the Member Services telephone number shown on your ID card.

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance up to each one's plan formula minus whatever the primary plan paid. This is called non-duplication of benefits. The total reimbursement will never be more than the amount that would have been paid if the secondary plan had been the primary plan -- 50% or 80% or 100% -- whatever it may be. The balance due, if any, is the responsibility of the Covered Person.

If a Covered Person is eligible for benefits under this Plan, and another plan(s), but does not make claims for benefits payable under another plan(s) the benefits payable under this Plan will be reduced to the extent of benefits that would have been payable under another plan had claims been made thereof. This reduction is regardless of coordination payment order.

THE UNIVERSITY STUDENT ATHLETIC PLAN is designed to protect against unexpected medical expense and to meet most students' needs while on campus and throughout the Policy Year. Often a student covered by a Health Maintenance Organization (HMO) or a managed care policy at home, has limited or no benefits while at the University, in other parts of the U.S. or in a foreign country. When reviewing your current policy, check to ensure that it provides access to healthcare providers in the University area and provides comprehensive coverage, extending beyond emergency care to include hospitalization (including room and board, physicians' fees, surgical expenses), lab tests, x-rays, prescription drugs, mental health care, and sports injuries.

If you are covered under another health insurance plan as well, your other plan will be primary and your Student Athletic Plan will pay on an excess basis.
Plan means a plan, which provides benefits or services for, or by reason of, medical, or dental care or treatment through:

(1) Group, blanket, franchise, or subscriber insurance coverage;

(2) Pre-paid plans for:
- (a) group hospital service;
- (b) group medical service;
- (c) group practice;
- (d) individual practice; and
- (e) any other such plans for members of a group;

(3) Any plan provided by:
- (a) labor management trusts;
- (b) unions;
- (c) employer organizations;
- (d) professional organization; or
- (e) employee benefit organizations;

(4) A government program or statute, other than a state medical assistance plan that implements Title XIX of the Social Security Act of 1965;

(5) Any group or group type hospital indemnity of more than $100 per day;

(6) Medicare (Title XVII of the Social Security Act); and

(7) Any group, group-type and individual automobile "no fault" and traditional automobile "fault" type contracts.

Allowable Charge. For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

> **Excess Provision.** No benefit under this Plan is payable for any expense incurred for Injury or Sickness which is paid or payable by other valid and collectible insurance or under an automobile insurance policy. Covered medical expenses exclude amounts not covered by the primary insurer due to penalties imposed on the Covered person for not complying with plan provisions or requirements.

Claims determination period. Benefits will be coordinated on a Plan Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

The Plan may request or provide information from another insurer or any other organization or person for purposes of determining allowable charges. This information may be provided or obtained without consent or notice to any other person. This Plan will not pay claims that appear to be the liability of another plan or person without having all documentation and guarantee of Plan Rights to Recovery formally agreed to by the Plan Participant and /or Legal Representative.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Covered Person may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The payment for benefits received by a Covered Person under the Plan shall be made in accordance with the assignment of rights by or on behalf of the Covered Person as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Covered Person, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Covered Person to the payments of those benefits.

The Covered Person:

(1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

(2) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any responsible third party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms: "Covered Person" means anyone covered under the Plan, including minor dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Recovery from another plan under which the Covered Person is covered. This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. The University has appointed Student Education Benefit Trust to be Plan Administrator and serve at the convenience of the Plan. If the Plan Administrator resigns, the University shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

The Plan Administrator maintains the discretion and authority to audit claims, or facilitate the auditing of claims, to determine if those claims are properly payable under the terms of the Plan. The decision of the Plan Administrator as to whether a claim is properly payable based upon an audit shall also be final and binding upon all persons dealing with the Trust or Plan or claiming any benefit thereto.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain members of the Plan's administration perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these administrators from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these administrators are permitted to have such access subject to the following:

(1) **General.** The Plan shall not disclose Protected Health Information to any member of the Plan's administration unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Plan's administration shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. Genetic information will not be used or disclosed for underwriting purposes.

(3) **Authorized Administrators.** The Plan shall disclose Protected Health Information only to members of the Plan's administration who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Plan's administration" shall refer to all students and other persons under the control of the plan Administrator.

(a) **Updates Required.** The Plan Administrator shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted.** An authorized member of the Plan's administration who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) **Resolution of Issues of Noncompliance.** In the event that any member of the Plan's administration uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) **Certification of Plan Administrator.** The Plan Administrator must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Plan Administrator with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or benefit plan of the Plan Administrator;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Plan Administrator still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

(j) Ensure the adequate separation between the Plan and member of the Plan's administration, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of Florida Memorial University's administration are designated as authorized to receive Protected Health Information from Florida Memorial University Student Athletic Plan ("the Plan") in order to perform their duties with respect to the Plan:

- Director of Business Planning
- Director of Risk Management
- Bursar Services Manager
- Assistant Athletic Directors
- Athletic Trainers
- Medical Director of Student Health Center
- Associate Staff Physician
- Staff Physician
- Nurse Practitioner
- Staff Nurse
- Medical Assistant
- Administrative Assistant
- Receptionist

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Plan Administrator agrees to the following:

(1) The Plan Administrator agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Plan Administrator creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Plan Administrator shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The Plan Administrator shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Plan administrators and (4) Certification of Plan Administrator described above.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Student and Dependent Coverage:

The level of Student premiums will be set by the Plan Administrator. These premiums will be used in funding the cost of the Plan as soon as practicable after they have been received from the Plan Administrator.

Benefits are paid directly from the Plan through the Claims Administrator.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

GENERAL PLAN INFORMATION

PLAN NAME

Florida Memorial University Student Athletic Plan

PLAN SPONSOR: Florida Memorial University

TAX ID NUMBER: 30-6373515

PLAN EFFECTIVE DATE: 8/1/2017

PLAN YEAR ENDS: 7/31

PLAN ADMINISTRATOR

Student Educational Benefit Trust
(877) 233-5159

CLAIMS ADMINISTRATOR

Continental Benefits
P.O. Box 3610
Brandon, FL 33509-3610
(844) 223-2607