Wrap-Around Summary Plan Description

AVE MARIA UNIVERSITY
EMPLOYEE WELFARE BENEFIT PLAN
SUMMARY PLAN DESCRIPTION

Amended and Restated Effective
July 1, 2014

This document, together with the attached documents listed on the final page of this document, constitutes the Summary Plan Description required by ERISA § 102.

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Definitions

Capitalized terms used in the Plan have the following meanings:

AD&D "AD&D" means accidental death and dismemberment insurance.

COBRA "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Code "Code" means the Internal Revenue Code of 1986, as amended.

Company "Company" means AVE MARIA UNIVERSITY, or any successor thereto.

Employee "Employee" means any common-law employee of the Company who satisfies the eligibility provisions of Section 4 and who is not excluded from participation by the terms of an applicable component benefit program.

ERISA "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

HIPAA "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

Plan "Plan" means this AVE MARIA UNIVERSITY Employee Welfare Benefit Plan.

Plan Administrator "Plan Administrator" means AVE MARIA UNIVERSITY

USERRA "USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994.

1. Introduction

The Company maintains the Plan for the exclusive benefit of its full-time employees and their spouses and dependents. The Plan provides benefits through the following component benefit programs:

- Medical Insurance Contracts (Attachment #1);
- Dental Insurance Contract (Attachment #2)
- Vision Insurance Contract (Attachment #3)
- Group Term Life and ADD Insurance Contract and (Attachment #4)
- Long-Term Disability Contract (Attachment #5)
- Short-Term Disability Contract (Attachment #6)
- Flexible Spending Account (Attachment #7).

Some of these component benefit programs require you to make an annual election to enroll for coverage. The details of such annual elections are described in the Attachments.

Each of these component benefit programs is summarized in a certificate of insurance booklet issued by an insurance company, a summary plan description (SPD) or another governing document prepared by the Company. A copy of each booklet, summary, or other governing document is attached to this document in Attachments #1 through #7 as noted above.

This document and its Attachments constitute the SPD for each of the component plans to the extent required by ERISA § 102.

2. General Information About the Plan

Plan Name: AVE MARIA UNIVERSITY Employee Welfare Benefit Plan

Type of Plan: Welfare plan providing medical, dental, long-term disability, short-term disability, group term life and accidental death & dismemberment and a flexible spending account.

Plan Year The plan year is November 1 to October 31.

Plan Number The plan number is 510.

Effective Date The effective date of the plan is January 1, 2013. It was most recently amended on July 1, 2014..

Funding Medium and Type of Plan Administration Most of the insurance benefits under the Plan are fully insured. The managed care medical program is fully insured by Blue Cross Blue Shield of Florida. The dental insurance is fully insured by Florida Combined Life Insurance Company. The vision insurance is fully insured by VSP Vision Plan. The long-term disability, short-term disability, life insurance and accidental death & dismemberment are fully insured by Mutual of Omaha. The FSA is administered by Wageworks.

The insurance companies and HMO, not the Company, are responsible for paying claims with respect to these programs. The Company shares responsibility with the insurance companies and HMO for administering these program benefits, as described in Section 6.

Insurance premiums for employees and their eligible family members are paid in part by the Company out of its general assets and in part by employees' pre-tax payroll deductions. The Plan Administrator provides a schedule of the applicable premiums during the initial and subsequent open enrollment periods and upon request for each of the component benefit programs, as applicable.

Plan Sponsor AVE MARIA UNIVERSITY
5050 Ave Maria Blvd.
Ave Maria, Fl. 34142
239 304-7074

Plan Sponsor's Employer Identification Number: 03-0482006

Insurance Companies: Blue Cross Blue Shield of Florida
PO Box 1798
Jacksonville, Fl. 32224
866 946-2583

Florida Combined Life Insurance Company
5011 Gate Parkway Blvd. Suite 400
Jacksonville, Fl. 32224
904 828-7800

VSP Vision Plan
333 Quality Drive
Rancho Cordova, Ca. 95670
800 877-7195

Mutual of Omaha
Mutual of Omaha Plaza
Omaha, Ne. 68175
800-769-7159

WageWorks
1100 Park Place 4th Floor

San Mateo, Ca. 94003
888-990-5099

Plan Administrator Same as Insurance Companies

Named Fiduciary Same as Insurance Companies

Agent for Service of Legal Process AVE MARIA UNIVERSITY
5050 Ave Maria Blvd.
Ave Maria, Fl. 34142
239 304-7074
Attention: H. James Towey

Insurance Rebates The employer will equally divide any received insurance rebates among the plan participants. The allocations will be remitted to each individual in the form of a check and sent to them via first class mail.

Important Disclaimer: Benefits hereunder are provided pursuant to an insurance or HMO contract or pursuant to a governing plan document adopted by the Company. If the terms of this document conflict with the terms of such insurance or HMO contract or governing plan document, then the terms of the insurance contract or governing plan document will control, rather than this document; unless otherwise required by law.

3. Eligibility and Participation Requirements

Eligibility and Participation An eligible employee with respect to the Plan will be any common-law employee of the Company who is eligible to participate in and receive benefits under one or more of the component benefit programs. To determine whether you or your family members are eligible to participate in a component benefit program, please read the eligibility information contained within the Attachments for the applicable component benefit programs.

Certain component benefit programs require that you make an annual election to enroll for coverage. Information about enrollment procedures, including when coverage begins and ends for the various component benefit programs, is found within the Attachments. If you are an eligible employee, you may begin participating in the Plan upon your election to participate in a component benefit program in accordance with the terms and conditions established for that program. Again, you may consult the enrollment procedures located within the Attachments for additional information.

Termination of Participation Your participation and the participation of your eligible family members in the Plan will terminate on the last day of the month in which you terminate employment with the Company. Coverage also may terminate if you fail to pay your share of an applicable premium, if your hours drop below any required hourly threshold, if you submit false claims, or for any other reason as set forth in the Attachments or other governing documents for the component benefit program. You should consult the applicable Attachments for specific termination events and information.

Continuation Coverage Under COBRA and USERRA If medical, dental, vision or Flexible spending account coverage for you or your eligible family members ceases because of certain "qualifying events" specified in COBRA (such as termination of employment, reduction in hours, divorce, death, or a child's ceasing to meet the definition of dependent), then you and your eligible family members may have the right to purchase continuation coverage for a temporary period of time. If you have any questions about your COBRA rights, please read the "Summary of Rights and Obligations Regarding Continuation of Plan Coverage," a copy of which is listed below.

Summary of Rights and Obligations Regarding Continuation of Plan Coverage

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of healthcare coverage under the Plan. **This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their health coverage.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of health coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under one of the benefit options that is considered a "group health plan" is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under a health plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

  If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under a health plan because any of the following qualifying events happens:
- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

  Your dependent children will become qualified beneficiaries if they lose coverage under a health plan because any of the following qualifying events happens:
- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs (within 30 days of loss of Social Security disability status). An untimely Qualified Event Notice is considered to have no effect and shall be rejected.

The Plan requires that you provide the Qualifying Event Notice in writing by mail to the Plan Administrator. Under no circumstances will an oral notice be effective.

In the Qualifying Event Notice, you are required to provide certain information regarding the qualifying event such as an identification of the type of event, the date the event occurred and the name of the individual to whom the event is applicable. The qualifying events listed below require specific documentation attached to the Qualifying Event Notice:

Qualifying Event	Documentation Required with Notice
Divorce or legal separation	Certified copy of the court order granting the divorce or legal separation.
Death of covered employee	Copy of death certificate.
Qualification for Social Security Disability	Copy of the Social Security Administration determination
Loss of Social Security	

Disability Status	Copy of Social Security Administration final determination.

To be considered valid, the notice must be completed in full and all required enclosures must be supplied. However, the Plan provides that a Qualifying Event Notice otherwise received timely, but which does not contain all required information or enclosures will not be considered untimely if the Plan Administrator is able to identify the Plan, identify the covered employee or qualified beneficiary, identify the qualifying event or disability, and identify the date on which the qualifying event occurred. The Plan Administrator, in such event, may require additional supplementary information from the covered employee or qualified beneficiary. The completed Qualifying Event Notice must be mailed to the Plan Administrator at the address listed in this SPD. It is recommended that you send the completed Qualifying Event Notice by registered mail, return receipt requested, but it is not required. When you submit a completed Qualifying Event Notice, you need to retain a copy (including copies of all enclosures) and any proof of mailing.

Second-Chance COBRA Election

If you are an employee eligible to receive Trade Adjustment Assistance (TAA) benefits, and you (i) lost health coverage due to a job loss that resulted in eligibility for TAA benefits, and (ii) failed to elect COBRA during your original COBRA election period, you may be entitled to a second 60-day COBRA election period. The new election period begins on the first day of the month in which you are certified for TAA benefits, but your election must be made within six months of the initial loss of group health coverage. In addition, the petition for trade assistance benefit certification must not have been filed before November 4, 2002.

You may make an election under the second 60-day election period by completing the COBRA Election Notice which you can request by contacting the Plan Administrator and returning it to the Plan Administrator at the indicated address, within the 60-day period and before expiration of the six month eligibility period. If you elect COBRA under this "second-chance" provision, your maximum period of continuation coverage will be based on the date of your original qualifying event. Your coverage will begin on the first day of the 60-day "second-chance" election period. In addition, the period between your original loss of coverage and the beginning of the 60-day second chance election period will not count against the 63-day HIPAA break in coverage rule for purposes of pre-existing conditions. The COBRA Election Notice will provide you with additional information regarding electing COBRA during this second-chance period.

How Is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. To notify the Plan Administrator of the determination by the Social Security Administration that you, your spouse or your dependent is eligible for disability, a Qualifying Event Notice must be completed and returned to the Plan Administrator. A copy of the determination by the Social Security Administration must be attached to the Qualifying Event Notice.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Coverage through the Marketplace
If you experience a loss of coverage under the Plan, there may be other coverage options for you and your family. When key parts of the health care law take effect, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

If You Have Questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Additionally, continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to USERRA. More information about coverage available pursuant to USERRA is included in the certificate of insurance booklet or SPD.

4. Summary of Plan Benefits

Benefits and Contributions The Plan provides you and your eligible dependents with medical, dental, vision, long-term disability, short-term disability, group term life and ADD insurance and a medical flexible spending account. A summary of each benefit provided under the Plan is set forth in the attached certificate of insurance or HMO booklet, SPD, or other governing document among the applicable Attachments.

The cost of the benefits provided through the component benefit programs will be funded in part by Company contributions and in part by pre-tax employee contributions. The Company will determine and periodically communicate your share of the cost of the benefits provided through each component benefit program, and it may change that determination at any time.

The Company will make its contributions in an amount that (in the Company's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. The Company will pay its contribution and your contributions to an insurance carrier or HMO . Your contributions toward the cost of a particular benefit will be used in their entirety prior to using Company contributions to pay for the cost of such benefit.

Qualified Medical Child Support Orders With respect to component benefit plans that are group health plans, the Plan will also provide benefits as required by any qualified medical child support order (QMCSO) (defined in ERISA § 609(a)). A "medical child support order" (MCSO) is an order, decree, or judgment of a court of competent jurisdiction which (i) is made pursuant to a state domestic relations law (including a community property law) and provides for child support with respect to a child of a participant under a group health plan or provides for health benefit coverage to the child under the group health plan; or (ii) enforces a law relating to medical child support described in Social Security Act § 1908 which respect to a group health plan.

A "qualified medical child support order" (QMCSO) is a medical child support order which (i) creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a participant or beneficiary is eligible under a group health plan, (ii) provides certain required information with respect to

the order, and (iii) does not require the Plan to provide benefits not otherwise available under the Plan, except to the extent necessary to meet the requirements of Social Security Act § 1908.

The order must clearly state—

(i) the name and the last known mailing address (if any) of the participant and the name and mailing address of each alternate recipient covered by the order (however, the name and mailing address of the state or political subdivision thereof may be substituted),
(ii) a reasonable description of the type of coverage to be provided by the Plan to each such alternate recipient, or the manner in which such type of coverage is to be determined,
(iii) the period to which such order applies, and
(iv) each plan to which such order applies.

Certain procedural requirements are prescribed. The Plan Administrator must promptly notify the participant and each alternate recipient of the receipt of a medical child support order and the Plan's procedures for determining whether medical child support orders are QMCSOs. Within a reasonable period after receipt of the order the Plan Administrator must determine whether the order is a QMCSO and notify the participant and each alternate recipient of the determination. Each component plan that is a group health plan must establish reasonable procedures to determine whether medical child support orders are QMCSOs. Such a procedure must be in writing, provide notification to each person specified in a MCSO as eligible to receive plan benefits, and permit an alternate recipient to designate a representative for receipt of copies of notices with respect to the MCSO.

Special Rights on Childbirth With respect to component benefit plans that offer such services, note that group health plans and health insurance issuers offering group insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than the above periods. In any case, such plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

Michelle's Law Michelle's Law applies to component plans that are group health plans for plan years beginning on or after October 9, 2009 (for calendar year plans, the law is effective beginning January 1, 2010). Michelle's Law provides continued coverage under group health plans for dependent children who are covered under the Employer's group medical plan, as a student but lose their student status because they take a medically necessary leave of absence from school.

As a result, if your child is no longer a student, as defined in the plan, because he/she is on a medically necessary leave of absence, your child may continue to be covered under the Plan for up to one year from the beginning of the leave of absence. This continue coverage applies if, immediately before the first day of the leave of absence, your child was (1) covered under the plan and (2) enrolled as a student at a post-secondary educational institution (includes colleges and universities).

For purposes of this continued coverage, a "medically necessary leave of absence" means a leave of absence from a post-secondary educational institution, or any change in enrollment of the child at that institution, that:

1. begins while the child is suffering from a serious illness or injury
2. is medically necessary
3. causes the child to lose student status for purposes of coverage under the plan.

This coverage provided to dependent children during any period of continued coverage:

1. is available for up to one year after the first day of the medically necessary leave of absence, but ends earlier if coverage under the plan would otherwise terminate, and
2. stays the same as if your child had continued to be a covered student and had not taken a medically necessary leave of absence.

If the coverage provided by the plan is changed during this one-year period, the plan must provide the changed coverage for the dependent child for the remainder of the medically necessary leave of absence unless, as a result of the change, the plan no longer provides coverage for dependent children.

If you believe your child is eligible for this continued coverage, the child's treating physician must provide a written certification to the plan stating that your child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

Mental Health Parity Act The Mental Health Parity Act (MHPA) of 1996 applies to any component plans that are group health plans. MHPA was originally enacted to provide parity between mental health benefits and medical/surgical benefits. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) added provisions related to substance use disorder benefits and requires parity in financial requirements and treatment limitations, and became effective for plan years beginning after October 3, 2009 (for calendar year plans, on January 1, 2010).

Nothing in the MHPA or MHPAEA requires a component group health plan to offer mental health benefits or substance use disorder benefits. However, if the particular component plan does elect to provide such coverage, then the parity requirements will apply, in accordance with current regulations.

If you have questions about the MHPA or the MHPAEA, please contact the Plan Administrator, or look on the DOL website.

The Women's Health and Cancer Rights Act "The Women's Health and Cancer Rights Act" requires group health plans to make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

The Genetic Information Nondiscrimination Act prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Children's Health Insurance Program If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

5. How the Plan Is Administered

Plan Administration The administration of the Plan is under the supervision of the Plan Administrator. An individual or committee may be designated to act on behalf of the Plan Administrator.

The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, authorizing benefit payments, and gathering information necessary for administering the Plan. The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s), and expressly describes the nature and scope of the delegated responsibility.

The Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan.
The Company will bear its incidental costs of administering the Plan.

Plan and Authority of Insurance Company Certain benefits under the Plan are fully insured or provided by contract with an HMO. Group insurance contracts provide for the following benefits:

Blue Cross Blue Shield of Florida PO Box 1798 Jacksonville, Fl. 32224 866 946-2583	Group Medical Plan
Florida Combined Life Insurance Company 5011 Gate Parkway Blvd. Suite 400 Jacksonville, Fl. 32224 904 828-7800	Group Dental Plan
VSP Vision Plan 333 Quality Drive Rancho Cordova, Ca. 95670 800 877-7195	Vision Plan
Mutual of Omaha Mutual of Omaha Plaza Omaha, Ne. 68175 800-769-7159	Life, voluntary life, AD&D, ltd, std
WageWorks 1100 Park Place 4th Floor San Mateo, Ca. 94003 888-990-5099	FSA

The insurance companies or HMO are responsible for (a) determining eligibility for and the amount of any benefits payable under their respective component benefit plans; and (b) prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to their respective component benefit plans.

Questions If you have any general questions regarding the Plan or regarding your eligibility for, or the amount of, any benefit payable under the self-funded component benefit plans, please contact the Human Resources Manager, who acts on behalf of the Plan Administrator.

If you have any question regarding your eligibility for, or the amount of, any benefit payable under the fully insured component benefit plans, please contact the appropriate insurance company.

6. Circumstances That May Affect Benefits

Denial, Recovery, or Loss of Benefits Your benefits (and the benefits of your eligible family members) will cease when your participation in the Plan terminates. See Section 4. Your benefits will also cease upon termination of the Plan. Other circumstances can result in the termination, reduction, recovery (through subrogation or reimbursement), or denial of benefits. For example, benefits may be denied under the medical or dental benefit programs if you have a preexisting condition and incur costs within the exclusionary period. You should consult the certificate of insurance booklets, SPDs and other governing documents among the applicable Attachments for additional information.

7. Amendment or Termination of the Plan

Amendment or Termination The Company, as Plan Sponsor, has the right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument duly adopted by the Company or any of its delegates. The Human Resources Manager of the Company may sign insurance contracts for this Plan on behalf of the Company, including amendments to those contracts, and may adopt (by a written instrument) amendments to the Plan that he or she considers to be administrative in nature or advisable in order to comply with applicable law.

8. No Contract of Employment

No Contract of Employment The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and the Company to the effect that you will be employed for any specific period of time.

9. Claims Procedures

Claims for Fully Insured or HMO Benefits For purposes of determining the amount of, and entitlement to, benefits of the component benefit programs provided under insurance or contracts, the respective insurer or HMO is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance or HMO contract.

To obtain benefits from the insurer or HMO of a component benefit program, you must follow the claims procedures under the applicable insurance or HMO contract, which may require you to complete, sign, and submit a written claim on the insurer's form. In that case, the form is available from the Plan Administrator.

The insurance company or HMO will decide your claim in accordance with its reasonable claims procedures, as required by ERISA. The insurance company or HMO is obligated to comply with ERISA's claims and appeals procedures. The insurance company or HMO has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the insurance company or HMO denies your claim in whole or in part, then you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the insurance company or HMO for a review of the denied claim. The insurance company or HMO will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA. If you don't appeal on time, you will lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing suit in state or federal court).

See the attached certificate of insurance or HMO booklet for more information about how to file a claim and for details regarding the insurance company's or HMO's claims procedures, including with respect to internal or external appeals, to the extent required by federal health care reform legislation.

Claims for Self-Funded Benefits – Medical Flexible Spending Account - For purposes of determining the amount of, and entitlement to, benefits under the component benefit programs provided through the Company's general assets, the Plan Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-funded arrangement.

To obtain benefits from a self-funded arrangement, you must complete, execute, and submit to the Plan Administrator a written claim on the form available from the Plan Administrator. The Plan Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary to decide your claim.

The Plan Administrator will decide your claim in accordance with reasonable claims procedures, as required by ERISA. The Plan Administrator is obligated to comply with ERISA's claims and appeals procedures. The Plan Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the Plan Administrator denies your claim in whole or in part, then you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the Plan Administrator for a review of the denied claim. The Plan Administrator will decide your appeal in accordance with reasonable claims procedures, as required by ERISA. If you don't appeal on time, you will lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court).

See the SPD or other governing document behind the applicable Attachments for more information about how to file a claim and for details regarding the claims procedures applicable to your claim.

10. Statement of ERISA Rights

Your Rights
As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, 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 insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description (SPD). The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case AVE MARIA UNIVERSITY, as Plan Administrator, is required by law to furnish each participant with a copy of this summary annual report.

COBRA and HIPAA Rights Continue health care coverage for yourself, your spouse, or your 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 SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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

Enforce Your Rights 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 that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, 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 XYZ Corporation, as Plan Administrator, to provide the materials and pay you up to $110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a

claim for benefits which is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan (discussed in Section 8), you may file suit in a state or federal court.

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

Assistance with Your Questions If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory) or contact 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.

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11.Attachments:

Attachment #1: Medical Benefits Insurance Certificate Booklet
Attachment #2: Dental Insurance Certificate Booklet
Attachment #3: Vision Insurance Certificate Booklet
Attachment #4: Group Term Life and AD&D Insurance Certificate Booklet
Attachment #5: Long-Term Disability Insurance Certificate Booklet
Attachment #6: Short-Term Disability Insurance Certificate Booklet
Attachment #7: Medical Flexible Spending Account Summary Plan Description