FLORIDA INSTITUTE OF TECHNOLOGY

FLEXIBLE SPENDING ACCOUNT PLAN

As Amended and Restated Effective April 1, 2022

INDEPENDENT COLLEGES AND UNIVERSITIES AND BENEFITS ASSOCIATION
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ARTICLE I.
INTRODUCTION

1.1 Establishment of Plan

FLORIDA INSTITUTE OF TECHNOLOGY (the "Employer") has established the FLORIDA INSTITUTE OF TECHNOLOGY Flexible Spending Account Plan (the "Plan"). Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in Article II. This Plan document constitutes the summary plan description, as required by ERISA Section 102.

The Plan is designed to permit an Eligible Employee to pay for his or her eligible Benefits on a pre-tax basis.

1.2 Legal Status

This Plan is intended to qualify as a "cafeteria plan" under Code § 125 and the regulations issued thereunder and shall be interpreted to accomplish that objective.

The Health Care Spending Account ("HCSA") Portion is intended to qualify as a "self-insured medical reimbursement plan" under Code § 105, and the Medical Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Code § 105(b). The Dependent Care Spending Account ("DCSA") Portion of the Plan is intended to qualify as a "dependent care assistance program" under Code § 129, and the Dependent Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Code § 129(a).

The HCSA Portion and the DCSA Portion are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Code §§ 105 and 129. The HCSA Portion is also a separate plan for purposes of applicable provisions of ERISA, HIPAA, and COBRA. In the event that the HCSA Portion is determined not to be a separate plan, the Plan shall be designated as a hybrid entity for purposes of HIPAA, such that it shall be a covered entity only with respect to the HCSA Portion.

ARTICLE II.
DEFINITIONS

2.1 Definitions

"Account(s)" means the HCSA or the DCSA, as applicable.

"Amendment & Restatement Effective Date" of this Plan means April 1, 2022.

"Benefits" means Pre-tax Benefits, the HCSA Benefits, and the DCSA Benefits offered under the Plan.

"Benefit Package Option" means a qualified benefit under Code § 125(f) that is offered under a cafeteria plan or an option for coverage under an underlying accident or health plan.

"Dependent" means: (a) for purposes of accident or health coverage (to the extent funded under the Pre-tax Benefit Payment Portion, and for purposes of the HCSA Portion), (1) a dependent as defined in Code § 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof (including domestic partners that so qualify), (2) any child (as defined in Code § (f)(1)) of the Participant who as of the end of the taxable year has not attained age 27, and (3) any child of the Participant to whom IRS Revenue Procedure 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year); and (b) for purposes of the DCSA Portion, a dependent means a Qualifying Individual. Notwithstanding the foregoing, the HCSA Portion will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of "Dependent."

"Dependent Care Expenses"

"FMLA" means the Family and Medical Leave Act of 1993, as amended.

"Plan Year" means the 12-month period commencing April 1 and ending on March 31, except in the case of a short plan year representing the initial Plan Year or where the Plan Year is being changed, in which case the Plan Year shall be the entire short plan year.

"Pre-tax Benefits" means the Pre-tax Benefits that may be paid for on a pre-tax Salary Reduction basis as described in Section 6.1.

"Pre-tax Benefit Payment"

An individual is eligible to participate in this Plan (including the Pre-tax Benefit Payment Portion, the HCSA Portion and the DCSA Portion) if the individual satisfies the eligibility requirements of the Medical Insurance Plan. Eligibility for Pre-tax Benefits shall also be subject to the additional requirements, if any, specified in the applicable employee benefit plans or insurance policies. Once an Employee has met the Plan's eligibility requirements, the Employee may elect coverage, effective as of the first day of the month following or coinciding with of his or her full-time employment provided that he or she enrolls within 30 days after becoming eligible, or for any subsequent Plan Year, in accordance with the procedures described in Article IV.

3.2 Termination of Participation

A Participant will cease to be a Participant in this Plan upon the earlier of:

(a) The termination of this Plan; or

(b) The last day of the month in which the Employee ceases (because of retirement, termination of employment, layoff, reduction of hours, or any other reason) to be an Eligible Employee. Notwithstanding the foregoing, for purposes of pre-taxing COBRA coverage, certain Employees may continue eligibility for certain periods on the terms and subject to the restrictions described in Section 6.4 for Medical Insurance Benefits, Section 7.8 for HCSA Benefits and Section 8.8 for DCSA Benefits.

Termination of participation in this Plan will automatically revoke the Participant's elections. The Insurance Benefits will terminate as of the date specified in the Insurance Plans. Reimbursements from the HCSA and DCSA after termination of participation will be made pursuant to Section 7.8 for HCSA Benefits and Section 8.8 for DCSA Benefits.

3.3 Participation Following Termination of Employment or Loss of Eligibility

If a Participant terminates his or her employment for any reason, including (but not limited to) disability,

(a) With after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer;

(b) with pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation (if any), including unused sick days and vacation days, or pre-paying all or a portion of the Contributions for the expected duration of the leave on a pre-tax Salary Reduction basis out of pre-leave Compensation. To pre-pay the Contributions, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year); or

(c) Under another arrangement agreed upon between the Participant and the Plan Administrator (, the Plan Administrator may fund coverage during the leave and withhold "catch-up" amounts from the Participant's Compensation on a pre-tax or after-tax basis) upon the Participant's return.

If the Employer requires all Participants to continue health Insurance Benefits and HCSA Benefits during an unpaid FMLA leave, then the Participant may elect to discontinue payment of the Participant's required Contributions until the Participant returns from leave. Upon returning from leave, the Participant will be required to repay the Contributions not paid by the Participant during the leave. Payment shall be withheld fro

on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Plan Administrator. If a Participant goes on an unpaid leave that affects eligibility, then the election change rules in Section 10.3(d) will apply.

ARTICLE IV.
METHOD AND TIMING OF ELECTIONS

4.1 Elections When First Eligible

An Employee who first becomes eligible to participate in the Plan mid-year may elect to commence participation in one or more Benefits on the date after the eligibility requirements have been satisfied; provided, however, that an Election Form/Salary Reduction Agreement is submitted to the Plan Administrator

4.4 Irrevocability of Elections

Unless an exception applies (as described in Article XI), a Participant's election under the Plan is

period that begins immediately following the close of that Plan Year and ends on the day that is two months plus 15 days following the close of the Plan Year (, June 15).

6.2 Contributions for Cost of Coverage

The annual Contribution for a Participant's Pre-tax Benefits is equal to the amount as set by the Employer, which may or may not be the same amount charged for the Insurance Benefits.

6.3 Insurance Benefits Provided Under the Insurance Plans

Insurance Benefits will be provided by the Insurance Plans, as listed in Appendix B, not this Plan. The types and amounts of Insurance Benefits, the requirements for participating in the Insurance Plans, and the other terms and conditions of coverage and benefits of the Insurance Plans are set forth in the Insurance Plans. All claims to receive benefits under the Insurance Plans shall be subject to and governed by the terms and conditions of the Insurance Plans and the rules, regulations, policies, and procedures adopted in accordance therewith, as may be amended from time to time.

6.4 Medical Insurance Benefits; COBRA

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, as applicable, whose coverage terminates under a health Insurance Benefit because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA), shall be given the opportunity to continue on a self-

7.2 Contributions for Cost of Coverage of HCSA Benefits

(b) . The maximum annual benefit amount that a Participant may elect to receive under this Plan in the for

7.6 Forfeiture of HCSA; Use-It-or-Lose-It Rule

(a) . If any balance remains in the Participant's HCSA for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance shall not be carried over to reimburse the Participant for Medical Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance.

(b) . All forfeitures under this Plan shall be used as follows: first, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements (, providing HCSA Benefits) with respect to all Participants in excess of the Contributions paid by such Participants through Salary Reductions; second, to reduce the cost of administering the HCSA Portion during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations. In addition, any HCSA benefit payments that are unclaimed (, uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Medical Care Expense was incurred shall be forfeited and applied as described above.

7.7 Reimbursement Claims Procedure for HCSA

(a) . Within 30 days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Medical Care Expenses (if the Plan Administrator approves the claim), or the Plan Administrator will notify the Participant that his or her claim has been denied. This time period may be extended by an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete the previously incomplete reimbursement claim.

(b)- . A Participant who has elected to receive HCSA Benefits for a Period of Coverage may apply for reimbursement by submitting a request in writing to the Plan Administrator in such form as the Plan Administrator may prescribe, by no later than June 30 following the close of the Plan Year in which the Med

FLORIDA INSTITUTE OF TECHNOLOGY is the named fiduciary for the HCSA Portion for purposes of ERISA § 402(a).

7.10 Coordination of Benefits with HRA, etc.

HCSA Benefits are intended to pay benefits solely for Medical Care Expenses for which Participants have not been previously reimbursed and will not seek reimbursement elsewhere. Accordingly, the HCSA shall not be considered to be a group health plan for coordination of benefits purposes, and HCSA Benefits shall not be taken into account when determining benefits payable under any other plan. Notwithstanding the foregoing, however, in the event that an expense is eligible for reimbursement under both the HCSA and the HRA, the HCSA will pay first.

ARTICLE VIII.
DCSA PORTION

8.1 DCSA Benefits

- The amount of the requested reimbursement;
- The name of the person, organization, or entity to whom the Expense was or is to be paid, and taxpayer identification number (Social Security number, if the recipient is a person);
- A statement that such Expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source;
- the Participant's certification that he or she has no reason to believe that the reimbursement requested, added to his or her other reimbursements to date for Dependent Care Expenses incurred during the same calendar year, will exceed the applicable statutory limit for the Participant as described in Section 8.4(b); and
- Other such details about the expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise (, a more detailed certification from the Participant).

The application shall be accompanied by bills, invoices, or other statements from an independent

. Protected health information means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information does not include information about persons living or deceased.

The Employer shall have access to PHI from the HCSA only as permitted under this Article IX or as otherwise required or permitted by HIPAA. HIPAA and its implementing regulations were modified by the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), the statutory provisions of which are incorporated herein by reference.

9.2 Permitted Disclosure of Enrollment/Disenrollment Information

The HCSA may disclose

to

- Ensure

10.3 Events Permitting Exception to Irrevocability Rule

An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right. Election changes on account of a HIPAA special enrollment attributable to the birth, adoption, or placement for adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 30 days).

For purposes of this Section 10.3(e)(1), the term “loss of eligibility” includes (but is not limited to) loss of eligibility due to legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction of hours, or any loss of eligibility for coverage that is measured with reference to any of the foregoing; loss of coverage offered through an HMO that does not provide benefits to individuals who do not reside, live, or work in the service area because an individual no longer resides, lives, or works in the sf thintif4( )-11wh8(ouh222)4(pe)-4(c)4(i)5(al)-7( )6(i)-5(9( )(i)-5()-5(th)-2( )7(n)-13(th)7(e)-4( )-42(ur

(1) Participants are required to increase their elective contributions (by increasing Salary Reductions) to reflect insignificant increases in their required contribution for their Benefit Package Option(s), and to decrease their elective contributions to reflect insignificant decreases in their required contribution. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including but not limited to the dollar amount or percentage of the cost change. The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected employees' elective contributions on a prospective basis.

(2) . If the Plan Administrator determines that the cost charged to an Employee of a Participant's Benefit Package Option(s) significantly increases during a Period of Coverage, then the Participant may (A) make a corresponding prospective increase in his or her elective contributions (by increasing Salary Reductions); (B) revoke his or her election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Package Option that provides similar coverage (but not the HCSA); or (C) drop coverage prospectively if there is no other Benefit Package Option available that provides similar coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidance.

(3) If the Plan Administrator determines that the cost of any Benefit Package Option (such as the PPO for the Medical Insurance Plan) significantly decreases during a Period of Coverage, then the Plan Administrator may permit the following election changes: (A) Participants who are enrolled in that Benefit Package Option may make a corresponding prospective decrease in their elective contributions (by decreasing Salary Reductions); (B) Participants who are enrolled in another Benefit Package Option (such as an HMO, but not the HCSA) may change their election on a prospective basis to elect the Benefits Package Option that has decreased in cost (such as the PPO for the Medical Insurance Plan); or (C) Employees who are otherwise eligible under Section 3.1 may elect the Benefits Package Option that has decreased in cost on a prospective basis, subject to the terms and limitations of the Benefits Package Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant in accordance with prevailing IRS guidance.

(4) The above "Change in Cost" provisions (Sections 10.3(h) (1) through 10.3(h) (3)) apply to DCSA Benefits only if the cost change is imposed by a dependent care provider who is not a "relative" of the Employee. For this purpose, a relative is an individual who is related as described in Code §§ 152(d) (2) (A) through (G), incorporating the rules of Code §§ 152(f) (1) and 152(f) (4).

(i)
The definition of "similar coverage" under Section 10.3(h) applies also to this Section 10.3(i).

(1) . If coverage is "significantly curtailed" (as defined below), Participants may elect coverage under another Benefit Package Option that provides similar coverage. In addition, as set forth below, if the coverage curtailment results in a "Loss of Coverage" (as defined below), then Participants may drop coverage if no similar coverage is offered by the Employer. The Plan Administrator in its sole discretion, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant," and whether a Loss of Coverage has occurred.

(A) . If the Plan Administrator

Participant remains a Participant under this Plan in accordance with Section 3.2), then the Participant may increase his or her election to pay for such coverage (this rule does not apply to a Participant's Spouse who becomes eligible for COBRA or similar coverage as a result of divorce, annulment, or legal separation).

(B) ¶ . For a Change in Status in which a Participant or his or her Spouse or Dependent gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of the Participant's Spouse or Dependent as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Plan Administrator may rely on a Participant's certification that the Participant has obtained or will obtain coverage under the Spouse's or Dependent's employer's plan unless the Plan Administrator has reason to believe that the Participant's certification is incorrect.

(3) . With respect to the DCSA Benefits, a Participant may change or terminate his or her election upon a Change in Status if (i) such change, or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under an employer's plan; or (ii) the election change is on account of and corresponds with a Change in Status that affects the eligibility of Dependent Care Expenses for the tax exclusion under Code § 129.

A Participant entitled to change an election as described in this Section 10.3 must do so in accordance with the procedures described in Section 10.2.

11.2 Claims Procedures for Medical Insurance Benefits

Claims and reimbursement for Insurance Benefits shall be administered in accordance with the claims procedures for the Insurance Benefits, as set forth in the plan documents and/or summary plan description for the Insurance Plans.

ARTICLE XII.
RECORDKEEPING AND ADMINISTRATION

12.1 Plan Administrator

The administration of this Plan shall be under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that this Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

12.2 Powers of the Plan Administrator

The Plan Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters thereunder, and all determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following discretionary authority:

(a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan (provided that, notwithstanding the first paragraph in this Section 12.2, the Plan Administrator shall exercise such exclusive power with respect to an appeal of a claim under Section 11.1);

(b) To prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;

(c) To prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Plan Administrator determines to be appropriate;

(d) To request and receive from all Employees and Participants such information as the Plan Administrator shall from time to time determine to be necessary for the proper administration of this Plan;

(e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide benefits under this Plan;

(f) To receive, review, and keep on file such reports and information regarding the benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;

(g) To appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;

(h) To sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

(i) To secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

(j) To maintain the books of accounts, records, and other data in the manner necessary for the proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

12.3 Reliance on Participant, Tables, etc.

The Plan Administrator may rel

12.9 Inability to Locate Payee

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment

13.5 Code and ERISA Compliance

It is intended that this Plan meet all applicable requirements of the Code and ERISA and of all regulations issued thereunder. (ERISA applies to the Medical Insurance Plan and the HCSA Portion but not to the DCSA Portion.) This Plan shall be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause, or provision of this Plan and the Code and/or ERISA, the provisions of the Code and ERISA shall be deemed controlling, and any conflicting part, clause, or provision of this Plan shall be deemed superseded to the extent of the conflict.

13.6 No Guarantee of Tax Consequences

Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes and to notify the Plan Administrator if the Participant has any reason to believe that such payment is not so excludable.

13.7 Indemnification of Employer

If any Participant receives one or more payments or reimbursements under this Plan on a tax-free basis and if such payments do not qualify for such treatment under the Code, then such Participant shall indemnify and reimburse the Employer for any liability that it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

13.8 Non-Assignability of Rights

The right of any Participant to receive any reimbursement under this Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to the extent required by law.

13.9 Headings

The headings of the various Articles and Sections are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

13.10 Plan Provisions Controlling

In the event that the terms or provisions of any summary or description of this Plan is in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall be controlling.

13.11 Severability

Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent possible.

If your claim for a 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 inst

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising the FLORIDA INSTITUTE OF TECHNOLOGY Flexible Spending Account Plan, FLORIDA INSTITUTE OF TECHNOLOGY has caused this Plan to be executed in its name and on its behalf, on this ___ day of _____, 2022.

FLORIDA INSTITUTE OF TECHNOLOGY

Date: _____ By: _____

Initials: _____

APPENDIX B

INSURANCE PLANS

- Medical Insurance Plan
- Employee Benefit Plans such as Dental, V

APPENDIX C

ELIGIBLE AND INELIGIBLE EXPENSE LISTING

ACNE LASER TREATMENT
Expenses paid for acne treatment are reimbursable.

ACUPUNCTURE
Medical expenses paid for acupuncture are reimbursable.

ADOPTION
The cost of the adoption itself is not reimbursable; however, things like physicals for the adoptive parents, pre-adoption counseling, and other health related expenses are reimbursable.

ADULT DIAPERS
Expenses paid for diapers are reimbursable.

ALCOHOLISM, DRUG OR SUBSTANCE ABUSE
Medical expenses paid to a treatment center for alcohol or drug abuse are reimbursable. This includes meals and lodging provided by the center during treatment.

ALLERGY AND SINUS RELIEF
(See Over-The-Counter Medicines and Drugs for other items.)
The following are considered reimbursable medical expenses:

- Electrostatic air purifier.
- Home/automobile air conditioners (when the person suffers from allergies).
- Humidifier (when the person suffers from allergies).
- Pillows, mattress covers, etc. to alleviate an allergic condition.
- Special vacuum cleaners for persons with respiratory problems.

Note: Expenses must be accompanied by a doctor's certification indicating the specific medical disorder, the specific treatment needed, and how this treatment will alleviate the medical condition.

ALTERNATIVE PROVIDERS

AUTOMOBILE
Special Equipment: The amount paid for the cost of special hand controls and other special equipment installed in an automobile for the use of a handicapped person is reimbursable. The amount paid for the cost of handicap stickers or tags is reimbursable.
Special Design: The amount by which the cost of an automobile specially designed to hold a wheelchair is more than the cost of a regular automobile is reimbursable.

BABY FORMULA
The *cost difference* between Protein formulas and soybean formulas and non-milk formulas are reimbursable *if you have a prescription or a certification* from the baby's doctor noting that this particular formula is necessary for the child's well-being.

BATTERIES
Expenses paid for the purchase of batteries are reimbursable when they are used for the sole purpose of an item that is also covered. This would include, but not be limited to, batteries for blood pressure machines, wheelchairs, heart defibrillators, hearing aids, etc. Request for reimbursement should include a description of the item the batteries are purchased for.

BIRTH CONTROL RELATED
Medical expenses paid for birth control pills, injections, condoms, and devices are reimbursable.

BLOOD CORD STORAGE
Blood cord storage for immediate use to cure or treat a specific medical condition is eligible reimbursable. If storage is for possible future use for disease or disorders that do not currently exist, it is not reimbursable.

BODY SCAN
The cost of electronic body scans is reimbursable.

BRAILLE BOOKS AND MAGAZINES
The amount by which the cost of Braille books and magazines for use by a visually impaired person exceeds the price for regular books and magazines is reimbursable.

BREAST AUGMENTATION

BREAST PUMPS AND SUPPLIES
Breast pumps and supplies are reimbursable.

BREAST RECONSTRUCTION SURGERY
Breast reconstructive surgery following a mastectomy for cancer is reimbursable.

BREAST REDUCTION
Medical expenses related to breast reduction surgery are reimbursable only if medically necessary.

Note: Expenses must be accompanied by a doctor's certification indicating the specific medical disorder, the specific treatment needed, and how this treatment will alleviate the medical condition.

CAPITAL EXPENSE

Amounts paid for special equipment or improvements in your home, if primarily motivated by medical considerations, are eligible medical expenses. The amount paid for the improvement is reduced by the increase in the value of the property. The rest is the eligible medical expense. If the value of the property is not increased by the improvement, the entire cost is an Eligible Expense. The cost for improvements that you would make in the absence of the medical condition does not qualify as a medical expense. Improvements made for personal convenience or that may just be beneficial to your general health do not qualify. Certain capital expenses made for the primary purpose of accommodating a personal residence to one's handicapped condition that does not increase the value of the property, may generally be included in full as medical expenses. Examples of eligible expenditures include:

- Constructing entrance or exit ramps to your residence.
- Widening doorways at entrances or exits to your residence.
- Widening or otherwise modifying hallways and interior.
- Installing railing, support bars, or other modifications to bathrooms.
- Lowering or making other modifications to kitchen cabinets and equipment.
- Altering the location of or modifying electrical outlets and fixtures.
- Installing porch lifts and other forms of lifts. Generally, this does not include elevators, because they may add to the fair market value of your residence, and any medical expense therefore would have to be decreased to that extent.
- Modifying fire alarms, smoke detectors, etc.
- Modifying stairways.
- Adding handrails or grab bars whether or not in bathrooms.
- Modifying hardware on doors.
- Modifying areas in the front entrance and exit doorways.
- Grading of ground to provide access to the residence.

Operation and Upkeep: If a capital expense qualifies as an eligible medical expense, amounts paid for operation

3. -	Subtract line 2 from line 1.	$_____
	This is the deductible medical expense.	$_____

CHILDBIRTH CLASSES

Expenses for childbirth classes are reimbursable but are limited to expenses incurred by the mother-to-be.

CPAP
(Sleep Apnea) machine and supplies are reimbursable.

CRUTCHES
The amount paid to buy or rent crutches, canes, walkers, and medical equipment are reimbursable.

CUSHIONS
The costs of cushions, including inflatable, are not covered (unless prescribed by a physician to treat a medical condition).

DOCTORS' FEES

Fees paid to doctors are reimbursable. This includes, but is not limited to, fees paid to a (n):

- Anesthesiologist
- Chiropodist
- Chiropractor
- Christian Science Practitioner
- Dentist
- Dermatologist
- Gynecologist
- Neurologist
- Obstetrician
- Oculist
- Ophthalmologist
- Optician
- Orthodontist
- Orthopedist
- Osteopath
- Pediatrician
- Physician
- Physiotherapist
- Podiatrist
- Psychiatrist

Other

- Charges for transfer of medical records are eligible.
- Charges for use of facility for blood donations are eligible.
-

Tuition payments to a special school for a child, who has severe learning disabilities caused by mental or physical impairments, including nervous system disorders, are reimbursable. A doctor must recommend that the child

with the person receiving the medical care. For example: a parent traveling with a sick child is allowed up to $100 per night as a medical expense for lodging. Meals are not reimbursable.

LONG TERM CARE

Long term care services are not reimbursable. Medical expenses incurred while a resident receiving long-term care benefits are reimbursable. Long term care insurance premiums are not reimbursable.

MASSAGE THERAPY AND EQUIPMENT

Fees paid for massages and equipment (i.e. massage chair) are not reimbursable unless to treat a physical defect or illness.

Note: Expenses must be accompanied by a doctor's certification indicating the specific medical disorder, the specific treatment needed, and how this treatment will alleviate the medical condition.

MATERNITY CLOTHES

Expenses for maternity clothes are not reimbursable.

- The maintenance cost for operating the devices (e.g., electricity for air conditioner use) is also an Eligible Medical Expense.
- The maintenance cost for a home swimming pool for a person suffering from emphysema may be considered an Eligible Medical Expense. An appraisal of the property value before and after installation is required with submission. Only the portion of the expense that exceeds the increase in property value is eligible as a medical expense.
- Furnace air filters are eligible.
- Warranties are not eligible.

Note: Expenses must be accompanied by a doctor

Items ordinarily used for personal living and family purposes only if it is used primarily to prevent or alleviate a disease or disability and You would not have had the expense were it not for the medical condition are reimbursable.

- Diapers (e.g., Depends™) are eligible if they are needed to relieve the effects of a particular disease.
- Hospital kits are eligible.
- Special Baby Formula: The *cost difference* between protein formulas, soybean formulas, and non-milk formulas is eligible *if you have an Rx or a certification* from the baby's doctor noting that this particular formula is necessary for the child's well-being.
- Wig for hair loss due to any disease is eligible.
- Hospital telephones, TV, newspapers, etc., are not eligible.
- Sanitary napkins are not eligible.

Note: Expenses must be accompanied by a doctor's certification indicating the specific medical disorder, the specific treatment needed, and how this treatment will alleviate the medical condition.

PLANE TICKETS

PRIVATE HOSPITAL ROOM
The extra cost of a private hospital room is reimbursable.

PROSTHESIS

PSYCHIATRIC CARE
Expenses for psychiatric care are reimbursable. These expenses include the cost of supporting a mentally ill dependent at a specially equipped medical center where the dependent receives medical care.

PSYCHOANALYSIS
Expenses for psychoanalysis are reimbursable.

PSYCHOLOGIST
Expenses for psychological care are reimbursable.

RADON REMEDIATION
Expenses incurred to remove radon from the residence are reimbursable.

SAVINGS CLUB
Dues to join a club that offers discounts on health items are not reimbursable (i.e. a pharmacy savings club).

SCHOOLS, SPECIAL
Payments to a school for a mentally impaired or physically disabled person are reimbursable if the reason for using the school is its resources for relieving the disability. For example, the cost of a school that teaches Braille to the visually impaired, lip reading to the hearing impaired, or gives remedial language training to correct a condition caused by a birth defect is reimbursable.

- The cost of meals, lodging, and education supplied by a school or institution is eligible as a medical expense only if the reason for the patient being on-site is the resources the school has for relieving the mental or physical disability.
- The cost of sending a problem dependent to a school for benefits the dependent may get from the course of study and disciplinary methods is not an Eligible Expense.
- The cost of a boarding school while recuperating from an illness is not an Eligible Expense.
- The cost to prepare a dependent to live alone or become self-sufficient in the future would be eligible.

SHIPPING CHARGES

Shipping charges incurred when paying for an eligible expense are reimbursable.

SMOKING CESSATION PROGRAM

Smoking is considered an addiction therefore the cost of a program or prescription medication to stop smoking is reimbursable; however non-prescription medicines are not reimbursable. Most stop-smoking patches and gum are non-prescription and therefore are not reimbursable.

SPECIAL FOODS

The costs of special foods and/or beverages - even if prescribed - that substitute for other foods or beverages which a person would normally consume and which satisfy nutritional requirements (such as the consumption of bananas for potassium), are not reimbursable; However, prescribed special foods or beverages are reimbursable if they are consumed primarily to alleviate or treat an illness or disease, and not for nutritional purposes. Special foods and beverages are rei

The cost of equipment that displays the audio part of TV programs as subtitles for the hearing-impaired is reimbursable. This may include an adapter that attaches to a regular TV or the cost of a specially equipped TV in excess of the cost of the same model regular TV set.

THERAPY
Therapy you receive as medical or mental treatment is reimbursable.

- Massage for a specific disorder is reimbursable.
- Patterning Exercises: Payments made to an individual for giving patterning exercises to a mentally handicapped dependent are reimbursable. These exercises consist of physical manipulation of the dependent's arms and legs to imitate crawling and other normal movements.

Note: Expenses must be accompanied by a doctor's certification indicating the specific medical disorder, the specific treatment needed, and how this treatment will alleviate the medical condition.

TRANSPLANTS
Expenses you pay for the medical care you receive because you are a donor or a possible donor of a kidney or other organ, this includes transportation is reimbursable. You can include any expenses you pay for the medical care of a donor in connection with the donating of an organ. This includes donor transportation.

TRANSPORTATION
Amounts paid for transportation primarily for and essential to medical care is reimbursable. Proof of medical care is required. An individual may be reimbursed $.16 per mile (or the maximum amount allowed by the IRS) or actual car expenses when traveling in his/her own vehicle to obtain medical care. Mileage documentation is required. The cost of tolls and parking can be added to this amount. This includes:

- Actual use expenses, such as gas and oil (instead of $.16 per mile). Do not include expenses for a general repair, maintenance, depreciation, and insurance.
- Bus, taxi, train, plane fare, or ambulance service.
- Cost of transportation for parents if accompanying a child who needs medical care.
- Parking fees and tolls (receipts required).
- Trips to the pharmacy to pick up prescriptions and/or medical supplies.
- Transportation expenses for regular visits to see a mentally ill dependent if these visits are recommended as part of treatment.
- Transportation expenses of a nurse or other person who can give injections, medications, or other treatment required by a patient who is traveling to get medical care and are unable to travel alone.
- Transportation to Alcoholics Anonymous meetings.
- Transportation expenses to attend special conferences in order to obtain information for the treatment of a specific medical condition. Lodging and meals do not qualify.

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TRIPS

Amounts you pay for transportation to another city if the trip is primarily for and essential to, receiving medical services are reimbursable. You may be able to include up to $50 per night for lodging.

You cannot include in medical expenses a trip or vacation taken merely for a change in environment, improvement of morale, or general improvement of health, even if the trip is made on the advice of a doctor; However,

TUITION FEES

Tuition charges for a medically dysfunctional dependent are reimbursable. Tuition fees paid to a private school as a personal preference over public schooling for general education are not reimbursable.

VACCINES

Expenses for vaccines are reimbursable.

WEIGHT LOSS PROGRAMS, TREATMENT, AND PRESCRIPTIONS
Amounts you pay to lose weight if it is a treatment for a specific disease diagnosed by a physician (such as obesity, hypertension, or heart disease) are reimbursable. This includes fees you pay for membership in a weight reduction group as well as fees for attendance at periodic meetings.

You cannot include membership dues in a gym, health club, or spa as medical expenses, but you can include separate fees charged there for weight loss activities. You cannot include the cost of diet food or beverages in medical expenses because the diet food and beverages substitute for what is normally consumed to satisfy nutritional needs. You can include the cost of special food in medical expenses only if:

1. The food does not satisfy normal nutritional needs,
2. The food alleviates or treats an illness, and
3. The need for the food is substantiated by a physician

The amount you can include in medical expenses is limited to the amount by which the cost of the special food exceeds the cost of a normal diet.

Note: Expenses must be accompanied by a doctor's certification indicating the specific medical disorder, the specific treatment needed, and how this treatment will alleviate the medical condition.

WHEELCHAIR
Amounts paid for a manual or motorized wheelchair used mainly for the relief of sickness or disability is reimbursable. The cost of operating and maintaining the wheelchair is also reimbursable.

X-RAY FEES
Amounts paid for X-rays taken for medical reasons are reimbursable.

*INELIGIBLE RECEIPTS

In addition, the following are not acceptable receipts:

- Bankcard statements.
- Credit/debit card terminal receipts
- Charges submitted that are illegible.
- Estimates of expenses. (A statement is required showing date of service and type of medical expense.)

**ELIGIBLE DEPENDENT CARE SPENDING ACCOUNT (DCSA) EXPENSES

- Au Pair Agency Fees - Required application or agency fees or deposits that are paid in connection with the actual placement of an au pair or other caregiver.
- Expenses for a daycare center, summer day camp, or preschool. The facility must be licensed under state or local law if it cares for seven or more children.

APPENDIX D

APPEALS PROCEDURES

If your claim for Benefits is denied, the following appeals procedures shall apply.

The applicable insurance company will decide your claim in accordance with its claims procedures. If your claim is denied, you may appeal to the insurance company for a review of the denied claim. If you do not appeal on time, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court). Note that under certain circumstances, you may also have the right to obtain external review (that is, review outside of the plan). For more information about how to file a claim and for details regarding the medical and dental insurance companies' claims procedures, consult the claims procedures applicable under that plan or policy, as described in the plan document or summary plan description for the Medical Insurance Benefits or other Insurance Plans.

However, if (a) a claim for reimbursement under the HCSA or DCSA Portions of the Plan is wholly or partially denied, or (b) you are denied a Benefit under the Plan (such as the ability to pay for Medical Insurance Benefits, HCSA, or DCSA Benefits on a pre-tax basis) due to an issue germane to your coverage under the Plan (for example, a determination of a Change in Status; a "significant" change in contributions charged; or eligibility and participation matters under the Plan), then the appeals procedures described below will apply.

If your claim is denied in whole or in part, you will be notified in writing by the Plan Administrator within 30 days after the date the Plan Administrator received your claim. This time period may be extended for an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Plan Administrator is expected to be made. Where a claim is incomplete, the extension notice will also specifically describe the required information, will allow you 45 days from receipt of the notice in which to provide the specified information, and will have the effects of suspending the time for a decision on your claim unti1.52 TfW*nBT/F5 466.15 327.65 Tm0 g0W*nBTs(n)8(g)o08 g0W*nBTs(n)8(g)oe3,5 g(i)-5(

claim should not have been denied. It should include any additional facts and/or documents that you feel support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your appeal.