# FLORIDA INSTITUTE OF TECHNOLOGY

# FLEXIBLE SPENDING ACCOUNT PLAN

**(With Pre-Tax Benefit Payment, Health Care Spending Account, And Dependent Care Spending Account Portions)**

**As Amended and Restated Effective April 1**

414(n)) or an individual classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll or is determined by the IRS or others to be a common-law employee of the Employer; (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Employer; (c) any employee covered under a collective bargaining agreement; (d) any self-employed individual; (e) any partner in a partnership; and (f) any more-than-2% shareholder in a Subchapter S corporation. The term "Employee" does include "former Employees"

## ARTICLE III.
## ELIGIBILITY AND PARTICIPATION

### 3.1 Eligibility to Participate

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 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 date on 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.

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## 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 (or online at http://icubabenefits.org) before the date on which participation will commence. An Employee who does not elect benefits when first eligible may not enroll until the next Open Enrollment Period unless an event occurs that would justify a mid-year election change, as described under Section 10.3. Eligibility for Pre-tax Benefits shall be subject to the additional requirements, if any, specified in the Insurance Plans. The provisions of this Plan are not intended to override any exclusion, eligibility requirements, or waiting periods specified in the Insurance Plans.

### 4.2 Elections During Open Enrollment Period

During each Open Enrollment Period with respect to a Plan Year, the Plan Administrator shall provide an Election Form/Salary Reduction Agreement electronically (at http://icubabenefits.org) to each Employee who is eligible to participate in this Plan. The Election Form/Salary Reduction Agreement shall enable the Employee to elect to participate in the various portions of this Plan for the next Plan Year and to authorize the necessary Salary Reductions to pay for the Benefits elected. The Election Form/Salary Reduction Agreement must be returned to the Plan Administrator on or before the last day of the Open Enrollment Period, and it shall become effective on the first day of the next Plan Year. If an Eligible Employee fails to return the Election Form/Salary Reduction Agreement (or enroll online at http://icubabenefits.org) during the Open Enrollment Period, then the Employee may not elect any Benefits under this Plan until the next Open Enrollment Period unless an event occurs that would justify a mid-year election change, as described under Section 10.3.

### 4.3 Failure of Eligible Employee to File an Election Form/Salary Reduction Agreement

If an Eligible Employee fails to file an Election Form/Salary Reduction Agreement within the time period described in Sections 4.1 and 4.2, then the Employee may not elect any Benefits under the Plan (a) until the next Open Enrollment Period or (b) until an event occurs that would justify a mid-year election change, as described under Section 10.3. If an Employee who fails to file an Election Form/Salary Reduction Agreement is eligible for Insurance Benefits and has made an effective election for such Benefits, then the Employee's share of the Contributions for such Benefits will be paid with after-tax dollars outside of this Plan until such time as the Employee files, during a subsequent Open Enrollment Period (or after an event occurs that would justify a mid-year election change as described under Section 10.3), a timely Election Form/Salary Reduction Agreement to elect Pre-tax Benefits. Until the Employee files such an election, the Employer's portion of the Contribution will also be paid outside of this Plan.

### 4.4 Irrevocability of Elections

Unless an exception applies (as described in Article XI), a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates.

## ARTICLE V.
## BENEFITS OFFERED AND METHOD OF FUNDING

### 5.1 Benefits Offered

When first eligible or during the Open Enrollment Period as described under Article IV,

Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year) where COBRA coverage arises either (a) because the Employee ceases to be eligible because of a reduction in hours; or (b) because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (*e.g.*, Employees who cease to be eligible because of retirement, termination of employment, or layoff), contributions for COBRA coverage for health Insurance Benefits shall be paid on an after-tax basis (unless may be otherwise permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year).

## ARTICLE VII.
## HCSA PORTION

### 7.1 HCSA Benefits

An Eligible Employee can elect to participate in the HCSA Portion by electing (a) to receive benefits in the form of reimbursements for Medical Care Expenses from the HCSA (HCSA Benefits); and (b) to pay the Contributions for such HCSA Benefits on a pre-tax Salary Reduction basis. Unless an exception applies (as described in Article X), any such election is irrevocable for the duration of the Period of Coverage to which it relates.

### 7.2 Contributions for Cost of Coverage of HCSA Benefits

The annual Contribution for a Participant's HCSA Benefits is equal to the annual benefit amount elected by the Participant, subject to the dollar limits set forth in Section 7.4(b).

### 7.3 Eligible Medical Care Expenses for HCSA

Under the HCSA Portion, a Participant may receive reimbursement for Medical Care Expenses incurred during the Period of Coverage for which an election is in force.

(a) *Incurred.* A Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished and not when the Participant is formally billed for, is charged for, or pays for the medical care.

(b) *Medical Care Expenses.* Medical Care Expenses means expenses incurred by a Participant or his or her Spouse or Dependents for medical care, as defined in Code § 213(d), but only to the extent that the expense has not been reimbursed through the insurance or otherwise. If only a portion of a Medical Care Expense has been reimbursed elsewhere, then the HCSA can reimburse the remaining portion of such Medical Care Expense if it otherwise meets the requirements of this Article VII. Notwithstanding the foregoing, the term Medical Care Expenses does not include:

(1) Premium payments for other health coverage, including but not limited to health insurance premiums for any other plan, whether or not sponsored by the Employer;

(2) Medicines or drugs, unless the medicine or drug is a prescribed drug (determined without regard to whether the medicine or drug is available without a prescription) or is insulin (for this purpose, the Plan Administrator shall have sole discretion

## 7.5 Establishment of HCSA

The Plan Administrator will establish and maintain a HCSA with respect to each Participant for each Plan Year or other Period of Coverage for which the Participant elects to participate in the HCSA Portion, but it will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under Section 7.6.

(a) *Debiting of Accounts*. A Participant's HCSA for a Plan Year or other Period of Coverage will be debited for any reimbursement of Medical Care Expenses incurred during such period.

(b) *Available Amount Not Based on Credited Amount*. As described in Section 7.4, the amount available for reimbursement of Medical Care Expenses is the Participant's annual benefit amount, reduced by prior reimbursements for Medical Care Expenses incurred during the Plan Year or other Period of Coverage; it is not based on the amount credited to the HCSA at a particular point in time. Thus, a Participant's HCSA may have a negative balance during a Plan Year or other Period of Coverage, but the aggregate amount of reimbursement shall in no event exceed the maximum dollar amount elected by the Participant under this Plan.

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

(a) *Use-It-or-Lose-It Rule*. If any balance remains in the Participant's HCSA for a Period of Coverage after all reimbu

eligible, provided that the Participant (or the Participant's estate) files a claim within 90 days after the date that the Participant ceases to be a Participant.

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 the HCSA Portion 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-pay basis the same coverage that he or she had under the HCSA Portion the day before the qualifying event for the periods prescribed by COBRA. Specifically, such individuals will be eligible for COBRA continuation coverage only if, under Section 7.5, they have a positive HCSA balance at the time of a COBRA qualifying event (taking into account all claims submitted before the date of the qualifying event). Such individuals will be notified if they are eligible for COBRA continuation coverage. If COBRA is elected, it will be available only for the remainder of the Plan Year in which the qualifying event occurs; such COBRA coverage for the HCSA Portion will cease at the end of the Plan Year and cannot be continued for the next Plan Year. Such continuation coverage shall be subject to all conditions and limitations under COBRA.

Contributions for coverage for HCSA Benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year) where COBRA coverage arises either (a) because the Employee ceases to be eligible because of a redu3-134(pre)]TJdJnan8ses to bA-3( e)-3(s)4( )-103(t)-2(o )-103(

## ARTICLE VIII.
## DCSA PORTION

### 8.1 DCSA Benefits

An Eligible Employee can elect to participate in the DCSA Portion by electing to receive benefits in the form of reimbursements for Dependent Care Expenses and to pay the Contributions for such benefits (if any) on a pre-tax Salary Reduction basis. Unless an exception applies (as

are incurred for services provided by a dependent care center (*i.e.*, a facility (including a day camp) that provides care for more than six individuals (other than individuals residing at the facility) on a regular basis and receives a fee, payment, or grant for such services), then the center must comply with all applicable state and local laws and regulations.

(d) *Exclusion.* Dependent Care Expenses do not include amounts paid to:

(1) An individual with respect to whom a personal exemption is allowable under Code § 151(c) to a Participant or his or her Spouse;

(2) A Participant's Spouse;

(3) A Participant's child (as defined in Code § 152(f) (1)) who is under 19 years of age at the end of the year in which the expenses were incurred; or

(4) A parent of a Participant's under age 13 qualifying child (as defined in Code § 152(a) (1)).

**8.4**

(i) The Participant is married and files a joint federal income tax return;

(ii) the Participant is married, files a separate federal income tax return, and meets the following conditions: (a) the Participant maintains as his or her home a household that constitutes (for more than half of the taxable year) the principal abode of a Qualifying Individual (*i.e.*, the Dependent for whom the Participant is eligible to receive reimbursements under the DCSA); (b) the Participant furnishes over half of the cost of maintaining such household during the taxable year; and (c) during the last six months of the taxable year, the Participant's Spouse is not a member of such household (*i.e.*, the Spouse maintained a separate residence); or

(iii) The Participant is single or is the head of the household for federal income tax purposes; or

(B) $2,500 for the calendar year if the Participant is married and resides with the Spouse but files a separate federal income tax return.

The minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage shall be $50.

(c) *Changes; No Proration*. For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Election Form/Salary Reduction Agreement or another document. If a Participant enters the DCSA Portion mid-year or wishes to increase his or her election mid-year as permitted under Section 8.4, then there will be no proration rule (*i.e.*, the Participant may elect coverage up to the maximum dollar limit or may increase coverage up to the maximum dollar limit, as applicable).

(d) *Effect on Maximum Benefits If Election Change Permitted*. Any change in an election under Article X affecting annual contributions to the DCSA Portion also will change the maximum reimbursement benefits for the balance of the Period of Coverage (commencing with the election change), as further limited by Sections 8.4(a) and (b). Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the Contributions, if any, made as of the end of the portion of the Period of Coverage immediately preceding the change in election, to (2) the total Contributions scheduled to be made during the remainder of such Period of Coverage to the DCSA, reduced by (3) reimbursements during the Period of Coverage.

## 8.5 Establishment of DCSA

The Plan Administrator will establish and maintain a DCSA with respect to each Participant who has elected to participate in the DCSA Portion, but it will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under Section 8.6.

(a) *Crediting of Accounts*. A Participant's DCSA will be credited periodically during each Period of Coverage with an amount equal to the Participant's Salary Reductions elected to be allocated to such Account.

(b) *Debiting of Accounts.* A Participant's DCSA will be debited during each Period of Coverage for any reimbursement of Dependent Care Expenses incurred during the Period of Coverage.

Care Expenses incurred in the month following termination of employment or other cessation of eligibility if such month is in the current Plan Year, provided that the Participant (or the Participant's estate) files a claim within 90 days after the date t

## ARTICLE IX.
## HIPAA PROVISIONS FOR HCSA

### 9.1 Provision of Protected Health Information to Employer

Members of the Employer's workforce have access to the individually identifiable health information of Plan participants for administrative functions of the HCSA. When this health information is provided from the HCSA to the Employer, it is Protected Health Information ("PHI"). The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations restrict the Employer's ability to use and disclose PHI. The following HIPAA definition of PHI applies for purposes of this Article IX:

> *Protected Health Information*. 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 includes information of 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 the Employer information on whether the individual is participating in the Plan.

### 9.3 Permitted Uses and Disclosure of Summary Health Information

The HCSA may disclose Summary Health Information to the Employer, provided that the Employer requests the Summary Health Information for the purpose of modifying, amending, or terminating the HCSA.

"Summary Health Information" means information (a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a health plan; and (b) from which the information describ(m)7(al)7(th)4( I)4(7(be)-3(n)10(

Employer on behalf of the HCSA

## ARTICLE X.
## IRREVOCABILITY OF ELECTIONS; EXCEPTIONS

### 10.1 Irrevocability of Elections

Except as described in this Article X, a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates. In other words, unless an exception applies, the Participant may not change any elections for the duration of the Period of Coverage regarding:

(a) Participation in this Plan;

(b) Salary Reduction amounts; or

(c) Election of particular Benefit Package Options (including the HCSA Option).

### 10.2 Procedure for Making New Election If Exception to Irrevocability Applies

(a) *Timeframe for Making New Election.* A Participant (or an Eligible Employee who,

**10.3 Events Permitting Exception to Irrevocability Rule**

A Participant may change an election as described below in this Section 10.3 upon the occurrence of the stated events for the applicable portion of this Plan:

(a) *Open Enrollment Period (Applies to Pre-tax Benefits, HCSA Benefits, and DCSA Benefits)*. A Participant may change an election during the Open Enrollment Period in accordance with Section 3.2.

(b) *Termination of Employment (Applies to Pre-tax Benefits, HCSA Benefits, and DCSA Benefits).* A Participant's election will terminate under the Plan upon termination of employment in accordance with Sections 3.3 and 3.4, as applicable.

(c) *Leaves of Absence (Applies to Pre-tax Benefits, HCSA Benefits, and DCSA Benefits)*. A Participant may change an election under the Plan upon FMLA leave in accordance with Section 3.4 and upon non-FMLA leave in accordance with Section 3.5.

(d) *Change in Status* (*Applies to Pre-tax Benefits, HCSA Benefits as Limited Below, and DCSA Benefits as Limited Below*). A Participant may change his or her actual or deemed election under the Plan upon the occurrence of a Change in Status, but only if such election change is made on account of, and corresponds with, a Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer (the "General Consistency Requirement"). A Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer includes a Change in Status that results in an increase or decrease in the number of an Employee's family members (*i.e.*, a Spouse and/or Dependents) who may benefit from the coverage.

(e) *HIPAA Special Enrollment Rights (Applies to Pre-tax Medical Insurance Benefits, but Not to Dental or Vision Insurance, HCSA or DCSA Benefits)*. If a Participant or his or her Spouse or Dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit), as required by HIPAA under Code § 9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election (including, when required by HIPAA, an election to enroll in another benefit package under a group health plan), provided that the election change corresponds with such HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise in the following circumstances:

(1) a Participant or his or her Spouse or Dependent declined to enroll in group health plan coverage because he or she had coverage, and eligibility for such coverage is subsequently lost because: (A) the coverage was provided under COBRA and the COBRA coverage was exhausted; or (B) the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage were terminated;

(2) A new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption;

(3) the Participant's or Dependent's coverage under a Medicaid plan or state children's health insurance program is terminated as a result of loss of eligibility for such coverage; or

(4) The Participant or Dependent becomes eligible for a state premium assistance subsidy from a Medicaid plan or through a state children's health insurance program with respect to coverage under the group health plan.

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

for the same category of benefits for the same individuals (*e.g.*, family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, (1) an HCSA is not similar coverage with respect to an accident or health plan that is not a HCSA; (2) an HMO and a PPO are considered to be similar coverage; and (3) coverage by another employer, such as a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.

(1) *Increase or Decrease for Insignificant Cost Changes.* 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) *Significant Cost Increases*. 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) *Significant Cost Decreases.* 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 Benefit 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 Benefit Package Option that has decreased in cost on a prospective basis, subject to the terms and limitations of the Benefit 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) *Limitation on Change in Cost Provisions for DCSA Benefits.* The above "Change in Cost

(i) *Change in Coverage (Applies to Pre-tax Benefits and DCSA Benefits, but Not to HCSA Benefits).* The definition of "similar coverage" under Section 10.3(h) applies also to this Section 10.3(i).

(1) *Significant Curtailment*. 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) *Significant Curtailment Without Loss of Coverage*. If the Plan Administrator determines that a Participant's coverage under a Benefit Package Option under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed without a Loss of Coverage (*e.g.*, when there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost-sharing limit under an accident or health plan) during a Period of Coverage, the Participant may revoke his or her election for the affected coverage, and in lieu thereof, prospectively elect coverage under another Benefit Package Option that provides similar coverage (but not the HCSA). Coverage under a plan is deemed to be "significantly curtailed" only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally.

(B) *Significant Curtailment with a Loss of Coverage*. If the Plan Administrator determines that a Participant's Benefit Package Option coverage under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed, and if such curtailment results in a Loss of Coverage during a Period of Coverage, then the Participant may revoke his or her election for the affected coverage and may either prospectively elect coverage under another Benefit Package Option that provides similar coverage (but not the HCSA) or drop coverage if no other Benefit Package Option providing similar coverage is offered by the Employer.

(C) *Definition of Loss of Coverage*. Fo>BDC 57finitp(i)-2mieepouseo61.87 264u82(F)14

(ii) A reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her Spouse or Dependent is currently in a course of treatment; or

(iii) Any other similar fundamental loss of coverage.

(2) *Addition or Significant Improvement of a Benefit Package Option*. If, during a Period of Coverage, the Plan adds a new Benefit Package Option or significantly improves an existing Benefit Package Option, the Plan Administrator may permit the following election changes: (A) Participants who are enrolled in a Benefit Package Option other than the newly added or significantly improved Benefit Package Option may change their elections on a prospective basis to elect the newly added or significantly improved Benefit Package Option; and (B) Employees who are otherwise eligible under Section 3.1 may elect the newly added or significantly improved Benefit Package Option on a prospective basis,

employment status such that the Participant becomes ineligible for HCSA coverage; or (E) a Dependent's ceasing to satisfy eligibility requirements for HCSA coverage. Notwithstanding the foregoing, such cancellation will not become effective to the extent that it would reduce future contributions to the HCSA to a point where the total contributions for the Plan Year are less than the amount already reimbursed for the Plan Year.

(2) The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine, based on prevailing IRS guidance, whether a requested change is on account of, and corresponds with, a Change in Status. Assuming that the general consistency requirement is satisfied, a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her election based on the specified Change in Status:

(A) *Loss of Spouse or Dependent Eligibility; Special COBRA Rules*. For a Change in Status involving a Participant's divorce, annulment, or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance coverage for (i) the Spouse involved in the divorce, annulment, or legal separation; (ii) the deceased Spouse or Dependent; or (iii) the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Change in Status. Notwithstanding the foregoing, if the Participant or his or her Spouse or Dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Employer's plan because of a reduction in hours or because the Participant's Dependent ceases to satisfy the eligibility requirements for coverage (and the 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) *Gain of Coverage Eligibility Under Another Employer's Plan*. 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) *Special Consistency Rule for DCSA Benefits*. 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

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.

**10.4 Election Modifications Required by Plan Administrator**

The Plan Administrator may, at any time, require any Participant or class of Participants to amend the amount of their Salary Reductions for a Period of Coverage if the Plan Administrator determines that such action is necessary or advisable in order to (a) satisfy any of the Code's nondiscrimination requirements applicable to this Plan or other cafeteria plan; (b) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized; (c) maintain the qualified status of benefits received under this Plan; or (d) satisfy Code nondiscrimination requirements or other limitations applicable to the Employer's qualified plans. In the event that contributions need to be reduced for a class of Participants, the Plan Administrator will reduce Salary

## 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;

## ARTICLE XIII.
## GENERAL PROVISIONS

### 13.1 Expenses

All reasonable expenses incurred in administering the Plan are currently paid by forfeitures to the extent provided in Section 7.6 with respect to HCSA Benefits and Section 8.6 with respect to DCSA Benefits, and then by the Employer.

### 13.2 No Contract of Employment

Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be employed for any specific period of time. All Employees are considered to be employed at the will of the Employer.

### 13.3 Amendment and Termination

This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer may amend or terminate all or any part of this Plan at any time for any reason by resolution of the Employer's Board of Directors or by any person or persons authorized by the Board of Directors to take such action, and any such amendment or termination will automatically apply to the Related Employers that are participating in this Plan.

### 13.4 Governing Law

This Plan shall be construed, administered, and enforced according to the laws of the State of Florida, to the extent not superseded by the Code, ERISA, or any other federal law.

### 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 P¶artici

### 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

| | |
|---|---|
| *Third Party Administrator*: | ICUBA<br>Attn: Benefits Administration<br>P.O. Box 616927<br>Orlando, FL 32861-6927<br>1-866-377-5102<br>1-866-377-5180 (Fax)<br>benefitsadministration@icuba.org |
| *Named Fiduciary*: | Florida Institute of Technology<br>Attention: Human Resources<br>150 West University Blvd |

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 the HCSA Portion, called "fiduciaries" of the HCSA Portion, have a duty to do so prudently and in the

**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 _____, 2016.

Florida Institute of Technology

Date: _____ By:_____

Its: _____

## APPENDIX A

## RELATED EMPLOYERS THAT HAVE ADOPTED THIS PLAN, WITH THE APPROVAL OF FLORIDA INSTITUTE OF TECHNOLOGY

No Related Employers have adopted this Plan. Florida Institute of Technology is the only employer participating in this Plan.

## APPENDIX B

## INSURANCE PLANS

Medical Insurance Plan

employee benefit plans such as dental, vision, eap, and pharmacy

## APPENDIX C

## ELIGIBLE AND INELIGIBLE MEDICAL CARE 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.

**AUTOMOBILE**

**Special Equipment:** The amount paid for the cost of special hand controls and other special

**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

Sex therapy costs are eligible, but the cost of a hotel room prescribed by the therapist is not eligible.

Marriage counseling is not eligible.

**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).

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

**DANCING LESSONS, SWIMMING LESSONS, EXERCISE CLASSES, ETC.**
The cost of dancing lessons, swimming lessons, exercise classes, etc., are not generally eligible medical expenses, even if they are recommended by a doctor for the general improvement of one's health.

**DENTAL TREATMENT**
Amounts you pay for the prevention and alleviation of dental disease are reimbursable. Preventive treatment includes the services of a dental hygienist or dentist for such procedures as teeth cleaning, the application of sealants, and fluoride treatments to prevent tooth decay. Treatment to alleviate dental disease include services of a dentist for procedures such as X-rays, fillings, braces, extractions, dentures, and other dental ailments.

Services that may be deemed cosmetic such as teeth bleaching, bonding, porcelain veneers or whitening are not eligible for reimbursement.

Water fluoridation units and water piks are eligible as a medical expense if prescribed by a doctor.

***Note: that these items must be accompanied by a doctorôs certification indicating the specific medical disorder, the specific treatment needed, and how this treatment will alleviate the medical condition.***

**DIAPERS**

*See Cosmetic Surgery and Procedures.*

**EMPLOYMENT TAXES**
*See Nursing Services.*

**EXERCISE EQUIPMENT**
The cost of exercise equipment for general well-being is not reimbursable. If the equipment is prescribed by a physician as a part of physical therapy to treat specific medical conditions, then the expense is eligible for reimbursement.

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

**FERTILITY ENHANCEMENT**
The following expenses are considered reimbursable:

Egg donor charges not covered by any medical plan.
Embryo replacement and storage.
Fertility exams, etc.
In vitro fertilization.
Reverse vasectomy.
Sperm implants due to sterility.
Sperm washing.
Artificial insemination.

**The following expenses do not qualify:**

Medical expenses for a surrogate mother.
Sperm storage for possible future use.

**FUNERAL EXPENSES**
Expenses for funerals are not eligible for reimbursement.

**GUIDE DOG OR OTHER SERVICE ANIMAL**
The costs of buying, training, and maintaining a guide dog or other service animal to assist a visually/hearing impaired person, or a person with other physical disabilities are reimbursable.

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

**HAIR TRANSPLANT**
Surgical hair transplants **are not** reimbursable unless deemed medically necessary because of trauma, injury, disease, or genetic defect.

**HEALTH CLUB DUES**
Health club dues, YMCA® dues, or amounts paid for steam baths for general health or to relieve physical or mental discomfort are not reimbursable.

**HEALTH INSTITUTE**
You can include in medical expenses fees you pay for treatment at a health institute only if the treatment is prescribed by a physician.

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

**HEARING AIDS**
The cost of a hearing aid and the batteries needed to operate the aid are reimbursable. A telephone or television adapter for the deaf, lip reading lessons and hearing exams reimbursable.

**HERBAL MEDICATIONS**
The costs of herbs taken for general well-being are not reimbursable. However, the costs of herbs taken to alleviate a specific medical condition are reimbursable.

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

**HOME MEDICAL TEST**

Medical care is provided by a doctor in a licensed hospital or in a medical care facility related to, or the equivalent of, a licensed hospital; and

There is no significant element of personal pleasure, recreation or vacation in the travel away from home.

The amount you include in medical expenses may not exceed $50 for each night for each person. Lodging is included for a person for whom transportation expenses are a medical expense because that person is traveling 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.

spouse, or your dependent. The majority of the time spent at the conference must be spent attending sessions on medical information.

The cost of meals and lodging while attending the conference is not reimbursable.

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

**MEDICAL EQUIPMENT MAINTENANCE**
Air conditioners, central air, heaters, humidifiers, or air purifiers, which are home installations for the purpose of relieving an allergy or difficulty in breathing due to a medical condition, are Eligible Medical Expenses.

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 doctorôs certification indicating the specific medical disorder, the specific treatment needed, and how this treatment will alleviate the medical condition.***

**MEDICAL INFORMATION**
Amounts paid to a plan that keeps medical information in a computer data bank and retrieves and furnishes the information upon request to an attending physician are reimbursable.

**MEDICINES**
Amounts paid for prescribed medicines and drugs are reimbursable. A prescribed drug is one which requires a prescription by a doctor for its use by an individual. The cost of insulin is also reimbursable. The cost of a prescribed drug brought in (or ordered and shipped) from another country cannot be reimbursed. The importation of prescribed drugs by individuals is illegal under federal law (even if allowed by state law). However, you can be reimbursed for the cost of a prescribed drug that you purchased and consumed in another country if the drug is legal in both the other country and the United States. *See Over-The-Counter Medicines and Drugs.*

**NURSING HOME**
The cost of medical care in a nursing home, home for the aged or similar institution, for yourself, your spouse, or your dependents are reimbursable. This includes the cost of meals and lodging in the home if a principal reason for being there is to get medical care. Do not include the cost of meals and lodging if the reason for being in the home is personal. You can, however, include in medical expenses the part of the cost that is for medical or nursing care.

**NURSING SERVICES**
Wages and other amounts paid for nursing services are reimbursable. Services neeervi

solutions [redacted] and family planning items, denture adhesives, insulin and diabetic [redacted] monitors, and first aid supplies, peroxide and rubbing alcohol.

**OXY[redacted]**
Amo[redacted]gen equipment to relieve breathing problems caused by a medical con[redacted]

**P[redacted]**
*S[redacted]*

**[redacted]**

[redacted]ersonal living and family purposes only if it is used primarily to prevent or [redacted]bility and You would not have had the expense were it not for the medical [redacted].

[redacted]nds TM) are eligible if they are needed to relieve the effects of a particular

[redacted]gible.
[redacted]ula: The ***cost difference*** between protein formulas, soybean formulas, and [redacted] is eligible ***if you have an Rx or a certification*** from the baby's doctor [redacted]icular formula is necessary for the child's well being.
[redacted]e to any disease is eligible.
[redacted], TV, newspapers, etc., **are not** eligible.
[redacted]**e not** eligible.

[redacted]***accompanied by a doctorôs certification indicating the s¶***

¶

**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 is 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.

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

**STERILIZATION**
The cost of legal sterilization is reimbursable. Vasectomy or tubal ligations are eligible.

**SUBSTANCE ABUSE**
*See Alcoholism, Drug or Substance Abuse.*

**TELEPHONE**
The costs of purchasing and repairing special telephone equipment that lets a hearing-impaired person communicate over a regular telephone are reimbursable.

**TELEVISION**
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 doctorôs certification indicating the specific medical disorder, the specific treatment needed, and how this treatment will alleviate the medical condition.***

**TRANSPLANTS**
Expenses you pay for medical care you receive because you are a donor or a possible donor of a kidney or other organ, this includes transportation are 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 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).**

**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 day care center, summer day camp or preschool. The facility must be licensed under state or local law if it cares for seven or more children.
Expenses for an unlicensed day care center that cares for six or fewer children.
Expenses at an adult day care facility (but not expenses for overnight, nursing home facilities).
The cost of day care and housekeeping services in your home for your child or other qualifying individual.
The cost of meals, lunches and snacks, supplied by a day care provider (not the cost of meals while on field trips and outings or those meals included as part of the cost of such trips).

**INELIGIBLE DEPENDENT CARE SPENDING ACCOUNT (DCSA) EXPENSES**

Day care for a child age 13 or older.
Overnight summer camp (cannot prorate for the day portion).
Kindergarten or school tuition for a child age 5 and older.
Expenses for any care provided to a qualifying dependent by another dependent or child under age 19.
Housekeeping expenses not related to dependent day care.
The expenses for which you claim a dependent day care tax credit on your federal income tax return.
The registration fees paid for day care, summer camp, kindergarten, preschool, etc. The only exceptio