

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.

“Change in Status” means any of the events described below, as well as any other events included under subsequent changes to Code § 125 or regulations issued thereunder, which the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under the Plan:

(a) *Legal Marital Status.* A change in a Participant’s legal marital status, including marriage, death of a Spouse, divorce, legal separation, or annulment;

(b) *Number of Dependents.* Events that change a Participant’s number of Dependents, including birth, death, adoption, and placement for adoption;

(c) *Employment Status.* Any of the following events that change the employment status of the Participant or his or her Spouse or Dependents: (1) a termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence; (4) a change in worksite; and (5) if the eligibility conditions of this Plan or other employee benefits plan of the Participant or his or her Spouse or Dependent depend on the employment status of that individual and there is a change in that individual’s status with the consequence that the individual becomes (or ceases to be) eligible under this Plan or other employee benefits plan, such as if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa), with the consequence that the employee ceases to be eligible for the Plan;

(d) *Dependent Eligibility Requirements.* An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as attaining a specified age, student status, or any similar circumstance; and

(e) *Change in Residence.* A change in the place of residence of the Participant or his or her Spouse or Dependents.

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

“Code” means the Internal Revenue Code of 1986, as amended.

“Contributions” means the amount contributed to pay for the cost of Benefits (including self-funded Benefits as well as those that are insured), as calculated under Section 6.2 for Pre-tax Benefits, Section 7.2 for HCSA Benefits, and Section 8.2 for DCSA Benefits.

“Compensation” means the wages or salary paid to an Employee by the Employer, determined prior to (a) any Salary Reduction election under this Plan; (b) any salary reduction election under any other cafeteria plan; and (c) any compensation reduction under any Code § 132(f) (4) plan; but determined after (d) any salary deferral elections under any Code § 401(k), 403(b), 408(k) or 457(b) plan or arrangement. Thus, “Compensation” generally means wages or salary paid to an Employee by the Employer, as reported in Box 1 of Form W-2 but adding back any wages or salary forgone by virtue of any election described in (a), (b), or (c) of the preceding sentence.

“DCSA” means the Dependent Care Spending Account.

“DCSA Benefits” has the meaning described in Section 8.1.

“DCSA Portion” means the portion of this Plan described in Article VIII.

“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” has the meaning described in Section 8.3.

“Earned Income” shall have the meaning given such term in Code § 129(e) (2).

“Effective Date” of this Plan means April 1, 2003.

“Election Form/Salary Reduction Agreement” means the electronic enrollment form provided by the Administrator for the purpose of allowing an Eligible Employee to participate in this Plan by electing Salary Reductions to pay for any of the following: Pre-tax Benefits, HCSA Benefits, and DCSA Benefits. It includes an agreement pursuant to which an Eligible Employee or Participant authorizes the Employer to make Salary Reductions.

“Eligible Employee” means an Employee eligible to participate in this Plan, as provided in Section 3.1

“Employee” means an individual that the Employer classifies as a common-law employee and who is on the Employer’s W-2 payroll, but does not include the following: (a) any leased employee (including but not limited to those individuals defined as leased employees in Code § 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” for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the Employer, but only to the extent specifically provided elsewhere under this Plan.

“Employer” means FLORIDA INSTITUTE OF TECHNOLOGY and any Related Employer that adopts this Plan with the approval of FLORIDA INSTITUTE OF TECHNOLOGY. Related Employers that have adopted this Plan, if any, are listed in Appendix A to this Plan. However, for purposes of Section 13.3, “Employer” means only FLORIDA INSTITUTE OF TECHNOLOGY.

“Employment Commencement Date” means the first regularly scheduled working day on which the Employee first performs an hour of service for the Employer for Compensation.

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

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

“HCSA” means the Health Care Spending Account.

“HCSA Benefits” has the meaning described in Section 7.1.

“HCSA Portion” means the portion of this Plan described in Article VII.

“Health Reimbursement Arrangement” or **“HRA”** means a health reimbursement arrangement as defined in IRS Notice 2002-45.

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

“Insurance Benefits” means the Employee’s coverage under one or more of the Insurance Plans, as described in Appendix B to this Plan.

“Insurance Plan(s)” means the underlying employee benefit plans or insurance policies, as described in Appendix B to this Plan.

“Medical Care Expenses” has the meaning defined in Section 7.3.

“Medical Insurance Benefits” means the Employee’s Medical Insurance Plan coverage for purposes of this Plan.

“Medical Insurance Plan” means the INDEPENDENT COLLEGES AND UNIVERSITIES AND BENEFITS ASSOCIATION Medical, Behavioral Health, and Prescription Drug Plan, including any riders thereto, and any other plan(s) that the Employer maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such plan), providing major medical type benefits through self-insurance or a group insurance policy or policies. The Employer may substitute, add, subtract, or revise at any time the menu of such plans and/or the benefits, terms, and conditions of any such plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

“Open Enrollment Period” with respect to a Plan Year means the months preceding the start of a new Plan Year, as determined by the Employer or its delegee.

“Participant” means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Article III.

“Period of Coverage” means the Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date on which participation commences, as described in Section 3.1; and (b) for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date on which participation terminates, as described in Section 3.2.

“Plan” means the FLORIDA INSTITUTE OF TECHNOLOGY Flexible Spending Account Plan as set forth herein and as amended from time to time.

“Plan Administrator” means FLORIDA INSTITUTE OF TECHNOLOGY; provided, however, that the FLORIDA INSTITUTE OF TECHNOLOGY has delegated full authority to act on behalf of the Plan Administrator to the INDEPENDENT COLLEGES AND UNIVERSITIES AND BENEFITS ASSOCIATION (“ICUBA”), except with respect to appeals, for which the Plan Administrator has the full authority to decide, as described in Section 12.1.

“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 Portion” means the portion of this Plan described in Article VI.

“QMCSO” means a qualified medical child support order, as defined in ERISA § 609(a).

“Qualifying Dependent Care Services” has the meaning described in Section 8.3.

“Qualifying Individual” means (a) a tax dependent of the Participant as defined in Code § 152 who is under the age of 13 and who is the Participant’s qualifying child as defined in Code § 152(a)(1); (b) a tax dependent of the Participant as defined in Code § 152, but determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, who is physically or mentally incapable of self-care and who has the same principal place of abode as the Participant for more than half of the year; or (c) a Participant’s Spouse who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year. Notwithstanding the foregoing, in the case of divorced or separated parents, a Qualifying Individual who is a child shall, as provided in Code § 21(e)(5), be treated as a Qualifying Individual of the custodial parent (within the meaning of Code § 152(e)) and shall not be treated as a Qualifying Individual with respect to the non-custodial parent.

“Related Employer” means any employer affiliated with FLORIDA INSTITUTE OF TECHNOLOGY that, under Code § 414(b), § 414(c), or § 414(m), is treated as a single employer with FLORIDA INSTITUTE OF TECHNOLOGY for purposes of Code § 125(g) (4).

“Salary Reduction” means the amount by which the Participant’s Compensation is reduced and applied by the Employer under this Plan to pay for one or more of the Benefits, as permitted for the applicable portion, before any applicable state and/or federal taxes have been deducted from the Participant’s Compensation (*i.e.*, on a pre-tax basis).

“Spouse” means an individual who is legally married to a Participant as determined under applicable state law (and who is treated as a spouse under the Code). Notwithstanding the above, for purposes of the DCSA Portion, the term “Spouse” shall not include (a) an individual legally separated from the Participant under a divorce or separate maintenance decree; or (b) an individual who, although married to the Participant, files a separate federal income tax return, maintains a principal residence separate from the Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant.

“Student” means an individual who, during each of five or more calendar months during the Plan Year, is a full-time student at any educational organization that normally maintains a regular faculty and curriculum and normally has an enrolled student body in attendance at the location where its educational activities are regularly carried on.

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 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, retirement, layoff, or voluntary resignation, and then is rehired at any time after then the Employee will must complete the waiting period described in Section 3.1 before again becoming eligible to participate in the Plan.

3.4 FMLA Leaves of Absence

(a) *Health Benefits.* Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA, then to the extent required by the FMLA, the Employer will continue to maintain the Participant's health Insurance Benefits and HCSA Benefits on the same terms and conditions as if the Participant were still an active Employee. That is, if the Participant elects to continue his or her coverage while on leave, the Employer will continue to pay its share of the contributions.

An Employer may require Participants to continue all health Insurance Benefits and HCSA Benefits coverage for Participants while they are on paid leave (provided that Participants on non-FMLA paid leave are required to continue coverage). If so, the Participant's share of the Contributions shall be paid by the method normally used during any paid leave.

In the event of unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued), a Participant may elect to continue his or her health Insurance Benefits and HCSA Benefits during the leave. If the Participant elects to continue coverage while on FMLA leave, then the Participant may pay his or her share of the Contributions in one of the following ways:

(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 (e.g., 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 from the Participant's Compensation either on a pre-tax or after-tax basis, as agreed to by the Plan Administrator and the Participant.

If a Participant's health Insurance Benefits or HCSA Benefits coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), then the Participant is permitted to re-enter the health Insurance Benefits or HCSA Benefits, as applicable, upon return from such leave on the same basis as when the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA. In addition, the Plan may require Participants whose health Insurance Benefits or HCSA Benefits coverage terminated during the leave to be reinstated in such coverage upon return from a period of unpaid leave, provided that Participants who return from a period of unpaid, non-FMLA leave are required to be reinstated in such coverage. Notwithstanding the preceding sentence, with regard to HCSA Benefits, a Participant whose coverage ceased will be permitted to elect whether to be reinstated in the HCSA Benefits at the same coverage level as was in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro-rata for the period of FMLA leave during which the Participant did not pay Contributions. If a Participant elects a coverage level that is reduced pro-rata for the period of FMLA leave, then the amount withheld from a Participant's Compensation on a pay-period-by-pay-period basis for the purpose of paying for reinstated HCSA Benefits will be equal to the amount withheld prior to the period of FMLA leave.

(b) *Non-Health Benefits.* If a Participant goes on a qualifying leave under the FMLA, then entitlement to non-health benefits (such as DCSA Benefits) is to be determined by the Employer's policy for providing such Benefits when the Participant is on non-FMLA leave, as described in Section 3.5. If such policy permits a Participant to discontinue contributions while on leave, then the Participant will, upon returning from leave, be required to repay the Contributions not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Plan Administrator and the Participant or as the Plan Administrator otherwise deems appropriate.

3.5 Non-FMLA Leaves of Absence

If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the Contributions due for the Participant will be paid by pre-payment before going

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 (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, Participants will be given the opportunity to elect one or more of the following Benefits:

- (a) Pre-tax Benefits, as described in Article VI;
- (b) HCSA Benefits, as described in Article VII; and
- (c) DCSA Benefits, as described in Article VIII.

In no event shall Benefits under the Plan be provided in the form of deferred compensation. Notwithstanding the foregoing, amounts remaining in a Participant's HCSA and DCSA at the end of a Plan Year can be used to reimburse the Participant for Medical Care Expenses and Dependent Care Expenses.

5.2 Employer and Participant Contributions

(a) *Employer Contributions.* For Participants who elect Insurance Benefits described in Article VI, the Employer will contribute a portion of the Contributions as provided in the open enrollment materials furnished to Employees and/or on the Election Form/Salary Reduction Agreement. There are no Employer contributions for HCSA Benefits or DCSA Benefits.

(b) *Participant Contributions.* Participants who elect any of the Insurance Benefits described in Article VI may pay for the cost of that coverage on a pre-tax Salary Reduction basis, or with after-tax deductions, by completing an Election Form/Salary Reduction Agreement. Participants who elect HCSA or DCSA Benefits must pay for the cost of that coverage on a pre-tax Salary Reduction basis by completing an Election Form/Salary Reduction Agreement.

5.3 Using Salary Reductions to Make Contributions

(a) *Salary Reductions per Pay Period.* The Salary Reduction for a pay period for a Participant is, for the Benefits elected, an amount equal to (1) the annual Contributions for such Benefits (as described in Section 6.2 for Pre-tax Benefits, Section 7.2 for HCSA Benefits, and Section 8.2 for DCSA Benefits, as applicable), divided by the number of pay periods in the Period of Coverage; (2) an amount otherwise agreed upon between the Employer and the Participant; or (3) an amount deemed appropriate by the Plan Administrator (*i.e.*, in the event of shortage in reducible Compensation, amounts withheld and the Benefits to which Salary Reductions are applied may fluctuate). If a Participant increases his or her election under the HCSA Portion or DCSA Portion to the extent permitted under Section 10.3, the Salary Reductions per pay period will be, for the Benefits affected, an amount equal to (1) the new election change, divided by the number of pay periods in the balance of the Period of Coverage and commencing with the election change; (2) an amount otherwise agreed upon between the Employer and the Participant; or (3) an amount deemed appropriate by the Plan Administrator (*i.e.*, in the event of shortage in reducible Compensation, amounts

withheld and the Benefits to which Salary Reductions are applied may fluctuate).

(b) *Considered Employer Contributions for Certain Purposes.* Salary Reductions are applied by the Employer to pay for the Participant's share of the Contributions for the Pre-tax Benefits, HCSA Benefits, and the DCSA Benefits and, for the purposes of this Plan and the Code, are considered to be Employer contributions.

(c) *Salary Reduction Balance upon Termination of Coverage.* If, as of the date that any elected coverage under this Plan terminates, a Participant's year-to-date Salary Reductions exceed or are less than the Participant's required Contributions for the coverage, then the Employer will, as applicable, either return the excess to the Participant as additional taxable wages or recoup the due Salary Reduction amounts from any remaining Compensation.

(d) *After-Tax Contributions for Pre-tax Benefits.* For those Participants who elect to pay their share of the Contributions for any of the Insurance Benefits with after-tax deductions, both the Employee and Employer portions of such Contributions will be paid outside of this Plan.

5.4 Funding This Plan

All of the amounts payable under this Plan shall be paid from the general assets of the Employer, or if elected by the Employer, shall be held in trust; provided, however, that Pre-tax Benefits are paid as provided in the applicable employee benefit plan or insurance policy. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. The Employer may hire an unrelated third-party paying agent to make Benefit payments on its behalf. The maximum contribution that may be made under this Plan for a Participant is the total of the maximums that may be elected (a) as Employer and Participant Contributions for Pre-tax Benefits, as described in Section 6.2; and (b) as described under Section 7.4(b) for HCSA Benefits and Section 8.4(b) for DCSA Benefits.

ARTICLE VI. PRE-TAX BENEFIT PAYMENT PORTION

6.1 Benefits

The Pre-tax Benefit Payment Portion offers Participants the ability to pay for benefits under the Insurance Plans on a pre-tax Salary Reduction basis. The Insurance Plans are listed in Appendix B to this Plan. Notwithstanding any other provision in this Plan, the Insurance Benefits are subject to the terms and conditions of the Insurance Plans, and no changes can be made with respect to such Insurance Benefits under this Plan (such as mid-year changes in election) if such changes are not permitted under the applicable Insurance Plan. An Eligible Employee can (a) elect benefits under the Pre-tax Benefit Payment Portion by electing to pay for his or her share of the Contributions for Insurance Benefits on a pre-tax Salary Reduction basis (Pre-tax Benefits); or (b) elect no benefits under the Pre-tax Benefit Payment Portion and pay for his or her share of the Contributions, if any, for Insurance Benefits with after-tax deductions outside of this Plan. Unless an exception applies, such election is irrevocable for the duration of the Period of Coverage to which it relates. A Participant's Salary Reductions during a Plan Year under the Pre-tax Benefit Payment Portion may be applied by the Employer to pay the Participant's share of the Contributions for Insurance Benefits that are provided to the Participant during the

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 (*i.e.*, 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-pay basis the same coverage that he or she had under the health Insurance Plan the day before the qualifying event for the periods prescribed by COBRA. Such continuation coverage shall be subject to all conditions and limitations under COBRA.

Contributions for COBRA coverage for health Insurance 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 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 to determine, on a uniform and consistent basis, whether a particular item is a medicine or drug and whether the requirement of a prescription has been satisfied);

(3) Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease (for this purpose, "cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease); or

(4) Any other expense that is excluded under Appendix C or otherwise under the terms of this Plan.

7.4 Maximum and Minimum Benefits for HCSA

(a) *Maximum Reimbursement Available; Uniform Coverage.* The maximum dollar amount elected by the Participant for reimbursement of Medical Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) shall be available at all times during the Period of Coverage, regardless of the actual amounts credited to the Participant's HCSA pursuant to Section 7.5. Notwithstanding the foregoing, no reimbursements will be available for Medical Care Expenses incurred after coverage under this Plan has terminated, unless the Participant has elected COBRA as provided in Section 7.8.

(b) *Maximum and Minimum Dollar Limits.* The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Period of Coverage shall be the maximum amount permitted under Code section 125(i), subject to Section 7.5(b). The minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Period of Coverage shall be \$50. Reimbursements due for Medical Care Expenses incurred by the Participant's Spouse or Dependents shall be charged against the Participant's HCSA.

(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 HCSA Portion mid-year or wishes to increase his or her election mid-year as permitted under Section 10.3, then there will be no proration rule (*i.e.*, the Participant may elect coverage up to the maximum dollar limit or may increase coverage to the maximum dollar limit, as applicable).

(d) *Effect on Maximum Benefits If Election Change Permitted.* Any change in an election under Article X (other than under Section 10.3(c) for FMLA leave) that increases Contributions to the HCSA Portion also will change the maximum reimbursement benefits for the balance of the Period of Coverage commencing with the election change. Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding (1) the Contributions (if any) made by the Participant 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 by the Participant during the remainder of such Period of Coverage to the HCSA, reduced by (3) all reimbursements made during the entire Period of Coverage. Any change in an election under Section 10.3(c) for FMLA leave will change the maximum reimbursement benefits in accordance with the regulations governing the effect of the FMLA on the operation of cafeteria plans.

(e) *Monthly Limits on Reimbursing OTC Drugs.* Only reasonable quantities of over the counter ("OTC") drugs or medicines of the same kind may be reimbursed from a Participant's HCSA in a single calendar month (even assuming that the drug otherwise meets the requirements of this Article VII, including that it has been prescribed (unless it is insulin) and is for medical care under Code § 213(d)).

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 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) *Use of Forfeitures.* 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 (*i.e.*, 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 (*e.g.*, 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) *Timing.* 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) *Claims Substantiation.* 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 Medical Care Expense was incurred (except that for a Participant who ceases to be eligible to participate, this must be done no later than 90 days after the date that eligibility ceases, as described Section 7.8) setting forth:

- The person(s) on whose behalf Medical Care Expenses have been incurred;
- The nature and date of the Expenses so incurred;
- The amount of the requested reimbursement;
- A statement that such Expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source; and
- Other such details about the expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise (*e.g.*, a statement from a medical practitioner that the expense is to treat a specific medical condition, or a more detailed certification from the Participant).

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and showing the amounts of such Medical Care Expenses, along with any additional documentation that the Plan Administrator may request. If the HCSA is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), the Participant will be required to comply with substantiation procedures established by the Plan Administrator in accordance with Revenue Ruling 2003-43, IRS Notice 2006-69, or other IRS guidance.

(c) *Claims Denied.* For reimbursement claims that are denied, see the appeals procedure in Article XI.

(d) *Claims Ordering; No Reprocessing.* All claims for reimbursement under the HCSA Portion will be paid in the order in which they are approved. Once paid, a claim will not be reprocessed or otherwise re-characterized solely for the purpose of paying it (or treating it as paid) from amounts attributable to a different Plan Year or Period of Coverage.

7.8 Reimbursements from HCSA After Termination of Participation; COBRA

When a Participant ceases to be a Participant under Section 3.2, the Participant's Salary Reductions, and election to participate will terminate. The Participant will not be able to receive reimbursements for Medical Care Expenses incurred after the end of the day on which the Participant's employment terminates or the Participant otherwise ceases to be eligible. However, such Participant (or the Participant's estate) may claim reimbursement for any Medical Care Expenses incurred during the Period of Coverage prior to the date that the Participant ceases to be 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 reduction of 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 HCSA Benefits shall be paid on an after-tax basis (unless permitted otherwise 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).

7.9 Named Fiduciary for HCSA

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

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 described in Article X), such election of DCSA Benefits is irrevocable for the duration of the Period of Coverage to which it relates.

8.2 Contributions for Cost of Coverage for DCSA Benefits

The annual Contributions for a Participant's DCSA Benefits is equal to the annual benefit amount elected by the Participant, subject to the dollar limits set forth in Section 8.4(b).

8.3 Eligible Dependent Care Expenses

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

(a) *Incurred.* A Dependent Care Expense is incurred at the time the Qualifying Dependent Care Services giving rise to the expense is furnished, not when the Participant is formally billed for, is charged for, or pays for the Qualifying Dependent Care Services (*e.g.*, services rendered for the month of June are not fully incurred until June 30 and cannot be reimbursed in full until then).

(b) *Dependent Care Expenses.* "Dependent Care Expenses" are expenses that are considered to be employment-related expenses under Code § 21 (b)(2) (relating to expenses for the care of a Qualifying Individual necessary for gainful employment of the Employee and Spouse, if any, and expenses for incidental household services), if paid for by the Eligible Employee to obtain Qualifying Dependent Care Services; provided, however, that this term shall not include any expenses for which the Participant or other person incurring the expense is reimbursed for the expense through insurance or any other plan. If only a portion of a Dependent Care Expense has been reimbursed elsewhere (*e.g.*, because the Spouse's DCSA imposes maximum benefit limitations), the DCSA can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article VIII.

(c) *Qualifying Dependent Care Services.* “Qualifying Dependent Care Services” means services that: (1) relate to the care of a Qualifying Individual that enable the Participant and his or her Spouse to remain gainfully employed after the date of participation in the DCSA Portion and during the Period of Coverage; and (2) are performed:

(A) in the Participant’s home; or

(B) Outside the Participant’s home for (i) the care of a Participant’s qualifying child who is under age 13; or (ii) the care of any other Qualifying Individual who regularly spends at least eight hours per day in the Participant’s household. In addition, if the expenses 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 Maximum and Minimum Benefits for DCSA

(a) *Maximum Reimbursement Available.* The maximum dollar amount elected by the Participant for reimbursement of Dependent Care Expenses incurred during a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) shall only be available during the Period of Coverage to the extent of the actual amounts credited to the Participant’s DCSA pursuant to Section 8.5. No reimbursement will be made to the extent that such reimbursement would exceed the balance in the Participant’s Account (that is, the year-to-date amount that has been withheld from the Participant’s Compensation for reimbursement for Dependent Care Expenses for the Period of Coverage, less any prior reimbursements). Payment shall be made to the Participant in cash as reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which the Participant’s election is effective, provided that the other requirements of this Article VIII have been satisfied.

(b) *Maximum and Minimum Dollar Limits.* The maximum 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 \$5,000 or, if lower, the maximum amount that the Participant has reason to believe will be excludable from his or her income at the time the election is made as a result of the applicable statutory limit for the Participant. The applicable statutory limit for a Participant is the smallest of the following amounts:

(1) The Participant’s Earned Income for the calendar year;

(2) the Earned Income of the Participant's Spouse for the calendar year (for this purpose, a Spouse who is not employed during a month in which the Participant incurs a Dependent Care Expense and is either (A) physically or mentally incapable of self-care or (B) a Student shall be deemed to have Earned Income in the amount specified in Code § 21(d) (2)); or

(3) Either \$5,000 or \$2,500 for the calendar year, as applicable:

(A) \$5,000 for the calendar year if one of the following applies:

(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.

(c) *Available Amount Is Based on Credited Amount.* As described in Section 8.4, the amount available for reimbursement of Dependent Care Expenses may not exceed the year-to-date amount credited to the Participant's DCSA, less any prior reimbursements for Dependent Care Expenses incurred during the Period of Coverage (*i.e.*, it is based on the amount credited to the DCSA at a particular point in time). Thus, a Participant's DCSA may not have a negative balance during a Period of Coverage.

8.6 Forfeiture of DCSA; Use-It-or-Lose-It Rule

If any balance remains in the Participant's DCSA 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 Dependent Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance. 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 (*i.e.*, providing DCSA 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 DCSA 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 the Plan Administrator deems appropriate, consistent with applicable regulations. In addition, any DCSA benefit payments that are unclaimed (*e.g.*, uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Dependent Care Expense was incurred shall be forfeited and applied as described above.

8.7 Reimbursement Claims Procedure for DCSA

(a) *Timing.* 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 Dependent 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 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) *Claims Substantiation.* A Participant who has elected to receive DCSA Benefits for a Period of Coverage may apply for reimbursement by submitting a request for reimbursement 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 Dependent Care Expense was incurred (except for a Participant who ceases to be eligible to participate, by no later than 90 days after the date that eligibility ceases, as described in Article VIII, Section 8.8), setting forth:

- The person(s) on whose behalf Dependent Care Expenses have been incurred;
- The nature and date of the Expenses so incurred;

- 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 (e.g., a more detailed certification from the Participant).

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Dependent Care Expenses have been incurred and showing, the amounts of such Expenses, along with any additional documentation that the Plan Administrator may request. Except for the final reimbursement claim for a Period of Coverage, no claim for reimbursement may be made unless and until the aggregate claim for reimbursement is at least \$25.

(c) *Claims Denied.* For reimbursement claims that are denied, see the appeals procedure in Article XI.

8.8 Reimbursements from DCSA After Termination of Participation

When a Participant ceases to be a Participant under Section 3.2, the Participant's Salary Reductions (if any) and election to participate will terminate. The Participant will not be able to receive reimbursements for Dependent Care Expenses incurred after the end of the day on which the Participant's employment terminates or the Participant otherwise ceases to be eligible; provided, however, such Participant (or the Participant's estate) may claim reimbursement for any Dependent 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 that the Participant's employment terminates or the Participant otherwise ceases to be eligible.

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 described at 42 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

9.4 Permitted and Required Uses and Disclosure of PHI for Plan Administration Purposes

Unless otherwise permitted by law and subject to the conditions of disclosure described in Section 9.5 and obtaining written certification pursuant to Section 9.7, the HCSA may disclose PHI to the Employer, provided that the Employer uses or discloses such PHI only for Plan administration purposes. “Plan administration purposes” means administration functions performed by the Employer on behalf of the HCSA, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related functions.

Notwithstanding the provisions of this Plan to the contrary, in no event shall the Employer be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR § 164.504(f).

9.5 Conditions of Disclosure for Plan Administration Purposes

The Employer agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the HCSA, the Employer shall:

- Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;

- Ensure that any agent, including a subcontractor, to whom it provides PHI received from the HCSA agrees to the same restrictions and conditions that apply to the Employer with respect to PHI;
- Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
- Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make available PHI to comply with HIPAA's right to access in accordance with 45 CFR § 164.524;
- Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526;
- Make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;
- make its internal practices, books, and records relating to the use and disclosure of PHI received from the HCSA available to the Secretary of Health and Human Services for purposes of determining compliance by the HCSA with HIPAA's privacy requirements;
- if feasible, return or destroy all PHI received from the HCSA that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- Ensure that the adequate separation between the HCSA and the Employer (*i.e.*, the "firewall"), required in 45 CFR § 504(f) (2) (iii), is satisfied.

The Employer further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the HCSA, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI, and it will ensure that any agents (including subcontractors) to whom it provides such electronic PHI agrees to implement reasonable and appropriate security measures to protect the information. The Employer will report to the HCSA any security incident of which it becomes aware.

9.6 Adequate Separation Between Plan and Employer

The Employer shall allow the following persons access to PHI: the Vice President of Human Resources, the Benefits Manager, assistants to the Vice President of Human Resources and the Benefits Manager, Human Resources and payroll staff performing HCSA functions, the Plan Administrator, and any other Employee who needs access to PHI in order to perform Plan administration functions that the Employer performs for the HCSA (such as quality assurance, claims processing, auditing, monitoring, payroll, and appeals)). No other persons shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use PHI to the extent necessary to perform the plan administration functions that the Employer performs for the HCSA. In the event that any of these specified employees does not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Employer for non-compliance pursuant to the Employer's employee discipline and termination procedures.

The Employer will ensure that the provisions of this Section 9.6 are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

9.7 Certification of Plan Sponsor

The HCSA shall disclose PHI to the Employer only upon the receipt of a certification by the Employer that the Plan has been amended to incorporate the provisions of 45 CFR § 164.504(f) (2) (ii), and that the Employer agrees to the conditions of disclosure set forth in Section 9.5.

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, when first eligible under Section 3.1 or during the Open Enrollment Period under Section 3.2, declined to be a Participant) may make a new election within 30 days of the occurrence of an event described in Section 10.3 (or within 60 days of the occurrence of an event described in Section 10.3(e)(3) or (4)), as applicable, but only if the election under the new Election Form/Salary Reduction Agreement is made on account of, and is consistent with, the event. Notwithstanding the foregoing, a Change in Status (e.g., a divorce or a Dependent's losing student status) that results in a beneficiary becoming ineligible for coverage under an Insurance Plan shall automatically result in a corresponding election change regardless of whether such change is requested by the Participant within the normal 30-day period.

(b) *Effective Date of New Election.* Elections made pursuant to this Section 10.2 shall be effective for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in Section 10.3(e) for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the next calendar month following the 30 days of employment or the date that the election change was filed, but, as determined by the Plan Administrator, election changes may become effective later to the extent that the coverage in the applicable Benefit Package Option commences later).

(c) *Effect of New Election Upon Amount of Benefits.* For the effect of a changed election upon the maximum and minimum benefits under the HCSA and DCSA Portions, see Sections 7.4 and 8.4, respectively.

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 the 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 works in the service area (whether or not within the choice of the individual), and in the case of HMO coverage in the group market, no other benefit package is available to the individual; a situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and a situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

(f) *Certain Judgments, Decrees and Orders (Applies to Pre-tax and HCSA Benefits, but Not to DCSA Benefits)*. If a judgment, decree, or order (collectively, an "Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a QMCSO) requires accident or health coverage (including an election for HCSA Benefits) for a Participant's child (including a foster child who is a Dependent of the Participant), then a Participant may (1) change his or her election to provide coverage for the child (provided that the Order requires the Participant to provide coverage); or (2) change his or her election to revoke coverage for the child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan and such coverage is actually provided.

(g) *Medicare and Medicaid (Applies to Pre-tax Benefits, to HCSA Benefits as Limited Below, but Not to DCSA Benefits)*. If a Participant or his or her Spouse or Dependent who is enrolled in a health or accident plan under this Plan becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), then the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid and/or the Participant's HCSA coverage may be canceled (but not reduced). 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. Furthermore, if a Participant or his or her Spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then the Participant may prospectively elect to commence or increase the accident or health coverage of the individual who loses Medicare or Medicaid eligibility and/or the Participant's HCSA coverage may commence or increase.

(h) *Change in Cost (Applies to Pre-tax Benefits, to DCSA Benefits as Limited Below, but Not to HCSA Benefits)*. For purposes of this Section 10.3(h), "similar coverage" means coverage 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 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) *Limitation on Change in Cost Provisions for DCSA Benefits.* 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) *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 Benefits 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 drops coverage if no other Benefit Package Option providing similar coverage is offered by the Employer.

(C) *Definition of Loss of Coverage.* For purposes of this Section 10.3(i) (1), a "Loss of Coverage" means a complete loss of coverage (including the elimination of a Benefits Package Option, an HMO ceasing to be available where the Participant or his or her Spouse or Dependent resides, or a Participant or his or her Spouse or Dependent losing all coverage under the Benefits Package Option by reason of an overall lifetime or annual limitation). In addition, the Plan Administrator, in its sole discretion, on a uniform and consistent basis, may treat the following as a Loss of Coverage:

(i) a substantial decrease in the medical care providers available under the Benefits Package Option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in the PPO for the Medical Insurance Plan or in an HMO);

(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, 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 there has been an addition of, or a significant improvement in, a Benefit Package Option in accordance with prevailing IRS guidance.

(3) *Loss of Coverage Under Other Group Health Coverage.* A Participant may prospectively change his or her election to add group health coverage for the Participant or his or her Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code § 7701(a)(40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Package Option(s).

(4) *Change in Coverage Under Another Employer Plan.* A Participant may make a prospective election change that is on account of, and corresponds with, a change made under an employer plan (including a plan of the Employer or a plan of the Spouse's or Dependent's employer), so long as (A) the other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or (B) the Plan permits Participants to make an election for a Period of Coverage that is different from the plan year under the other cafeteria plan or qualified benefits plan. For example, if an election is made by the Participant's Spouse during his or her employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a requested change is on account of and corresponds with a change made under the other employer plan, in accordance with prevailing IRS guidance.

(j) *Special Limitations to HCSA Benefits and DCSA Benefits*

(1) Election changes may not be made to reduce HCSA coverage during a Period of Coverage; provided, however, that election changes may be made to cancel HCSA coverage completely due to the occurrence of any of the following events: (A) death of a Spouse; (B) divorce, legal separation, or annulment; (C) death of a Dependent; (D) change in 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 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.

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 Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest contribution amount and continuing with the Participant in the class who had elected the next-highest Salary Reduction amount, and so forth, until the defect is corrected.

ARTICLE XI. APPEALS PROCEDURE

11.1 Procedure If Benefits Are Denied Under This Plan

If a claim for reimbursement under this Plan is wholly or partially denied, then claims shall be administered in accordance with the appeals procedures set forth in Appendix D of this Plan.

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 rely upon the direction, information, or election of a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

12.4 Provision for Third-Party Plan Service Providers

The Plan Administrator, subject to the approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

12.5 Fiduciary Liability

To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

12.6 Compensation of Plan Administrator

Unless otherwise determined by the Employer and permitted by law, any Plan Administrator that is also an Employee of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the Employer.

12.7 Bonding

The Plan Administrator shall be bonded to the extent required by ERISA.

12.8 Insurance Contracts

The Employer shall have the right (a) to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the Plan; and (b) to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments, or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of and be retained by the Employer, to the extent that such amounts are less than aggregate Employer contributions toward such insurance.

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 is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or another person shall be forfeited following a reasonable time after the date any such payment first became due. The determination of "reasonable time" shall be made by the Administrator in its sole discretion.

12.10 Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Employee, the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under Code § 125 or the regulations issued thereunder, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other people the credits to the account or distributions to which he or she is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due to the Plan or the Employer from Compensation paid by the Employer.

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 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.

**ARTICLE XIV.
PLAN INFORMATION AND STATEMENT OF ERISA RIGHTS**

14.1 Plan Identifying Information

Plan Name: FLORIDA INSTITUTE OF TECHNOLOGY Flexible Spending Account Plan

Type of Plan: This Plan is intended to qualify as a “cafeteria plan” under Code § 125 and the regulations issued thereunder. The 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 DCSA Portion 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).

Plan Year: The plan year is April 1 through March 31.

Plan Number: The plan number is #519.

Effective Date: The effective date of the Plan is April 1, 2003.

Funding Medium: The Plan is paid for by the Employer out of the Employer’s general assets unless the Employer has otherwise elected to fund the Plan through a trust.

Type of Plan Administration: **The Plan is administered by a third-party administrator.**

Plan Sponsor: FLORIDA INSTITUTE OF TECHNOLOGY
150 W. University Blvd.
Melbourne, FL 32901

Plan Sponsor’s EIN: 596046500

Administrator: FLORIDA INSTITUTE OF TECHNOLOGY
150 W. University Blvd.
Melbourne, FL 32901

Third Party Administrator: Ameriflex
Ameriflex Claims Department
P.O. Box 269009
Plano, TX 75026
claims@myameriflex.com

Named Fiduciary: INDEPENDENT COLLEGES AND UNIVERSITIES BENEFITS ASSOCIATION
Attention: Human Resources
4850 Millenia Blvd
Orlando, Florida 32839

**Agent for Service
Of Legal Process:** FLORIDA INSTITUTE OF TECHNOLOGY
Attention: Human Resources
150 W. University Blvd.
Melbourne, FL 32901

14.2 Statement of ERISA Rights

As a participant in the HCSA Portion, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Administrator's office and at other specified locations, such as worksites, all documents governing the HCSA Portion, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the HCSA Portion with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Administrator, copies of documents governing the operation of the HCSA Portion, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions (SPD). The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the HCSA Portion's annual Form 5500, if any is required by ERISA to be prepared (the Administrator is required by law to furnish each Participant with a copy of this summary annual report).

You are entitled to continue health care coverage under COBRA for yourself, your Spouse, or your Dependents if there is a loss of coverage under the HCSA Portion as a result of a qualifying event. You, your Spouse, or your Dependents may have to pay for such coverage. Review the documents governing the HCSA Portion on the rules governing your COBRA continuation rights.

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 interest of you and other participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining an HCSA Portion benefit or exercising your rights under ERISA.

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 instance, if you request a copy of plan documents or the latest annual report (Form 5500), if any, from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Administrator to provide the materials and pay you up to \$110 per day until you receive the materials unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits, which is denied or ignored in whole or in part, and if you have exhausted the claims procedure available to you under the HCSA Portion, you may file suit in a state or federal court. In addition, if you disagree with the Plan Administrator's decision or lack thereof regarding the qualified status of a medical child support order, you may file suit in federal court.

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

If you have any questions about the HCSA Portion, you should contact the Administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory) or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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 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 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

Expenses paid to alternative providers for homeopathic or holistic treatments or procedures are generally not covered unless to treat a specific medical condition.

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.

AMBULANCE

Medical expenses paid for ambulance service are reimbursable.

ARTIFICIAL LIMBS/TEETH

Medical expenses paid for an artificial limb are reimbursable.

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.

BRILLE 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

See Cosmetic Surgery and Procedures.

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 and upkeep also qualify as eligible medical expenses as long as the medical reason for the capital expense still exists. This is so even if none or only part of the original capital expense qualified as a medical care expense. Examples would be the cost of the fuel to operate, the cost of repairs, and cleaning costs.

Improvements to property rented by a handicapped person: Amounts paid by a handicapped person to buy and install special plumbing fixtures, mainly for medical reasons, in a rented house may qualify as eligible medical expenses.

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.

The following worksheet may be used to figure out the amount of a reimbursable capital expense:

Operation and Maintenance

1. -	Enter the cost of the improvement.	\$ _____
2. -	Enter the increase in the value of the home.	\$ _____
	If line 2 is equal to or greater than line 1, the amount is not reimbursable. If line 2 is less than line 1, go on to line 3.	\$ _____

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. Expenses incurred by a “coach” – even if that is the father-to-be – are not reimbursable. To qualify as medical care, the classes must address specific medical issues, such as labor, delivery procedures, breathing techniques and nursing.

CHIROPRACTOR

Expenses paid to a chiropractor for medical care are reimbursable.

CHRISTIAN SCIENCE PRACTITIONER

Medical expenses paid to Christian Science practitioners are reimbursable.

CONCEIRGE PROVIDERS AND SERVICES

Generally, you cannot include in medical expenses current payments for medical care (including medical insurance) to be provided substantially beyond the end of the plan year. You may be reimbursed for fees incurred or payments made during the current plan year.

COSMETIC SURGERY AND PROCEDURES

A cosmetic surgery or procedure is any surgery or procedure that is directed at improving the patient’s appearance and does not meaningfully promote the proper function of the body or prevent or alleviate an illness or disease. Cosmetic surgery or procedures are generally not eligible for medical expenses unless the surgery or procedures are necessary to improve a deformity that arises from or is directly related to a birth defect, a disfiguring disease, or an injury resulting from an accident or trauma.

- Special bras for mastectomy patients are eligible.
- Cosmetics (make-up) **are not** eligible.
- Face-lifts are generally **not** eligible.
- Hair removal (by electrolysis or laser) is generally **not** eligible.
- Hair transplants are generally **not** eligible.
- Liposuction is generally **not** eligible.
- Tattooing and body piercing 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.

COUNSELING

Counseling must be performed to alleviate or prevent a physical or medical defect or illness. Eligibility is determined by the nature of the treatment and not the license of the practitioner.

- Bereavement and grief counseling are eligible.
- Non-licensed therapist counseling is eligible, but it must be for medical care.
- Psychotherapy and psychoanalysis are eligible.
- Telephone consultation costs are eligible.
- 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 doctor's 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: these items 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.

DIAPERS

Diapers (e.g., Depends TM) for a handicapped or disabled child or adult are reimbursable.

DIAGNOSTIC DEVICES/SERVICES

The cost of devices used in diagnosing and treating illness and disease is reimbursable.

Example. You have diabetes and use a blood sugar test kit to monitor your blood sugar level. You can include the cost of the blood sugar test kit in your medical expenses.

DIETARY SUPPLEMENTS

The costs of dietary supplements taken for general well-being are not reimbursable; however, the costs of supplements taken to alleviate a specific medical condition are reimbursable.

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.

DOCTORS' FEES

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

- Anesthesiologist
- Chiropracist
- 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.
- Late fees, finance fees, etc., are **not** eligible.
- Missed appointments fees are **not** eligible.

DOULA

Expenses paid for a doula whose primary purpose is for delivery of the infant are reimbursable. Charges where the primary purpose is childcare after delivery are not covered.

DRUGS

See Medicines.

DRUG ADDICTION

See Alcoholism, Drug or Substance Abuse.

ELECTROLYSIS OR HAIR REMOVAL

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 doctor's certification indicating the specific medical disorder, the specific treatment needed, and how this treatment will alleviate the medical condition.

FEMININE HYGIENE PRODUCTS

The CARES Act of March 2020 expanded the benefits of FSAs by adding feminine hygiene products to the list of expenses eligible for reimbursement.

Eligible expenses for reimbursement include, but are not limited to including tampons, pads, liners, cups, sponges, and other similar products.

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 doctor's 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 doctor's 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 doctor's certification indicating the specific medical disorder, the specific treatment needed, and how this treatment will alleviate the medical condition.

HOME MEDICAL TEST

Amounts paid for home medical tests such as pregnancy tests, ovulation tests and kits, semen analysis kits, and drug tests are reimbursable.

HOSPITAL

Expenses incurred as a hospital in-patient or out-patient for laboratory, surgical and diagnostic services are reimbursable.

HOUSEHOLD HELP

The cost of household help, even if recommended by your doctor, is not reimbursable. Certain expenses paid to an attendant providing nursing-type service may be eligible. *See Nursing Services.*

INSURANCE PREMIUMS

Premiums for any health, life, dental, or vision plans are not reimbursable.

LABORATORY FEES

Laboratory fees that are part of medical care are reimbursable.

LEAD-BASED PAINT REMOVAL

The cost of removing lead-based paints from surfaces in your home to prevent a dependent that has or has had lead poisoning from eating the paint is reimbursable. These surfaces must be in poor repair (peeling or cracking) or within the dependent's reach. The cost of repairing the scraped area is not reimbursable. If instead of removing the paint, you cover the area with wallboard or paneling, you would treat these items as *(see) Capital Expenses*. The cost of painting the wallboard is not reimbursable. Paint removal or, asbestos removal as a precaution and not because of a specific medical condition **does not** qualify.

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.

LEARNING DISABILITY

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 attend the school. Also, tutoring fees paid on a doctor's recommendation for a child's tutoring by a teacher who is specially trained and qualified to work with children who have severe learning disabilities are reimbursable.

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.

LEGAL FEES

Legal fees paid to authorize treatment for mental illness are reimbursable; however, if parts of the legal fees include, for example, guardianship or estate management fees, are not reimbursable.

Legal fees to get a divorce, even if recommended by a physician, do **not** qualify.

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.

LIFETIME CARE-ADVANCE PAYMENTS

The part of a life-care fee or "founder's fee" you pay either monthly or as a lump sum under an agreement with a retirement home is reimbursable. The part of the payment you include is the amount properly allocable to medical care. The agreement must require that you pay a specific fee as a condition for the home's promise to provide lifetime care that includes medical care. You can use a statement from the retirement home to prove the amount properly allocable to medical care. The statement must be based either on the home's prior experience or on information from a comparable home.

Dependents with disabilities

You can include in medical expenses advance payments to a private institution for lifetime care, treatment, and training of your physically or mentally impaired child upon your death or when you become unable to provide care. The payments must be a condition for the institution's future acceptance of your child and must not be refundable.

Payments for future medical care

Generally, you cannot include in medical expenses current payments for medical care (including medical insurance) to be provided substantially beyond the end of the year. This rule does not apply in situations where future care is purchased in connection with obtaining lifetime care of the type described earlier.

LODGING

The cost of meals and lodging at a hospital or similar institution, if the primary reason for being there is to receive medical care is reimbursable.

The cost of lodging (not provided in a hospital or similar institution) while away from home is reimbursable if:

- The lodging is primarily for and essential to medical care;
- The lodging is not lavish or extravagant under the circumstances;
- 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.

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.

MATERNITY SUPPORT

Expenses paid for a maternity support band are reimbursable.

MATTRESS AND MATTRESS BOARDS

Mattresses and mattress boards for the treatment of a specific medical condition are reimbursable.

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.

MEALS

See Lodging. You can only include meals that are part of inpatient care.

MEDICAL ALERT PROGRAMS

Expenses incurred to enroll in a medical alert program are reimbursable.

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.

MEDICAL CONFERENCES

Amounts paid for admission and transportation to a medical conference if the medical conference concerns the chronic illness of yourself, your spouse, or your dependent are reimbursable. The costs of the medical conference must be primarily for and necessary to the medical care of you, your 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 doctor's 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 doctor's 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 that 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 need not be performed by a nurse as long as the services are of a kind generally performed by a nurse. This includes services connected with caring for the patient's condition, such as giving medication or changing dressings, as well as bathing and grooming the patient.

Only the amount spent for nursing services is reimbursable. If the attendant also provides personal and household services, these amounts must be divided between the times spent performing household and personal services and the time spent on nursing services.

Meals - Amounts paid for an attendant's meals are also reimbursable. This cost may be calculated by dividing a household's total food expenses by the number of household members to find the cost of the attendant's food, then apportioning that cost in the same manner used for apportioning an attendant's wages between nursing services and all other services.

Upkeep - Additional amounts paid for household upkeep because of an attendant are also reimbursable. This includes extra rent or utilities paid because of having to move to a larger apartment to provide space for an attendant.

Infant care - Nursing or babysitting services for a normal, healthy infant are not reimbursable. Social Security, unemployment (FUTA) and Medicare taxes paid for a nurse, attendant or other person who provides medical care are reimbursable.

OPERATIONS

Amounts you pay for legal operations that are not for unnecessary cosmetic surgery are reimbursable.

OPTOMETRIST

See Vision Care.

ORTHODONTIA

Orthodontia services are reimbursable. This type of service does not fit the normal 'fee for service' arrangements seen with other care, and reimbursement can be made once charges have been billed. This can be a one-time fee less any amount paid, or to be paid by your insurance plan, or as you are billed each month.

ORGAN DONOR

See Transplants.

OSTEOPATH

Amounts you pay to an osteopath for medical care are reimbursable.

OVER-THE-COUNTER MEDICINES AND DRUGS

The CARES Act of March 2020 expanded the benefits FSAs by removing the prescription requirement for several OTC drugs and medicines to the list of expenses eligible for reimbursement.

Eligible expenses for reimbursement include, but are not limited to acetaminophen, acne products, allergy products, antacid remedies, antibiotic creams/ointments, anti-fungal foot sprays/creams, aspirin, baby care products, cold remedies, (including shower vapor tabs), cough syrups and drops, medicated eye and ear drops, ibuprofen, laxatives, migraine remedies, motion sickness, nasal sprays, pain relievers, sleep aids, teething gels, and topical creams for itching, stinging, burning, pain relief, sore healing or insect bites, band-aids, bandages, and wraps, braces, and supports, catheters, contact lens solutions and supplies, contraceptives and family planning items, denture adhesives, insulin, and diabetic supplies, diagnostic tests, and monitors, and first aid supplies, peroxide and rubbing alcohol. *The expanded eligible expenses list is a permanent change, and these newly added items are retroactively eligible beginning on January 1, 2020*

OXYGEN

Amounts paid for oxygen or oxygen equipment to relieve breathing problems caused by a medical condition is reimbursable.

PARKING

See Transportation.

PERSONAL ITEMS

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

See Transportation.

PRIVATE HOSPITAL ROOM

The extra cost of a private hospital room is reimbursable.

PROSTHESIS

See Artificial Limbs/Teeth.

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. *See Counseling.*

PSYCHOLOGIST

Expenses for psychological care are reimbursable. *See Counseling.*

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 reimbursable only to the extent that their cost is greater than the cost of the commonly available version of the same product.

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.

SPEECH/VOICE THERAPY

Speech/Voice therapy expenses are reimbursable if rendered for developmental delay or are restorative or rehabilitative in nature.

SPORTS ORTHOTICS

Expenses paid for sports orthotics are reimbursable.

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.

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 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.

This does not include:

- Transportation expenses to and from work, even if the condition requires an unusual means of transportation.
- Transportation of disabled to and from work.
- Transportation expenses if, for non-medical reasons only, you choose to travel to another city, such as a resort area, for an operation or other medical care prescribed by a doctor.
- Transportation expenses incurred primarily or substantially for personal reasons.

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, see *Medical Conferences*.

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. See *Learning Disability and Schools, Special*.

VACCINES

Expenses for vaccines are reimbursable.

VAPOR UNITS AND REFILLS

Expenses paid for the purchase of vapor units such as plug-in units, or their refill cartridges are reimbursable.

VISION CARE

Optometric services and medical expenses for eyeglasses and contact lenses needed for medical reasons are reimbursable. Eye exams and expenses for contact lens solutions are also reimbursable. However, premiums for contact lens or eyeglasses replacement insurance are not reimbursable. Other vision services that are covered are:

- Contact lens cases.
- Corrective swim goggles.
- Eye charts.
- Eyeglass cases.
- Eyeglass cleaning supplies such as cleaning cloths.
- Reading glasses.
- Eyeglass repair or repair kits.
- Safety glasses when the lens corrects visual acuity.
- Sunglasses or sunglass clips when the lens corrects visual acuity.
- Vision shaping.
- Lasik.

VITAMINS

Daily multivitamins taken for general well-being are not reimbursable. Vitamins taken as a treatment for a specific medical condition diagnosed by a physician are reimbursable.

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.

WALKER AND ACCESSORIES

Expenses paid for a walker to aid mobility and their accessories such as baskets for carrying items 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.

- Expenses for an unlicensed daycare center that cares for six or fewer children.
- Expenses at an adult daycare facility (but not expenses for overnight, nursing home facilities).
- The cost of daycare and housekeeping services in your home for your child or other qualifying individuals.
- The cost of meals, lunches, and snacks supplied by a daycare 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**

- Daycare 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 daycare.
- The expenses for which you claim a dependent daycare tax credit on your federal income tax return.
- The registration fees paid for daycare, summer camp, kindergarten, preschool, etc. The only exception is day camp or registration fees applied toward the first payable bill. These are eligible once the initial bill has been paid and the service has been provided.
- The cost of meals while on field trips and outings or those meals included as part of the cost of such trips.

APPENDIX D

APPEALS PROCEDURES

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

Medical Insurance Benefits or Other Insurance Plans. 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.

Claims Under the Pre-tax Benefit Payment Portion, HCSA Portion, or DCSA Portion. 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 until the specified information is provided.

Notification of a denied claim will set out:

- A specific reason or reasons for the denial;
- The specific Plan provision on which the denial is based;
- A description of any additional material or information necessary for you to validate the claim and an explanation of why such material or information is necessary; and
- Appropriate information on the steps to be taken if you wish to appeal the Plan Administrator's decision, including your right to submit written comments and have them considered your right to review (upon request and at no charge) relevant documents and other information, and your right to file suit under ERISA (where applicable) with respect to any adverse determination after an appeal of your claim.

Appeals. If your claim is denied in whole or part, then you (or your authorized representative) may request review upon written application to the Plan Administrator. Your appeal must be made in writing within 180 days after your receipt of the notice that the claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that you feel your

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.

Decision on Review. Your appeal will be reviewed and decided by the Plan Administrator or other entity designated in the Plan in a reasonable time not later than 60 days after the Plan Administrator receives your request for review. The Plan Administrator may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of a medical expert consulted in connection with your appeal will be provided. If the decision on review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

- The specific reason(s) for the decision on review;
- The specific Plan provision(s) on which the decision is based;
- A statement of your right to review (upon request and at no charge) relevant documents and other information;
- If an “internal rule, guideline, protocol, or other similar criteria” is relied on in making the decision on review, then a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criteria will be provided free of charge to you upon request; and
- A statement of your right to bring suit under ERISA § 502(a) (where applicable).