

FLORIDA INSTITUTE OF TECHNOLOGY

HEALTH REIMBURSEMENT ACCOUNT PLAN

As Amended and Restated Effective April 01, 2023



INDEPENDENT COLLEGES AND UNIVERSITIES BENEFITS ASSOCIATION, INC.
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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 Health Reimbursement Account Plan (the “Plan”) effective April 01, 2003. This Plan is hereby amended and restated, effective April 01, 2023. This Plan is intended to permit an Eligible Employee to obtain reimbursement of Medical/Dental/Prescription Expenses on a nontaxable basis from his or her HRA Account. This Plan document constitutes the summary plan description, as required by Section 102 of the Employee Retirement Income Security Act of 1974 (“ERISA”).

Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in Article II.

1.2 Legal Status

This Plan is intended to qualify as an employer-provided medical reimbursement plan under Sections 105 and 106 of the Internal Revenue Code of 1986, as amended (the “Code”) and the treasury regulations issued thereunder, and as a health reimbursement arrangement (“HRA”), within the meaning of IRS Notice 2002-45, and shall be interpreted to accomplish that objective. The Plan is also intended to be an “integrated HRA” (*i.e.*, the Plan is integrated with the INDEPENDENT COLLEGES AND UNIVERSITIES BENEFITS ASSOCIATION Medical, Behavioral Health, and Prescription Drug Plan, including any riders and or amendments thereto (the “ICUBA Medical Plan”) with a “spend-down” feature (*i.e.*, former employees with vested HRAs can spend down their HRA balance on eligible Medical/Dental/Prescription Expenses until the account balance is exhausted). This Plan is intended to satisfy the minimum value method of integration described in IRS Notice 2013-54 and DOL Technical Release 2013-3, as detailed in Treasury Regulation Section 54.9815-2711(d) and DOL Regulation Section 2590.715-2711(d) through integration with the ICUBA Medical Plan. This Plan is not intended to be integrated with Medicare Parts B and D. This Plan and the ICUBA Medical Plan shall be interpreted to accomplish these objectives.

The Medical/Dental/Prescription Expenses reimbursed under the Plan are intended to be eligible for exclusion from Participants’ gross income under Code Section 105(b).

ARTICLE II. DEFINITIONS

2.1 Definitions

“**Administrator**” means FLORIDA INSTITUTE OF TECHNOLOGY; provided, however, that the FLORIDA INSTITUTE OF TECHNOLOGY has delegated full authority to act on behalf of the Administrator to the INDEPENDENT COLLEGES AND UNIVERSITIES BENEFITS ASSOCIATION (“ICUBA”), except with respect to eligibility and appeals, for which the Administrator has the full authority to decide, as described in Section 9.1.

“**Amendment & Restatement Effective Date**” of this Plan means April 01, 2023.

“**Benefits**” means the reimbursement benefits for Medical/Dental/Prescription Expenses described under Article VI.

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

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

“**Compensation**” means the wages or salary paid to an Employee by the Employer.

“**Covered Individual**” means, for purposes of Article VI, a Participant, Spouse, or Dependent.

“**Dependent**” means (a) any individual who is a Participant’s child as defined by Code Section 152(f)(1) (b) any tax dependent of a Participant as defined in Code Section 105(b) (including a domestic partner if he or she so qualifies); provided, however, that any child to whom Code Section 152(e) applies (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child’s support for the calendar year) is treated as a dependent of both parents. Notwithstanding the foregoing, the HRA will provide Benefits in accordance with the applicable requirements of any qualified medical child support order (“QMCSO”) even if the child does not meet the definition of “Dependent.”

A Dependent may be one of the persons described below.

1. The legally recognized spouse of a Participant. A spouse that is legally separated or divorced from the Participant shall not be a Dependent, except for purposes of COBRA Continuation Coverage.
2. A child who is:
 - A natural child;
 - A legally adopted child, which shall be defined as a child adopted or placed for adoption with the Participant before the child reaches age 18. A child is considered placed for adoption when the Participant provides support, and the child resides with the Participant (defined below) in anticipation of adoption. The child’s placement for adoption ends upon the termination of the legal obligation;
 - A stepchild;
 - A child of a Participant required to be covered in accordance with applicable requirements of any Qualified Medical Child Support Order as defined by ERISA Section 609;
 - A child with proof of legal guardianship by the Participant, where the Participant provides Support and the child resides with the Participant;
 - a) A foster child or other children in court-ordered temporary or other custody of the Participant;
 - or
 - b) A child over age 26 who is continuously incapable of self-support because of a Disability (see Disabled Child).
3. A child shall be deemed a Dependent until the date in which such child:
 - Reaches the end of the calendar year in which the age of 26 was attained;
 - Becomes a Participant;
 - Serves on extended active duty in the Armed Forces; or
 - Is over 26 years of age and is no longer continuously incapable of self-support because of a Disability

A child of a Participant shall be deemed a Dependent until the last day of the calendar year in which such child attains 26 years of age. The child may be married, live outside the home, and/or be employed.

“Disabled Child” shall mean an unmarried enrolled Dependent child with a mental or physical disability which reaches age 26 when coverage would otherwise end on December 31st following the child’s 26th birthday, the Plan will continue to cover the child, as long as:

- the child is unable to be self-supporting due to a mental or physical disability;
- the child depends mainly on you for support;
- you provide to ICUBA proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached age 26 during the calendar year; and
- you provide proof, upon ICUBA's request, that the child continues to meet these conditions.

The proof will include a recent examination and certification by the treating physician of a child’s continued disability. However, you will not be asked for this information more than once a year. If you do not supply such proof within 30 days, the Plan will no longer pay Benefits for that child.

Coverage will continue, as long as the enrolled Dependent is incapacitated and dependent upon you unless coverage is otherwise terminated in accordance with the terms of the Plan.

“Effective Date” of this Plan means April 01, 2003.

“Electronic Protected Health Information” has the meaning described in 45 CFR Section 160.103 and generally includes Protected Health Information that is transmitted by electronic media or maintained in electronic media. Unless otherwise specifically noted, Electronic Protected Health Information shall not include enrollment/disenrollment information and summary health information.

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

“Employee” means an individual whom 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 Section 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 in accordance with Section 3.2.

“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 9.3, “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.

“Health Insurance Plan” means the INDEPENDENT COLLEGES AND UNIVERSITIES 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.

“Highly Compensated Individual” means an individual defined under Code Section 105(h), as amended, as a “highly compensated individual” or “highly compensated employee.”

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

“HRA” means a health reimbursement arrangement as defined in IRS Notice 2002-45.

“HRA Account” means the HRA Account described in Section 6.4.

“ICUBA Medical Plan” means the INDEPENDENT COLLEGES AND UNIVERSITIES BENEFITS ASSOCIATION Medical, Behavioral Health, and Prescription Drug Plan, including any riders thereto.

“ICUBA Medical Plan’s HRA-Eligible Benefit Option” means the ICUBA Medical Plan’s Preferred PPO, and High Deductible PPO Plan options.

“Medical/Dental/Prescription Expenses” has the meaning defined in Section 6.2.

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

“Participant” means an individual 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 Eligible Employees who first become Participants, it shall mean the portion of the Plan Year following the date participation commences, as described in Section 3.1; and (b) for Participants who terminate participation, it shall mean the portion of the Plan Year prior to the date participation terminates, as described in Section 3.2. A different Period of Coverage (e.g., a calendar month) may be established by the Administrator and communicated to Participants.

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

“Plan Year” means the 12-month period commencing April 1 and ending on March 31, except in the case of a short plan year resulting from a change in the Plan Year, in which case the Plan Year shall be the entire short plan year.

“Privacy Official” shall have the meaning described in 45 CFR Section 164.530(a).

“Protected Health Information” shall have the meaning described in 45 CFR Section 160.103 and

generally includes individually identifiable health information held by, or on behalf of, the Plan.

“**QMSCO**” means a qualified medical child support order, as defined in ERISA Section 609(a).

“**Related Employer**” means any employer affiliated with FLORIDA INSTITUTE OF TECHNOLOGY that, under Code Section 414(b), (c), or (m), is treated as a single employer with FLORIDA INSTITUTE OF TECHNOLOGY for purposes of Code Section 105.

“**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).

“**USERRA**” means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

ARTICLE III. ELIGIBILITY AND PARTICIPATION

3.1 Eligibility to Participate

An individual is an Eligible Employee and may participate in this Plan if the individual is an Employee and is also enrolled in the ICUBA Medical Plan’s HRA-Eligible Benefit Option. Once an Employee becomes an Eligible Employee by meeting the Plan’s eligibility requirements, the Eligible Employee’s coverage under the Plan as a Participant will automatically commence (a) on the first day of the Plan Year if such Eligible Employee enrolled in the ICUBA Medical Plan’s HRA-Eligible Benefit Option during the ICUBA Plan’s open enrollment or (b) on the date that such Eligible Employee first begins participating in the ICUBA Medical Plan’s HRA-Eligible Benefit Option, subject, in each case, to Section 4.1.

3.2 Termination of Participation

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

- the termination of this Plan; or
- the date on which the Employee ceases to be an Eligible Employee (because of ceasing to be enrolled in the ICUBA Medical Plan’s HRA-Eligible Benefit Option or because of retirement, termination of employment, layoff, reduction in hours, or any other reason), provided that eligibility may continue beyond such date if the Participant was vested in his or her HRA Account or the Participant elected COBRA coverage for the ICUBA Medical Plan’s HRA-Eligible Benefit Option and this Plan. If a Participant’s HRA is vested, then his participation in this Plan shall cease on the date that his HRA balance is exhausted.

Reimbursements from the HRA Account after the termination of participation will be made pursuant to Section 6.7 (relating to a run-out period for submitting claims incurred prior to termination and relating to COBRA).

3.3 Participation Following Termination of Employment or Loss of Eligibility

If a Non-Vested Employee (whether or not a Participant) terminates his or her employment or ceases to be an Eligible Employee for any other reason (including, but not limited to, a reduction in hours or loss of the ICUBA Medical Plan’s HRA-Eligible Benefit Option coverage) and, as such, forfeits his or her HRA Account balance, then such forfeited HRA Account shall not be reinstated if he or she is later rehired or again becomes an

Eligible Employee.

3.4 FMLA and USERRA Leaves of Absence

Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA or USERRA, then to the extent required by the FMLA or USERRA, as applicable, the Employer will continue to maintain the Participant's Benefits on the same terms and conditions as if the Participant were still an active Eligible Employee.

3.5 Non-FMLA and Non-USERRA Leaves of Absence

If a Participant goes on a leave of absence that is not subject to the FMLA or USERRA, the Participant will be treated as having terminated participation, as described above under Section 3.2.

ARTICLE IV. ABILITY TO OPT-OUT

4.1 Opting Out and Waiving Future Reimbursements from the HRA

The Plan is considered 'integrated' with the Medical Plan. As such, and as required by IRS Notice 2013-54, Participants shall be permitted to *permanently* 'opt-out of' and waive future reimbursements from the Plan annually and upon the termination of employment. Participants may opt-out of and waive future reimbursements from the Plan by contacting the Administrator.

Under the terms of the ICUBA HRA: When permitting initial election opportunities for HRA coverage, ICUBA will, by default, auto-enroll all employees into their employer's health reimbursement plan election. The positive election status will remain in force and continue into the next plan year given the employee is still enrolled in an HRA eligible medical plan.

How to Permanently Waive or Opt-out

ICUBA has an HRA Opt-out Form; Employees can contact their employer's human resources office or contact ICUBA Benefits Administration at benefitsadministration@icuba.org to request a copy of the form.

ARTICLE V. BENEFITS OFFERED AND METHOD OF FUNDING

5.1 Benefits Offered

When an Eligible Employee becomes a Participant in accordance with Article III, an HRA Account will be established for such Participant to receive Benefits in the form of reimbursements for Medical/Dental/Prescription Expenses, as described in Article VI. In no event shall Benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Medical/Dental/Prescription Expenses.

5.2 Employer and Participant Contributions

- (a) *Employer Contributions.* The Employer funds the full amount of the HRA Accounts.
- (b) *Participant Contributions.* There are no Participant contributions for Benefits under the Plan

(except as required under any applicable continuation of coverage requirements).

- (c) *No Funding Under Cafeteria Plan.* Under no circumstances will the Benefits be funded with salary reduction contributions, employer contributions (e.g., flex credits), or otherwise under a cafeteria plan, nor will salary reduction contributions or employer contributions be treated as Employer contributions to the Plan.

5.3 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. Nothing herein will be construed to require the Employer or the 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 or the Administrator from which any payment under this Plan may be made.

ARTICLE VI. HEALTH REIMBURSEMENT BENEFITS

6.1 Benefits

The Plan will reimburse a Participant for Medical/Dental/Prescription Expenses up to the unused amount in such Participant's HRA, as set forth and adjusted under Section 6.3.

6.2 Eligible Medical/Dental/Prescription Expenses

Under the HRA Account, a Participant may receive reimbursement for Medical/Dental/Prescription Expenses incurred during a Period of Coverage.

- (a) *Incurred.* A Medical/Dental/Prescription Expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays for the medical care. Medical/Dental/Prescription Expenses incurred before a Participant first becomes covered by the Plan are not eligible.
- (b) *Medical/Dental/Prescription Expenses Generally.* "Medical/Dental/Prescription Expenses" means expenses incurred by (1) an active Participant (or his or her Spouse and/or Dependents if such Spouse and/or Dependents are participants in the ICUBA Medical Plan's HRA-Eligible Benefit Option) or (2) a terminated Participant whose HRA is vested for medical care, as defined in Code Section 213 (including, for example, amounts for certain hospital bills, doctor and dental bills and prescription drugs), but shall not include expenses that are described in subsection (c). Reimbursements due for Medical/Dental/Prescription Expenses incurred by the Participant or the Participant's Spouse, or Dependents (if eligible) shall be charged against the Participant's HRA Account.
- (c) *Medical/Dental/Prescription Expenses Exclusions.* "Medical/Dental/Prescription Expenses" shall not include (1) Pre-tax health insurance premiums for individual policies or for any other group health plan (including a plan sponsored by the Employer); (2) the expenses listed as exclusions under Appendix E to this Plan. Notwithstanding the foregoing, an HRA Account may reimburse (A) COBRA premiums that a Participant pays on an after-tax basis under any other group health plan sponsored by the Employer, (B) premiums that a Participant pays on an after-

tax basis for retiree health coverage, and (C) premiums that a Participant pays on an after-tax basis for qualified long-term care insurance.

- (d) *Cannot Be Reimbursed or Reimbursable From Another Source.* Medical/Dental/Prescription Expenses may be reimbursed from the Participant's HRA Account only to the extent that the Participant or other individual incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through the Health Insurance Plan, other insurance, or any other accident or health plan (but see Section 6.9 if the other health plan is a Health FSA). If only a portion of a Medical/Dental/Prescription Expense has been reimbursed elsewhere (e.g., because the Health Insurance Plan imposes copayment or deductible limitations), the HRA Account may reimburse the remaining portion of such expense if it otherwise meets the requirements of this Article VI.

6.3 Maximum Benefits

- (a) *Maximum Benefits.* The maximum dollar amount that may be credited to an HRA Account for an Employee who participates in the Plan for an entire 12-month Period of Coverage is set forth in Appendix B hereto. Unused amounts may be carried over to the next Period of Coverage, as provided in Section 6.5.
- (b) *Changes.* For subsequent Plan Years, the maximum dollar limit may be changed by the Administrator and shall be communicated to Employees during Open Enrollment or through the SPD or other documents.
- (c) *Nondiscrimination.* Reimbursements to Highly Compensated Individuals may be limited or treated as taxable compensation to comply with Code Section 105(h), as may be determined by the Administrator in its sole discretion.

6.4 Establishment of HRA Account

The Administrator will establish and maintain an HRA Account with respect to each Participant but will not create a separate fund or otherwise segregate assets for this purpose. The HRA Account so established will merely be a recordkeeping HRA Account with the purpose of keeping track of contributions and available reimbursement amounts. A Participant's HRA Account shall be subdivided into an Active HRA Account and a Terminated-Vested HRA Account.

- (a) *Crediting of Active HRA Account.* A Participant's Active HRA Account will be credited in accordance with the provisions set forth in Appendix C hereto.
- (b) *Debiting of Active HRA Account.* A Participant's Active HRA Account will be debited during each Period of Coverage for any reimbursement of Medical/Dental/Prescription Expenses incurred during the Period of Coverage while he or she is an active Participant or incurred during a Period of Coverage but being paid out over a period of time through a payment plan that may extend to other Periods of Coverages due to an insufficient amount in the Participant's Active HRA Account.
- (c) *Debiting of Terminated-Vested HRA Account.* A Participant's Terminated-Vested HRA Account will be debited for any reimbursement of Medical/Dental/Prescription Expenses incurred and submitted after he or she ceases to be an active Participant (i.e., a Participant's Terminated-

Vested HRA Account shall be available to reimburse Medical/Dental/Prescription Expenses. A Participant's Terminated-Vested HRA Account, if any, shall be debited an administrative fee at the beginning of each month starting with the first month that he or she ceases to be an Eligible Employee. Such administrative fee shall be determined by the Administrator, in its sole discretion.

- (d) *Available Amounts.* For an active Participant, the amount available for reimbursement of Medical/Dental/Prescription Expenses is the amount credited to the Participant's Active HRA Account under subsection (a) reduced by prior reimbursements debited under subsection (b). For a terminated-vested Participant, the amount available for reimbursement of Medical/Dental/Prescription Expenses is the credited amount remaining in the Participant's Terminated-Vested HRA Account after termination, plus interest credited in accordance with subsection (e) hereof and reduced by prior reimbursements debited under subsection (c). A terminated-vested Participant may not utilize his or her Terminated-Vested HRA Account while he or she is an Eligible Employee of the Employer or any other entity that participates in the ICUBA Medical Plan.
- (e) *Interest.* The amount in a terminated-vested Participant's Terminated-Vested HRA Account that is available for reimbursement of Medical/Dental/Prescription Expenses (as described in subsection (c) above) shall be credited with interest earned during a quarter (if any) on March 31, June 30, September 30, and December 31.

6.5 Carryover of HRAs

If any balance remains in the Participant's HRA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, such balance shall be carried over to reimburse the Participant for Medical/Dental/Prescription Expenses incurred during a subsequent Period of Coverage. However, unless a Participant (a) is vested in his or her HRA or (b) has elected COBRA continuation coverage in accordance with Section 6.7, then (1) upon the termination of employment or other loss of eligibility, such Participant's coverage shall cease and expenses incurred after such time shall not be reimbursed and (2) Non-vested Participants shall be given a grace period of 90 days from the HRA coverage end date to submit all eligible claims incurred during the benefit period as stated in Section 6.8 (a).

6.6 Reimbursement Procedure

- (a) *Timing.* Within 30 days after receipt by the Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Medical/Dental/Prescription Expenses (if the Administrator approves the claim), or the Administrator will notify the Participant that his or her claim has been denied. The 30-day time period may be extended for an additional 15 days for matters beyond the control of the Administrator, including in cases where a reimbursement claim is incomplete. The 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 an incomplete reimbursement claim.
- (b) *Claims Substantiation.* A Participant who seeks Benefits may apply for reimbursement by submitting an application in writing to the Administrator in such form as the Administrator may prescribe, within 12 months of the date that the Medical/Dental/Prescription Expense was incurred, setting forth:

- the individual(s) on whose behalf Medical/Dental/Prescription Expenses have been incurred;
- the nature and date of the Medical/Dental/Prescription Expenses so incurred;
- the amount of the requested reimbursement; and
- a statement that such Medical/Dental/Prescription Expenses have not otherwise been reimbursed and are not reimbursable through any other source.

The application shall be accompanied by bills, invoices, insurance explanation of benefits (EOB), or other statements from an independent third party (e.g., a hospital, physician, or pharmacy) showing that the Medical/Dental/Prescription Expenses have been incurred and the amounts of such Medical/Dental/Prescription Expenses, together with any additional documentation that the 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 claims for reimbursement total at least \$5. If the HRA is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement, etc.), the Participant will be required to comply with substantiation procedures established by the Administrator in accordance with Section 7.10 and applicable IRS guidance regarding electronic payment card programs.

6.7 Vesting

A Participant will become fully vested in his or her HRA Account after (a) he or she has remained an Eligible Employee for 36 consecutive months and (b) the Employer has made continuous contributions to such Participant's HRA Account for a consecutive 36-month period. If a Participant ceases to be an Eligible Employee (e.g., he or she terminates employment with the Employer, he or she stops participating in the ICUBA Medical Plan's HRA-Eligible Benefit Option, etc.) before vesting in his or her HRA Account and then later becomes an Eligible Employee again, then such individual shall recommence participation in the HRA with a new HRA Account since his or her old HRA Account balance was forfeited and a new 36-month vesting period will commence (i.e., his or her old vesting service will not count toward the new 36-month vesting period). COBRA continuation coverage shall not count toward vesting of an HRA Account. Only a Participant may vest in his or her HRA Account (i.e., Dependents and Spouses may not vest in an HRA Account unless they are also enrolled as Participants in an ICUBA Medical Plan HRA-Eligible Benefit Option due to their status as an eligible employee with a Member Institution).

6.8 Reimbursements After Termination; COBRA

(a) *Reimbursements After Termination.* When a non-vested Participant ceases to be a Participant under Section 3.2, the Participant will not be able to receive reimbursements for Medical/Dental/Prescription Expenses incurred after his or her participation terminates. However, such Participant (or the Participant's estate) may claim reimbursement for any Medical/Dental/Prescription Expenses incurred during the Period of Coverage prior to termination of participation; provided, however, that the Participant (or the Participant's estate) files a claim within 90 calendar days from the date he ceased to be a Participant under Section 3.2 in which the Medical/Dental/Prescription Expense arose.

(b) *COBRA.* Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, the Participant and his or her Spouse and Dependents ("Qualified Beneficiaries"), whose coverage terminates under the HRA because of a COBRA qualifying event, shall be given the opportunity to continue (on a self-pay basis) the same coverage that he or she had under the HRA on the day before the qualifying event for

the periods prescribed by COBRA (subject to all conditions and limitations under COBRA) so long as the Qualified Beneficiaries make a COBRA election to continue participating in the ICUBA Medical Plan's HRA-Eligible Benefit Option. However, in the event that such coverage is modified for all similarly situated non-COBRA Participants prior to the date continuation coverage is elected, Qualified Beneficiaries shall be eligible to continue the same coverage that is provided to similarly situated non-COBRA Participants. Once a premium payment is made for a given Period of Coverage, Qualified Beneficiaries shall be credited with the monthly reimbursement accrual (*i.e.*, the maximum annual reimbursement amount, divided by the number of months in that Period of Coverage) that is made available to similarly-situated non-COBRA beneficiaries, and any unused reimbursement amounts from the previous Period of Coverage shall be carried over to the next Period of Coverage (provided that the applicable premium is paid). A premium for COBRA shall be charged to Qualified Beneficiaries in such amounts and shall be payable at such times as are established by the Administrator and permitted by COBRA.

6.9 Named Fiduciary; Compliance With ERISA, COBRA, HIPAA, etc.

(a) FLORIDA INSTITUTE OF TECHNOLOGY is the named fiduciary for the Plan for purposes of ERISA Section 402(a).

(b) Benefits shall be provided in compliance with ERISA, COBRA, HIPAA, FMLA, USERRA, and other group health plan laws to the extent required by such laws.

6.10 Coordination of Benefits; Health FSA (HCSA) to Reimburse First

Benefits under this Plan are solely intended to reimburse Medical/Dental/Prescription Expenses not previously reimbursed or reimbursable elsewhere. To the extent that an otherwise eligible Medical/Dental/Prescription Expense is payable or reimbursable from another source, that other source shall pay or reimburse prior to payment or reimbursement from this Plan. Without limiting the foregoing, if the Participant's Medical/Dental/Prescription Expenses are covered by both this Plan and by a Health FSA (HCSA), then this Plan shall not be available for reimbursement of such Medical/Dental/Prescription Expenses until after amounts available for reimbursement under the Health FSA have been exhausted.

6.11 Electronic Payment Cards

If the Employer allows payments under the Plan to be accessed by an electronic payment card (*e.g.*, debit card, credit card, or similar arrangement, etc.), Participants will be required to comply with substantiation procedures established by the Administrator in accordance with applicable IRS guidance regarding electronic payment card programs. In addition, the following provisions shall apply:

(a) *Initial and Periodic Certification.* Before receiving an electronic payment card, a Participant must certify that he or she will only use the card to pay for Medical/Dental/Prescription Expenses, will not use the card for expenses that have already been reimbursed, will not seek reimbursement under any other health plan for expenses paid for with the card, and will acquire and keep sufficient documentation (see subsection (d) below) for expenses paid with the card. The Participant must also agree to abide by any other terms and conditions of the card program as set forth herein and, in any cardholder, agreement issued in conjunction with the card, including but not limited to the payment of any fees for participation in the card program and the Plan's right to recoup improper card payments by withholding amounts from Compensation and offsetting against other HRA claims. The Participant must reaffirm these agreements during each subsequent open enrollment period for the card to remain activated. In addition, these agreements are reaffirmed each time the Participant uses the card. Failure to abide by these agreements may result in the deactivation of the card.

(b) *Deactivation of Card.* A Participant's card will be deactivated when participation in the HRA ceases or at other times as set forth herein (e.g., for failure to comply with the Plan's substantiation and recoupment procedures, etc.). A Participant whose card has been deactivated must request reimbursement for Medical/Dental/Prescription Expenses through other methods approved by the Administrator (e.g., by submitting paper claims, etc.).

(c) *Merchants; Card Use.* Card use is limited to eligible merchants as provided in applicable IRS guidance and as further identified by the Administrator or its designee. The card's debit balance (or credit limit, as applicable) must be limited to the amount of the Participant's available HRA Account balance. Each time the card is swiped, the Participant certifies to the Plan that the expense for which payment under the HRA is being made is a Medical/Dental/Prescription Expense that has not already been reimbursed from another source and that reimbursement for the expense will not be sought from another source. Use of a card to pay for a service or product is not considered to be a claim for benefits under the Plan; a claim does not arise until a paper or electronic reimbursement request is submitted.

(d) *Documentation.* For each expense that is paid with the card, the Participant must obtain and retain a bill, invoice, or other statements from the merchant describing the service or product, the date of the service or sale, and the amount of the expense. The documentation must be retained until the close of the Plan Year following the Plan Year in which the card transaction occurred. If the Participant is asked to provide the documentation to the Plan, he or she must do so within the period specified in the request. A Participant who is unable to provide adequate or timely substantiation upon request from the Plan must repay the Plan for the unsubstantiated expense. In addition, the Participant's card may be deactivated.

(e) *Correction of Improper Payments.* Participants must repay the Plan for any improper payments that are made with their cards. Improper payments may be recouped in accordance with applicable IRS guidance. If the Plan is unable to recoup an improper payment, the Employer will treat the payment as it would treat any other business indebtedness. If the debt is not collected and the Employer forgives the indebtedness, the payment will be treated as wages in the year in which the indebtedness was forgiven.

ARTICLE VII. HIPAA PROVISIONS

7.1 General

As a HIPAA Health Plan, the Plan shall comply with the standards for privacy of protected health information as set forth in the Privacy Rule, the security standards for the protection of Electronic PHI as set forth in the Security Rule, and the notification requirements for Breaches of Unsecured PHI under the Breach Notification Rule.

7.2 Definitions

For purposes of this Article, the following definitions shall apply:

(a) "Breach" shall mean the acquisition, access, use, or disclosure of an individual's PHI in a manner not permitted under the Privacy Rule. A Breach shall be presumed unless the Plan determines there is a low probability that the PHI has been compromised. A Breach does not include (1) an unintentional acquisition, access, or use of PHI by a workforce member or person acting under the authority of a covered entity or business associate, if such acquisition, access, or use was in good faith and within the scope of authority and does not result in further impermissible use or disclosure; (2) an inadvertent disclosure by a person who is authorized to

access PHI to another person authorized to access PHI at the same covered entity or business associate or organized health care arrangement and the information received is not further used or disclosed in a manner not permitted under the Privacy Rule; or (3) a disclosure of PHI where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

(b) “Breach Notification Rule” means the regulations issued under HIPAA set forth in subpart D of 45 CFR Part 164.

(c) “Electronic Protected Health Information” or “Electronic PHI” means PHI that is transmitted by or maintained in electronic media.

(d) “Health Care Operations” is as defined under 45 CFR §160.501.

(e) “HIPAA Health Plan,” as defined under 45 CFR §160.103, means an individual or group plan that provides, or pays the cost of, medical care, and includes those plans and arrangements listed in 45 CFR §160.103.

(f) “Payment” is as defined under 45 CFR §160.501, and means activities undertaken by a HIPAA Health Plan to obtain contributions or to determine or fulfill its responsibility for coverage and provision of benefits, or to obtain or provide reimbursement for the provision of health care.

(g) “Privacy Policy” means the Employer HIPAA Privacy Policy.

(h) “Privacy Rule” means the regulations issued under HIPAA set forth in subpart E of 45 CFR Part 164.

(i) “Protected Health Information” or “PHI” means individually identifiable health information that (1) relates to the past, present, or future physical or mental condition of a current or former Participant, Spouse, or Dependent, provision of health care to a Participant, Spouse, or Dependent, or payment for such health care; (2) can either identify the Participant, Spouse, or Dependent, or there is a reasonable basis to believe the information can be used to identify the Participant, Spouse, or Dependent; and (3) is received or created by or on behalf of the Plan.

(j) “Responsible Employee” means an employee (including a contract, temporary, or leased employee) of the Plan or of the Employer whose duties (1) require that the employee have access to PHI for purposes of Payment or Health Care Operations; or (2) make it likely that the employee will receive or have access to PHI. Persons designated as Responsible Employees are described in Section 10.3.

(k) “Security Incident,” as defined under 45 CFR §164.304, means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

(l) “Security Rule” means the regulations issued under HIPAA set forth in subpart C of 45 CFR Part 164.

7.3 Responsible Employees

Only Responsible Employees shall be permitted to use, disclose, create, receive, access, maintain, or transmit PHI or Electronic PHI on behalf of the Plan. The use or disclosure of PHI or Electronic PHI by Responsible

Employees shall be restricted to the Plan administration functions that the Employer performs on behalf of the Plan pursuant to Section 10.4.

(a) Employer employees who perform the following functions on behalf of the Plan are Responsible Employees: (1) claims determination and processing functions; (2) Plan vendor relations functions; (3) benefits education and information functions; (4) Plan administration activities; (5) legal department activities; (6) Plan compliance activities; (7) information systems support activities; (8) internal audit functions; and (9) human resources functions.

(b) In addition to those individuals described in subsection (a), the Plan HIPAA privacy official and security official, and Employer employees to whom the Plan HIPAA privacy official and security official have delegated any of the following responsibilities, shall also be Responsible Employees: (1) implementation, interpretation, and amendment of the Privacy Policy; (2) Privacy Rule, Breach Notification Rule, or Security Rule training for Employer employees; (3) investigation of and response to complaints by Participants, Spouses, Dependents, and/or employees; (4) preparation, maintenance, and distribution of the Plan's privacy notice; (5) response to requests by Participants, Spouses, or Dependents to inspect or copy PHI; (6) response to requests by Participants, Spouses, or Dependents to restrict the use or disclosure of their PHI; (7) response to requests by Participants, Spouses, or Dependents to receive communications of their PHI by alternate means or in an alternate manner; (8) amendment and response to requests to amend the PHI of Participants, Spouses, or Dependents; (9) response to requests by Participants, Spouses, or Dependents for an accounting of disclosures of their PHI; (10) response to requests for information by the Department of Health and Human Services; (11) approval of disclosures to law enforcement or to the military for government purposes; (12) maintenance of records and other documentation required by the Privacy Rule, Breach Notification Rule, or Security Rule; (13) negotiation of Privacy Rule, Breach Notification Rule, and Security Rule provisions and/or reasonable security provisions into contracts with third-party service providers; (14) maintenance of Plan PHI or Electronic PHI security documentation; or (15) approval of access to Electronic PHI by Participants, Spouses, or Dependents.

7.4 Permitted Uses and Disclosures

Responsible Employees may access, request, receive, use, disclose, create, and/or transmit PHI only to perform certain permitted and required functions on behalf of the Plan, consistent with the Privacy Policy. This includes:

- (a) uses and disclosures for the Plan's own Payment and Health Care Operations functions;
- (b) uses and disclosures for another HIPAA Health Plan's Payment and Health Care Operations functions;
- (c) disclosures to a health care provider, as defined under 45 CFR §160.103, for the health care provider's treatment activities;
- (d) disclosures to the Employer, acting in its role as Plan Sponsor, of (1) summary health information for purposes of obtaining health insurance coverage or premium bids for HIPAA Health Plans or for making decisions to modify, amend, or terminate a HIPAA Health Plan; or (2) enrollment or disenrollment information;
- (e) disclosures of a Participant's, Spouse's, or Dependent's PHI to the Participant or the Dependent or his or her personal representative, as defined under 45 CFR §164.502(g);
- (f) disclosures to a Participant's, Spouse's, or Dependent's family members or friends involved in

the Participant's, Spouse's, or Dependent's health care or payment for the Participant's, Spouse's, or Dependent's health care, or to notify a Participant's, Spouse's, or Dependent's family in the event of an emergency or disaster relief situation;

- (g) uses and disclosures to comply with workers' compensation laws;
- (h) uses and disclosures for legal and law enforcement purposes, such as to comply with a court order;
- (i) disclosures to the Secretary of Health and Human Services to demonstrate the Plan's compliance with the Privacy Rule, Security Rule, or Breach Notification Rule;
- (j) uses and disclosures for other governmental purposes, such as for national security purposes;
- (k) uses and disclosures for certain health and safety purposes, such as to prevent or lessen a threat to public health, to report suspected cases of abuse, neglect, or domestic violence, or relating to a claim for public benefits or services;
- (l) uses and disclosures to identify a decedent or cause of death, or for tissue donation purposes;
- (m) uses and disclosures required by other applicable laws; and
- (n) uses and disclosures pursuant to the Participant's authorization that satisfies the requirements of 45 CFR §164.508.

7.5 Prohibited Uses and Disclosures

Notwithstanding anything in the Plan to the contrary, use or disclosure of Protected Health Information is prohibited in the following situations:

(a) *Genetic Information.* Use or disclosure of Protected Health Information that is Genetic Information about an individual for underwriting purposes shall not be a permitted use or disclosure. The term "underwriting purposes" includes determining eligibility for benefits, computation of premium or contribution amounts, or the creation, renewal, or replacement of a contract of health insurance.

(b) *Employment-Related Actions.* Use or disclosure of Protected Health Information for the purpose of employment-related actions or decisions shall not be a permitted use or disclosure.

(c) *Other Benefits.* Use or disclosure of Protected Health Information in connection with any other benefit or employee benefit plan of the Employer, except as expressly permitted in Section 7.4, shall not be a permitted use or disclosure.

7.6 Certification Requirement

The Plan shall disclose PHI, including Electronic PHI, to Responsible Employees only upon receipt of a certification by the Employer that the Employer agrees:

- (a) not to use or further disclose PHI other than as permitted or required by this Article and the Privacy Policy or as required by law;

(b) to take reasonable steps to ensure that any agents to whom the Employer provides PHI or Electronic PHI received from the Plan agree: (1) to the same restrictions and conditions that apply to the Employer with respect to such PHI; and (2) to implement reasonable and appropriate security measures to protect such Electronic PHI;

(c) not to use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer other than another Health Plan;

(d) to report to the Plan any use or disclosure of PHI, including Electronic PHI, that is inconsistent with the uses or disclosures described in Section 7.4, or any Security Incident, of which the Employer becomes aware;

(e) to make available PHI for inspection and copying in accordance with 45 CFR §164.524;

(f) to make available PHI for amendment, and to incorporate any amendments to PHI, in accordance with 45 CFR §164.526;

(g) to make available PHI required to provide an accounting of disclosures in accordance with 45 CFR §164.528;

(h) to make its internal practices, books, and records relating to the use and disclosure of PHI and Electronic PHI, received on behalf of the Plan, available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Rule, the Breach Notification Rule, or the Security Rule;

(i) if feasible, to return or destroy all PHI and Electronic PHI received from the Plan that the Employer still maintains in any form and retain no copies of such PHI and Electronic PHI 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 PHI infeasible and Electronic PHI;

(j) to take reasonable steps to ensure that there is adequate separation between the Plan and the Employer's activities in its role as Plan sponsor and employer, and that such adequate separation is supported by reasonable and appropriate security measures; and

(k) to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any Electronic PHI that the Employer creates, receives, maintains, or transmits on behalf of the Plan.

7.7 Mitigation

In the event of noncompliance with any of the provisions set forth in this Article:

(a) The HIPAA privacy official or security official, as appropriate, shall address any complaint promptly and confidentially. The HIPAA privacy official or security official, as appropriate, first will investigate the complaint and document the investigation efforts and findings.

(b) If PHI, including Electronic PHI, has been used or disclosed in violation of the Privacy Policy or inconsistent with this Article, the HIPAA privacy official and/or the security official, as appropriate, shall take immediate steps to mitigate any harm caused by the violation and to minimize the possibility that such a violation will recur.

(c) If a Responsible Employee or other Employer-employee is found to have violated the Privacy Policy and/or policy developed under the Security Rule, such personnel shall be subject to disciplinary action up to and including termination.

7.8 Breach Notification

Following the discovery of a breach of unsecured PHI, the Plan shall notify each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed as a result of a Breach, in accordance with 45 CFR §164.404, and shall notify the Secretary of Health and Human Services in accordance with 45 CFR §164.408. For a breach of unsecured PHI involving more than 500 residents of a State or jurisdiction, the Plan shall notify the media in accordance with 45 CFR §164.406. "Unsecured PHI" means PHI that is not secured through the use of a technology or methodology specified in regulations or other guidance issued by the Secretary of Health and Human Services.

ARTICLE VIII. APPEALS PROCEDURE

8.1 Procedure If Benefits Are Denied Under This Plan

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

ARTICLE IX. RECORDKEEPING AND ADMINISTRATION

9.1 Administrator

The administration of this Plan shall be under the supervision of the Administrator. It is the principal duty of the 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.

9.2 Powers of the Administrator

The 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 Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the 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;
- (b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to enroll in and submit claims pursuant to this Plan;
- (c) to prepare and distribute information explaining this Plan and the Benefits under this Plan in such manner as the Administrator determines to be appropriate;
- (d) to request and receive from all Employees and Participants such information as the 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 Administrator determines to be reasonable and appropriate;
- (f) to receive, review, and keep on file such reports and information concerning the Benefits covered by this Plan as the 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.

9.3. Reliance on Participant, Tables, etc.

The Administrator may rely upon the information submitted by 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 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 Administrator.

9.4 Provision for Third-Party Plan Service Providers

The 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.

9.5 Fiduciary Liability

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

9.6 Compensation of Administrator

Unless otherwise determined by the Employer and permitted by law, any Administrator who 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 the Administrator's duties shall be paid by the Employer.

9.7 Bonding

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

9.8 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.

9.9 Inability to Locate Payee

If the 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 that any such payment first became due. The determination of "reasonable time" shall be made by the Administrator in its sole discretion.

(a) In the event that the Administrator is unable to reach a terminated-vested Participant because the identity or whereabouts of such Participant cannot be ascertained, the Administrator will conduct a reasonable and diligent search using one or more of the search methods described in paragraph (d) below; provided, however, that if the missing terminated-vested Participant's HRA Account is less than \$50, such amount shall be immediately forfeited, subject to paragraph (c) below.

(b) If a missing terminated-vested Participant remains un-located after six (6) months following the date the Administrator first attempts to locate the missing Participant using any of the search methods described below, or in the event of an un-cashed benefit check, after one-hundred and eighty (180) days following the date of the issuance of the benefits check, the Administrator may forfeit the missing terminated-vested Participant's HRA Account unless forfeiture is contrary to applicable law. If the Administrator forfeits the missing terminated-vested Participant's HRA Account, the forfeiture will occur at the end of the six (6) month period described above.

(c) If a missing terminated-vested Participant whose HRA Account was forfeited thereafter, at any time, but before the Plan has been terminated, makes a claim for his or her forfeited HRA Account, the Administrator will restore the forfeited HRA Account to the same dollar amount as the amount forfeited, unadjusted for net income gains or losses occurring subsequent to the forfeiture. The Administrator will make the restoration in the Plan Year in which the missing terminated-vested Participant makes the claim, first from the amount, if any, of Forfeitures the Administrator would otherwise allocate for the Plan Year, and then from the amount or additional amount, the Employer contributes to the Plan for the Plan Year.

(d) Permissible search methods include one or more of the following methods: (i) provide a notice to the missing Participant at the Participant's last known address by certified or registered mail; (ii) check with other employee benefit plans of the Employer that may have more up-to-date information regarding the Participant's whereabouts; or (iii) use a commercial locator service, credit reporting agencies, the Internet, or other general search methods. With respect to the search method in (ii) above, if the Administrator encounters privacy concerns, the Administrator may request that the Employer or other Plan fiduciary, contact the Participant or forward a letter requesting that the Participant contact the Plan Administrator.

9.10 Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the HRA Account of any Participant, or the amount of Benefits paid or to be paid to a Participant or other person, the Administrator shall, to the extent that it deems administratively possible and otherwise permissible under Code Section 105, the regulations issued thereunder or other applicable law, 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 another person the amounts or distributions to which he or she is properly entitled under the Plan. Such action by the Administrator may include withholding of any amounts due to the Plan or the Employer from Compensation paid by the Employer.

ARTICLE X. GENERAL PROVISIONS

10.1 Expenses

All reasonable expenses incurred in administering the Plan are currently paid by forfeitures, if any, and then by the Employer.

10.2 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.

10.3 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.

10.4 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.

10.5 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. 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/or 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.

10.6 No Guarantee of Tax Consequences

Neither the 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 Administrator if the Participant has any reason to believe that such payment is not so excludable.

10.7 Indemnification of Employer

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

10.8 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 such extent as may be required by law.

10.9 Headings

The headings of the various Articles and Sections (but not subsections) 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.

10.10 Plan Provisions Controlling

In the event that the terms or provisions of any summary or description of this Plan, or of any other instrument, are 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.

10.11 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 XI. PLAN INFORMATION AND STATEMENT OF ERISA RIGHTS

11.1 Plan Identifying Information

Plan Name: FLORIDA INSTITUTE OF TECHNOLOGY Health Reimbursement Account Plan

Type of Plan: The Plan is intended to qualify as an employer-provided medical reimbursement plan under Code Sections 105 and 106 and the regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45. The Plan is also intended to be an "integrated HRA" (*i.e.*, the Plan is integrated with the FLORIDA INSTITUTE OF TECHNOLOGY, Inc. Medical, Behavioral Health, and Prescription Drug Plan, including any riders thereto) with a "spend-down" feature (*i.e.*, former employees with vested

HRAs can spend down their HRA balance on eligible Medical/Dental/Prescription Expenses until the HRA balance is exhausted).

- 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 01, 2003.
- Funding Medium:** The HRA is paid for by the Employer out of the Employer's general assets unless the Employer has otherwise elected to fund the HRA through a trust.
- Type of Plan Administration:** The Administrator pays applicable Benefits from the general assets of the Employer unless the Employer has elected to fund the Plan through a trust.
- Plan Sponsor:** FLORIDA INSTITUTE OF TECHNOLOGY
150 W. University Blvd.
Melbourne, Florida 32901
- Plan Sponsor's EIN:** 596046500
- Administrator:** INDEPENDENT COLLEGES AND UNIVERSITIES BENEFITS ASSOCIATION
4850 Millenia Blvd
Orlando, Florida 32839
benefitsadministration@icuba.org
- Third Party Administrator:** Ameriflex
P.O. Box 269009
Plano, TX 75026
claims@myameriflex.com
- Named Fiduciary:** FLORIDA INSTITUTE OF TECHNOLOGY
Attention Human Resources
150 W. University Blvd.
Melbourne, Florida 32901
- Agent for Service of Legal Process:** FLORIDA INSTITUTE OF TECHNOLOGY
Attention Human Resources
150 W. University Blvd.
Melbourne, Florida 32901

11.2 **Statement of ERISA Rights**

As a participant in the Plan, 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 Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions (SPD). The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared (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 Plan 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 Plan 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 your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

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

If you have any questions about your Plan, 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 Health Reimbursement Account Plan, FLORIDA INSTITUTE OF TECHNOLOGY has caused this Plan to be executed in its name and on its behalf, on this ___ day of _____, 2023.

Date: _____

By: _____

Its: _____

APPENDIX A

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

No Related Employers have adopted this Plan. FLORIDA INSTITUTE OF TECHNOLOGY is the only employer participating in this Plan.

APPENDIX B

MAXIMUM BENEFITS

The maximum dollar amount FLORIDA INSTITUTE OF TECHNOLOGY may credit to an HRA Account for an Employee who participates in the Plan for an entire 12-month Period of Coverage is \$3,120.00.

**APPENDIX C
CREDITING OF HRA**

A Participant's HRA will be credited at the beginning of each calendar month with an amount equal to the applicable maximum dollar limit for the Period of Coverage divided by the number of months in that Period of Coverage (e.g., divided by 12 in a 12-month Plan Year), increased by any carryover of unused HRA balances from prior Periods of Coverage.

APPENDIX D APPEALS PROCEDURE

If your claim for Benefits is denied, then you have the right to be notified of the denial and to appeal the denial, both within certain time limits. The rules regarding denied claims for Benefits under the Plan are discussed below.

A. When must I receive a decision on my claim?

You are entitled to notification of the decision on your claim within 30 days after the Administrator's receipt of the claim. This 30-day period may be extended by an additional period of up to 15 days if the extension is necessary due to conditions beyond the control of the Administrator. The Administrator is required to notify you of the need for the extension and the time by which you will receive a determination on your claim. If the extension is necessary because of your failure to submit the information necessary to decide the claim, then the Administrator will notify you regarding what additional information you are required to submit, and you will be given at least 45 days after such notice to submit the additional information. If you do not submit the additional information, the Administrator will make the decision based on the information that it has.

B. What information will a notice of denial of a claim contain?

If your claim is denied, the notice that you receive from the Administrator will include the following information:

- Information about your claim, including the date of service, health care provider, claim amount, and any diagnosis and treatment code and their corresponding meanings, to the extent such information is available;
- The specific reason for the denial;
- A reference to the specific Plan provision(s) on which the denial is based;
- Any denial code (and its corresponding meaning) that was used in denying the claim;
- A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;
- A description of the Plan's internal and external review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA Section 502(a) following a denial on review; and
- If the Administrator relied on an internal rule, guideline, protocol, or similar criteria in making its determination, either a copy of the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request.

C. Do I have the right to appeal a denied claim?

Yes, you have the right to an internal appeal and, if applicable, an external review to an independent review organization.

D. Do I have to appeal a denied claim before I can go to court?

You will not be allowed to take legal action against the Plan, the Employer, the Administrator, or any other entity

to whom administrative or claims processing functions have been delegated unless you exhaust your *internal* appeal rights. But you do not have to pursue *external* review in order to preserve your right to file a lawsuit. (In fact, as explained later in this Appendix D, you may be unable to take further legal action if you pursue an external appeal because the external appeal process results in a binding determination.)

E. What are the requirements of my internal appeal?

Your internal appeal must be in writing, must be provided to the Administrator, and must include the following information:

- Your name and address;
- The fact that you are disputing a denial of a claim or the Administrator's act or omission;
- The date of the notice that the Administrator informed you of the denied claim; and
- The reason(s), in clear and concise terms, for disputing the denial of the claim or the Administrator's act or omission.

You should also include any documentation that you have not already provided to the Administrator.

F. Is there a deadline for filing my internal appeal?

Yes. Your internal appeal must be delivered to the Administrator within 180 days after receiving the denial notice or the Administrator's act or omission. *If you do not file your internal appeal within this 180-day period, you lose your right to appeal.* Your internal appeal will be heard and decided by the Administrator.

G. How will my internal appeal be reviewed?

Any time before the internal appeal deadline, you may submit copies of all relevant documents, records, written comments, testimony, and other information to the Administrator. The Plan is required to provide you with reasonable access to and copies of all documents, records, and other information related to the claim. When reviewing your internal appeal, the Administrator will take into account all relevant documents, records, comments, and other information that you have provided with regard to the claim, regardless of whether or not such information was submitted or considered in the initial determination.

If the Administrator receives new or additional evidence that it considered, relied upon, or generated in connection with the claim, other than evidence that you have provided to it, you will be provided with this information and given a reasonable opportunity to respond to the evidence before the due date for the Administrator's notice of final internal adverse benefit determination. Similarly, if the Administrator identifies a new or additional reason for denying your claim, that new or additional reason will be disclosed to you, and you will be given a reasonable opportunity to respond to that new rationale before the due date for the Administrator's notice of final internal adverse benefit determination.

The internal appeal determination will not afford deference to the initial determination and will be conducted by a fiduciary of the Plan who is not: (1) the individual who made the original determination; (2) an individual who is a subordinate of the individual who made the initial determination; or (3) an individual whose terms and conditions of employment are affected by the results of his or her decision.

If the internal appeal determination will be based on the medical judgment of a health care professional retained by the Administrator, the health care professional retained for purposes of the internal appeal will not be an individual who was consulted in connection with the determination that is being appealed or any subordinate of that individual.

H. When will I be notified of the decision on my internal appeal?

The Administrator must notify you of the decision on your internal appeal within 60 days after receipt of your request for review.

I. What information is included in the notice of the denial of my internal appeal?

If your internal appeal is denied, the notice that you receive from the Administrator will include the following information:

- Information about your claim, including the date of service, health care provider, claim amount, and any diagnosis and treatment code and their corresponding meanings, to the extent such information is available;
- The specific reason for the denial upon review;
- A reference to the specific Plan provision(s) on which the denial is based;
- Any denial code (and its corresponding meaning) that was used in denying the claim;
- A statement providing that you are required to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits;
- If an internal rule, guideline, protocol, or similar criterion was relied upon in making the review determination, either the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the review determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request; and
- A statement of your right to bring an external appeal or a civil action under ERISA Section 502(a).

J. Do I have the right to seek a review of a denied claim to an external third party?

You have the right to an external review of the Administrator's denial of your internal appeal unless the Benefit denial was based on your (or your Spouse's or Dependent's) failure to meet the Plan's eligibility requirements.

K. What are the requirements of my external review?

Please contact the Administrator for additional details regarding the process for requesting external review under the Plan.

L. Is there a deadline for filing my external appeal?

Yes. Your external appeal must be filed with the external reviewer within 4 months of the date you were served with the Administrator's response to your internal appeal request. If you do not file your appeal within this 4-month period, you lose your right to appeal. For example, if you received the internal appeal decision on

January 3, 2023, you must appeal the decision by May 3, 2023 (or, if that is not a business day, the next business day thereafter).

M. When will I be notified of the decision on my external appeal?

The external reviewer must notify you and the Administrator of its decision on your external appeal within 45 days after its receipt of your request for external review. The external reviewer's decision is binding upon the parties unless other State or Federal law remedies are available. Such remedies may or may not exist. Therefore, unless another legal right exists under your claim, use of the external review process may terminate your right to bring a lawsuit on your claim.

APPENDIX E

ELIGIBLE AND INELIGIBLE HEALTH CARE EXPENSE LISTING

ABORTION

You can include in medical expenses the amount you pay for a legal abortion.

ACUPUNCTURE

You can include in medical expenses the amount you pay for acupuncture.

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

You can include in medical expenses amounts you pay for an inpatient's treatment at a therapeutic center for alcohol addiction. This includes meals and lodging provided by the center during treatment.

You can also include in medical expenses amounts you pay for transportation to and from alcohol recovery support organization (for example, Alcoholics Anonymous) meetings in your community if the attendance is pursuant to medical advice that membership in Alcoholics Anonymous is necessary for the treatment of a disease involving the excessive use of alcohol.

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

You can include in medical expenses amounts you pay for ambulance service.

ANNUAL PHYSICAL EXAMINATION

See *Physical Examination, later*.

ARTIFICIAL LIMB

You can include in medical expenses the amount you pay for an artificial limb.

ARTIFICIAL TEETH

You can include in medical expenses the amount you pay for artificial teeth.

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.

BABYSITTING, CHILDCARE, AND NURSING SERVICES FOR A NORMAL, HEALTHY BABY

You can't include in medical expenses amounts you pay for the care of children, even if the expenses enable you, your spouse, or your dependent to get medical or dental treatment. Also, any expense allowed as a childcare credit can't be treated as an expense paid for medical care.

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.

BANDAGES

You can include in medical expenses the cost of medical supplies such as bandages.

BODY SCAN

You can include in medical expenses the cost of an electronic body scan.

BRILLE BOOKS AND MAGAZINES

You can include in medical expenses the part of the cost of Braille books and magazines for use by a visually im- paired person that is more than the cost of regular printed editions.

BREAST AUGMENTATION

See Cosmetic Surgery and Procedures.

BREAST PUMPS AND SUPPLIES

You can include in medical expenses the cost of breast pumps and supplies that assist lactation. This doesn't include the costs of excess bottles for food storage.

BREAST RECONSTRUCTION SURGERY

You can include in medical expenses the amounts you pay for breast reconstruction surgery, as well as breast prosthesis, following a mastectomy for cancer. *See Cosmetic Surgery, later.*

CAPITAL EXPENSES

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 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. \$ _____

Operation and upkeep. Amounts you pay for operation and upkeep of a capital asset qualify as medical expenses as long as the main reason for them is medical care. This rule applies even if none or only part of the original cost of the capital asset qualified as a medical care expense.

Improvements to property rented by a person with a disability. Amounts paid to buy and install special plumbing fixtures for a person with a disability, mainly for medical reasons, in a rented house are medical expenses.

Example. John has arthritis and a heart condition. He can't climb stairs or get into a bathtub. On his doctor's advice, he installs a bathroom with a shower stall on the first floor of his two-story rented house. The landlord didn't pay any of the cost of buying and installing the special plumbing and didn't lower the rent. John can include in medical expenses the entire amount he paid.

CAR

You can include in medical expenses the cost of special hand controls and other special equipment installed in a car for the use of a person with a disability.

Special design. You can include in medical expenses the difference between the cost of a regular car and a car specially designed to hold a wheelchair.

Cost of operation. The includible costs of using a car for medical reasons are explained under Transportation, later.

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

You can include in medical expenses fees you pay to a chiropractor for medical care.

CHRISTIAN SCIENCE PRACTITIONER

You can include in medical expenses fees you pay to Christian Science practitioners for medical care.

CONCIERGE 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.

CONTACT LENSES

You can include in medical expenses amounts you pay for contact lenses needed for medical reasons. You can also include the cost of equipment and materials required for using contact lenses, such as saline solution and enzyme cleaner. See Eyeglasses and Eye Surgery, later.

COSMETIC SURGERY AND PROCEDURES

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.

CONTROLLED SUBSTANCES

You can't include in medical expenses amounts you pay for controlled substances (such as marijuana, laetrile, etc.

COSMETIC SURGERY

Generally, you can't include in medical expenses the amount you pay for cosmetic surgery. This includes any procedure that is directed at improving the patient's appearance and doesn't meaningfully promote the proper function of the body or prevent or treat illness or disease. You generally can't include in medical expenses the amount you pay for procedures such as facelifts, hair transplants, hair removal (electrolysis), and liposuction.

You can include in medical expenses the amount you pay for cosmetic surgery if it is necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease.

Example. An individual undergoes surgery that re- moves a breast as part of treatment for cancer. She pays a surgeon to reconstruct the breast. The surgery to reconstruct the breast corrects a deformity directly related to the disease. The cost of the surgery is included in her medical expenses.

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 is 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

You can include in medical expenses the amount you pay to buy or rent crutches.

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

You can include in medical expenses the amounts you pay for the prevention and alleviation of dental disease. 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 includes 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.

DIAGNOSTIC DEVICES

You can include in medical expenses the cost of devices used in diagnosing and treating illness and disease.

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.

DIAPER SERVICE

You can't include in medical expenses the amount you pay for diapers or diaper services unless they are needed to relieve the effects of a particular disease.

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
- Chiropodist
- Chiropractor
- Christian Science Practitioner
- Dentist
- Dermatologist
- Gynecologist
- Neurologist
- Obstetrician
- Oculist

- Ophthalmologist
- Optician
- Orthodontist
- Orthopedist
- Osteopath
- Pediatrician
- Physician
- Physiotherapist
- Podiatrist
- Psychiatrist

Other

- Charges for transfer of medical records are eligible.
- Charges for use of a 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 the delivery of the infant are reimbursable. Charges, where the primary purpose is childcare after delivery, are not covered.

Disabled Dependent Care Expenses

Some disabled dependent care expenses may qualify as either:

- Medical expenses, or
- Work-related expenses for purposes of taking a credit for dependent care. See *ICUBA DCSA Plan document*, and *IRS Publication 503* <https://www.irs.gov/forms-pubs/about-publication-503> for, *Child and Dependent Care Expenses*.

You can choose to apply them either way as long as you don't use the same expenses to claim both a credit and a medical expense deduction.

DRUG ADDICTION

You can include in medical expenses amounts you pay for an inpatient's treatment at a therapeutic center for drug addiction. This includes meals and lodging provided by the center during treatment.

You can also include in medical expenses amounts you pay for transportation to and from drug treatment meetings in your community if the attendance is pursuant to medical advice that the membership is necessary for the treatment of a disease involving the excessive use of drugs.

DRUGS

See Medicines, later.

ELECTROLYSIS OR HAIR REMOVAL

See Cosmetic Surgery, earlier.

EYE EXAM

You can include in medical expenses the amount you pay for eye examinations.

EYEGLASSES

You can include in medical expenses amounts you pay for eyeglasses and contact lenses needed for medical reasons. See Contact Lenses, earlier, for more information.

EYE SURGERY

You can include in medical expenses the amount you pay for eye surgery to treat defective vision, such as laser eye surgery or radial keratotomy.

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.*

FAMILY/GROUP THERAPY

Expenses for family, group, or marriage therapy are not reimbursable

FERTILITY ENHANCEMENT

You can include in medical expenses the cost of the following procedures performed on yourself, your spouse, or your dependent to overcome an inability to have children.

- Procedures such as in vitro fertilization (including temporary storage of eggs or sperm).
- Surgery, including an operation to reverse prior surgery that prevented the person operated on from having children.

FOUNDER'S FEE

See Lifetime Care—Advance Payments, later.

FUNERAL EXPENSES

Expenses for funerals are not eligible for reimbursement.

FUTURE MEDICAL CARE

Generally, you can't include in medical expenses current payments for medical care (including medical insurance) to be provided substantially beyond the end of the year. This rule doesn't apply in situations where the future care is purchased in connection with obtaining lifetime care, as explained under Lifetime Care—

Advance Payments, or qualified long-term care insurance contracts, as explained under Long-Term Care, earlier.

GUIDE DOG OR OTHER SERVICE ANIMAL

You can include in medical expenses the costs of buying, training, and maintaining a guide dog or other service animal to assist a visually impaired or hearing disabled person, or a person with other physical disabilities. In general, this includes any costs, such as food, grooming, and veterinary care, incurred in maintaining the health and vitality of the service animal so that it may perform its duties.

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 and the physician issues a statement that the treatment is necessary to alleviate a physical or mental disability or illness of the individual receiving the treatment.

HEARING AIDS

You can include in medical expenses the cost of a hearing aid and batteries, repairs, and maintenance needed to operate it.

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 a home medical test such as pregnancy test, ovulation test and kits, semen analysis kits, and drug tests are reimbursable.

HOME CARE

See Nursing Services, later.

HOME IMPROVEMENTS

See Capital Expenses, earlier.

HOSPITAL SERVICES

You can include in medical expenses amounts you pay for the cost of inpatient care at a hospital or similar institution if a principal reason for being there is to receive medical care. This includes amounts paid for meals and lodging. Also see Lodging, later.

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*.

ILLEGAL OPERATIONS AND TREATMENTS

You can't include in medical expenses amounts you pay for illegal operations, treatments, or controlled substances whether rendered or prescribed by licensed or unlicensed practitioners.

INSURANCE PREMIUMS

You can include in medical expenses insurance premiums you pay for policies that cover medical care. Medical care policies can provide payment for treatment that includes:

- Hospitalization, surgical services, X-rays;
- Prescription drugs and insulin;
- Dental care;
- Replacement of lost or damaged contact lenses; and
- Long-term care (subject to additional limitations). See Qualified Long-Term Care Insurance Contracts under Long-Term Care, later.

If you have a policy that provides payments for other than medical care, you can include the premiums for the medical care part of the policy if the charge for the medical part is reasonable. The cost of the medical part must be separately stated in the insurance contract or given to you in a separate statement.

You cannot include premiums you pay for:

- Life insurance policies.
- Policies providing payment for loss of earnings.
- Policies for loss of life, limb, sight, etc.
- Policies that pay you a guaranteed amount each week for a stated number of weeks if you are hospitalized for sickness or injury.
- The part of your car insurance premiums that provides medical insurance coverage for all persons injured in or by your car because the part of the premium for you, your spouse, and your dependents is not stated separately from the part of the premium for medical care for others.
- Health or long-term care insurance if you elected to pay these premiums with tax-free distributions from a retirement plan made directly to the insurance provider and these distributions would otherwise have been included in income.

- Taxes imposed by any governmental unit, such as Medicare taxes, are not insurance premiums.

Medicare Part A

If you are covered under social security (or if you are a government employee who paid Medicare tax), you are enrolled in Medicare Part A. The payroll tax paid for Medicare Part A isn't a medical expense.

If you aren't covered under social security (or weren't a government employee who paid Medicare tax), you can voluntarily enroll in Medicare Part A. In this situation, you can include the premiums you paid for Medicare Part A as a medical expense.

Medicare Part B

Medicare Part B is supplemental medical insurance. Premiums you pay for Medicare Part B are a medical expense. Check the information you received from the Social Security Administration to find out your premium.

Medicare Part D

Medicare Part D is a voluntary prescription drug insurance program for persons with Medicare Part A or B. You can include as a medical expense premium you pay for Medicare Part D.

PREPAID INSURANCE PREMIUMS

Premiums you pay before you are age 65 for insurance for medical care for yourself, your spouse, or your dependents after you reach age 65 are medical care expenses in the year paid if they are:

- Payable in equal yearly installments or more often; and
- Payable for at least 10 years, or until you reach age 65 (but not for less than 5 years).

LABORATORY FEES

You can include in medical expenses the amounts you pay for laboratory fees that are part of medical care.

LACTATION EXPENSES

See Breast Pumps and Supplies, earlier.

LEAD-BASED PAINT REMOVAL

You can include in medical expenses the cost of removing lead-based paints from surfaces in your home to prevent a child who has or had lead poisoning from eating the paint. These surfaces must be in poor repair (peeling or cracking) or within the child's reach. The cost of repainting the scraped area isn't a medical expense.

If, instead of removing the paint, you cover the area with wallboard or paneling, treat these items as capital expenses. See Capital Expenses, earlier. Don't include the cost of painting the wallboard as a medical expense.

LEGAL FEES

You can include in medical expenses legal fees you paid that are necessary to authorize treatment for mental illness. However, you can't include in medical expenses fees for the management of a guardianship estate, fees for conducting the affairs of the person being treated, or other fees that aren't necessary for medical care.

LEARNING DISABILITY

See Special Education, later.

LIFETIME CARE—ADVANCE PAYMENTS

You can include in medical expenses a 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. 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 can't include in medical expenses current payments for medical care (including medical insurance) to be provided substantially beyond the end of the year. This rule doesn't apply in situations where future care is purchased in connection with obtaining lifetime care of the type described earlier.

LODGING

You can include in medical expenses the cost of meals and lodging at a hospital or similar institution if a principal reason for being there is to receive medical care. See Nursing Home, later.

You may be able to include in medical expenses the cost of lodging not provided in a hospital or similar institution. You can include the cost of such lodging while away from home if all of the following requirements are met.

- The lodging is primarily for and essential to medical care.
- The 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.
- The lodging isn't lavish or extravagant under the circumstances.
- There is no significant element of personal pleasure, recreation, or vacation in the travel away from home.

The amount you include in medical expenses for lodging can't be more than \$50 for each night for each person. You can include lodging for a person traveling with the person receiving the medical care. For example, if a parent is traveling with a sick child, up to \$100 per night can be included as a medical expense for lodging. Meals aren't included.

Don't include the cost of lodging while away from home for medical treatment if that treatment isn't received from a doctor in a licensed hospital or in a medical care facility related to, or the equivalent of, a licensed hospital or if that lodging isn't primarily for or essential to the medical care received.

LONG-TERM CARE

You can include in medical expenses amounts paid for qualified long-term care services and certain amounts of premiums paid for qualified long-term care insurance contracts.

QUALIFIED LONG-TERM CARE SERVICES

Qualified long-term care services are necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, re-habilitative services, and maintenance and personal care services (defined later) that are:

- Required by a chronically ill individual, and
- Provided pursuant to a plan of care prescribed by a licensed health care practitioner.

Chronically ill individual. An individual is chronically ill if, within the previous 12 months, a licensed health care practitioner has certified that the individual meets either of the following descriptions.

- He or she is unable to perform at least two activities of daily living without substantial assistance from other individuals for at least 90 days, due to a loss of functional capacity. Activities of daily living are eating, toileting, transferring, bathing, dressing, and continence.
- He or she requires substantial supervision to be protected from threats to health and safety due to severe cognitive impairment.

Maintenance and personal care services. Maintenance or personal care services is care that has as its primary purpose the providing of a chronically ill individual with needed assistance with his or her disabilities (including protection from threats to health and safety due to severe cognitive impairment).

QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS

- A qualified long-term care insurance contract is an insurance contract that provides only coverage of qualified long-term care services. The contract must:
- Be guaranteed renewable;
- Not provide for a cash surrender value or other money that can be paid, assigned, pledged, or borrowed;
- Provide those refunds, other than refunds on the death of the insured or complete surrender or cancellation of the contract, and dividends under the contract must be used only to reduce future premiums or increase future benefits; and
- Generally not pay or reimburse expenses incurred for services or items that would be reimbursed under Medicare, except where Medicare is a secondary payer, or the contract makes per diem or other periodic payments without regard to expenses.

The amount of qualified long-term care premiums you can include is limited. You can include the following as medical expenses on Schedule A (Form 1040).

- Qualified long-term care premiums up to the following amounts.
 - a) Age 40 or under—\$450.
 - b) Age 41 to 50—\$850.
 - c) Age 51 to 60—\$1,690.
 - d) Age 61 to 70—\$4,520.
 - e) Age 71 or over—\$5,640.
- Unreimbursed expenses for qualified long-term care services.

Note. The limit on premiums is for each person.

Also, if you are an eligible retired public safety officer, you can't include premiums for long-term care insurance if you elected to pay these premiums with tax-free distributions from a qualified retirement plan made directly to the insurance provider and these distributions would otherwise have been included in your income.

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

You can include in medical expenses the cost of meals at a hospital or similar institution if a principal reason for being there is to get medical care.

You can't include in medical expenses the cost of meals that aren't part of inpatient care. Also see Weight-Loss Program and Nutritional Supplements, later.

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

You can include in medical expenses 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. 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 isn't deductible as a medical expense.

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 PLAN

You can include in medical expenses 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.

MEDICINES

You can include in medical expenses amounts you pay for prescribed medicines and drugs. A prescribed drug is one that requires a prescription by a doctor for its use by an individual. You can also include amounts you pay for insulin. Except for insulin, you can't include in medical expenses amounts you pay for a drug that isn't prescribed.

Imported medicines and drugs. If you imported medicines or drugs from other countries, see Medicines and Drugs From Other Countries under What Expenses Aren't Includible, later.

MEDICINES AND DRUGS FROM OTHER COUNTRIES

In general, you can't include in your medical expenses the cost of a prescribed drug brought in (or ordered and shipped) from another country. You can only include the cost of a drug that was imported legally. For example, you can include the cost of a prescribed drug the Food and Drug Administration announces can be legally imported by individuals.

You can include the cost of a prescribed drug you purchase and consume in another country if the drug is legal in both the other country and the United States.

NURSING HOME

You can include in medical expenses the cost of medical care in a nursing home, home for the aged, or similar institution, for yourself, your spouse, or your dependents. This includes the cost of meals and lodging in the home if a principal reason for being there is to get medical care.

Don't 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.

Employment taxes. You can include as a medical expense social security tax, FUTA, Medicare tax, and state employment taxes you pay for an attendant who provides medical care. If the attendant also provides personal and household services, you can include as a medical expense only the amount of employment taxes paid for medical services, as explained earlier. For information on employment tax responsibilities of household employers, see Pub. 926.

OPERATIONS

You can include in medical expenses amounts you pay for legal operations that aren't for cosmetic surgery. See Cosmetic Surgery under What Expenses Aren't Includible, later.

OPTOMETRIST

See Eyeglasses, earlier.

Organ Donors

See Transplants, later.

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.

OSTEOPATH

You can include in medical expenses amounts you pay to an osteopath for medical care.

OVER-THE-COUNTER MEDICINES AND DRUGS

The CARES Act of March 2020 expanded the benefits FSAs and HRAs by removing the prescription requirement for several OTC drugs and medicines, and by adding feminine hygiene products to the list of expenses eligible for reimbursement. Some of the most common items that removed the prescription requirement include:

- Cold, cough, and flu medicine
- Cups, tampons, pads, liners, and disposable and non-disposable period underwear
- Pain relievers and anti-inflammatory medications
- Allergy and sinus medicine
- Digestive aids and laxatives
- Baby rash ointments and creams
- Baby electrolytes
- Sleep aids
- Skin treatments for conditions such as eczema and psoriasis
- Acid controllers
- Acne medications

Items that will continue to be eligible without a doctor's prescription after March 2020 include, but are not limited to 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.

OXYGEN

You can include in medical expenses amounts you pay for oxygen and oxygen equipment to relieve breathing problems caused by a medical condition.

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.

PHYSICAL EXAMINATION

You can include in medical expenses the amount you pay for an annual physical examination and diagnostic tests by a physician. You don't have to be ill at the time of the examination.

PHYSICAL THERAPY

Payments made to an individual for giving patterning exercises to a mentally or physically 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.

PREGNANCY TEST KIT

You can include in medical expenses the amount you pay to purchase a pregnancy test kit to determine if you are pregnant.

PRIVATE HOSPITAL ROOM

The extra cost of a private hospital room is reimbursable.

PROSTHESIS

See Artificial Limb and Breast Reconstruction Surgery, earlier.

PSYCHIATRIC CARE

You can include in medical expenses amounts you pay for psychiatric care. This includes the cost of supporting a mentally ill dependent at a specially equipped medical center where the dependent receives medical care. See Psychoanalysis next and Transportation, later.

PSYCHOANALYSIS

You can include in medical expenses payments for psychoanalysis. However, you can't include payments for psychoanalysis which is part of the required training to be a psychoanalyst.

PSYCHOLOGIST

You can include in medical expenses amounts you pay to a psychologist for medical care.

RADON REMEDIATION

Expenses incurred to remove radon from the residence are reimbursable.

SAVINGS CLUB

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

SHIPPING CHARGES

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

SPECIAL EDUCATION

You can include in medical expenses fees you pay 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 learning disabilities caused by mental or physical impairments, including nervous system disorders.

You can include in medical expenses the cost (tuition, meals, and lodging) of attending a school that furnishes special education to help a child to overcome learning disabilities. Overcoming the learning disabilities must be the primary reason for attending the school and any ordinary education received must be incidental to the special education provided. Special education includes:

- Teaching Braille to a visually impaired person,
- Teaching lip reading to a hearing disabled person, or
- Giving remedial language training to correct a condition caused by a birth defect.

You can't include in medical expenses the cost of sending a child with behavioral problems to a school where the course of study and the disciplinary methods have a beneficial effect on the child's attitude if the availability of medical care in the school isn't a principal reason for sending the student there.

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 is 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

You can include in medical expenses the cost of a legal sterilization (a legally performed operation to make a person unable to have children). Also see Vasectomy, later.

STOP-SMOKING PROGRAMS

You can include in medical expenses amounts you pay for a program to stop smoking. However, you can't include in medical expenses amounts you pay for drugs that don't require a prescription, such as nicotine gum or patches, that are designed to help stop smoking.

SUBSTANCE ABUSE

See Alcoholism, Drug or Substance Abuse.

SUNSCREEN

Sunscreen with SPF 15+ and "broad spectrum" are reimbursable. SPF<15 and suntan lotion are not reimbursable

SURGERY

See Operations, earlier.

TEETH WHITENING

You can't include in medical expenses amounts paid to whiten teeth. See Cosmetic Surgery, earlier.

TELEPHONE

You can include in medical expenses the cost of special telephone equipment that lets a person who is deaf, hard of hearing, or has a speech disability communicate over a regular telephone. This includes teletypewriter (TTY) and telecommunications device for the deaf (TDD) equipment. You can also include the cost of repairing the equipment.

TELEVISION

YOU CAN INCLUDE in medical expenses the cost of equipment that displays the audio part of television programs as subtitles for persons with a hearing disability. This may be the cost of an adapter that attaches to a regular set. It may also be the part of the cost of a specially equipped television that exceeds the cost of the same model regular television set.

THERAPY

You can include in medical expenses amounts you pay for therapy received as medical treatment.

TRANSPLANTS

You can include in medical expenses amounts paid for the medical care you receive because you are a donor or a possible donor of a kidney or other organ. This includes transportation.

You can include any expenses you pay for the medical care of a donor in connection with the donation of an organ to you, your spouse, or your dependent. This includes 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 \$.24 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 \$.24 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

You can include in medical expenses amounts you pay for transportation to another city if the trip is primarily for, and essential to, receiving medical services. You may be able to include up to \$50 for each night for each person. You can include lodging for a person traveling with the person receiving the medical care. For example, if a parent is traveling with a sick child, up to \$100 per night can be included as a medical expense for lodging. Meals aren't included. See Lodging, earlier.

You can't 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, earlier.

TUITION

Under special circumstances, you can include charges for tuition in medical expenses. See Special Education, earlier.

A lump-sum fee that includes education, board, and medical care—without distinguishing which part of the fee results from medical care—is not considered an amount payable for medical care. However, you can include charges for a health plan included in a lump-sum tuition fee if the charges are separately stated or can easily be obtained from the school.

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.

VASECTOMY

You can include in medical expenses the amount you pay for a vasectomy.

VETERINARY FEES

You generally can't include veterinary fees in your medical expenses but see Guide Dog or Other Service Animal under What Medical Expenses Are Includible, earlier.

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.

VISION CORRECTION SURGERY

See Eye Surgery, earlier.

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 PROGRAM

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.

You can't include in medical expenses the cost of a weight-loss program if the purpose of the weight loss is the improvement of appearance, general health, or sense of well-being. You can't include amounts you pay to lose weight unless the weight loss is a treatment for a specific disease diagnosed by a physician (such as obesity, hypertension, or heart disease). If the weight-loss treatment isn't for a specific disease diagnosed by a physician, you can't include either the fees you pay for membership in a weight-reduction group or fees for attendance at periodic meetings. Also, you can't include membership dues in a gym, health club, or spa.

You can't 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.

See Weight-Loss Program under What Medical Expenses Are Includible, earlier.

WHEELCHAIR

YOU CAN INCLUDE in medical expenses the amounts you pay for a wheelchair used for the relief of a sickness or disability. The cost of operating and maintaining the wheelchair is also a medical expense.

WIG

You can include in medical expenses the cost of a wig purchased upon the advice of a physician for the mental health of a patient who has lost all of his or her hair from disease.

X-RAY

You can include in medical expenses amounts you pay for X-rays for medical reasons.