

**YOUR
FLEXIBLE SPENDING ACCOUNT
Plan Document
APRIL 1, 2008**

THIS DOCUMENT IS INTENDED FOR ALL EMPLOYEES AND OTHER BENEFICIARIES ELIGIBLE FOR AND/ OR CURRENTLY RECEIVING COVERAGE FOR BENEFITS UNDER A FLEXIBLE SPENDING ACCOUNT

INDEPENDENT COLLEGES AND UNIVERSITIES BENEFITS ASSOCIATION, INC.



THIS PLAN DOCUMENT CONSTITUTES THE SUMMARY PLAN DESCRIPTION REQUIRED BY ERISA SECTION 102.

This Plan Document Includes a Rider that must be read with the entirety of this document.

TABLE OF CONTENTS

Introduction	4
Eligibility and Participation.....	5
Enrollment and Participation Requirements	6
Election Procedures.....	6
When Participation Ends.....	6
Changes of Elections Due to Status	6
Termination of Employment	8
Death	8
Non-Discrimination Requirements	8
Reimbursement Credits	8
Reimbursement Options	8
Flexible Spending Accounts May Affect Your Social Security Benefit	9
Health Care Spending Accounts.....	9
Eligible Health and Dental Care Expenses	9
Eligible and Ineligible Health Care Expense Listing.....	9
Contribution Decisions	23
Health Care Spending Account Limitations	23
At Year End.....	23
Optional Continuation Coverage.....	23
The Heroes Earning Assistance and Relief Tax Act of 2008	23
Dependent Care Spending Accounts.....	23
Eligible Dependent Care Expenses	23
Contribution Decisions	24
Dependent Care Spending Account Limitations	24
At Year End.....	24
Reimbursements Affect Your Eligibility for the Dependent Care Credit	24
Annual Statement of Reimbursements	24
Debit Card.....	25
How to File Claims From Your Health Care Spending Account.....	27
How to File An Appeal	30
How to File Claims For Your Dependent Care Spending Account	32
How to File An Appeal	32
COBRA Continuation Options.....	33
Responsibilities for Plan Administration	39
Rights of Plan Participants	42
General Plan Information	44
Definitions	45
Rider 1	47

INTRODUCTION

Your Employer has established these Flexible Spending Accounts (FSA) to provide You with additional health coverage benefits. The FSA is meant to comply with The Employee Retirement Income Security Act of 1974 (ERISA), as amended and other Regulations promulgated there under, as amended from time to time. This document and any amendments constitute the governing document of the FSA. The FSA is designed and administered exclusively for the Employees of participating Institutions. You are entitled to this coverage if the provisions in this document have been satisfied. Oral statements or representations by anyone, which are contrary to this document, are not authoritative sources of information and may not be relied upon. The benefits of the FSA are outlined in this Plan Document.

Flexible Spending Accounts are permitted for medical reimbursement, dependent care assistance and adoption expenses. These are types of Cafeteria Plans that offer You an ability to fund certain qualified benefits on a pre-tax basis through a salary reduction agreement. You specifically determine how much You will contribute towards the Health Care Spending Account (HCSA) and the Dependent Care Spending Account (DCSA). Throughout the Plan year, as You and/or Your eligible dependents incur covered expenses, You may use Your FSA to pay for those expenses. Independent Colleges & Universities Benefits Association, Inc. (ICUBA) is the Administrator of the Flexible Spending Account Plan, which offers employees a choice between two "cafeteria plan" options: Health Care Spending Account and a Dependent Care Spending Account (DCSA). Each is established by Your Employer within the requirements of Internal Revenue Code Section 125. This document describes a HCSA as defined under Internal Revenue Code Sections 105 and 106 and a DCSA as defined under Code Section 129. This plan is designed to provide You with the opportunity to elect deductions from Your paycheck on a pretax basis to be used for reimbursements for health care expenses and/or dependent care not otherwise covered under other plans and/or reimbursements. You may access Your election through use of the ICUBA Benefits Card™. You can access the account balance 24 hours a day on the Internet at <http://icubabenefits.org>. As used in this document, the word Year refers to the Benefit Year which is the 12 month period beginning April 1 and ending March 31. This document is intended to give You a summary of the plan offered by Your Employer. It is not a contract between Your Employer and You. Your Employer intends to continue the plan, but reserve the right, in their sole discretion, to Amend, modify in any manner, or terminate the Plan at any time, which may result in the modification or termination of Your coverage. Expenses incurred prior to the Plan modification or termination will be paid as provided under the terms of the Plan prior to its modification or termination.

ELIGIBILITY AND PARTICIPATION

Who is Eligible?

You are eligible for coverage under an ICUBA Flexible Spending Account (FSA) if You are an Active, full-time Employee of an ICUBA member institution and You are a legal resident of the United States or Canada. An Active Employee is an employee who is on the regular payroll of the Institution and who has begun to perform the duties of his or her job with the Institution on a full-time basis, as defined as follows:

- a. An Employee regularly scheduled to work at a position for a minimum of 75% of a work week as defined by the Member and shall not be less than 28 hours per week;
- b. A faculty member under an academic contract for a minimum of 18 undergraduate semester credit hours annualized, or equivalent, during the academic year;
- c. An Employee on an Approved Leave of Absence;
- d. An Employee on an Approved Sabbatical; or
- e. An Employee on an Approved Disability Leave.

Who is Not Eligible?

The following are not eligible to participate in the ICUBA FSA Plan:

- a. Leased employees;
- b. Collectively bargained employees, unless an agreement between the Member and the collectively bargained group specifies coverage for such individuals;
- c. Temporary employee;
- d. A member of the Member's Board of Directors, unless engaged in the conduct of the business on a full time basis;
- e. An independent contractor or consultant who is paid on other than a regular wage or salary;
- f. A student employee;
- g. Adjunct faculty; or
- h. Employees who terminate employment with their institution and are rehired during the same Year as the termination may not participate in this Plan for the remainder of the Plan Year if he/she revokes their existing benefit elections.

ENROLLMENT AND PARTICIPATION REQUIREMENTS

You must enroll during the Enrollment Period before the beginning of each Plan Year. If You are hired after the beginning of the Year, You must enroll within 30 days of Your eligibility date or Your enrollment will be delayed until the next regular Enrollment Period. All applicable forms must be returned to Your Employer or You may make Your election online at <http://icubabenefits.org> or provide Your Employer with an Enrollment Form entered on-line or before the last day of the Enrollment Period.

ELECTION PROCEDURES

Benefits under this Plan are financed by amounts You elect to have deducted from Your paycheck during the Plan Year and deposited into Your Flexible Spending Account (FSA). You must decide on the amount to be deposited and designate this amount during the Enrollment Period before the beginning of the Year. If You choose to participate, Your reimbursement accounts make it possible for You to pay certain Eligible Expenses with salary reductions. This money is free from federal income tax and Social Security taxes, as well as most state and local income taxes. Because Your reimbursement account deposits are not taxed, You gain a significant tax advantage; however, if You receive reimbursement for an expense under this Plan, You cannot claim a federal income tax credit or deduction for that expense.

An important point to keep in mind is that the government applies certain rules to these accounts in exchange for the tax advantage. After You determine the amount of Your salary reduction, You can only change Your decision if You have a qualifying change in status. It is also crucial to remember that You must use all the money in Your account for expenses incurred before the Year ends. Any money You do not use will be forfeited. This forfeiture rule makes it important that You plan the use of Your account(s) carefully.

WHEN PARTICIPATION ENDS

Subject to any health care continuation rights in the health care reimbursement plan, Your participation ends on the earlier of the date You terminate employment with Your Employer, the date no further deposits can be made to Your flexible spending account, or the date You are no longer eligible to participate in this Plan, or the date the Plan ends. Your Employer and ICUBA intend that the Plan will continue, but reserve the right, in their sole discretion, to Amend, modify in any manner or terminate Plan at any time, which may result in the modification or termination of Your coverage. Expenses incurred prior to the Plan modification or termination will be paid as provided under the terms of the Plan prior to its modification or termination.

CHANGES OF ELECTIONS DUE TO STATUS

You may change Your election decisions during the Year only if You have a qualifying change in status. This may result in You, Your spouse or Your dependent gaining or losing eligibility for coverage and the election change corresponds with that gain or loss of coverage. Qualifying status changes include the following:

- Legal Marital Status: Events that change Your legal marital status, including marriage, death of spouse, divorce, legal separation or annulment;
- Number of Dependents: Events that change the number of eligible Dependents, including regaining eligibility status (i.e. returning to school full-time), birth, adoption, placement for adoption, or death of a Dependent;
- Employment Status: Events that change employment status such as termination or

commencement of You, Your spouse's or Your dependent's employment, a reduction or increase in hours of employment by You, Your spouse, or Your Dependent, including a switch between part-time and full-time, a strike or lockout, commencement or return from an unpaid leave of absence, and any change in Your spouse or Dependent's employment status that results in that person becoming (or ceasing to be eligible) under a Plan;

- Dependent Satisfies or Ceases to Satisfy the Requirements for Unmarried Dependents;
- Residence or Worksite: A change in the place of residence or work for You, Your spouse, or Your Dependent; or
- Other Events:

Judgment, Decree or Order. If You are subject to a judgment, decree or order resulting from a divorce or similar proceeding that requires You to provide medical coverage for Your child, subject to the Employer's approval, You may make a corresponding change in Your election. If Your former spouse or another individual is required to provide coverage for Your child pursuant to such a judgment, decree or order, subject to the Employer's approval, You may make a corresponding change in Your election.

Medicare/Medicaid Coverage. If You, Your spouse, or Your dependent becomes entitled to Medicare or Medicaid or loses eligibility, a corresponding election change is permitted.

Eligibility for COBRA. If You, Your spouse or Your dependent becomes eligible for and elects COBRA under the Plan, You may make a corresponding election to pay for the continuation coverage.

Family and Medical Leave Act: if You take leave under the Family and Medical Leave Act of 1993 ("FMLA") You make other elections concerning group health coverage that are permitted by FMLA.

Significant Cost Increases. If the cost of benefits significantly increases during a Plan Year, as determined by the Employer, You may elect to increase Your election or You may elect coverage under another benefit option, if any, that offers similar coverage, as determined by the Employer.

Coverage Changes. If coverage under a benefit option is significantly curtailed during a Plan Year, as determined by the Employer, You may revoke Your election or elect coverage under another benefit option that offers similar coverage, as determined by the Employer and may make a corresponding change in Your election. If the Employer adds a new benefit option during a Plan Year, You may elect the new benefit option.

Changes under another Employer's Plan. You may also change Your elections to correspond to certain changes that Your spouse or a dependent makes to his or her benefit elections under a benefit Plan offered by his or her Employer. These rights are subject to conditions or restrictions that may be imposed by the Employer or any insurance company providing benefits under the Plan.

You must notify the Plan Administrator, in writing, within 30 days of a change in status and comply with all other Plan provisions and requirements. Modified elections are effective when the form is received and approved by the Plan Administrator.

TERMINATION OF EMPLOYMENT

If You terminate employment, no further deposits can be made to Your health care spending account unless You elect Continuation of Coverage (COBRA) under federal law. If You elect COBRA under federal law, You must continue to make contributions to Your health care spending account on an after-tax basis based on the elections You made prior to the beginning of the Year, and may submit requests for reimbursements for expenses incurred through the end of the Year. If You do not make the required after-tax contributions, Your benefits will cease at that time. If You do not elect COBRA under federal law and have a balance remaining in Your health care spending account, You will be able to submit requests for reimbursement within 90 days of the time that Your active benefits terminated, but only for expenses incurred prior to the termination date.

DEATH

If You should pass away with a balance in Your account, Your beneficiary will be able to submit requests for reimbursement for expenses incurred through the end of the Plan Year (04/01-03/31) for You or one of Your Dependents.

NON-DISCRIMINATION REQUIREMENTS

The Plan will comply with all federal tax law requirements necessary to obtain the tax benefits of a cafeteria Plan, including the requirements that the Plan not discriminate in favor of certain "key employees" or "highly compensated employees." If You are a highly compensated or key employee, the amount of Your salary reduction may be limited.

REIMBURSEMENT CREDITS

Each Year, Your Employer will credit Your reimbursement account(s) in the form of Flex Dollars equal to the amount of Your salary reductions. The maximum amount that may be contributed to Your reimbursement accounts for any Year, including salary reduction amounts, cannot exceed that amount determined by Your Employer. You may elect to contribute a maximum of \$5,000 to Your Dependent Care Spending Account and a maximum amount determined by Your Employer to Your Health Care Spending Account.

REIMBURSEMENT OPTIONS

You may choose to have Your Flex Dollars deposited in a reimbursement account under one or more of the following plans:

- The Health Care Spending Account.
- The Dependent Care Spending Account.

All Flex Dollars will be credited on a pro rata basis for each pay period during the Year. If You do not elect to have any Flex Dollars credited to either the health care or dependent care spending account plan, You will receive Your normal compensation.

FLEXIBLE SPENDING ACCOUNTS MAY AFFECT YOUR SOCIAL SECURITY BENEFIT

Because the reimbursement account and other before-tax benefit costs reduce the amount You pay in Social Security taxes, they may cause Your benefits from Social Security to be reduced.

HEALTH CARE SPENDING ACCOUNTS

The Health Care Spending Account (HCSA) enables You to be reimbursed with pretax dollars for expenses which are not covered by Your medical, dental, or vision plan. You can be reimbursed for eligible health care expenses for Yourself and family members You claim as Dependents on Your federal tax return. Family members' expenses can be reimbursed even if You do not cover these individual under Your health care plan(s).

ELIGIBLE HEALTH AND DENTAL CARE EXPENSES

The ICUBA Health Care Spending Account allows all Eligible Medical Expenses allowed by law, as determined by the IRS, to be eligible for reimbursement under this Plan. You may wish to access IRS Publication 502 "Medical and Dental Expenses", which can be accessed by logging onto <http://icubabenefits.org> and selecting the Document Center. ICUBA will provide You with an ICUBA BENEFITS CARD™ which acts as a MASTERCARD® HEALTH DEBIT CARD to use to pay for Your Eligible Expenditures. When using the debit card, it is important to know the available balance in Your account. The Plan requires that You exhaust the available balance in Your Health Care Spending Account (HCSA) prior to accessing the available funds in Your Health Reimbursement Account (HRA). In addition, You may submit to ICUBA proof of the expenses You have incurred that have not been paid by any other health coverage. If the request qualifies as an expense that the HCSA has agreed to pay, You will receive a reimbursement payment soon thereafter. Remember, reimbursements made from the HCSA are generally not subject to federal income tax or withholding, nor are they subject to Social Security taxes. You may not claim an Eligible Expenditure as a deduction on Your personal income tax return nor be reimbursed by other health coverage (including any other Health Care Spending Account [HCSA], medical savings account, health savings account, insurance policy, etc.)

ELIGIBLE AND INELIGIBLE HEALTH CARE EXPENSE LISTING

ACUPUNCTURE:

Acupuncture services are an eligible medical expense.

ADOPTION FEES:

Adoption Fees are not eligible. However, medical expenses incurred by an adopted child who is claimed as a dependent are eligible. Care must be for the adopted child and incurred when the child qualifies as Your dependent. A child's medical care expenses are eligible during the adoption process as long as the child qualifies as Your dependent, and is enrolled in an ICUBA Medical Plan.

AIR CONDITIONERS AND AIR PURIFIERS: See MAINTENANCE and ALLERGY RELIEF.

ALCOHOLISM, DRUG OR SUBSTANCE ABUSE:

Payment to a treatment center for alcohol or substance abuse is an eligible medical expense. This includes meals and lodging provided by the center during medical treatment (mental, nervous or addictive treatments provided on an inpatient level).

ALLERGY RELIEF:

The following are considered eligible medical expenses. (Note: In the case that these expenses increase

the value of the property, only the portion of the expense that exceeds the increase in value is eligible.)

- 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.

AMBULANCE: The amount paid for ambulance service is an eligible medical expense.

ARTIFICIAL LIMBS/TEETH: The amount paid for artificial limbs/teeth is an eligible medical expense.

ARTIFICIAL INSEMINATION: The following expenses are considered eligible medical expense:

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

The following expenses do not qualify:

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

AUTOMOBILE:

Special Equipment: The amount paid for the cost of special hand controls and other special equipment installed in an automobile for the use of a handicapped person is an eligible medical expense. The amount paid for the cost of handicap stickers or tags is an eligible medical expense.

Special Design: The amount by which the cost of an automobile specially designed to hold a wheelchair is more than the cost of a regular automobile is an Eligible Medical Expense.

Cost of Operation: The cost of operating a specially equipped automobile, except as discussed under **TRANSPORTATION**, is not an eligible medical expense.

BABY FORMULAS: See **MEDICINES**

BIRTH CONTROL RELATED:

Birth control items prescribed by Your doctor are Eligible Medical Expenses, including the following:

- Birth control pills
- Norplant
- Depo-Provera Injections

BRILLE BOOKS & MAGAZINES:

The part of the cost of Braille books and magazines that is more than the price for regular books and magazines is an Eligible Expense. See also **GUIDE DOGS**.

CAPITAL EXPENSE:

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

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

CHILD BIRTH RELATED EXPENSES:

- The services of a Midwife are an eligible medical expense.
- Childbirth prep classes, Lamaze classes, and breast pumps are not Eligible Expenses. The IRS considers these items to be for personal convenience and not to be medically necessary.

CHIROPRACTORS: Fees paid to a chiropractor for medical care are eligible medical expenses.

- Bed boards and back supports are eligible medical expenses if they are prescribed to provide relief

for a specific medical condition.

- Vitamins and supplements provided by a chiropractor **are not** eligible

CHRISTIAN SCIENCE PRACTITIONERS: Fees paid to Christian Science practitioners are eligible medical expenses.

CONTACT LENSES:

- Contact lenses and contact lens solution are eligible.
- Contact lens insurance or maintenance agreements **are not** eligible.

COSMETIC SURGERY OR PROCEDURES:

A cosmetic surgery or procedure is any surgery or procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or alleviate an illness or disease. Cosmetic surgery or procedures are generally not eligible 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.
- Porcelain veneers (if rejected by the dental carrier), bonding, and tooth whitening are generally **not** eligible.
- Tattooing and body piercing are **not** eligible.

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

COUNSELING:

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

- Bereavement and grief counseling 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.

CRUTCHES:

The amount paid to buy or rent crutches, canes, walkers, and medical equipment are all eligible medical expenses. See **MEDICAL SUPPLIES**.

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. Hydrotherapy is eligible if recommended by a doctor for a specific medical condition.

DENTAL TREATMENT:

The amounts paid for dental treatment such as x-rays, fillings, braces, extractions, and dentures are eligible medical expenses. Bonding and sealants for dentures are eligible.

- Bonding and sealants for dentures are eligible.
- Services that may be deemed cosmetic such as teeth bleaching, bonding, and porcelain veneers (unless allowed by the dental carrier) or whitening are not eligible for reimbursement. See **COSMETIC SURGERY**.

DIAPERS:

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

DOCTORS' FEES:

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

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

Other:

- Charges for transfer of medical records are eligible.
- Charges for use of facility for blood donations are eligible.
- Late fees, finance fees, etc., are **not** eligible.
- Missed appointments fees are **not** eligible.

DRUGS:

Only those drugs that require a prescription are eligible. However, there is a specific exception for Insulin, which is eligible even if obtained without a prescription. Any other drugs obtained by reason of prescription that are also available without prescription are not eligible.

Drugs for weight loss do not qualify unless the weight loss is **required** due to a specific medical condition. If prescribed for general health, it does not qualify.

DRUG ADDICTION:

The cost of long distance telephone counseling for a substance abuser seeking professional help is an eligible medical expense. See **ALCOHOLISM**.

ELECTROLYSIS OR HAIR REMOVAL:

The amount paid for hair removal through electrolysis or laser hair removal is generally considered cosmetic and is not eligible medical expense unless deemed medically necessary. See **COSMETIC SURGERY** or **PROCEDURES**.

EYEGASSES:

Fees for eyeglasses and contact lenses needed for medical reasons are Eligible Medical Expenses.

- Eye examinations are eligible.
- Prescription eyeglasses are eligible.
- Prescription sunglasses and prescription sports goggles are eligible.
- Contact lenses and cleaning solutions are eligible.
- Over-the-counter reading glasses are eligible.
- Radial Keratotomy is eligible.
- Lasik eye surgery is eligible.
- Artificial eye and polish are eligible.
- Contact lens insurance and maintenance agreements are **not** eligible.
- Non-prescription sunglasses are **not** eligible.

FUNERAL EXPENSES:

- Funeral expenses **are not** an eligible medical expense.
- Bereavement counseling is eligible. See **COUNSELING**.

GUIDE DOG:

The cost of a guide dog for the blind or deaf is an eligible medical expense. Costs incurred for the care of the dog are also eligible medical expenses.

HAIR TRANSPLANT:

Surgical hair transplants **are not** an eligible expense unless deemed medically necessary because of trauma, injury, disease, or genetic defect.

HANDICAPPED PERSONS:

The fee for training and maintaining a guide dog or other animal (including food, veterinarian fees) for the benefit of a visually or hearing impaired person is an eligible expense. The fee for employing someone to escort a blind dependent to school is eligible. Cassette books for a visually handicapped person may be included. The difference in cost between the recorded book and the typewritten book is considered an eligible medical expense. A tape recorder for a blind person is also eligible.

HEALTH CLUB DUES:

Health or fitness club dues **are not** eligible even if incurred at the suggestion of a physician.

HEARING AIDS:

The cost of a hearing aid and the batteries needed to operate the aid are eligible medical expenses. A telephone or television adapter for the deaf, lip reading lessons and hearing exams are eligible medical expenses.

HOSPITAL SERVICES: Amounts paid for hospital services are eligible medical expenses.

HOUSEHOLD HELP:

The cost of household help, even if recommended by Your doctor, is not eligible as a medical expense. Certain expenses paid to an attendant providing nursing type service may be eligible. See **NURSING**.

LABORATORY FEES:

The amounts paid for laboratory fees that are part of Your medical care are eligible medical expenses. For example, blood tests, cardiographs, metabolism tests, stool exams, spinal tests, urinalysis, x-ray exams, pap smears, cholesterol tests, thyroid profile, storage fees for blood taken for future surgery, and laboratory handling fees are also eligible.

LEAD-BASED PAINT REMOVAL:

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

LEARNING DISABILITY:

Eligible Medical Expenses include tuition fees You pay to a special school for a dependent that has learning disabilities caused by a mental or physical handicap, including nervous system disorders. Your doctor must recommend that the dependent with the specific medical condition or disability attend the school. The school must specialize in the treatment of the disorder. Tutoring fees You pay, on Your doctor's certification, for the dependent's tutoring by a teacher who is specially trained and qualified to work with people who have severe learning disabilities, is an Eligible Expense. Remedial reading for a dependent suffering from dyslexia or speech therapy to improve reading disabilities is 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.**

LEGAL FEES:

- Legal fees paid to authorize treatment for mental illness are eligible. However, if parts of the legal fees include, for example, guardianship or estate management fees, You may not include that part in medical expenses.
- Legal fees to get a divorce, even if recommended by a physician, do **not** qualify.

LIFETIME CARE:

- Fees paid to a long-term care facility do not qualify.
- Medical expenses incurred while a resident in a long-term care facility qualify.

LODGING:

Eligible Medical Expenses may include the cost of meals and lodging at a hospital or similar institution, if the primary reason for being there is to receive medical care.

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

- The lodging is primarily for and essential to medical care;
- The lodging is not lavish or extravagant under the circumstances;
- Medical care is provided by a doctor in a licensed hospital or in a medical care facility related to, or the equivalent of, a licensed hospital; and
- There is no significant element of personal pleasure, recreation or vacation in the travel away from home.

The amount You include in medical expenses may not exceed \$50 for each night for each person. Lodging is included for a person for whom transportation expenses are a medical expense because that person is traveling with the person receiving the medical care. For example: a parent traveling with a sick child is allowed up to \$100 per night as a medical expense for lodging. Meals are not an Eligible Expense.

LONG TERM CARE:

See **LIFETIME CARE**. Long term care services do not qualify. Medical expenses incurred while a resident receiving long-term care benefits are eligible for reimbursement. Long term care insurance premiums are **NOT** eligible expenses. ***You may use a Health Reimbursement Account (HRA), NOT A HEALTH CARE SPENDING ACCOUNT (HCSA) to pay for long-term care insurance premiums.***

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 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.

MATERNITY CLOTHES:

Maternity clothes are not an Eligible Expense.

MEALS:

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

MEDICAL INFORMATION:

Amounts paid to a plan that keeps medical plan information by computer and that can give the information when needed are Eligible Medical Expenses (e.g., a national information bank that holds medical information on computer).

- Charges to transfer records due to a change in physicians are eligible.

MEDICAL SUPPLIES:

Expenses paid for medical supplies used to aid a person suffering from a physical defect and/ or illnesses are eligible. This includes but is not limited to the following:

- Bandages
- Blood pressure kit
- Cholesterol testing kit
- Diabetic supplies (including Diabetic training classes)
- Diabetic Pump
- Glucose kit
- Orthopedic shoes (excess cost over regular shoes), orthotics
- Rental of medical healing equipment: wheelchairs, crutches, canes, walkers, etc.
- Truss

Note: Expenses may require a doctor's certification indicating the specific medical disorder, the specific supplies needed, and how these supplies will alleviate the medical condition.

MEDICINES/DRUGS:

Amounts paid for medicines and drugs are Eligible Expenses if they are prescribed by a doctor and are otherwise not available without a prescription.

- Over the counter Medicine are also Eligible Expenses.
- Toiletries, cosmetics, and sundry items **are not** eligible for reimbursement.
- Hygienic supplies **are not** eligible.
- Special Baby Formulas: The *cost difference* between Protein formulas and soybean formulas and non-milk formulas are eligible *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.

MENTALLY HANDICAPPED, SPECIAL HOME FOR:

The cost of keeping a mentally handicapped person in a special home, not the home of a relative, on the recommendation of a psychiatrist to help the person adjust from life in a mental hospital to community living is an Eligible Medical Expense.

MISCELLANEOUS:

Additional items that are considered Eligible Expenses:

- Circumcision
- CPR training
- Dental adhesive
- Home pregnancy tests
- Homeopathy **with doctor's certification** prescribing the cure
- Hypnosis **with doctor's certification** prescribing the specific ailments
- Medical alert bracelet
- Medical services for persons unable to get about or subject to seizures
- Public or Employer health screening (i.e., VDRL, cholesterol, diabetes-glucose, blood pressure)
- Sales tax and shipping and handling fees associated with:
 - Tanning bed prescribed by a doctor for psoriasis; or
 - Waterbed prescribed by a doctor for a specific ailment and not for general well being.

Note: Expenses may require a doctor's certification indicating the specific medical disorder, the specific treatment needed, and how this treatment will alleviate the medical condition.

NURSING HOME:

The cost of medical care, including meals and lodging in a nursing home or home for the aged, rest home or sanitarium, is an Eligible Medical Expense if the primary reason for being there is to get medical care. Such expenses are not eligible if the person has been certified as capable of self care. See **LODGING**.

NURSING SERVICES:

Eligible Medical Expenses may include wages and other amounts paid for nursing services. Services do not need to be performed by a nurse as long as the services are the type generally performed by a nurse. This includes services connected with caring for the patient's dressings, as well as bathing and grooming the patient. Extra rent or utilities expense for a large apartment with enough space (extra bedroom) for a nurse or private attendant is eligible.

OPERATIONS:

Amounts paid for legal operations/surgery that are not cosmetic in nature are Eligible Medical Expenses. See **COSMETIC SURGERY**.

OPTOMETRIST:

Optometrist fees are eligible.

ORTHODONTIA:

Orthodontia is a covered medical expense, but it can be "tricky" because of the extended nature of the treatment and the manner in which fees are paid. We strongly encourage any participant planning to pay for orthodontia treatment through the HCSA to call The ICUBA FLEX Administrator in advance at 1-866-377-5102. Orthodontic treatment is usually provided over an extended period of time, with an initial examination

and installation, and monthly adjustments. The services are often paid for over an extended period of time, with an initial down payment, and monthly payments over the life of the contract. Expenses may only be reimbursed after they have been incurred (i.e., after the service for which fees are paid have been performed), which means after the actual service has been provided. However, if the orthodontia fee payment schedule is a reasonable approximation, in both time and dollars, of the actual costs and services provided over the duration of treatment, then Eligible Expenditures may include the initial down payment and the monthly charges as each payment is made according to the fee schedule. The participant, therefore, has two ways to submit documentation in order to be reimbursed - either on a "services provided" basis or on a "fee payment schedule" basis. The first method is the same as any other medical expense and requires the participant to submit a statement from the orthodontist showing that a service has been provided and stating the cost of that service. The second method allows the participant to submit proof that payment has been made at the required time called for by the payment schedule. For example, if we assume the treatment is expected to last 24 months, and the contract calls for a down payment of \$800 and a monthly charge of \$100 for each of the next 24 months. Eligible Expenditures include the \$800 down payment as long as accompanied by a receipt showing that the initial service has been provided and payment has been made. Eligible Expenditures also include \$100 per month upon receipt of documentation showing that the monthly payment has been made. This documentation could either be a receipt from the orthodontist showing that payment has been received for the current month's scheduled charge, or a photocopy of the current month's payment coupon and the participant's personal check.

- You cannot pre-pay for services and be reimbursed at the time of that payment. You can only be reimbursed as services are provided.
- If You decide to pay off the contract early while the treatment is still continuing You can only be reimbursed as services are provided.
- If the treatment is completed sooner than expected and You decide to pay off the remainder of the contract early You can be reimbursed for that payment because the services are complete.

OXYGEN:

Amounts paid for oxygen or oxygen equipment to relieve breathing problems caused by a medical condition is an Eligible Medical Expense.

PENILE IMPLANTS:

This is an Eligible Expense if impotence is due to organic causes, trauma, post-prostatectomy, or diabetes.

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.

PERSONAL ITEMS:

You may include in medical expenses an item 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. See **MISCELLANEOUS**.

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

PROSTHESIS:

A prosthetic is an Eligible Expense. See Artificial Limb/Teeth.

PSYCHIATRIC CARE:

Amounts paid for psychiatric care are Eligible Medical Expenses. Eligible Expenses include the cost of supporting a mentally ill dependent at a specially equipped medical center where the dependent receives medical care.

PSYCHOANALYSIS:

Amounts paid for psychoanalysis are Eligible Expenses. A payment for psychoanalysis that is part of a person's training to be a psychoanalyst is not an Eligible Expense. See **COUNSELING**.

PSYCHOLOGIST:

Amounts paid to a psychologist for medical care are Eligible Expenses. See **COUNSELING**.

SCHOOLS, SPECIAL:

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

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

SMOKING CESSATION PROGRAM:

Smoking is considered an addiction therefore the cost of a program or prescription medication to stop smoking is an Eligible Medical Expense. However non-prescription medicines **are not** eligible. Most stop-smoking patches and gum are non-prescription and therefore **are not** eligible.

SPEECH/VOICE THERAPY:

Eligible if rendered for developmental delay or is restorative or rehabilitative in nature. No doctor's note is required.

STERILIZATION:

The cost of legal sterilization is an Eligible Medical Expense. Vasectomy or tubal ligations are eligible.

SUBSTANCE ABUSE:

See **ALCOHOLISM, DRUG OR SUBSTANCE ABUSE**

TELEPHONE:

The cost and repair of special telephone equipment that allows a deaf person to communicate over a regular telephone is an Eligible Medical Expense. See **HANDICAPPED PERSONS**.

THERAPY:

Therapy You receive as medical or mental treatment is an Eligible Expense.

- Massage for a specific disorder is eligible. No prescription is required unless the condition is one that would normally be diagnosed by a physician, but the receipt must clearly state the condition being treated.
- Patterning Exercises: Payments made to an individual for giving patterning exercises to a mentally handicapped dependent are eligible. These exercises consist of physical manipulation of the dependent's arms and legs to imitate crawling and other normal movements.

TRANSPLANTS:

You may include as medical expenses payments for surgical, hospital, laboratory and transportation expenses for a donor or a possible donor of a kidney or other organ (heart, eye, etc). See **DOCTOR'S FEES**.

TRANSPORTATION:

Amounts paid for transportation primarily for and essential to medical care qualify as medical expenses. An individual may be reimbursed \$.13 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 \$.13 per mile). Do not include expenses for general repair, maintenance, depreciation, and insurance.
- Bus, taxi, train, plane fare, or ambulance service.
- Cost of transportation for parents if accompanying a child who needs medical care.
- Parking fees and tolls (**receipts required**).
- Trips to 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:

Trips to a doctor or dentist are eligible. See **TRANSPORTATION**.

- Childcare fees while at doctor's office **are not** eligible.
- A trip or vacation taken for a change in environment, improvement of morale, or general improvement of health, even if made on the advice of a doctor, **is not** an Eligible Medical Expense.

TUITION FEES:

Tuition charges for a medically dysfunctional dependent are Eligible Expenses. Tuition fees paid to a private school as a personal preference over public schooling for general education **are not** an Eligible Expense. See **LEARNING DISABILITY** and **SCHOOLS, SPECIAL**.

VITAMINS:

Vitamins *must be prescribed by a doctor and available only with a prescription to be considered eligible*. Over-the-counter vitamins **are not** eligible even if prescribed by a doctor.

WATER FLUORIDATION UNITS AND WATER PIK:

These are eligible as a medical expense if prescribed by a doctor for treatment for a specific medical condition.

Note: Expenses must be accompanied by a doctor's certification indicating the specific medical disorder and that this treatment will directly cure or mitigate the medical condition.

WEIGHT LOSS PROGRAM:

The cost of exercise equipment or weight-loss programs for general health, even if recommended by a doctor, **is not** an Eligible Medical Expense. Weight loss expenses incurred directly as treatment of a particular medical condition do qualify.

Note: Expenses must be accompanied by a doctor's certification indicating a specific medical disorder that requires the weight loss program, the specific treatment needed, and how this treatment will alleviate the medical condition (e.g., hypertension).

WHEELCHAIR:

Amounts paid for a manual or motorized wheelchair used mainly for the relief of sickness or disability is an Eligible Medical Expense. The cost of operating and maintaining the wheelchair is also an Eligible Medical Expense. See **MAINTENANCE**.

X-RAY FEES:

Amounts paid for x-rays for medical reasons are Eligible Medical Expenses. Both medical and dental x-rays are Eligible.

CONTRIBUTION DECISIONS

If You choose to participate in the Health Care Spending Account, the maximum annual amount of pretax Flex Dollars that You may elect to have deposited is determined by Your Employer. The annual amount You choose to have deposited in Your Health Care Spending Account through salary reductions will be deducted from Your pay throughout the Year in equal amounts.

HEALTH CARE SPENDING LIMITATIONS

Reimbursement for Eligible Expenses will only be made if reimbursement is not made from any other insurance policy or benefit plan covering You, Your spouse, or Your Dependents. Reimbursement for eligible expenses will only be made for eligible health care expenses incurred previously during the Year (and in the case of new employees, only during the portion of the Year after participation began). Eligible health care expenses do not include the cost of other health coverage such as premiums paid under other health plans. The total amount of reimbursement that You will receive from the Health Care Spending Account (whether or not the amount has been deducted from Your pay) will not exceed Your annual election amount.

AT YEAR END

The total deposit amount You designated for the plan Year can be used only to reimburse expenses incurred during that plan Year. You must submit claims for Eligible Expenses within 90 days of the end of the Year in order to be reimbursed for these expenses. In compliance with the Internal Revenue Service guidelines, if a balance remains in Your account(s) after the Year's reimbursements have been processed, *this amount will be forfeited and returned to Your Employer*. This forfeiture rule makes it important that You plan the use of Your spending account(s) carefully. To minimize Your risk of forfeiture, You may want to be conservative in Your estimate of the expenses that You will have.

OPTIONAL CONTINUATION COVERAGE

To the extent mandated by federal law, You will be allowed to continue coverage under the Health Care Spending Account even after Your termination of employment. Such coverage, however, will require You to continue making the deposits You have elected on an after-tax basis.

THE HEROES EARNING ASSISTANCE AND RELIEF TAX ACT OF 2008 (THE HEROES ACT)

The Heroes Act provides relief from the "use it or lose it" rule to certain military personnel. A "qualified reservist distribution" from a health flexible spending account is permitted if (i) the employee has been ordered or called to active service for a period of at least 179 days and (ii) the distribution is made on or after the date of the call or order, but before the end of the health flexible spending account period of coverage. Qualified reservist distributions are tax-free.

DEPENDENT CARE SPENDING ACCOUNTS

The Dependent Care Spending Account enables You to be reimbursed for eligible dependent care expenses with pretax dollars.

ELIGIBLE DEPENDENT CARE EXPENSES

Dependent care expenses are eligible for reimbursement if they meet all of the requirements for such expenses under Code Section 129, as well as the definition of an eligible dependent as reported on Your IRS Form 1040. In general, such requirements are as follows:

- ***The expenses must be necessary to enable You to work.*** If You are married, Your spouse also must work, be a full-time student, or be physically or mentally challenged.

- You must maintain a household which includes as a member a physically or mentally challenged spouse, a Dependent under age 13, or physically or mentally challenged Dependents who are unable to care for themselves. *They must be eligible to be claimed as Dependents on Your federal tax return.*
- The expenses must be for qualified household services or for the care of the qualifying Dependents or spouse.
- Payments cannot be to someone You claim as a Dependent on Your federal income tax return or to Your child if he or she is under age 19. However, payments can be made to a relative who is not a Dependent, even if he or she lives in Your home.

CONTRIBUTION DECISIONS

If You choose to participate in the dependent care reimbursement plan, the maximum annual amount of pretax Flex Dollars that You may elect to have deposited is \$5,000 (\$2,500 if You are married but file a separate tax return), or the lesser of the earned income of You or Your spouse. The annual amount You choose to have deposited in Your Dependent Care Spending Account through salary reductions will be deducted from Your pay throughout the Year in equal amounts.

DEPENDENT CARE SPENDING ACCOUNT LIMITATIONS

Reimbursement for Eligible Expenses will only be made if reimbursement is not made from any other insurance policy or benefit plan covering You, Your spouse, or Your Dependents. Reimbursement for Eligible Expenses will only be made for eligible dependent care expenses incurred previously during the Year (and in the case of new employees, only during the portion of the Year after participation began). The total amount of reimbursement that You will receive from the dependent care reimbursement account will not exceed the amounts in Your account at the time of reimbursement.

AT YEAR END

The total deposit amount You designated for the Year can be used only to reimburse expenses incurred during that Year. You must submit claims for Eligible Expenses within 90 days of the end of the Year (Extension through 6/15 with a 6/29 grace period in order to be reimbursed for these expenses. In compliance with the Internal Revenue Service guidelines, if a balance remains in Your account(s) after the Year's reimbursements have been processed, this amount will be forfeited and returned to Your Employer. This forfeiture rule makes it important that You plan the use of Your reimbursement account(s) carefully. To minimize Your risk of forfeiture, You may want to be conservative in Your estimate of the expenses that You will have.

REIMBURSEMENT AFFECT YOUR ELIGIBILITY FOR THE DEPENDENT CARE CREDIT

You will not be able to claim a federal income tax credit for any dependent care expenses reimbursed under this Plan. In some cases, especially for employees in lower tax brackets or who have large amounts of other tax deductions, it may be more beneficial to claim the tax credit for such expenses instead of electing to have those expenses reimbursed from pretax salary reduction amounts. You should consult with Your tax advisor if You believe this alternative may apply to You.

ANNUAL STATEMENT OF REIMBURSEMENTS

The Plan Administrator will furnish to You on Form W-2, on or before January 31 of each Year, the amounts paid to You from Your dependent care reimbursement account during the previous calendar Year. You must include on Your individual income tax return the name, address and taxpayer identification number of the persons to whom You paid the reimbursed dependent care expenses.

DEBIT CARD

The ICUBA Benefits Card is issued by Metavante Bank, the largest reimbursement card company for flexible spending account administration. The card electronically accesses and debits Your flexible spending account when an Eligible Expense is incurred. If the funds are not in the account, the transaction *will simply be denied*. The ICUBA Benefits Card™ allows reimbursement to be made at point of sale without the need to issue a check or make a direct deposit into Your bank account for reimbursement. The ICUBA Benefits Card™ provides for instant reimbursements for prescription, doctor, dentist, ophthalmologist and optometrist co-pays and out of pocket costs. If the dependent care provider accepts MasterCard, The ICUBA Benefits Card™ may be used for the Dependent Care Spending Account also.

Because the HCSA is regulated by the IRS, there may be instances where receipts are required for SUBSTANTIATION, so paper receipts should be saved for at least three weeks from the date of service. Employees may access history of expenditures and remaining balances through the Internet by logging onto <http://icubabenefits.org>, or by calling ICUBA at 1-866-377-5102. If a transaction is not approved, it will be denied at Point of Sale. In the unlikely event that a sale does go through, but it was an ineligible expense, for instance an employee charges their Rx co-pay of \$25 plus a \$10.99 DVD at the pharmacy counter, and then ICUBA takes the following steps to recover the \$10.99:

1. Send participant letter asking them to reimburse their own account for an ineligible Expense of \$10.99
2. If the participant does not do this the amount can be deducted from future reimbursement paid to participant for legitimate expenses
3. As a last resort the Employer may be asked to payroll deduct that amount in order to reimburse the account

The ICUBA Benefits Card™ may be suspended or cancelled immediately upon notification by ICUBA or the Employer.

Employees enrolled in the HCSA will have full and immediate availability to their entire 12 month elected amount on the first day of the plan Year (i.e., April 1). Funds in the HCSA are accessible to employees through The ICUBA Benefits Card™. Employees may pay for Eligible Medical Expenses from their HCSA either through The ICUBA Benefits Card™ at point of sale, or by submitting hard copy reimbursement to ICUBA. Any monies left in the HCSA after March 31 are only available until June 30 for services incurred April 1 through March 31, and must be submitted in hardcopy to ICUBA. Any monies left in the HCSA after June 30 reverts back to the Employer. There is no Personal Identification Number ("PIN") associated with the MasterCard® Health Debit Card. For consumer activated terminals, the "credit" option must be chosen in order for the ICUBA Benefits Card to be accepted. Some of the eligible Merchants are as follows:

- Chiropractors
- Dentists/Orthodontists
- Discount Stores
- Drug Stores and Pharmacies
- Home Health Care Services
- Medical Equipment Providers

- Medical Service Practitioners
- Physicians
- Psychiatric Hospitals
- Opticians
- Optometrists
- Orthopedic and Prosthetic Appliances
- Osteopaths
- Supermarkets

HOW TO FILE CLAIMS FROM YOUR HEALTH CARE SPENDING ACCOUNT

The following applies to Health Care Spending Account claims that are filed on or after the first day of the first plan Year following April 1 but not later than June 30 of the following Year

How to File a Claim for Reimbursement

When You have a Claim to submit for payment, You must:

- Login to <http://icubabenefits.org> or You can obtain a claim form from ICUBA by emailing benefitsadministration@icuba.org, by calling 1-866-377-5102 or by logging onto Your Human Resource website.
- Complete the Employee portion of the form.
- Scan, email or fax copies of all receipts from the service provider for which You are requesting reimbursement referencing the system generated claim number.
- You may also request that reimbursement be made to You directly deposited into Your bank account by completing a Direct Deposit form available from the same resources mentioned above.

When Claims Should Be Filed

All requests for benefits may be filed at any time during the Year and within the 90-day period immediately following the end of the Year (i.e., June 30), providing You have not used Your health debit card to pay for Your Eligible Medical Expenses. After claims are received, each claim will be granted or denied by The Contract Administrator within the number of days specified in this section of the booklet for the specific type of claim. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless it's not reasonably possible to submit the claim in that time. The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion. If a claim is wholly or partially denied, the Claims Administrator will furnish the Plan Participant with a written notice of this denial. This written notice will be provided after the receipt of the Claim within the specified timeframe noted below. The written notice will contain the following information:

- The specific reason or reasons for the denial;
- Specific reference to those Plan provisions on which the denial is based;
- A description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and
- Appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review.

Claims Procedures

Following is a description of how the Plan processes Claims for health care reimbursements. A Claim is defined as any request for a Plan reimbursement, made by a claimant or by a representative of a claimant, which complies with the Plan's procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

There are different kinds of Claims and each one has a specific timetable for approval, payment, request for further information, or denial of the Claim. If You have any questions regarding this procedure, please contact the Plan Administrator. The definitions of the types of Claims and the timetables are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for reimbursement for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim. A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine may make the determination. In the case of a Claim involving Urgent Care, the following timetable applies:

- Notification to claimant of reimbursement determination 72 hours
- Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim
- Notification to claimant, orally or in writing 24 hours
- Response by claimant, orally or in writing 48 hours
- Reimbursement determination, orally or in writing 48 hours

Ongoing courses of treatment, notification of:

- Reduction or termination before the end of treatment 72 hours
- Determination as to extending course of treatment 24 hours

If there is an adverse reimbursement determination on a Claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's reimbursement determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method.

Pre-Service Claim

A Pre-Service Claim means any Claim for a Health Care Reimbursement under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to pre-certification.

In the case of a Pre-Service Claim, the following timetable applies:

- Notification to claimant of reimbursement determination 15 days
- Extension due to matters beyond the control of the Plan 15 days

Insufficient information on the Claim:

- Notification of 15 days
- Response by claimant 45 days

Notification, orally or in writing, of failure to follow

- The Plan's procedures for filing a Claim 5 days

Ongoing courses of treatment:

- Reduction or termination before end of the treatment 15 days
- Request to extend course of treatment 15 days

- Review of adverse reimbursement determination 15 days per benefit appeal

Post-Service Claim

A Post-Service Claim means any Claim for a health care reimbursement that is not a Claim involving Urgent Care or Pre-Service; in other words, a Claim that is a request for payment under the Plan for covered medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

- Notification to claimant of reimbursement determination 30 days
- Extension due to matters beyond the control of the Plan 15 days

Insufficient information on the Claim:

- Notification of 15 days
- Response by claimant 45 days
- Review of adverse reimbursement determination 30 days per benefit appeal

Notice to Claimant of Adverse Reimbursement Determinations

Except with Urgent Claims, when the notification may be orally followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of any adverse reimbursement determination. The notice will state, in a manner calculated to be understood by the claimant:

- The specific reason or reasons for the adverse determination.
- Reference to the specific Plan provisions on which the determination was based.
- A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.
- A description of the Plan's review procedures, incorporating any voluntary appeal procedures offered by the Plan, and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an adverse reimbursement determination on review.
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access

to, and copies of, all documents, records, and other information relevant to the Claim.

IMPORTANT NOTE

You and Your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact Your local U.S. Department of Labor Office.

- If the adverse reimbursement determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse reimbursement determination and a copy will be provided free of charge to the claimant upon request.
- If the adverse reimbursement determination is based on the Medical Necessity or Experimental and/or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

HOW TO FILE AN APPEAL

When a claimant receives an adverse reimbursement determination, the claimant has 180 days following receipt of the notification in which to appeal the decision. A claimant may submit written comments, documents, records, and other information relating to the Claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a reimbursement determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

- was relied upon in making the reimbursement determination;
- was submitted, considered, or generated in the course of making the reimbursement determination, without regard to whether it was relied upon in making the reimbursement determination;
- demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that reimbursement determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial reimbursement determination. The review will not afford deference to the initial adverse reimbursement determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual. If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is not

considered eligible under this reimbursement plan, the fiduciary shall consult with a professional who was not involved in the original reimbursement determination. This professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

Voluntary Appeals, Including Voluntary Arbitration during voluntary dispute resolution, any statute of limitations or other defense based on timeliness is tolled during the time any voluntary appeal is pending. The Plan waives any right to assert that a claimant has failed to exhaust administrative remedies because he or she did not elect to submit a benefit dispute to the voluntary appeal provided by the Plan. A claimant may elect a voluntary appeal after exhaustion of appeals of an adverse reimbursement determination as explained in the section above, entitled, "Appeals." However, this voluntary appeal may be conducted as one of the two appeals available to the claimant.

The Plan will provide to the claimant, at no cost and upon request, sufficient information about the voluntary appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal. This information will include a statement that the decision will have no effect on the claimant's rights to any other benefits under the Plan; will list the rules of the appeal; state the claimant's right to representation; enumerate the process for selecting the decision maker; and give circumstances, if any, that may affect the impartiality of the decision maker. No fees or costs will be imposed on the claimant as part of the voluntary level of appeal, and the claimant will be told this.

If You Have Questions about a Claim

If You have questions about a claim, You may call: 1-866-377-5102 or email benefitsadministration@icuba.org. Our claims professionals will be happy to help You. However, so that we can handle Your questions properly and promptly, please have the following information available when You call:

- The Claimant's name.
- The Employee's Social Security Number.
- The Employer's name.
- The Employee's name.
- The type of claim submitted.
- The dollar amount of the claim.
- The date of service

HOW TO FILE CLAIMS FROM YOUR DEPENDENT CARE SPENDING ACCOUNT

How to File a Claim for Reimbursement

The appropriate claim forms may be obtained from the ICUBA Benefits Site at <http://icubabenefits.org>.

The following steps should be followed in order to file a reimbursement claim:

1. Complete the employee portion of the reimbursement claim form in full. ALL QUESTIONS MUST BE ANSWERED.
2. Have the dependent care provider complete the provider's portion of the form (if applicable) and attach all necessary documentation of expenses to the reimbursement claim form.
3. When You submit claims for dependent care expenses, You must provide a written statement from the provider of services or supplies stating that the expense has been incurred and the amount of the expense, a written statement that the expense has been reimbursed or is not reimbursable under any other plan coverage, and a written statement that the amount will not be claimed as a tax deduction.
4. Send the above to the Claims/Contract Administrator: ICUBA P.O. Box 616927 Orlando, FL 32861-6927

Reimbursement from Your dependent care reimbursement account will be made at the time the reimbursement claim is processed only up to the amount that has already been deposited into Your account. All requests for benefits may be filed at any time during the Year and within the 90-day period immediately following the end of the Year (i.e., June 30).

HOW TO FILE AN APPEAL

If You believe a claim was improperly settled the following process is available:

1. Within 60 days of receipt of the claim, You may request, in writing or verbally, that the Plan conduct a review of the processed claim. The Plan will review the processed claim and inform You whether or not an error was made. Any errors will be corrected promptly.
2. If You are not satisfied with the above review, a written request for a second review may be submitted to the Plan within 60 days of the first review. The request should state, in clear and concise terms, the reason for disagreement with the way the claim was processed. When the written request is received, the claim will be reviewed again and the results of this review furnished in writing to You within 60 days in most cases, but in all questions or requests for a review of denied benefits should include a copy of the initial denial letter and any other pertinent information. Send all information to: ICUBA P.O. Box 616927 Orlando, FL 32861-6927 1-866-377-5102

COBRA CONTINUATION OPTIONS

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires that most Employers sponsoring a Flexible Spending Account Plan ("Plan") offer Employees and their families covered under their health Plan the opportunity for a temporary extension of health coverage (called "COBRA continuation coverage") in certain instances where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is Flexible Spending Account Plan coverage that an Employer must offer to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates for up to a statutory-mandated maximum period of time or until they become ineligible for COBRA continuation coverage, whichever occurs first. The right to COBRA continuation coverage is triggered by the occurrence of one of certain enumerated events that result in the loss of coverage under the terms of the Employer's Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated Active Employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who is a Qualified Beneficiary?

In general, a Qualified Beneficiary is:

- (i) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

- (ii) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (iii) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a qualified beneficiary, then a Spouse or Dependent child of the individual is not considered a Qualified Beneficiary by virtue of the relationship to the individual.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a **Qualifying Event**?

A Qualifying Event is any of the following if the Plan provides that the Plan Participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

- (i) The death of a covered Employee.
- (ii) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
- (iii) The divorce or legal separation of a covered Employee from the Employee's Spouse.
- (iv) A covered Employee's enrollment in the Medicare program.
- (v) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (e.g., attainment of the maximum age for dependency under the Plan).
- (vi) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, Spouse, or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA law are also met. Any increase in contributions that must be paid by a covered Employee, or the Spouse or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event occurs, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the Employee portion of premiums for coverage under the Plan during the FMLA leave.

What is The Election Period And How Long Must It Last?

An election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Employer's Plan. A Plan can condition availability of COBRA continuation coverage upon the timely election of such coverage. An election of COBRA continuation coverage is a timely election if it is made during the election period. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

Is A Covered Employee Or Qualified Beneficiary Responsible For Informing The Plan Administrator Of The Occurrence Of A Qualifying Event?

In general, the Employer or Plan Administrator must determine when a Qualifying Event has occurred. However, each covered Employee or Qualified Beneficiary is responsible for notifying the Plan Administrator of the occurrence of a Qualifying Event that is:

- (i) A Dependent child's ceasing to be a Dependent child under the generally applicable requirements of the Plan.
- (ii) The divorce or legal separation of the covered Employee.

The Plan is not required to offer the Qualified Beneficiary an opportunity to elect COBRA continuation coverage if the notice is not provided to the Plan Administrator within 60 days after the later of: the date of the Qualifying Event or the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event.

Is a Waiver Before The End Of The Election Period Effective To End a Qualified Beneficiary's Election Rights?

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Employer or Plan Administrator, as applicable.

When may a Qualified Beneficiary's COBRA Continuation Coverage be Terminated?

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- (i) The last day of the applicable maximum coverage period.
- (ii) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- (iii) The date upon which the Employer ceases to provide any Flexible Spending Account Plan (including successor Plans) to any Employee.
- (iv) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any Pre-Existing Condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- (v) The date, after the date of the election that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
- (vi) In the case of a Qualified Beneficiary entitled to a Disability extension, the later of:
 - (a) 29 months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the Disabled Qualified Beneficiary whose Disability resulted in the Qualified Beneficiary's entitlement to the Disability extension is no longer Disabled, whichever is earlier; or
 - (b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the Disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What Is The Maximum Coverage Periods For COBRA Continuation Coverage?

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

- (ii) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a Disability extension and 29 months after the Qualifying Event if there is a Disability extension.

- (ii) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:
 - (a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or
 - (b) 18 months (or 29 months, if there is a Disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the retired covered Employee ends on the date of the retired covered Employee's death. The maximum coverage period for a Qualified Beneficiary who is the Spouse, surviving Spouse or Dependent child of the retired covered Employee ends on the earlier of the date of the Qualified Beneficiary's death or the date that is 36 months after the death of the retired covered Employee.

- (iv) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

- (v) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under What Circumstances Can The Maximum Coverage Period Be Expanded?

If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified

Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event or the Medicare Enrollment Date.

How Does A Qualified Beneficiary Become Entitled To A Disability Extension?

A Disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been Disabled at any time during the first 60 days of COBRA continuation coverage. The Disability extension also will be granted to any non-Disabled family member who is a Qualified Beneficiary. To qualify for the Disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the Disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage.

Can A Plan Require Payment For COBRA Continuation Coverage?

Yes. For any period of COBRA continuation coverage, a Plan can require the payment of an amount that does not exceed 102% of the applicable premium except the Plan may require the payment of an amount that does not exceed 150% of the applicable premium for any period of COBRA continuation coverage covering a Disabled qualified beneficiary that would not be required to be made available in the absence of a Disability extension. A Flexible Spending Account Plan can terminate a qualified beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made to the Plan with respect to that qualified beneficiary.

Must The Plan Allow Payment For COBRA Continuation Coverage To Be Made In Monthly Installments?

Yes. The Plan is also permitted to allow for payment at other intervals.

What Is Timely Payment For COBRA Continuation Coverage?

Timely Payment means payment that is made to the Plan by the date that is 30 days after the first day of that period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non COBRA beneficiaries for the period.

Notwithstanding the above paragraph, a Plan cannot require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is sent to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A 'reasonable period of time' is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

Plan Administrator

Flexible Spending Account Plan is the benefit Plan of Your Employer, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual may be appointed by Your Employer to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, Your Employer shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

Duties of the Plan Administrator

- (1) To administer the Plan in accordance with its terms.
- (2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
- (3) To decide disputes this may arise relative to a Plan Participant's rights.
- (4) To prescribe procedures for filing a claim for benefits and to review claim denials.
- (5) To keep and maintain the Plan documents and all other records pertaining to the Plan.
- (6) To appoint a Claims Administrator to pay claims.
- (7) To perform all necessary reporting as required by ERISA.
- (8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.
- (9) To delegate to any person or entity such powers, duties and responsibilities, as it deems appropriate.

Plan Administrator Compensation

The Plan Administrator serves without compensation; however, all expenses for Plan administration, including compensation for hired services, will be paid by the Plan.

Fiduciary

A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

Fiduciary Duties

A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties, which must be carried out:

- (1) With care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;
- (2) By diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and
- (3) In accordance with the Plan documents to the extent that they agree with ERISA.

The Named Fiduciary

The named fiduciary is Your Employer,

Claims Administrator Is Not a Fiduciary

A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

Funding the Plan and Payment of Benefits

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The Plan Administrator will set the level of any Employee contributions. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

Plan Is Not an Employment Contract

The Plan is not to be construed as a contract for or of employment.

Clerical Error

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

Amending and Terminating the Plan

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

Conformity with the Law

Except to the extent preempted by federal law, this Plan will provide any coverage required to be provided by any applicable state or federal law. If any provision of this Plan is contrary to any applicable law to which it is subject, the provision is hereby automatically changed to meet the law's minimum requirement.

RIGHTS OF PLAN PARTICIPANTS

As a participant in this Plan You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual Year report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual Year report (Form 5500 Series) and updated summary Plan description. The administrator may make a reasonable charge for the copies.

Continue health care coverage for a Plan Participant, Spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or Dependents may have to pay for such coverage. Review this summary Plan description and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under this group health Plan, if an Employee or Dependent has Creditable Coverage from another Plan. The Employee or dependent should be provided a certificate of Creditable Coverage, free of charge, from the group health Plan when coverage is lost under the Plan, when a person becomes entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if a person requests it before losing coverage, or if a person requests it up to 24 months after losing coverage. Without evidence of Creditable Coverage, a Plan Participant may be subject to Pre-Existing Conditions exclusion for 12 months (18 months for Late Enrollees) after the Enrollment Date of coverage.

Receive a summary of the Plan's annual Year financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual Year report.

Continue Flexible Spending Account Plan Coverage

Continue health care coverage for Yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or Your Dependents may have to pay for such coverage. Review this summary Plan description and the documents governing the Plan on the rules governing Your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Flexible Spending Account 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, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your rights under ERISA.

Enforce Your Rights

If Your claims for a welfare benefit are 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 You can take to enforce the above rights. For instance, if You request a copy of Plan documents or the latest Annual report 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 Plan administrator to provide the materials and pay You up to \$110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If You have a claim for benefits that is denied or ignored, in whole or in part, You may file in a state or Federal court. In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, You may file suit in Federal court. If it should happen the Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If You are successful the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

Assistance with Your Questions

If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the Plan administrator, You should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance Inquiries, Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.

GENERAL PLAN INFORMATION

Type of Administration

The Plan is a self-funded group health Plan and the administration is provided through a third party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees, if applicable. The Plan is not insured.

Plan Name

ICUBA Flexible Spending Account

Plan Numbers

506

Tax Id Number this would be the Employer Tax ID Plan

Commencement Date

April 1, 2004

Plan Year

April 1 through March 31
Extension through June 15th Grace
period through June 29th

Claims/Contract Administrator

ICUBA
P.O. Box 616927
Orlando, FL 328161-6927
Toll-Free Phone Number: 866-577-5102 Toll-
Free fax: 866-377-5180

DEFINITIONS

The following terms have special meanings and when used in this Plan will be capitalized.

Actively at Work/Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis. An Employee who is absent due to Illness or Injury will be considered an Active Employee.

Amend additions, deletions or changes the provisions of the Plan and applies to all Covered Persons, including those persons covered before the Amendment becomes effective, unless otherwise specified.

Amendment is a formal document signed by the representative of Your Employer

Benefit Year is the 12-month period beginning April 1 and ending March 31. All annual deductibles and benefit maximums accumulate during the Benefit Year.

Claim is any request for a Plan reimbursement made by You or Your authorized representative in accordance with the Plan's procedures for filing claims.

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

Contract Administrator is ICUBA who has been hired as the third party contract administrator by ICUBA to perform claims processing and other specified administrative services in relation to the Plan. The Contract Administrator is not an insurer of health benefits under this Plan is not a fiduciary of the Plan and does not exercise any of the discretionary authority and responsibility granted to the Plan Administrator. The Contract Administrator is not responsible for plan financing and does not guarantee the availability of benefits under this Plan.

Code refers to the Internal Revenue Code of 1986, as amended or replaced from time to time.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is a member of ICUBA.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

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

Flex Dollars are the pretax dollar amounts deposited into Your spending accounts consisting of elective salary reduction amounts.

Physically or Mentally Challenged is the inability of a person to be self-sufficient as the result of a

condition such as but not limited to mental retardation, cerebral palsy, epilepsy or another neurological disorder and diagnosed by a Physician as a permanent and continuing condition preventing the individual from being self-sufficient.

Plan means Your Employer's Flexible Spending Account Plan, which is a benefit Plan for Employees of Your Employer and is described in this document.

Plan Administrator is Your Employer.

Plan Participant is any Employee, Dependent or qualified Retiree who is covered under this Plan.

Plan Sponsor is Your Employer.

Plan Year is the 12-month period beginning April 1 and ending March 31 or on the day following the end of the first plan Year that is a short plan Year.

Practitioner is a Physician or person acting within the scope of applicable state licensure certification requirements and holding the degree of:

- Optician
- Certified Nurse Midwife (C.N.M.)
- Certified Registered Nurse Anesthetist (C.R.N.A.)
- Physician's Assistant
- Doctor of Social Work (D.S.W.)
- Master of Social Work (M.S.W.)
- Speech Therapist
- Acupuncturist
- Nurse Practitioner
- Nutritionist/Dietician
- Occupational Therapist
- Registered Physical Therapist (R.P.T.)
- Psychologist (Ph.D., Ed.D. Psy.D.)
- Licensed Clinical Social Worker (L.C.S.W.)
- Registered Respiratory Therapist

Usual and Customary or Usual and Reasonable Charge is a charge that is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider:

- Medical complications or unusual circumstances that require more time, skill or experience.
- The Plan will reimburse the actual charge billed if it is lesser than the Usual and Reasonable Charge.
- The Plan Administrator has the discretionary authority to decide whether charge is Usual and Reasonable.

Rider #1

This Rider applies to Florida Institute of Technology and Palm Beach Atlantic University.

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