

**FLORIDA INSTITUTE OF TECHNOLOGY
HEALTH REIMBURSEMENT ACCOUNT PLAN**

As Adopted Effective April 1, 2011

ARTICLE I. INTRODUCTION

1.1 Establishment of Plan

Florida Institute of Technology (The “Employer”) has established the Florida Institute of Technology Health Reimbursement Account Plan (the “Plan”) effective 4/1/2003. This Plan is amended and restated effective April 1, 2011. Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in Article II.

This Plan is intended to permit an Eligible Employee to obtain reimbursement of Medical/Dental/Prescription Expenses on a nontaxable basis from his or her HRA Account.

1.2 Legal Status

This Plan is intended to qualify as an employer-provided medical reimbursement plan under Sections 105 and 106 of the Internal Revenue Code of 1986, as amended (the “Code”) and the regulations issued thereunder, and as a health reimbursement arrangement (“HRA”) as defined under IRS Notice 2002-45, and shall be interpreted to accomplish that objective. The Plan is also intended to be an “integrated HRA” (*i.e.*, the Plan is integrated with the Independent Colleges and Universities Benefits Association, Medical, Behavioral Health, and Prescription Drug Plan’s PPO 70 and Risk/Reward options) with a “spend-down” feature (*i.e.*, former employees with vested HRA Accounts can spend down their HRA account balance on eligible Medical/Dental/Prescription Expenses until the account balance is exhausted).

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

ARTICLE II. DEFINITIONS

2.1 Definitions

“**Administrator**” means Florida Institute of Technology; provided, however, that the Florida Institute of Technology has delegated full authority to act on behalf of the Plan Administrator to the Independent Colleges and Universities Benefits Association (“ICUBA”), except with respect to appeals, for which the Plan Administrator has the full authority to decide, as described in Section 9.1.

“**Amendment & Restatement Effective Date**” of this Plan means April 1, 2011.

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

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

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

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

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

“Dependent” means (a) any individual who is a Participant’s child as defined by Code Section 152(f)(1) and who has not attained age 26 and (b) any tax dependent of a Participant as defined in Code Section 105(b) (including a domestic partner if he or she so qualifies); provided, however, that any child to whom Code Section 152(e) applies (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child’s support for the calendar year) is treated as a dependent of both parents. Notwithstanding the foregoing, the HRA Account will provide Benefits in accordance with the applicable requirements of any qualified medical child support order (“QMCSO”) even if the child does not meet the definition of “Dependent.”

“Effective Date” of this Plan means 4/1/2003.

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

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

“Employee” means an individual that the Employer classifies as a common-law employee and who is on the Employer’s W-2 payroll, but does not include the following: (a) any leased employee (including but not limited to those individuals defined as leased employees in Code Section 414(n)) or an individual classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee for the period during which such individual is so classified, whether or not any such individual is on the Employer’s W-2 payroll or is determined by the IRS or others to be a common-law employee of the Employer; (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Employer; (c) any employee covered under a collective bargaining agreement; (d) any self-employed individual; (e) any partner in a partnership; and (f) any more-than-2% shareholder in a Subchapter S corporation. The term “Employee” does include “former Employees” for the limited purpose of allowing continued eligibility for Benefits under the Plan in accordance with Section 3.2.

“Employer” means Florida Institute of Technology and any Related Employer that adopts this Plan with the approval of Florida Institute of Technology. Related Employers that have adopted this Plan, if any, are listed in Appendix A to this Plan. However, for purposes of Section 9.3, “Employer” means only Florida Institute of Technology.

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

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

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

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

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

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

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

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

“ICUBA Medical Plan” means the Independent Colleges and Universities Benefits Association Medical, Behavioral Health, and Prescription Drug Plan.

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

“Open Enrollment Period” with respect to a Plan Year means the months of January through March preceding the start of a new Plan Year, or such other period as may be prescribed by the Administrator.

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

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

“Plan” means the Florida Institute of Technology Health Reimbursement Account Plan as set forth herein and as amended from time to time.

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

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

“Protected Health Information” shall have the meaning described in 45 CFR Section 160.103 and generally includes individually identifiable health information held by, or on behalf of, the Plan.

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

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

“**Spouse**” means an individual who is legally married to a Participant as determined under applicable state law (and who is treated as a spouse under the Code).

“**SPD**” means the separate summary plan description describing the terms of this Plan.

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

ARTICLE III. ELIGIBILITY AND PARTICIPATION

3.1 Eligibility to Participate

An individual is an Eligible Employee and may participate in this Plan if the individual is an Employee and is also enrolled in the ICUBA Medical Plan’s PPO 70 or Risk/Reward option. Once an Employee becomes an Eligible Employee by meeting the Plan’s eligibility requirements, the Eligible Employee’s coverage under the Plan as a Participant will automatically commence (a) on the first day of the Plan Year if such Eligible Employee enrolled in the ICUBA Medical Plan’s PPO 70 or Risk/Reward option during the ICUBA Plan’s open enrollment or (b) on the date that such Eligible Employee first begins participating in the ICUBA Medical Plan’s PPO 70 or Risk/Reward option.

3.2 Termination of Participation

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

- the termination of this Plan; or
- the date on which the Employee ceases to be an Eligible Employee (because of ceasing to be enrolled in the ICUBA Medical Plan’s PPO 70 or Risk/Reward option or because of retirement, termination of employment, layoff, reduction in hours, or any other reason), provided that eligibility may continue beyond such date if the Participant was vested in his or her HRA Account or the Participant elected COBRA coverage for this Plan and the ICUBA Medical Plan’s PPO 70 or Risk/Reward option. If a Participant’s HRA Account is vested, then his participation in this Plan shall cease on the date that his HRA Account balance is exhausted.

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

3.3 FMLA and USERRA Leaves of Absence

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

3.4 Non-FMLA and Non-USERRA Leaves of Absence

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

ARTICLE IV. VESTING

4.1 Vesting

A Participant will become fully vested in his or her HRA Account after (a) he or she has remained an Eligible Employee for 36 consecutive months and (b) the Employer has made continuous contributions to such Participant's HRA Account for a consecutive 36-month period. If a Participant ceases to be an Eligible Employee (*e.g.*, he or she terminates employment with the Employer, he or she stops participating in the ICUBA Medical Plan's PPO 70 or Risk/Reward option, etc.) before vesting in his or her HRA Account and then later becomes an Eligible Employee again, then such individual shall recommence participation in the HRA with a new HRA Account since his or her old HRA Account balance was forfeited and a new 36-month vesting period will commence (*i.e.*, his or her old vesting service will not count toward the new 36-month vesting period). COBRA continuation coverage shall not count toward vesting of an HRA Account. Only a Participant may vest in his or her HRA Account (*e.g.*, Dependents and Spouses may not vest in an HRA Account).

ARTICLE V. BENEFITS OFFERED AND METHOD OF FUNDING

5.1 Benefits Offered

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

5.2 Employer and Participant Contributions

- (a) *Employer Contributions.* The Employer funds the full amount of the HRA Accounts.
- (b) *Participant Contributions.* There are no Participant contributions for Benefits under the Plan (except as required under any applicable continuation of coverage requirements).
- (c) *No Funding Under Cafeteria Plan.* Under no circumstances will the Benefits be

funded with salary reduction contributions, employer contributions (*e.g.*, flex credits) or otherwise under a cafeteria plan, nor will salary reduction contributions or employer contributions be treated as Employer contributions to the Plan.

5.3 Funding This Plan

All of the amounts payable under this Plan shall be paid from the general assets of the Employer, or if elected by the Employer, shall be held in trust. Nothing herein will be construed to require the Employer or the Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, HRA Account or asset of the Employer from which any payment under this Plan may be made.

ARTICLE VI. HEALTH REIMBURSEMENT BENEFITS

6.1 Benefits

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

6.2 Eligible Medical/Dental/Prescription Expenses

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

- (a) *Incurred.* A Medical/Dental/Prescription Expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays for the medical care. Medical/Dental/Prescription Expenses incurred before a Participant first becomes covered by the Plan are not eligible.
- (b) *Medical/Dental/Prescription Expenses Generally.* "Medical/Dental/Prescription Expenses" means expenses incurred by a Participant (or his or her Spouse and/or Dependents if (1) such Spouse and/or Dependents are participants in the ICUBA Medical Plan's PPO 70 or Risk/Reward option or (2) the Participant's HRA Account is vested) for medical care, as defined in Code Section 213 (including, for example, amounts for certain hospital bills, doctor and dental bills and prescription drugs), but shall not include expenses that are described in subsection (c). Reimbursements due for Medical/Dental/Prescription Expenses incurred by the Participant or the Participant's Spouse or Dependents (if eligible) shall be charged against the Participant's HRA Account.
- (c) *Medical/Dental/Prescription Expenses Exclusions.* "Medical/Dental/Prescription Expenses" shall not include (1) health insurance premiums for individual policies or for any other group health plan (including a plan sponsored by the Employer); (2) unprescribed medicines or drugs (other than insulin), without regard to whether such medicine or drug could be obtained without a prescription; and (3) the expenses listed as exclusions under Appendix B to this Plan. Notwithstanding the foregoing,

an HRA Account may reimburse (A) COBRA premiums that a Participant pays on an after-tax basis under any other group health plan sponsored by the Employer, (B) premiums that a Participant pays on an after-tax basis for retiree health coverage, and (C) premiums that a Participant pays on an after-tax basis for qualified long-term care insurance.

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

6.3 Maximum Benefits

- (a) *Maximum Benefits.* The maximum dollar amount that may be credited to an HRA Account for an Employee who participates in the Plan for an entire 12-month Period of Coverage is as follows:

	PPO 70 BLUE CHOICE	PPO 70 BLUE OPTIONS	RISK/REWARD BLUE CHOICE	RISK/REWARD BLUE OPTIONS
EMPLOYEE ONLY	\$720.00	\$720.00	\$1,200.00	\$1,200.00
EMPLOYEE+SPOUSE	\$1,440.00	\$1,440.00	\$2,400.00	\$2,400.00
EMPLOYEE+CHILDREN	\$1,440.00	\$1,440.00	\$2,400.00	\$2,400.00
FAMILY	\$1,440.00	\$1,440.00	\$2,400.00	\$2,400.00

Unused amounts may be carried over to the next Period of Coverage, as provided in Section 6.5.

- (b) *Changes.* For subsequent Plan Years, the maximum dollar limit may be changed by the Administrator and shall be communicated to Employees during Open Enrollment or through the SPD or other document.
- (c) *Nondiscrimination.* Reimbursements to Highly Compensated Individuals may be limited or treated as taxable compensation to comply with Code Section 105(h), as may be determined by the Administrator in its sole discretion.

6.4 Establishment of HRA Account

The Administrator will establish and maintain an HRA Account with respect to each Participant. The HRA Account so established will merely be a recordkeeping HRA Account with the purpose of keeping track of contributions and available reimbursement amounts.

- (a) *Crediting of HRA Account.* A Participant's HRA Account will be credited at the beginning of each calendar month with an amount equal to the applicable maximum dollar limit for the Period of Coverage divided by the number of months in that Period of Coverage (*e.g.*, divided by 12 in a 12-month Plan Year), increased by any carryover of unused HRA Account balances from prior Periods of Coverage.
- (b) *Debiting of HRA Accounts.* A Participant's HRA Account will be debited during each Period of Coverage for any reimbursement of Medical/Dental/Prescription Expenses incurred during the Period of Coverage. In addition, a Participant's vested HRA Account, if any, shall be debited an administrative fee each month starting with the first month that he or she ceases to be an Eligible Employee. Such administrative fee shall be determined by the Administrator, in its sole discretion.
- (c) *Available Amounts.* The amount available for reimbursement of Medical/Dental/Prescription Expenses is the amount credited to the Participant's HRA Account under subsection (a) reduced by prior reimbursements debited under subsection (b).
- (d) *Interest.* The amount in a Participant's HRA Account that is available for reimbursement of Medical/Dental/Prescription Expenses (as described in subsection (c) above) shall be credited with interest earned during a quarter (if any) on March 31, June 30, September 30, and December 31.

6.5 Carryover of HRA Accounts

If any balance remains in the Participant's HRA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, such balance shall be carried over to reimburse the Participant for Medical/Dental/Prescription Expenses incurred during a subsequent Period of Coverage. However, unless a Participant (a) is vested in his or her HRA Account or (b) has elected COBRA continuation coverage in accordance with Section 6.7, then (1) upon termination of employment or other loss of eligibility, such Participant's coverage shall cease and expenses incurred after such time shall not be reimbursed and (2) any HRA benefit payments that are unclaimed (*e.g.*, uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Medical/Dental/Prescription Expense was incurred shall be forfeited.

6.6 Reimbursement Procedure

- (a) *Timing.* Within 30 days after receipt by the Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Medical/Dental/Prescription Expenses (if the Administrator approves the claim), or the Administrator will notify the Participant that his or her claim has been denied. The 30-day time period may be extended for an additional 15 days for matters beyond the control of the Administrator, including in cases where a reimbursement claim is incomplete. The Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete an incomplete reimbursement claim.
- (b) *Claims Substantiation.* A Participant who seeks Benefits may apply for reimbursement by submitting an application in writing to the Administrator in such

form as the Administrator may prescribe, by no later than the last day of the Plan Year in which the Medical/Dental/Prescription Expense was incurred, setting forth:

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

The application shall be accompanied by bills, invoices, or other statements from an independent third party (*e.g.*, a hospital, physician, or pharmacy) showing that the Medical/Dental/Prescription Expenses have been incurred and the amounts of such Medical/Dental/Prescription Expenses, together with any additional documentation that the Administrator may request. Except for the final reimbursement claim for a Period of Coverage, no claim for reimbursement may be made unless and until the aggregate claims for reimbursement total at least \$5.

6.7 Reimbursements After Termination; COBRA

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

(b) *COBRA.* Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, the Participant and his or her Spouse and Dependents ("Qualified Beneficiaries"), whose coverage terminates under the HRA Account because of a COBRA qualifying event, shall be given the opportunity to continue (on a self-pay basis) the same coverage that he or she had under the HRA Account on the day before the qualifying event for the periods prescribed by COBRA (subject to all conditions and limitations under COBRA) so long as the Qualified Beneficiaries make a COBRA election to continue participating in the ICUBA Medical Plan's PPO 70 or Risk/Reward option. However, in the event that such coverage is modified for all similarly-situated non-COBRA Participants prior to the date continuation coverage is elected, Qualified Beneficiaries shall be eligible to continue the same coverage that is provided to similarly-situated non-COBRA Participants. At the end of each month in the Period of Coverage, Qualified Beneficiaries shall be credited with the monthly reimbursement accrual (*i.e.*, the maximum annual reimbursement amount, divided by the number of months in that Period of Coverage) that is made available to similarly-situated non-COBRA beneficiaries, and any unused reimbursement amounts from the previous Period of Coverage shall be carried over to the next Period of Coverage (provided that the applicable premium is paid). A premium for COBRA shall be charged to Qualified Beneficiaries in such amounts and shall be payable at such times as are established by the

Administrator and permitted by COBRA.

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

(a) Florida Institute of Technology is the named fiduciary for the Plan for purposes of ERISA Section 402(a).

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

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

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

**ARTICLE VII.
HIPAA PRIVACY AND SECURITY**

7.1 Employer's Certification of Compliance

The Plan shall not disclose Protected Health Information to the Employer unless the Employer certifies that the Plan document incorporates the provisions of 45 CFR Section 164.504(f) (2) (ii) and the Employer agrees to conditions of disclosure set forth in this Article VII.

7.2 Permitted Disclosure of Enrollment/Disenrollment Information

The Plan may disclose to the Employer information on whether an individual is a Participant in the Plan.

7.3 Permitted Uses and Disclosures of Summary Health Information

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

“Summary Health Information” means information (a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a health plan; and (b) from which the information described at 42 CFR Section 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR Section 164.514(b)(2)(i)(B) need only be aggregated to the level of a five digit ZIP code.

7.4 Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes

Unless otherwise permitted by law, the Plan may disclose a Covered Individual's Protected Health Information to the Employer, provided that the Employer will use or disclose such Protected Health Information only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Employer on behalf of the Plan, such as quality assurance, claims processing (including appeals), auditing, and monitoring. Plan administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related functions. Any disclosure to and use by the Employer of a Covered Individual's Protected Health Information will be subject to and consistent with the provisions of this Article VII (including, but not limited to, the restrictions on the Employer's use and disclosure described in Section 7.5) and the specifications and requirements of the administrative simplification provisions of HIPAA and its implementing regulations at 45 CFR Parts 160-64.

7.5 Restrictions on Employer's Use and Disclosure of Protected Health Information

- (a) The Employer will neither use nor further disclose a Covered Individual's Protected Health Information, except as permitted or required by the Plan document, or as required by law.
- (b) The Employer will ensure that any agent, including any subcontractor, to which it provides a Covered Individual's Protected Health Information or Electronic Protected Health Information received from the Plan, agrees to the restrictions, conditions, and security measures of the Plan document that apply to the Employer with respect to the Protected Health Information or Electronic Protected Health Information, respectively.
- (c) The Employer will not use or disclose a Covered Individual's Protected Health Information for employment-related actions or decisions, or in connection with any other benefit or employee benefit plan of the Employer.
- (d) The Employer will report to the Plan any use or disclosure of a Covered Individual's Protected Health Information that is inconsistent with the uses and disclosures allowed under the Plan document of which the Employer becomes aware.
- (e) The Employer will make Protected Health Information available to the Plan or to the Covered Individual who is the subject of the information in accordance with 45 CFR Section 164.524.
- (f) The Employer will make a Covered Individual's Protected Health Information available for amendment, and will on notice amend a Covered Individual's Protected Health Information, in accordance with 45 CFR Section 164.526.
- (g) The Employer will track disclosures it may make of a Covered Individual's Protected Health Information that are HRA Accountable under 45 CFR Section 164.528 so that it can make available the information required for the Plan to provide an HRA Accounting of disclosures in accordance with 45 CFR Section 164.528.
- (h) The Employer will make its internal practices, books, and records relating to its use and disclosure of a Covered Individual's Protected Health Information received from

the Plan available to the Plan and to the U.S. Department of Health and Human Services to determine compliance with the HIPAA Privacy Rule at 45 CFR Part 164, Subpart E.

- (i) The Employer will, if feasible, return or destroy all Protected Health Information of a Covered Individual, in whatever form or medium, received from the Plan, including all copies thereof and all data, compilations, or other works derived therefrom that allow identification of any Covered Individual who is the subject of the Protected Health Information, when the Covered Individual's Protected Health Information is no longer needed for the Plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all such Protected Health Information, the Employer will limit the use or disclosure of any Covered Individual's Protected Health Information that cannot feasibly be returned or destroyed to those purposes that make the return or destruction of the information infeasible.
- (j) The Employer will ensure that the adequate separation between the Plan and the Employer (*i.e.*, the "firewall"), required by 45 CFR Section 504(f) (2) (iii), is satisfied.

7.6 Adequate Separation Between the Employer and the Plan

- (a) Only the following employees or classes of employees or other workforce members under the control of the Employer may be given access to a Covered Individual's Protected Health Information or Electronic Protected Health Information received from the Plan or a business associate servicing the Plan:
 - The Privacy Official;
 - Employees in the Employer's Human Resources Department;
 - Employees in the Employer's Office of General Counsel; and
 - Any other class of employees designated in writing by the Privacy Official.
- (b) The employees, classes of employees, or other workforce members identified in Section 7.6(a) will have access to a Covered Individual's Protected Health Information or Electronic Protected Health Information only to perform the Plan administration functions that the Employer provides for the Plan, as specified in Section 7.4.
- (c) The employees, classes of employees, or other workforce members identified in Section 7.6(a) will be subject to disciplinary action and sanctions pursuant to the Employer's employee discipline and termination procedures, for any use or disclosure of a Covered Individual's Protected Health Information or Electronic Protected Health Information in breach or violation of or noncompliance with the provisions of this Article VII.

7.7 Security Measures for Electronic Protected Health Information

The Employer will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of a Covered Individual's Electronic Protected Health Information that the Employer creates, receives, maintains, or transmits on the Plan's behalf.

7.8 Notification of Security Incident

The Employer will report to the Plan any attempted or successful unauthorized access, use, disclosure, modification, or destruction of information, or interference with system operations in the Employer's information systems, of which the Employer becomes aware.

ARTICLE VIII. APPEALS PROCEDURE

8.1 Procedure If Benefits Are Denied Under This Plan

If a claim for reimbursement under this Plan is wholly or partially denied, claims shall be administered in accordance with the claims procedures set forth in the summary plan description for this Plan. An external review process shall be provided as legally required and as further set forth in the SPD.

ARTICLE IX. RECORDKEEPING AND ADMINISTRATION

9.1 Administrator

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

9.2 Powers of the Administrator

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

- (a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of Benefits under this Plan;
- (b) To prescribe procedures to be followed and the forms to be used by Employees and Participants to enroll in and submit claims pursuant to this Plan;
- (c) To prepare and distribute information explaining this Plan and the Benefits under this Plan in such manner as the Administrator determines to be appropriate;

- (d) To request and receive from all Employees and Participants such information as the Administrator shall from time to time determine to be necessary for the proper administration of this Plan;
- (e) To furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Administrator determines to be reasonable and appropriate;
- (f) To receive, review, and keep on file such reports and information concerning the Benefits covered by this Plan as the Administrator determines from time to time to be necessary and proper;
- (g) To appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;
- (h) To sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;
- (i) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and
- (j) To maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

9.3. Reliance on Participant, Tables, etc.

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

9.4 Provision for Third-Party Plan Service Providers

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

9.5 Fiduciary Liability

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

9.6 Compensation of Administrator

Unless otherwise determined by the Employer and permitted by law, any Administrator who

is also an Employee of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of the Administrator's duties shall be paid by the Employer.

9.7 Bonding

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

9.8 Insurance Contracts

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

9.9 Inability to Locate Payee

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

9.10 Effect of Mistake

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

ARTICLE X. GENERAL PROVISIONS

10.1 Expenses

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

10.2 No Contract of Employment

Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be

employed for any specific period of time. All Employees are considered to be employed at the will of the Employer.

10.3 Amendment and Termination

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

10.4 Governing Law

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

10.5 Code and ERISA Compliance

It is intended that this Plan meet all applicable requirements of the Code and ERISA, and of all regulations issued thereunder. This Plan shall be construed, operated and administered accordingly, and in the event of any conflict between any part, clause, or provision of this Plan and the Code and/or ERISA, the provisions of the Code and/or ERISA shall be deemed controlling, and any conflicting part, clause, or provision of this Plan shall be deemed superseded to the extent of the conflict.

10.6 No Guarantee of Tax Consequences

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

10.7 Indemnification of Employer

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

10.8 Non-Assignability of Rights

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

10.9 Headings

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

10.10 Plan Provisions Controlling

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

10.11 Severability

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

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising the Florida Institute of Technology Health Reimbursement Account Plan, Florida Institute of Technology has caused this Plan to be executed in its name and on its behalf, on this ___ day of _____, 2011.

Florida Institute of Technology

Date: _____

By: _____

Its: _____

APPENDIX A

**RELATED EMPLOYERS THAT HAVE ADOPTED THIS PLAN,
WITH THE APPROVAL OF Florida Institute of Technology**

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

APPENDIX B

EXCLUSIONS: MEDICAL/DENTAL/PRESCRIPTION EXPENSES THAT ARE NOT REIMBURSABLE FROM THE HRA ACCOUNT

The Florida Institute of Technology Health Reimbursement Account Plan document contains the general rules governing what Medical/Dental/Prescription Expenses are reimbursable. This Appendix B, as referenced in the Plan document, specifies certain expenses that are not reimbursable, even if they meet the definition of “medical care” under Code Section 213(d) and may otherwise be reimbursable under IRS guidance pertaining to HRAs.

Exclusions:

The following expenses are not reimbursable even if they meet the definition of “medical care” under Code Section 213(d) and may otherwise be reimbursable under IRS guidance pertaining to HRAs:

- Health insurance premiums for any other plan (including a plan sponsored by the Employer). Notwithstanding the foregoing, the HRA Account may reimburse COBRA premiums that a Participant pays on an after-tax basis under any other group health plan sponsored by the Employer.
- Long-term care services.
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. “Cosmetic surgery” means any procedure that is directed at improving the patient’s appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- The salary expense of a nurse to care for a healthy newborn at home.
- Funeral and burial expenses.
- Household and domestic help (even though recommended by a qualified physician due to an Employee’s, Spouse’s, or Dependent’s inability to perform physical housework).
- Custodial care.
- Costs for sending a problem child to a special school for benefits that the child may receive from the course of study and disciplinary methods.
- Social activities, such as dance lessons (even though recommended by a physician for general health improvement).
- Bottled water.
- Cosmetics, toiletries, toothpaste, etc.
- Uniforms or special clothing, such as maternity clothing.

- Automobile insurance premiums.
- Transportation expenses except for the following: (1) transportation expenses for a parent who must go with a child who needs medical care, (2) transportation expenses for a nurse or other person who gives injections, medications, or other treatment required by a patient who is traveling to get medical care and is unable to travel alone, and (3) transportation expenses for an individual who travels to visit a mentally ill dependent, if such visits are recommended as part of treatment.
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
- Any item that does not constitute “medical care” as defined under Code Section 213(d).
- Any over-the-counter medicine or drug, unless (1) the Participant obtains a prescription for the medicine or drug, or (2) the medicine or drug is insulin.