

NOVA SOUTHEASTERN UNIVERSITY
HEALTH REIMBURSEMENT ACCOUNT PLAN

As Amended and Restated Effective April 1, 2015

ARTICLE I. INTRODUCTION

1.1 Establishment of Plan

NOVA SOUTHEASTERN UNIVERSITY (the “Employer”) has established the NOVA SOUTHEASTERN UNIVERSITY Health Reimbursement Account Plan (the “Plan”) effective April 1, 2003. This Plan is amended and restated effective April 1, 2015. Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in Article II. This Plan document constitutes the summary plan description, as required by Section 102 of the Employee Retirement Income Security Act of 1974 (“ERISA”).

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.

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, Inc. Medical, Behavioral Health, and Prescription Drug Plan, including any riders and or amendments thereto) with a “spend-down” feature (*i.e.*, former employees with vested HRAs can spend down their HRA balance on eligible Medical/Dental/Prescription Expenses until the 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 NOVA SOUTHEASTERN UNIVERSITY; provided, however, that the NOVA SOUTHEASTERN UNIVERSITY has delegated full authority to act on behalf of the Administrator to the Independent Colleges and Universities Benefits Association (“ICUBA”), except with respect to appeals, for which the Administrator has the full authority to decide, as described in Section 9.1.

“**Amendment & Restatement Effective Date**” of this Plan means April 1, 2015.

“**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 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 April 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 NOVA SOUTHEASTERN UNIVERSITY and any Related Employer that adopts this Plan with the approval of NOVA SOUTHEASTERN UNIVERSITY. 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 NOVA SOUTHEASTERN UNIVERSITY.

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

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

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

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

“**ICUBA Medical Plan**” means the Independent Colleges and Universities Benefits Association, Inc. Medical, Behavioral Health, and Prescription Drug Plan, including any riders thereto.

“**ICUBA Medical Plan’s HRA-Eligible Benefit Option**” means the eligible ICUBA Medical Plan’s that provide HRA benefits.

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

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

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

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

“**Plan**” means the NOVA SOUTHEASTERN UNIVERSITY 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 NOVA SOUTHEASTERN UNIVERSITY that, under Code Section 414(b), (c), or (m), is treated as a single employer with NOVA SOUTHEASTERN UNIVERSITY for purposes of Code Section 105.

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

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

ARTICLE III. ELIGIBILITY AND PARTICIPATION

3.1 Eligibility to Participate

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

3.2 Termination of Participation

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

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

Reimbursements from the HRA 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 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 for a consecutive 36-month period. If a Participant ceases to be an Eligible Employee (*e.g.*, he or she terminates employment with the Employer, he or she stops participating in the ICUBA Medical Plan's HRA-Eligible Benefit Option, etc.) before vesting in his or her HRA and then later becomes an Eligible Employee again, then such individual shall recommence participation in the HRA with a new HRA since his or her old HRA 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. Only a Participant may vest in his or her HRA (*e.g.*, Dependents and Spouses may not vest in an HRA). In the unfortunate event of the participant's death; there will be a 90 day period in which claims can be submitted for reimbursement. Claims can be submitted for eligible expenses for the deceased and all eligible dependents. Services must be incurred within 12 months of the participant's death. HRA funds remaining after 90 days are forfeited.

4.2 Opting Out and Waiving Future Reimbursements from

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

**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 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 HRAs.
- (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 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, as set forth and adjusted under Section 6.3.

6.2 Eligible Medical/Dental/Prescription Expenses

Under the HRA, 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 HRA-Eligible Benefit Option or (2) the Participant’s HRA is vested) for medical care, as defined in Code Section 213 (including, for example, amounts for certain hospital bills, doctor and dental bills and prescription drugs), but shall not include expenses that are described in subsection (c). Reimbursements due for Medical/Dental/Prescription Expenses incurred by the Participant or the Participant’s Spouse or Dependents (if eligible) shall be charged against the Participant’s HRA.
- (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 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 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 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 for an Employee who participates in the Plan for an entire 12-month Period of Coverage is set forth in Appendix C hereto. Unused amounts may be carried over to the next Period of Coverage, as provided in Section 6.5.
- (b) *Changes.* For subsequent Plan Years, the maximum dollar limit may be changed by the Administrator and shall be communicated to Employees during Open Enrollment or through the SPD or other 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

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

- (a) *Crediting of HRA.* A Participant's HRA will be credited in accordance with the provisions set forth in Appendix D hereto.
- (b) *Debiting of HRA.* A Participant's HRA 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, if any, shall be debited an administrative fee each month starting with the first full 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 under subsection (a) reduced by prior reimbursements debited under subsection (b).
- (d) *Interest.* The amount in a Participant's HRA that is available for reimbursement of Medical/Dental/Prescription Expenses (as described in subsection (c) above) shall be credited with interest earned during a quarter (if any) on March 31, June 30, September 30, and December 31.

6.5 Carryover of HRAs

If any balance remains in the Participant's HRA for a Period of Coverage after all reimbursements have been made for the Period of Coverage, such balance shall be carried over to reimburse the Participant for Medical/Dental/Prescription Expenses incurred during a subsequent Period of Coverage. However, unless a Participant (a) is vested in his or her HRA or (b) has elected COBRA continuation coverage in accordance with Section 6.7, then (1) upon 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, within 12 months of the date that the Medical/Dental/Prescription Expense was incurred, setting forth:

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

The application shall be accompanied by bills, invoices, 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 because of a COBRA qualifying event, shall be given the opportunity to continue (on a self-pay basis) the same coverage that he or she had under the HRA on the day before the qualifying event for the periods prescribed by COBRA (subject to all conditions and limitations under COBRA) so long as the Qualified Beneficiaries make a COBRA election to continue participating in the ICUBA Medical Plan. 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 beginning 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) NOVA SOUTHEASTERN UNIVERSITY 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 (including finance/payroll staff performing HRA functions);
 - 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 appeals procedures set forth in Appendix C of this Plan.

ARTICLE IX. RECORDKEEPING AND ADMINISTRATION

9.1 Administrator

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

9.2 Powers of the Administrator

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

- (a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact,

questions relating to eligibility and participation, and questions of Benefits under this Plan;

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

ARTICLE XI. PLAN INFORMATION AND STATEMENT OF ERISA RIGHTS

11.1 Plan Identifying Information

Plan Name: NOVA SOUTHEASTERN UNIVERSITY Health Reimbursement Account Plan

Type of Plan: The Plan is intended to qualify as an employer-provided medical reimbursement plan under Code Sections 105 and 106 and the regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45. The Plan is also intended to be an "integrated HRA" (*i.e.*, the Plan is integrated with the Independent Colleges and Universities Benefits Association, Inc. Medical, Behavioral Health, and Prescription Drug Plan, including any riders thereto) with a "spend-down" feature (*i.e.*, former employees with vested HRAs can spend down their HRA balance on eligible Medical/Dental/Prescription Expenses until the HRA balance is exhausted).

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

Plan Number: The plan number is #507.

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

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

Type of Plan Administration: The Administrator pays applicable Benefits from the general assets of the Employer unless the Employer has elected to fund the Plan through a trust.

Plan Sponsor: Nova Southeastern University
3301 College Avenue
Fort Lauderdale, Florida 33314

Plan Sponsor's EIN: 581083502

Administrator: Nova Southeastern University
Attention: Human Resources
3301 College Avenue
Fort Lauderdale, Florida 33314

Third Party Administrator: ICUBA
Attn: Benefits Administration
P.O. Box 616927
Orlando, FL 32861-6927
1-866-377-5102
1-866-377-5180 (Fax)
benefitsadministration@icuba.org

Named Fiduciary: Nova Southeastern University
Attention: Human Resources
3301 College Avenue
Fort Lauderdale, Florida 33314

Agent for Service Of Legal Process: Nova Southeastern University
Attention: Human Resources
3301 College Avenue
Fort Lauderdale, Florida 33314

11.2 Statement of ERISA Rights

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

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

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

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Administrator to provide the materials and pay you up to \$110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits, which is denied or ignored in whole or in part, and if you have exhausted the claims procedure available to you under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof regarding the qualified status of a medical child support order, you may file suit in federal court.

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

If you have any questions about your Plan, you should contact the Administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in

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

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising the NOVA SOUTHEASTERN UNIVERSITY Health Reimbursement Account Plan, NOVA SOUTHEASTERN UNIVERSITY has caused this Plan to be executed in its name and on its behalf, on this ____ day of _____, 2015.

NOVA SOUTHEASTERN UNIVERSITY

Date: _____

By: _____

Its: _____

APPENDIX A

RELATED EMPLOYERS THAT HAVE ADOPTED THIS PLAN, WITH THE APPROVAL OF NOVA SOUTHEASTERN UNIVERSITY

No Related Employers have adopted this Plan. NOVA SOUTHEASTERN UNIVERSITY is the only employer participating in this Plan.

APPENDIX B

ELIGIBLE AND INELIGIBLE HEALTH CARE EXPENSE LISTING

ACNE LASER TREATMENT

Expenses paid for acne treatment are reimbursable.

ACUPUNCTURE

Medical expenses paid for acupuncture are reimbursable.

ADOPTION

The cost of the adoption itself is not reimbursable; however things like physicals for the adoptive parents, pre-adoption counseling, and other health related expenses are reimbursable.

ADULT DIAPERS

Expenses paid for diapers are reimbursable.

ALCOHOLISM, DRUG OR SUBSTANCE ABUSE

Medical expenses paid to a treatment center for alcohol or drug abuse are reimbursable. This includes meals and lodging provided by the center during treatment.

ALLERGY AND SINUS RELIEF

(See Over-The-Counter Medicines and Drugs for other items.)

The following are considered reimbursable medical expenses.

- Electrostatic air purifier.
- Home/automobile air conditioners (when the person suffers from allergies).
- Humidifier (when the person suffers from allergies).
- Pillows, mattress covers, etc. to alleviate an allergic condition.
- Special vacuum cleaners for persons with respiratory problems.

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

ALTERNATIVE PROVIDERS

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

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

AMBULANCE

Medical expenses paid for ambulance service are reimbursable.

ARTIFICIAL LIMBS/TEETH

Medical expenses paid for an artificial limb are reimbursable.

AUTOMOBILE

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

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

BABY FORMULA

The *cost difference* between Protein formulas and soybean formulas and non-milk formulas are reimbursable *if you have a prescription or a certification* from the baby's doctor noting that this particular formula is necessary for the child's well being.

BATTERIES

Expenses paid for the purchase of batteries are reimbursable when they are used for the sole purpose of an item that is also covered. This would include, but not be limited to, batteries for blood pressure machines, wheelchairs, heart defibrillators, hearing aids, etc. Request for reimbursement should include a description of the item the batteries are purchased for.

BIRTH CONTROL RELATED

Medical expenses paid for birth control pills, injections, condoms and devices are reimbursable.

BLOOD CORD STORAGE

Blood cord storage for immediate use to cure or treat a specific medical condition is eligible reimbursable. If storage is for possible future use for disease or disorders that do not currently exist, it is not reimbursable.

BODY SCAN

The cost of electronic body scans is reimbursable.

BRILLE BOOKS AND MAGAZINES

The amount by which the cost of Braille books and magazines for use by a visually impaired person exceeds the price for regular books and magazines is reimbursable.

BREAST AUGMENTATION

See Cosmetic Surgery and Procedures.

BREAST PUMPS AND SUPPLIES

Breast pumps and supplies are reimbursable.

BREAST RECONSTRUCTION SURGERY

Breast reconstructive surgery following a mastectomy for cancer is a reimbursable.

BREAST REDUCTION

Medical expenses related to breast reduction surgery are reimbursable only if medically necessary.

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

CAPITAL EXPENSE

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

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

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

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

Operation and Maintenance

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

CHILDBIRTH CLASSES

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

CHIROPRACTOR

Expenses paid to a chiropractor for medical care are reimbursable.

CHRISTIAN SCIENCE PRACTITIONER

Medical expenses paid to Christian Science practitioners are reimbursable.

CONCEIRGE PROVIDERS AND SERVICES

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

COSMETIC SURGERY AND PROCEDURES

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

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

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

COUNSELING

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

- Bereavement and grief counseling is eligible.
- Non-licensed therapist counseling is eligible, but it must be for medical care.
- Psychotherapy and psychoanalysis are eligible.
- Telephone consultation costs are eligible.
- Sex therapy costs are eligible, but the cost of a hotel room prescribed by the therapist is not eligible.
- Marriage counseling is not eligible.

CPAP

(Sleep Apnea) machine and supplies are reimbursable.

CRUTCHES

The amount paid to buy or rent crutches, canes, walkers, and medical equipment are reimbursable.

CUSHIONS

The costs of cushions, including inflatable, are not covered (unless prescribed by a physician to treat a medical condition).

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

DANCING LESSONS, SWIMMING LESSONS, EXERCISE CLASSES, ETC.

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

DENTAL TREATMENT

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

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

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

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

DIAPERS

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

DIAGNOSTIC DEVICES/SERVICES

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

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

DIETARY SUPPLEMENTS

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

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

DOCTORS' FEES

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

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

Other

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

DOULA

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

DRUGS

See Medicines.

DRUG ADDICTION

See Alcoholism, Drug or Substance Abuse.

ELECTROLYSIS OR HAIR REMOVAL

See Cosmetic surgery and Procedures.

EMPLOYMENT TAXES

See Nursing Services.

EXERCISE EQUIPMENT

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

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

FAMILY/GROUP THERAPY

Expenses for family, group or marriage therapy are not reimbursable

FERTILITY ENHANCEMENT

The following expenses are considered reimbursable:

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

The following expenses do not qualify:

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

FUNERAL EXPENSES

Expenses for funerals are not eligible for reimbursement.

GUIDE DOG OR OTHER SERVICE ANIMAL

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

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

HAIR TRANSPLANT

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

HEALTH CLUB DUES

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

HEALTH INSTITUTE

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

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

HEARING AIDS

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

HERBAL MEDICATIONS

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

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

HOME MEDICAL TEST

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

HOSPITAL

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

HOUSEHOLD HELP

The cost of household help, even if recommended by your doctor, is not reimbursable.

Certain expenses paid to an attendant providing nursing type service may be eligible. *See Nursing Services.*

INSURANCE PREMIUMS

Insurance premiums you pay with after-tax dollars that cover medical care are reimbursable. Policies can provide payment for:

- Hospitalization, surgical fees, X-rays, etc.
- Prescription drugs.
- Dental care.
- Replacement of lost or damaged contact lenses.
- Membership in an association that gives cooperative or so-called “free-choice” medical service, or group hospitalization and clinical care.
- Qualified long-term care insurance contracts (subject to additional limitations). See *Qualified Long-Term Care Insurance Contracts* under *Long-Term Care Insurance Contracts*, later.

If you have a policy that provides more than one kind of insurance payment, the premiums for the medical care part of the policy (if the charge for the medical part is reasonable) is reimbursable. The cost of the medical part must be separately stated in the insurance contract or given to you in a separate statement.

You cannot include premiums you pay for:

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

Prepaid Insurance Premiums

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

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

LABORATORY FEES

Laboratory fees that are part of medical care are reimbursable.

LEAD-BASED PAINT REMOVAL

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

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

LEARNING DISABILITY

Tuition payments to a special school for a child, who has severe learning disabilities caused by mental or physical impairments, including nervous system disorders, are reimbursable. A doctor must recommend that the child attend the school. Also, tutoring fees paid on a doctor's recommendation for a child's tutoring by a teacher who is specially trained and qualified to work with children who have severe learning disabilities are reimbursable.

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

LEGAL FEES

Legal fees paid to authorize treatment for mental illness are reimbursable; however, if parts of the legal fees include, for example, guardianship or estate management fees, are not reimbursable. Legal fees to get a divorce, even if recommended by a physician, do **not** qualify.

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

LIFETIME CARE-ADVANCE PAYMENTS

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

Dependents with disabilities

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

Payments for future medical care

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

LODGING

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

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

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

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

LONG-TERM CARE INSURANCE CONTRACTS

Qualified long-term care insurance contract is an insurance contract that provides only coverage of qualified long-term care services. Qualified long-term care insurance contract is reimbursable.

The contract must:

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

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

1. Qualified long-term care monthly premium up to the amounts shown below:
 - Age 40 or under - \$290
 - Age 41 to 50 - \$550

- Age 51 to 60 - \$1,110
- Age 61 to 70 - \$2,950
- Age 71 or over - \$3,680

2. Unreimbursed expenses for qualified long-term care services.

Note. The limit on premiums is for each person.

Also, you cannot include premiums for long-term care insurance if you elected to pay these premiums with tax-free distributions from a qualified retirement plan made directly to the insurance provider and these distributions would otherwise have been included in income.

LONG TERM CARE SERVICES

Long term care services are reimbursable. Medical expenses incurred while a resident receiving long-term care benefits are reimbursable. Long term care insurance premiums are reimbursable.

MASSAGE THERAPY AND EQUIPMENT

Fees paid for massages and equipment (i.e. massage chair) are not reimbursable unless to treat a physical defect or illness.

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

MATERNITY CLOTHES

Expenses for maternity clothes are not reimbursable.

MATERNITY SUPPORT

Expenses paid for a maternity support band are reimbursable.

MATTRESS AND MATTRESS BOARDS

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

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

MEALS

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

MEDICAL ALERT PROGRAMS

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

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

MEDICAL CONFERENCES

Amounts paid for admission and transportation to a medical conference if the medical conference concerns the chronic illness of yourself, your spouse, or you're dependent are reimbursable. The costs of the medical conference must be primarily for and necessary to the medical care of you, your

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

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

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

MEDICAL EQUIPMENT MAINTENANCE

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

- The maintenance cost for operating the devices (e.g., electricity for air conditioner use) is also an Eligible Medical Expense.
- The maintenance cost for a home swimming pool for a person suffering from emphysema may be considered an Eligible Medical Expense. An appraisal of the property value before and after installation is required with submission. Only the portion of the expense that exceeds the increase in property value is eligible as a medical expense.
- Furnace air filters are eligible.
- Warranties **are not** eligible.

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

MEDICAL INFORMATION

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

MEDICARE PART A

If you are covered under social security (or if you are a government employee who paid Medicare tax), you are enrolled in Medicare A. The payroll tax paid for Medicare A is not reimbursable. If you are not covered under social security (or were not a government employee who paid Medicare tax), you can voluntarily enroll in Medicare A. In this situation, premiums you paid for Medicare A as a medical expense are reimbursable.

MEDICARE PART B

Medicare B is a supplemental medical insurance. Premiums you pay for Medicare B are reimbursable. If you applied for it at age 65 or after you became disabled, the monthly premiums you paid are reimbursable. If you were over age 65 or disabled when you first enrolled check the information you received from the Social Security Administration to find out your premium.

MEDICARE PART D

Medicare D is a voluntary prescription drug insurance program for persons with Medicare A or B. Medicare part D premiums are reimbursable.

MEDICINES

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

NURSING HOME

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

NURSING SERVICES

Wages and other amounts paid for nursing services are reimbursable. Services need not be performed by a nurse as long as the services are of a kind generally performed by a nurse. This includes services connected with caring for the patient's condition, such as giving medication or changing dressings, as well as bathing and grooming the patient.

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

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

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

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

OPERATIONS

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

OPTOMETRIST

See Vision Care.

ORTHODONTIA

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

ORGAN DONOR

See Transplants.

OSTEOPATH

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

OVER-THE-COUNTER MEDICINES AND DRUGS

Starting January 1, 2011, eligible expenses that ***will require a doctor’s prescription*** for reimbursement may include, but are not limited to acetaminophen, acne products, allergy products, antacid remedies, antibiotic creams/ointments, anti-fungal foot sprays/creams, aspirin, baby care products, cold remedies, (including shower vapor tabs), cough syrups and drops, medicated eye and ear drops, ibuprofen, laxatives, migraine remedies, motion sickness, nasal sprays, pain relievers, sleep aids, teething gels, and topical creams for itching, stinging, burning, pain relief, sore healing or insect bites.

Items that will continue to be ***eligible without a doctor’s prescription*** after January 1, 2011 include, but are not limited to band aids, bandages and wraps, braces and supports, catheters, contact lens solutions and supplies, contraceptives and family planning items, denture adhesives, insulin and diabetic supplies, diagnostic tests and monitors, and first aid supplies, peroxide and rubbing alcohol.

OXYGEN

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

PARKING

See Transportation.

PERSONAL ITEMS

items ordinarily used for personal living and family purposes only if it is used primarily to prevent or alleviate a disease or disability and You would not have had the expense were it not for the medical condition are reimbursable.

- Diapers (e.g., Depends TM) are eligible if they are needed to relieve the effects of a particular disease.
- Hospital kits are eligible.
- Special Baby Formula: The ***cost difference*** between protein formulas, soybean formulas, and non milk formulas is eligible ***if you have an Rx or a certification*** from the baby’s doctor noting that this particular formula is necessary for the child’s well being.
- Wig for hair loss due to any disease is eligible.
- Hospital telephones, TV, newspapers, etc., **are not** eligible.

- Sanitary napkins **are not** eligible.

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

PHYSICAL THERAPY

Payments made to an individual for giving patterning exercises to a mentally or physically handicapped dependent are reimbursable. These exercises consist of physical manipulation of the dependent's arms and legs to imitate crawling and other normal movements

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

PLANE TICKETS

See Transportation.

PRIVATE HOSPITAL ROOM

The extra cost of a private hospital room is reimbursable.

PROSTHESIS

See Artificial Limbs/Teeth.

PSYCHIATRIC CARE

Expenses for psychiatric care are reimbursable. These expenses include the cost of supporting a mentally ill dependent at a specially-equipped medical center where the dependent receives medical care.

PSYCHOANALYSIS

Expenses for psychoanalysis are reimbursable. *See Counseling.*

PSYCHOLOGIST

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

RADON REMEDIATION

Expenses incurred to remove radon from the residence are reimbursable.

SAVINGS CLUB

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

SCHOOLS, SPECIAL

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

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

SHIPPING CHARGES

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

SMOKING CESSATION PROGRAM

Smoking is considered an addiction therefore the cost of a program or prescription medication to stop smoking is reimbursable; however non-prescription medicines **are not** reimbursable. Most stop-smoking patches and gum are non-prescription and therefore **are not** reimbursable.

SPECIAL FOODS

The costs of special foods and/or beverages - even if prescribed - that substitute for other foods or beverages which a person would normally consume and which satisfy nutritional requirements (such as the consumption of bananas for potassium), are not reimbursable; However, prescribed special foods or beverages are reimbursable if they are consumed primarily to alleviate or treat an illness or disease, and not for nutritional purposes. Special foods and beverages are reimbursable only to the extent that their cost is greater than the cost of the commonly available version of the same product.

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

SPEECH/VOICE THERAPY

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

SPORTS ORTHOTICS

Expenses paid for sports orthotics are reimbursable.

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

STERILIZATION

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

SUBSTANCE ABUSE

See Alcoholism, Drug or Substance Abuse.

SUNSCREEN

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

TELEPHONE

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

TELEVISION

The cost of equipment that displays the audio part of TV programs as subtitles for the hearing-impaired is reimbursable. This may include an adapter that attaches to a regular TV or the cost of a specially-equipped TV in excess of the cost of the same model regular TV set.

TRANSPLANTS

Expenses you pay for medical care you receive because you are a donor or a possible donor of a kidney or other organ, this includes transportation are reimbursable. You can include any expenses you pay for the medical care of a donor in connection with the donating of an organ. This includes donor transportation.

TRANSPORTATION

Amounts paid for transportation primarily for and essential to medical care is reimbursable. Proof of medical care is required. An individual may be reimbursed \$.24 per mile (or the maximum amount allowed by the IRS) or actual car expenses when traveling in his/her own vehicle to obtain medical care. Mileage documentation is required. The cost of tolls and parking can be added to this amount. This includes:

- Actual use expenses, such as gas and oil (instead of \$.24 per mile). Do not include expenses for 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

Amounts you pay for transportation to another city if the trip is primarily for and essential to, receiving medical services are reimbursable. You may be able to include up to \$50 per night for lodging.

You cannot include in medical expenses a trip or vacation taken merely for a change in environment, improvement of morale, or general improvement of health, even if the trip is made on the advice of a doctor; However, *see Medical Conferences*.

TUITION FEES

Tuition charges for a medically dysfunctional dependent are reimbursable. Tuition fees paid to a private school as a personal preference over public schooling for general education **are not** reimbursable. *See Learning Disability and Schools, Special*.

VACCINES

Expenses for vaccines are reimbursable.

VAPOR UNITS AND REFILLS

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

VISION CARE

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

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

VITAMINS

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

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

WALKER AND ACCESSORIES

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

WEIGHT LOSS PROGRAMS, TREATMENT AND PRESCRIPTIONS

Amounts you pay to lose weight if it is a treatment for a specific disease diagnosed by a physician (such as obesity, hypertension, or heart disease) are reimbursable. This includes fees you pay for membership in a weight reduction group as well as fees for attendance at periodic meetings.

You cannot include membership dues in a gym, health club, or spa as medical expenses, but you can include separate fees charged there for weight loss activities. You cannot include the cost of diet food or beverages in medical expenses because the diet food and beverages substitute for what is normally consumed to satisfy nutritional needs. You can include the cost of special food in medical expenses only if:

1. The food does not satisfy normal nutritional needs;
2. The food alleviates or treats an illness; and
3. The need for the food is substantiated by a physician

The amount you can include in medical expenses is limited to the amount by which the cost of the special food exceeds the cost of a normal diet.

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

WHEELCHAIR

Amounts paid for a manual or motorized wheelchair used mainly for the relief of sickness or disability is reimbursable. The cost of operating and maintaining the wheelchair is also reimbursable.

X-RAY FEES

Amounts paid for X-rays taken for medical reasons are reimbursable.

INELIGIBLE RECEIPTS

In addition, the following are not acceptable receipts:

- Bankcard statements.
- Credit/debit card terminal receipts.
- Charges submitted that are illegible.
- Estimates of expenses. (A statement is required showing date of service and type of medical expense.)

APPENDIX C

MAXIMUM BENEFITS

The maximum dollar amount that may be credited to an HRA for an Employee who participates in the Plan for an entire 12-month Period of Coverage is \$1800.

APPENDIX D

CREDITING OF HRA

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

APPENDIX E
APPEALS PROCEDURE

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

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

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

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

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

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

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

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

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

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

E. What are the requirements of my internal appeal?

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

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

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

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

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

G. How will my internal appeal be reviewed?

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

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

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

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

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

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

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

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

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

- A statement of your right to bring an external appeal or a civil action under ERISA Section 502(a).

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

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

K. What are the requirements of my external review?

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

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

Yes. Your external appeal must be filed with the external reviewer within 4 months of the date you were served with the Plan Administrator's response to your internal appeal request. If you do not file your appeal within this 4-month period, you lose your right to appeal. For example, if you received the internal appeal decision on January 3, 2015, you must appeal the decision by May 3, 2015 (or, if that is not a business day, the next business day thereafter).

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

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