

STATE OF RHODE ISLAND FLEXIBLE BENEFITS PLAN
SUMMARY PLAN DESCRIPTION

TABLE OF CONTENTS

**I
ELIGIBILITY**

1. When can I become a participant in the Plan? 1
2. What are the eligibility requirements for our Plan? 1
3. When is my entry date?..... 1
4. What must I do to enroll in the Plan?..... 1

**II
OPERATION**

1. How does this Plan operate? 1

**III
CONTRIBUTIONS**

1. What happens to contributions made to the Plan?..... 1
2. When must I decide which accounts I want to use?..... 2
3. When is the election period for our Plan? 2
4. May I change my elections during the Plan Year?..... 2
5. May I make new elections in future Plan Years?..... 2

**IV
BENEFITS**

1. What benefits are offered under the Plan? 2
2. Health Care Flexible Spending Arrangement 2
3. Day Care Flexible Spending Arrangement 3

**V
BENEFIT PAYMENTS**

1. When will I receive payments from my accounts? 3
2. What happens if I don't spend all Plan contributions during the Plan Year?..... 4
3. Family and Medical Leave Act (FMLA) 4
4. What happens if I terminate employment?..... 4
5. Will my Social Security benefits be affected? 5

**VI
HIGHLY COMPENSATED AND KEY EMPLOYEES**

1. Do limitations apply to highly compensated employees? 5

**VII
PLAN ACCOUNTING**

1. Periodic Statements..... 5

**VIII
GENERAL INFORMATION ABOUT OUR PLAN**

1.	General Plan Information.....	5
2.	Employer Information.....	5
3.	Plan Administrator Information.....	5
4.	Service of Legal Process.....	6
5.	Type of Administration.....	6
6.	Claims Submission.....	6

**IX
ADDITIONAL PLAN INFORMATION**

1.	Claims Process.....	6
----	---------------------	---

**X
SUMMARY**

1.	Summary.....	6
----	--------------	---

**XI
ELIGIBLE EXPENSES**

1.	HCFSA Eligible Expenses.....	6
2.	DCFSA Allowable Expenses.....	11

STATE OF RHODE ISLAND FLEXIBLE SPENDING ARRANGEMENT ("FSA") PLAN

INTRODUCTION

We have amended the "Flexible Spending Arrangement Plan" (the "FSA Plan") that we previously established for you and other eligible employees. Read this Summary Plan Description (SPD) carefully so that you understand the provisions of our amended FSA plan and the benefits you will receive. This SPD describes the FSA Plan's benefits and obligations as contained in the legal State of Rhode Island Cafeteria Plan (the "Cafeteria Plan") document, which governs the operation of the FSA Plan. The Cafeteria Plan document is written in much more technical and precise language. If the non-technical language in this SPD and the technical, legal language of the Cafeteria Plan document conflict, the Cafeteria Plan document always governs. Also, if there is a conflict between an insurance contract and either the Cafeteria Plan document or this SPD, the insurance contract will control. If you wish to receive a copy of the legal Cafeteria Plan document, please contact your Human Resources agency.

This SPD describes the current provisions of the FSA Plan which are designed to comply with applicable legal requirements. The FSA Plan is subject to federal laws, such as the Internal Revenue Code and other federal and state laws which may affect your rights. The provisions of the FSA Plan are subject to revision due to a change in laws or due to pronouncements by the Internal Revenue Service (IRS) or other federal agencies. We may also amend or terminate this FSA Plan. If the provisions of the FSA Plan that are described in this SPD change, we will notify you.

We have attempted to answer most of the questions you may have regarding your benefits in the FSA Plan. If this SPD does not answer all of your questions, please contact your Human Resources agency.

I ELIGIBILITY

1. When can I become a participant in the FSA Plan?

Before you become an FSA Plan member (referred to in this SPD as a "Participant"), there are certain rules which you must satisfy. First, you must meet the eligibility requirements and be an active employee. After that, the next step is to actually join the FSA Plan on the "entry date" that we have established for all employees. The "entry date" is defined in Question 3 below. You will also be required to complete certain application forms before you can enroll in the Health Care FSA ("HCFSA") or Dependent Care FSA ("DCFSA").

2. What are the eligibility requirements for our FSA Plan?

You will be eligible to join the FSA Plan once you have satisfied the conditions for coverage under our group medical plan. Of course, if you were already a participant before this amendment, you will remain a participant.

3. When is my entry date?

You can join the FSA Plan on the same day you can enter our group medical plan.

4. What must I do to enroll in the FSA Plan?

Before you can join the FSA Plan, you must complete an application to participate in the FSA Plan. The application includes your personal choices for each of the benefits which are being offered under the FSA Plan. You must also authorize us to set some of your earnings aside in order to pay for the benefits you have elected.

II OPERATION

1. How does this FSA Plan operate?

Before the start of each Plan Year, you will be able to elect to have some of your upcoming pay contributed to the FSA Plan. These amounts will be used to pay for the benefits you have chosen. The portion of your pay that is paid to the FSA Plan is not subject to Federal income or Social Security taxes. In other words, this allows you to use tax-free dollars to pay for certain kinds of benefits and expenses which you normally pay for with out-of-pocket, taxable dollars. However, if you receive a reimbursement for an expense under the FSA Plan, you cannot claim a Federal income tax credit or deduction on your return. (See the Article entitled "General Information About Our FSA Plan" for the definition of "Plan Year.")

III CONTRIBUTIONS

1. What happens to contributions made to the FSA Plan?

Before each Plan Year begins, you will select the benefits you want and how much of the contributions should go toward each benefit. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year. Later, they will be used to pay for the expenses as they arise during the Plan Year.

2. When must I decide which accounts I want to use?

You are required by Federal law to decide before the Plan Year begins, during the election period (defined below). You must decide two things. First, which benefits you want and, second, how much should go toward each benefit.

3. When is the election period for our FSA Plan?

You will make your initial election on or before your entry date. (You should review Section I on Eligibility to better understand the eligibility requirements and entry date.) Then, for each following Plan Year, the election period is established by the Employer and applied uniformly to all Participants. It will normally be a period of time prior to the beginning of each Plan Year. The Employer will inform you each year about the election period. (See the Article entitled "General Information About Our FSA Plan" for the definitions of Plan Year and FSA Plan Administrator.)

4. May I change my elections during the Plan Year?

Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, there are certain limited situations when you can change your elections. You are permitted to change elections if you have a "change in status" and you make an election change that is consistent with the change in status. Currently, Federal law considers the following events to be a change in status:

- Marriage, divorce, death of a spouse, legal separation or annulment;
- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;
- Any of the following events for you, your spouse or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that affects eligibility for benefits;
- One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance; and
- A change in the place of residence of you, your spouse or dependent that would lead to a change in status, such as moving out of a coverage area for insurance.

In addition, if you are participating in the DCFSA, then there is a change in status if your dependent no longer meets the qualifications to be eligible for day care.

There are detailed rules on when a change in election is deemed to be consistent with a change in status. In addition, there are laws that give you rights to change health coverage for you, your spouse, or your dependents. If you change coverage due to rights you have under the law, then you can make a corresponding change in your elections under the FSA Plan. If any of these conditions apply to you, you should contact your Human Resources agency.

You may not change your election under the DCFSA if the cost change is imposed by a day care provider who is your relative.

5. May I make new elections in future Plan Years?

Yes, you may. For each new Plan Year, you may change the elections that you previously made. If you do not make new elections you will not be considered a Participant under the FSA Plan for the upcoming Plan Year.

**IV
BENEFITS**

1. What benefits are offered under the FSA Plan?

Under our FSA Plan, you can pay for the following benefits or expenses during the year:

2. Health Care Flexible Spending Arrangement ("HCFSA")

The HCFSA enables you to pay for expenses allowed under Sections 105 and 213(d) of the Internal Revenue Code which are not covered by our medical plan and save taxes at the same time. The HCFSA allows you to be reimbursed by the Employer for expenses incurred by you and your dependents.

Drug costs, including insulin, may be reimbursed.

You may be reimbursed for "over the counter" drugs only if those drugs are prescribed for you. You may not, however, be reimbursed for the cost of other health care coverage maintained outside of the Cafeteria Plan, or for long-term care expenses. A non-comprehensive list of covered expenses is available at the end of this SPD and, upon request, from the FSA Plan Administrator.

The most that you can contribute to your HCFSA each Plan Year is \$2,500. In addition, you will be eligible to carryover amounts left in your Health Care Flexible Spending Arrangement, up to \$500. This means that amounts you do not use during a Plan Year can be carried over to the next Plan Year and used for expenses incurred in the next Plan Year. In order to be reimbursed for a health care expense, you must submit to the FSA Plan Administrator an itemized bill from the service provider. We will also provide you with a debit or credit card to use to pay for medical expenses. The FSA Plan Administrator will provide you with further details. Amounts reimbursed from the FSA Plan may not be claimed as a deduction on your personal income tax return. Reimbursement from the fund shall be paid at least once a month. Expenses under this FSA Plan are treated as being "incurred" when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged, or you pay for the medical care.

You may be reimbursed for expenses for any child until the end of the calendar year in which the child reaches age 26. A child is a natural child, stepchild, foster child, adopted child, or a child placed with you for adoption. If a child gains or regains eligibility due to these new rules, that qualifies as a change in status to change coverage.

3. Dependent Care Flexible Spending Arrangement ("DCFSA")

The DCFSA enables you to pay for out-of-pocket, work-related dependent day-care costs with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time. Single employees can also use the account.

An eligible dependent is someone for whom you can claim expenses on Federal Income Tax Form 2441 "Credit for Child and Day Care Expenses." Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Day Care arrangements which qualify include:

- (a) A Dependent (Day) Care Center, provided that if care is provided by the facility for more than six individuals, the facility complies with applicable state and local laws;
- (b) An Educational Institution for pre-school children. For older children, only expenses for non-school care are eligible; and
- (c) An "Individual" who provides care inside or outside your home: The "Individual" may not be a child of yours under age 19 or anyone you claim as a dependent for Federal tax purposes.

You should make sure that the Day Care expenses you are currently paying for qualify under our FSA Plan.

The law places limits on the amount of money that can be paid to you in a calendar year from your DCFSA. Generally, your reimbursements may not exceed the lesser of: (a) \$5,000 (if you are married filing a joint return or you are head of a household) or \$2,500 (if you are married filing separate returns); (b) your taxable compensation; (c) your spouse's actual or deemed earned income (a spouse who is a full time student or incapable of caring for himself/herself has a monthly earned income of \$250 for one dependent or \$500 for two or more dependents).

Also, in order to have the reimbursements made to you from this account be excludable from your income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred. In addition, Federal tax laws permit a tax credit for certain day care expenses you may be paying for even if you are not a Participant in this FSA Plan. You may save more money if you take advantage of this tax credit rather than using the DCFSA under our FSA Plan. Ask your tax adviser which is better for you.

V BENEFIT PAYMENTS

1. When will I receive payments from my accounts?

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. The FSA Plan Administrator will provide you with acceptable forms for submitting these requests for reimbursement. If the request qualifies as a benefit or expense that the FSA Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements which are made from the FSA Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes. The provisions of the insurance contracts will control what benefits will be paid and when. You will only be reimbursed from the DCFSA to the extent that there are sufficient funds in the Account to cover your request.

2. What happens if I don't spend all FSA Plan contributions during the Plan Year?

Any monies left at the end of the Plan Year will be forfeited. For the HCFSA, you must submit claims no later than 167 days after the end of the Plan Year. For the DCFSA, you must submit claims no later than 167 days after the end of the Plan Year. Because it is possible that you might forfeit amounts in the FSA Plan if you do not fully use the contributions that have been made, it is important that you decide how much to place in each account carefully and conservatively. Remember, you must decide which benefits you want to contribute to and

how much to place in each account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each account will be used up entirely.

3. Family and Medical Leave Act (FMLA)

If you take leave under the Family and Medical Leave Act, you may revoke or change your existing elections for the HCFSA. If your coverage in these benefits terminates, due to your revocation of the benefit while on leave or due to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return. For the HCFSA, you may continue your coverage or you may revoke your coverage and resume it when you return. You can resume your coverage at its original level and make payments for the time that you are on leave. For example, if you elect \$1,200 for the year and are out on leave for 3 months, then return and elect to resume your coverage at that level, your remaining payments will be increased to cover the difference - from \$100 per month to \$150 per month. Alternatively your maximum amount will be reduced proportionately for the time that you were gone. For example, if you elect \$1,200 for the year and are out on leave for 3 months, your amount will be reduced to \$900. The expenses you incur during the time you are not in the HCFSA are not reimbursable.

If you continue your coverage during your unpaid leave, you may pre-pay for the coverage, you may pay for your coverage on an after-tax basis while you are on leave, or you and your Employer may arrange a schedule for you to "catch up" your payments when you return.

4. What happens if I terminate employment?

If you terminate employment during the Plan Year, your right to benefits will be determined in the following manner:

- (a) You will still be able to request reimbursement for qualifying dependent care expenses incurred during the remainder of the Plan Year from the balance remaining in your DCFSA account at the time of termination of employment. However, no further salary redirection contributions will be made on your behalf after you terminate. You must submit claims within 167 days after the end of the Plan Year in which termination occurs.
- (b) You may elect to continue your participation in the HCFSA for the remainder of the Plan Year.
- (c) If you elect to continue your participation in the HCFSA, you must continue to make any required contributions to the FSA Plan.
- (d) If you elect not to continue participation in the HCFSA, participation will cease and no further salary redirection contributions will be contributed on your behalf. You will be able to submit claims for health care expenses. However, you will be able to submit claims for health care expenses that were incurred before the end of the period for which payments to the HCFSA have already been made. You must submit claims within 167 days after the end of the Plan Year in which termination occurs.

5. Will my Social Security benefits be affected?

Your Social Security benefits may be slightly reduced because when you receive tax-free benefits under our FSA Plan, it reduces the amount of contributions that you make to the Federal Social Security system as well as our contribution to Social Security on your behalf.

VI HIGHLY COMPENSATED

1. Do limitations apply to highly compensated employees?

Under the Internal Revenue Code, highly compensated employees generally are Participants who are officers, shareholders or highly paid.

If you are within these categories, the amount of contributions and benefits for you may be limited so that the FSA Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents.

FSA Plan experience will dictate whether contribution limitations on highly compensated employees will apply. You will be notified of these limitations if you are affected.

VII PLAN ACCOUNTING

1. Periodic Statements

The FSA Plan Administrator will provide you with a statement of your account periodically during the Plan Year that shows your account balance(s). It is important to read these statements carefully so you understand the balance(s) remaining to pay for a benefit. Remember, you want to spend all the money you have designated for a particular benefit by the end of the Plan Year.

VIII
GENERAL INFORMATION ABOUT OUR FSA PLAN

This Section contains certain general information which you may need to know about the FSA Plan.

1. General FSA Plan Information

State of Rhode Island Flexible Spending Arrangement Plan is the name of the FSA Plan.

Your Employer has assigned Plan Number 501 to your FSA Plan.

The provisions of your amended FSA Plan become effective on July 1, 2014. Your FSA Plan was originally effective on July 1, 2008.

Your FSA Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on July 1 and ends on June 30.

2. Employer Information

Your Employer's name, address, and identification number are:

State of Rhode Island
1 Capitol Hill
Providence, Rhode Island 02908
05-6000522

3. Plan Administrator Information

The name, address and business telephone number of your FSA Plan Administrator are:

Flex-Plan Services, Incorporated
PO Box 53250
Bellevue, Washington 98015
(425) 452-3500
1-800-669-FLEX (3539)

The FSA Plan Administrator keeps the records for the FSA Plan and is responsible for the administration of the FSA Plan. The FSA Plan Administrator will also answer any questions you may have about our FSA Plan. You may contact the FSA Plan Administrator for any further information about the FSA Plan.

4. Service of Legal Process

The name and address of the FSA Plan's agent for service of legal process are:

State of Rhode Island
1 Capitol Hill
Providence, Rhode Island 02908

5. Type of Administration

The type of Administration is Employer Administration.

6. Claims Submission

Claims for expenses should be submitted to:

Flex-Plan Services, Inc.
PO Box 53250
Bellevue, Washington 98015

IX
ADDITIONAL FSA PLAN INFORMATION

1. Claims Process

If a Dependent Care or medical expense claim under the FSA Plan is denied in whole or in part, you or your beneficiary will receive written notification. The notification will include the reasons for the denial, with reference to the specific provisions of the FSA Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims

review procedure. Within 60 days after denial, you or your beneficiary may submit a written request for reconsideration of the denial to the FSA Plan Administrator.

You must file both level one and level two appeals by submitting a written request by email, fax, or mail. Indicate either level one or two appeal on the email, fax, or letter.

Email: claims@flex-plan.com

Fax: 425-451-7002 or 866-535-9227

Mail to: Flex-Plan Services, PO Box 53250, Bellevue Washington 98015.

X SUMMARY

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities and save for the future. Our FSA Plan will help you keep more of the money you earn by lowering the amount of taxes you pay. The FSA Plan is the result of our continuing efforts to find ways to help you get the most for your earnings.

If you have any questions, please contact the FSA Plan Administrator.

XI ELIGIBLE EXPENSES

1. HCFSA ELIGIBLE EXPENSES

Over-the-Counter Medicines and Drugs Requiring a Prescription:

- Allergy medication
- Analgesics
- Antacids
- Anti diarrheal
- Antibiotic ointment
- Antifungal foot cream
- Anti-gas medication
- Anti-itch cream/gel
- Antiseptic
- Asthma relief
- Burn cream
- Chloraseptic sprays
- Cold Sore Treatment
- Cold/cough medication
- Diaper rash ointment
- Hemorrhoid medication
- Hydrogen Peroxide
- Ipecac syrup
- Lactose intolerance pills
- Laxative
- Lice Treatment Products
- Motion Sickness pills/bracelet
- Pain relievers
- Parasitic Treatment
- Rubbing Alcohol
- Smoking cessation products
- Stool softener
- Throat lozenges
- Urinary Tract Infection Treatments
- Wart treatment
- Yeast infection treatment

Eligible Expenses:

- A**
- Acupuncture
- Adaptive equipment (e.g. raised toilet seat)
- Ambulance fees
- B**
- Bandage tape
- Bandages
- Blood pressure monitor

Braces (knee, ankle, wrist)
Breast pumps & supplies

C

Chiropractic services
Co-insurance
Contact lens solution
Contacts
Contraceptives
Copays and deductibles
CPAP machine
Crutches

D

Dental services (excludes veneers and other cosmetic procedures)
Diabetes testing supplies
Diabetic supplies
Doctor visits
Doula services (must be licensed and some postpartum doula expense are excluded)
Drug addiction treatment

E

Eye drops
Ear Wax Removal Kits
Eye exams

F

Fertility treatment
First aid supplies
Flu shots

H

Hearing aid supplies
Hearing aids
Home medical equipment
Hormone therapy
Humidifier
Hypnosis

I

Individual Counseling

L

Lab work
Lactation consultants
Lamaze
Laser eye surgery

M

Medical abortion
Medical alert bracelet & current year membership fees
Mileage (to receive medical care)

N

Non-cosmetic surgery
Naturopathic Visits

O

Occupational Therapy
Orthotics

P

Physical exams
Physical therapy
Pregnancy test
Prenatal vitamins
Prescription drugs
Prescription glasses
Psychotherapy

R

Reading glasses

S

Saline Nasal Spray
Service animals
Speech Therapy
Sterilization procedures
Sunscreen SPF 30 or greater (proof of SPF required)

T

Thermometer

V

Vaccinations

W

Walker
Wheelchair & repair

X

X-rays

Acne Treatment - Over-the-counter acne medications are reimbursable if prescribed you must submit the Rx or a letter of medical necessity (an "LMN") for reimbursement. The cost of normal skin care is not reimbursable. Medical services used to treat acne require an LMN indicating that the procedure is not cosmetic and treats a medical condition.

Air Fare - Amounts paid for transportation primarily for, and essential to, medical care are reimbursable. Proof of medical visit corresponding with the travel is required. Companion travel expenses are not eligible unless necessary due to the patient's medical condition. Transportation expenses must not include a personal element. For example airfare for a two week trip to Hawaii which includes a dentist appointment would not be reimbursable.

Anesthesia - Anesthesia administered for cosmetic procedures or otherwise ineligible expenses are not reimbursable.
Automobile - Medical expenses for special hand controls and other equipment installed in a vehicle are reimbursable if used primarily for care. The cost of operating the vehicle is not eligible. LMN or additional documentation may be required.

Birthing Classes or Lamaze - The class must address specific medical issues; labor, delivery and breathing techniques. The cost of the 'mother-to-be' is eligible; however, the costs of 'father-to-be' and/or a coach are not eligible.

Braille Books and Magazines - The cost difference between a regular book or magazine and the braille books/magazines is reimbursable.

Breast Augmentation - Medical costs related to the removal of breast implants that are defective, causing a medical condition, or restorative procedures for cancer patients are reimbursable. Cosmetic procedures such as implants or injections are not reimbursable.

Breast Reduction - Expenses related to a breast reduction are reimbursable only if the procedure is medically necessary and not cosmetic in nature. LMN required.

Capital Expenses - Expenses for special equipment or improvements to a home are reimbursable if the primary purpose is medical care. For further details, see discussion under the heading "Capital expenses" below. LMN required as well as an appraisal before and after the expense is incurred. Cost of appraisal is not reimbursable and online appraisals are not sufficient (Zillow) as the actual capital expense must be considered in the appraisal.

Chair - The cost difference between a special chair and a normal chair is reimbursable. The chair must be primarily for medical care. Expense requires documentation indicating the cost of three comparables in order to determine the cost difference. LMN required.

Christian Science Practitioner - Expenses for a Christian Science Practitioner are reimbursable if used to treat a medical condition.

Deductibles - Expenses applied against a medical or dental insurance deductible are eligible. This is not to be confused with a premium, premiums are not eligible.

Dental Services and Products - Expenses for dental services and products are reimbursable. This includes expenses for X-rays, fillings, braces, extractions, dentures, etc. Veneers, teeth whitening and other cosmetic services are not reimbursable. Hygiene products including toothpaste, floss, mouthwash, and toothbrush/sonicare products are not reimbursable.

Elastic hosiery - Hosiery used to alleviate a medical condition is reimbursable.

Fertility Treatment - Medical expenses related to the treatment of infertility, including in vitro fertilization, are reimbursable. Only storage fees for the current plan year are reimbursable. Storage fees for a future plan year are not reimbursable.

Founder's Fee/Lifetime Care - Part of a life-care fee or "founder's fee" paid either monthly or as a lump sum under an agreement with a retirement home if it is allocable to medical care. The agreement must require a specified fee payment as a condition for the home's promise to provide lifetime care that includes medical care. Advance payments to a private institution for the lifetime care, treatment and training of an employee's physically or mentally impaired dependent upon the employee's death or inability to provide care are reimbursable. The payments must be a condition for the institution's future acceptance of the dependent and must not be refundable.

Guide Dogs - The cost of a guide dog or other animal used by the visually impaired or hearing impaired person is reimbursable. Food and veterinarian cost associated with a dog or other animal are also reimbursable. An LMN is required.

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

Human Guide - Expenses for a human guide are reimbursable. For example, the expense of guiding a blind child to school is reimbursable.

In vitro fertilization - Medical expenses related to the treatment of infertility, including in vitro fertilization, are reimbursable. Storage fees for the current plan year only are reimbursable. Storage fees for a future plan year are not reimbursable.

Legal fees - Legal fees required to receive medical care are reimbursable. Legal assistance must be a necessary expense in order to receive the care (e.g. the care could not have been provided without legal assistance). However, any part of a legal fee that is a management fee; for example, a guardianship or estate management fee is not reimbursable. Additional documentation may be required.

Lodging and meals - Lodging and meal expenses at a hospital or similar institution are reimbursable if the employee's primary reason for being there is to receive medical care. The cost of lodging not provided in a hospital or similar institution while an employee is away from home is reimbursable if four requirements are met: (1) the lodging is primarily for and essential to medical care; (2) medical care is provided by a doctor in a licensed hospital or other medical care facility; (3) the lodging is not lavish or extravagant under the circumstances; and (4) there is no significant element of personal pleasure, recreation, or vacation in the travel away from home.

If the lodging is not provided at a hospital or similar institution then the reimbursable amount cannot exceed \$50 for each night for each person. Lodging expenses includes companion expenses if that person must travel with the patient. For example, \$100 per night may qualify as a medical expense for lodging if a parent is traveling with a sick child.

Meals expenses incurred away from home while undergoing medical treatment are not expenses for medical care and are not reimbursable even if the trip is made on the advice of a doctor. This is specific to meal expenses outside of a hospital. See above paragraph for meal expenses at a hospital.

Medical records - The fees associated with transferring medical records to a new practitioner are reimbursable.

Mileage - Expenses paid for transportation primarily for and essential to the rendition of medical care are reimbursable. The mileage rate is indexed each year for inflation. The cost of tolls and parking may also be reimbursable. Proof of office visit corresponding with the mileage required.

Naturopathic Expenses - Naturopathic doctor visits are reimbursable. Naturopathic medicines (dietary supplements etc.) will require a LMN to be reimbursable.

Nursing Home - The cost of medical care in a nursing home or similar facility for the employee, employee's spouse, or tax dependent is reimbursable. This includes the cost of meals and lodging in the facility if the primary reason for being there is to receive medical care. Qualified long-term care services cannot be reimbursed on a tax-excludable basis through a flexible spending arrangement on or after January 1, 1997. For this purpose, qualified long-term care expenses are defined in Code Section 7702B(c) as: necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, which: (A) are required by chronically ill individual, and (B) are provided pursuant to a plan of care prescribed by a licensed health care practitioner. Thus, under the above definition, expenses that are otherwise reimbursable medical expenses may be long-term care expenses. Code Section 7702B(c)(2) defines a "chronically ill individual" to be a person who (among other things) is "certified" by a licensed health care practitioner as being unable to perform at least two activities of daily living for a period of at least 90 days due to a loss of functional capacity.

Optometrist - Optometric services and expenses for eyeglasses and contact lenses required to treat a medical condition are reimbursable. Premiums for contact lens replacement insurance are not reimbursable.

Organ transplants - Payments for surgical, hospital, laboratory and transportation expenses for a prospective or actual donor of a kidney or other organ are reimbursable.

Orthodontia - Unlike other HCFSA expenses which are deemed incurred when the services are rendered, orthodontia expenses are deemed incurred when paid. Therefore, only payments made during your eligibility period and plan year may be reimbursed.

Proof of payment to an orthodontic provider is required for reimbursement. Payments made toward orthodontia in a previous plan year or before your eligibility period are not reimbursable. This rule provides for two options for reimbursement. If a participant pays a lump sum up front then that payment can be reimbursed in full (provided the lump sum is paid during the same plan year from which reimbursement is requested and while the participant was covered under the plan). Second, participants that do not pay up front and opt for monthly payments can be reimbursed as those monthly payments are made (provided the monthly payment is paid during the same plan year from which reimbursement is requested and while the participant was covered under the plan). Again, proof of payment is required.

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

Phone - The cost of purchasing and repairing a special telephone that permits a hearing-impaired person to communicate is reimbursable.

Physical Therapy - Amounts paid for physical therapy to treat a medical condition are reimbursable. Payments made to an individual for special exercises administered to a mentally disabled child are also reimbursable.

Psychiatric Care - Expenses for psychiatric care, including the cost of a facility where the dependent receives medical care, are reimbursable.

Sexual Counseling - Expenses for counseling by a licensed medical practitioner to treat a medical condition are reimbursable.

Smoking cessation program - Expenses for participation in a smoking cessation program and prescription and over-the-counter smoking cessation products are reimbursable with a prescription or LMN.

Special foods - the difference in cost between the special food the commonly available "comparable" version of the same product are reimbursable. You must provide the cost of three comparables for us to determine the cost difference. The special foods must be prescribed and consumed primarily to alleviate or treat an illness or disease, and not for nutritional purposes. Diet food or food related to a weight loss program are not "special foods" and are not reimbursable. An example of a special food is gluten free food consumed by person with a gluten protein allergy. LMN required.

Special home for mentally impaired - The cost of keeping a mentally disabled person in a special home (not the home of a relative) is reimbursable if recommended by a licensed medical practitioner to treat a medical condition.

Special Schools - expenses paid to a special school for a mentally impaired or physically disabled person if the primary purpose for using the school is to treat a medical condition. This includes the cost of a school that:

- Teaches Braille to a visually impaired child
- Teaches lip-reading to a hearing-impaired child
- Provides remedial language training to correct a condition caused by a birth defect
- Schools for autistic children

Meals, lodging, and ordinary education supplied by a special school is reimbursable only if the main reason for using the school is its resources for treating the mental or physical disability. The cost of sending a child without a specific medical condition to a special school to benefit from the course of study or disciplinary methods is not reimbursable. LMN required.

Sterilization - Expenses related to legal sterilization, including vasectomy and reverse vasectomy, are reimbursable.

Transportation - Expenses for transportation primarily for and essential to medical care are reimbursable. This includes bus, taxi, train or plane fare, ambulance service, parking fees, tolls and expenses of a parent who must accompany a child who needs medical care.

Capital Expenses - Improvements or special equipment installed in the home may qualify for reimbursement if their main purpose is medical care. A LMN is required. The amount reimbursable is reduced by any increase in the value of the property. If the value of the property is not increased by the improvement, the entire cost of the improvement may be reimbursable. If the improvement or modification does not increase the value of the residence then the full cost may be reimbursable. These improvements include, but are not limited to:

- Constructing entrance or exit ramps
- Widening doorways at entrances or exits
- Widening or otherwise modifying hallways and interior doorways

- Installing railing, support bars or other modifications to bathrooms
- Lowering or making other modifications to kitchen cabinets and equipment
- Moving or otherwise modifying electrical outlets and fixtures
- Installing porch lifts and other forms of lifts (but generally not elevators)
- Modifying fire alarms, smoke detectors and other warning systems; modifying stairways
- Adding handrails or grab bars
- Modifying hardware on doors
- Modifying areas in front entrance and exit doorways
- Re-grading the ground to provide access to the residence

Only reasonable costs are considered medical care. Additional costs for personal motives, such as for architectural or aesthetic reasons, are not reimbursable.

2. DCFSA ALLOWABLE EXPENSES

Keep in mind that dependent day care expenses must be for children 12 or younger, unless the child is incapable of self-care.

- Au Pair: The costs relating to an au pair for the care of a child are reimbursable.
- Baby-sitter: As long as the sitter is not a dependent of the participant, or a spouse, the costs are eligible.
- Before and after school care
- Day Camp: If not overnight. Only the cost for the child to attend the camp is eligible.
- Childcare by a relative: Cannot be a dependent of the plan holder. Must be at least 18.
- Deposits: As long as the deposit is for daycare services that will be provided within the plan year the claim is being filed; and the service has been provided. Prorating may be necessary for those services that extend from one year to another.
- Elder Care: Costs relating to the care of a dependent adult who is unable to care for themselves will qualify only if: 1) such expenses are not attributable to medical services; 2) the elderly person is a qualifying individual; and 3) in the case of services provided outside the employee's household the person still regularly spends at least eight hours each day in the employee's home. Elder day care will often qualify, but 24 hour care in a nursing home will not. LMN required.
- Care of Child Incapable of self-care: Children 13 and over incapable of self-care will be subject to restrictions as listed above under Elder Care (must spend at least eight hours a day in the home etc.). However, qualifying children under the age of 13 incapable of self-care do not need to spend at least eight hours a day in the employee's home. However, expenses for such children would still have to meet other requirements that could be affected by the amount of time they spend away from home. Please check with your tax advisor or IRS publication 501 and 503. LMN required for any child 13 and over.
- Extended Day Programs: Activities provided after school, which are primarily custodial in nature.
- FICA and FUTA taxes: Paid to a daycare provider are eligible.
- Field Trips
- Nanny Fees: Costs relating to the payment of a nanny for the care of a child are reimbursable.
- Nursery School/Pre-School/Pre-Kindergarten
- Registration Fees: As long as the registration fee is for daycare services that will be provided within the plan year the claim is being filed; and the service has been provided. Prorating may be necessary for those services that extend from one year to another
- Sick-child care: Only if they are enabling the parent to go to work.