HIGHLIGHTS OF YOUR

FLEXIBLE BENEFIT PLAN

FOR UNITED CHURCH OF CHRIST MINISTRIES

(effective January 1, 2019)

The Pension Boards
United Church of Christ, Inc.

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United Church of Christ, Inc.

WHERE FAITH & FINANCE INTERSECT

Operating at the intersection of faith and finance, we are caring professionals partnering with those engaged in the life of the Church to provide valued services leading to greater financial security and wellness.

HEALTH PLAN MISSION

To provide the highest standard of service, access to care, and options to active, inactive, and retired UCC clergy and lay employees.

January 2019

Dear UCC Colleague,

We are pleased to provide you with this copy of **Highlights of Your Flexible Benefit Plan for United Church of Christ Ministries** (also known as a "Flexible Spending Account" or "FSA" Plan).

One of the most important features of the FSA Plan is that the benefits offered are generally ones that you are already paying for, but normally with money that has first been subject to federal income and Social Security taxes. Under the FSA Plan, these same expenses are paid for with a portion of your pay before federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save.

The FSA Plan consists of:

- a Health Care Reimbursement Account, which can help with expenses related to medical, pharmacy, dental, and vision care; and

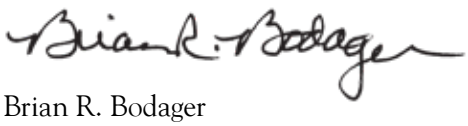
- a Dependent Care Assistance Account, which can help with work-related dependent day care costs.

You are encouraged to read this booklet carefully to learn about the FSA Plan's benefits. If you have any questions, please contact us at **1.800.642.6543**.

We hope that you continue to be pleased with the benefits available to Plan participants, and we covenant to work with you to provide the best possible benefits at the most effective cost.

May you enjoy good health and abundant blessings.

Best regards,



Brian R. Bodager
President and Chief Executive Officer

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Introduction

The Flexible Benefit Plan for UCC Ministries (also known as a "Flexible Spending Account" or "FSA") was established for you and other eligible UCC employees. Under this Plan, you will be able to choose among certain benefits. The benefits you may choose are outlined in this **Highlights** booklet. We will also provide other important information concerning the Plan, such as the rules you must satisfy before you can join.

One of the most important features of the Plan is that the benefits offered are generally ones that you are already paying for, but normally with money that has first been subject to federal income and Social Security taxes. Under the Plan, these same expenses will be paid for with a portion of your pay before federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save.

The FSA Plan consists of:

- a Health Care Reimbursement Account that can help with expenses related to medical, pharmacy, dental and vision care; and
- a Dependent Care Assistance Account, which can help with work-related dependent day care costs.

Please read this **Highlights** booklet carefully so that you understand the provisions of our Plan and the benefits you will receive. You should direct any questions to the Plan Administrator, the Pension Boards. There is a Plan document on file, which you may review if you desire. In the event there is a conflict between this booklet and the Plan document, the Plan document will take precedence.

I. Eligibility

1. When Can I Become a Participant in the Plan?

In order to participate in the Plan, you must first meet the eligibility requirements. Then you will be required to complete the application form (*Election Form and Compensation Reduction Agreement*) in order to enroll in the Plan.

2. What Are the Eligibility Requirements for Our Plan?

If you are currently an employee, you may enroll only during the open enrollment period at the end of each year for an effective date of coverage of January 1 of the following year. However, a new employee must complete one (1) month of employment before becoming eligible to enroll. This means that after completing a month of employment you are eligible to participate in the Plan on the first of the month following the date on which you completed one (1) month of employment.

If your employer adopts the Plan during the year or if you become eligible during the year, you will be given 30 days to elect to participate in the Plan. If you elect to participate in the Plan, your election will be prospective only.

3. When Is My Entry Date?

Once you have met the eligibility requirements, your entry date will be the first day of the month following the date on which you completed one (1) month of employment.

4. What Must I Do to Enroll in the Plan?

To enroll in the Plan, you must complete the *Election Form and Compensation Reduction Agreement*. The *Election Form and Compensation Reduction Agreement* must include your personal choice for each of the benefits offered under the Plan. You also must authorize your employer to set aside some of your earnings to pay for the benefits you have elected.

II. Operation

1. How Does This Plan Operate?

Before the start of each year, you will be able to elect to have some of your upcoming pay contributed to the Plan. You must make new elections each year. These amounts will be placed in special funds or accounts for the benefits you have chosen. The portion of your salary that is paid to the Plan is not subject to federal income or Social Security taxes. This allows you to use tax-free dollars to pay for certain kinds of benefits and expenses that you normally pay for with out-of-pocket, taxable dollars. However, if you receive a reimbursement for an expense under the Plan, you cannot claim a federal income tax credit or deduction on your federal tax return for that expense.

The Pension Boards–United Church of Christ, Inc. ("Pension Boards") has made a special arrangement with Highmark Blue Cross Blue Shield to assist with administration and to process all claims for reimbursement.

III. Contributions

1. How Much of My Pay May My Employer Redirect?

Each year, you may elect to have your employer contribute on your behalf enough of your compensation to pay for the benefits that you elect under the Plan. These amounts will be deducted from your pay over the course of the year. For the Health Care Reimbursement Account and Dependent Care Assistance Account, the plan will allow deferrals up to the maximum allowable amounts as designated by the IRS.

2. What Happens to Contributions Made to the Plan?

Before each Plan Year begins or when you first become eligible, you will select the account(s) you want and determine how much of your contributions should go toward each account. 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. (See Section IX, **General Information About Our Plan** (p. 12), for the definition of Plan Year.) Contributions to the Plan will be used to pay for the expenses as they arise during the Plan Year.

3. When Must I Decide Which Accounts I Want to Use?

Federal law requires that during the election period, before the Plan Year begins or when you first become eligible, you decide on the benefits you want and how much you want to contribute to each account.

4. When Is the Election Period for Our Plan?

Your election period will start on the date you first meet the eligibility requirements and end 30 days after your entry date. (You should review Section I on **Eligibility** (p. 3) to better understand the terms "eligibility requirements" and "entry date.") Then, for each following Plan Year, the election period will be the month of November prior to the start of the next Plan Year.

5. May I Change My Elections During the Plan Year?

Generally, after the beginning of the Plan Year you cannot change the elections you have made. However, there are certain limited situations in which election changes are allowed. 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 "changes 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 (e.g., from part-time to full-time status);
- one of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, or any similar circumstance; and
- a change in the place of residence for you, your spouse or dependent.
- For Dependent Care Assistance Accounts, the following qualifies as a change in status:
  - If your dependent no longer meets the eligibility qualifications for dependent care.
  - If the cost of dependent care increases during the year, you may change your elections; however, you may not change your election under the Dependent Care Reimbursement Account if the cost change is imposed by a dependent care provider who is your relative.

Please note: If you will be enrolling in Medicare sometime during the Plan Year after you have enrolled in the FSA Plan, you cannot reduce your election for the year based on your reduced out-of-pocket medical expenses. It is, therefore, very important to calculate your estimated out-of-pocket expenses, including a possible reduction in expenses if you become eligible for Medicare during the Plan Year, prior to submitting your election for the Plan Year.

6. May I Make New Elections in Future Plan Years?

Yes, a new election must be made for each separate Plan Year. This allows you to change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. If you do not make new elections during the election period before a new Plan Year begins, we will consider that to mean you have elected not to participate for the upcoming Plan Year.

If you enroll in the FSA Plan and do not have your health coverage through the UCC Medical Benefits Plan, your employer will be billed a monthly administrative fee of $12 for your participation in the FSA Plan. Please note that this $12 administrative fee cannot be withheld from your pre-tax salary. Only contributions to the FSA can be deferred from pre-tax salary.

If you are covered by the UCC Medical Benefits Plan as a dependent of your spouse, it is important that you indicate that on your FSA application. This will enable us to make sure that your employer is not billed the monthly $12 administrative fee.

IV. Benefits

1. What Benefits Are Available?

Under our Plan, you can choose to receive your entire compensation or use a portion to pay for the following benefits or expenses during the year:

Health Care Reimbursement Account

The Health Care Reimbursement Account enables you to pay for expenses that are not covered by the UCC Medical, Dental, Prescription or Vision Plans and save taxes at the same time. The account allows you to be reimbursed by the Plan for out-of-pocket medical, dental, prescription and vision expenses incurred by you and your dependents. The expenses that qualify are those permitted by Section 213 of the Internal Revenue Code of 1986, as amended. A list of covered expenses is available on p. 15 of this booklet.

In order to be reimbursed for a health care expense, you must submit to the Claims Administrator, Highmark Blue Cross Blue Shield, a copy of your Explanation of Benefits (EOB) showing the amounts not paid, or an itemized bill from the service provider. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return.

Dependent Care Assistance Account

The Dependent Care Assistance Account 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 may also use the account.

An eligible dependent is any member of your household for whom you can claim expenses on federal income tax Form 2441, *Credit for Child and Dependent Care Expenses*. Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent care arrangements that qualify include:

- 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;
- an educational institution for preschool children (for older children, only expenses for non-school care are eligible);
- 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 dependent care expenses you are currently paying for qualify under our Plan. The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Assistance Account. 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 deemed 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 dependent care expenses you may be paying for, even if you are not a participant in this Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Assistance Account under our Plan. Consult with your tax adviser to find out which is better for you.

2. Are Costs Incurred by My Domestic Partner Eligible for Reimbursement?

In order to determine whether your domestic partner qualifies as your dependent and is eligible to have her/his medical claims reimbursed through the FSA Plan, **all three** of the following criteria, based on federal guidelines, must be met:

- The domestic partner must be an individual who, for the taxable year of the employee, has the same principal place of residence as the employee.
- The domestic partner must be an individual who, for the taxable year of the employee, is a member of the employee's household.
- Over one-half of the domestic partner's support is provided by the employee for the employee's tax year.

If one or more of the criteria listed above is not met, then your domestic partner does not qualify as your dependent for benefit plan purposes and you will not be reimbursed for his/her out-of-pocket medical expenses through the FSA Plan.

If you will be covering your domestic partner's out-of-pocket claims through the FSA Plan, please contact the Pension Boards so that you can complete the required forms: *Statement of Domestic Partnership and Financial Interdependence* and *Certification of Domestic Partner as a Dependent or Non-Dependent*.

V. Benefit Payments

1. When Will I Receive Payments for My Expenses?

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.

Participants will be issued a debit card that can be used to pay for qualifying out-of-pocket expenses.

The Internal Revenue Code (IRC) requires that you use your FSA debit card only for eligible expenses. You may need to provide documents to prove that your medical claim is an eligible expense. You can upload these receipts to your member website when you submit a claim, or when you get a request for documents. To ensure compliance with IRS regulations:

- Retain all itemized receipts and documentation as Highmark BCBS or the IRS may request validation of any account withdrawals.
- If requested, you are obligated to submit receipts to prove expenses are eligible under your specific plan and applicable IRS regulations.
- Itemized receipts should include: provider name, date of service, type of service and cost to you.

Failure to provide requested substantiation of debit card use may result in suspension or cancellation of your debit card.

Participants may file a claim by logging in at **www.highmarkbcbs.com** and clicking on the **Spending** tab.

The Highmark website can also be used to assist in the management of your FSA by allowing you to:

- Request additional cards for qualified dependents
- Report a card lost or stolen
- Obtain up-to-date account balance
- View account activity
- View alerts such as receipt requests

Paper claim forms for submitting requests for expense reimbursement can be accessed on the Pension Boards' website **(www.pbucc.org),** or you may request forms by contacting the Pension Boards toll-free at **1.800.642.6543,** or by e-mail at **info@pbucc.org**.

If the request qualifies as a benefit or expense under the provisions of the Plan, you will receive a reimbursement payment soon thereafter. Remember, reimbursements made from the Plan are not subject to federal income tax or withholding, nor are they subject to Social Security taxes. Reimbursement for medical expenses is limited to the annual amount you elect. You will only be reimbursed from the Dependent Care Assistance Account to the extent that there are sufficient funds in the account to cover your request. Reimbursement checks are mailed directly to your address.

2. What Happens If I Don't Spend All Plan Contributions?

The Pension Boards allows employees to carry over up to $500 of the unused amounts left in their health FSAs at the end of the plan year for expenses in the next year.

It is important to note that for any remaining balance over $500, the "use or lose" rule still applies and that money over $500 must be used by December 31 of the following year. Any money remaining in your account over the $500 carryover after December 31 will be forfeited. Employees have until March 31 of the following year to submit expenses that were incurred prior to December 31.

Carryover of up to $500 of health FSA funds will become available after the claims filing deadline of March 31 has passed.

The Dependent Care Assistance Account offers a grace period of 2.5 months and does not offer carry-over of unused funds from the prior year. You may file claims using amounts of the prior year's funds for expenses incurred through March 15. Claims must be filed by March 31.

Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that you have made, it is important that you carefully and conservatively decide how much to place in each account. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins or within 30 days of your first eligibility. You want to be sure that the amount you decide to place in each account will be used up entirely. Forfeited amounts are used to help pay Plan administration expenses and claims.

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 Health Care Reimbursement Account. 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 Health Care Reimbursement Account, 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 were on leave.

For example, if you elect $1,200 for the year and are out on leave for three 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. Claims incurred during the three months when you were on leave can be submitted for reimbursement.

However, if you elect $1,200 for the year and after the three months of leave you opt to continue paying the remaining payments at $100 a month, at the end of the year your annual election will be only $900. In this situation, the expenses you incur during the months that you are on leave are ineligible for reimbursement from the Health Care Reimbursement Account.

You can continue your coverage during your unpaid leave by:

- pre-paying for the coverage;
- paying for your coverage on an after-tax basis while on leave; or
- arranging with your employer a schedule for you to "catch up" on your payments when you return.

4. Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are going into or returning from military service, you may have special rights to health care coverage under your Health Care Reimbursement Account under the Uniformed Services Employment and Reemployment

Rights Act (USERRA) of 1994. These rights can include extended health care coverage. If you may be affected by this law, please ask the Administrator for further details.

5. What Happens If I Terminate Employment?

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

- You will still be able to request reimbursement for qualifying dependent care expenses for the remainder of the Plan Year from the balance remaining in your Dependent Care Assistance Account at the time of termination of employment. However, no further salary redirection contributions will be made on your behalf after you terminate.

- If you do not elect to continue participation in the Health Care Reimbursement Account following your termination, you may submit claims only for expenses incurred prior to the last day of the month following your termination. Eligible claims should be submitted to the Plan during the Plan Year or Short Plan Year.

It is your responsibility to notify the Pension Boards of a divorce, legal separation or other change in marital status, change in a spouse's address, or a child losing dependent status under the Plan, within sixty (60) days of the event. We will notify the Claims Administrator of any changes that are made.

6. Will My Social Security Benefits Be Affected?

Your Social Security benefits may be slightly reduced because tax-free benefits received under the FSA will reduce the amount of contributions that you make to the Social Security system as well as employer contributions to Social Security on your behalf.

VI. Premium Payment Plan

Your employer must adopt the Plan in order to withhold premiums from your salary as pre-tax money. Once the Plan is adopted, your employer can withhold each month, from your salary before taxes, the premiums that you are paying. If you elect to participate in this Plan, you must agree to have the premiums paid on a pre-tax basis instead of an after-tax basis. The Pension Boards will send your employer an invoice on a monthly basis.

If you are currently paying all or a portion of the premiums for your Health, Dental and/or Vision Plans your employer can, if they adopt the Flexible Benefit Plan, withhold the premium payments from your pay on a pre-tax basis. Please note that premium payments made under this Plan will only cover the premiums paid for your spouse and dependents while you are participating in the UCC Health, Dental and Vision Plans.

VII. Participation in the Plan While Receiving Short-Term Disability (STD) Benefits

If you are participating in the FSA Plan and have been approved to receive Short-Term Disability (STD) benefits, you have one of the two options shown below:

(1) Elect to continue making contributions to the Plan on an after-tax basis and continue participation in the Plan until such time that you are approved for Long-Term Disability (LTD) benefits. Once you begin receiving LTD benefits, you will cease to be a participant in the Flexible Benefit Plan. You will be able to make claims only for expenses incurred during the portion of the Plan Year before you started your LTD benefits.

(2) Elect not to continue participation in the Plan, in which case you will cease to be a Plan participant. You will be able to make claims only for expenses incurred during the portion of the Plan Year preceding the date that your compensation and deferrals to the Flexible Benefit Plan ended.

A disabled member can resume participation in the Plan when compensation resumes. However, this member would not be permitted to submit claims for expenses incurred during the period of non-participation in the Plan.

VIII. Plan Accounting

1. Periodic Statements

The Claims Administrator will periodically provide you with a statement of your account during the Plan Year that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for a benefit. You may access a summary of your account online by logging into your account at **www.highmarkbcbs.com** and clicking the **Spending** tab. Remember, you want to claim all the money you have designated for a Dependent Care Assistance benefit and for a Health Care Reimbursement benefit by March 31 following the Plan Year.

IX. General Information About Our Plan

This Section contains some general information about the Plan that you need to know.

1. General Plan Information

Flexible Benefit Plan for United Church of Christ Ministries is the name of the Plan.

The Plan became effective on April 1, 2005, which is called the "Effective Date of the Plan." The Plan was amended and restated effective January 1, 2019.

The Plan's records are maintained on a 12-month basis. This is known as the "Plan Year." The Plan Year begins on January 1 and ends on December 31, except for the first Plan Year, which began when the Plan was adopted. In addition, an employer that adopts the Plan on a day other than January 1 may have an initial "Short Plan Year" of less than 12 months.

2. Sponsor Information

The Pension Boards' name, address, and federal employer identification number (EIN) are:

The Pension Boards–United Church of Christ, Inc.
475 Riverside Drive, Room 1020
New York, NY 10115-0059
EIN: 13-5562403

The Plan allows other employers to adopt its provisions. You or your beneficiaries may examine or obtain a complete list of employers, if any, that have adopted your Plan by making a written request to the Pension Boards.

3. Plan Administrator Information

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

The Pension Boards–United Church of Christ, Inc.
475 Riverside Drive, Room 1020
New York, NY 10115-0059
1.800.642.6543

The Administrator keeps the records for the Plan and is responsible for its administration. Therefore, please feel free to contact the Administrator for any further information about the Plan.

4. Service of Legal Process

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

The Pension Boards–United Church of Christ, Inc.
475 Riverside Drive, Room 1020
New York, NY 10115-0059

5. Type of Administration

The type of Administration is Employer Administration.

6. Claims Submission

Paper claims for expenses should be submitted to:

Spending Account Processing
PO Box 25173
Lehigh Valley, PA 18002-5173
1.866.763.9471

Please visit **www.pbucc.org** to obtain a claim form.

Claims may be submitted online by logging in at **www.highmarkbcbs.com** and clicking the **Spending** tab.

X. Additional Plan Information

1. Claims Process

Expenses incurred during the Plan Year (January 1 through December 31) may be submitted for reimbursement throughout the year. In order to be eligible for reimbursement of any expenses for a given Plan Year, you must submit your claim by March 31 following the Plan year. Any claims submitted (postmarked, faxed or e-mailed) after that time will not be considered for reimbursement. This provision will be in effect for all Plan Years.

In the case of a claim for medical expenses under the Health Care Reimbursement Account, or dependent care expenses under the Dependent Care Reimbursement Account, the following timetable for claims applies:

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the claim:	
Notification of	15 days
Response by participant	45 days
Review of claim denial	60 days

2. Appeals

If a claim under the Plan is denied in whole or in part, you or your beneficiary(ies) will receive written notification. The notification will include:

- the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based;
- a description of any additional information needed to process the claim;
- an explanation of the claims.

If you fail to respond within 90 days, your claim is treated as denied. Within 60 days after denial, you or your beneficiary(ies) may submit a written request for reconsideration of the appeal to the Pension Boards.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary(ies) may review pertinent documents and submit issues and comments in writing. The Pension Boards will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended an additional 60 days under certain circumstances.) In this response, the Pension Boards will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Pension Boards has the exclusive right to interpret the appropriate Plan provisions. Decisions of the Administrator are conclusive and binding.

XI. 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. The Plan will help you keep more of the money you earn by lowering the amount of taxes you pay. The 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 Pension Boards.

Qualifying Medical Care Expenses

Qualifying medical expenses include only those expenses incurred for:

1. yourself;
2. your spouse;
3. all dependents you list on your federal tax return.

Under the Plan, you will be reimbursed only for those types of medical expenses normally deductible on your federal income tax return (without regard to the 10% of adjusted gross income limitation). IRS Publication 502, ***Medical and Dental Expenses***, has a checklist of medical expenses that can be deducted and therefore reimbursed under this Plan, and those that cannot. However, regardless of any statements in Publication 502 to the contrary, expenses under this 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 when you pay for the medical care.

Qualifying medical expenses include expenses you have incurred for:

a. medicine, drugs, and vaccines that your doctor prescribed;

b. medical doctors, dentists, eye doctors, orthodontists, chiropractors, osteopaths, podiatrists, psychiatrists, psychologists, physical therapists, acupuncturists and psychoanalysts (medical care only);

c. medical examinations, X-ray and laboratory services, insulin treatment and whirlpool baths prescribed by a physician;

d. nursing help (if you pay someone to do both nursing and housework, you can be reimbursed only for the cost of the nursing help);

e. hospital care (including meals and lodging), clinic costs and lab fees;

f. medical treatment at a center for substance abuse;

g. medical aids such as hearing aids (and batteries), false teeth, eyeglasses, contact lenses, braces, orthopedic shoes, crutches, wheelchairs, guide dogs and the cost of maintaining them;

h. ambulance service and other travel costs to get medical care. If you use your own car, you can claim what you spend for gas and oil to go to and from the place you receive the care; or you can claim 18 cents a mile. Add parking and tolls to the amount you claim under either method.

You cannot obtain reimbursement for:

a. the basic cost of Medicare insurance (Medicare A);

b. life insurance or income protection policies;

c. accident, health or indemnity/chronic condition insurance for you or members of your family;

d. the hospital insurance benefits tax withheld from your pay as part of the Social Security tax or paid as part of Social Security self-employment tax;

e. nursing care for a healthy baby;

f. illegal operations or drugs;

g. travel your doctor told you to take for rest or change;

h. cosmetic surgery;

i. long-term care expenses.

Over-the-Counter Medicines Covered in Special Circumstances

Some over-the-counter medicines may be reimbursed if they are accompanied by a prescription from a medical doctor indicating they are being purchased to treat a specified illness or condition. The table on the next page gives you some of the items that do and do not require a prescription.

Eligible OTC Expenses that DO NOT Require a Prescription	*Eligible OTC Expenses that Require a Prescription*
Bandages, gauze and related items	Allergy and sinus medicines: Actifed, Benadryl, Claritin, Sudafed
Blood pressure monitors	Antacids and acid reducers: Mylanta, Pepcid AC, Prilosec, TUMS, Zantac
Cholesterol test kits and supplies	Antidiarrheals and laxatives: Ex-Lax, Imodium AD, Kaopectate
Condoms and other OTC contraceptives	Antifungal creams: Lamisil AT, Lotrimin AD, Micatin
Contact lens cleaning solutions	Anti-itch lotions and creams: Benadryl Cream, Calamine Lotion
Crutches, canes, walkers, and wheelchairs	Aspirin and pain relievers: Advil, Excedrin, Motrin, Tylenol
Fertility monitors	Cold and flu medicines: Afrin, Nyquil, Theraflu
First-aid kits	Cough suppressants: Robitussin, Vicks 44
Hearing aids and batteries	Diaper rash ointments: Balmex, Desitin
Heat wraps and cold packs	Digestive aids: Lactaid, Lactase, Beano
Incontinence supplies (Depends, Serenity pads)	First aid creams and sprays: Bactine, Neosporin
Insulin, diabetic supplies, and test kits	Hemorrhoid treatments: Preparation H, Hemroid, Tronolane
Latex gloves	Liniments: BENGAY, Flexall
Occlusal guards (for teeth grinding)	Menstrual cycle medicines: Midol, Pamprin, Premsyn PMS
Oral syringes	Motion sickness medicines: Dramamine, Marezine
Ovulation predictor kits	Nicotine gum and patches: Nicoderm CQ, Nicorette
Pregnancy test kits	Respiratory treatments: Primatene, Vicks VapoRub
Reading glasses and other OTC eyeglasses	Sleep aids: Sominex, Sleepinal, Tylenol PM, Unisom Sleep Tabs
Thermometers	Teething pain relievers: Orajel

The Pension Boards
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