

**UNIVERSITY CORPORATION FOR ATMOSPHERIC RESEARCH (UCAR)
HEALTH BENEFIT HRA**

SUMMARY PLAN DESCRIPTION

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INTRODUCTION

University Corporation for Atmospheric Research (UCAR) (the "Employer") has established a Health Benefits HRA (the "HRA"). The purpose of this HRA is to reimburse Participants for certain medical expenses that are unreimbursed by the medical plan ("Eligible Medical Expenses") and incurred by the Participant and their Covered Dependents. This HRA is intended to qualify as a self-insured medical reimbursement plan for purposes of Section 105 and 106 of the Internal Revenue Code ("Code").

This Summary Plan Description, or "SPD", describes the basic features of the HRA, including the rights and responsibilities of covered individuals, the Employer, and the Plan Administrator. Attached to this SPD is a Plan Information Appendix that provides important information specifically related to this HRA (e.g. the name of the sponsoring employer and plan administrator, the plan number, and the maximum level of reimbursement available under this particular HRA). If you do not have a Plan Information Appendix for this SPD, you should contact the Employer. The Plan Information Appendix may be replaced from time to time to reflect changes made in the plan. You should check your Plan Information Appendix to ensure that you have the most recent Plan Information Appendix. You may contact the Employer if you have concerns that the Plan Information Appendix that you have is outdated. Other appendices may be attached to this SPD to the extent referenced in the SPD. The Plan Information Appendix and any other appendices referenced in this SPD should be considered a part of the SPD (i.e. the SPD, the Plan Information Appendix and any other applicable appendices together constitute the entire SPD).

This HRA has been established and is operated in accordance with both this SPD and the official plan document. This SPD (including the applicable appendices) has been incorporated into and made a part of the official plan document (i.e. the official plan document and this SPD together constitute the plan document for this HRA). Although the SPD has been incorporated into and made a part of the plan document, the terms of the official plan document will control if there is a conflict between this SPD and the official plan document.

PART I:
General Information about the Plan

**You will notice that certain terms and/or phrases are capitalized throughout this SPD. These terms and/or phrases are important and you should remember them. The capitalized terms and phrases are defined either in this SPD or in the official plan document.*

Q-1. What is the HRA?

Generally, the HRA is an employer provided reimbursement account. The HRA works as follows:

- The Employer establishes a Health Reimbursement Arrangement (“Reimbursement Account”) for each Participant (see Q-2 for more information on how to become a Participant).
- Each Plan Year, the Employer allocates a specified amount of Employer contributions, called “HRA Dollars”, to each Participant’s Reimbursement Account for reimbursement of Eligible Medical Expenses.
- Unlike Health FSA amounts, you may not lose HRA dollars that you do not use during a Plan Year.
- You do not have to pay for your HRA coverage as an active employee.

Q-2. Who can participate in the HRA?

You are eligible to participate in this HRA if you are an Employee of the Employer (including any Adopting Employer) and participate in the Employer’s Health Plan. Eligible employees who become covered under this HRA are called “Participants”.

Q-3. Are my dependents covered under the HRA?

If you become a Participant, you may also be reimbursed for Eligible Medical Expenses incurred by your Covered Dependents. A “Covered Dependent” is any individual who is your legal spouse or a dependent and also covered under the Employer’s Health Plan. All Covered Dependents must be a “dependent” of yours or your legal spouse under the Code. You are required to provide proof of dependent status upon request by the Plan Administrator (or its designee). Failure to provide such proof may result in a delay in coverage under this HRA.

In addition, this HRA will cover a child of yours (as defined by applicable state law) in accordance with a Qualified Medical Child Support Order (“QMCSO”) to the extent the QMCSO does not require coverage not otherwise offered under this HRA. The Plan Administrator will make a determination as to whether the order is a QMCSO in accordance with the Plan’s QMCSO procedures. The Plan Administrator will notify both you and the affected child once a determination has been made. You may request a copy of the Plan’s QMCSO procedures, free of charge, by contacting the Plan Administrator of this HRA (as identified in the Plan Information Appendix).

Q-4. What is the effective date of coverage under this HRA?

Coverage under this HRA for an Eligible Employee and Eligible Dependent(s) begins on the applicable date identified in the “Effective Date of Coverage” section of the Plan Information

Appendix. In no event will the coverage under this HRA begin before the effective date of this HRA.

Q-5. When does coverage under this HRA end?

Coverage for a Participant and/or Covered Dependent ends on the earlier of the day that the benefit credit amount is exhausted or death of the participant. However, you, your covered spouse, and/or your covered child(ren) may be eligible to continue coverage under this HRA beyond the date that coverage would otherwise end if coverage is lost for certain reasons. Your continuation of coverage rights and responsibilities are described in Q-18 below. All HRA dollars that are not applied towards Eligible Medical Expenses incurred before your termination date in accordance with Q-15 of this SPD are forfeited.

Q-7. What is an “Eligible Medical Expense”?

“Eligible Medical Expense” is a medical care expense *incurred* by you or your Covered Dependents that satisfy all of the conditions described in the “Eligible Medical Expense” section of the Plan Information Appendix. All expenses that are not within the scope of “Eligible Medical Expenses” described in the Plan Information Appendix are excluded. “Incurred” means the date the service or treatment is provided; not when the expense arising from the service or treatment is paid. Thus, an expense that has been paid but not incurred (e.g. pre-payment to a physician) will not be reimbursed until the services or treatment giving rise to the expense has been provided. Also, an otherwise Eligible Medical Expense will not be reimbursed unless the requirements described in Q-15 below have been satisfied.

In no event will the following expenses be eligible for reimbursement:

- a) any expense that is not a Code Section 213(d) expense
- b) any expenses incurred for qualified long term care services
- c) expenses incurred *prior to the date* that coverage under this HRA becomes effective
- d) expenses incurred *after the date* that coverage under this HRA ends
- e) expenses that have been reimbursed by another plan or for which you plan to seek reimbursement under another health plan.

Q-8. What is a Health Reimbursement Arrangement?

Once you become a Participant, the Employer establishes a Reimbursement Account for you. The Reimbursement Account is a notational bookkeeping account that keeps a record of HRA dollars allocated to your account and reimbursements made to you under this HRA. You have no property rights in the Reimbursement Account.

Q-9. Who contributes to my Reimbursement Account?

While you are an active employee, only the Employer contributes to your Reimbursement Account (with HRA Dollars). In fact, federal laws prohibit you from contributing to your Reimbursement Account with any portion of a pre-tax salary reduction made under a Code Section 125 cafeteria plan. You may, however, be required to pay the “applicable premium” for continuation of HRA coverage under COBRA (please refer to Q-18 below for more information regarding COBRA continuation coverage).

Q-10. How are HRA dollars allocated to my Reimbursement Account?

Each Plan Year, the Employer may allocate a specified amount of HRA dollars to your Reimbursement Account. The maximum annual HRA Dollar amount is identified in the “HRA

Dollar” section of the Plan Information Appendix. The amount of HRA Dollars allocated to your Reimbursement Account is determined in the sole discretion of the Employer and may vary depending on circumstances such as family status. Nevertheless, the annual amount of HRA Dollars allocated to each Participant’s Reimbursement Account will be determined in a uniform and non-discriminatory manner in comparison to other similarly situated employees.

In addition, HRA Dollars will be allocated to your Reimbursement Account in accordance with the “HRA Dollar” section of the Plan Information Appendix (e.g. all at once at the beginning of the year or periodically throughout the year on a pro-rata basis, or on an as needed basis).

Q-11. What happens if I do not use all of the HRA Dollars allocated to my Reimbursement during the Plan Year?

Unlike Health FSA dollars, if you do not use all of the HRA Dollars allocated to your Reimbursement Account in accordance with Q-10 of this SPD, all or a portion of the HRA Dollars remain in your Reimbursement Account for future reimbursement of Eligible Medical Expenses. The amount of unused HRA Dollars that you may “carry over” is described in the “Carry Over” section of the Plan Information Appendix. Any funds that you are not entitled carry over in accordance with this Q-11 will be forfeited and returned to the employer.

Q-12. Is there a limit on how much can be allocated to my Reimbursement Account?

Yes, there is a limit. The amount in your Reimbursement Account can never exceed the Reimbursement Account Maximum identified in the “Reimbursement Account” section of the Plan Information Appendix. Any HRA Dollars that you would otherwise be entitled to under the terms of this HRA will be forfeited to the extent they will cause your Reimbursement Account to exceed the Reimbursement Account Maximum. If your Reimbursement Account has reached the Reimbursement Account Maximum, you will receive no more HRA Dollars until the Reimbursement Account amount has gone below the Reimbursement Account Maximum. At such time you will be entitled to receive your share of HRA Dollars, not to exceed the Reimbursement Account Maximum, at the next regularly scheduled allocation. For example, if HRA Dollars are allocated monthly and your Reimbursement Account balance goes below the Reimbursement Account Maximum in June, you will be entitled to receive an HRA Allocation in July. If HRA Dollars are allocated each January 1, and your Reimbursement Account balance goes below the Reimbursement Account maximum you will receive an HRA Dollar allocation the following January 1.

Q-13. What is the maximum amount of reimbursement that I may receive under the HRA?

The maximum reimbursement amount that you can receive is equal to your Reimbursement Account balance at the time the request for reimbursement is processed. Any portion of a claim for reimbursement that exceeds the maximum reimbursement amount will be pended and processed when the Reimbursement Account becomes sufficient. Pended claims will be processed and, if appropriate, paid before any new claims are processed and paid.

Q-14. Can I change my level of coverage under the HRA during the Plan Year? No

Q-15. How do I receive reimbursement under the HRA?

You can obtain a reimbursement form from the Third Party Administrator (identified in the Plan Information Appendix). You must complete the reimbursement form and submit it to the Third Party Administrator with a copy of your insurance premium bill, an EOB (explanation of benefits) or, if no EOB is provided, a written statement from the service provider. The written statement

from the service provider must contain the following: a) the name of the patient, b) the date service or treatment was provided, c) a description of the service or treatment; and d) the amount incurred. **You may submit requests for reimbursement of Eligible Medical Expenses at any time prior to the end of the Run Out Period described in the Plan Information Appendix. Requests for reimbursements submitted after the Run Out Period will not be reimbursed.**

Your HRA claim is deemed filed when it is received by the Third Party Administrator. If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following the determination. Any unclaimed reimbursement amounts (e.g., failing to cash a reimbursement check) will be forfeited and returned to the Employer if not claimed (or cashed) by the "Payment Claim Date" identified in the Plan Information Appendix. If your claim for reimbursement is denied, in whole or in part, you will be notified in accordance with the HRA's claims review procedures described in Q-16 below.

Q-16. What happens if my claim for benefits is denied?

If you are denied a benefit under the Plan, you should proceed in accordance with the following claims review procedures:

Step 1: *Notice is received from Third Party Administrator.* If your claim is denied, you will receive written notice from the Third Party Administrator that your claim is denied as soon as reasonably possible but no later than 30 days after receipt of the claim. For reasons beyond the control of the Third Party Administrator, the Third Party Administrator may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the Third Party Administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

Step 2: *Review your notice carefully.* Once you have received your notice from the Third Party Administrator, review it carefully. The notice will contain:

- the reason(s) for the denial and the Plan provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- a description of the Plan's appeal procedures and the time limits applicable to such procedures; and
- a right to request all documentation relevant to your claim.

Step 3: *If you disagree with the decision, file an Appeal.* If you do not agree with the decision of the Third Party Administrator, you may file a written appeal. You should file your appeal no later than 180 days after receipt of the notice described in Step 1. If the Plan has established only one level of review, you should file your appeal with the Plan Administrator. If the Plan has established two levels of appeal, you should file your appeal with the third party administrator. The notice of denial referenced in Step 1 above will indicate whether the plan has 1 or 2 levels of appeal. Regardless, you should submit all information identified in the notice

of denial, as necessary, to perfect your claim and any additional information that you believe would support your claim.

Step 4: *Notice of Denial is received from claims reviewer.* If the claim is again denied, you will be notified in writing. If the Plan has established two levels of appeal, as set forth in the notice of denial, the notice will be sent no later than 30 days after receipt of the appeal by the third party administrator. Otherwise, notice of the denial will be sent no later than 60 days after the Plan Administrator receives the appeal.

Step 5: *Review your notice carefully.* You should take the same action that you took in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the third party administrator.

Step 6 (if there is a second level of appeal as indicated in the notice of denial): *If you still disagree with the Third Party Administrator's decision, file a 2nd Level Appeal with the Plan Administrator.* If you still do not agree with the Third Party Administrator's decision, you may file a written appeal with the Plan Administrator within 60 days after receiving the first level appeal denial notice from the third party administrator. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe would support your claim.

Important Information

Other important information regarding your appeals:

- Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal);
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information; and
- You cannot file suit in federal court until you have exhausted these appeals procedures.

Q-17. What happens if I receive overpayments or reimbursements are made in error from this HRA?

If it is later determined that you and/or your Covered Dependent(s) received an overpayment or a payment was made in error (e.g., you were reimbursed for an expense under the HRA that is later paid for by some other medical plan), you will be required to refund the overpayment or erroneous reimbursement to the HRA.

If you do not refund the overpayment or erroneous payment, the Plan reserves the right to offset future reimbursement equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from your pay. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Administrator may treat the overpayment as a bad debt, which have tax implications for you. In addition, if the Plan Administrator determines that you have submitted a fraudulent claim, the Plan Administrator may terminate your coverage under this HRA.

Q-18. What is "Continuation Coverage" and how does it work?

A federal law called "COBRA" requires most employers sponsoring group health plans to offer covered employees and certain covered family members the opportunity for a temporary

extension of health care coverage (called “Continuation Coverage”) in certain instances where coverage under the group health plan would otherwise end. These rules apply to the Plan unless the Employer is a small employer as defined under applicable law. The Plan Administrator will tell you whether the Plan is subject to these rules. Below is a description of your rights and responsibilities under COBRA.

When Coverage May Be Continued Under COBRA

If you are a Participant or a Covered Dependent under the HRA and the Employer is not a small employer as defined under applicable law, then you may elect to continue your coverage under the HRA.

Type of Coverage

If you choose continuation coverage, you are entitled to the level of coverage under the HRA in effect for you immediately preceding the qualifying event. At the beginning of each plan year that COBRA is in effect, you will be entitled to an increase in your Reimbursement Account Balance equal to the sum of the HRA Dollars allocated to similarly situated active participants (subject to any restrictions applicable to similarly situated active participants) so long as you continue to pay the applicable premium.

Cost

For the period of continuation coverage, the cost of such coverage will not exceed 102% of the “applicable premium”, as determined by the Plan Administrator, or 150% of the “applicable premium” during any disability extension to which you may be entitled, as determined by the Social Security Administration. The Plan Administrator will notify you of the applicable premium. The notice you receive will describe the premium payment requirements under the Plan (e.g., who you pay the premium to, etc.).

When Continuation Coverage Ends

Continuation coverage under this HRA will continue for the number of months as set forth in the applicable COBRA laws.

Q-19. How long will the Plan remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time for any reason. All modifications/terminations effectuated by the Employer will be applied to all Participants and Covered Dependents except as otherwise stated.

Q-20. Does the Plan coordinate benefits with other Medical Plans?

Only medical care expenses that have not been or will not be reimbursed by any other source may be Eligible Medical Expenses (to the extent all other conditions for Eligible Medical Expenses have been satisfied). As such, this HRA does not coordinate benefits with any other group or individual health coverage except as provided herein.

If you are also a participant in a Health Flexible Spending Arrangement (commonly referred to as a Health FSA) sponsored by your Employer, the expenses covered both by the HRA and the Health FSA will be paid as described in the Plan Information Appendix.

Q-21. Who do I contact if I have questions about the HRA?

If you have any questions about the HRA, you should contact the Third Party Administrator or the Plan Administrator. Contact information for the Third Party Administrator and the Plan Administrator is provided in the Plan Information Appendix.

**PART II:
ERISA RIGHTS**

This HRA may be a welfare benefit plan as defined in the Employee Retirement Income Security Act (ERISA). If it is an employee welfare benefit plan subject to ERISA, ERISA provides that you, as a Plan Participant, will be entitled to:

1. Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The Plan Administrator may apply a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Continue Plan Coverage

Continue Plan coverage for you, your spouse, or your dependents if there is a loss of coverage under the plan as a result of a qualifying event. However, you or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

3. Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the 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 the Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit from the Plan, or from exercising your rights under ERISA.

4. Enforcement of Your Rights

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or 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 (e.g., if it finds your claim is frivolous).

5. Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance obtaining documents from the Plan Administrator, you should contact the nearest office of the U.S. Department of Labor, Pension and Welfare Benefits Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

PLAN INFORMATION APPENDIX

HEALTH BENEFIT HRA SUMMARY PLAN DESCRIPTION

This Appendix provides information specific to **UCAR HRA**.

**The effective date of this Plan Information Appendix is January 1, 2009*

I. GENERAL PLAN INFORMATION

1. Name, address, and telephone number of the Employer/Plan Sponsor:	University Corporation for Atmospheric Research (UCAR) P.O. Box 3000 Boulder, CO 80307 303-497-1000
2. Name, address, and telephone number of the Plan Administrator: The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan. The Plan Administrator may delegate one or more of its responsibilities to one or more committees.	Extend Health, Inc. Salt Lake City, UT 84109
3. Address for Service of Legal Process:	University Corporation for Atmospheric Research (UCAR) P.O. Box 3000 Boulder, CO 80307 303-497-1000
4. Employer's federal tax identification number:	84-0412668
5. Plan Number	502
6. Original Effective Date of the HRA:	January 1, 2009
7. Plan Year:	January 1, 2009 through December 31, 2009
8. Third Party Administrator:	Extend Health, Inc. Salt Lake City, UT 84109
9. Identity of Component Medical Plan(s) under which this HRA is a component.	High-Deductible Health Plan
10. How is the HRA funded?	General Assets

II. EFFECTIVE DATE OF COVERAGE

A. The effective date of coverage for Participants is as follows:

The effective date corresponding to a health plan selection made through Extend Health.

B. The effective date of coverage for Covered Dependents is as follows:

Same as employee

III. ELIGIBLE MEDICAL EXPENSES

The following medical expenses are eligible for reimbursement under this Plan (provided all other terms and conditions of the HRA have been satisfied):

Individual and Family Health Insurance Premiums

Medicare Premiums

Dental and Vision Plan Premiums

Out of Pocket Expenses

Prescription medications

Over the counter medications

Services and products that are medically necessary to treat a specific condition.

A complete list of standard HRA eligible expenses are attached.

IV. HRA Dollars

HRA Dollars will be allocated to your Reimbursement Account the first day of each new plan year.

V. Roll Over

Any remaining balance at the end of the calendar year will roll over into the next plan year.

VI. PAYMENT CLAIM DATE

Because your HRA rolls over from year to year, there is no expiration date on your claims or deadline for you to file.

Sample Expenses Eligible for Reimbursement

Medical Expenses which are not already covered by your insurance may be eligible for reimbursement through your HRA Plan. The following expenses are considered eligible based upon IRS Code § 213(d) and IRS Publication 502. This list should not be considered a complete list, but merely an example of the most commonly accepted items. See IRS documentation for further guidance on the eligibility of an item.

Medical Expenses

- Acupuncture
- Addition Programs
- Adoption Medical Expenses
- Alcoholism Treatment Ambulance
- Artificial Limbs
- Bandages
- Birth-Control Pills
- Blood Sugar Test Kit/Strips
- Body Scan
- Carpal Tunnel Wrist Supports
- Chiropractors
- Cold Medicines
- Contraceptives
- Contact lenses
- Co-Payments
- Deductibles
- Eye Exams
- Eye Glasses and Cleaners
- Fertility Treatments*
- First Aid Kit
- Flu Shots
- Guide Dog
- Hearing Aids and Batteries
- Hospital Services
- Immunizations
- Insurance Premiums
- Laboratory Fees
- Laser Eye Surgery/Lasik
- Medic Alert Bracelet
- Monitoring Devices*
- Operations
- Optometrist
- Oxygen
- Physical Therapy
- Pregnancy Tests
- Psychiatric Care
- Reading Glasses
- Sleep Deprivation Treatment
- Smoking Cessation Programs
- Sunglasses (prescription only)
- Transportation Expenses*
- Vasectomy
 - Wheelchair
 - X-Ray Fees

*Contact Extend Benefits for Details

Drugs and Medicines

- Acne Treatment
- Allergy Medicines
- Antacids
- Antihistamine
- Aspirin
- Cough Suppressants
- Decongestants
- Diaper Rash Ointments
- Insulin
- Motion Sickness Medication
- Prescription Drugs
- Sunburn Cream
- Viagra