NATIONAL UNIVERSITY OF HEALTH SCIENCES
FLEXIBLE BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

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I. INTRODUCTION

The National University of Health Sciences (the "University") has established and maintains the National University of Health Sciences Flexible Benefit Plan (the "Plan"). The Plan offers eligible employees the opportunity to choose among certain group medical care and dependent care benefits and to pay for them on a before-tax basis. This Summary Plan Description describes the general features of the Plan as in effect on January 1, 2004.

If you are eligible to participate, the Plan allows you to have a portion of your pay applied on a before-tax basis to cover your share of the cost of medical, dental and vision insurance premiums and to reimburse you for eligible medical care and dependent care expenses. As a result, your federal and state income taxes and Social Security taxes in most cases will be reduced, making more of your pay available for you and your family. If you are eligible but choose not to participate in the Plan, your unreduced pay will be paid to you in full.

As you know, income tax laws change frequently and these changes may affect different individuals in different ways. Therefore, the University cannot assure you that it will be to your advantage to participate in the Plan. You may want to consult your own tax or financial advisor before making benefit elections under the Plan.

This Summary Plan Description explains the terms of the Plan and answers some commonly asked questions about participation. **While every effort has been made to make this Summary Plan Description as accurate as possible, if there are any inconsistencies between this Summary Plan Description and the provisions of the Plan document, the provisions of the Plan document will govern.** Any questions concerning the Plan will be determined in accordance with the provisions of the Plan document and not this Summary Plan Description. The benefits and other provisions described in this Summary Plan Description are effective only if you are eligible to participate and become a participant in accordance with the terms of the Plan.

You may examine copies of the Plan and related documents without charge, and may obtain copies for a reasonable charge. Please contact the Plan Administrator to examine or obtain a copy of these documents.

II. WHO IS ELIGIBLE TO PARTICIPATE IN THE PLAN

If you are employed by the University and are regularly scheduled to work at least 40 hours per week, you are eligible to participate in the Plan. Your participation in the "premium payment" portion of the Plan described in Section III will begin as soon as you (and, if applicable, your dependents) are eligible to participate in the Benefit Plans (as defined later in this Summary Plan Description). Your participation in the Medical Care Reimbursement

Account and Dependent Care Reimbursement Account may begin after you have been employed by the University for 12 months.

Please note: The following individuals are not eligible to participate in the Plan, even if they provide services to the University:

- employees regularly scheduled to work less than 40 hours per week;
- temporary or contract employees;
- leased employees, as defined under the Internal Revenue Code;
- individuals covered by a collective bargaining agreement that does not provide coverage under the Plan, provided that the type of benefits provided by the Plan were the subject of good-faith bargaining; and
- any individual designated by the University on its records as an independent contractor or consultant, even if a court, the Internal Revenue Service or other entity determined that the individual is a common law employee.

III. BENEFITS AVAILABLE UNDER THE PLAN

One of the advantages of the Plan is that it offers choices, so you can elect what is best for your individual circumstances. To make these benefit choices, you will want to consider your personal circumstances carefully. The Plan currently offers you the following benefit choices: payment of your share of the premium for coverage on a pre-tax basis under the University's group benefits programs ("Benefit Plans"), a Medical Care Reimbursement Account and a Dependent Care Reimbursement Account. If you elect not to participate in the Plan, you will receive your full pay or salary, but no Plan benefits.

Benefit Plan Coverage

The University maintains certain Benefit Plans for its eligible employees that require you to share in the cost of coverage. If you enroll in any of the Benefit Plans that require you to pay for coverage, the Plan reduces the cost of obtaining this coverage for you and your dependents by allowing you to pay your share of the premium with before-tax pay. This benefit is called the "premium payment" portion of the Plan. If you elect to participate in the premium payment portion of the Plan, the amount you pay for your Benefit Plan premiums will be withheld from each of your paychecks on a before-tax basis and forwarded to the administrator of the Benefit Plan(s).

Medical Care Reimbursement Account

Some medical care expenses are not covered under the University's health, dental and vision plans. For example, deductibles and co-payments come out of your pocket, as do expenses in excess of reasonable and customary charges and expenses for certain procedures or treatments excluded from coverage.

The Plan offers you the opportunity to pay for these uncovered medical, dental and/or vision expenses with before-tax dollars. You may elect to contribute a portion of your before-tax pay each Plan Year (which is the calendar year) for this purpose. The University will provide you with enrollment materials that explain the maximum amount you may contribute in any year. Amounts withheld from your paychecks will be put into a Medical Care Reimbursement Account from which you can draw reimbursements as you incur uncovered medical care expenses during the year.

Only eligible medical care expenses can be reimbursed from your Medical Care Reimbursement Account. The Internal Revenue Service sets guidelines for eligible and ineligible expenses. Please refer to the attached Appendix for a list of examples.

Dependent Care Reimbursement Account

The Plan also allows you to contribute up to $5,000 ($2,500 if you are married but file separate tax returns) in before-tax dollars to a Dependent Care Reimbursement Account. The amount in your Dependent Care Reimbursement Account is then used to reimburse you for eligible dependent care expenses. Examples of eligible expenses include fees for child care centers, nursery school, family day care providers, baby sitters and care for disabled dependents.

Since a Dependent Care Reimbursement Account is for expenses related to the care of qualified dependents, certain guidelines apply. A qualified dependent must be either:

- a child under age 13 for whom you are entitled to claim an exemption on your federal income tax return, or
- your spouse or other dependent (of any age) who is physically or mentally incapable of caring for himself or herself.

Each Plan Year you may contribute to your Dependent Care Reimbursement Account the lesser of:

- $5,000 ($2,500 if you are married but file separate tax returns); or
- if you are single, the amount of your earned income for the year; or
- if you are married, the amount of your or your spouse's earned income for the year, whichever is less.

Please note: If you are married and live with your spouse, you will be eligible for these benefits only if your spouse works or attends school full-time. Each month that your spouse is a full-time student, or is incapable of caring for himself or herself, he or she will be considered to have earned income of $250 ($500 if you have two or more dependents).

If you do not live with your spouse and your dependent(s) reside with you, you may be entitled to contribute the entire $5,000 for a Plan Year (rather than

$2,500). Please contact the Plan Administrator if you think this rule might apply to you.

There are some important things to remember ***before*** you decide to participate in the Dependent Care portion of the Plan.

- You must be able to provide your child's daycare provider's name, address, and Employer Identification/Social Security Number in order to be reimbursed for the expense from your Dependent Care Reimbursement Account.
- If your daycare provider is your spouse or dependent, you cannot be reimbursed for the expense from your Dependent Care Reimbursement Account.
- If you terminate employment mid-year, you will be allowed to make claims for expenses incurred after your termination, up to your remaining Account balance, provided you still have eligible daycare expenses.

You should note that instead of making before-tax contributions to a Dependent Care Reimbursement Account, it may be more advantageous for you to use the income tax credit available under the Internal Revenue Code for dependent care expenses. Although most employees will save money by participating in a Dependent Care Reimbursement Account, this is not always the case. You may save more by taking the income tax credit, but you may not use both for the same dependent care expenses. Please consult your tax advisor before electing to establish a Dependent Care Reimbursement Account.

Reimbursements from Medical Care and Dependent Care Reimbursement Accounts

If you establish a Medical Care Reimbursement Account and/or Dependent Care Reimbursement Account, the amounts you designate will be credited to individual accounts established in your name. Your accounts do not earn interest during the year. They are simply bookkeeping records to keep track of the amount of before-tax pay you have contributed to your accounts, and how much is available to pay for each of your elected benefits.

You will be paid from your accounts as you submit claims for reimbursement. You must document your claims by submitting appropriate paid receipts. The University will provide you with the necessary claim forms.

For reimbursements from your Medical Care Reimbursement Account, you must provide a description of the medical care expense from the service provider, plus a written statement that such amounts are not reimbursable from another group health plan. The Explanation of Benefits provided by your health plan will be sufficient for this purpose. In the event that your group health, dental or vision plan excludes from coverage treatment that is covered under this Plan, a paid receipt is sufficient.

To receive reimbursements from your Dependent Care Reimbursement Account, you must submit a paid receipt including the name, address and taxpayer identification number (or Social Security number) of the caregiver.

If you submit a proper claim for medical care expenses that exceeds the amount you have contributed to your Medical Care Reimbursement Account as of the date you request reimbursement, your claim will be paid up to the total amount you elected to contribute to your Medical Care Reimbursement Account for the whole year (minus any prior reimbursements).

> **Example:** *Employee A elects to have $80 each month ($960 for the year) deposited into her Medical Care Reimbursement Account. At the end of March (after she has deposited $240 into her Account), Employee A submits a proper claim for medical care expenses in the amount of $1,000. If Employee A has received no prior reimbursements for the year, the Plan Administrator will reimburse Employee A for $960 (the full amount she will deposit for the year), even though Employee A has thus far only deposited $240 into her Medical Care Reimbursement Account. Employee A, of course, must continue to make deposits for the remainder of the year and will not be eligible for any further reimbursements from her Medical Care Reimbursement Account.*

Dependent care expenses, on the other hand, will be reimbursed from your Dependent Care Reimbursement Account only up to the amount you have contributed as of the date you submit the claim for reimbursement. Claims for dependent care expenses that cannot be paid in full will be held over for payment until the next reimbursement period, provided that your Dependent Care Reimbursement Account has sufficient funds at that time.

> **Example:** *Employee B elects to have $400 each month ($4,800 for the year) deposited into his Dependent Care Reimbursement Account. At the end of March (after he has deposited $1,200 into his Account), Employee B submits a proper claim for dependent care expenses in the amount of $3,000. If Employee B has received no prior reimbursements, the Plan Administrator will reimburse Employee B the $1,200 he has thus far deposited into his Dependent Care Reimbursement Account. As Employee B makes future deposits during the remainder of the Plan Year, he will receive additional reimbursements until the entire $3,000 claim has been reimbursed.*

Amounts you contribute to your Medical Care Reimbursement Account cannot be used to pay for dependent care expenses. Likewise, amounts you contribute to your Dependent Care Reimbursement Account cannot be used to reimburse you for medical care expenses.

IV. HOW TO BECOME A PARTICIPANT

Voluntary Participation

Participation in the Plan is completely voluntary. If you choose to participate in the Plan, you will designate on an enrollment form (the "Enrollment Form") your benefit elections and the amount of before-tax pay you wish to contribute toward your elected benefits. If you choose not to participate, you will receive your full pay or salary, but no Plan benefits. The University will provide you with the necessary Enrollment Form.

There are three components to the Plan: the premium payment portion, the medical care reimbursement portion, and the dependent care reimbursement portion, all of which are discussed in this document. You may choose to participate in any or all of the portions of the Plan. However, you may not elect benefits for which you are not eligible under the terms of the Plan and any Benefit Plan. This Plan simply offers you the opportunity to elect certain benefits, but only if you are eligible for those benefits. It is possible that some employees may not be eligible for all benefits offered under the Plan.

> **Example:** *If you do not have any eligible dependents, or if you do, but you have a stay-at-home spouse who is not a full-time student, you will not be able to participate in the dependent care portion of the Plan.*

Paycheck Reductions

Your total annual before-tax contributions for the benefits you designate on your Enrollment Form will be divided by the number of your regular compensation payments in the calendar year. That amount will be withheld from your paycheck each payroll period and applied toward your benefit choices.

Eligibility and Participation

You will be eligible to participate in the Plan if you are regularly scheduled to work 40 hours per week. You may begin participating in the premium payment portion of the Plan when you are eligible to participate in a Benefit Program that requires you to pay part of the premium for coverage. You will be eligible to participate in the Medical Care Reimbursement Account and Dependent Care Reimbursement Account portions of the Plan after you complete 12 months of employment with the University. To participate, you must submit a completed Enrollment Form, which the University will provide to you.

You elect to participate in the Medical Care Reimbursement Account and Dependent Care Reimbursement Account portions of the Plan on the basis of an entire Plan Year. Your Enrollment Form is valid for one Plan Year and must be renewed each year. You must complete and file your Enrollment Form with the Plan Administrator during the open enrollment period which is held towards the end of each Plan Year. You will be notified by Human Resources when the open enrollment period begins and ends each year. Your participation in the premium payment portion of the Plan is based on the enrollment and renewal provisions of the Benefit Plans. Please see Human Resources for more information on the enrollment conditions of the Benefit Plans.

Changing Your Elections

Once you submit an Enrollment Form for a Plan Year, you generally cannot change or revoke your elections during that Plan Year. However, there are important exceptions to this general rule. You may change or revoke your elections if you (i) have a change in status or (ii) terminate employment during the Plan Year. A change in status includes:

- your marriage or divorce;

- death of your spouse or child;
- birth, adoption or foster placement of a child;
- start or loss of employment by your spouse;
- a change between full-time and part-time employment status by you or your spouse;
- taking or returning from an unpaid leave of absence by you or your spouse;
- a significant gain or loss in the health coverage (not including changes in the cost of coverage) of your spouse, attributable to your spouse's employment.

Other events may be recognized for this purpose under applicable law or regulations. Please contact Human Resources if you have any questions on whether you may change your benefit elections during the Plan Year.

If you experience a change in status, you may change your elections under the Plan for the remainder of the Plan Year. Such a change, however, must be based on and consistent with the change in your status.

Please note: You must notify the Plan Administrator within 31 days after the date the change in status occurs. If you do not notify the Plan Administrator within 31 days, you will have to wait until the next Plan Year to change your Plan elections.

Forfeiture of Unused Amounts

Before making your benefit elections, you should carefully estimate your expenses for medical care and dependent care services during the coming year. You will want to avoid contributing more money than you think you will use during the year. You will have until March 1 of the following year to file for reimbursements of eligible expenses incurred during the Plan Year. ***Any unused amounts left over in your Account(s) after all proper claims have been reimbursed will be forfeited. Unused amounts cannot be carried over into the next Plan Year.*** You begin each new Plan Year with Account balances of zero.

V. DURATION OF PARTICIPATION AND COVERAGE

Duration of Participation and Reemployment

Your participation in the Plan and your Plan contributions will end on the earliest of:

(i) The date you cease to be an eligible employee under the Plan;

(ii) The last day for which your election to participate remains in effect;

(iii) The date you are no longer eligible for the benefits you elected under the Plan;

(iv) The date on which you fail to make the contributions necessary to pay for the benefits you elected under the Plan; or

(v) The date the Plan is terminated.

Generally, if you terminate employment with the University and do not elect to continue participating in your Medical Care Reimbursement Account (see explanation under *Continued Coverage of Medical Care Reimbursement Account*), you will be considered to have revoked your coverage under that portion of the Plan. If you are subsequently rehired within the same Plan Year, you will not be able to resume participation in your Medical Care Reimbursement Account until the start of the next Plan Year. You may, however, be entitled to certain continued benefits from your Dependent Care Reimbursement Account, if you were contributing to one as of your termination (as explained under *Continued Benefits Under Dependent Care Reimbursement Account*, below). If you are rehired in a new Plan Year, you may participate in the Plan on the same basis as any newly hired employee, subject to any applicable restrictions in the Plan and any underlying employee benefit plans offered through the Plan.

Continued Participation During Unpaid Leaves of Absence

When you take an unpaid leave of absence — whether under the Family and Medical Leave Act of 1993 ("FMLA"), the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), or otherwise — you will be entitled to continue to participate in the Plan under either of the following options:

- *Pre-Pay*. Before you begin an unpaid leave of absence, you may pre-pay on a before-tax basis the amounts due for your benefit elections for the duration of the leave or until the end of the Plan Year, whichever is earlier. These amounts are your "Required Contributions," and you may have them deducted from one or more of your paychecks before you go on leave. If your leave extends beyond the end of the Plan Year, thereby resulting in a short-fall of before-tax Required Contributions, you may continue during the next Plan Year to make your Required Contributions on an after-tax basis, under the *pay-as-you-go* option explained below. You may not pre-pay any Required Contributions due for the following Plan Year

- *Pay-As-You-Go*. You also may elect to pay your Required Contributions during an unpaid leave of absence on an after-tax, pay-as-you-go basis. Under this option, you will be responsible for paying your Required Contributions on or before the first day of each calendar month. Your participation in the Plan will terminate if you fail to pay any Required Contributions within 30 days of their due date.

Alternatively, if you take an unpaid leave of absence, you also are entitled to revoke your benefit elections. In that case, your participation in the Plan ends, and you will not need to make any contributions during your leave. Generally, if you revoke your elections during a particular Plan Year, you are not entitled to resume participation in the Plan until the following Plan Year. However, if you revoke your benefit elections upon taking an unpaid leave under the FMLA or

USERRA, and you return to your employment within the same Plan Year, you will be entitled to resume participation in the Plan immediately. Your participation will resume using the same benefit elections you had made for that Plan Year before taking the unpaid FMLA or USERRA leave.

Continued Participation During Paid Leaves of Absence

If you take a paid leave of absence (whether under the FMLA, USERRA or otherwise) you continue to participate in the Plan on the same basis as an active employee. The full amounts you elected for Plan benefits will continue to be deducted from your paychecks during the paid leave of absence, even if your pay during the absence is at a reduced percentage.

Continued Coverage Under Medical Care Reimbursement Account

If your employment with the University is terminated, you may continue to submit claims for eligible medical care expenses provided *before* the date of your termination of employment. You may submit such claims for up to 60 days following the end of the calendar year in which your employment terminated. However, unless you elect to continue your coverage and make required after-tax contributions (as explained below), you will not be eligible to claim reimbursement for any medical care expenses incurred *after* your termination of employment.

As described in *COBRA RIGHTS*, below, if your employment is terminated during a Plan Year you may be able to continue your participation in your Medical Care Reimbursement Account for the remainder of that Plan Year by electing to make Required Contributions on an after-tax, pay-as-you-go basis. Required Contributions must be made on or before the first day of each calendar month. Your continued participation will terminate if you do not pay any Required Contribution within 30 days of its due date. If you continue to participate, you may continue to receive reimbursement from your Medical Care Reimbursement Account for medical care expenses incurred both before and after your termination of employment, but not beyond the end of the Plan Year. You will be treated as an active participant under the Plan to the extent required by law for the remainder of the Plan Year.

Continued Benefits Under Dependent Care Reimbursement Account

If your employment with the University is terminated, you may continue to submit Dependent Care Reimbursement Account expenses for claims incurred during the calendar year for up to 60 days following the end of the calendar year, whether you incurred the dependent care expenses before or after your termination of employment. You will be reimbursed for eligible expenses up to the remaining balance in your Dependent Care Reimbursement Account as of your termination date. After all proper claims have been reimbursed, you will forfeit any balance remaining in your Dependent Care Reimbursement Account on March 1 of the following calendar year.

Termination of Participation in Premium Payment Portion

Your participation in the premium payment portion of the Plan will terminate when your employment with the University terminates. Upon termination of your employment, you may have rights to continued coverage under any Benefit Plan which is considered a group health

plan in accordance with COBRA (see *COBRA RIGHTS*, below) and will be governed by the terms of the Benefit Plan.

VI. CLAIMS PROCEDURE

The University will provide you with the necessary forms for submitting claims for reimbursement under your Medical Care Reimbursement Account and/or Dependent Care Reimbursement Account. Claims for eligible expenses submitted on the appropriate forms and accompanied by acceptable documentation will be paid monthly after receipt by the Plan Administrator. To be eligible for reimbursement, all expenses must be incurred before the end of the Plan Year, and all claims for reimbursement must be submitted no later than 60 days after the end of the Plan Year. Payment will be made directly to you and not to the service provider.

If you believe you are entitled to a greater benefit than that determined by the Plan Administrator, you may file a claim in writing with the Plan Administrator. Claims for benefits under the underlying employee benefit plans offered through the Plan will be made in accordance with the claims procedure for those plans. The following timelines and procedures will apply to claim determinations for the Medical Care Reimbursement Account and Dependent Care Reimbursement Account.

Medical Care Reimbursement Account Claims—Initial Decision

Within 30 days after the receipt of your claim, the Plan Administrator will make a decision on your claim. The Plan Administrator may extend the 30-day period by up to an additional 15 days if necessary due to circumstances beyond the Plan's control. If the Plan Administrator must extend the period, the Plan Administrator will provide you with a written notice of the extension, before the end of the 30-day period, which explains why the extension is necessary and the expected decision date. If you do not properly submit all the necessary information needed to determine your claim, the Plan Administrator will contact you to let you know what additional information is needed. You will have 45 days to provide the information. The time during which the Plan Administrator is waiting to receive your information will not count towards the timeframe for responding to your claim.

Appealing the Denial of a Medical Care Reimbursement Account Claim

If your Medical Care Reimbursement Account claim is denied, you or your authorized representative may, within 180 days after the receipt of the written notice, write the Plan Administrator to appeal the denial. You may obtain, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim. You may also submit written comments, documents, records and other information relevant to your claim. Someone other than the person who made the first determination on your claim will make the decision on your appeal. The Plan Administrator will disclose the identity of any medical or vocational experts who were consulted in connection with your claim. If the benefit decision is based on a medical judgment, the Plan Administrator will consult with a health care professional who has the appropriate training and experience in the field of medicine involved.

The Plan Administrator's decision on appeal will be made within 60 days after receiving the appeal.

Dependent Care Reimbursement Account Claims—Initial Decision

Within 90 days after the receipt of your claim, the Plan Administrator will make a decision on your claim. The Plan Administrator may extend the 90-day period by up to an additional 90 days if required by special circumstances. If the Plan Administrator must extend the period, the Plan Administrator will provide you with a written notice of the extension, before the end of the 90-day period, which indicates the special circumstances requiring the extension and the expected decision date.

Appealing the Denial of a Dependent Care Reimbursement Account Claim

If your Dependent Care Reimbursement Account claim is denied, you or your authorized representative may, within 60 days after the receipt of the written notice, write the Plan Administrator to appeal the denial. You may obtain, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim. You may also submit written comments, documents, records and other information relevant to your claim. The Plan Administrator's decision on appeal usually will be made within 60 days after receiving the appeal, unless special circumstances require an extension of an additional 60 days. If the Plan Administrator cannot make a decision within the initial 60-day period, the Plan Administrator will provide you with a written notice, before the end of the 60-day period, which indicates the special circumstances requiring the extension and the expected decision date.

Claims Decision Notices

If your claim is completely or partially denied either on the initial claim or on appeal, the Plan Administrator will provide you with a written notice of the denial containing:

- The specific reason(s) for the denial and reference to the pertinent Plan provisions upon which the denial is based;
- In the case of the denial of an initial claim, a description of any additional material or information you need to perfect your claim and the reasons why such material or information is necessary;
- In the case of a denial of an initial claim, an explanation of the Plan's appeal procedures;
- In the case of a denial on appeal, a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim;
- For claims under the Medical Care Reimbursement Account, if an internal rule, guideline, protocol or similar criterion was relied on in making the decision, either a copy of that document, or a statement that such a document was relied upon and that a copy will be furnished (free of charge) upon request;

- For claims under the Medical Care Reimbursement Account, if the decision was based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the Plan's terms to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request; and

- A statement that you have the right to bring a civil action under ERISA Section 502(a) following a denial on appeal.

The decision on appeal will be final and binding on participants, dependents and any other interested party. In no event will you or your covered eligible dependents be entitled to challenge a decision of the Plan Administrator in court or in any other administrative proceedings until the above claim and appeal procedures have concluded.

VII. MISCELLANEOUS INFORMATION

No Guarantee of Employment

The Plan document and this Summary Plan Description do not constitute an employment agreement between you and the University. Neither the establishment and maintenance of the Plan, nor anything contained in the Plan or this Summary Plan Description, gives you the right to continue in employment with the University or to be reemployed after termination of employment, or limits any rights the University may have to discipline you or terminate your employment with the University.

No Vested Right to Benefits

Except to the extent of expenses incurred by a participant, as specifically provided in the Plan, no individual participating in or covered by the Plan has any guaranteed or vested right to receive, or to continue to receive, Plan benefits.

Amendment and Termination

The University, in its sole discretion, reserves the right to amend or to terminate the Plan at any time, with or without advance notice to employees. Any such amendment or termination may be made by proper action of the Board of Trustees of the University or its delegate.

Protection Against Creditors

To the extent permitted by law, and except for monies owed to the University, no Plan benefit payment will be subject in any way to alienation, sale, transfer, assignment, garnishment, execution or encumbrance of any kind, and any attempt to do so will be void.

Plan Administrator Authority

The Plan Administrator has the sole discretion to interpret the Plan and to decide all matters arising in connection with the administration of the Plan, including the discretionary

authority to make factual determinations and to determine eligibility for benefits. The Plan Administrator may adopt uniform rules for the administration of the Plan as it deems necessary or appropriate. The decisions of the Plan Administrator will be final and conclusive with respect to all questions relating to the Plan. No person has the authority to make any verbal statements of any kind at any time that (i) are legally binding on the University or (ii) alter the actual Plan document and contracts maintained in connection with the Plan.

Because of the federal tax advantages available under the Plan, the Internal Revenue Service requires the University to conduct tests to ensure that the Plan does not discriminate in favor of highly compensated employees. If these tests are not satisfied, benefits paid to highly compensated employees will become subject to federal income tax. The University reserves the right to reduce the contributions made to the Plan by highly compensated employees in order to assure compliance with the nondiscrimination requirements. Should this apply to you, you will be notified.

VIII. STATEMENT OF ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants will be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations all documents governing the Plan, including insurance contracts and 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 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 Administrator may make 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.

Continue Group Health Coverage

You will be entitled to continue medical care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. 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.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a Plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file a 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 Plan Administrator. If you have a claim for benefits which 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 medical child support order, you may file suit in federal court.

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

Assistance With Your Questions

If you have any questions about the Plan, you should contact the Human Resources Department. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

IX. COBRA RIGHTS

The requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), apply to the Medical Care Reimbursement Account and to any of the Benefit Plans which are considered to be group health plans. Therefore, under certain

circumstances, you may elect to continue making after-tax contributions to these plans and continue to be covered by and be reimbursed (under the Medical Care Reimbursement Account) for medical care expenses incurred *after* your termination of employment. For more information on your COBRA rights under any of the Benefit Plans, please refer to the summary plan description for that Benefit Plan.

Upon the occurrence of any of the qualifying events described below, you (or your eligible dependents) may elect to continue contributing to the Medical Care Reimbursement Account according to the COBRA rules. A "qualifying event" is any of the following:

- For you, your eligible spouse or other eligible dependents, your termination as an employee of the University (other than for gross misconduct) or a reduction of your hours that makes you ineligible to participate in the Plan;
- For your eligible spouse or other eligible dependents, your death;
- For your eligible dependents and your spouse, a divorce or legal separation between you and your spouse;
- For your eligible dependents and spouse, loss of the right to participate in the Plan due to your becoming entitled to Medicare; or
- For your eligible dependent child, ceasing to qualify as a dependent under the Plan.

You or your spouse may elect or decline continuation coverage on behalf of any eligible covered family member who is a minor. You or your spouse may also elect (but not decline) continuation coverage for any other eligible covered family member who is an adult. You may also elect continuation coverage for an eligible child who is born to you, adopted by you, or placed for adoption with you while your continuation coverage is effective. You must notify the Plan Administrator in writing within 30 days of your newborn or adopted child's birth, adoption or placement for adoption.

You or your eligible dependent(s) must notify the Plan Administrator in writing within 60 days after a divorce or legal separation or after an eligible dependent child ceases to qualify as an eligible dependent under the Plan. If such notice is not provided, the right to continue participating in the Plan under COBRA rules will be lost.

The University is required to notify the Plan Administrator of the following qualifying events within 30 days of the following events:

- Your death;
- Your termination or reduction in hours you work; or
- Your becoming entitled to Medicare.

The Plan Administrator must, within 14 days of being notified of a qualifying event, advise you or your covered eligible dependent(s) of the right to continue participating in the Plan. You (or your dependent(s)) must elect to continue participating in the Plan within 60 days of the later of the following:

- The date you would lose the right to participate in the Plan because of a qualifying event, or
- The date you or your eligible dependent(s) are advised by the Plan Administrator of the right to continue participating in the Plan under COBRA rules.

Notice to your eligible spouse of the right to continue participating in the Plan will be deemed notice to any eligible dependent children residing with your spouse.

To continue Medical Care Reimbursement Account coverage, you and your eligible dependent(s) will be required to contribute to the Plan on an after-tax basis an amount equal to the amount you were contributing at the time of the qualifying event, plus 2%. The contributions must be made by no later than the last day of the calendar month to which the contribution applies and must be sent to the COBRA third party administrator.

You can elect to continue coverage under the Medical Care Reimbursement Account for the rest of the Plan Year in which the qualifying event occurs as long as the maximum benefit you could receive from the account exceeds the amount you will contribute for continuation coverage. You may not continue your Medical Care Reimbursement Account after the end of the Plan Year in which the qualifying event occurs.

> **Example 1:** *John elected to contribute $2,000 to his Medical Care Reimbursement Account in 2004. When he terminated employment in 2004, he had contributed $700 and filed no claims for reimbursement. Since the amount that he will contribute to his account for continuation coverage ($1,300) is less than the maximum benefit that he can receive from the account for the Plan Year ($2,000), he can elect continuation coverage under the Medical Care Reimbursement Account for the rest of 2004.*
>
> **Example 2:** *The facts are the same as in Example 1 except that John had received $1,500 in reimbursements from his Medical Care Reimbursement Account when he terminated employment. Since the amount that he would contribute to his account for continuation coverage ($1,300) is more than the maximum benefit that he could receive from the account for the rest of 2004 ($500), he cannot elect continuation coverage under the Medical Care Reimbursement Account.*

Other events will end your right to continue participating in the Plan. Your right to continued participation will end before the maximum period on the earliest of the following:

- The date the University ceases to provide any group health plan coverage for all employees;

- The date you or your eligible dependent(s) fail to make the Required Contributions;

- The date you or your eligible dependent becomes either covered under another employer's group health plan or entitled to Medicare.

If you or your eligible dependent(s) become covered by another employer's group health plan and have a pre-existing condition that is not covered by that plan, then the right to continue making contributions (at least for that pre-existing condition) will not be terminated due to that other coverage.

If you or your eligible dependent(s) elect to continue participation in the Plan after a qualifying event, then you or your eligible dependent(s) will have 45 days from the date of the election to make the required contribution. That initial contribution must cover the entire period from the date of the qualifying event to the date of your election.

If you have any questions about COBRA coverage, contact the Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA offices are available through EBSA's website.)

X. GENERAL PLAN INFORMATION

The University is the Plan sponsor and Plan Administrator of the Plan and has the authority to administer the Plan and interprets its terms. For more information on the Plan, please contact the Plan Administrator.

Name of Plan:	National University of Health Sciences Flexible Benefit Plan, a component plan of the National University of Health Sciences Welfare Benefit Plan
Plan Number:	501
Plan Sponsor:	National University of Health Sciences 200 East Roosevelt Road Lombard, Illinois 60148-4583 (630) 889-6556
Employer Identification Number:	36-1521940
Plan Administrator:	The Plan Sponsor
Type of Plan:	Welfare benefit plan offering benefits through a "cafeteria plan"

format under Section 125 of the Internal Revenue Code.

Plan Funding:	The Plan is self-funded. Plan benefits are not guaranteed by an insurance contract. Benefits are entirely paid through employee contributions.
Agent for Service of Legal Process:	The Plan Sponsor
Plan Year:	The calendar year

APPENDIX

EXPENSES ELIGIBLE FOR REIMBURSEMENT FROM MEDICAL CARE REIMBURSEMENT ACCOUNT

This Appendix provides examples of eligible medical care expenses for which you can submit claims for reimbursement from your Medical Care Reimbursement Account and examples of ineligible medical care expenses which will not be reimbursed from your Account.

A. EXAMPLES OF ELIGIBLE EXPENSES

Examples of medical care expenses that may be reimbursed from your Medical Care Reimbursement Account include:

- *Acupuncture*
- *Alcoholism* — Payments to a treatment center for alcohol or drug addiction. This includes meals and lodging provided by the center during medical treatment.
- *Ambulance*
- *Artificial limb*
- *Artificial teeth*
- *Birth control pills* — Birth control pills that are prescribed by your doctor are reimbursable from your Medical Care Reimbursement Account.
- *Braille books and magazines* — The part of the cost of Braille books and magazines for a visually-impaired person that is more than the price for regular books and magazines is reimbursable from your Medical Care Reimbursement Account.
- *Capital expenses* — Amounts you pay for special equipment installed in your home or for improvements, if their main purpose is medical care are reimbursable from your Medical Care Reimbursement Account. The cost of permanent improvements that increase the value of the property may be partly included as a medical expense. The cost of the improvement is reduced by the increase in the value of the property. The difference is a medical expense. If the value of the property is not increased by the improvement, the entire cost is included as a medical expense.

  Certain improvements made to accommodate your

personal residence to your disabled condition, or that of your spouse or your dependents who live with you, do not usually increase the value of the residence and the cost can be included in full as medical expenses. These improvements include, but are not limited to, the following items:

- Constructing entrance or exist ramps to your residence,
- Widening doorways at entrances or exists to your residence,
- Widening or otherwise modifying hallways and interior doorways,
- Installing railing, support bars, or other modifications to bathrooms,
- Lowering of or making other modifications to kitchen cabinets and equipment,
- Altering the location of 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 anywhere in the house,
- Modifying hardware on doors,
- Modifying areas in front entrance and exit doorways, and
- Grading of ground to provide access to the residence.

		Only reasonable costs to accommodate a personal residence to a disabled condition are considered medical care. Additional costs for personal motives, such as for architectural or aesthetic reasons, are not medical expenses.
•	*Automobile*	Cost of special hand controls and other special equipment installed in an automobile for the use of a person with disabilities. The amount by which the cost of an automobile specially designed to hold a wheelchair is more than the cost of a regular car is a medical expense. You cannot deduct the cost of operating a specially equipped car.
•	*Chiropractors*	
•	*Christian Science practitioners*	
•	*Contact lenses/solutions*	Amounts you pay for contact lenses needed for medical reasons. You can also include the cost of equipment and materials required for using contact lenses, such as saline solution and enzyme cleaner is reimbursable from your Medical Care Reimbursement Account.
•	*Cosmetic surgery*	Amounts you pay for cosmetic surgery, or for any cosmetic treatment, if it is necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease is reimbursable from your Medical Care Reimbursement Account. Conversely, amounts you expend for cosmetic surgery or treatments that are solely for cosmetic purposes or to improve your general appearance are not reimbursable from your Account.
•	*Crutches*	Amount you pay to buy or rent crutches.
•	*Dental treatment*	Amounts you pay for dental treatment. This includes fees paid to dentists for X-rays, fillings, braces, extractions, dentures, etc. Amounts you pay for treatments that are solely cosmetic in nature (*i.e.,* teeth bleaching), are not reimbursable from your Account.
•	*Eyeglasses*	Amounts you pay for eyeglasses and contact lenses needed for medical reasons. You can also include fees paid for eye examinations.

- *Guide dog or other animal* — Cost of a guide dog or other animal trained to assist persons with physical disabilities. Amounts you pay for the care of these specially trained animals are also medical expenses.

- *Hearing aids* — Cost of a hearing aid and the batteries you buy to operate it.

- *Health Institute* — Fees you pay for treatment at a health institute only if the treatment is prescribed by a physician and the physician issues a statement that the treatment is necessary to alleviate a physical or mental defect or illness in the individual receiving the treatment.

- *Hospital services* — Cost of inpatient care at a hospital or similar institution if the main reason for being there is to receive medical care. This includes amounts paid for meals and lodging.

- *Laboratory fees* — Amounts you pay for laboratory fees that are part of your medical care.

- *Laetrile* — If prescribed by a doctor and purchased and used in a location where the sale and use are legal.

- *Lead-based paint removal* — Cost of removing lead-based paints from surfaces in your home to prevent a child who has or has had lead poisoning from eating the paint. These surfaces must be in poor repair (peeling or cracking) or within the child's reach.

- *Learning disability* — Tuition fees you pay to a special school for a child who has severe learning disabilities caused by mental or physical impairments, including nervous system disorders. Your doctor must recommend that the child attend the school.

  You can also include tutoring fees you pay on your doctor's recommendation for the child's tutoring by a teacher who is specially trained and qualified to work with children who have severe learning disabilities.

- *Legal fees* — Legal fees paid to authorize treatment for mental illness.

- *Lifetime care* — A part of a life-care fee or "founder's fee" you pay either monthly or as a lump sum under an agreement with a retirement home. The part of the payment you include is the amount properly 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.

  Dependents with disabilities. Advance payments to a private institution for lifetime care, treatment, and training of your physically or mentally impaired dependent upon your death or when you become unable to provide care. The payment must be a condition for the institution's future acceptance of your dependent and must not be refundable.

- *Lodging* — Cost of meals and lodging at a hospital or similar institution if your main reason for being there is to receive medical care.

  Also the cost of lodging not provided in a hospital or similar institution. You can include the cost of such lodging while away from home if you meet all of the following requirements.

  1. The lodging is primarily for and essential to medical care.

  2. The medical care is provided by a doctor in a licensed hospital or in a medical care facility related to, or the equivalent of, a licensed hospital.

  3. The lodging is not lavish or extravagant under the circumstances.

  4. There is no significant element of personal pleasure, recreation, or vacation in the travel away from home.

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

- *Massage Therapy/ Physical Therapy* — Amounts paid to a board certified massage therapist, or to a physical therapist for massage therapy or physical therapy only if the treatment is prescribed by a physician and the physician issues a statement that the treatment is necessary to alleviate a physical or mental defect or illness in the individual receiving the treatment.

- *Medical information* — Amounts paid to a plan that keeps your medical information so that it can be retrieved from a computer data bank for your medical care.

- *Medical services* — Amounts you pay for medical services provided by:
    - Physicians
    - Surgeons
    - Specialists, or
    - Other medical practitioners

- *Medicines* — Amounts you pay for prescribed medicines and drugs. A prescribed drug is one which requires a prescription by a doctor for its use by an individual. You can also include amounts you pay for insulin. Homeopathic drugs that are prescribed by a physician and that are not available absent such a prescription are reimbursable from your Medical Care Reimbursement Account.

- *Special home for mentally disabled* — Cost of keeping a mentally retarded person in a special home, not the home of a relative, on the recommendation of a psychiatrist to help the person adjust from life in a mental hospital to community living.

- *Non-prescription medicines* — Amounts paid for non-prescription (over-the-counter) medications, such as antacids, allergy medicines, pain relievers and cold medications, used for the treatment of disease or injury.

- *Nursing home* — Cost of medical care in a nursing home or home for the aged for yourself, your spouse, or your dependents. This includes the cost of meals and lodging in the home if the main reason for being there is to get medical care.

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

  Only the amount spent for nursing services is a medical expense. If the attendant also provides personal and household services, these amounts must be divided between the time spent performing household and personal services and the time spent for nursing services. **However, certain expenses for household services or for the care of a qualifying individual incurred to allow you to work may qualify for the child and dependent care credit.**

  Also, part of the amounts you pay for that attendant's meals. Divide the food expense among the household members to find the cost of the attendant's foods. Then apportion that cost in the same manner, as described above, that you apportioned the attendant's wages between nursing services and all other services. If you had to pay additional amounts for household upkeep because of the attendant, you can include the extra amounts with your medical expenses. This includes extra rent or utilities you pay because you moved to a larger apartment to provide space for the attendant.

  Employment taxes. You can include social security tax, FUTA, Medical tax, and state employment taxes you pay for a nurse, attendant, or other person who provides medical care as a medical expense.

- *Nutritionist* — Costs incurred by you for visiting a nutritionist are only reimbursable from your Medical Care Reimbursement Account if the visit is determined to be medically necessary for the treatment of a specific ailment, as determined by your physician in writing. An example of such an ailment would be diabetes.
- *Operations*
- *Osteopath*
- *Oxygen* — Amounts you pay for oxygen or oxygen equipment to relieve breathing problems caused by a medical condition.
- *Personal use items* — Where an item purchased in a special form primarily to alleviate a physical defect is one that a normal form is ordinarily used for personal, living, or family purposes, the excess of the cost of the special form over the cost of the normal form is a medical expense.
- *Psychiatric care* — This includes the cost of supporting a mentally ill dependent at a specially equipped medical center where the dependent receives medical care.
- *Psychoanalysis* — Cost of psychoanalysis, but you cannot include payments for psychoanalysis that you must get as a part of your training to be a psychoanalyst.
- *Psychologist*
- *Special schools* — Payments to a special school for a mentally impaired or physically disabled person if the main reason for using the school is its resources for relieving the disability. You can include, for example, the cost of a school that:
    - Teaches Braille to a visually impaired child,
    - Teaches lip reading to a hearing impaired child, or
    - Gives remedial language training to correct a condition caused by a birth defect.

  The cost of meals, lodging, and ordinary education supplied by a special school can be included in medical

expenses only if the main reason for the child's being there is the resources the school has for relieving the mental or physical disability.

You cannot include in medical expenses the cost of sending a problem child to a special school for benefits the child may get from the course of study and the disciplinary methods.

- *Sterilization and termination of pregnancy* — Cost of a legal sterilization (a legally performed operation to make a person unable to have children) or a legal abortion.

- *Telephone* — Cost and repair of special telephone equipment that lets a hearing-impaired person communicate over a regular telephone.

- *Television* — Cost of equipment that displays the audio part of television programs as subtitles for hearing-impaired persons. This may be the cost of an adapter that attaches to a regular set. It also may be the cost of a specially equipped television that exceeds the cost of the same model regular television set.

- *Therapy* — Amounts you pay for therapy you receive as medical treatment.

  "Patterning" exercises. Payments you make to an individual for giving "patterning" exercises to a mentally retarded child are medical care expenses. These exercises consist mainly of coordinated physical manipulation of the child's arms and legs to imitate crawling and other normal movements.

- *Transplants* — Payments for surgical, hospital, laboratory, and transportation expense for a donor or a possible donor of a kidney or other organ. You cannot include expenses if you did not pay for them.

  A donor or possible donor can include surgical, hospital, laboratory, and transportation expenses in medical expenses only if he or she pays for them.

- *Transportation* — Amounts paid for transportation primarily for, and essential to, medical care qualify as medical expenses.

  You can include:

  - Bus, taxi, train, or plane fares, or ambulance service,
  - Actual car expenses, such as gas and oil (do not include expenses for general repair, maintenance, depreciation, and insurance),
  - Parking fees and tolls,
  - Transportation expenses of a parent who must go with a child who needs medical care,
  - Transportation expenses of a nurse or other person who can give injections, medications, or other treatment required by a patient who is traveling to get medical care and is unable to travel alone, and
  - Transportation expenses for regular visits to see a mentally ill dependent, if these visits are recommended as a part of treatment.

  If you cannot provide a paid receipt for transportation costs, such as metered parking, or bus or train fare, your written certification that such cost was incurred, accompanied by a copy of the physician's bill for the visit will be sufficient.

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

- *Tuition* — Charges for medical care included in the tuition of a college or private school, if the charges are separately stated in the bill or given to you by the school.

- *Wheelchair* — Amounts you pay for a wheelchair used mainly for the relief of sickness or disability, and not just to provide transportation to and from work. The cost of operating and keeping up the wheelchair is also a medical expense.
- *X-ray fees* — Amounts you pay for X-rays that you get for medical reasons.

B. EXAMPLES OF INELIGIBLE EXPENSES

Examples of medical care expenses that ***cannot*** be reimbursed from your Medical Care Reimbursement Account include:

- *Cosmetic surgery* — Except that surgery to correct congenital abnormality, personal injury or disfiguring disease, which can be reimbursed as a medical expense.
- *Hair transplants*
- *Hair removal (electrolysis)*
- *Funeral and burial expenses*
- *Household and domestic help* — Even if recommended by a physician due to your or your dependent's inability to perform housework.
- *Certain special schools* — Cost of sending problem child to a special school for benefits the child may receive from the course of study and disciplinary methods.
- *Illegal operation or treatment* — Any expenses incurred in connection with an illegal operation or treatment.
- *Health club dues* — You may not include in medical expenses any health club dues, YMCA dues, steam baths, etc.
- *Dancing lessons or swimming lessons* — Even if recommended by a qualified physician for general health improvement.
- *Bottled water*

• *Maternity clothes, diaper service, etc.*	
• *Cosmetics and toiletries*	Amounts paid for cosmetics, toiletries, toothpastes, etc. are not included in medical care expenses.
• *Vitamins*	Vitamins taken for general health purposes.
• *Vacation or travel*	Medical care expenses do not include vacation or travel taken for general health purposes, improvement of morale or to relieve physical or mental discomfort.
• *Transportation expenses to and from work*	Transportation expenses to and from work, even though a physical condition may require special means of transportation.
• *Automobile insurance premiums*	Automobile insurance, including the segment of premiums providing medical coverage for persons injured through accident by an employee's car.
• *Life insurance premiums*	Premiums paid for life insurance policies or for policies providing repayment for loss of earnings or for accidental loss of life, limb, sight, etc.
• *General health expenses*	Expenditures that are merely beneficial to the general health of the person, such as exercise, fitness, nutrition, recreation, vacation or membership in a spa or health club.
• *Dependent care expenses*	
• *Weight loss programs*	Even if your doctor prescribes the program.
• *Smoking programs*	Even if your doctor suggests the program.

NATIONAL UNIVERSITY OF HEALTH SCIENCES
FLEXIBLE BENEFIT PLAN

SUMMARY PLAN DESCRIPTION