VEBA PLAN SUMMARY
HEALTH REIMBURSEMENT ARRANGEMENT FOR ACTIVE EMPLOYEES

Your governmental employer ("Employer") has adopted the Minnesota Service Cooperatives VEBA Plan to provide health reimbursement arrangements for eligible employees, their Spouses and Dependents. The VEBA Plan permits Employees to pay Eligible Health Expenses from individual accounts. Your VEBA Plan account is funded entirely with Employer contributions.

Your account in the VEBA Plan will be available for the reimbursement of Eligible Health Expenses incurred during your employment and after your termination of employment.

This Summary describes the VEBA Plan's provisions as of the Effective Date, and answers important questions about it. Keep this Summary, and refer to it to answer important questions about the VEBA Plan.

What does "VEBA" stand for?

"VEBA" is short for "voluntary employees' beneficiary association." If you are part of a group of employees represented by a labor union, you are a member of the VEBA if provided for in a collective bargaining agreement between the union and your Employer. If you are not represented by a labor union, you are a member of the VEBA if provided for in a personnel policy of your Employer.

The VEBA has been organized as a trust designed to be exempt from taxes under Section 501(c)(9) of the Internal Revenue Code (the "Code"). As used in this Summary, the term "VEBA Plan" includes not only the trust, but also the health reimbursement arrangements that are funded through the trust. Additional eligibility rules may apply in order for you to participate in the health reimbursement arrangement.

INTRODUCTION

When you become eligible for the VEBA Plan, your Employer will make one or more contributions to an individual account in your name. The timing and amount of contributions will be determined under your collective bargaining agreement or personnel policy. You are not entitled to choose between taxable cash compensation and contributions to VEBA Plan. Your VEBA Plan account has the following additional features:

- Your account is funded entirely with Employer contributions.
- Your account may only be used for Eligible Health Expenses for you or your Dependents.
- You may access your account both during and after your employment.
- You may direct the investment of your account in mutual funds that represent a broad range of risk and return.

Your Employer may offer one or more of the VEBA coverage options listed below, and the definition of "Eligible Health Expenses" will vary depending on which of the VEBA coverage options are offered. If more than one option is offered, the definition of Eligible Health Expenses will vary depending upon which VEBA coverage option you choose prior to the beginning of the Plan Year.

- *General-Purpose VEBA Option*. For purposes of this Option, "Eligible Health Expenses" means medical care expenses incurred by you or your Dependents (including your Spouse) that are related to the diagnosis, treatment or prevention of disease, sickness or injury.

- *Limited-Purpose VEBA Option*. Employees who choose this Options may be eligible to contribute to a health savings account (an "HSA") if they are also covered by a high deductible health plan (with the meaning of Section 223 of the Code) and they do not have any disqualifying coverage. For purposes of this Option, "Eligible Health Expenses" means expenses incurred by you or your Dependents (including your Spouse) for medical care expenses that are related to the diagnosis, treatment or prevention of disease, sickness or injury; provided, however, that such expense is limited to one or more of the following categories of coverage, as determined by your Employer: vision care, dental care, preventive care (as defined in Section 223(c) of the Code), or Eligible Health Expenses incurred after you satisfied the applicable minimum deductible for a high deductible health plan (as defined in Section 223(c) of the Code).

- *Employee-Plus-Children VEBA Option*. Employees may choose this option if their spouse wishes to remain eligible to contribute to an HSA. For purposes of this Option, "Eligible Health Expenses" means expenses incurred by you or your child who is your Dependent (but not by your Spouse) for medical care expenses that are related to the diagnosis, treatment or prevention of disease, sickness or injury.

If your Employer offers VEBA coverage options in addition to the General-Purpose VEBA Option, and you fail to elect any of the VEBA Options listed above during the open enrollment period before the beginning of a Plan Year, you will be deemed to have elected the General-Purpose VEBA Option for the duration of that Plan Year.

The VEBA Plan offers you more choices than are available through traditional health insurance:

- You may use your VEBA Plan funds for any Eligible Health Expenses, whether or not such expenses are covered under your Employer's major medical plan.

- You may use your VEBA Plan funds to pay for physicians and specialists without obtaining a referral, and whether or not they belong to a particular network.

- You may use your VEBA Plan funds to pay for prescription drugs and many over-the-counter drugs, whether or not they are name-brand or generic.

- You may create a health care fund for retirement, if you use your VEBA Plan funds wisely.

Tips for conserving your VEBA Plan funds

1. Take advantage of discounts that may be available through your major medical plan for covered services:

   - Your Employer has pooled its purchasing power with other employers to obtain discounts from physicians and hospitals, and for prescription drugs.
   - While you are a member in your Employer's major medical plan, discounts will be passed through to your VEBA Plan account if the service is a covered benefit under the major medical plan.
   - See your *Comprehensive Major Medical Health Plan Summary Plan Description* for more information on covered benefits.

2. Use generic drugs rather than "name brand" drugs advertised on T.V.

3. Invest in preventive care.

   - Your major medical plan covers a fixed amount of preventive care expenses with no out-of-pocket charges. Take advantage of this feature to stay healthy!

   The VEBA Plan works together with other benefit programs:

   - The VEBA Plan is offered alongside a high deductible health plan. The annual deductible and out-of-pocket maximums on your high deductible plan will increase each year to keep pace with inflation.
   - The VEBA Plan may supplement a medical expense reimbursement account in your cafeteria plan.
   - The VEBA Plan may supplement a health savings account if you elect the Limited-Purpose VEBA Option and you are otherwise an eligible individual.
   - The VEBA Plan may be administered in tandem with your high deductible health plan, cafeteria plan and health savings account to create the effect of a single arrangement (the "Crossover" administration feature).

IMPORTANT: READ NEXT PARAGRAPHS CAREFULLY

This VEBA Plan Summary is a summary only. It does not alter the VEBA Plan, and the actual text of the underlying plan and trust documents control in all instances. If there is an inconsistency between the contents of this Summary and the contents of the plan and trust, your rights under the VEBA Plan shall be determined under the plan and trust and not under this Summary. The plan and trust may be reviewed during regular business hours at your Employer's main office, or at the office of the Service Cooperative of which your Employer is a member.

Your VEBA Plan is designed to supplement a major medical health care plan. VEBA Plans may also interact with health savings accounts and cafeteria plans containing medical expense reimbursement accounts. For information on your major medical health care plan, consult the summary plan description for that arrangement. For information on other benefit arrangements,

including your cafeteria plan, consult your Employer or union representative. This Summary may not alter the terms of other employee benefit plans, or of any collective bargaining agreement, personnel policy, or insurance contract.

HOW TO USE YOUR VEBA PLAN ACCOUNT

Each year, your Employer will contribute a fixed amount to an account established in your name in the VEBA Plan. Your Employer will also make available a major medical plan with relatively higher deductibles, co-pays and/or co-insurance. These benefits are intended to complement one another. Used appropriately, they will provide you the opportunity to maximize the value of your long-term health coverage.

This Summary will use examples based on hypothetical Employer contributions. *Actual contributions to your VEBA Plan account will vary*. Refer to the collective bargaining agreements or personnel policies of the Employer for information on contributions to your VEBA Plan account.

This Summary will also use examples based on a hypothetical high deductible health plan. *Actual deductibles, co-pays, and co-insurance in your major medical plan will vary.* Refer to the *Comprehensive Major Medical Health Plan Summary Plan Description* for information on deductibles, co-pays, co-insurance, out-of-pocket-maximums, and other important features.

Here is an example of a VEBA Plan account in action:

Mary's employer offers a major medical plan with a $4,000 annual deductible for family coverage, and a $2,000 annual deductible for single coverage. Once the annual deductible is met, the plan provides for reimbursement of covered expenses at 100% if Mary and her family use in-network physicians, and 80% if they use out-of-network physicians.

Mary chooses family coverage. Her employer makes a contribution of $2,000 to her VEBA Plan account (she would have received less had she elected single coverage).

Mary's Eligible Health Expenses in Year 1 are as follows:

	Amount of expense
Inoculations for children	$200
Preventive cancer screening	$250
Doctor visits during flu season	$500
Eyeglasses	$200

- The first $200 for inoculations is paid entirely by the major medical plan, without any reduction to Mary's VEBA Plan account. This is because the major medical plan covers well-child care and similar mandated benefits on a first dollar basis.

- The next $250 for preventive cancer screening is also paid by the major medical plan. Although not mandated by state law, the plan design covers up to $250 in preventive care each year on a first dollar basis.

- The next $500 for doctor visits is paid from Mary's VEBA Plan account. The annual deductible is reduced by $500.

- The final $200 is also paid from Mary's VEBA Plan account. Although eyeglasses are Qualified Health Expenses under the VEBA Plan, they are not covered expenses under the major medical plan. As a result, the cost of eyeglasses will not be applied to reduce the annual deductible under the major medical plan.

At the end of Year 1, Mary has $1,300 remaining in her VEBA Plan account. This amount "rolls over" into her VEBA Plan for Year 2.

In Year 2, Mary receives another contribution of $2,000. This amount is added to the $1,300 saved in the previous year, for a total balance of $3,300. The annual deductible and out-of-pocket maximum under the major medical plan is indexed for inflation, and the deductible increases to $2,100 for single coverage and $4,200 for family in Year 2.

Here are some alternative scenarios for Year 2:

- Scenario 1: Mary breaks her leg. Her medical bills are $10,000. Although the deductible for family coverage is $4,200, the deductible is limited to $2,100 for individual family members. Mary applies $2,100 from her VEBA account towards the medical bill. Upon reaching her annual deductible, Mary has coverage of 100% if she chooses in-network physicians and hospitals, and 80% for out-of-network physicians.

- Scenario 2: Mary and her husband play too much tennis, and both will require knee surgery. Mary only has $3,300 in her VEBA account, and the cost of surgery will be $10,000 each. Because the deductible for individual family members is $2,100, Mary knows that she and her husband will have $900 in unreimbursed medical expenses. Mary sets aside $900 from her pre-tax pay to a medical expense reimbursement account in her cafeteria plan. After obtaining all necessary approvals, she and her husband undergo surgery for the cost of $20,000. Of this amount, $3,300 is paid from the VEBA Plan and $900 from Mary's cafeteria plan. Now that she and her husband have met the $2,100 deductible (for individual family members), the balance is paid from her major medical plan. (She and her husband use in-network physicians). Any expenses incurred by Mary's children in Year 2 will be covered by the plan, because she and her husband have met the combined family deductible of $4,200.

- Mary's employer contributes another $2,000 to her VEBA Plan account in the following year. Because the $900 she used for the surgery was paid with pre-tax dollars through her cafeteria plan, she cannot be reimbursed for that amount from the VEBA Plan. But she has $2,000 in her VEBA Plan account to use for future expenses.

- Scenario 3: Mary starts Year 2 with $3,300. She incurs routine medical expenses of $1,000. At the end of the year, she has $2,300 remaining in her VEBA Plan account.

- Mary's employer contributes another $2,000 in Year 3. Her VEBA Plan balance is now $4,300. Mary is on track to building a health care savings account for retirement.

ELIGIBILITY

Eligibility

If you are a member of the VEBA, you will be eligible to receive a contribution under the health reimbursement arrangement if you enroll in the major medical plan sponsored by your Employer. Additional terms and conditions of eligibility may be found in your collective bargaining agreement or personnel policy.

Once you have established a VEBA Plan account, you will remain eligible to participate for as long as you have a positive balance in your account.

How to enroll

You and your Dependents are automatically enrolled in the VEBA Plan if you meet the eligibility requirements above. Eligible Health Expenses incurred by your Dependents may be reimbursed from your VEBA Plan account regardless of whether you elect single or family coverage under your Employer's major medical plan.

"Dependents" under the VEBA Plan

The term "Dependents" includes your Spouse (unless you have elected the Employee-Plus-Children VEBA Option) and your Dependent children to age 19, and children attending post-secondary education on a full-time basis to age 24. Other Dependents include children who are older than the limiting age but who are handicapped and certain grandchildren. The term Dependent also includes Dependents of your Dependent, and married Dependents filing jointly. If both you and your Spouse are employees of the Employer, and either or both maintain an account under the VEBA Plan, either or both of you may be reimbursed from the other's account for Eligible Health Expenses (unless either or both have elected the Employee-Plus-Children VEBA Option).

Adding new Dependents

The rules for adding new Dependents are described in the *Comprehensive Major Medical Health Plan Summary Plan Description* and in the plan document for the VEBA Plan. In general, newborn children are covered as of the date of birth. Other Dependents, including new Spouses, stepchildren, and children placed for adoption, are generally covered on the date your Employer receives an application for coverage.

Your Employer's major medical plan may exclude coverage for pre-existing conditions for limited periods. The VEBA Plan does not exclude coverage for pre-existing conditions.

When coverage begins

If you are eligible on the Effective Date, your coverage under the VEBA Plan will begin on that date. If you become eligible after the Effective Date, your coverage under the VEBA Plan will begin on the earlier of the date you enroll in your Employer's major medical plan, or the date your Employer makes a contribution to your VEBA Plan account.

YOUR VEBA PLAN AND OTHER BENEFITS

Negotiated discounts

If you are covered under your Employer's major medical plan, discounts that have been negotiated with network providers and for prescription drugs under the plan will apply to covered benefits that are reimbursed by your VEBA Plan.

For example, assume you have elected single coverage under your Employer's major medical plan. Also assume that the plan has a $2,000 annual deductible, and you incur medical expenses for outpatient surgery.

If you use a network physician, the cost of the surgery is $1,000. This amount is automatically deducted from your VEBA Plan account using the crossover administration feature.

If you use an out-of-network physician, the cost of the surgery is $1,500. You must pay this amount out-of-pocket and submit a claim for reimbursement (crossover will not apply).

If your Employer permits individuals to "opt out" of health insurance coverage but still remain eligible for VEBA Plan contributions, medical expenses that are paid through the VEBA Plan account will not be eligible for negotiated discounts. Nor will discounts be available for Dependents if you have elected single coverage under your Employer's major medical plan.

Effect of VEBA Plan expenses on annual deductible

Certain medical expenses that are paid through your VEBA Plan account will be credited against the annual deductible under your Employer's major medical plan. In order to be credited against the annual deductible, these expenses must be covered under your Employer's plan. If you spend $200 on eyeglasses, for example, this expense may be reimbursed from your VEBA Plan account. But it will not be applied to reduce the annual deductible under your Employer's major medical plan, because it is not a covered expense under your Employer's major medical plan.

What is "Crossover"?

Crossover refers to the automatic payment of medical expenses from your cafeteria plan, your VEBA Plan account, and your Employer's major medical plan, in that order. If you elect crossover administration, for example, and you incur an expense at the doctor's office, the expense will be paid in the following steps:

Step 1: Invoice is sent to Blue Cross Blue Shield Minnesota, who serves as the claims administrator for your major medical plan;

Step 2: Any amount not paid by the major medical plan is sent to SelectAccount (MII Life, Incorporated), who serves as claims administrator for the VEBA Plan;

Step 3: If SelectAccount (MII Life, Incorporated) administers your Employer's cafeteria plan, it deducts the expense from amounts you may have set aside in your medical expense reimbursement account;

Step 4: SelectAccount (MII Life, Incorporated) deducts any remaining unpaid expense from your VEBA Plan account; and

Step 5: You are responsible for any unpaid balance.

Crossover permits expenses to be paid automatically from your cafeteria plan and VEBA Plan account.

Using your VEBA Plan with a cafeteria plan

Your VEBA Plan account is NOT part of a cafeteria plan. You are not permitted to contribute to your VEBA Plan account with pre-tax salary deductions. Because it is not part of a cafeteria plan, your VEBA Plan is not subject to the use-it-or-lose-it requirement. This means that any unspent balance in your account will "roll over" into the following year and be added to your Employer's contributions for the following year.

If you participate in a cafeteria plan with a medical expense reimbursement account, that account IS subject to the "use-it-or-lose-it" rule. This means that any unspent balance in that account will be forfeited at year-end. Before making a salary reduction election to your cafeteria plan, make certain you know the order in which medical expenses are paid. Consider the following example:

John sets aside $1,000 to his cafeteria plan medical expense reimbursement account. John's Employer contributes $1,000 to his VEBA Plan account. That year, John incurs $1,500 in Eligible Health Expenses.

Scenario 1: The VEBA Plan pays first, and the cafeteria plan pays second.	Scenario 2: The cafeteria plan pays first, and the VEBA Plan pays second.
The VEBA Plan pays $1,000. The cafeteria plan pays $500. At the end of the year, John forfeits the $500 remaining in his cafeteria plan. following year.	The cafeteria plan pays $1,000. The VEBA Plan pays $500. At the end of the year, the $500 remaining in John's VEBA Plan "rolls over" into the

If SelectAccount (MII Life, Incorporated) does not administer your Employer's cafeteria plan medical expense reimbursement account, the VEBA Plan will pay first (Scenario 1 will apply). If SelectAccount (MII Life, Incorporated) administers your Employer's cafeteria plan, the cafeteria plan will pay first (Scenario 2) unless your Employer elects a different method.

Suspending Your VEBA Plan to Gain Health Savings Account Eligibility

If permitted under collective bargaining agreements or personnel policies of your Employer, you (or your surviving Dependent) may elect, before the beginning of the plan year, to forgo the payment or reimbursement of Eligible Health Expenses incurred during the plan year so that you (or your surviving Dependent) may contribute to a Health Savings Account. The option of forgoing the payment or reimbursement of Eligible Health Expenses is available only to you (or your surviving Dependents) if you (or your surviving Dependents) are covered by a high deductible health plan within the meaning of Code Section 223(c)(2). If you choose to suspend your VEBA Plan, you will be required to elect the Limited-Purpose VEBA Option, and such

suspension shall not apply to reimbursement of claims for dental or vision expenses, preventive care expenses or expenses incurred after satisfaction of the deductible under the Employer's high deductible health plan and preventive care ("Excepted Medical Expenses"). Eligible Health Expenses incurred during the suspended plan year (other than the Excepted Medical Expenses it otherwise allowed to be paid or reimbursed by the VEBA Plan), cannot be paid or reimbursed by the VEBA Plan currently or later (i.e., after the VEBA plan year ends). However, your Employer may continue to make contributions to your account during the suspension period and these amounts will be available for the payment or reimbursement of the Excepted Medical Expenses incurred during the suspension period as well as Eligible Health Expenses incurred in later VEBA plan years in which no suspension is in effect.

CONSUMER PRIVACY

By your participation in this arrangement, you and your Dependents have agreed to allow all health care providers to give the Claims Administrator information on medical care they provide to you or your Dependents. The Claims Administrator will keep all such information strictly confidential. If a health care provider requires specific authorization to release records, you or your Dependents agree to provide this authorization. The failure of you or your Dependents to provide authorization or requested information may result in denial of your claim.

CUSTOMER SERVICE

Questions?	The Claims Administrator's customer service staff is available to answer your questions about your benefits and claims payments. Monday through Friday: 7:00 AM - 7:00 PM CST *Hours are subject to change without prior notice.*
Customer Service Telephone Number	(651) 662-5065 or toll free at 1-800-859-2144
SelectAccount (MII Life, Incorporated) Website	http://www.selectaccount.com
Claims Administrator's Mailing Address	Claim forms, claim review requests, and written inquiries may be mailed to the address below: MII Life, Incorporated d/b/a SelectAccount Attn: VEBA Administration P.O. Box 64193 St. Paul, MN 55164-0193
Claims Administrator's Fax Number	(651) 662-7247
Trustee's Contact Information	MG Trust Company 700 17th Street Suite 300 Denver, Colorado 80202

TERMINATION OF COVERAGE

Termination of employment or similar event

Employer contributions will cease upon your termination of employment, retirement, layoff, reduction in hours, transfer to another employee group, or similar event that makes you ineligible for contributions (see your collective bargaining agreement or personnel policy).

Following such event, you will retain access to your VEBA Plan account for the reimbursement of Eligible Health Expenses until such time as your account is depleted. Annual administrative expenses will be paid from your account.

Former Dependents

The account balance you have accumulated while you have Dependents will continue to be available to former Dependents for reimbursement of Eligible Health Expenses after divorce or loss of Dependent status. Your former Dependent may also elect continuation coverage with regard to the right to receive future Employer contributions.

Loss of coverage by Dependents

If your Dependent no longer qualifies for coverage under your Employer's major medical plan, he or she will no longer be eligible for reimbursement of Eligible Health Expenses through the VEBA Plan. In that circumstance, your Dependent may elect continuation coverage under the major medical plan and the VEBA Plan. Eligible Health Expenses for your Dependent will be reimbursed from your VEBA Plan account during the continuation coverage period.

The rules governing continuation coverage are set forth in the *Comprehensive Major Medical Health Plan Summary Plan Description*.

Benefits following death

On your death, your eligible Dependents will continue to have access to your VEBA Plan account. They may be reimbursed for Eligible Health Expenses you incurred before your death, and for Eligible Health Expenses they incur following your death.

If you die without a Spouse or other eligible Dependent, your VEBA Plan account will revert to the VEBA. For collectively bargained groups, and unless otherwise provided for in a collective bargaining agreement, any amounts that revert to the VEBA Plan upon death will be allocated uniformly to the accounts of members in the VEBA who are current or retired employees of the Employer, and who are current or retired members of the same collective bargaining unit. For nonunion employees, and unless otherwise provided for in a personnel policy, any such amounts will be allocated uniformly to members of the VEBA who are current or retired employees of the Employer.

CONTINUATION COVERAGE

Qualifying Events

Employer contributions may be continued if coverage ends due to any of the qualifying events listed below. In order to be eligible to continue Employer contributions, you or your

Dependent must be covered under the Plan before the qualifying event. In all cases, continuation ends if the VEBA Plan ends or required charges are not paid when due.

Qualifying Event	Who May Continue	Maximum Continuation Period
Employment ends (except gross misconduct dismissal), retirement, leave of absence, layoff or reduction in hours	Employee and Dependents	Earlier of: 1. 18 months, or 2. enrollment date in other group coverage.
	Totally disabled Dependent[1]	Earlier of: 1. 29 months after the employee leaves employment, or 2. date total disability ends, or 3. date of enrollment in Medicare, or 4. date coverage would otherwise end.
Divorce	Former Spouse and any Dependent children who lose coverage	Earlier of: 1. enrollment date in other group coverage, or 2. date coverage would otherwise end.
Death of employee	Surviving Spouse and Dependent children	Earlier of: 1. enrollment date in other group coverage, or 2. date coverage would otherwise end if the employee had lived.
Dependent child loses eligibility	Dependent child	Earliest of: 1. 36 months from the date of losing eligibility, 2. enrollment date in other group coverage, or 3. date coverage would otherwise end.
Total disability of employee[2]	Employee and Dependents	Earlier of: 1. date total disability ends, or 2. date coverage would otherwise end.
Early retirement	Early retiree[3] and Dependents	Earlier of: 1. enrollment date in other coverage, or 2. date coverage would otherwise end.

[1] If the Dependent is disabled at the time the employee leaves employment or becomes disabled within the first 60 days of continuation coverage, continuation for the Dependent may be extended beyond 18 months of continuation. In order to qualify, the disabled Dependent must meet the following notice requirements during the 18 months of continuation:

a) The Dependent must apply for Social Security benefits and be determined to have been totally disabled at the time of the qualifying event or within the first 60 days of continuation coverage.

b) The Dependent must notify the Claims Administrator of the disability determination within 60 days of the determination and during the initial 18 month continuation period.

[2] Total disability means the employee's inability to engage in or perform the duties of the employee's regular occupation or employment within the first two (2) years of disability. After the first two (2) years, it means the employee's inability to engage in any paid employment or work for which the employee may, by education and training, including rehabilitative training, be or reasonably become qualified. For employees disabled prior to January 1, 1992, total disability means the employee's inability to engage in or perform the duties of the employee's regular occupation or employment from the date of disability.

[3] An early retiree is an employee who at termination of employment has met the age and service requirements necessary to receive an annuity from a Minnesota pension plan.

Notification

Qualified beneficiaries[4] must notify the Employer within 60 days of a qualifying event, such as divorce that would result in a loss of coverage for a Dependent. Qualified beneficiaries that wish to continue coverage must notify the Employer in writing. The Employer must notify qualified beneficiaries of the option to continue coverage within 10 days of receiving notice of a qualifying event.

Qualified beneficiaries have 60 days to choose to continue, starting with the date of the notice of continuation or the date coverage ended, whichever is later. Failure to choose continuation within the required time period will render the qualified beneficiary ineligible to choose continuation at a later date. Qualified beneficiaries have 45 days from the date of choosing continuation to pay the first continuation charges, except that surviving Dependents of a deceased employee have 90 days to pay the first continuation charges. After this initial grace period, qualified beneficiaries must pay charges monthly in advance to the Employer to maintain coverage in force.

Charges for Continuation

Charges for continuation coverage will be equal to the annual Employer contribution, plus a two (2) percent administration fee (if the qualifying event for continuation is the employee's total disability, the administration fee is not required). All charges are paid directly to the Employer. The Employer will provide qualified beneficiaries, upon request, written verification of the cost of continuation coverage at the time of eligibility or at any time during the continuation period.

Additional Qualifying Events

If additional qualifying events occur during continuation (i.e., divorce, death of the former covered employee, or Dependent child loses eligibility), a qualified beneficiary may be entitled to election rights of his or her own and an extended continuation period. This applies only when the initial qualifying event for continuation is the employee's termination of employment, reduction in hours, retirement, leave of absence, or layoff.

When a second qualifying event occurs, such as the death of the former covered employee, the Dependent must notify the Employer of the additional event within 60 days after it occurs in order to continue coverage. Continuation charges must be paid in the same manner as for the initial qualifying event. Unless the initial qualifying event provides for longer coverage (in which case the longer coverage applies), a second qualifying event entitles the qualified beneficiaries to 36 months of coverage beginning on the date the original maximum coverage period began.

Coordination with High Deductible Health Plan

If eligible employees are required to enroll in the Employer's high deductible health plan before receiving contributions to the Health Reimbursement Arrangement for Active Employees,

[4] A qualified beneficiary is any individual covered under the VEBA Plan on the day before the qualifying event, as well as a child who is born to or placed for adoption with the covered employee during the period of continuation coverage.

the Employer may, on a uniform and consistent basis, require that such eligible employees elect and maintain in force continuation coverage under the high deductible health plan as a condition precedent to electing and maintaining continuation coverage under the Health Reimbursement Arrangement for Active Employees.

Special Continuation Rules in the Event of Divorce or a Dependent Child Losing Eligibility

A qualified beneficiary can only elect to continue the coverage that existed before the qualifying event. This means that, for example, upon a qualifying event of divorce, your former spouse losing coverage will continue to have access to the Account Balance that existed as of the date of the qualifying event until that Account Balance is depleted by the former spouse and/or covered employee.

Employer contributions that are made to the VEBA Plan following the election of continuation coverage by a former spouse or Dependent will be separated into a subaccount. This means that Employer contributions made for the former Spouse or Dependent will not be available for use by the employee. Similarly, contributions made to the VEBA Plan for the employee after the divorce or child's loss of eligibility will not be available to the former Spouse or Dependent.

Special Rule for Preexisting Conditions

If qualified beneficiaries obtain other group coverage that excludes benefits for preexisting conditions, they may choose to remain on continuation coverage for a preexisting condition until the date continuation would otherwise end or until the preexisting clause of the new plan is met, whichever occurs first. This Plan is primary and determines benefits first for the preexisting condition. The Plan is not primary for any other condition. For a newborn child born during continuation, the other group coverage plan is primary starting on the date of birth.

COORDINATION OF BENEFITS

If you maintain a medical expense reimbursement account through your Employer's cafeteria plan, and also maintain a balance in your VEBA Plan account, it is important to know which account must be used first for the reimbursement of Eligible Health Expenses. The default rule is that your VEBA Plan account must be exhausted before Eligible Health Expenses will be reimbursed from your cafeteria plan account.

The default rule may be reversed if your Employer so elects. In that case, your VEBA Plan account is not available for reimbursement of Eligible Health Expenses until any amount you set aside in your cafeteria plan for the year has been exhausted. You should confirm how the ordering rule operates before entering into your next salary reduction arrangement under your cafeteria plan.

In general, your VEBA Plan account will only reimburse you for medical expenses that are not paid or reimbursable from any other source, including Medicare. Notwithstanding this rule, if you or your Dependents are in the first 30 months of Medicare eligibility or entitlement due to End Stage Renal Disease (ESRD), you or your Dependents will be treated as if your are not yet eligible for Medicare under this rule since Medicare must be your secondary insurance for those

first 30 months (unless you or your Dependents were entitled to Medicare due to age or disability on a primary basis at the time of ESRD-based Medicare eligibility).

AMENDMENT AND TERMINATION

Except as limited by any collective bargaining agreement, and subject to the terms of the Trust, the Employer shall have the right to terminate, suspend, withdraw, amend or modify this Plan, upon mutual agreement with the Service Cooperative, VEBA Committee, in whole or in part at any time. The Minnesota Service Cooperative VEBA Committee has the right to amend the Plan for law changes at any time.

PLAN ADMINISTRATOR

Your Employer is the Plan administrator. The Plan administrator is responsible for selecting VEBA Plan benefits, rights and features among an array of options made available through the VEBA Committee, and for adopting personnel policies and/or entering into collective bargaining agreements that do not discriminate with respect to VEBA eligibility or contributions. Except to the extent that it delegates Plan responsibilities to the Claims Administrator, Employer shall have full discretionary authority to make any and all factual and legal determinations necessary to determine eligibility for benefits or the amount of any benefits. Except to the extent reserved to the VEBA Committee, your Employer shall also have full discretionary authority to construe the terms of the Plan. This discretion includes, but is not limited to, the authority to make any rules, regulations, statements, or computations that your employer deems necessary to administer the Plan.

CLAIMS AND APPEALS

Claims for reimbursement under the VEBA Plan should submitted to the Claims Administrator. Each claim for benefits that is not submitted directly by a medical care provider shall contain a written statement containing the following information:

1) the person or persons on whose behalf Eligible Health Expenses have been incurred;
2) the nature of the expense so incurred;
3) the date the expense is incurred;
4) the name of the service provider
5) the amount of the requested reimbursement; and
6) a statement that such expenses have not otherwise been paid through insurance or reimbursed from any other source, and that reimbursement will not be sought from any other source

All claims must be submitted within 18 months after they were incurred or they will be denied as untimely. If the Claims Administrator determines that your claim should be reimbursed, such payment will be made from the VEBA Plan's trust.

If you disagree with the action the Claims Administrator has taken on your claim, the Claims Administrator will review the resolution of your claim using the process outlined below. You

may request an external review of the final determination the Claims Administrator makes about your request after you have exhausted the Claims Administrator's appeal process. You may contact the Commissioner of Commerce at any time by calling 1-800-657-3602 or 651-296-4026.

Initial Review

If you disagree with the action the Claims Administrator has taken on your claim, call the Claims Administrator for an explanation of the claim's resolution at the number provided in the "Customer Service" section. The Claims Administrator will try to review the resolution of your claim within 10 days.

Appeals

If you are not satisfied with the Claims Administrator's explanation of the claim's resolution, you may request that your claim be reviewed. You may submit your request for review in writing, or you may request a form that will include all the necessary information to file your written request for review. If you need assistance, the Claims Administrator will complete the form and mail it to you for your signature. The Claims Administrator will notify you within 10 days that it has received your written request for review. Within 30 days of receiving your written request and all necessary information, the Claims Administrator will notify you in writing of its determination and the reasons for the determination. If the Claims Administrator is unable to make a determination within 30 days due to circumstances outside its control, the Claims Administrator may take up to 14 additional days to make a determination. If the Claims Administrator takes more than 30 days to make a determination, the Claims Administrator will inform you in advance of the reasons for the extension.

If you disagree with the action the Claims Administrator has taken on your written request for review, you may appeal the determination in writing and request either a hearing or a written reconsideration. If you request a hearing, you and any person you choose may present testimony or other information. The Claims Administrator will provide you written notice of its determination and all key findings within 45 days after the Claims Administrator receives your written request for a hearing. If you request a written reconsideration, you may provide the Claims Administrator with any additional information you believe is necessary. The Claims Administrator will provide you written notice of its determination and all key findings within 30 days after the Claims Administrator receives your request for a written reconsideration. You are entitled to examine all pertinent documents and to submit issues and comments in writing. If you request, the Claims Administrator will provide you a complete summary of the appeal decision.

External Review

If your appeal concerns a covered health care service or claim and you disagree with the Claims Administrator's appeal determination, you or anyone you authorize to act on your behalf, may submit the appeal determination to external review. The state of Minnesota has contracted with an independent organization to conduct the external review of your appeal. This independent organization meets the state's requirements to conduct external review of health-related disputes. Your written request for external review must be submitted to the

Commissioner of Commerce along with a filing fee of $25. The commissioner may waive the fee in cases of financial hardship.

You may request external review by contacting the Department of Commerce at:

Minnesota Department of Commerce
Attention Enforcement Division
85 Seventh Place East, Suite 500
St. Paul, Minnesota 55101

The external review organization will notify you and the Claims Administrator that it has received your request for external review. Within 10 business days of receiving notice from the external review organization, you and the Claims Administrator must provide the external review organization any information to be considered. Both you and the Claims Administrator will be able to present a statement of facts and arguments. You may be assisted or represented by any person of your choice at your expense. The external review organization will send written notice of its decision to you, the Claims Administrator, and the commissioner within 40 days of receiving the request for external review. The external review organization's decision is binding on the Claims Administrator, but not binding on you.

ELIGIBLE HEALTH EXPENSES

You may be reimbursed from your VEBA Plan account for medical care expenses you incur that are related to the diagnosis, treatment, or prevention of disease, sickness or injury. Eligible Health Expenses that will be reimbursed from your VEBA Plan account include the following:

Abortion — The amount paid by you or your Dependents for a legal abortion is eligible for reimbursement.

Acupuncture — The amount paid by you or your Dependents for acupuncture is eligible for reimbursement.

Alcoholism — Payments made by you or your Dependents to a treatment center for alcoholics or drug addicts are eligible for reimbursement. This includes meals and lodging provided by the center during medical treatment.

Ambulance — Amounts paid by you or your Dependents for ambulance service are eligible for reimbursement.

Artificial limb — Amounts paid by you or your Dependents for an artificial limb are eligible for reimbursement.

Birth control pills — Expenses paid by you or your Dependents for birth control pills prescribed by a doctor are eligible for reimbursement.

Braille books and magazines — The cost of Braille books and magazines paid for and used by a blind or visually handicapped participant that is more than the price for regular books and magazines is eligible for reimbursement.

Capital expenses — Amounts paid by you or your Dependents for special equipment installed in your home or for improvements, if the main reason is for medical care, are eligible for reimbursement. Permanent improvements that increase the value of the property

may be partly eligible for reimbursement. The amount paid for the improvement is reduced by the increase in the value of the property. The rest is eligible for reimbursement. If the value of the property is not increased by the improvement, the entire cost is eligible for reimbursement.

Certain capital expenses generally do not increase the value of a personal residence and may generally be eligible for reimbursement in full. Expenses made for the primary purpose of accommodating a personal residence to the handicapped condition of you or your Dependents are eligible for reimbursement.

These expenses include, but are not limited to, the following items.

- Constructing entrance or exit ramps to the residence.
- Widening doorways at entrances or exits to the 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. Generally, this does not include elevators, because they may add to the fair market value of the residence, and any reimbursement would have to be decreased to that extent.
- 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.
- Grading of ground to provide access to the residence.

If expenses similar to those listed above are incurred to adapt a personal residence to the handicapped condition of you or your Dependents, the full expenses are eligible for reimbursement, provided the expenses do not increase the fair market value of your residence. Only reasonable costs incurred to accommodate a personal residence to the handicapped condition are considered to be incurred for the purpose of medical care or are directly related to medical care for these purposes. Additional costs attributable to personal motivations, such as for architectural or aesthetic reasons, are ***not*** eligible for reimbursement.

Car

Special equipment. The cost paid by you or your Dependents of special hand controls and other special equipment installed in a car for the use of a handicapped person is eligible for reimbursement.

Special Design. The amount by which the cost of a car specially designed to hold a wheelchair is more than the cost of a regular car is eligible for reimbursement.

Cost of operation. The cost of operating a specially equipped car is ***not*** eligible for reimbursement, except as discussed under **Transportation**.

Chiropractors

Fees paid by you or your Dependents to a chiropractor for medical care are eligible for reimbursement.

Christian Science

Fees paid to Christian Science practitioners are eligible for

practitioners reimbursement.

Contact lenses See **Eyeglasses**.

Cosmetic surgery The amounts paid by you or your Dependents for cosmetic surgery or similar procedures directed at improving an individual's appearance are ***not*** eligible for reimbursement unless the surgery or procedure is necessary to ameliorate a deformity arising from a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease.

Crutches The amount paid by you or your Dependents to buy or rent crutches is eligible for reimbursement.

Dancing lessons, swimming lessons, etc. The cost of dancing lessons, swimming lessons, etc. for you or your Dependent is ***not*** eligible for reimbursement, even if they are recommended by a doctor for the general improvement of the health of such person.

Dental treatment The amounts paid by you or your Dependents for dental treatment are eligible for reimbursement. This includes fees paid to dentists for X-rays, fillings, braces, extractions dentures, etc.

Diaper service ***Not*** eligible for reimbursement.

Doctor's fees Fees paid by you or your Dependents to doctors are eligible for reimbursement. This includes, but is not limited to, fees to:

anesthesiologists	ophthalmologists
chiropodists	osteopaths
dermatologists	pediatricians
gynecologists	podiatrists
neurologists	psychiatrists
obstetricians	surgeons

Drugs See **Medicines**.

Drug addition See **Alcoholism**.

Electrolysis or hair removal See **Cosmetic Surgery**.

Eyeglasses Amounts paid by you or your Dependents for eyeglasses and contact lenses needed for medical reasons are eligible for reimbursement. Fees paid by you or your Dependents for eye examinations are also eligible for reimbursement.

Fertility Enhancement The cost of the following procedures to overcome the inability to have children:

- Procedures such as *in vitro* fertilization (including temporary storage of eggs or sperm).
- Surgery, including an operation to reverse a prior sterilization procedure.

Founder's fee See **Lifetime care – advance payments**.

Funeral expenses ***Not*** eligible for reimbursement.

Group medical insurance	See **Insurance – premiums, policies, and plans**.
Guide Dog	The cost paid by you or your Dependents for a guide dog for the blind or deaf is eligible for reimbursement. The cost of a dog or other animal trained to assist persons with other physical disabilities is also eligible for reimbursement. Amounts paid by you or your Dependents for the care of the dog are also eligible for reimbursement.
Hair transplant	See **Cosmetic Surgery**.
Handicapped persons	See **Schools, special**.
Health club dues	Amounts paid by you or your Dependents for health club dues, YMCA dues, or steam baths for general health or to relieve physical or mental discomfort not related to a particular medical condition are ***not*** eligible for reimbursement.
Hearing aids	The costs paid by you or your Dependents of a hearing aid and the batteries purchased to operate it are eligible for reimbursement.
Hospital Services	Amounts paid by you or your Dependents for hospital services are eligible for reimbursement. Also see **Lodging**.
Household help	The cost paid by you or your Dependents for household help, even if a doctor recommends it because the individual is physically unable to do housework is ***not*** eligible for reimbursement. However, see **Nursing services**.
Insurance premiums, policies, and plans	The cost paid by you or your Dependents for health insurance premiums, policies or plans are eligible for reimbursement. This includes amounts for retiree coverage, continuation coverage (including continuation coverage under COBRA), Medicare Part B coverage, and eligible long-term care premiums. You are **not** eligible for reimbursement of health insurance premiums you pay on a pre-tax basis for coverage under your Employer's group health plan. Nor may you be reimbursed for premiums paid by your Spouse on a pre-tax basis for coverage under a group health plan of your Spouse's employer.
Laboratory fees	The amounts paid by you or your Dependents for laboratory fees that are part of medical care are eligible for reimbursement.
Laetrile	Amounts paid by you or your Dependents for laetrile prescribed by a doctor and purchased and used in a location where the sale and use are legal are eligible for reimbursement.
Laser Eye Surgery	Amounts paid for radial keratotomy or other eye surgery are eligible for reimbursement if the procedures are done primarily to promote the correct function of the eye.
Lead-based paint removal	The cost paid by you or your Dependents of removing lead-based paints from surfaces in your home to prevent a child who has or had lead poisoning from eating the paint is eligible for reimbursement. These surfaces must be in

poor repair (peeling or cracking) or within the child's reach. The cost of repainting the scraped area is ***not*** eligible for reimbursement.

If, instead of removing the paint, the area is covered with wallboard or paneling, these items would be treated as capital expenses. See **Capital expenses**. The cost of painting the wallboard is ***not*** eligible for reimbursement.

Learning disability

Tuition fees paid by you or your Dependents to a special school for a child who has severe learning disabilities caused by a mental or physical handicap, including nervous system disorders, are eligible for reimbursement. A doctor must recommend that the child attend the school. See **Schools, special**.

Tutoring fees paid by you or your Dependents on a 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 are also eligible for reimbursement.

Legal fees

Legal fees paid by you or your Dependents to authorize treatment for mental illness are eligible for reimbursement. However, if part of the legal fee includes, for example, a guardianship or estate management fee, that part is ***not*** eligible for reimbursement.

Lifetime care - advance payments

Not eligible for reimbursement.

Lodging

The costs paid by you or your Dependents of meals and lodging at a hospital or similar institution if the main reason for being there is to receive medical care are eligible for reimbursement. See **Nursing home**.

The cost paid by you or your Dependents of lodging (not provided in a hospital or similar institution) while away from home is eligible for reimbursement if all of the following requirements are met.

- The lodging is primarily for and essential to medical care;
- 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;
- The lodging is not lavish or extravagant under the circumstances; and
- There is no significant element of personal pleasure, recreation, or vacation in the travel away from home.

The amount eligible for reimbursement 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 (meals are not deductible).

The cost of meals and lodging while away from home for medical treatment that is not received at a medical facility, or for the relief of a specific condition, even if the trip is made on the advice of a doctor is ***not*** eligible for reimbursement.

Maternity clothes

Not eligible for reimbursement.

Meals

See **Lodging**.

Medical

Amounts paid for admission and transportation to a medical conference

conferences are eligible for reimbursement if the medical conference concerns the chronic illness of the participant, the participant's Spouse, or the participant's Dependent. The costs of the medical conference must be primarily for and necessary to the medical care of you or your Dependents. The majority of time at the conference must be spent attending sessions on medical information. The cost of meals and lodging while attending the conference is ***not*** reimbursable as a medical expense.

Medical information plan Amounts paid by you or your Dependents to a plan that keeps medical information so that it can be retrieved from a computer data bank for medical care are eligible for reimbursement.

Medicines Amounts paid by a participant, Spouse or Dependent for medicines and drugs that require a prescription, or for insulin are eligible for reimbursement. A prescribed drug is one that requires a prescription by a doctor for its use by an individual.

Amounts paid by a participant, Spouse or Dependent for non-prescription medicines and drugs used to alleviate or treat personal injuries or sickness are also eligible for reimbursement. Examples of such non-prescription drugs include antacid, allergy medicines, pain relievers, and cold treatment medicines. Examples of items that are ***not*** medicines and drugs and are therefore ***not*** eligible for reimbursement include toiletries (such as toothpaste), cosmetics (such as face creams) and dietary supplements (such as vitamins).

Amounts paid for controlled substances (such as marijuana, laetrile, etc.) in violation of federal law are ***not*** reimbursable. Also see **Laetrile**.

Mentally retarded, special home for The cost of keeping a mentally retarded Dependent 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 is eligible for reimbursement.

Nursing home The cost of medical care paid by you or your Dependents, including meals and lodging, for him or herself in a nursing home or home for the aged, if the main reason for being there is to get medical care, is eligible for reimbursement.

The cost of meals and lodging if the reason for being in the home is personal or family is ***not*** eligible for reimbursement. Only the part of the cost that is for medical or nursing care is eligible for reimbursement.

Nursing services Wages and other amounts paid by you or your Dependents for nursing services are eligible for reimbursement. 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 the bathing and grooming of the patient.

Some or all of the amounts paid by you or your Dependents for an attendant's meals are eligible for reimbursement. To find the cost of the attendant's food, divide the food expense among the household members. If additional amounts had to be paid for household upkeep because of the attendant, the extra amounts are eligible for reimbursement. This includes extra rent paid by you or your Dependents because he or she moved to a larger apartment to provide space for the attendant, or the extra cost of utilities for the attendant. If the attendant also

provides personal and household services, these amounts must be divided between the time spent in performing household and personal services and the time spent for nursing services. Only the amount spent for nursing services is eligible for reimbursement.

Social security tax. Social security tax paid by you or your Dependents for a nurse, attendant, or other person who provides medical care is eligible for reimbursement.

Operations — Amounts paid by you or your Dependents for legal operations are eligible for reimbursement.

Optometrist — See **Eyeglasses**.

Oxygen — Amounts paid for oxygen or oxygen equipment to relieve breathing problems caused by a medical condition are eligible for reimbursement.

Personal use items — The cost of an item ordinarily used for personal, living, and family purposes if it is used primarily to prevent or alleviate a physical or mental defect or illness is eligible for reimbursement. For example, a wig purchased upon the advice of a physician for the mental health of a patient who has lost all of his or her hair from disease can be included with medical expenses.

Prosthesis — See **Artificial limb**.

Psychiatric care — Amounts paid by you or your Dependents for psychiatric care are eligible for reimbursement. This includes the cost of supporting a mentally ill Dependent at a specially equipped medical center where the Dependent receives medical care. See **Psychoanalysis** and **Transportation**.

Psychoanalysis — Payments made by you or your Dependents for psychoanalysis are eligible for reimbursement. Payments for psychoanalysis which is required as a part of training to be a psychoanalyst are ***not*** eligible for reimbursement.

Psychologist — Amounts paid by you or your Dependents to a psychologist for medical care are eligible for reimbursement.

Schools, special — Payments made by you or your Dependents to a special school for a mentally or physically handicapped person if the main reason for using the school is that it has resources for relieving the handicap are eligible for reimbursement. Expenses eligible for reimbursement include, for example, the cost of a school that:

- Teaches Braille to a blind child,
- Teaches lip reading to a deaf 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 handicap.

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 are ***not*** eligible for reimbursement.

Smoking program Uncompensated amounts paid by taxpayers for participation in a smoking-cessation program and for prescribed drugs designed to alleviate nicotine withdrawal are expenses for medical care that are eligible for reimbursement. However, amounts paid for drugs (other than insulin) not requiring a prescription, such as nicotine gum and certain nicotine patches, are ***not*** eligible for reimbursement.

Sterilization The cost paid by you or your Dependents of a legal sterilization (a legally performed operation to make a person unable to have children) is eligible for reimbursement.

Surgery See **Operations**.

Telephone The cost and repair paid by you or your Dependents of special telephone equipment that lets a deaf person communicate over a regular telephone are eligible for reimbursement.

Television The cost paid by you or your Dependents of equipment that displays the audio part of television programs as subtitles for the deaf is eligible for reimbursement. This may be the cost of an adapter that attaches to a regular set. It also may be the excess cost of a specially equipped television over the cost of the same model regular television set.

Therapy Amounts paid by you or your Dependents for therapy received as medical treatment are eligible for reimbursement.

"Patterning" exercises. Payments made by you or your Dependents to an individual for giving "patterning" exercises to a mentally retarded child are eligible for reimbursement. These exercises consist mainly of coordinated physical manipulation of the child's arms and legs to imitate crawling and other normal movements.

Transplants Payments made by you or your Dependents for surgical, hospital, laboratory, and transportation expenses for a donor or a possible donor of a kidney or other organ are eligible for reimbursement.

Transportation Amounts paid by you or your Dependents for transportation primarily for and essential to medical care are eligible for reimbursement. Expenses eligible for reimbursement include:

- Bus, taxi, train, or plane fare, or ambulance service,
- Actual car expenses, such as gas and oil,
- Expenses for general repair, maintenance, depreciation, and insurance are ***not*** eligible for reimbursement,
- In lieu of actual gas and oil charges, you may claim 20¢ per mile for transportation expenses in 2007; 19¢ per mile beginning in 2008 and thereafter according to IRS announcements,
- Parking fees and tolls,
- Parent's transportation expenses if a parent 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, or
- Transportation expenses for regular visits to see a mentally ill Dependent, if these visits are recommended as a part of treatment.

The following expenses are ***not*** eligible for reimbursement:

- The transportation expenses to and from work of you or your Dependents, even if the condition requires an unusual means of transportation, or
- The transportation expenses of you or your Dependents if, for nonmedical reasons only, he or she chooses to travel to another city, such as a resort area, for an operation or other medical care prescribed by a doctor.

Trips — The cost paid by you or your Dependents of a trip or vacation taken for a change in environment, improvement of morale, or general improvement of health, even if the trip is made on the advice of a doctor, is ***not*** eligible for reimbursement.

Tuition fees — Charges paid by you or your Dependents for medical care that are included in the tuition fee of a college or private school if the charges are separately stated in the bill, or given to him or her by the school, are eligible for reimbursement. See **Learning disability** and **Schools, special**.

Vacation — See **Trips**.

Vasectomy — Amounts paid by you or your Dependents for a vasectomy are eligible for reimbursement. See also **Sterilization**.

Weight loss program — The cost paid by you or your Dependents for a weight loss program undertaken at a physician's direction to treat an existing disease (such as heart disease) is eligible for reimbursement. However, a weight loss program to maintain general health is ***not*** eligible for reimbursement (even if a doctor advises the program).

Wheelchair — Amounts paid by you or your Dependents for an autoette or a manual or motorized wheelchair used mainly for the relief of sickness or disability, and not just to provide transportation to and from work, are eligible for reimbursement. The cost of operating and keeping up the autoette or wheelchair is also eligible for reimbursement.

X-ray fees — Amounts paid by you or your Dependents for X-rays that received for medical reasons are eligible for reimbursement.