

# LABOR-MANAGEMENT HEALTHCARE FUND

## HEALTH REIMBURSEMENT ARRANGEMENT FOR WELLNESS

### SUMMARY PLAN DESCRIPTION

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## OVERVIEW

### PURPOSE OF PLAN

This Plan, commonly known as an HRA or Health Reimbursement Arrangement, is designed to encourage your participation in the wellness programs of the Labor-Management Healthcare Fund (the "LMHF") by providing a limited benefit amount for reimbursement of eligible health care expenses incurred by eligible employees, their spouses and dependents. Neither the value of the coverage, nor the amounts paid from eligible employees' HRA accounts is subject to income taxation. Reimbursements are paid for by Labor-Management Healthcare Fund. Your HRA account is not insured by the Pension Benefit Guaranty Corporation (PBGC), an agency of the federal government; the PBGC generally requires or provides insurance for certain pension plans only.

### PLAN CHANGES

The Plan is administered and maintained in accordance with the official plan document, which is on file with the Plan Administrator. The Plan Sponsor has the exclusive right, at any time or times, to amend the Plan, retroactively or otherwise, to any extent and in any manner that it may deem advisable. Neither this document nor any other document (e.g., employee handbook, enrollment documentation, etc.) or verbal communication can serve as an amendment to the official plan document.

### QUESTIONS REGARDING BENEFITS

Questions concerning your HRA benefits should be directed to the Plan Administrator; no one else is authorized to answer your questions, and you should not rely on any information that is furnished by anyone else.

### PLAN TERMINATION

While the Trustees of the Labor-Management Healthcare Fund intend to continue the Plan indefinitely, it reserves the right in its sole discretion to terminate the Plan at any time and for any reason. The Trustees of the Labor-Management Healthcare Fund make no promise to continue Plan benefits in the future and rights to future benefits do not vest. In particular, neither termination of employment nor retirement can result in the right to continued benefits under the Plan except as expressly provided.

## PLAN IDENTIFICATION AND ADMINISTRATION

### PLAN NAME

Labor-Management Healthcare Fund Health Reimbursement Arrangement for Wellness Plan

### PLAN YEAR

The Plan Year is the 12-consecutive month period ending on the last day of December of each year.

### PLAN SPONSOR AND PLAN ADMINISTRATOR

LMHF Board of Trustees  
Labor-Management Healthcare Fund  
90 Anderson Road  
Cheektowaga, NY 14225  
Telephone Number: (716) 601-7980

Employer Identification Number: 20-0422657

The Plan Administrator, is responsible for administering the Plan according to its terms. In carrying out its functions, the Plan Administrator has the authority and discretion to construe the terms of the Plan, and to determine all questions arising in connection with the administration, interpretation and application of the Plan.

### CLAIMS ADMINISTRATOR

Nova Healthcare Administrators, Inc.  
P.O. Box 2066  
Williamsville, NY 14231  
Telephone Number: (716) 505-8566

The Claims Administrator is responsible for the payment of medical claims.

### AGENT FOR SERVICE OF LEGAL PROCESS

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

LMHF Board of Trustees  
Labor-Management Healthcare Fund  
90 Anderson Road  
Cheektowaga, NY 14225  
Telephone Number: (716) 601-7980

## PARTICIPATION

### ELIGIBLE/INELIGIBLE CLASSIFICATIONS

All employees on a participating employer's W-2 payroll who are participants in a LMHF medical health plan are eligible (spouses included).

The Plan Administrator has the exclusive discretion to determine whether any employee is eligible for coverage. An employee will be considered an eligible employee only if the Plan Administrator determines that he or she meets the eligibility requirements set forth above.

### NEW EMPLOYEES

If you are an eligible new hire, your coverage will become effective as of the effective date of health insurance participation. You must be an active LMHF member at the time of your annual physical to be eligible.

### SPOUSE BENEFIT

Spouses are also eligible for an HRA account benefit.

For the purposes of this Plan, a spouse is a person to whom you are legally married under applicable state law. Therefore, eligibility under this Plan is not available for non-dependent domestic partners.

### WHEN COVERAGE TERMINATES

Your Plan coverage will terminate thirty (30) days after your health insurance coverage under a LMHF medical plan is terminated due to either termination, resignation or retirement or immediately if you have obtained benefits fraudulently. Your coverage is also terminated if the balance in your HRA is \$5.00 or less and you have not added to or made a claim for benefits for 15 months.

Upon termination, your HRA account will be forfeited (except as provided below). To obtain reimbursement for claims incurred before coverage ends, you (or your estate) must file a claim within 30 days following the date coverage terminates

Upon termination or retirement, the employee has 30 days to incur and submit claims for reimbursement.

### COBRA CONTINUATION

To the extent required by COBRA, you and your spouse and dependents, may continue coverage if coverage terminates because of a COBRA qualifying event. A qualified individual will be given the opportunity to continue (on a self-pay basis) the same coverage the qualified individual had the day before the qualifying event for the periods prescribed by COBRA (subject to all conditions and limitations under COBRA). The Plan Administrator will notify each person who is eligible for COBRA continuation coverage.

## HRA BENEFITS

### YOUR HRA ACCOUNT

The Plan Administrator will maintain an HRA account on your behalf. Amounts credited to your account for a Plan Year (including the dates as of which these amounts will be credited) are determined by the LMHF and communicated to all participants as part of the Plan's enrollment communications. The benefits currently available are set forth in Appendix A to this SPD. Eligible expenses incurred during the Plan Year for which a timely reimbursement request is submitted will be reimbursed up to the balance of your HRA account as of the date the expense is submitted for reimbursement.

### HOW BENEFITS ARE PAID

The HRA account maintained on your behalf is an unfunded account used by the Plan Administrator to keep track of the amounts available for reimbursement of eligible expenses. Your account is credited with LMHF's contributions and debited whenever a claim is paid (or reimbursed). Please note that your HRA account is not "funded" (i.e., the Plan Administrator will not establish a separate bank or investment account to hold your contributions).

All of a Participant's unused HRA Account will be carried over to the next Plan Year, and credited to the Participant's HRA Account as of the first day of the next Plan Year.

### ELIGIBLE EXPENSES

#### General Purpose HRA

Eligible expenses are expenses incurred by you, or your spouse or dependents for medical care including, for example, amounts for certain hospital bills, doctor and dental bills and prescription drugs. A list of some of the health care expenses that may (and may not) be reimbursed from your HRA is available from the Plan Administrator and/or Plan Sponsor and is also included in the packet containing your initial HRA debit card.

Expenses that are not eligible for reimbursement are set forth on Appendix B, attached.

### REIMBURSEMENT REQUIREMENTS

In order to be reimbursable, an eligible health care expense must meet all of the following requirements:

- The expense must be an expense for health care that would be eligible for a deduction for federal income tax purposes if it were not reimbursed through this Plan.
- The eligible expense must be incurred by yourself, your Spouse or one of your Dependents (see definition of *Spouse and Dependent*, below). Expenses incurred by anyone else are not subject to reimbursement.
- The expense is not paid or reimbursed from any source other than through this Plan.
- The expense must be incurred during the Plan Year while your coverage is in effect.
- You must apply for reimbursement no later than February 15 following the last day of the plan year.

Note the following:

- A claim is incurred when the services provided are rendered and not when you are billed or pay for the services.
- If you prepay for health care services that will not be rendered until the following year, you cannot claim expenses for those services until that following year. If an eligible health care service will be rendered over a period of time beyond the end of the current year, the cost of the services will be pro-rated by month and reimbursement paid only for that portion of the expense attributable to the service rendered in the current year, regardless of when you pay the provider. This limitation applies most often in the case of orthodontia services, but it may apply in other circumstances where treatment programs extend beyond one year.

WHO IS YOUR "SPOUSE"

- Your Spouse is the person to whom you are legally married under applicable state law. Expenses incurred by your domestic partner *are not* eligible for reimbursement unless your domestic partner qualifies as *qualifying relative* (see definition of *Dependent*).

WHO IS A "DEPENDENT"

- A person is a "Dependent" if he or she is a *qualifying child*, or *qualifying relative*.
- A child is a *qualifying child* if he or she meets all of the following requirements:
  - The individual is your child, grandchild, brother, sister, step-brother, or step-sister (or a descendant of your brother, sister, step-brother, or step-sister).
  - The individual is a U.S. citizen, national, or resident of the U.S., Mexico or Canada.
  - The individual lives with you in your principal residence and has lived with you for more than one-half of the year.
  - As of December 31st of the year in which the eligible expense is incurred, the individual is under 26 years of age or if the child is permanently and totally disabled regardless of age.
- A person is a *qualifying relative* if he or she meets all of the following requirements:
  - The person is your child or grandchild, your brother, sister, step-brother or step-sister, your father or mother, or grandparent or great-grandparent, your step-father or step-mother, a son or daughter of your brother or sister, a brother or sister of your father or mother, a son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law or any other individual (except for your spouse) who lives with you and is a member of your household.
  - The individual is a U.S. citizen, national, or resident of the U.S., Mexico or Canada.
  - You provide over one-half of the individual's support for the calendar year.

- The person is not your qualifying child or the qualifying child of any other person for that year.

There are special rules for divorced parents. Please contact the Plan Administrator if you have questions concerning these rules.

For the purposes of these rules, the term child includes your step-son (or step-daughter), an eligible foster child and an adopted child (including a child placed with you for legal adoption).

## REIMBURSEMENT PROCEDURE

### PAPER CLAIMS

You may apply for reimbursement by submitting an application in writing to the Claims Administrator in such form as the Claims Administrator may prescribe setting forth:

- the person or persons on whose behalf eligible expenses have been incurred;
- the nature and date of the expense incurred;
- the amount of the requested reimbursement; and
- A statement that the expense incurred has not otherwise been reimbursed and is not reimbursable through any other source.

The application must be accompanied by bills, invoices, or other statements from an independent third party showing that expenses has been incurred and showing the amount of the expense, together with any additional documentation that the Claims Administrator may request.

Within 30 days after receipt by the Claims Administrator of a reimbursement claim, your employer will reimburse you for the expense (if the Plan Administrator approves the claim), or the Claims Administrator will notify you that your claim has been denied. This time period may be extended for an additional 15 days for matters beyond the control of the Claims Administrator, including in cases where a reimbursement claim is incomplete. The Claims Administrator will provide written notice of any extension, including the reasons for the extension, and will allow you 45 days in which to complete an incomplete reimbursement claim.

### ELECTRONIC PAYMENT

If available, eligible expenses may be reimbursed through debit or credit cards and other electronic media, under procedures implemented by the Claims Administrator.

### CLAIMS DENIED

For reimbursement claims that are denied, see the appeals procedure set forth in the section titled "Disputed Claims Procedure".



## LEAVES OF ABSENCE

### FMLA LEAVES OF ABSENCE

If you take a leave of absence while your HRA coverage is in effect, your coverage will continue on the same terms and conditions as if you were still an active employee to the extent required by FMLA. For example, if this HRA is linked to your participation in your employer's medical insurance plan, your right to continue participation in this Plan will be subject to your continued participation in the medical insurance plan during your FMLA leave.

### UNIFORMED SERVICE UNDER USERRA

Continued participation in the Plan is permitted under certain conditions when you are serving in the United States military after having been a participant in this Plan. Additional information is available from the Plan Administrator.

### NON-FMLA LEAVES OF ABSENCE

If you go on an unpaid leave of absence your right to continued HRA coverage is governed by your employer's leave policies. Your employer will provide you with additional information concerning your rights during a leave of absence that does not qualify under FMLA or USERRA.

### TERMINATION OF COVERAGE

If you do not return from a leave of absence, your coverage will be terminated. You may, however, be eligible to continue coverage through COBRA.

## DISPUTED CLAIMS PROCEDURES

Any person who believes he or she is being denied any rights or benefits under the Plan, is required to file a claim in writing with the Nova Healthcare Administrators Inc.

### NOTICE OF DENIED CLAIM

If your claim is denied in whole or in part, you will be notified in writing by the Claims Administrator within 30 days of the date the Claims Administrator received your claim. This time period may be extended for an additional 15 days for matters beyond the control of the Claims Administrator, including in cases where a claim is incomplete. The Claims Administrator will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Claims Administrator is expected to be made. Where a claim is incomplete, the extension notice will also specifically describe the required information, will allow you 45 days from receipt of the notice in which to provide the specified information, and will suspend the time for a decision on your claim until the specified information is provided.

Notification of a denied claim will set out:

- the specific reason or reasons for the denial;
- the specific plan provision on which the denial is based;
- a description of any additional material or information necessary for you to validate the claim and an explanation of why such material or information is necessary;
- appropriate information on the steps to be taken if you wish to appeal the Administrator's decision, including your right to submit written comments and have them considered, your right to review (upon request and at no charge) relevant documents and other information, and your right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of your claim.

### APPEAL OF DENIED CLAIM

If your claim is denied in whole or part, you (or your authorized representative) may request review upon written application to the Claims Administrator. Your appeal must be made in writing within 180 days of your receipt of the notice that the claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts and/or documents that you feel support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your appeal.

Your appeal will be reviewed and decided by the Claims Administrator or other entity designated in the plan in a reasonable time not later than 60 days after the Claims Administrator receives your request for review. The Claims Administrator may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of a medical expert consulted in connection with your appeal will be provided.

If the decision on review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

- The specific reason(s) for the decision on review;
- The specific plan provision(s) on which the decision is based.
- A statement of your right to review (upon request and at no charge) relevant documents and other information;
- If an internal “rule, guideline, protocol or other similar criterion” is relied on in making the decision on review, a description of the specific rule, guideline, protocol or other similar criterion or a statement that such a rule, guideline, protocol or other similar criterion was relied on and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to you upon request.

Upon receipt of a final adverse benefit determination, you will have four months following receipt to request an external review of the claim. This external review will be conducted by an independent review organization in accordance with federal guidance.

## HIPAA PRIVACY RIGHTS

### USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Except for certain permitted uses and disclosures, the Privacy Rules issued by the federal government prohibits the HRA Plan from using or disclosing certain health information about you that is created or received by the HRA Plan without your written authorization. For additional information about your privacy rights, please either refer to the HRA Plan’s Privacy Notice or contact the HRA Plan’s Privacy Official.

If you wish to authorize the HRA Plan to use or disclose your PHI in a manner that is not otherwise permitted, you must submit a signed and completed authorization form to the HRA Plan. You may request a copy of the authorization form from Human Resources.

### PERMITTED USES AND DISCLOSURES

The HRA Plan is permitted under the Privacy Rule to use or disclose your PHI without your authorization only for purposes related to:

- Health care treatment;
- Payment for health care;
- Health care operations; and
- Other specifically permitted exceptions, such as disclosures to assist disaster relief, disclosures to lessen serious health or safety threats, or disclosures to business associates.

### DISCLOSURES TO THE PLAN SPONSOR

After the Plan Sponsor has certified to the HRA Plan that it is in compliance with the Privacy Rule, the HRA Plan may disclose PHI to the Plan Sponsor without your authorization to the extent that the PHI is necessary for the Plan Sponsor to perform HRA Plan administration functions. The HRA Plan may not disclose any more PHI to the Plan Sponsor than is necessary for the Plan Sponsor to fulfill its administration functions, and the

HRA Plan may not disclose PHI to the Plan Sponsor for purposes of any employment-related actions or in connection with any other employee benefit provided by the Plan Sponsor.

To the extent that your PHI is disclosed to the Plan Sponsor, the Plan Sponsor will:

- Not use or further disclose PHI, except as permitted or required by the Plan document, or as required by law;
- Ensure that any agent, including any subcontractor, to whom the Plan Sponsor provides PHI or certain electronic media received from the Plan, agree to the restrictions, conditions, and security measures of that apply to the Plan Sponsor with respect to PHI;
- Not use or disclosure PHI for employment-related actions or decisions unless authorized by you;
- Not use or disclose PHI in connection with any other benefit or employee benefit plan provided by the Plan Sponsor unless authorized by you;
- Report to the HRA Plan's Privacy Officer any misuse or improper disclosure of PHI;
- Make PHI available in accordance with the requirements of the Privacy Rule;
- Make PHI available to you for amendment and incorporate any amendments to PHI in accordance with the requirements of the Privacy Rule;
- Make available to you the information required to provide an accounting of disclosures in accordance with the requirements of the Privacy Rule;
- Make internal practices, books and records relating to the Plan Sponsor's use and disclosure of PHI available to the Secretary of Health and Human Services for the purposes of determining the HRA Plan's compliance with HIPAA; and
- If feasible, return or destroy all PHI received from the HRA Plan that the Plan Sponsor still maintains in any form, and retain no copies of the PHI, when the PHI is no longer needed for the purpose for which the disclosure was made

The Plan Sponsor may only disclose your PHI or certain electronic PHI to the following Plan Sponsor employees and may only do so to the extent that the Plan Sponsor's employees perform HRA Plan Administration functions:

- The Privacy Official
- Employees in the Plan Sponsor's Human Resources Department
- Employees in the Plan Sponsor's Office of General Counsel; and
- Any other class of employees designated in writing by the Privacy Official.

If an employee of the Plan Sponsor does not comply with the requirements of the Privacy Rule, then the Plan Sponsor may apply appropriate sanctions to the employee in order to ensure compliance with the Privacy Rule. If you become aware of any inappropriate use or improper disclosure of PHI, contact the Privacy Official immediately at (716) 601-7980.

**Appendix A**  
**Inclusions – Medical Expenses That Are Reimbursable**

**Wellness Incentive Plan**

<p><b>BABY/CHILD TO AGE 13</b></p> <ul style="list-style-type: none"> <li>▪ Lactation Consultant*</li> <li>▪ Lead-Based Paint Removal</li> <li>▪ Special Formula*</li> <li>▪ Tuition: Special School/Teacher for Disability or Learning Disability*</li> <li>▪ Well Baby Care</li> </ul> <p><b>DENTAL</b></p> <ul style="list-style-type: none"> <li>▪ Dental X-Rays</li> <li>▪ Dentures and Bridges</li> <li>▪ Exams and Teeth Cleaning</li> <li>▪ Extractions and Fillings</li> <li>▪ Gum Treatment</li> <li>▪ Oral Surgery</li> <li>▪ Orthodontia and Braces</li> </ul> <p><b>EYES</b></p> <ul style="list-style-type: none"> <li>▪ Artificial Eyes</li> <li>▪ Eyeglasses and Contact Lenses</li> <li>▪ Laser Eye Surgeries</li> <li>▪ Prescription Sunglasses</li> <li>▪ Radial Keratotomy/LASIK</li> </ul> <p><b>HEARING</b></p> <ul style="list-style-type: none"> <li>▪ Hearing Devices and Batteries</li> <li>▪ Hearing Examinations</li> </ul> <p><b>LAB EXAMS/TESTS</b></p> <ul style="list-style-type: none"> <li>▪ Blood Tests and Metabolism Tests</li> <li>▪ Body Scans</li> <li>▪ Cardiographs</li> <li>▪ Laboratory Fees</li> <li>▪ Urine and Stool Analyses</li> <li>▪ X-Rays</li> </ul>	<p><b>MEDICAL EQUIPMENT/SUPPLIES</b></p> <ul style="list-style-type: none"> <li>▪ Abdominal and Back Supports*</li> <li>▪ Air Purification Equipment*</li> <li>▪ Arches and Orthopedic Shoes</li> <li>▪ Contraceptive Devices</li> <li>▪ Crutches and Wheel Chairs</li> <li>▪ Hospital Beds</li> <li>▪ Medic Alert Bracelet or Necklace</li> <li>▪ Oxygen*</li> <li>▪ Post-Mastectomy Clothing</li> <li>▪ Prosthesis</li> <li>▪ Splints/Casts or Support Hose*</li> <li>▪ Syringes</li> <li>▪ Wigs*</li> </ul> <p><b>MEDICAL PROCEDURES/SERVICES</b></p> <ul style="list-style-type: none"> <li>▪ Acupuncture</li> <li>▪ Alcohol and Drug Addiction (inpatient and outpatient treatment)</li> <li>▪ Ambulance</li> <li>▪ Hospital Services</li> <li>▪ Infertility Treatment</li> <li>▪ In Vitro Fertilization</li> <li>▪ Norplant Insertion or Removal</li> <li>▪ Physical Examination (not employment-related)</li> <li>▪ Reconstructive Surgery (due to a congenital defect or accident)</li> <li>▪ Service Animals*</li> <li>▪ Sterilization/Sterilization Reversal</li> <li>▪ Transplants (including organ donor)</li> <li>▪ Transportation*</li> <li>▪ Vaccinations and Immunizations</li> </ul>	<p><b>MEDICATION</b></p> <ul style="list-style-type: none"> <li>▪ Birth Control</li> <li>▪ Homeopathic Medications*</li> <li>▪ Insulin</li> <li>▪ Prescription Drugs</li> <li>▪ Weight Loss Drugs*</li> </ul> <p><b>OBSTETRICS</b></p> <ul style="list-style-type: none"> <li>▪ Lamaze Class</li> <li>▪ Midwife Expenses</li> <li>▪ OB/GYN Exams</li> <li>▪ OB/GYN Prepaid Maternity Fees (reimbursable after date of birth)</li> <li>▪ Pre- and Postnatal Treatments</li> </ul> <p><b>PRACTITIONERS</b></p> <ul style="list-style-type: none"> <li>▪ Allergist</li> <li>▪ Chiropractor</li> <li>▪ Christian Science Practitioner</li> <li>▪ Dermatologist</li> <li>▪ Homeopath or Naturopath*</li> <li>▪ Osteopath</li> <li>▪ Physician</li> <li>▪ Psychiatrist or Psychologist</li> </ul> <p><b>THERAPY</b></p> <ul style="list-style-type: none"> <li>▪ Alcohol and Drug Addiction</li> <li>▪ Counseling (not marital or career)</li> <li>▪ Exercise*</li> <li>▪ Hypnosis</li> <li>▪ Massage*</li> <li>▪ Occupational</li> <li>▪ Physical</li> <li>▪ Speech</li> <li>▪ Weight Loss Programs*</li> </ul>
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**Note: This list is not meant to be all-inclusive. Also, expenses marked with an asterisk (\*) are “potentially eligible expenses” that require a letter of medical necessity from your healthcare provider to qualify for reimbursement.**

## **Appendix B**

### **Exclusions – Medical Expenses That Are Not Reimbursable**

The LMHF Health Reimbursement Arrangement Plan document contains the general rules governing what expenses are reimbursable. This Appendix B, as referenced in the Plan document, specifies certain expenses that *are not reimbursable*, even if they meet the definition of “medical care” under Code 213 and may otherwise be reimbursable under IRS guidance pertaining to HRAs.

#### **Exclusions:**

*The following expenses are not reimbursable*, even if they meet the definition of “medical care” under Code 213 and may otherwise be reimbursable under IRS guidance to HRAs.

- Pregnancy testing kits.
- Long-term care services.
- Cosmetic surgery or other similar procedures, unless the surgery or procedures is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury relating from an accident or trauma, or a disfiguring disease. “Cosmetic Surgery” means any procedure that is directed at improving the patient’s appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- The salary expense of a nurse to care for a healthy newborn at home.
- Funeral and burial expense.
- Household and domestic (even though recommended by a physician due to an Employee’s or Dependent’s inability to perform physical housework).
- Massage therapy except under certain circumstances when medically necessary.
- Home or automobile improvements.
- Custodial care.
- Cost for sending a problem child to a special school for benefits that the child may receive from the course or study and disciplinary methods.
- Health club or fitness program dues, even if the program is necessary to alleviate a specific medical condition such as obesity.
- Social activities, such as a dance lessons (even though recommended by a physician for general health improvement).
- Bottled water.
- Maternity clothes.
- Diaper serviced or diapers.
- Cosmetic, toiletries, toothpaste, etc.
- Vitamins and food supplements, even if prescribed by a physician.
- Uniforms or special clothing, such as maternity clothing.
- Automobile insurance premiums.
- Transportation expenses of any sort, including transportation expenses to receive medical care.
- Psychotherapy (including psychoanalysis).
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
- An item that does not constitute “medical care” as defined under Code 213.