NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

Access.
Quality.
Affordability.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) SUMMARY PLAN DESCRIPTION (SPD)

PLAN YEAR 2024

Effective July 1, 2023 – June 30, 2024

Administered By
HSA Bank
P O Box 2744
Fargo, ND 58108-2744
www.hsabank.com
833-228-9364

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Amendment Log

Any amendments, changes or updates to this document will be listed here. The amendment log will include what sections are amended and where the changes can be found.

Welcome PEBP Participant

Welcome to the State of Nevada Public Employees' Benefits Program (PEBP). PEBP provides a variety of benefits such as medical, HRA, HSA, dental, life insurance, flexible spending accounts, and other voluntary insurance benefits for eligible State and local government employees, retirees, and their eligible dependents.

As a PEBP participant, you may access whichever benefit plan (the Consumer Driven Health Plan, Low Deductible PPO Plan (LD PPO), the Exclusive Provider Organization (EPO) Plan, or Health Maintenance Organization (HMO) Plan) is offered in your geographical area that best meets your needs, subject to specific eligibility and Plan requirements. You are also encouraged to research Plan provider access and quality of care in your service area.

All PEBP participants choosing a Plan should examine this document, the PEBP Self-Funded PPO Dental Plan Master Plan Document (MPD), the PEBP Active Employee Health and Welfare Wrap Plan Document, PEBP Retiree Health and Welfare Wrap Plan Document, the Section 125 Document, and the PEBP Enrollment and Eligibility MPD. These documents are available at www.pebp.state.nv.us.

MPD's are a comprehensive description of the benefits available to you. Relevant statutes and regulations are noted throughout this document for reference. In addition, helpful material is available from PEBP or any PEBP vendor listed in the Participant Contact Guide.

PEBP encourages you to stay informed of the most up to date information regarding your health care benefits. It is your responsibility to know and follow the requirements as described in PEBP's Master Plan Documents.

Sincerely,

Public Employees' Benefits Program

Accessing Other Information

You will also want to access the following documents for information related to dental, life, enrollment and eligibility, COBRA, third-party liability and subrogation, HIPAA and Privacy and Security and mandatory notices. These documents are available on your member E-PEBP portal account which can be accessed at www.pebp.state.nv.us and clicking on the orange log in icon, or by contacting PEBP at 775-684-7000 or 800-326-5496.

- State of Nevada PEBP Active Employee Health and Welfare Wrap Plan Document
- State of Nevada PEBP Retiree Health and Welfare Wrap Plan Document
- Consumer Driven Health Plan (CDHP) Master Plan Document; CDHP Summary of Benefits and Coverage for Individual and Family
- Low Deductible PPO (LD PPO) Master Plan Document; Low Deductible PPO Plan Summary of Benefits and Coverage for Individual and Family
- PEBP PPO Dental Plan and Summary of Benefits for Life Insurance Master Plan Document
- EPO Plan Master Plan Document; EPO Plan Summary of Benefits and Coverage for Individual and Family
- Health Plan of Nevada Evidence of Coverage (EOC) and Summary of Benefits and Coverage
- PEBP Enrollment and Eligibility Master Plan Document
- Flexible Spending Accounts (FSA) Summary Plan Description
- Health Reimbursement Arrangement Summary Plan Description (SPD)
- Section 125 Health and Welfare Benefits Plan Document
- Medicare Retiree Health Reimbursement Arrangement Summary Plan Description

This Plan is administered in accordance with regulations of Section 125, 105 and 106 of the Internal Revenue Code. For information regarding Section 105, 106, and 125, please see the Active Employee Health and Welfare Wrap Plan Document available at www.pebp.state.nv.us.

Introduction

Health Reimbursement Arrangement

This Summary Plan Description (SPD) provides, in general terms, the main features of the State of Nevada Public Employees' Benefits Program Health Reimbursement Arrangement ("HRA"), how it can work for you, and how it can benefit you. Definitions of all capitalized terms in this SPD are contained in the Definitions section of this document.

The purpose of the Health Reimbursement Arrangement (HRA) is to reimburse for Eligible Employees', up to certain limits, for their own, and their Eligible Spouse' and Dependents' qualifying Health Care Expenses. Reimbursements for Health Care Expenses paid by the HRA generally are excluded from taxable income.

You should read this Summary Pan Description carefully so that you understand the provisions of the HRA and the benefits you will receive. PEBP wants you to be fully informed of the benefits available to you under the HRA while you are a Participant. You should direct any questions you have to PEBP (Plan Administrator) or the HRA Administrator. A copy of the HRA Summary Plan Description is available at www.pebp.state.nv.us or by request by calling the PEBP office at 775-684-7000 or 800-326-5496.

Administrative Information

The Public Employees' Benefits Program (PEBP) is the Plan Administrator for the HRA. The HRA is intended to qualify as an Employer-funded Health Care reimbursement plan under IRS Code §105 and 106 and the regulations issued thereunder, and as a Health Reimbursement Arrangement as defined under IRS Notice 2002-45. The Plan Administrator's failure to enforce any provision of the HRA shall not affect its rights to later enforce that provision or any other provision of the HRA.

PEBP has retained HSA Bank as the HRA the third-party administrator and provide certain administrative services associated with the HRA. HSA Bank is not a fiduciary of the HRA. HSA Bank has no discretionary authority to interpret HRA provisions or issues arising under the HRA, such as issues with eligibility, coverage, and benefits.

Nothing herein will be construed to require PEBP or HSA Bank to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the PEBP from which any payment under this HRA may be made. The HRA is paid for by the State of Nevada Public Employees' Benefits Program and funded with contributions from participating Employers and Eligible Participants, held in an internal service fund. There is no trust or other fund from which benefits are paid. HSA Bank does not finance or insure the HRA. While PEBP has complete responsibility for the payment of benefits out of its internal service fund, it may hire an unrelated third-party HRA Administrator to make Benefit payments on its behalf.

If there is a conflict between this Summary Plan Description and the Master Plan Document, the Master Plan Document will take precedence.

The provisions of the HRA, as initially adopted or subsequently amended and restated are effective July 1, 2023 – June 30, 2024.

Per NRS 287.0458 no officer or employee has an inherent right to benefits provided under the PEBP.

General Information About the HRA

What is the amount PEBP will contribute to the HRA?

For Plan Year 2024, (July 1, 2023 – June 30, 2024), PEBP will contribute $300 for each Eligible Employee covered on a PEBP medical plan on July 1, 2023. The contribution amount for Employees hired after July 1, 2023, who enroll in a PEBP medical plan, the contribution amount is prorated based on the coverage effective date and the remaining months in the Plan Year.

What is the HRA?

The HRA is PEBP funded reimbursement account. The HRA works as follows:

- PEBP establishes a notional account called a Health Reimbursement Arrangement for each Eligible Employee enrolled in a PEBP-sponsored medical plan (CDHP, LD, EPO, and HMO) with coverage effective on or after July 1, 2023.
- Each Plan Year, PEBP has the discretion to set the HRA funding amount. HRA funding is not guaranteed from one Plan Year to the next Plan Year.
- HRAs are employer-funded accounts.
- Employees do not contribute to the HRA.
- Unlike Health FSA amounts, Employees do not forfeit unused HRA dollars while covered under the same PEBP-sponsored medical plan.

What is the purpose of the HRA?

The HRA is intended to reimburse Eligible Employees, up to certain limits, for their own and their Spouses' and Dependents' qualified Health Care Expenses in accordance with Section 213(d) of the IRS code.

Are there any limitations on benefits available from the HRA?

A Health Care Expense is an expense that is related to the diagnosis, care, mitigation, treatment, or prevention of disease. Some examples of Health Care Expenses include, but are not limited no, (a) insulin; (b) prescribed drugs and medications (whether or not the drug or medicine could be purchased without a prescription), (c) medical devices such as crutches, bandages, and diagnostic devices such as blood-sugar test kits; (d) dental expenses € dermatology; (f) physical therapy; and (g) contact lenses or gasses used to correct a vision impairment.

Some examples of expenses that are not eligible for reimbursement include the following:

- Over-the-counter drugs or medicines that are purchased without a prescription.

- Health insurance premiums for any other plan. (Notwithstanding the foregoing, the HRA Account may reimburse COBRA premiums that a Participant pays on an after-tax basis under the Employer's major medical or other health insurance plan.)
- Cosmetic surgery not covered under a Plan.
- The salary expenses of a nurse to care for a healthy newborn at home.
- Funeral and burial expenses.
- Household and domestic help (even if recommended by a qualified physician due to an Employee's, Spouse's, or Dependent's inability to perform physical housework).
- Home or automobile improvements.
- Custodial care.
- Costs for sending a problem child to a special school for benefits that the child may receive from the course of study and disciplinary methods.
- Social activities, such as dance lessons (even if recommended by a physician for general health improvement).
- Bottled water.
- Maternity clothes.
- Diaper service or diapers.
- Cosmetics, toiletries, toothpaste, etc.
- Uniforms or special clothing, such as maternity clothing.
- Automobile insurance premiums.
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
- Any item that does not constitute “medical care” as defined under IRS Code §213(d).

Is the HRA offered separately as a stand-alone option?

The HRA is not offered as a stand-alone option. Instead, it is integrated with a PEBP-sponsored medical plan, this means, Employees must be enrolled in a PEBP medical plan to qualify for the HRA.

Are the HRA dollars transferrable to another PEBP medical plan?

No, generally, the HRA dollars are not transferrable from one PEBP medical plan to another PEBP medical plan.

Who is eligible for the HRA?

Eligible Employees enrolled in a PEBP-sponsored medical plan with coverage effective on or after **July 1, 2023**.

Eligible Employees are permitted to enroll in a PEBP-sponsored medical plan during their new hire initial enrollment period, the annual open enrollment period, or during the Plan Year to the extent permitted by the PEBP-sponsored medical plan (e.g., due to a Qualifying Event or a Special Enrollment Period). For information regarding Qualifying Events and Special Enrollment Opportunities, refer to the Enrollment and Eligibility Master Plan Document available at www.pebp.state.nv.us.

Are my spouse and dependents eligible for reimbursement of Eligible Medical Expenses under the HRA?

Reimbursements under an HRA can be made to the following individuals:

1. Employees,
2. Spouses and dependents of those employees,
3. Any person you could have claimed as a dependent on your return except that:
    a. The person filed a joint return.
    b. The person had a gross income of $4,400 or more; or
    c. You, or your spouse if filing jointly, could be claimed as dependent on someone else's 2022 return.
    d. Your child under age 27 at the end of the tax year.
    e. Spouses and dependents of deceased employees.

Note: A child of parents that are divorced, separated, or living apart for the last 6 months of the calendar year is treated as the dependent of both parents whether the custodial parent releases the claim to the child's exemption. See IRS Publication 969

What benefits are offered through the HRA?

The HRA will maintain an "HRA Account" for Eligible Employees to keep a record of the amounts available for reimbursement of Eligible Health Care expenses. The HRA Account is merely a recordkeeping account; it is not funded (all reimbursements are paid by HSA Bank from PEBP's internal fund), and it does not bear interest or accrue earnings.

Are there limitations on prescriptions under the HRA?

Reimbursement for prescriptions is limited to IRS Code 213(d) eligible expenses.

How will the HRA work?

The HRA will reimburse you for eligible Health Care Expenses to the extent that you have a positive balance in your HRA Account. If you have a claim under your PEBP medical plan or other

health insurance plan, you should follow the claims procedure applicable to that plan, as described in the Master Plan Document or Summary Plan Description.

For claims associated with the HRA, you should file your claim for reimbursement as soon as possible after you have incurred the expense. All claims must be substantiated or verified as an eligible expense. Submitting claims can be done online, mobile app, or by mail. HSA Bank issues a debit card with the HRA which provides easy access to HRA dollars, especially at pharmacies and doctors' offices.

Claims must be submitted within 365 days of the incurred expense date in accordance with NAC 287.610. For information regarding how to file a claim, visit the HSA Bank website at www.hsabank.com/

Does HSA Bank offer direct deposit?

Yes, HSA Bank only offers direct deposit. There is no option for a mailed check.

What happens if I received an overpayment?

If you receive reimbursement and it is later determined that you received an overpayment or payment was made in error (e.g., you were reimbursed for an expense that is later paid by an insurance plan), you will be required to refund the improper payment to HSA Bank. If you do not refund the improper payment, the Plan Administrator reserves the right to offset future reimbursement equal to the improper payment. If all other attempts to recoup the improper payment are unsuccessful, PEBP may treat the overpayment as a bad debt, which may have income tax consequences for you.

What if I have a Flexible Spending Account (FSA) in addition to my HRA?

If an expense is eligible for reimbursement under both the HRA and a FSA, reimbursement should be requested first from the FSA before the HRA.

What is a carryover of Account Balance of unused funds?

The HRA allows for a carryover of the account balance. Unused funds in the HRA are not forfeit at the end of each year but remain available to reimburse Eligible Heath Care Expenses incurred in later years. Note: Employees must remain covered under the same medical plan to qualify for carryover of unused funds.

May I elect to permanently opt out of your HRA Account?

You may elect to permanently opt out of and waive any right to future reimbursement from your HRA Account. The opt out option will be offered at initial new hire enrollment, open enrollment, and at termination. Opting out of the HRA also includes declining coverage under a PEBP medical plan.

What if I terminate my employment or lose eligibility during the Plan Year?

If you cease to be an Eligible Employee (for example, if you die, retire, or terminate employment), your participation in the HRA will terminate unless you qualify for and elect COBRA continuation coverage as described below.

- Upon termination of employment, you failure to elect continuation of coverage under COBRA for your medical plan will result in the waiver of future reimbursements. The remaining balance of the HRA will be forfeited.

What if I go out on Family Medical Leave Act ("FMLA") or the Uniformed Services Employment and Reemployment Rights Act ("USERRA")?

If you decline coverage while on a FMLA or USERRA, you may have rights to reinstate the HRA upon returning from leave if you enroll in the same medical plan that you were enrolled in prior to taking leave.

What if I go out on unpaid Leave Without Pay or Workers' Compensation?

Your coverage under a Plan with a HRA during a paid or unpaid leave of absence will be treated in the same manner that your coverage under the medical plan is treated during a leave of absence. Upon returning from leave, you must be enrolled in the same medical plan prior to taking leave. For details regarding leave of absences, refer to the Enrollment and Eligibility Master Plan Document available at www.pebp.state.nv.us.

What is COBRA continuation coverage? What happens if terminate my employment during the Plan Year? If I or my Spouse or Dependent has a COBRA Qualifying Event, can I continue coverage under the same medical plan?

Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that gives certain Employees, Spouses, and Dependent children of Employees the right to temporary continue health care coverage under the medical plan. If you, your Spouse, or your Dependent children incur an event known as a "Qualifying Event," and if such individual is covered under the PEBP's medical plan when the Qualifying Event occurs, the individual incurring the Qualifying Event will be entitled under COBRA to elect to continue his or her coverage under the medical plan if he or she pays the applicable premium for such coverage. "Qualifying Events" are certain types of events that would cause, except for the application of COBRA's rules, an individual to lose his or her health insurance coverage. A Qualifying Event includes the following events:

- Your termination from employment or reduction of hours.
- Your divorce or legal separation from your Spouse.
- Your becoming eligible to receive Medicare benefits.

- Your Dependent child ceasing to qualify as a Dependent.

If the Qualifying Event is termination from employment, then the COBRA continuation coverage runs for a period of 18 months following the date that regular coverage ended. COBRA continuation of coverage may be extended to 36 months if another Qualifying Event occurs. during the initial 18-month period. You are responsible for informing your Employer of the second Qualifying Event within 60 days after the second Qualifying Event occurs. COBRA continuation coverage may also be extended to 29 months in the case of an individual who becomes disabled within 60 days after the date the entitlement to COBRA continuation coverage initially arose and who continues to be disabled at the end of the 18 months. (In the event that family coverage is continued under COBRA, the Employee, Spouse, and Dependents may all extend coverage to 29 months regardless of which individual has become disabled.) In all other cases to which COBRA applies, COBRA continuation coverage shall be for a period of 36 months.

For more information, refer to the Enrollment and Eligibility Master Plan Document at www.pebp.state.nv.us

Are my HRA benefits taxable?

The HRA is intended to meet certain requirements of existing federal tax laws, under which the benefits that you receive under the HRA generally are not taxable to you. However, PEBP and HSA Bank cannot guarantee the tax treatment to any given Participant, since individual circumstances may produce differing results. If there is any doubt, you should consult your own tax advisor.

Claim Denials and Appeal Process

What happens if my claim for HRA Benefits is denied?

If your claim for Benefits is denied, then you have the right to be notified of the denial and to appeal the denial, both within certain time limits. The rules regarding denied claims for Benefits under the HRA are discussed below.

When must I receive a decision on my claim?

You are entitled to notification of the decision on your claim within 30 days after HSA Bank receives the claim. This 30-day period may be extended if necessary due to conditions beyond HSA Bank's control, such as situations where a claim is incomplete. HSA Bank is required to notify you of the need for the extension and the time by which you will receive a determination on your claim. If the extension is necessary because of your failure to submit the information necessary to decide the claim, then HSA Bank will notify you regarding what additional information you are required to submit. If you do not submit the additional information, HSA Bank will make the decision based on the information that it has.

What information will a notice of denial of claim contain?

If your claim is denied, the notice that you receive from HSA Bank will include the following information:

- The specific reason and references for the denial.
- Any denial code (and its corresponding meaning) that was used in denying the claim.
- A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary.
- A description of the HRA's internal appeal process and external review procedures and the time limits applicable to such procedures, including a statement of your rights following a denial on review; and
- If HSA Bank relied on an internal rule, guideline, protocol, or similar criteria in making its determination, either a copy of the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you, free of charge, upon request.

Do I have a right to appeal a denied claim?

Yes, you have the right to file an appeal with HSA Bank. Additional information regarding your review rights is available by request from PEBP or HSA Bank.

What are the requirements of my Level 1 appeal?

Your internal appeal must be in writing, must be provided to HSA Bank and must include the following information:

- Your name and address.
- The fact that you are disputing a denial of a claim or HSA Bank's act or omission.
- The date of the notice that HSA Bank informed you of the denied claim; and
- The reason(s), in clear and concise terms, for disputing the denial of the claim or HSA Bank's act or omission. You should also include any documentation that you have not already provided to HSA Bank.

Is there a deadline for filing my Level 1 appeal?

Yes. Your internal appeal must be delivered to HSA Bank within 180 days after reviewing the denial notice or HSA Bank's act or omission. If you do not file your internal appeal within this 180-day period, you lose your right to appeal. Your internal appeal will be heard and decided by HSA Bank. (NAC 287.670)

How will my Level 1 appeal be reviewed?

Prior to the internal appeal deadline, you may submit copies of all relevant documents, records, written comments, testimony, and other information to HSA Bank. The HRA is required to provide you with reasonable access to and copies of all documents, records, and other information related to the claim. When reviewing your internal appeal, HSA Bank will consider all relevant documents, records, comments, and other information that you have provided regarding the claim, regardless of whether such information was submitted or considered in the initial determination. If HSA Bank receives new or additional evidence that it considered, relied upon, or generated in connection with the claim, other than evidence that you have provided to it, you will be provided with this information and given a reasonable opportunity to respond to the evidence before the due date for HSA Bank's notice of final internal adverse benefit determination. Similarly, if HSA Bank identifies a new or additional reason for denying your claim, that new or additional reason will be disclosed to you, and you will be given a reasonable opportunity to respond to that new rationale before the due date for HSA Bank's notice of final internal adverse benefit determination.

The appeal determination will not afford deference to the initial determination and will be conducted by a fiduciary of the HRA who is not: (1) the individual who made the original determination; (2) an individual who is a subordinate of the individual who made the initial determination; or (3) an individual whose terms and conditions of employment are affected by

the results of his or her decision. If the internal appeal determination will be based on the medical judgment of a health care professional retained by HSA Bank, the health care.

When will I be notified of the decision of my Level 1 appeal?

You will be notified of the decision of your appeal generally within 60 days following receipt of your request for review.

What information is included in the notice of denial of my Level 1 appeal?

If your Level 1 appeal is denied, the notice that you receive from HSA Bank that will include supplemental information for the denial. This may include, but is not limited to:

- Information about your claim, including the date of service, health care provider, claim amount, and any diagnosis and treatment code and their corresponding meanings, to the extent such information is available;
- The specific reason for the denial upon review;
- A reference to the specific HRA provision(s) on which the denial is based;
- Any denial code (and its corresponding meaning) that was used in denying the claim;
- A statement providing that you are required to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits;
- If an internal rule, guideline, protocol, or similar criterion was relied upon in making the review determination, either the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the review determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request; and
- A statement of your right to request a Level 2 appeal.

Do I have the right to seek review of a denied claim to an external review?

You have the right to an external review of the denial of your claim, and any subsequent internal appeals process determination to uphold that denial, unless the Benefit denial was based on your (or your Spouse's or Dependent's) failure to meet the HRA's eligibility requirements.

What are the requirements of an external review?

After exhausting the initial appeal process, you may file a request for external review. which is done by calling HSA Bank's Client Assistance Center at 1-833-228-9364 or writing appeal on the internal appeal denial letter and submitting it to HSA Bank. The appeal will then be sent to a third party for review and decision making

When will I be notified of the decision on my external appeal?

The external reviewer must notify you and PEBP of its decision on your external appeal within 45 days after it receives the complete information. The external reviewer's decision is binding upon the parties unless other State or Federal law remedies are available. Such remedies may or may not exist. Therefore, unless another legal right exists under your claim, use of the external review process may terminate your right to bring a lawsuit on your claim.

Definitions

In this document, the following terms, when capitalized, shall have the following meanings unless a different meaning is clearly required by the context.

Plan Administrator. Public Employees' Benefits Program.

Benefits. The reimbursement benefits for Health Care Expenses described in the HRA.

COBRA. The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

CODE. The Internal Revenue Code of 1986, as amended.

Dependent. A Dependent is a Participant's child as defined in Code §152(f)(1) who has not attained age 27, or a Dependent as defined in Code §105(b); provided, however, that any child to whom Code §152(e) applies shall be treated as a dependent of both parents. Note that the Code §105(b) definition is similar to the Code §152 definition that is used to determine your tax dependents, except that an individual's status as a Dependent is determined without regard to the gross income limitation for a "qualifying relative" and certain other provisions of Code §152. The HRA will provide Benefits in accordance with the applicable requirements of any qualified medical child support order, even if the child does not meet the definition of Dependent.

Electronic Protected Health Information or EPHI. Has the meaning described in 45 CFR §160.103 and generally includes Protected Health Information that is transmitted by electronic media or maintained in electronic media. Unless otherwise specifically noted, Electronic Protected Health Information shall not include enrollment/disenrollment information and summary health information (as such terms are defined in HIPAA).

Eligible Employee. An Employee who has met the eligibility requirements to enroll in a PEBP-sponsored medical plan.

Employee. An Employee of the Employer who receives Compensation from the Employer.

ERISA. The Employee Retirement Income Security Act of 1974, as amended.

Health FSA. A Health Flexible Spending Account as defined in Prop. Treas. Reg. §1.125- 5(a)(1).

HIPAA. The Health Insurance Portability and Accountability Act of 1996, as amended.

HRA Account. The recordkeeping account established in your name by the Plan Administrator based on which eligible Health Care Expenses will be paid or reimbursed.

HRA. The Public Employees' Benefits Program Health Reimbursement Arrangement (HRA) Plan, as amended or restated from time to time.

Health Care Expenses. A Health Care Expense is an expense that is related to the diagnosis, care, mitigation, treatment, or prevention of disease. Some examples of Health Care Expenses are (a) insulin; (b) prescribed drugs and medicines (whether the drug or medicine could be purchased without a prescription); (c) medical devices such as crutches, bandages, and diagnostic devices such as blood-sugar test kits; (d) dental expenses; (e) dermatology; (f) physical therapy; and (g) contact lenses or glasses used to correct a vision impairment.

Participant. An Eligible Employee who becomes a Participant in the HRA.

Protected Health Information or PHI. This generally includes all information, whether written or oral, in connection with the HRA that (1) is created or received by the HRA; (2) relates to your past, present, or future physical or mental health, the provision of health care to you, or the past, present, or future payment for the provision of health care; and (3) identifies you or could be used to identify you.

Privacy Rule. The regulations that were issued by the Department of Health and Human Services in accordance with the requirements of HIPAA. Information regarding the HIPAA Privacy and Security of Protected Health Information is available in the Active Employee Health and Welfare Wrap Plan Document at www.pebp.state.nv.us.

Spouse. An individual of same-sex or opposite sex who is legally married to a Participant as determined under applicable federal and/or state law (and who is treated as a Spouse under the Code).

Third Party Administrator. An organization that processes insurance claims or certain aspects of employee benefit plans for a separate entity. For purposes of this document, the Third-Party Administrator is HSA Bank.

Miscellaneous

Effect of the HRA on Your Employment Rights
The HRA is not to be construed as giving you any rights against the HRA except those expressly described in this document. The HRA is not a contract of employment between you and the Employer.

Prohibition Against Assignment of Benefits
No Benefit payable at any time under the HRA shall be subject in any manner to alienation, sale, transfer, assignment, pledge, attachment, or encumbrance of any kind.

Overpayments or Errors
If it is later determined that you and/or your Spouse or Dependent(s) received an overpayment or a payment was made in error, you will be required to refund the overpayment or erroneous reimbursement to the HRA. If you do not refund the overpayment or erroneous payment, the HRA and the Employer reserve the right to offset future reimbursement equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from your pay. If all other attempts to recoup the improper payment are unsuccessful, PEBP may treat the overpayment as a bad debt, which may have income tax consequences for you.

Family and Medical Leave Act and USERRA (if applicable)
If you go on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA) or Uniformed Services Employment and Reemployment Rights Act (USERRA), then to the extent required by the FMLA or USERRA, as applicable, the Employer will continue to maintain HRA Benefits on the same terms and conditions as if the Participant were still an active Eligible Employee. If you go on a leave of absence that is not subject to the FMLA or USERRA, you will be treated as having terminated participation.

Other Notices Which May be Required by Law

Mandatory notices can be found on PEBP's website.

Newborns' and Mothers' Health Protection Act of 1996 (NMPHA)
Group health plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or to less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998 (WHCRA)
The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy. This law applies generally both to persons covered under group health plans and persons with individual health insurance coverage. But WHCRA does NOT require health plans or issuers to pay for mastectomies. If a group health plan or health insurance issuer chooses to cover mastectomies, then the plan or issuer is generally subject to WHCRA requirements.

Michelle's Law
"Michelle's Law", enacted October 9, 2008, requires group and individual health plans to continue to cover otherwise eligible dependent children taking a medical leave of absence from a postsecondary educational institution (e.g., a college, university, or vocational school) due to a serious illness or injury. Dependent children on a leave of absence must be covered until the earlier of one year from the first day of the leave of absence or the date on which the coverage otherwise would terminate.

The Genetic Information Nondiscrimination Act of 2008 (GINA)
GINA prohibits discrimination by health insurers and Employers based on individuals' genetic information. Genetic information includes the results of genetic tests to determine whether someone is at increased risk of acquiring a condition in the future, as well as an individual's family medical history. GINA imposes the following restrictions prohibits the use of genetic information in making employment decisions restricts the acquisition of genetic information by Employers and others; imposes strict confidentiality requirements; and prohibits retaliation against individuals who oppose actions made unlawful by GINA or who participate in proceedings to vindicate rights under the law or aid others in doing so.

Health Information Technology for Economic and Clinical Health Act (HITECH Act)

HITECH was passed as part of the American Recovery and Reinvestment Act of 2009 to strengthen the privacy and security protection of health information, and to improve the workability and effectiveness of HIPAA Rules.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008
This law amends ERISA, the Public Health Service Act (PHSA), and the Internal Revenue Code (IRC) and applies to all ERISA group health plans and to health insurers that provide insurance coverage to group health plans. In general, this new law requires group health plans that provide mental health or substance use disorder benefits to provide such benefits on par with medical-surgical benefits.

Effective Date of the HRA
The Effective Date of the modifications herein is **July 1, 2023**.

Plan Administrator
The Plan is administered by PEBP and has been established and shall be maintained for the exclusive benefit of the employees of the employer. PEBP is the Plan Administrator and functions as the Plan Administrator, unless another individual or entity is appointed by the Plan Administrator. The Plan Administrator shall have full charge of the operation and management of the plan. The Plan Administrator has retained the services of HSA Bank to administer the HRA benefits described in this Summary Plan Description.

HRA Administrator
PEBP has contracted with HSA Bank to process claims for the HRA program. Contact HSA Bank if you have questions regarding claims or eligible expenses.

Address:	**HSA Bank HRA Claim Submission** **PO Box 2744** **Fargo, ND 58108-2744**
Web:	**www.hsabank.com**
Phone:	**833-228-9364**

Plan Fiduciary
PEBP is the Plan Fiduciary under the plan. The Plan Fiduciary shall have maximum legal discretionary authority to construe and interpret the terms and conditions of the plan, to review all denied claims for benefits under the Plan with respect to which it has been designated named Fiduciary, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a participant's rights, and to decide questions of Plan interpretation and those of fact relating to the plan. The decisions of the Plan Fiduciary will be final and binding on all interested parties. Every Fiduciary and other person who handles funds or other property of this Plan shall be bonded as required by law.

Plan Changes

PEBP reserves the right to amend the HRA at its sole discretion. Any amendments to the Plan will be incorporated in writing into the master copy of the Plan on file with PEBP, or a written copy will be kept with the master copy of the plan.

Prohibition Against Rescission

Under Section 2712 of the PHSA, the Plan Administrator is prohibited from rescinding or retroactively terminating the coverage of a cover person under a Benefit Option that is a group health plan that is not excepted or exempt under Section 2712 of the PHSA, unless such covered person commits and at, practice, omission that constitutes fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a Dependent; provided, however, that the foregoing prohibition shall not prohibit retroactive termination in the event: (i) a Participant fails to timely pay premiums towards the cost of coverage; (ii) the Plan erroneously covers an ex-spouse of a Participant because the Participant failed to timely report a divorce to the Plan Administrator; (iii) the Plan erroneously covers a Participant due to a reasonable administrative delay in terminating coverage; or (iv) any other circumstance under which retroactive termination would not violate PPACA.

No Guarantee of Tax Consequences

Neither the Employer nor the Plan Administrator makes any commitment or guarantee that any amounts paid or allocated to or for the benefit of a Participant under the Plan, HRA or any component benefit will be excludable from Participant's gross income for federal, state, and/or local income tax purposes, or that any federal, state, and/or local tax treatment will apply or be available to a Participant. It shall be the obligation of each Participant to determine whether any coverage, benefit, or other payment under the Plan is excludable from the Participant's gross income for federal, state, and/or local income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment treated by the Employer if the Participant has reason to believe that any such payment by the Employer as nontaxable is, in fact, not so excludable.

Nondiscrimination

The Plan Administrator shall not operate the Plan in a manner that causes discrimination in favor of those Participants or Employees who are (or were) officers or highly compensated Employees or key Employees of the Employer. In addition, whenever, in the administration of the Plan any discretionary action by the Plan Administrator is required, the Plan Administrator shall exercise authority in a nondiscriminatory manner so that all persons similarly situated shall receive substantially the same treatment.