PEBP FLEXIBLE SPENDING ACCOUNT (FSA)
HEALTH CARE FSA (HCFSA)
DEPENDENT CARE FSA (DCFSA)
LIMITED PURPOSE FSA (LPFSA)
PLAN YEAR 2026

(EFFECTIVE JULY 1, 2025– JUNE 30, 2026)

775-684-7000

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Flexible Spending Accounts (FSA)

A Flexible Spending Account (FSA) is a tax-advantaged account that allows participants of the Public Participants' Benefits Program (PEBP) to set aside money from their paycheck (pre-tax salary reductions) to pay for eligible health care expenses and dependent care expenses, potentially saving on federal income taxes. FSAs are a voluntary benefit.

There are three types of flexible spending accounts offered by PEBP: A Health Care FSA, Limited-Purpose FSA, and Dependent Care FSA. PEBP's FSA benefits are subject to IRS Publication 969.

Health Care FSA

Health Care Flexible Spending Account (HCFSA), sometimes referred to as a medical FSA or general-purpose FSA, is a voluntary option for active participants covered under the PEBP Consumer Driven Health Plan (CDHP) with a Health Reimbursement Arrangement (HRA), Low-Deductible PPO Plan (LD PPO), EPO Plan, or HMO plan. In accordance with IRS provisions, the Healthcare FSA is not available to active participants covered under the Consumer Driven Health Plan (CDHP) with a Health Savings Account (HSA).

Flexible spending accounts permit reimbursement for eligible expenses incurred by participants, or their eligible dependents incurred during the plan year for medical, dental, vision, and some over-the-counter expenses if the expense is not reimbursed by insurance. Eligible health care expenses are defined in Section 213(d) of the Internal Revenue Code. For additional information regarding what medical expenses are includible, refer to IRS Publication 502 available at https://www.irs.gov/forms-pubs/about-publication-502. For information related to Health Savings Accounts and other tax-favored plans, refer to IRS Publication 969 at https://www.irs.gov/forms-pubs/about-publication-969

Limited Purpose FSA

The Limited Purpose Flexible Spending Account (LPFSA) is an option for active participants covered under the PEBP Consumer Driven Health Plan (CDHP) with a Health Savings Account (HSA). A LPFSA is much like a Health Care FSA; the main difference is the LPFSA is set up to reimburse only eligible dental and vision expenses, such as:

- Vision exams, LASIK surgery, contact lenses, and eyeglasses
- Dental cleanings, X-rays, fillings, crowns, and orthodontia

IRS provisions do not permit contributions to an HSA and a HCFSA since both the HSA and the HCFSA apply funds toward medical expenses. However, IRS provisions do permit enrollment in both an HSA and a LPFSA as LPFSA reimbursement is restricted to only vision and dental expenses.

Dependent Care FSA

The Dependent Care FSA is an option to pay for childcare or adult dependent care to allow a participant and their spouse (if married) to attend school full time, work, or to look for work.

The Dependent Care FSA covers expenses for a person being cared for as a dependent on their income tax return who is:

- Younger than 13; or
- Physically or mentally disabled individual aged 13 and above. Must be certified as disabled by a physician.

"Before Tax" or "Pre-Tax"

FSA deductions from paychecks are exempt from federal tax. These deductions reduce taxable income reported on income tax returns.

FSA Eligibility and Enrollment

Eligibility Criteria

A participant must be an employee in one of the State of Nevada payroll centers -- excluding the Nevada System of Higher Education participants who have separate plans. The employee must work at least 80 hours each month and must be enrolled in health benefits with active coverage through PEBP.

Since these plans are authorized by the Internal Revenue Code, medical expenses of any family member who is a dependent for tax purposes (special rules apply to children of divorced parents) qualify for the tax savings under the FSA (HCFSA, Limited Purpose FSA and/or DCFSA), even if they are not covered under one of the health/dental plans offered by PEBP.

Enrollment

There are two ways for participants to enroll. 1) They may enroll within 60 days of their hire date or, 2) during open enrollment. The 2026 FSA open enrollment (OE) will be held in May 2025 with a start date of July 1, 2025.

New-hire enrollments may be effective on the first day of the month concurrent with their health coverage effective date if the FSA enrollment request is received by the Third-Party Administrator ("TPA") prior to the health insurance effective date. If the FSA enrollment request is received after the health insurance effective date, the FSA effective date will be determined by the TPA.

- A new benefits-eligible employee must submit an enrollment election with the TPA within 60 days of the initial health coverage effective date to participate in the FSA plan.
- Elections are irrevocable. However, participants may change or revoke their election mid-year due to a qualifying life status event (QLSE). The HCFSA and Limited Purpose FSA have slightly different rules regarding enrollment elections and mid-year changes. Mid-year enrollment and changes must be requested within 60 days of the QLSE.
- Participants enrolling for the first time should only include reimbursable expenses for services received from FSA on effective dates through the end of the Plan Year (June 30th).

See the charts on the following pages which outline mid-year qualifying life status events and their applicability.

Qualifying Life Events	Mid-Year change is Applicable	
	Dependent Care FSA	**Health Care & Limited Purpose FSA's**
Change in Status Special notes concerning "changes in status": • In the event of **divorce**, **annulment**, **legal separation**, **death of spouse/dependent** or **dependent ceases to be eligible**, the employee may only be permitted to change or revoke the election for the affected individual. • In the event **eligibility is gained** under family member coverage through another employer health care plan as a result of a change in marital status or employment status, the employee may be permitted to change or revoke his or her HCFSA election, and/or DCFSA election only if the coverage under the other health care plan takes effect or is increased.	Applicable Applicable	Applicable Applicable
Cost Changes with Automatic Increase/Decrease in Elective Contributions This change applies whether due to action by the employer (e.g., reduced employer contribution) or employee (e.g., switching to part-time employment status).	Applicable	Not Applicable
Significant Cost Changes The change applies when the cost charged to participants for a benefits package option significantly increases or decreases. This change applies whether due to action by the employer or employee.	Applicable	Not Applicable
Significant Curtailment of Coverage This change applies when coverage for the employee, spouse or dependent is significantly curtailed with or without loss of coverage (e.g., an increase in deductible or HMO option is eliminated).	Applicable	Not Applicable
Addition or Significant Improvement of Benefit Package Option	Applicable	Not Applicable
Change in Coverage under another Employer Cafeteria Plan or Qualified Benefits Plan This change applies when the other cafeteria plan or qualified benefits plan permits participants to make an election change that would be permitted; or the cafeteria plan permits participants to make an election for a period of coverage that is different from the	Applicable	Not Applicable

Qualifying Life Events	Mid-Year change is Applicable	
	Dependent Care FSA	**Health Care & Limited Purpose FSA's**
period of coverage under the other cafeteria plan or qualified benefits plan.		
Loss of Coverage under Group Health Plan of Governmental or Educational Institution	Applicable	Not Applicable
Changes in 401(k) Contributions	Not Applicable	Not Applicable
HIPAA Special Enrollment Rights	Not Applicable	Applicable
COBRA Qualifying Events	Not Applicable	Applicable
Judgment, Decree or Order This change applies when a dependent becomes eligible as the result of a judgment, decree or order resulting from divorce, legal separation, annulment or change in legal custody that requires accident or health coverage for a dependent child.	Not Applicable	Applicable
Medicare or Medicaid Eligibility	Not Applicable	Applicable
FMLA Leaves of Absence	Applicable	Applicable
Pre-Tax HSA Contributions	Not Applicable	Not Applicable
As used herein, "Applies" either means that the election can be revoked, or it may be changed. Any change or revocation must be (a) consistent with the events described in this section to the extent that it is necessary or appropriate as the result of such change and (b) consistent with Treasury Regulation § 1.125-3, Treasury Regulation § 1.125-4, IRS Notice 2004-50 and 2004-33 I.R.B. 196.		

FSA & Participants on Family Medical Leave Act (FMLA) Leave

Plan participants on FMLA leave are entitled to maintain coverage for the HCFSA. Coverage and claims reimbursement will not be disrupted if monthly contributions are received (either by payroll deduction or by direct payment to the plan) by the end of each month.

The participant must contact their agency representative before going on leave, to arrange for prepayment of contributions. Reimbursements will be discontinued if the contribution is not received by the end of any month. A participant who terminates coverage prior to going on family medical leave may immediately reinstate coverage for qualifying expenses upon return to work. Such reinstatement of coverage and continuation of the original election must be made within 60 days of returning to work.

Plan Elections

A Plan Year election cannot be changed unless there is a qualifying life event.

Claims Processing

Participants must complete and submit a claim form along with copies of invoices or statements as verification of the qualifying expenses incurred. Invoices and/or statements must be from the provider/store stating the date of service/purchase, a description of services/products**,** the expense amount, the name of the service provider/store and the person for whom the service was provided.

For over the counter (OTC) items, the receipt or documentation from the store must include the name of the item printed (by the store) on the receipt, and participants must indicate the existing or imminent medical condition for which the item will be used on the claim form, or on a separate enclosed statement each time these items are claimed.

- Purchases for general good health will not be accepted.
- For items covered by insurance, copies of insurance explanations of benefits statements may be used instead of original physician bills if the date of service and charges are shown, including copies of payment receipts.
- Documentation and/or copies will not be returned.

Orthodontic expenses may be assumed to be incurred at the time a payment is made. To claim orthodontic expenses, a copy of the treatment contract, the payment schedule, and verification of payment are required. Acceptable verification of payment includes recipes, cancelled checks and credit card statements.

Claim Forms

- Claim forms available by logging on to the E-PEBP Portal at https://pebp.nv.gov/ or by calling **UMR** at 1-888-763-8232.
- Mail or fax claims to **UMR** (see address or fax number above) or submit online.
- Claims are typically processed within 1 business day of submission
- Direct deposit and email authorization form
- On-line account information

NOTE: Claims must be filed by October 31st following the end of the Plan Year.

Coverage under both Health FSA and HRA

Participants who have coverage under both the Health FSA and HRA are required to submit claims to the Health FSA first, until funds are exhausted.

Coverage under both Limited-Purpose FSA and HSA

Participants who have coverage under both the Limited Purpose FSA and HSA are required to submit to the Limited Purpose FSA first, until funds are exhausted.

Reimbursement

The Third-Party Administrator (TPA) will review claims and all supporting documentation. Claim reimbursements are typically issued within one business day of approval of the claim. The

amount of the reimbursement will either be the full approved amount of the claim or the balance of the annual election, whichever is less. Payment under the medical FSA is not limited to the amount in the account at the time they claim as monthly contributions will continue for the remainder of the Plan Year.

Claim reimbursements may be made by direct deposit into the participants bank account on record. Participants shall receive a notice of payment by mail or email. Participants may request a check instead of payment by direct deposit.

Health care expenses are eligible for reimbursement when incurred, not when paid.

Allowable expenses must be incurred during the current Plan Year and claims must be submitted to the TPA by October 31st following the end of the Plan Year.

Health Care/Limited Purpose FSA

The reimbursement limit for a HCFSA plan is established by the Internal Revenue Service. The limit for calendar year **2025** is **$3,300** for the medical FSA or the Limited Purpose FSA. The **$3,300** limit does not include the potential carryover from one Plan Year to another.

NOTE: This is a per participant deduction limitation, not a household limitation, so if an employee and his or her spouse each have an HCFSA, they could each establish a HCFSA with a **$3,300** deduction.

Qualifying Expenses

Only the portion of the expenses owed after insurance payments can be claimed. Qualifying expenses are those expenses which are incurred by the taxpayer or their eligible dependents during the Plan Year for medical care as defined in Section 213(d) of the Internal Revenue Code, excluding insurance premiums and long-term care expenses.

Qualifying medical care expenses include amounts incurred for the diagnosis, cure, mitigation, treatment, or prevention of disease, and for treatments affecting any part or function of the body. Refer to IRS Publication 502 for additional information (www.irs.gov/pub/irs-pdf/p502.pdf). However, expenses qualify for the medical FSA based on when incurred, not when paid and federal regulations do not allow any insurance premiums or long-term care expenses to be included under the FSA.

Below is a partial listing of qualified expenses:

Deductibles	Insulin
Copays	Orthodontics (braces)
Coinsurance	Hearing aids, including batteries
Over-the-counter treatment products such as bandages, blood-pressure monitors, diabetic supplies, carpal tunnel wrist supports	Ambulance, transportation expenses if the transportation is primarily for and essential to medical care.
Menstrual products such as tampons, pads, and liners	Dental expenses (except cosmetic dental expenses)
Vision care expenses such exams, prescription contact lenses/glasses, corrective eye surgery	Usual and customary charges, excess; qualifying medical expenses in excess of the plan's usual, customary, and reasonable charges.

Non-Qualifying Expenses

Below is a partial listing of non-qualified expenses:

- Cosmetic procedures: Most cosmetic procedures do not qualify. This includes cosmetic surgery or other procedures that are directed at improving the patient's appearance and do not meaningfully promote the proper function of the body or

prevent or treat illness or disease. Examples include face lifts, hair transplants, hair removal (electrolysis), teeth whitening, and liposuction. There is an exception, however, for procedures that are necessary to ameliorate a deformity arising from congenital abnormality, personal injury from accident or trauma, or disfiguring disease—these may qualify.

- Diet foods: Special foods to treat a specific disease (such as obesity) do not qualify to the extent that they stratify ordinary nutritional requirements. Thus, food associated with a weight-loss program, such as special pre-packaged meals, would not qualify, since it just meets normal nutritional needs.
- Insurance premiums are not qualifying expenses.
- Late fees (e.g., for late payments of bills for medical services.
- Marijuana (or other controlled substances) is in violation of federal law. Won't qualify, even if a state law allows its use with a physician's prescription (for example, to treat a medical condition).
- Toothbrushes: Will not qualify even if a dentist recommends special toothbrushes (such as electric or battery-powered) to treat a medical condition like gingivitis.
- The cost of a weight-loss program, if the purpose of weight control is to maintain general good health.
- Health club dues.

Changes Due to the CARES Act

The CARES Act, passed by Congress on March 27, 2020, repealed a rule from the 2010 Affordable Care Act that disallowed tax-free reimbursement of over-the-counter drugs or medicines (collectively "OTC") without a prescription. With this change, HCFSAs and HSAs cannot cover OTC without prescriptions.

Most medical devices and supplies are already eligible without prescription, so there is no change with respect to those.

Merchants that have implemented the Inventory Information Approval System (IIAS) cannot accept and FSA debit card, even if there is an presription on file. Participants will be required to submit a reimbursement request, along with a copy of the prescription and the cash register receipt in order to be reimbursed for these expenses.

Dependent Care FSA

Dependent care expenses are limited to:

- Care for children under age 13, for whom a participant has more than 50% custody, or
- Care for a spouse or dependent who is physically or mentally incapable of caring for himself or herself and who lives in a participants' home at least 8 hours each day.

Qualifying Expenses

- Expenses paid to a dependent care center.
- Expenses paid to a "babysitter".
- Expenses paid for care of a dependent under age 13.
- Expenses paid for care of a dependent who is physically or mentally incapable of caring for herself or himself.

Non-Qualifying Expenses

- Care while a parent is not working, going to school full time, or looking for work.
- Care for a child for the parent has 50% or less physical custody.
- Care for child aged 13 or older who is not disabled.
- Overnight care or camps.
- Instructional or sport specific camps, e.g., ballet camp, soccer camp, summer school.

Establishing & Using the Dependent Care FSA

Include predictable expenses only. Participants must estimate their dependent care expenses over the Plan year and divide that estimate by the number of total paycheck deductions over the Plan Year. (Deductions are generally taken out of the second check of the month.)

Dependent care expenses are incurred on the day care is provided. Participants must receive dependent care services before a claim can be filed.

File Claims

Refer to page nine for how to file a claim. Only expenses incurred for care and well-being qualify a child under 13 or a mentally/physically disabled dependent such as day care or day camps. The following are non-allowable expenses:

- Child support
- Sports camps
- Overnight camps
- Summer school
- Private school expenses.
- Food
- Transportation
- Overnight camps

- Respite

Expenses are eligible for payment from the Plan based on when incurred, not when paid. Expenses are incurred when a dependent is provided with the care that gives rise to the expenses, and not when billed, charged, or paid for the care.

The tax identification (ID) number or Social Security number of the child/dependent care provider must be listed on each claim form.

Childcare providers must provide their tax ID number or their Social Security number on their invoices or statements.

Reimbursements

Participants must submit a completed claim form along with copies of invoices or statements from the provider to serve as proof that an allowable expense has been incurred. Statements are required to include the provider's name, the date(s) of service, a description of the services, and the expense amount. Copies of personal checks and paid receipts, without the above information, are not acceptable. Claim forms may be found on the TPAs website.

In lieu of providing the above documentation, the provider may complete the dependent care section of the claim form and sign on the line provided.

The TPA will review claims and all supporting documentation. Claim reimbursements are typically issued within one business day of approval of the claim. The amount of the reimbursement will either be the full approved amount of the claim or the balance of the annual election, whichever is less. Payment under the medical FSA is not limited to the amount in the account at the time they claim as monthly contributions will continue for the remainder of the Plan Year.

Claim reimbursements may be made by direct deposit into the participants bank account on record. Participants shall receive a notice of payment by mail or email. Participants may request a check instead of payment by direct deposit.

Allowable expenses must be incurred during the current Plan Year and claims must be submitted to the TPA by October 31st following the end of the Plan Year.

If a participant cancels, terminates, or loses coverage, they may continue to file claims for qualifying expenses incurred prior to termination during the same Plan Year until the participant has been reimbursed by the balance of their account.

Some important points to remember regarding a Dependent Care FSA

This category is an alternative to taking a "tax credit" on federal income taxes. Participants must choose which tax break they want, either the "Tax Credit" or the "FSA." The IRS will not allow both tax breaks on the same expenses.

For **Plan Year 2026**, the DCFSA is limited to **$5,000** for single taxpayers and **$2,500** for married individuals filing separately.

Generally, those participants with a combined taxable income over $69,000 or single parents with a taxable income over $37,000 will save more through the DCFSA.

Participants should contact a tax advisor to discuss their individual filing status, and which option is best for them.

Termination of Participation

Participation in the Plan will terminate when:

- A participant is no longer employed.
- A participant no longer works at least 80 hours per month.
- A participant no longer meets the qualifications of the Plan.
- A participant terminates their FSA during open enrollment.
- The Plan terminates.

Participants may continue to claim reimbursement from an FSA for up to three months after their date of termination for any eligible expenses incurred on or before the date their participation terminated.

Participants may not claim reimbursement for expenses that are incurred after their participation terminates.

Continuation of Coverage under COBRA

Health Reimbursement Only

Participants may continue the FSA if they elect COBRA. Note: This does not apply to retirees.

Continuation of FSA coverage only applies if there is a positive HCFSA account balance (including the remaining monthly administrative fee and the 2% COBRA administrative fee).

COBRA FSA benefits will end the earlier of:

- When a participant stops payment the monthly administration fee;
- The FSA balance is depleted; or,
- At the end of the applicable Plan Year.

If COBRA is elected, it will be available only for the remainder of the applicable Plan Year. Such continuation coverage shall be subject to all conditions and limitations under COBRA. Participants who have incurred a COBRA qualifying event because of no longer being actively employed will be responsible for the monthly administration fee. The monthly administration fee will be paid on an after-tax basis.

FSA Rights and Responsibilities

Participant Responsibilities

For dependent care, participants are required to file Schedule 2 with their IRS Form 1040 or Form 2441 with their IRS Form 1040 to support the amount redirected (pre-taxed) for the calendar year. This is for informational purposes.

Claim reimbursements made under this category are not taxable, but the amount redirected will appear on participants' W-2 form. This will inform the IRS that a participant has received a tax break on that expense through the FSA.

Employer Responsibilities

The employer shall perform the following responsibilities:

- Maintaining Plan records;
- Filing tax returns and reports required under federal and state law and complying with other governmental reporting and disclosure requirements;
- Authorizing payments and resolving questions concerning the Plan and interpreting, in its discretion, the Plan's provisions related to benefits and eligibility;
- Hiring outside professionals to assist with Plan administration and to render advice concerning the responsibility they have under the Plan, including but not limited to hiring a claims administrator, actuaries, attorneys, accountants, brokers, and consultants;
- Establishing policies, interpretations, practices, and procedures of the Plan;
- Receiving disclosures required of fiduciaries and other service providers under any federal or state law;
- Acting as the Plan's agent for service of legal process;
- Administering the Plan, including but not limited to the Plan's claims procedures as set forth in the Summary Plan Description and the Plan Administrator's Plan document;
- For those Participants participating in the HCFSA and/or DCFSA, establishing a separate bookkeeping account for each in order to manage the participant's funds; and,
- Performing other responsibilities allocated to the Plan Administrator by the administrative committee.

Delegation of Responsibilities

The employer may delegate their responsibilities hereunder to other persons or entities. Such delegation shall be effective only if the proposed delegate executes an instrument acknowledging acceptance of the delegated responsibilities, and only if the board of directors, if applicable, specifically authorizes such delegation. The board of directors, if applicable, may also delegate their responsibilities to officers or participants of the employer.

Claims Administrator Responsibilities

Under the Plan, the TPA has agreed to provide certain administrative services on behalf of the Plan Sponsor according to the terms and limitations of the Plan. Claims for benefits under the Plan shall be filed, processed, reviewed, and, if denied, appealed in accordance with the procedures set forth in this Summary Plan Description and the Plan Administrator's Plan document.

Except as otherwise provided by law, the appeal procedures set forth in this Summary Plan Description and the Plan Administrator's Plan document shall be the sole and exclusive remedy.

The TPA will not act nor assume the responsibility to act as the Plan Administrator or Plan Fiduciary on behalf of the Plan Sponsor. The TPA administers the plan by adjudicating claims in accordance with the terms of the plan.

General Provisions

Effective Date of the Plan

The Effective Date of the modifications herein is **July 1, 2025**.

Type of Administration

The Plan is administered through the Plan Administrator. PEBP is the Plan Administrator. The Plan Administrator shall have full charge of the operation and management of the plan. PEBP is also the Plan Sponsor, unless another individual or entity is appointed by the Plan Sponsor.

Each Flexible Spending Account (FSA) is administered by the Plan Administrator in accordance with federal regulations. Any forfeited funds may be used by the employer, at its discretion, to pay for administration of the Plan, to offset distributions from flexible spending accounts that exceed contribution, or for redistribution to contributors.

Plan Administrator

The Plan Sponsor has retained the services of UMR to administer the benefits described in this Summary Plan Description.

Address:	**P O Box 30541, Salt Lake City, UT 84130-0541, EDI #39026**
Phone:	**1-888-7NEVADA (1-888-763-8232)**
Web:	**www.UMR.com**

Plan Fiduciary

PEBP is the Plan Fiduciary and shall have maximum legal discretionary authority to construe and interpret the terms and conditions of the plan, to review 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 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, as the Plan Administrator and Sponsor, reserves the right to amend the Plan at its sole discretion. Any amendments to the Plan will be incorporated into this master plan document.

Plan Compliance

The Plan will make any necessary amendments to the Plan that are required to maintain compliance with federal regulations.

The participant may be required to make changes in his or her benefit elections as a result of this action, such as reducing or discontinuing his or her contribution to an FSA. In such event, the Plan Administrator will make the necessary adjustments to the participant's salary reduction amounts for the remainder of the Plan Year.

Plan is not an Employment Contract

The Plan is not a contract between the employer and the participant or an inducement or condition of employment. Nothing in the Plan gives any employee the right to retain the employee status or to interfere with the right of the employer to terminate the employment of any employee at any time.

Plan Right to Recovery

Whenever FSA reimbursement payments have been made from the Plan in excess of the maximum amount of payment necessary, according to the terms of the plan, the Plan will have the right to recover these excess payments. Whenever reimbursements have been made from the Plan that should not have been made according to the terms of the plan, the Plan will have the right to recover these incorrect or improper payments. The Plan has the right to recover any such overpayment, improper or incorrect payment from the person or entity to whom payment was made, or from any other appropriate party, whether such payment was made due to the Plan Administrator's own error.

The Plan reserves the right to follow certain correction procedures to recover improper payments. First, upon identifying an improper payment, the employer shall require the participant to pay back to the Plan an amount equal to the improper payment. Second, if the participant fails to pay back the improper payment, the employer has the right to withhold the amount of the improper payment from the participant's wages or other compensation to the extent consistent with applicable law. Third, if the improper payment amount remains outstanding, the employer has the right to utilize a claim substitution or offset approach to resolve improper claims. This process allows the employer to substitute, or apply, the improper payment amount for a future substantiated claim incurred during the same coverage period. No reimbursement shall be made on any such future claims until the improper payment amount is fully recouped by the plan. In addition, the employer may take other actions to ensure that further violations of the terms of reimbursement do not occur, whether through the participant's use of a reimbursement claim form, or use of a debit card, including temporary or permanent denial of access to the debit card.

Plan Termination

The employer reserves the right to terminate the Plan at any time and will communicate this action to the participant.

In the event the Plan is terminated, the employee may continue to submit timely requests for reimbursement from his or her FSA to recover any remaining balance as provided in the section entitled *Claims Processing and Reimbursement*.

Benefits Not Transferrable

Except as otherwise stated herein, no person other than the enrolled employee is entitled to receive benefits under this plan. Such right to benefits is not transferable.

Clerical Error

No clerical error on the part of the employer or Plan Administrator shall operate to defeat any of the rights, privileges, services, or benefits of any employee hereunder, nor create or continue

participation which would not otherwise validly become effective or continue in force hereunder. An equitable adjustment of contributions and/or reimbursements will be made when the error or delay is discovered. However, if more than 90 days have elapsed after the end of a Plan Year prior to discovery of any error, any adjustment of contributions shall be waived. No party shall be liable for the failure of any other party to perform.

Conformity with Statute(s)
Any provision of the Plan that conflicts with statutes that are applicable to this Plan is hereby amended to conform to the minimum requirements of said statute(s).

Death
Any benefit payments or FSA reimbursements payable to the participant under the Plan after his or her death will be paid to his or her surviving spouse. Eligible requests may be submitted after the participant's death. In the case of no surviving spouse, any payments will be paid to the participant's estate or designated beneficiary.

Incapacitation
The Plan Administrator may direct any reimbursement to the participant's legal representative, relative or friend, or in any other manner that the Plan Administrator considers appropriate on the participant's behalf if the participant is under a legal disability or, in the opinion of the Plan Administrator, the participant is incapacitated so as to be unable to submit a proper reimbursement request from his or her FSA or otherwise manage his or her financial affairs.

Incontestability
All statements made by the employer or by the participant shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under this Plan or be used in defense to a claim unless they are contained in writing and signed by the employer or by the participant. A statement made shall not be used in any legal contest unless such statement is made in writing and signed by such person and a copy of the instrument containing the statement is or has been furnished to the other party to such a contest.

Legal Actions
No action at law or in equity shall be brought to recover on the FSA reimbursements from the Plan after the expiration of 90 days following the end of the Plan Year, unless otherwise provided by applicable law.

Limits on Liability
Liability hereunder is limited to the services and benefits specified, and the employer shall not be liable for any obligation of the participant incurred in excess thereof. The employer shall not be liable for the negligence, wrongful act, or omission of any medical (health) care or dependent care provider, institution or their participants, or any other person. The liability of the Plan shall be limited to the cost of FSA reimbursements under the provisions stated herein and shall not include any liability for suffering or general damages.

Lost Distributees

Any reimbursement payable hereunder shall be deemed forfeited if the Plan Administrator is unable to locate the participant to whom payment is due. However, if the participant submits a request for reimbursement for the forfeited funds within the time prescribed in the sections entitled *"Health Care Reimbursement"* and *"Dependent Care Reimbursement,"* such funds shall be reinstated.

Misrepresentation

If the participant or anyone acting on behalf of a participant makes false statement on the application for enrollment or on a reimbursement request form and any attachments, or withholds information with intent to deceive or affect the acceptance of the enrollment application or the risks assumed by the Plan, or otherwise misleads the Plan, the Plan shall be entitled to recover its damages, including legal fees, from the participant, or from any other person responsible for misleading the Plan, and from the person for whom the benefits were provided.

Any material misrepresentation on the part of the participant in making application for coverage, or any application for reclassification thereof, or for service thereunder, or; establishing an FSA or seeking FSA reimbursement, shall render the benefits under this Plan invalid.

Pronouns

Any personal pronouns used in this Plan shall include either gender unless the context clearly indicates to the contrary.

Section 125

This booklet constitutes a Plan document under Section 125 of the Internal Revenue Code ("Code"). The portions of this document related to reimbursement of health expenses constitute a medical expense reimbursement plan under Section 105 of the Code. The portions of this document related to reimbursement of dependent care expenses constitute a separate written plan under Section 129 of the Code. The benefits payable hereunder are intended to be excludable from the participant's gross income under Sections 105, 106 and 129 of the Code, and this Plan document shall be interpreted to the maximum extent to provide this intended effect.

Tax Benefits

The employer bears no responsibility for and makes no warranties regarding any personal income tax filings, such as eligibility of any personal expenses for credits or deductions. It is his or her responsibility to determine what expenditures are eligible under federal, state, or local income tax regulations.

FSA Frequently Asked Questions (FAQs) (Participants)

Whose expenses qualify under my HCFSA?

Qualifying expenses are those for medical care for yourself (the participant), your spouse, your qualified child or qualified relative.

Where can I see a list of qualifying expenses for the HCFSA?

UMR has an exhaustive eligible expense list; the list can be found in your online UMR portal.

Do prescription medications (drugs available only by prescription from a physician) qualify for the HCFSA?

Generally, yes, as long as they are prescription drugs and are legal under Federal and State law. However, prescriptions that are purchased solely for cosmetic purposes which are not treating an existing medical condition do not qualify for reimbursement.

Additionally, Federal law does not allow reimbursement through your flexible spending for importation of drugs from foreign countries.

What are the requirements for reimbursements for over-the counter (OTC) medicines and drugs?

OTC drugs and medicines purchased on or after January 1, 2020, do not require a prescription and are eligible for reimbursement. Just submit a claim with a copy of the merchant itemized store receipt showing the store name, date of purchase, a description of each item, and dollar amount. Note: If OTC drug and medicines were purchased prior to January 1, 2020, a physician prescription is required.

Items such as vitamins, herbs or nutritional supplements are typically not eligible for reimbursement. In order to claim these items, you must have:

- an existing or imminent medical condition;
- a pre-printed receipt from the provider documenting the purchase; and
- a physician's diagnosis and prescription for the specific item(s).

How much does it cost me?

You pay a small administration fee of **$3.15** per month to participate in either one or both (HCFSA and/or DCFSA) flexible spending accounts.

What if I do not use all the money in my Flexible Spending Account?

If you have funds remaining in your DCFSA account at the end of the year, that amount will be forfeited by you as required by federal regulations. If you have funds remaining in your HCFSA or LPFSA at the end of the year, you will be permitted to carry over up to **$660** to the following Plan Year. Funds in excess of **$660** will be forfeited.

Are there any negatives that I should know about?

If you do not use all the money in your DCFSA, you will forfeit it. You will only be able to carry over up to **$660** of your HCFSA or Limited Purpose FSA. Any remaining amount you will forfeit.

Will the Medical Health Care FSA carryover affect my enrollment in the PEBP Health Savings Account?

Yes. The FSA carryover will make you ineligible for the PEBP health savings account. To be eligible for the PEBP health savings account you may either elect to decline the carryover prior to the next Plan Year or switch your enrollment to the Limited Purpose FSA and carry over the unused funds to your new account.

What if I am already in the FSA?

Participation in both accounts terminates at the end of each Plan Year. You must submit a new election to the TPA each year during Open Enrollment to reenroll.

If I enroll in the Health Savings Account (HSA), can I still enroll in the regular Health Care FSA?

No. Federal rules prevent an individual who is enrolled in a high-deductible health plan with an HSA to enroll in the HCFSA. However, you may sign up for the Limited Purpose FSA which allows you to set aside pre-tax money for vision and certain dental expenses.

Are there any restrictions if my spouse also contributes through his/her employer's FSA plan?

The reimbursement limit for a HCFSA plan is established by *each* employer, so you may each contribute an amount up to *each respective* employer's plan limit. However, you may only claim reimbursement of each expense from one plan (not the same expense under both plans). PEBP's limit for Plan Year 2025 is **$3,300** for the HCFSA or the LPFSA. The **maximum plan election** does not include any potential carryover remaining in your HCFSA or LPFSA from one year to another.

NOTE: This is a per participant deduction limitation, not a household limitation, so if an employee and his or her spouse each have a HCFSA, they could each establish a HCFSA with a **$3,300** deduction.

- For Plan Year **2025**, the DCFSA pretax contribution limit is $5,000 for single taxpayers and married couples filing jointly, and $2,500 for married individuals filing separately.

When can I make changes?

You can change benefits during open enrollment (prior to the start of each Plan Year)**.** Generally, you will not be able to change your election during the Plan Year. Refer to the *Health Care & Limited Purpose FSA's & dependent care FSA Qualifying Life Status Event Table* in this document.

To make an eligible change during the Plan Year, contact the TPA within 60 days of a qualifying life status event. the TPA may request proof of a qualifying life status event.

Qualifying change in life status events are defined as any one of the following four (4) changes in status.

1. Your legal marital status changes through marriage, divorce, death, or annulment.
2. Your number of dependents changes by reason of birth, adoption (or placement for adoption), or death. If your child no longer qualifies for day care because he or she turned 13, then that is a loss of a dependent under the DCFSA, but not under the HCFSA.

3. You have a change in employment status that affects eligibility under this plan, including a change from full time to part time or vice versa.

    a. If you terminate or take a leave of absence, you must be gone at least 31 days for the termination or leave of absence to qualify as a change in status. If your spouse or any of your dependents have an employment status change that affects eligibility under a plan maintained by your spouse's or any dependent's employer, then you may increase or add coverage under this Plan if coverage is lost under the other employer's plan.

    b. If a participant terminates and then returns to employment within 60 days in the same Plan Year, then your election will be reinstated as it was immediately prior to the termination of employment. If you return to employment after 60 days in the same Plan Year, then you may make a new election for the remainder of the Plan Year. You will not be able to be reimbursed for medical or dependent care expenses incurred during the termination period.

4. One of your dependents satisfies or ceases to satisfy the requirements for coverage under the HCFSA for unmarried dependents due to attainment of age, student status, or any similar circumstances.

    In addition, the change in status must result in a gain or loss of eligibility for coverage under this Plan or a plan maintained by your spouse's employer or one of your dependent's employers and your election modification must correspond with that gain or loss of coverage.

Examples of Allowable changes Due Resulting from Qualifying Life Status Changes

1. Adoption of a two-year-old child during the plan year.

    - As a result of the adoption, there is a change to the number of dependents in the household.
    - The child is now eligible for coverage under the HCFSA and the DCFSA.
    - Employees may increase the HCFSA and/or DCFSA election(s) or enroll in one or both of those plans if not already enrolled.
    - However, the employee would not be able to decrease or disenroll from the HCFSA or the DCFSA as the life event results in a gain of eligibility and not a loss of eligibility.

2. A judgment, decree, or court order resulting from a divorce, annulment, or change in legal custody (including a qualified medical child support order) that requires health coverage for an employee's child would be considered an allowable change to the HCFSA, to:

    - Provide coverage for the child, if the order requires coverage under an employee's plan; or,
    - Cancel coverage for the child if the order requires the former spouse to provide coverage.

- Changes to dependent care providers allow an employee to make an election change to reflect the cost of the new provider. Election decreases are allowed when the child is no longer in childcare or is only in after school care due to entering kindergarten or first grade. (This is considered a provider change.)

3. Employee who takes an unpaid leave under the Family Medical Leave Act (FMLA) or Uniformed Services Employment and Reemployment Rights Act (USERRA) for more than 31 days may revoke an existing election under the HCFSA. However, employees must revoke any DCFSA since employees are not working. Upon returning from FMLA or USERRA leave, employees may choose to be reinstated in either benefit if such coverage was terminated during the FMLA or USERRA leave. Such reinstatement will be on the same terms as prior to taking FMLA or USERRA leave. An employee shall have no greater right to benefits for the remainder of the Plan Year than an employee who has been continuously working during the Plan Year.

   If an employee's coverage under the HCFSA or DCFSA terminates while on FMLA or USERRA leave, the employee will not be entitled to receive reimbursements for claims incurred during the period when the coverage is terminated. If an employee elects to be reinstated in a benefit upon return from FMLA or USERRA leave, the coverage for the remainder of the Plan Year is equal to the election for the 12-month period of coverage, prorated for the period during the FMLA or USERRA leave for which no premiums were paid. (See additional information on FMLA or USERRA leave on page 18.)

Heroes Earnings Assistance & Relief Tax Act of 2008

Under the Heroes Earnings Assistance & Relief Tax Act of 2008, participants called to active military duty for a period of at least six months can receive a taxable distribution of the HCFSA funds to avoid forfeiture.

What are my rights on claims appeals?

You will receive written notice of any claims denied. You will have 30 days to file a written appeal of that specific claim denial with the TPA claims office. The TPA claims office will provide you with a written notice of the resolution of this appeal within 60 days of the appeal.