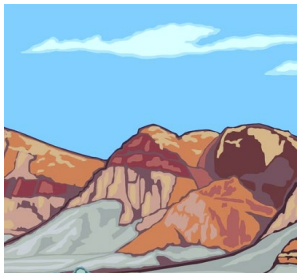
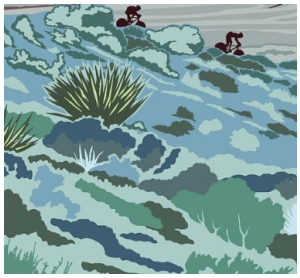
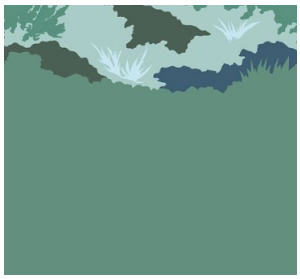
HEALTH REIMBURSEMENT ARRANGEMENT (HRA) MASTER PLAN DOCUMENT (MPD)

PLAN YEAR 2026

Effective July 1, 20254 – June 30, 2026








Public Employees' Benefits Program

775-684-7000

702-486-3100

1-800-326-5496

https://pebp.nv.gov

Administered By

hsabank

A Division of Webster Bank, N.A., Member FDIC

Table of Contents

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.

Introduction

Health Reimbursement Arrangement

This Master Plan Document (MPD) provides, in general terms, the main features of the State of Nevada Public Employees' Benefits Program Health Reimbursement Arrangement (HRA).

The purpose of the HRA is to reimburse eligible employees, up to certain limits, for their own, and their eligible dependents allowable health care expenses. Reimbursements for Health Care Expenses paid by the HRA generally are excluded from taxable income. Eligible employees and their eligible dependents shall be referred to as "participants" in this document.

PEBP encourages participants to be fully informed of the benefits available to them under an HRA. Participants should direct any questions to PEBP (Plan Administrator) or the HRA Administrator. A copy of the HRA Summary Plan Description is available at https://pebp.nv.gov/ or by request by calling the PEBP office at 775-684-7000 or 800-326-5496.

PEBP's HRA benefits are subject to IRS Publication 969.

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 uses a Third-Party Administrator (TPA) to process HRA reimbursements. For the purposes of this document, the TPA is HSA Bank. PEBP continues to 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 participants, held in an internal service fund. There is no trust or other funds 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.

The provisions of the HRA, as initially adopted or subsequently amended and restated are effective July 1, 2025 – June 30, 2026.

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

General Information About the HRA

For Plan Year **2026** (**July 1, 2025 – June 30, 2026**), PEBP will provide Legislatively approved supplemental funding for active State employees covered by any eligible health plan on **July 1, 2025**. The contribution amount for Employees enrolled in these plans who are hired after **July 1, 2025**, will be a prorated contribution based on the employee's coverage effective date and the remaining months in the Plan Year. The funding will be as follows:

Tier	One-Time Contribution
Legislature Appropriated One-Time Contribution	
State Active Employee Only	$300
State Active Employee + Spouse/Domestic Partner	$400
State Active Employee + Child(ren)	$400
State Active Employee + Family	$500

What is the HRA?

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

- PEBP establishes an account called a Health Reimbursement Arrangement for each Eligible Employee enrolled in the Consumer Driven Health Plan (CDHP) with effective coverage on or after **July 1, 2025**. The CDHP is the only eligible health plan for the plan year beginning July 1, 2025.
- 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 a 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 Spouse's 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 to, (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:

- 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).

HRA funds must be used on a prospective basis from the date of funding.

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 (CDHP, EPO, LD, and HPN); this means Employees must be enrolled in a PEBP-sponsored medical plan to qualify for the HRA.

Are the HRA dollars transferable to another PEBP medical plan?
The HRA funds are transferrable between the Consumer Driven Health Plan (CDHP), Low Deductible Plan (LD), Exclusive Provider Organization Plan (EPO), and Health Plan of Nevada (HPN). HRA funds are not transferable to the Via Benefits (Medicare Exchange) HRA.

Who is eligible for the HRA?
Eligible Employees enrolled in a PEBP-sponsored medical plan (CDHP, LD, EPO, and HPN) with effective coverage on or after **July 1, 2025**.
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 https://pebp.nv.gov/.

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:

- Employees,
- Spouses and dependents of those employees,
- Any person who could have been claimed as a dependent on the eligible employee's tax return except if:
    a. The person filed a joint return.
    b. The person had a gross income of $4,400 or more; or
    c. Participants, or their spouse if filing jointly, could be claimed as dependent on someone else's tax return.
- A child under age 27 at the end of the tax year.
- Spouses and dependents of deceased employees.

Note: A child of parents that is 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 participants for eligible Health Care Expenses to the extent that they have a positive balance in their HRA Account. If participant have a claim under a PEBP medical plan or other health insurance plan, participants 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, participants should file a claim for reimbursement as soon as possible after they 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 receive an overpayment?

If participants receive reimbursement and it is later determined that they received an overpayment or payment was made in error (e.g., participants were reimbursed for an expense that is later paid by an insurance plan), participants will be required to refund the improper payment to HSA Bank. If participants 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 participants.

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 for employees enrolled in a PEBP-sponsored medical plan. Note: HRA funds associated with a PEBP-sponsored medical plan are not transferable to the Medicare Exchange HRA. For details on the Medicare Exchange HRA, refer to the Medicare Exchange HRA SPD available at https://pebp.nv.gov/.

May I elect to permanently opt out of an HRA Account?
Participants may elect to permanently opt out of and waive any right to future reimbursement from an 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 participants cease to be an Eligible Employee (for example, if participants die, retire, and transition to an individual qualified Medicare plan through the Medicare Exchange, or terminate employment without continuing coverage under COBRA), their participation in the HRA will terminate and any remaining funds 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 participants decline coverage while on FMLA or USERRA leave, they may have rights to reinstate the HRA upon returning from leave if they enroll in the same medical plan that they were enrolled in prior to taking leave.

What if I go out on unpaid Leave Without Pay or Workers' Compensation?
Coverage under a Plan with an HRA during a paid or unpaid leave of absence will be treated in the same manner as coverage under the medical plan is treated during a leave of absence. Upon returning from leave, participants 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 https://pebp.nv.gov/.

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 temporarily continue health care coverage under the medical plan. If participants 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:

- A termination from employment or reduction of hours.
- A divorce or legal separation.
- A participant becomes eligible to receive Medicare benefits.
- A dependent child ceases 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. Participants are responsible for informing their 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 https://pebp.nv.gov/.

Are my HRA benefits taxable?

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

Claim Denials and Appeal Process

What happens if my claim for HRA Benefits is denied?

Participants have the right to be notified of a 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?

Participants are entitled to notification of the decision on their 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 participants of the need for the extension and the time by which they will receive a determination on their claim. If the extension is necessary because of a participant's failure to submit the information necessary to decide the claim, then HSA Bank will notify participants regarding what additional information participants are required to submit. If participants 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 a claim is denied, the notice that participants 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 necessary to process the claim;
- 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 participants' 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 participants, free of charge, upon request.

Do I have a right to appeal a denied claim?

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

What are the requirements of my Level 1 appeal?

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

- Participant name and address;
- The fact that participants are disputing a denial of a claim or HSA Bank's act or omission;
- The date of the notice that HSA Bank informed participants 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.

Participants should also include any documentation that participants have not already provided to HSA Bank.

Is there a deadline for filing my Level 1 appeal?

An appeal must be sent to HSA Bank within 180 days after reviewing the denial notice or HSA Bank's act or omission. If participants do not file an internal appeal within this 180-day period, participants lose the right to appeal. All internal appeals 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, participants may submit copies of all relevant documents, records, written comments, testimony, and other information to HSA Bank. The HRA is required to provide participants with reasonable access to and copies of all documents, records, and other information related to the claim. When reviewing an internal appeal, HSA Bank will consider all relevant documents, records, comments, and other information that participants 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 participants have provided to it, participants 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 a claim, that new or additional reason will be disclosed to participants, and participants 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?
Participants will be notified of their appeal decision within 60 days of receipt.

What information is included in the notice of denial of my Level 1 appeal?
If a Level 1 appeal is denied, the notice shall include supplemental information for the denial. This may include, but is not limited to:

- Information about the 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;
- 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 participants are required to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim;
- 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 participants free of charge upon request; and
- A statement of participants' right to request a Level 2 appeal.

Do I have the right to seek review of a denied claim to an external review?
Participants have the right to an external review of a claim denial after they have exhausted the internal appeals process, unless the denial was based on a participant's failure to meet the HRA's eligibility requirements.

What are the requirements of an external review?

After exhausting the initial appeal process, participants 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 an 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 participants and PEBP of its decision within 45 days after it receives the complete information. The external reviewer's decision is binding upon all parties unless other State or Federal law remedies are available. Such remedies may or may not exist.

Therefore, unless another legal right exists under the claim, use of the external review process terminates a participant's right to bring a lawsuit regarding the 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.

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.

Eligible Employee. For purposes of this document, a State active employee who has met the eligibility requirements to enroll in a PEBP-sponsored medical plan.

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).

HRA Account. The recordkeeping account established in the eligible employee's name by the Plan Administrator based on which eligible Health 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 allowable 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.

PEBP-Sponsored Medical Plan. The Consumer Driven Health Plan (CDHP), Low-Deductible Plan (LD), and Exclusive Provider Organization (EPO).

Plan Administrator. Public Employees' Benefits Program.

Miscellaneous

Effect of the HRA on Employment Rights

The HRA is not a contract of employment between participants and an 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 determined that a payment was made in error, participants will be required to refund the payment to the HRA. If the payment is not reimbursed, the HRA and the Employer reserve the right to offset future reimbursement equal to the erroneous payment amount or, if that is not feasible, to withhold such funds from a participant's pay. If all other attempts to recoup the erroneous payment are unsuccessful, PEBP may treat the overpayment as a bad debt, which may have income tax consequences for participants.

Family and Medical Leave Act and USERRA (if applicable)

Participants who go on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA) or Uniformed Services Employment and Reemployment Rights Act (USERRA) may maintain their HRA Benefits on the same terms and conditions as if the participant were still an active eligible employee.

Participants who go on a leave of absence that is not subject to the FMLA or USERRA will be treated as having terminated participation.

Reinstatement and Reinstated Employees

Under no circumstances shall a participant who received contributions during the Plan Year be eligible for additional contributions due to reinstatement of coverage or changing from a plan with an HSA to a plan with an HRA or vice versa.

Reinstated employees who return to active employment within the same Plan Year and who re-enroll in an HRA shall have their remaining HRA fund balance reinstated. Reinstated employees who re-enroll in the HRA more than one year after termination are not eligible for reinstatement of HRA balance reinstatement. No additional prorating of HRA funds is available to reinstatements unless the reinstated employee is eligible for additional prorated funding due adding new dependent(s).

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..

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, 2025**.

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 Third Party Administrator
PEBP has contracted with HSA Bank to process claims for the HRA program. Contact HSA Bank for 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.