# PEBP FLEXIBLE SPENDING ACCOUNT (FSA)
# HEALTH CARE FSA
# DEPENDENT CARE FSA
# LIMITED PURPOSE FSA
# PLAN YEAR 2022

**(EFFECTIVE JULY 1, 2021 – JUNE 30, 2022)**

**Public Employees' Benefits Program**

Administered By:

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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, 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 Premier 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 the Consumer Driven Health 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
- Premier Plan Master Plan Document; Premier 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
- 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 of the Internal Revenue Code. For information regarding Section 125, please see the Section 125 Health and Welfare Benefits Plan Document available at www.pebp.state.nv.us.**

## Flexible Spending Accounts

### Health Care FSA

Health Care Flexible Spending Account (HCFSA) is a PEBP-sponsored plan by which participants may obtain reimbursement for medical expenses that are not reimbursed through insurance or any other arrangement. HCFSAs are funded through pre-tax salary reductions.

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

Flexible spending accounts permit reimbursement for eligible expenses incurred by the taxpayer 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 employees 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 FSA 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 a 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

To qualify for this account, both you and your spouse must be gainfully employed (unless you are a single parent). If your spouse is a full-time student, actively looking for full-time employment, or disabled, you may also qualify if you meet strict IRS eligibility guidelines.

The Dependent Care FSA covers expenses if you claim the person being cared for as a dependent on your income tax return and the person is either:

- Younger than 13; or
- Physically or mentally incapable of self-care and regularly spends at least eight hours a day in your household. Regularly does not mean daily, but frequently, on a regular basis. A DCFSA is an option for active employees covered under the PEBP Consumer Driven Health Plan (CDHP), HMO or Premier EPO Plan that allows you to pay for dependent care expenses and lower your taxable income.

Here is how it works:

- You direct part of your before-tax pay into a special account to help pay work-related dependent care costs.
- You can use your dependent care account throughout the Plan Year to help pay for eligible expenses.
- Your expense must be for the purpose of allowing you and, if married, your spouse to be employed.

Refer to the section titled, '*Dependent Care FSA*' for more information.

## Who Qualifies for Reimbursement of Expenses for these Plans?

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.

### 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.

## FSA Tax Benefits

### "Before Tax" or "Pre-Tax"

FSA deductions from your paycheck are exempt from federal tax. These deductions reduce your taxable income reported on your income tax return. The HCFSA or Limited Purpose FSA can save you up to 15% - 35% in taxes on each dollar that you spend for your share of insurance deductibles, co-pays, or other eligible health care and/or dental expenses. Also, the DCFSA may save you more in taxes than the day-care tax credit (filed with your federal income tax return).

### Tax Savings

By electing to direct a portion of your salary through an FSA, you essentially bank your money in a TAX-FREE account. The money is used to pay for expenses that would otherwise be paid out of your take-home pay. The following example illustrates how an FSA could save this employee $375 in taxes! Savings will vary for each participant depending on variable information such as marital status, number of exemptions, and marginal tax bracket. Consult with your tax advisor to determine your actual potential savings.

| | Without **FSA** | With **FSA** | Savings with **FSA** |
|---|---|---|---|
| Annual Compensation | $30,000 | $30,000 | |
| Tax Free Expenses | 0 | 1,500 | |
| Taxable Income | $30,000 | $28,500 | |
| Federal Tax (after $5,000 exemptions) | 6,250 | 5,875 | $375 |
| Net Paycheck | $23,750 | $22,625 | |
| After Tax Expenses | 1,500 | 0 | |
| **Actual Take Home Pay** | **$22,250** | **$22,625** | **$375** |

## FSA Eligibility and Enrollment

### Eligibility Criteria

To be eligible for an FSA you must be:

1) An employee in one of the State of Nevada payroll centers -- excluding the Nevada System of Higher Education employees who have a separate plan;
2) Working at least 80 hours each month; and,
3) Enrolled in health benefits with active coverage through PEBP.

### Enrollment

The FSA Plan Year is July 1, 2021 through June 30, 2022. The 2021 FSA open enrollment (OE) will be held in May 2021. To participate in an FSA, you must enroll within 60 days of your hire date or during open enrollment each year for the upcoming Plan Year.

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 HealthSCOPE Benefits 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 HealthSCOPE.

- A new benefits-eligible employee must submit an enrollment election with HealthSCOPE Benefits within 60 days of the initial health coverage effective date to participate in the FSA plan.

- Elections are irrevocable. However, employees 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.

- Employees enrolling for the first time should only include reimbursable expenses for services received from FSA effective date 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.

| Health (Medical) Care, Limited Purpose and Dependent Care FSA Mid-Year Qualifying Life Status Events Table | | |
|---|---|---|
| **Events Permitting Election Change** | **Mid-Year change is Applicable** | |
| | **Dependent Care FSA** | **Health Care & Limited Purpose FSA's** |
| **Change in Status**<br>Special notes concerning "changes in status":<br>• 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. | Applicable | Applicable |
| • 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 |

| Health (Medical) Care, Limited Purpose and Dependent Care FSA Mid-Year Qualifying Life Status Events Table | | |
|---|---|---|
| **Events Permitting Election Change** | **Mid-Year change is Applicable** | |
| | **Dependent Care FSA** | **Health Care & Limited Purpose FSA's** |
| **Cost Changes with Automatic Increase/Decrease in Elective Contributions**<br>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**<br>The change applies when the cost charged to employee 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**<br>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**<br><br>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 period of coverage under the other cafeteria plan or qualified benefits plan. | Applicable | Not Applicable |
| **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 |

| Health (Medical) Care, Limited Purpose and Dependent Care FSA Mid-Year Qualifying Life Status Events Table | | |
|---|---|---|
| **Events Permitting Election Change** | **Mid-Year change is Applicable** | |
| | **Dependent Care FSA** | **Health Care & Limited Purpose FSA's** |
| **Judgment, Decree or Order**<br>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. | | |

## Claims Processing

You must submit a completed claim form along with copies of invoices or statements to serve as proof that you have incurred a qualified expense to receive payment. Statements are required to 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. You must indicate the existing or imminent medical condition for which the item will be used on the receipt, 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 made. To claim orthodontic down payments, you must include a copy of the treatment contract and payment schedule along with proof of payment or a receipt of payment stating the date the braces were placed.

### Claim Forms

- Claim forms available by logging on to your E-PEBP Portal at www.pebp.state.nv.us or the HealthSCOPE Benefits website at www.healthscopebenefits.com or by calling 1-888-763-8232
- Mail or fax claims to HealthSCOPE Benefits, Inc. (see address or fax number above) or submit online via www.healthscopebenefits.com
- Claims are typically processed within 1 business day of submission
- Direct deposit and email authorization form - www.healthscopebenefits.com
- On-line account information - www.healthscopebenefits.com

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

### Reimbursement

HealthSCOPE Benefits will review your claim and any necessary supporting documentation. If approved, HealthSCOPE Benefits will reimburse you for the medical care expenses. Claim reimbursements are typically issued within one business day of receipt of your claim.

You may be paid the full amount of your claim or the balance of your annual election, whichever is less, whenever you file a qualifying claim. Payment under the medical FSA is not limited to the amount in your account at the time of your claim. Your monthly contributions will continue for the remainder of the Plan Year.

Claim reimbursements may be made by direct deposit into the bank account of your choice. By using direct deposit, you will not need to wait for a check to arrive or get it deposited. A notice that a payment was made will be sent to you. This direct deposit notice is available by U.S. Mail or by e-mail. If you prefer, a check can be mailed to you instead of payment by direct deposit.

Health care expenses are eligible for payment from the Plan based on when incurred, not when paid. An expense is incurred when you or one of your eligible dependents is provided with medical care or purchases a qualifying product, and not when you are billed, are charged, or pay for the expense.

Allowable expenses must be incurred during the portion of the Plan Year that you were a participant. Claims for expenses incurred during the Plan Year must be submitted to HealthSCOPE Benefits by October 31st following the end of the Plan Year.

# Establishing & Using Your Health Care FSA or Limited Purpose FSA

## Estimate you and your Family's Annual Out-of-Pocket Health Care Expenses

You may include expenses for anyone who qualifies as a dependent for your federal tax return (spouse, children, etc.). Include predictable expenses only. (Remember that Plan Year 2022 is July 1, 2021 – June 30, 2022)

## Enroll in the Health Care FSA or Limited Purpose FSA

Download the Flexible Spending Form by logging onto the E-PEBP Portal at www.pebp.state.nv.us or contact PEBP at 775-684-7000 or 800-326-5496 to request a form. Enter your contribution amount for the Plan Year; submit your enrollment agreement to HealthSCOPE Benefits.

## Incur Medical Care Expenses

A medical care expense is incurred on the date a service is provided or a product is purchased to create that expense. You must incur medical care expenses *before* you file a claim for those expenses.

## File Claims

After you have incurred the medical care expenses and know the amount of your responsibility for the bill, you may submit a claim for those expenses to HealthSCOPE Benefits.

## Using the FSA Debit Card to pay for your Medical expenses

The FSA debit card provides a convenient method to pay for Out-of-Pocket medical expenses for you, your spouse, and/or any tax dependents. The IRS has stringent regulations regarding appropriate use of the FSA debit card, such as where the card can be used, and when follow-up documentation is required (use of the card DOES NOT necessarily eliminate all the paperwork). The card is a great benefit, but it is important that you take a moment and understand how it works.

### Is there a Cost for the Card?

No. There is no cost for the initial FSA debit card. However, there is a $5 fee to replace a lost card or to request additional cards. You pay a small administration fee of **$3.15** per month to participate in either one or both (medical and/or dependent care) flexible spending accounts.

### How do I Request a Card?

Current cardholders who renew for the following Plan Year will automatically have their card reloaded with the next year's election amount as of July 1. New enrollees will receive a welcome packet in the mail that includes an application for the debit card.

## Can I Request a Replacement Card if I Lose One?

Yes. Everyone who requests a card will receive two FSA debit cards in the mail. If you need to replace a lost card, they are available by calling HealthSCOPE Benefits directly at 1-888-763-8232 and placing your request. There is a $5 fee for each replacement card request. Please note that all cards will be in the name of the FSA participant.

## Where Can the Cards be used?

Per IRS regulations, the FSA debit card can only be used at health care providers (based upon the Merchant Category Code) and at stores that have implemented an Inventory Information Approval System (IIAS).

- **Health Care Merchant Category Codes (MCC):** Every merchant that accepts credit cards has an MCC, which is a general category that is assigned when the merchant applies for the right to accept credit cards. The FSA debit card will work to pay providers that have an MCC that indicates the merchant is a health care provider (hospital, doctor, dentist, optometrist, chiropractor, etc.).
- **Inventory Information Approval System (IIAS):** The IRS also allows the FSA debit card to be used at retail stores that have IIAS in place. IIAS restricts purchases with your FSA debit card to eligible expenses, and you will never be prompted for follow-up documentation for purchases at these stores. Please note that if you have a medical condition that allows you to claim expenses that are not normally eligible, the card will not be able to pay for these expenses at these stores. You will have to pay with a separate form of payment and submit a claim. The card will work at these stores, even if the MCC does not indicate it is a health care provider. Purchases at these stores will never require follow-up documentation.

Please note that as of July 1, 2009, IRS regulations require all pharmacies to have the IIAS in place, or your card may be declined at the point-of-sale.

## When Do I Have to Turn in Paperwork?

Debit card transactions can be accepted by the FSA administrator without any follow up if the merchant is an acceptable merchant type such as a physician's office or hospital and at least one of four other criteria are met. Transactions are electronically substantiated if:

- The dollar amount of the transaction at a health care provider equals the dollar amount of the co-payment or any combination of any known co-pays up to five times the highest known co-pay, for the employer-sponsored medical, vision or dental plan that participant has elected;

- The expense is a recurring expense that matches expenses previously approved as to amount, provider, and time period (e.g., for an employee who pays a monthly fee for orthodontia at the same provider for the same amount); or
- The merchant maintains a compliant Inventory Information Approval System (IIAS) for over-the-counter supplies and prescription medication (this system is allowable only if the merchant approves only qualifying items; all other purchased items must be paid for in a split tender transaction.)

Any transaction that does not meet the above criteria will prompt a request for follow-up documentation.

### What Happens if I Do Not Submit Requested Documentation?

Federal regulations require the cards be deactivated if follow up documentation is not provided when requested by HealthSCOPE Benefits. You will receive several notifications before the cards are deactivated and can always call HealthSCOPE Benefits for assistance in working through any concerns that come up.

### Maximum Plan Election

The IRS limits your annual elections to certain maximums. Refer to the applicable section within this document for more information.

### Does this Plan provide a Carryover Provision?

If your HCFSA or Limited Purpose FSA contains an unused balance at the end of the Plan Year you may carry over up to $550 to the following Plan Year. Any unused balance in excess of $550 at the end of the Plan Year is not subject to carryover and will be forfeited. The carryover amount does not affect the maximum Plan election. See the *Frequently Asked Questions* section for questions regarding HSA eligibility and the HCFSA carryover.

## Health Care/Limited Purpose FSA

The reimbursement limit for a HCFSA plan is established by the Internal Revenue Service. The limit for calendar year 2021 is $2,750 for the medical FSA or the Limited Purpose FSA. The $2,750 limit does not include the potential carryover of up to $550 remaining in your HCFSA or Limited Purpose FSA 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 a HCFSA, they could each establish a HCFSA with a $2,750 deduction.

## Qualifying Expenses

Only the portion of the expenses you owe 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 all 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. Please contact HealthSCOPE Benefits if you have a question on specific qualifying items.

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 substance 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 the weight control is to maintain your 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 can cover OTC without prescriptions. Eligible OTC includes any drugs or medications that are primarily for treatment (not cosmetic or for general health). Most medical devices and supplies are already eligible without prescription, so there is no change with respect to those.

If you use the FSA debit card at merchants that have implemented the Inventory Information Approval System (IIAS), you will not be able to pay for OTC medicine with the FSA debit card, even if you have a prescription on file with HealthSCOPE Benefits. You 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

Day care expenses are limited to care for children under age 13, for whom you have more than 50% custody, or for a spouse or dependent who is physically or mentally incapable of caring for himself or herself and who lives in your home at least 8 hours each day.

The expenses may not be paid to a child of yours who is under the age of 19 at the end of the year in which the expenses are incurred or to an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent.

## Qualifying Expenses

Expenses necessary for you to be gainfully employed:

- 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

Federal regulations do not allow any insurance premiums or long-term care expenses to be included under the FSA:

- Care while you are not working or looking for work.
- Care for child for whom you have 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

### Estimate your Total Dependent Care Expenses for the Plan Year

Include predictable expenses only. Remember that Plan Year 2022 is July 1, 2021 – June 30, 2022.

### Enroll in the Dependent Care FSA

Enter your estimated dependent care expenses. Divide your estimate by the number of deductions you will have taken during the Plan Year. (Deductions are generally taken out of the second check of the month.) Contact your agency representative if you need assistance.

## Receive Dependent Care Services

Dependent care expenses are incurred when the day care is provided. You must receive the dependent care services before you file a claim for those services.

## File Claims

You may include only those child/dependent care expenses that you incur for you and your spouse to be gainfully employed. Only expenses incurred for care and well-being qualify for this tax break (education related sports camps, summer school and private school expenses, food and transportation do not qualify). Child support payments are not allowable. Day camp fees incurred for you to work are allowable but overnight camps are not. Please refer to IRS Publication 503 for

further details on qualifying expenses. You may access this publication at https://www.irs.gov/publications/index.html.

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

After you have received the dependent care services, you may submit a claim for those expenses to HealthSCOPE Benefits.

### Receive Reimbursements

HealthSCOPE Benefits will review your claim, and if approved will reimburse you. Claim reimbursements are issued within one business day of the receipt of your claim up to the amount that you have on deposit in your account. If your claim exceeds your available funds, the difference will be recorded and paid as funds become available from your payroll contributions.

**Some important points you should remember regarding a Dependent Care FSA are:**

This category is an alternative to taking a "tax credit" allowed with your tax filing each year. You may receive a tax break on your expenses, but you must choose whether to use the "Tax Credit" or the "FSA". The IRS will not allow you to receive two tax breaks on the same expenses.

For Plan Year 2022 (July 1, 2021 – June 30, 2022), the DCFSA is limited to $5,000 for single taxpayers and $2,500 for married individuals filing separately. You will experience "tax savings" throughout the year with every paycheck you receive.

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

Please contact your tax advisor if you have questions about which is best for you. You must choose whether to use the tax credit or the DCFSA.

1. You and your spouse together may include up to $5,000 per calendar year ($2,500 in the case of a married individual filing a separate tax return for the calendar year) or the lesser of (after subtracting all FSA deductions) you or your spouse's earned income for the calendar year. In no event shall a married individual filing a separate tax return for the calendar year exceed $2,500. In the case of a spouse who is a full-time student at an educational institution or is physically or mentally incapable of caring for himself or herself, such spouse shall be deemed to have earned income of $250 per month if you have one dependent and $500 per month if you have two or more dependents.

**2**. Your Plan Year election cannot be changed unless you experience a qualifying life status event.

**3.** If your participation in the Plan terminates, you may continue to file claims for qualifying expenses incurred prior to your termination during the same Plan Year until you have been reimbursed the balance of your account. In addition, please refer to the continuation of coverage section titled *Continuation of Coverage under COBRA*.

**4**. You must submit a completed claim form along with copies of invoices or statements from the provider to serve as proof that you have incurred an allowable expense to receive payment. 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. Documentation and/or copies will not be returned. You will be provided with a supply of claim forms with your enrollment confirmation. Extra claim forms are available from the HealthSCOPE Benefits web site at www.healthscopebenefits.com or by calling 1-888-763-8232. In lieu of providing the above documentation, you may have the provider complete the dependent care section of the claim form and sign on the line provided. The dependent care services must have been provided before you file a claim for those services.

**5**. Claim reimbursements may be made by direct deposit into the bank account of your choice. By using direct deposit, you will not need to wait for a check to arrive or get it deposited. A notice that a payment was made will be sent to you. This direct deposit notice is available by U.S. Mail or by e-mail. If you prefer, a check can be mailed to you instead of payment by direct deposit.

**6.** The tax identification (ID) number or Social Security number of the child/dependent care provider must be listed on each of your claim forms and your federal income tax return. Please check with your childcare provider (before enrolling in this category) to be sure that you can obtain their tax ID number or their Social Security number.

**7.** Participants on leave (paid or unpaid) under FMLA or USERRA leave are entitled to terminate coverage during the leave and reinstate coverage immediately on return to work. Such reinstatement must be made within 60 days of returning to work.

## Termination of Participation

Your participation in the Plan will terminate when:

- You are no longer an eligible employee; or,
- You no longer satisfy the conditions for participation in the plan; or,
- You revoke all elections under the plan; or,
- The Plan terminates.

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

You will not be able to receive reimbursement for expenses that are incurred after your participation terminates.

## Continuation of Coverage under COBRA

### Health Reimbursement Only

If your health benefits and FSA coverage terminates because of a qualified event i.e., termination of employment (does not include retirement), you may continue your FSA coverage if you elect COBRA. Information regarding continuation of your FSA is included in the COBRA notification form that you receive from PEBP. Please note that continuation of FSA coverage only applies if you have a positive HCFSA account balance (including the remaining monthly administrative fee and the 2% COBRA administrative fee). COBRA FSA benefits will end on the earlier of:

- You cease paying the monthly administration fee;
- Your remaining 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. Employees 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

You are required to file Schedule 2 with your IRS Form 1040A or Form 2441 with your IRS Form 1040 to support the amount redirected (pre-taxed) for the calendar year. Please note that this is for informational purposes. You will not pay taxes on the redirected amount. Claim reimbursements made to you under this category are not taxable, but the amount redirected will appear on your W-2 form. This will inform the IRS that you have received a tax break on that expense through the FSA.

## Employer Responsibilities

The employer shall perform the following responsibilities:

- Maintaining all Plan records;
- Filing tax returns and reports required under federal and state law and complying with all 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 all 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 all 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 authorize such delegation. The board of directors, if applicable, may also delegate their responsibilities to officers or employees of the employer.

## Claims Administrator Responsibilities

Under the Plan, HealthSCOPE Benefits, Inc. ("HealthSCOPE Benefits") 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.

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

## FSA Frequently Asked Questions (FAQs)

**Health Care FSA (HCFSA)**

### 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?

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

### Do all 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 $550 to the following Plan Year. Funds in excess of $550 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 $550 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 $550 HCFSA 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 HealthSCOPE Benefits 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 2022 (July 1, 2021 – June 30, 2022) is $2,750 for the HCFSA or the LPFSA. The $2,750 limit does not include the potential carryover of up to $550 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 $2,750 deduction.

- For Plan Year 2022, 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 HealthSCOPE Benefits within 60 days of a qualifying life status event. HealthSCOPE Benefits may request proof of a qualifying life status event.

A. 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.

   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.

   If participation 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 event 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.
   - Employee 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 resulted 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, employee must revoke any DCFSA since employee is not working. Upon returning from FMLA or USERRA leave, employee 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, employee will not be entitled to receive reimbursements for claims incurred during the period when the coverage is terminated. If 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, employees 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 denied claims. You will have 30 days to file a written appeal of that specific claim denial with the HealthSCOPE Benefits claims office. The HealthSCOPE Benefits claims office will provide you with a written notice of the resolution of this appeal within 60 days of the appeal.

# General Provisions

## General Provisions

### Effective Date of the Plan

The Effective Date of the modifications herein is July 1, 2021.

### 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.

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 all contributors.

### Plan Administrator

PEBP has contracted with HealthSCOPE Benefits, Inc. to process all claims for the Flexible Spending Account program. Contact HealthSCOPE Benefits, Inc. if you have questions regarding claims or eligible expenses.

| | |
|---|---|
| Address: | P.O. Box 3627, Little Rock, AR 72203 |
| Phone: | 1-888-7NEVADA (1-888-763-8232) |
| Fax: | 1-877-240-0135 |
| Web: | www.healthscopebenefits.com |

### Plan Sponsor and Plan Administration

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 Sponsor and functions as the Plan Administrator, unless another individual or entity is appointed by the Plan Sponsor. The Plan Administrator shall have full charge of the operation and management of the plan. The Plan Sponsor has retained the services of HealthSCOPE Benefits, Inc. to administer the benefits described in this Summary Plan Description.

### 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

The employer reserves the right to amend the Plan at its sole discretion. The employer will communicate to the participant in writing regarding any such changes that affect you.

Any amendments to the Plan will be incorporated in writing into the master copy of the Plan on file with the employer, or a written copy will be kept with the master copy of the plan.

### 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 has 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 employees, 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 null and void.

## 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.

## Useful Links

IRS Publication 502: Medical and Dental Expenses

IRS Publication 503: Child and Dependent Care Expenses

IRS Publication 504: Special rules for children of divorced parents

IRS Publication 969 Health Savings Accounts and other Tax-Favored Health Plans

HealthSCOPE BENEFITS

## HEALTH CARE & DEPENDENT CARE REIMBURSEMENT REQUEST

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM PEBP Health Matters.

| EMPLOYEE INFORMATION | | | |
|---|---|---|---|
| NAME: | SSN #: | PHONE #: | |
| ☐ CHECK HERE IF NEW ADDRESS | EMPLOYER NAME: | | |
| ADDRESS: | EMAIL ADDRESS: | | |
| CITY: | STATE: | ZIP: | |

**REIMBURSABLE EXPENSES**

| DATES OF SERVICE - (MM/DD/YY) | | PROVIDER OF SERVICE *If Dependent Care service, SSN or ID number must be included. | PERSON FOR WHOM SERVICE WAS PROVIDED | EXPENSE TYPE* | REIMBURSEMENT AMOUNT REQUESTED |
|---|---|---|---|---|---|
| Start Date | End Date | | | | |
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |
| * Expense Type: M= Health Care / D= Dependent Care | | | | TOTAL: | $ |

**CERTIFICATION**

I certify the following is true:

1. The expenses listed above were incurred by me and/or my eligible dependents and qualify for reimbursement.
2. The expenses listed above are not eligible for reimbursement by any health care plan.
3. I have not and will not deduct the above listed expenses on my Federal Income Tax returns.
4. The appropriate bills, receipts, Explanation of Benefit statements or documentation for dependent care expenses are attached or verified by provider signature below.

| | |
|---|---|
| **Employee Signature**: | **Date:** |
| Provider of Dependent Care must certify dates and amounts listed above are correct for services rendered.<br>**Provider Signature:** **Provider Tax ID:** | **Date:** |

*Any person who knowingly and with intent to defraud or deceive any health care plan, files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime.*

PLEASE SEND COMPLETED FORM TO:

MAIL: HealthSCOPE Benefits
P.O. Box 3627
Little Rock, AR 72203

E-MAIL: PEBPFSA@HealthSCOPEBenefits.com

FAX: 877-240-0135 -OR- 501-218-7603
(Monday–Friday from 8am to 5pm CST)

FOR MORE INFORMATION ABOUT YOUR ACCOUNT, PLEASE VISIT OUR WEBSITE:
www.healthscopebenefits.com

**CUSTOMER SERVICE**
**1-888-763-8232**