FLEXIBLE SPENDING ACCOUNTS (FSA)
HEALTH CARE FSA
DEPENDENT CARE FSA
LIMITED SCOPE FSA

Plan Year 2014
July 1, 2013 – June 30, 2014

Summary Plan Description
and
Employee Enrollment

Public Employees’ Benefits Program (PEBP)

Administered By:

HealthSCOPE BENEFITS

P.O. Box 3627
Little Rock, AR 72203
1-888-7NEVADA
(1-888-763-8232)

www.healthscopebenefits.com
and www.pebp.state.nv.us
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The Basics of Flexible Spending Accounts

What are Flexible Spending Accounts (FSA’s)?

Flexible Spending Accounts (FSA’s) are a way to pay out-of-pocket (un-reimbursed) health care expenses (Medical FSA) and dependent care expenses (Dependent Care FSA) on a BEFORE-TAX basis!

This Plan is administered in accordance with the provisions of Federal regulations for a Section 125 Plan.

What is a Limited Purpose Flexible Spending Account?

A Limited Purpose (or Limited Scope) Flexible Spending Account is a savings option for employees that are enrolled in a Health Savings Account (HSA). In a Limited Purpose Flexible Spending Account you can only submit claims for eligible vision and dental expenses.

What Does “Before Tax” or “Pre-Tax” Mean?

FSA deductions from your paycheck are exempt from federal tax. These deductions reduce your taxable income reported on your income tax return.

Why Should I Participate?

Tax Savings Example

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. This example shows how an FSA could save this employee $375 in taxes!

<table>
<thead>
<tr>
<th></th>
<th>Without FSA</th>
<th>With FSA</th>
<th>Savings with FSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Compensation</td>
<td>$30,000</td>
<td>$30,000</td>
<td></td>
</tr>
<tr>
<td>Tax Free Expenses</td>
<td>0</td>
<td>1,500</td>
<td></td>
</tr>
<tr>
<td>Taxable Income</td>
<td>$30,000</td>
<td>$28,500</td>
<td>$375</td>
</tr>
<tr>
<td>Federal Tax (after $5,000 exemptions)</td>
<td>6,250</td>
<td>5,875</td>
<td>$375</td>
</tr>
<tr>
<td>Net Paycheck</td>
<td>$23,750</td>
<td>$22,625</td>
<td></td>
</tr>
<tr>
<td>After Tax Expenses</td>
<td>1,500</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Actual Take Home Pay</td>
<td>$22,250</td>
<td>$22,625</td>
<td>$375</td>
</tr>
</tbody>
</table>

This person could reduce their taxes by $375 by using the FSA!!

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.
Eligibility and Enrollment

To be eligible 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.

NOTE: Active employees covered under the PEBP Consumer Driven Health Plan (CDHP) with an HSA have a limited scope FSA benefit. You can use the limited scope FSA benefit to help pay for vision and certain dental expenses.

The FSA 2014 plan year is July 1, 2013 through June 30, 2014. FSA 2014 Open Enrollment (OE) will be held during in May, 2013. Check with PEBP or your agency representative to confirm future open enrollment dates. To participate in a flexible spending account, you must enroll during open enrollment each year for the upcoming plan year. You may also be eligible to enroll mid-year if you experience a qualifying life status event. The Medical and Dependent Care FSA have slightly different rules regarding making an election change or enrolling mid-year. See the chart below which sets out mid-year election change events and their applicability.

<table>
<thead>
<tr>
<th>Events Permitting Election Change</th>
<th>Dependent Care FSA</th>
<th>Health Care FSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Special Notes Concerning “Changes in Status”:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. In the event of a divorce, annulment, legal separation, death of spouse/dependent or dependent ceasing to be eligible, the Employee may only be permitted to change or revoke the election for the affected individual.</td>
<td>Applies</td>
<td>Applies</td>
</tr>
<tr>
<td>2. 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 Health Care FSA election, and/or Dependent Care FSA election only if the coverage under the other health care plan takes effect or is increased.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change Type</td>
<td>Applies</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>---------</td>
<td>----------------</td>
</tr>
<tr>
<td><strong>Cost Changes with Automatic Increase/Decrease in Elective Contributions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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).</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Significant Cost Changes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Significant Curtailment of Coverage</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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).</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Addition or Significant Improvement of Benefit Package Option</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Change in Coverage under other Employer Cafeteria Plan or Qualified Benefits Plan</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Loss of Coverage under Group Health Plan of Governmental or Educational Institution</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Changes in 401(k) Contributions</strong></td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
<tr>
<td><strong>HIPAA Special Enrollment Rights</strong></td>
<td>Not Applicable</td>
<td>Applies</td>
</tr>
<tr>
<td><strong>COBRA Qualifying Events</strong></td>
<td>Not Applicable</td>
<td>Applies</td>
</tr>
<tr>
<td>Judgment, Decree or order</td>
<td>Not Applicable</td>
<td>Applies</td>
</tr>
<tr>
<td>--------------------------</td>
<td>----------------</td>
<td>---------</td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare or Medicaid Eligibility</td>
<td>Not Applicable</td>
<td>Applies</td>
</tr>
<tr>
<td>FMLA Leaves of Absence</td>
<td>Applies</td>
<td>Applies</td>
</tr>
<tr>
<td>Pre-Tax HSA Contributions</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

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.

In addition, the following rules apply to enrollment:

- Mid-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, then the FSA coverage date will be the first of the month following.
- A new benefits-eligible employee must enroll with HealthSCOPE Benefits within 60 days of their health coverage effective date to obtain this coverage.
- You may also make future changes to your account within 60 days of any qualifying life status event.
- Employees enrolling for the first time should only include reimbursable expenses for services received from the FSA coverage effective date through the end of the plan year (June 30th).

**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.

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

**Claims Processing**
- Claim forms available at – www.healthscopebenefits.com
- 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
Before You Enroll

Medical FSA
♦ Long-term health care expenses do not qualify for reimbursement.
♦ Cosmetic procedures generally do not qualify.
♦ Orthodontic claims may be reimbursed as payments for orthodontia treatment are made.

Dependent Care FSA
♦ Documentation Requirement
♦ Required tax filing (Schedule 2 or Form 2441)

All claims must be filed by October 31st following the end of the Plan Year

Termination of Participation
Your participation in the Plan will terminate when:
• You are no longer an eligible employee;
• You no longer satisfy the conditions for participation in the Plan;
• 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.
Section II: Frequently Asked Questions

If I redirect (pre-tax) part of my pay, won’t I make less money?
No. By electing to direct a portion of your salary through an FSA, you essentially bank your money in a TAX-FREE account, which allows you to save money by reducing your taxes. For example, you pay an office visit co-payment to your doctor and then claim reimbursement for this expense from your TAX-FREE account. You pay no taxes on this reimbursement, and your spendable income will increase by the amount of your tax savings.

Why should I participate in the medical reimbursement account if I already have medical insurance?
The Medical Reimbursement Account offers a tax break on medical care expenses NOT reimbursed by insurance. For example, deductibles, co-pays, coinsurance, expenses for office visits, eye exams, glasses, prescribed medicine, and hospital care.

How much does it cost?
You pay a small fee of $3.25 per month to participate in either one or both flexible spending accounts.

What is the catch?
No catch. Congress approved FSA’s in 1978; the Tax Reform Act of 1986 reaffirmed their legitimacy. The plans have long been in many Fortune 500 companies’ benefit packages. Many state governments also include the plans in their benefit packages.

What if I don’t use all of the money in my Flexible Spending Account?
HealthSCOPE Benefits can help you estimate your allowable expenses for the plan year. However, if you do have funds remaining in your account at the end of the year, that amount will be forfeited by you as required by federal regulations.

Are there any negatives that I should know about?
If you do not use all the money in your account, you will forfeit it.

What if I’m already in the FSA?
Participation in both accounts terminates at the end of each plan year. You must re-enroll each year to continue your participation.

If I enroll in the PEBP Health Savings Account (HSA), can I still enroll in the regular Medical 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 Health Care FSA. However, you may sign up for the Limited Scope 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 health care FSA 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 the 2014 Plan Year is $2,500 for the health care FSA or the limited scope FSA.
NOTE: This is a per participant deduction limitation, not a household limitation, so if an employee and his/her spouse each have a health care FSA, they could each establish a health care FSA with a $2,500 deduction.

- For Plan Year 2014 (July 1, 2013 – June 30, 2014) your maximum monthly payroll contribution is $208.33.
- The Dependent Care FSA Plan calendar year limit is established by the IRS. You and your spouse may together elect a maximum of $5,000 for both the 2013 and 2014 Tax Years. Also, if you are married and do not file a joint tax return you can set aside up to $2,500 in the dependent care.

**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. However, if you plan well, that should not be a problem since you will only elect deductions equal to expenses that you know you will have.

You might be able to make a change under the following circumstances if you experience a life status event change;

- Are served with a judgment, decree or court order;
- Change your dependent care provider; or,
- Go on Family Medical Leave Act leave.

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.

Election changes are effective the first day of the month following the Plan Administrator’s receipt and approval of written notification of the new election. (For example: Your healthcare coverage is effective on February 1st and you submit your FSA enrollment on February 2nd, your expenses starting on March 1st will be reimbursable.) Any increase in the election amount designated by a participant may include only those expenses that the participant incurs **on or after the effective date of the increase**.

All changes shall be consistent with the 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 Dependent Care FSA, but not under the Medical FSA.

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 you return 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 Medical FSA 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.

For example:
- You adopt a two-year-old child during the plan year.
- Since your number of dependents changes due to the adoption, you experience a life status event.
- Your child is now eligible for coverage under the Medical and Dependent Care FSA’s.
- You would be allowed to increase the amount you set aside in the Medical and Dependent Care FSA’s, or enroll in those plans if you are not already enrolled.
- However, you would not be able to decrease or drop either category because there was only a gain of eligibility, and not a loss of eligibility.
- A decrease does not correspond with the gain of eligibility.

B. 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 your child allows you to make an election change to your Medical FSA, to:
   a. Provide coverage for the child, if the order requires coverage under your plan; or,
   b. Cancel coverage for the child, if the order requires your former spouse to provide coverage.

C. If you change dependent care providers, you may make an election change to reflect the cost of the new provider. Election decreases are allowed when your 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.)

D. If you take an unpaid leave under the Family Medical Leave Act (FMLA) or Uniformed Services Employment and Reemployment Rights Act (USERRA) for more than 31 days, you may revoke an existing election under the Medical FSA. However, you must revoke your Dependent Care FSA since you are not working. Upon returning from FMLA or USERRA leave, you 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. You 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 your coverage under the Medical or Dependent Care FSA’s terminates while you are on FMLA or USERRA leave, you will not be entitled to receive reimbursements for claims incurred during the period when the coverage is terminated. If you elect to be reinstated in a benefit upon return from FMLA or USERRA leave your coverage for the remainder of the plan year is equal to your 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.)

**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.
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 2014 is July 1, 2013 – June 30, 2014)

Enroll in the Medical Health Care FSA or Limited Scope FSA. Enter your estimated medical/dental/vision care for the Plan Year. (Deductions are generally taken out of the second check of each month.) Contact your agency representative if you need assistance. Remember, your maximum monthly contribution is $208.33.

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.

Receive reimbursements. 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.

Use 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 of the paperwork). The card is a great benefit, but it is important that you take a moment and understand how it works.

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).

1) 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.).

2) 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 don’t submit requested documentation?**

Federal regulations require that 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.

**Is there a cost for the card?**

No. There is no additional cost for the FSA Debit Card.

**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.
Important Points:

1. **Maximum Plan Election:** You may include up to $2,500 worth of qualifying expenses --but not more than your earned income.

2. **Your plan year election cannot be changed,** unless you experience a qualifying life status event.

3. **Medical FSA when you do not have an HSA:** You may include all medical, dental and vision expenses not covered or not reimbursed by insurance 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. Please refer to the list on page 10 and IRS Publication 502 for further details on qualifying expenses.

   NOTE: Active employees covered under the PEBP CDHP with an HSA have a limited scope FSA benefit. You can use the limited scope FSA benefit to help pay for vision and certain dental expenses only.

4. 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 dependents is provided with medical care or purchases a qualifying product, and not when you are billed, are charged, or pay for the expense.

5. Allowable expenses must be incurred during the portion of the plan year or grace period 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. After that, your account will be closed and you will forfeit any balance remaining in accordance with federal regulations.

   **Grace Period:** If you are a participant as of June 30th of a Plan Year, you may continue to incur expenses through September 15th to use any remaining funds in the Plan Year that just ended. Claims for expenses incurred during this Grace Period are paid from the oldest year’s funds first unless you request otherwise.

6. **You must submit a completed claim form along with copies of invoices or statements** to serve as proof that you have incurred an allowable expense in order 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 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.
   - Copies of receipts of payment, without the above, are not acceptable.
   - Copies of personal checks or credit card receipts are not sufficient documentation.
   - 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.

7. 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.

8. 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.

9. 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.

10. Participants on Family Medical Leave Act leave are entitled to maintain coverage for the Medical FSA. Coverage and claims reimbursement will not be disrupted as long as monthly contributions are received (either by payroll deduction or by direct payment to the Plan) by the end of each month. The participant must make arrangements, before going on leave, with their agency representative 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.

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

12. If you are enrolled in the Health Savings Account, you may sign up for the Limited Scope FSA, and use pre-tax money to pay for vision or dental expenses. The advantage to signing up for this program is that you can allow your HSA funds to stay in an interest bearing account, and still use pre-tax money for eligible expenses.
Medical/Limited Purpose FSA -- 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
- Co-pays
- Coinsurance
- Doctor’s fees
- Dental expenses -
- Vision care expenses
- Prescription glasses
- Contact lenses and solutions
- Corrective eye surgery
- Drugs and medicines
- Insulin
- Orthodontics (braces)
- Routine physicals
- Medical equipment (necessary for an existing medical condition)
- Hearing aids, including batteries
- Transportation expenses related to illness
- Chiropractor’s fees

**Note:** If you are covered under the PEBP CDHP and have an HSA, your FSA benefits are defined as a Limited Scope/Purpose FSA, your qualified expenses are limited to dental and vision services.

**NOTICE - Changes due to the Patient Protection and Affordable Care Act (PPACA)**

The federal health care reform bill passed in March, 2010 states that as of January 1, 2011, over the counter (OTC) drugs and medicines will only be reimbursable through your Health Care FSA if you have a valid prescription. See the list below for examples of OTC medicines. Insulin still qualifies for reimbursement without a prescription.

Equipment, supplies, and diagnostic devices such as bandages, hearing aid batteries, blood sugar test kits, etc. will remain eligible for reimbursement without a prescription.

Following is a list of examples of OTC medicine categories no longer eligible for reimbursement without a prescription after January 1, 2011:
<table>
<thead>
<tr>
<th>Acid Controllers</th>
<th>Allergy &amp; Sinus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anti-Diarrhea Products</td>
<td>Anti-Gas Products</td>
</tr>
<tr>
<td>Anti-Itch &amp; Insect Bite Products</td>
<td>Baby Rash Ointments</td>
</tr>
<tr>
<td>Cold Sore Remedies</td>
<td>Cough, Cold &amp; Flu Products</td>
</tr>
<tr>
<td>Digestive Aids</td>
<td>Hemorrhoid Remedies</td>
</tr>
<tr>
<td>Laxatives</td>
<td>Motion Sickness</td>
</tr>
<tr>
<td>Pain Relievers</td>
<td>Respiratory Treatments</td>
</tr>
<tr>
<td>Sleep Aids &amp; Sedatives</td>
<td>Stomach Ailment Remedies</td>
</tr>
</tbody>
</table>

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.

**Non-Qualifying Expenses**

- Cosmetic procedures; e.g. face-lifts, skin peeling, teeth whitening, veneers, hair replacement, removal of spider veins
  *These services do not generally qualify. For a medically necessary cosmetic procedure, enclose a note with the claim stating the existing medical condition and why the treatment is required.*
- Sun glasses, non-prescription or clip-on sunglasses
- Toiletries
- Expenses that are merely beneficial to your general health (e.g., vacations and vitamins)
- Herbs, vitamins and nutritional supplements not used to treat an existing diagnosed medical condition
- The cost of a weight-loss program if the purpose of the weight control is to maintain your general good health
- Health club dues
Section V: Dependent Care FSA

Estimate your total dependent care expenses for the plan year. Include predictable expenses only. Remember that Plan Year 2014 is July 1, 2013 – June 30, 2014.

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. Remember to not exceed $5,000 in any calendar 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. 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.

The Dependent Care FSA is limited to $5,000 for Plan Year 2014 for any number of dependents. In no event shall a married individual filing a separate tax return for the calendar year exceed $2,500. You will experience “tax savings” throughout the year with every paycheck you receive. If you are subject to the 25% federal tax rate you will save approximately 25% of expenses through the Dependent Care FSA. If you pay a higher federal rate, you will receive an even higher tax break through the Dependent Care FSA.

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 Dependent Care FSA.

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 Dependent Care FSA.

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 your (after subtracting all FSA deductions) 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. You may include only those child/dependent care expenses that you incur in order 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 in order for you to work are allowable but overnight camps are not. Please refer to page 13 and IRS Publication 503 for further details on qualifying expenses. You may access this publication at [www.irs.gov/pub/irs-pdf/p503.pdf](http://www.irs.gov/pub/irs-pdf/p503.pdf).

3. 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.

**4. YOUR PLAN YEAR ELECTION CANNOT BE CHANGED,** unless you experience a qualifying life status event.

5. 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.

6. 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.

7. Reimbursable **expenses** must be **incurred** during the portion of the plan year **after you become a participant. You must file claims** for expenses that you incurred during the plan year or grace period **by October 31st** following the end of the plan year. After that, your account will be closed and **any remaining balance will be forfeited** by you in accordance with federal regulations.

**Grace Period:** If you are a participant as of June 30th of a Plan Year you may continue to incur expenses through September 15th to use any remaining funds in the Plan Year that just ended. Claims for expenses incurred during this Grace Period are paid from the oldest year’s funds first unless you request otherwise. The FSA debit card will not be loaded with funds from the previous plan year. It is only loaded with funds from the current plan year, so it will be necessary for you to submit reimbursement requests to access funds during the FSA Grace Period.

8. If your participation in the Plan **terminates**, you may continue to file claims for qualifying expenses incurred **prior** to termination during the same plan year until you have been reimbursed the balance in your account. **You must file claims** for expenses that you incurred during the plan year **by October 31st** following the end of the plan year. In addition, please refer to the continuation of coverage section of the document titled COBRA.

9. **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 in order 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](http://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.**
10. **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.

11. 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 are able to obtain their tax ID number or their Social Security number.

13. **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.

14. 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.**

**Dependent Care FSA – 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**

- 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 age 13 or older who is not disabled
- Overnight care or camps
- Instructional or sport specific camps; e.g. Ballet camp, soccer camp, summer school
Section VI: Notices

Women's Health Cancer Rights Act of 1998
The Medical FSA as required by the Women’s Health and Cancer Rights Act of 1998, includes expenses for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Call HealthSCOPE Benefits at 1-888-763-8232 for more information or visit the following website http://www.dol.gov/index.htm.

Newborns' and Mothers' Health Protection Act of 1996
Group health plans and health insurance issuers 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 less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's nor 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). For more information please visit the following website http://www.dol.gov/index.htm.

HIPAA Privacy
The Privacy Rule provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes. For more information please visit the following website http://www.hhs.gov/ocr/office/index.html.
Section VII: Continuation Of Coverage Under COBRA  
(Health reimbursement only)

In the event that 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 Health FSA 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 as a result 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.
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 is in conflict 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.

Effective Date of the Plan
The Effective Date of the modifications herein is July 1, 2013.

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, as the case may be. 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 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.

**Plan 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, with no administrative cost to the participant. Any forfeited funds may be used by the Employer, at its discretion, to pay for administration of the Plan, to offset distributions from health care accounts that exceed contribution, or for redistribution to all contributors.

**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 or not such payment was made due to the Plan Administrator’s own error.

The Plan reserves the right to follow certain correction procedures in order 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 still 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 “Requesting Reimbursement & Appeal Rights.”

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.

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 also 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.

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 Health Care FSA and/or Dependent Care FSA, 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 is merely providing assistance with the administration of this Plan by adjudicating claims in accordance with the terms of the Plan.
# FLEXIBLE SPENDING ACCOUNT REIMBURSEMENT REQUEST FORM

## EMPLOYEE INFORMATION

<table>
<thead>
<tr>
<th>Name:</th>
<th>SSN #:</th>
<th>Phone #:</th>
</tr>
</thead>
</table>

| Check Here If New Address | Employer Name: |

| Address: | Email Address: |

| City: | State: | Zip: |

## REIMBURSABLE EXPENSES

<table>
<thead>
<tr>
<th>Dates of Service - (MM/DD/YY)</th>
<th>Provider of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start Date</td>
<td>End Date</td>
</tr>
</tbody>
</table>

*If Dependent Care service, SSN or ID number must be included.*

<table>
<thead>
<tr>
<th>Person for Whom Service Was Provided</th>
<th>Expense Type</th>
<th>Reimbursement Amount Requested</th>
</tr>
</thead>
</table>

| $ | $ | $ | $ | $ | $ | $ | $ |

* Expense Type: M= Health Care / D= Dependent Care

**TOTAL:** $

## CERTIFICATION

I certify that the work-related transit and/or parking expenses submitted for reimbursement were incurred by me during the period I was a participant in the Plan. I understand that the charges for which I am submitting reimbursement are eligible charges for reimbursement under the Plan in accordance with IRS guidelines. I also understand that I am solely responsible for submitting proper documentation of my eligible transit and/or parking expenses, and that I may be required to substantiate in the event of an employer or IRS inquiry that these are work related expenses that are eligible to be excluded from my federal taxable wages. I certify that I am responsible for compliance with all applicable administrative processes, tax regulations and documentation. I request reimbursement for the expenses itemized above and further certify that the information provided is true and correct. I will retain a copy of this form and all original receipts for my records.

**Employee Signature:**

**Date:**

Provider of Dependent Care must certify dates and amounts listed above are correct for services rendered.

**Provider Signature:**

**Provider Tax ID:**

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:** pebphsahra@healthscopebenefits.com

**FAX:** 877-240-0135

**FOR MORE INFORMATION ABOUT YOUR ACCOUNT, PLEASE VISIT OUR WEBSITE:**

www.healthscopebenefits.com

**CUSTOMER CARE**

888-763-8232