Flexible Spending Accounts (FSA)
Health Care (Medical) FSA
Dependent Care FSA
Limited Purpose/Scope FSA

Plan Year 2018
July 1, 2017 – June 30, 2018

Summary Plan Description
&
Employee Enrollment

Public Employees' Benefits Program (PEBP)

Administered By:

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Amendment Log

Any amendments, changes or updates to this document will be listed here.

The Basics of Flexible Spending Accounts

Flexible Spending Accounts

Flexible Spending Accounts (FSAs) 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 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.

Health Care (medical) FSA

A Health Care FSA, sometimes referred to as a medical FSA or general purpose FSA, is a savings option for active employees covered under the PEBP Consumer Driven Health Plan (CDHP) or PEBP contracted HMO Plan who do not qualify for a Health Savings Account (HSA).

Health Care FSA When <u>You Do Not Have an HSA</u>

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 IRS Publication 502 under the section titled "What Medical Expenses Are Includible" for further details on qualifying expenses.
Some examples of eligible medical expenses are:

- Chiropractor
- Contact lenses, including saline solution and enzyme cleaner expenses.
- Orthodontic claims may be reimbursed as payments for orthodontia treatment are made.

Some examples of non-eligible medical expenses are:

- Long-term health care expenses do not qualify for reimbursement.
- Cosmetic procedures generally do not qualify.

Limited Purpose/Scope FSA When <u>You Do Have an HSA</u>

A Limited Purpose /Scope Flexible Spending Account is a savings option for active employees covered under the PEBP Consumer Driven Health Plan (CDHP) with a Health Savings Account (HSA). A Limited Purpose/Scope health FSA is much like a health care FSA. The main difference is that the limited purpose account 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 rules state that you cannot have both an HSA and a health care FSA since both apply funds toward your medical expenses. A limited purpose FSA allows you to continue to contribute to an HSA. You maximize your savings and tax benefits by restricting your FSA reimbursement to only vision and dental expenses.

Dependent Care FSA

A dependent care FSA is a savings option for active employees covered under the PEBP Consumer Driven Health Plan (CDHP) or PEBP contracted HMO Plan that allows you to pay for dependent care expenses and lower your taxable income. Here's 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 Chapter in this document 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 (health care, limited purpose and/or dependent care), 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 health care 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.

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 health care 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 expenses. Also, the Dependent Care FSA 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.

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

	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**

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.

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 2018 plan year is July 1, 2017 through June 30, 2018. FSA 2018 Open Enrollment (OE) will be held during in May 2017. Check with PEBP or your agency representative to confirm future open enrollment dates. To participate in an FSA, you must enroll during open enrollment each year for the upcoming plan year.

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, the FSA coverage effective date will be determined by HealthSCOPE.

- 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).

You may also be eligible to enroll mid-year if you experience a qualifying life status event. The health care and limited purpose FSA's and dependent care FSA have slightly different rules regarding making an election change or enrolling mid-year. Your plan year election cannot be changed, unless you experience a qualifying life status event.

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

Health Care & Limited Purpose FSAs & 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 Special Notes Concerning "Changes in Status": • In the event of **Divorce**, **Annulment**, **Legal Separation**, **Death of spouse/dependent** or **Dependent ceases to be eligible**, the Employee may only be permitted to change or revoke the election for the affected individual. • In the event **Eligibility is Gained** under family member coverage through another employer health care plan as a result of a change in marital status or employment status, the Employee may be permitted to change or revoke his or her 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.	Applicable Applicable	Applicable Applicable
Cost Changes with Automatic Increase/Decrease in Elective Contributions This change applies whether due to action by the Employer (e.g., reduced employer contribution) or Employee (e.g., switching to part-time employment status).	Applicable	Not Applicable
Significant Cost Changes The change applies when the cost charged to 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 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

Health Care & Limited Purpose FSAs & 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**
Addition or Significant Improvement of Benefit Package Option	Applicable	Not Applicable
Change in Coverage under other Employer Cafeteria Plan or Qualified Benefits Plan This change applies when the other cafeteria plan or qualified benefits plan permits participants to make an election change that would be permitted; or the cafeteria plan permits participants to make an election for a period of coverage that is different from the 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
Judgment, Decree or order This change applies when a dependent becomes eligible as the result of a judgment, decree or order resulting from divorce, legal separation, annulment or change in legal custody that requires accident or health coverage for a dependent child.	Not Applicable	Applicable
Medicare or Medicaid Eligibility	Not Applicable	Applicable
FMLA Leaves of Absence	Applicable	Applicable
Pre-Tax HSA Contributions	Not Applicable	Not Applicable

As used herein, "Applies" either means that the election can be revoked or it may be changed. Any change or revocation must be (a) consistent with the events described in this section to the extent that it is necessary or appropriate as the result of such change and (b) consistent with Treasury Regulation § 1.125-3, Treasury Regulation § 1.125-4, IRS Notice 2004-50 and 2004-33 I.R.B. 196.

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 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 (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.
- 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.

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 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

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 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 Medical FSA or Limited Purpose/Scope 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 2018 is July 1, 2017 – June 30, 2018)

Enroll in the Medical Health Care FSA or Limited Purpose/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, the maximum monthly contribution is $216.67.

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 of 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 **$3.25** 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 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.

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 health care FSA or limited purpose FSA contains an unused balance at the end of the plan year you may carry over up to $500 to the following plan year. Any unused balance in excess of $500 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 Medical Health Care FSA carryover.

Health Care/Limited Purpose FSA

The reimbursement limit for a health care FSA Plan is established by the Internal Revenue Service. The limit for calendar year 2017 is $2,600 for the health care FSA or the limited scope FSA. The $2,600 limit does not include the potential carryover of up to $500 remaining in your Medical Health Care FSA or Limited Scope 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/her spouse each have a health care FSA, they could each establish a health care FSA with a $2,600 deduction.

- For Plan Year 2018 (July 1, 2017 – June 30, 2018) your maximum monthly payroll contribution is $216.67.

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
- Co-insurance
- Doctor's fee
- 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

Non-Qualifying Expenses

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

- Cosmetic procedures; e.g. face-lifts, skin peeling, teeth whitening, veneers, hair replacement, and/or 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.
- Sunglasses, 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.

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 that are not eligible for reimbursement without a prescription:

- Acid controllers
- Anti-diarrhea products
- Anti-itch & insect bite products
- Cold sore remedies
- Digestive aids
- Laxatives
- Pain relievers
- Sleep aids & sedatives
- Allergy & sinus products
- Anti-gas products
- Baby rash ointments
- Cough, cold & flu products
- Hemorrhoid remedies
- Motion sickness
- Respiratory treatments
- Stomach ailment remedies

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 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.

Establishing & Using the Dependent Care FSA

Estimate your total dependent care expenses for the plan year

Include predictable expenses only. Remember that Plan Year 2018 is July 1, 2017 – June 30, 2018.

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

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 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.

The Dependent Care FSA is limited to $5,000 for calendar year 2017 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. 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 of the document titled 'Termination & 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 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 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 are able to 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

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.

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 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.

FSA Frequently Asked Questions (FAQs)

If I redirect (pre-tax) part of my pay, will 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 me?

You pay a small administration fee of **$3.25** per month to participate in either one or both (medical and/or dependent care) 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 do not use all of the money in my Flexible Spending Account?

HealthSCOPE Benefits can help you estimate your allowable expenses for the plan year. If you have **funds remaining in your Dependent Care FSA 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 Medical Health Care FSA or Limited Scope FSA at the end of the year**, you will be permitted to carry over up to $500 to the following plan year. **Funds in excess of $500 will be forfeited**.

Are there any negatives that I should know about?

If you do not use all the money in your Dependent Care FSA, **you will forfeit it**. You will only be able to carry over up to $500 of your Medical Health Care FSA or Limited Scope 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 $500 Medical Health Care FSA carryover will make you ineligible for the PEBP Health Savings Account. To be eligible for the PEBP Health Savings Account you may either elect to decline the carryover prior to the next plan year or switch your enrollment to the Limited Scope 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 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 Plan Year 2018 (July 1, 2017 – June 30, 2018) is $2,600 for the health care FSA or the limited purpose FSA. The $2,600 limit does not include the potential carryover of up to $500 remaining in your Medical Health Care FSA or Limited Scope FSA from one year to another.

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 $2,600 deduction.

- For Plan Year 2018 (July 1, 2017 – June 30, 2018) your maximum monthly payroll contribution is $216.67.
- 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 2017 and 2018 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. 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 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:
   1. Provide coverage for the child, if the order requires coverage under your plan; or,
   2. 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.

General Notices and Provisions

General Provisions

Effective Date of the Plan

The Effective Date of the modifications herein is July 1, 2017.

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 health care 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
Email:	pebphsahra@healthscopebenefits.com
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 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.

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 '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 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.

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.

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.

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.

Michelle's Law

Under the Public Employees' Benefits Program ("PEBP"), most dependent children are eligible for health coverage until age 26. However, dependent children under a legal guardianship who are unmarried are generally eligible for health coverage until age 19. Eligibility for dependent children under a legal guardianship may be extended beyond age 19 to age 26 if the child satisfies all of the following conditions:

1) Remains unmarried;
2) Is either enrolled as a full-time student at an accredited institution or resides with the Participant;
3) Is eligible to be claimed as a dependent on the Participant's or his/her Spouse's or Domestic Partner's federal income tax return for the preceding calendar year; and
4) Is a grandchild, brother, sister, step-brother, step-sister, or descendent of such relative.

Because eligibility may be conditioned on maintaining full-time student status, Michelle's Law applies only to the extended eligibility for dependent children under a legal guardianship from ages 19 -26 who meet the conditions above.

Should a dependent child under a legal guardianship (as described above) take a medically necessary leave of absence for a serious illness or injury that causes loss of full-time student status, his or her coverage cannot be terminated before the date that is the earlier of - (1) one year after the first day of the medically necessary leave of absence; or (2) the date on which such coverage would otherwise terminate under the terms of the PEBP. A written certification stating that the dependent child is suffering from a serious illness or injury and that the leave of absence is medically necessary must be provided by a treating physician of the dependent child to PEBP in order for eligibility and coverage to continue.

For more details or to notify PEBP of a medically necessary leave of absence, please contact PEBP at (775) 684-7000 or (800) 326-5496.

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.

Privacy Notice

Disclosure and Access to Medical Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices ("Notice") applies to Protected Health Information (defined below) associated with PEBP to its participants and their covered dependents. This Notice describes how PEBP collectively as we, us, or our may use and disclose Protected Health Information to carry out payment and health care operations, and for other purposes that are permitted or required by law.

PEBP is declared a hybrid entity, the Plan is an affiliated covered entity and this Notification of Privacy Practice serves as notification for all health care components, your health information may be shared between health plans for continuum of care.

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of Protected Health Information and to provide individuals covered under our Group Health Plan with notice of our legal duties and privacy practices concerning Protected Health Information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all Protected Health Information maintained by us. If we make material changes to our privacy practices, copies of revised notices will be provided to all participants and posted on the PEBP website.

Privacy Notice Definitions

Group Health Plan means, for purposes of this Notice, all health care components offered by PEBP to our participants and their covered dependents.

Protected Health Information ("PHI") means individually identifiable health information, as defined by HIPAA, that is created or received by us and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

Uses and Disclosures of Your Protected Health Information

The following categories describe different ways that we use and disclose PHI. For each category of Uses and Disclosures we will explain what we mean and, where appropriate, provide examples for illustrative purposes. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted or required to use and disclose PHI will fall within one of the categories.

Uses and Disclosures with Your Permission - We will not use or disclose your medical information for any other purposes unless you give us your written authorization to do so. For example, in general and subject to specific conditions, we will not use or disclose your psychotherapy notes, will not use or disclose your protected health information for marketing, or fundraising, unless you give us a written authorization. If you give us written authorization to use or disclose your medical information for a purpose that is not described in this notice, in most cases, you may revoke it in writing at any time. Your revocation will be effective for your medical information we maintain, except where we have already taken action in reliance on your prior authorization.

Uses and Disclosures for Payment – We may make requests, uses, and disclosures of your PHI as necessary for payment purposes. For example, we may use information regarding your medical procedures and treatment to process and pay claims. We may also disclose your PHI for the payment purposes of a health care provider or a health plan.

Uses and Disclosures for Health Care Operations – We may use and disclose your PHI as necessary for our health care operations. Examples of health care operations include activities relating to the creation, renewal, or replacement of your Group Health Plan coverage, reinsurance, compliance, auditing, rating, business management, quality improvement and assurance, and other functions related to your Group Health Plan.

Family and Friends Involved in Your Care – If you are available and do not object, we may disclose your PHI to your family, friends, and others who are involved in your care or payment of a claim. If you are unavailable or incapacitated and we determine that a limited disclosure is in your best interest, we may share limited PHI with such individuals. For example, we may use our

professional judgment to disclose PHI to your Spouse or Domestic Partner concerning the processing of a claim.

Business Associates – At times we use outside persons or organizations to help us provide you with the benefits of your Group Health Plan. Examples of these outside persons and organizations might include vendors that help us process and manage your healthcare claims such as third party administrators, pharmacy benefit managers, health plan auditors and health maintenance organizations. At times it may be necessary for us to provide certain components of your PHI to one or more of these outside persons or organizations, additionally, one of these outside organizations may disclose your PHI to PEBP.

Other Products and Services – We may contact you to provide information about other health-related products and services that may be of interest to you. For example, we may use and disclose your PHI for the purpose of communicating to you about our health insurance products that could enhance or substitute for existing Group Health Plan coverage, and about health-related products and services that may add value to your Group Health Plan or provide other health care component benefits such as voluntary health flexible spending accounts.

Other Uses and Disclosures – We may make certain Other Uses and Disclosures of your PHI without Your Authorization.

- We may use or disclose your PHI for any purpose required by law. For example, we may be required by law to use or disclose your PHI to respond to a court order.
- We may disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations
- We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- We may disclose your PHI if authorized by law to a government oversight agency (e.g., a state insurance department) conducting audits, investigations, or civil or criminal proceedings.
- We may disclose your PHI in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.
- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for cadaveric organ, eye or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services, and we may also disclose your PHI for other specialized government functions such as national security or intelligence activities.
- We may disclose your PHI to workers' compensation agencies for your workers' compensation benefit determination.
- We will, if required by law, release your PHI to the Secretary of the Department of Health and Human Services for enforcement of HIPAA.

- We may disclose your PHI to report adverse reactions to medications.
- We may disclose your PHI to assist with certain product recalls.

Plan Sponsors- PEBP may use or disclose protected health information to the plan sponsor of a group health plan, if applicable, provided that any such plan sponsor certifies the information provided will be maintained in a confidential manner and not used for employment related decisions or for other employee benefit determinations or in any other manner not permitted by law.

In the event applicable law, other than HIPAA, prohibits or materially limits our Uses and Disclosures of Protected Health Information, as described above, we will restrict our Uses and Disclosure of your Protected Health Information in accordance with the more stringent standard.

PEBP will notify you promptly as required by law, if a breach occurs that may have compromised the privacy or security of your information.

Rights That You Have

Access to Your PHI – You have the right of access to copy and/or inspect your PHI that we maintain in designated record sets. Certain requests for access to your PHI must be in writing, must state that you want access to your PHI and must be signed by you or your representative (e.g., requests for medical records provided to us directly from your health care provider). Access request forms are available from PEBP at the address provided below. We may charge you a fee for copying and postage.

Amendments to Your PHI – You have the right to request that PHI that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. To be considered, your amendment request must be in writing, must be signed by you or your representative, and must state the reasons for the amendment/correction request.

Accounting for Disclosures of Your PHI – You have the right to receive an accounting of certain disclosures, we or our business associates, have made of your PHI in the six years prior to the date of your request. We are not required to account for disclosures we made before April 14, 2003, or disclosures to you, your personal representative or in accordance with your authorization or permission; for treatment, payment and other health care operations activities; as part of a limited data set; incidental to an allowable disclosure; or for national security or intelligence purposes; or to law enforcement or correctional institutions regarding persons in lawful custody. To be considered, your accounting request must be in writing and signed by you or your representative. You are entitled to one free disclosure accounting every 12 months. We reserve the right to charge you a reasonable fee for each additional accounting you request during the same 12-month period.

Restrictions on Use and Disclosure of Your PHI – You have the right to request restrictions on certain of our Uses and Disclosures of your PHI for insurance payment or health care operations, disclosures made to persons involved in your care, and disclosures for disaster relief purposes. For example, you may request that we not disclose your PHI to your spouse. Your request must describe in detail the restriction you are requesting. We are not required to agree to your request

but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a

termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction. You may make a request for a restriction (or termination of an existing restriction) by contacting us at the telephone number or address below.

Restrictions on Use of Genetic Information - We will not use your genetic information that is PHI for underwriting purposes.

Request for Confidential Communications – You have the right to request that communications regarding your PHI be made by alternative means or at alternative locations. For example, you may request that messages not be left on voice mail or sent to a particular address. We are required to accommodate reasonable requests if you inform us that disclosure of all or part of your information could place you in danger. Requests for confidential communications must be in writing, signed by you or your representative, and sent to us at the address below.

Right to a Copy of the Notice – You have the right to a paper copy of this Notice upon request by contacting us at the telephone number or address below.

Complaints – If you believe your privacy rights have been violated, you have the right to file a complaint with us in writing at the address below. You may also file a complaint in writing with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C., within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

For Further Information

If you have questions or need further assistance regarding this Notice, you may contact PEBP's Privacy Officer at the address or telephone number provided below.

Effective Date

This Notice of Privacy Practices for PEBP is effective July 1, 2017, and replaces all other privacy notices that have been in effect since April 14, 2003.

The Plan Sponsor certifies that this Master Plan Document incorporates the provisions set forth in 45 CFR 164.504(f)(2)(ii) and the Plan Sponsor agrees to such provisions in accordance with 45 CFR 164.504(f)(2)(ii)

You will find a copy of this notice on the PEBP website and in the Plan documents. Please call PEBP with any further questions regarding the privacy notice. (775) 684-7000 or (800) 326-5496.

If you feel your privacy rights have been violated, you may file a complaint with PEBP or with the federal government through the Office of Civil Rights. You will not be penalized for filing a complaint.

PEBP Privacy Officer
901 S. Stewart St., Ste. 1001
Carson City NV 89701

Office of Civil Rights
Dept. of Health & Human Services
907 7th St., Ste. 4 -100

(775) 684-7000 Phone
(800) 326-5496
(775) 684-7028 Fax

San Francisco CA 94103
(800) 368-1019 Phone
(415) 437-8329 Fax
TDD (800) 537-7697

http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

By law, PEBP is required to follow the terms in this privacy notice. PEBP has the right to change the way your personal medical information is used and given out. If PEBP makes any changes to the way your personal medical information is used and given out, you will get a new notice within 60 days of the change.

PEBP Security Practices

By law, PEBP is required to:

- put in place administrative, physical, and technical safety measures to reasonably protect your personal medical information that is stored electronically;
- make sure there are security measures in place to protect and separate your personal medical information that is stored electronically from other agencies, employees, or employers who do not need access to it;
- make sure that any agents or vendors who help PEBP with its operations also have in place security measures to protect PEBP personal medical information; and,
- report to the PEBP security officer any security problems or incidences resulting from unauthorized access, use or interference of systems operations in a system containing PEBP personal medical information, known by PEBP or any agent or vendor.

HEALTH CARE & DEPENDENT CARE REIMBURSEMENT REQUEST

HealthSCOPE BENEFITS

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	PERSON FOR WHOM SERVICE WAS PROVIDED	EXPENSE TYPE*	REIMBURSEMENT AMOUNT REQUESTED
Start Date	End Date	*If Dependent Care service, SSN or ID number must be included.			
					$
					$
					$
					$
					$
					$
					$
* 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. 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