2020

PEEHIP

PUBLIC EDUCATION FLEXIBLE EMPLOYEE'S BENEFITS PLAN

FLEXIBLE SPENDING ACCOUNTS | Premium Conversion Plan

Effective October 1, 2019

Public Education Employees' Health Insurance Plan
PEEHIP Flexible Employees' Benefits Board
P.O. Box 302150
Montgomery, AL 36130-2150
877-517-0020
334-517-7000
www.rsa-al.gov

HealthEquity
Customer Service 877-288-0719
Fax 801-999-7829
www.healthequity.com/peehip

Blue Cross and Blue Shield of Alabama
www.AlabamaBlue.com

The enclosed information summarizes your PEEHIP Flexible Employees' Benefits Plan. PEEHIP has contracted with Blue Cross and Blue Shield of Alabama to manage the PEEHIP Flexible Spending Accounts (FSA) plan. Blue Cross and Blue Shield of Alabama is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. Blue Cross and Blue Shield of Alabama is not an acting agent of the Association. HealthEquity is an independent and separate company contracted with Blue Cross to administer the FSA contracts. HealthEquity will process the PEEHIP flex claims and reimbursements and handle all FSA customer services issues.

NOTICE OF NON-DISCRIMINATION AND LANGUAGE ACCESS SERVICES:

Discrimination is Against the Law

The Public Employees' Health Insurance Plan (PEEHIP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PEEHIP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PEEHIP:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, or other formats); and
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact our 1557 Compliance Coordinator, at 1-877-517- 0020. If you believe that PEEHIP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Public Education Employees' Health Insurance Plan, 201 South Union Street, Montgomery, Alabama, 36104, Attn: 1557 Compliance Coordinator, 1- 877-517-0020, 1-877-517-0021 (fax), PEEHIP.Info@rsa-al.gov (email). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Section 1557 Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Multi-Language Interpreter Services

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-517-0020.

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-517-0020 번으로 전화해 주십시오.

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-877- 517-0020.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-517-0020.

Arabic: .877-517-0020-1 ركاذ ةغللا، نإف اتمخد ل ساما عدة ل ةيوغلا وت ت ف ا ر كل مجا ال نب. لصتا قب مر حم ةظول: اذإ تنك ثتت حد

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-517-0020.

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-517-0020.

Gujarati: ચના : જો તમેગજર તી બો_ત હો, તો :શલ્ ક ભ ષ સહ ય સેવ ઓ તમ ર મ ટ ઉપ_બધ છ. ફોન કરો 1-877-517-0020.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-517-0020.

Hindi: धयान द:े े यददआप ह ि दी बोलत हे े तो आपके ललए मुफत मेभाषा सहायता स वाए े उपलबध ह। 1-877- 517-0020 पर कॉल करे।

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-877-517-0020.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-517-0020.

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-517-0020.

Turkish: DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-877-517-0020 irtibat numaralarını arayın.

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1- 877-517-0020 まで、お電話にてご連絡ください。

Contents

Introduction

The following information summarizes the Public Education Flexible Employees' Benefits Plan. The purpose of the plan is to provide Public Education Employees with an option to pay for eligible health care and dependent care expenses using nontaxable income as allowed by Section 125 of the Internal Revenue Code of 1986. This booklet serves as the summary plan description for the Flexible Spending Accounts (FSA) plan.

The PEEHIP Flexible Spending Accounts contract is with Blue Cross and Blue Shield of Alabama. HealthEquity is a business associate and an independent company that provides account-based plan services to Blue Cross. HealthEquity is an experienced and strong administrator of Health Care and Dependent Care flex plans. HealthEquity will process the PEEHIP Flexible Spending Accounts reimbursements and handle all related customer service issues.

The PEEHIP sponsored plan offers three programs designed to save you money.

- Health Care Flexible Spending Account (Health FSA) allow active members to set aside tax free funds each year to pay for qualifying health care expenses incurred by them and their eligible dependent.

- Dependent Care Flexible Spending Account (DCRA) allows active members to set aside tax free money to pay for dependent day care expenses.

- Premium Conversion Plan allows active members to pay for their PEEHIP premiums using pre-tax dollars through their payroll system.

If you have any questions you may contact HealthEquity at 877-288-0719 or PEEHIP at 877-517-0020.

Public Education Flexible Employees' Benefits Plan

Eligibility

All actively employed members of PEEHIP are eligible to participate in the PEEHIP Flexible Employees' Benefits Plan. Actively employed members will be automatically enrolled in the Premium Conversion Plan when they enroll in PEEHIP coverage.

Your Enrollment Decision

Participation in the PEEHIP Health FSA and DCRA is voluntary. Each year, during the PEEHIP annual open enrollment period you will have an opportunity to enroll in the PEEHIP Flexible Employees' Benefits Plan that will be effective as of the first day of the next plan year. The plan year begins October 1, and ends September 30 of the following year. Enrollment in the FSA plan automatically cancels at the end of each plan year. To continue participation in the FSA plan, member must re-enroll each year during Open Enrollment. Members are not required to be enrolled in PEEHIP medical or optional plan coverage to enroll and participate in the FSA plan.

New employees can enroll in the Health FSA and/or DCRA within 30 days of employment with an effective date of the first of the month following your employment date. You will receive enrollment information from PEEHIP.

PEEHIP will allow members who are participating in another school system sponsored flexible spending accounts plan to enroll in the PEEHIP Flexible Employees' Benefits Plan for a "short plan year" upon the end of the school's flex plan year. These members must enroll in the PEEHIP Flexible Employees' Benefits Plan within 45 days following the school's flex plan's year end.

Open Enrollment Period

Open Enrollment for the PEEHIP Flexible Spending Accounts Plan begins July 1 and extends through September 30. The preferred method of enrollment is online via the Member Online Services link found on the main page of the PEEHIP web site at www.rsa-al.gov. Members may also complete a Flexible Spending Account Enrollment Application and return it via mail to PEEHIP.

Once you enroll in the PEEHIP FSA plan, you will receive a Welcome package from HealthEquity containing a Get Started guide with instructions for creating your online account in the HealthEquity member portal.

Contributions to the Account

During the annual enrollment period, you decide how much you want to contribute to your Health FSA and/or DCRA for the plan year. Contributions are made on a pretax basis and deducted from your paycheck during the plan year. The "plan year" will be October 1st through September 30th. When enrolling during Open Enrollment, your annual amount will be divided into 12 monthly contributions and withheld from your salary pre-tax. If you enroll outside of Open Enrollment, the annual amount will be divided by the number of months you are employed for the remainder of the plan year. In the event your employer is not able to withhold your monthly contribution from your paycheck, you may be required to send the missing contribution directly to PEEHIP.

PEEHIP reserves the right to limit the contributions and reimbursements to highly compensated members for the plan to satisfy certain nondiscrimination tests under federal law.

Health FSA Limit

You can direct up to a **maximum of $2,700** to your account each year to pay for eligible health care expenses for you and your dependents. There is a $120 minimum annual contribution amount.

In the case of a new employee, you decide how much you want to contribute for the balance of the year following your date of employment.

DCRA Limit

You can direct up to a **maximum of $5,000** to your account each year to pay for dependent day care expenses so you (and if married, your spouse) can work outside the home or attend school full-time. If you and your spouse file income taxes separately, the most either of you can put into a program like the DCRA is $2,500. There is a $120 minimum annual contribution amount.

Note: Unpaid volunteer work or volunteer work for a nominal salary does not qualify as work outside the home. Please refer to the Internal Revenue Service regulations for clarification.

Use It or Lose It Rule

Before deciding how much to contribute to your Health FSA or DCRA, it's important to carefully consider your needs and estimate your expenses for the year. You need to plan carefully because under the current IRS regulations, you forfeit any money in your Dependent Care account after all eligible expenses have been reimbursed, and will forfeit any unused amounts in excess of $500 remaining in your Health FSA at the end of the plan year. Refund of unused funds is not permitted. This is often referred to as the “use it or lose it” rule. You should also be aware that funds placed in a Health FSA cannot be transferred to a DCRA, or vice versa. To assist you in determining your contribution amount a Tax Savings Calculator is available at www.healthequity.com/peehip.

Apart from submitting all of your Reimbursement Requests by the close of each plan year, there are two plan features that help you avoid losing money as a result of the use it or lose it rule. The first feature is the $500 carryover provision; the second is the timely filing period.

$500 Carryover Provision (Applicable to Health FSA Only)

In accordance with IRS Notice 2013-71, PEEHIP allows up to $500 of unused funds remaining in your Health FSA at the end of the timely filing period to be carried over and used in the subsequent plan year. Any remaining balance in excess of $500 after all eligible medical, dental or vision claims have been reimbursed will be forfeited. On accounts that have overpayments, the overpayment amount will not be included in the carryover funds. The carryover provision will apply to all plan participants in active status.

The carryover provision does not affect the maximum contribution amount you can make to your health FSA. For plan year 2020, the maximum contribution amount is $2,700.

The $500 carryover provision is not cumulative. The carryover provision allows a maximum carryover amount of $500 per year, regardless of carryovers from prior years or account balance in the current year. For example, an employee who carries over $500 from year one to year two does not have up to $1,000 to carry over from year two to year three.

Rollover Only Account

A Rollover Only account will be automatically established at the end of the Timely Filing Period for members with Health FSA funds eligible for carryover but do not re-enroll in the Health FSA for the subsequent plan year. Debit card access is not available for Rollover Only accounts. Member must request a reimbursement using the Manual Reimbursement method. Members will have until the end of the plan year to use the funds in the Rollover Only account.

Note: Carryover funds may not be available for use until 30 days after the timely filing period has expired. Members must remain in active status to use carryover and Rollover Only account funds.

Timely Filing Period Deadline

The PEEHIP Flexible Spending Accounts plan does not allow a grace period for you to use funds after the plan has closed. However, the plan does allow additional time for you to submit a request for reimbursement of expenses incurred during the plan year. You have until January 15, 2021 to submit a Reimbursement Request for the Health FSA and the DCRA. This period is commonly referred to as the timely filing or run-out period. Expenses must have been incurred by the end of the plan year, September 30.

If you are no longer an actively employed member, you must submit requests for reimbursement for expenses incurred prior to the date you are no longer an actively employed member of PEEHIP within 105 days of the plan’s cancellation.

Order in Which Requests for Reimbursements are Processed (Health FSA Only)

A cafeteria plan is permitted to treat reimbursements of all claims for expenses that are included in the current plan year as reimbursed first from unused amounts credited for the current plan year and, only after exhausting these current plan year amounts, as then reimbursed from unused amounts carried over from the preceding plan year. Any unused amounts from the prior plan year that are used to reimburse a current year expense (a) reduce the amounts available to pay prior plan year expenses during the run-out period, (b) must be counted against the permitted carryover of up to $500, and (c) cannot exceed the permitted carryover.

Permitted Election Changes

Once you are enrolled in the Health FSA or DCRA, you can increase or decrease your contributions for the remainder of a plan year if you have a change in status. A change may be permitted if:

- You marry, divorce, become legally separated, or have your marriage annulled.
- Your dependent marries.
- You or your spouse gives birth to or adopts a child (including placement for adoption).
- Your spouse or a dependent die.
- Dependent loss of coverage.
- Dependent no longer in daycare. **(DCRA only)**
- Significant change in medical benefits or premiums.
- You take leave under the Family and Medical Leave Act.
- You or your spouse or your dependent begins or terminates employment, participates in a strike or lockout, or begins or returns from an unpaid leave of absence;
- You or your spouse or your dependent has a change in employment status that causes you or your spouse or your dependent to become eligible (or cease to be eligible) to participate in this program or a program covering your spouse or dependent (for example, switching from full-time to part-time employment).
- Your dependent qualifies or ceases to qualify as a dependent for purposes of Internal Revenue Code Sections 105(b) and 106(a).
- A judgment, decree, or order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order) requires coverage for your child or requires your spouse, former spouse or other individual to provide coverage for the child and that coverage is, in fact, provided.
- You or your spouse or dependent become enrolled in Medicare or Medicaid or lose eligibility for coverage under Medicare or Medicaid.
- Short plan year – may enroll outside of open enrollment if the member's participation in another employer sponsored plan ends outside of PEEHIP's open enrollment.

Any change in the amount of your contribution must be consistent with the change in status that has occurred and meet the requirements imposed by the IRS. For example:

- If you enrolled in a DCRA and your dependent reaches the age 13 and thereby ceases to be a qualified dependent for the purposes of the DCRA, you could elect to decrease the amount of your DCRA.

- If you enrolled in a Health FSA and you or your spouse has a baby, you could elect to increase your contributions to your Health FSA to cover an increase in anticipated health care expenses.

If you have a change in status that allows you to reduce your annual contribution amount, your new annual election amount cannot be less than $120, and may not be less than the greater of (a) the amount that has been deducted from your paycheck as of the date of change, or (b) the amount of the reimbursements you have received as of the date of change or date of request – whichever is later.

For a change to be permitted member must submit a Flexible Spending Account Status Change form along with supporting documentation to PEEHIP no later than 45 days following the event's occurrence.

Unpaid Leave, Termination and Retirement

If you go on an unpaid leave, terminate or retire before the end of the plan year, your participation in the Health FSA and DCRA will cancel the first day of the following month or when you have exhausted your employer paid contributions. Coverage will also end if you no longer meet the eligibility rules of the plan.

If you go on unpaid leave covered by the Family and Medical Leave Act (FMLA), you should check with PEEHIP to determine what your rights are relating to the Health FSA and DCRA elections. Generally, you can continue coverage under the Health FSA or revoke your existing election under the Health FSA. If you elect to continue your coverage, you can pre-pay contributions for the period of unpaid FMLA leave. You will not be entitled to receive reimbursements for expenses incurred during the period of unpaid FMLA leave if you do not continue contributions.

If you elect to be reinstated upon returning from the unpaid FMLA leave, you must choose to:

- Resume coverage at the level in effect before the unpaid FMLA leave and make up the unpaid premium payments; or

- Resume coverage at a level that is reduced and resume premium payments at the level in effect before the unpaid FMLA leave.

Return to employment

If you terminate employment and are rehired within 30 days and within the same plan year, then you must resume your original Health FSA and DCRA election for the remainder of the plan year. If you terminate employment and are rehired more than 30 days after your termination date and within the same plan year, then PEEHIP will permit you to make a new Health FSA and DCRA election for the remainder of the plan year.

Since you will forfeit any unused money in your account, you should carefully estimate your anticipated Health FSA and DCRA costs for the year before deciding the amount of your contribution. Remember, unless you have a change in status, your contribution amount cannot be changed until the next plan year.

How the Health FSA Works

The Health FSA allows you to set aside up to $2,700 a year, pretax, for health-related expenses not reimbursed by any other program or plan. You then use those pretax dollars to pay for or reimburse yourself for out-of-pocket health care expenses incurred during the plan year.

Eligible Expenses

Your Health FSA can be used to reimburse you for your own expenses, as well as those of your eligible dependents, as long as the expenses are:

- amounts paid for “medical care” as described in Internal Revenue Code Section 213(d);
- not reimbursable under any other health plan in which you participate; and
- incurred after the date of your enrollment and during the plan year; however, if your PEEHIP membership terminates during the plan year, health care expenses must be incurred before your termination date (unless you elect coverage under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1986 [COBRA]).

Specifically, health care expenses eligible under the plan are those not paid in full under any health care plan in which either you or your dependents participates, including annual deductible, copayments and fees over the usual and customary limits.

Eligible expenses do not include health, dental or life insurance premiums.

Following are some examples of health care expenses that are reimbursable by the Health FSA. This is a partial list extracted from IRS publications and is subject to change.

Allowable Health Care Expenses Include:

- ambulance transportation expenses
- artificial limbs
- artificial teeth
- birth control pills prescribed by a doctor
- blood glucose monitors and test strips
- braille books and magazines
- breast pumps
- chiropractors
- contact lenses, as well as the equipment and materials required for using them
- CPAP devices
- crutches and walkers
- dental fees
- doctors' fees (including telemedicine)
- drug and alcohol addiction treatment
- eyeglasses (including reading glasses)
- fertility enhancement (including in vitro fertilization and surgery)

- first aid kits
- guide dogs
- hearing aids
- hospital services
- lab fees
- learning disability tuition
- medical alert bracelet or necklace
- optometrists
- orthodontia
- oxygen
- prescription drugs (legend/prescription drugs which Federal Law prohibits dispensing without a prescription)
- prescribed over-the-counter drugs (drugs which are prescribed by a physician even though Federal Law does not require a prescription)
- special schools for the handicapped
- sterilization procedures
- surgery (other than cosmetic surgery)
- therapy (medical)
- transplants of organs
- transportation to/from health care provider
- weight-loss plans prescribed by a physician to treat a specific disease
- wheelchairs
- X-rays

For a complete list of additional eligible expenses consult your personal tax advisor or refer to IRS publication 502, Medical and Dental Expenses which contains a list of deductible expenses. (This publication can be obtained through your local IRS office or from www.irs.gov.)

Note: Misuse of spending account funds is a violation of Internal Revenue Service regulations.

Eligible Dependent Expenses

Your Health FSA can be used not only to cover your own expenses, but also can be used for the cost of services received by your spouse and your dependents who qualify as dependents for purposes of Internal Revenue Code Sections 105(b) and 106(a), even if they're not covered by the company's health or dental plan.

Under IRS regulations, eligible expenses incurred by your dependents, as described in Internal Revenue Code Sections 105(b) and 106(a), are eligible for reimbursement from your Health FSA. If you have a question as to whether or not a dependent is eligible, you should consult with the IRS or your personal tax advisor for more information.

What the Plan Doesn't Cover

Although the Health FSA covers a wide variety of health care expenses, there are some expenses that are not eligible for payment. For example, expenses you incur in connection with activities that are merely beneficial to your general health and not directly related to specific health care are not reimbursable.

Other types of health care that are not eligible include:

- Health, dental or life insurance premiums;
- expenses incurred for health clubs, spas and weight loss programs (unless prescribed by a physician solely for the purpose of treating an illness or accident);
- over-the-counter medicines and drugs unless prescribed by a physician and submitted with a copy of the prescription;
- expenses for which you receive benefits from any health, dental, vision or other health care plan;
- most kinds of cosmetic health services and supplies (unless medically necessary and not covered by a health plan), hair transplants, electrolysis, and teeth whitening;
- dietary and herbal supplements such as vitamins, fiber, and minerals (unless prescribed by a physician solely for the purpose of treating an illness);

The general rule is this: Health expenses are eligible for reimbursement from the account only if they're expenses paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body.

For additional examples of qualified and non-qualified expenses visit www.healthequity.com/peehip.

Tax Effects

The Health FSA can help you reduce your taxes, which in turn can increase your annual take home pay.

Tax Savings

The Health FSA lets you set aside a certain amount of money from your paycheck before you pay taxes. You are taxed only on the part of your pay remaining. The result is lower income, which means lower federal income taxes, lower Social Security taxes, and in many cases, lower state income taxes as well.

Effect on Other Benefit Plans

Because account contributions reduce Social Security taxes, your Social Security benefits could be slightly less than if you had not contributed to the plan. Consult with your employer's Benefits Office to determine the impact, if any, that your participation in the Health FSA may have on any other benefit plans offered by your employer.

Tax Credits

Under current tax regulations, you cannot claim a tax deduction for health care expenses that are paid for or reimbursed through the Health FSA. You can, however, take an itemized tax deduction for any

expenses in excess of your Health FSA contribution, up to the allowable limits under the law. Keep this in mind when determining whether or not to participate in the program, and contact your personal tax advisor if you have any questions.

IRS Non-Discrimination Requirements

The Health FSA is required to satisfy certain non-discrimination rules under Sections 125 and 105(h) of the Internal Revenue Code. PEEHIP is responsible for testing the plan to see whether it complies with these rules. If necessary, PEEHIP may suspend or curtail your contributions to or reimbursements from the plan to the extent determined necessary by your PEEHIP to satisfy these rules.

Health FSA Reimbursement

As previously mentioned, the timely filing period ends January 15th after the close of the plan year. At the end of the timely filing period, if there are unused funds in excess of $500 in your Health FSA (see rules pertaining to carryover funds), those funds will be forfeited and used by the Plan to help cover the plan's administrative costs.

Also, note that the money you direct into your Health FSA can only be used to pay for eligible health care expenses for you and your dependents. You can't pay for dependent daycare expenses from the Health FSA, nor can you pay for health care expenses from the DCRA. In addition, funds assigned to one account cannot be transferred to the other under any circumstances.

What Constitutes a Request for Reimbursement

The Health FSA is designed to pay for costs not covered by your health or dental plan or reimburse you for qualifying expenses you have already paid. Members may pay for eligible out of pocket expenses using the Flex debit card at the time of transaction or request a reimbursement using the Manual Reimbursement method.

Flex Debit Card (not available for DCRA)

When enrolling in a Health FSA you will be issued a HealthEquity Flex debit card to pay for you and your eligible dependents' out-of-pocket medical, prescription drugs, dental, and vision expenses. The card gives you immediate access to your Health FSA and is accepted at most health care providers and participating pharmacies. The Flex Debit card can be used to pay health related expenses which are reimbursable under the Health FSA. **You should retain copies of any invoices, receipts and other documents you receive in connection with a transaction made with the card** since you may have to file these with HealthEquity Customer Service in order to substantiate your charge. If you are enrolled in PEEHIP medical and dental coverage, co-pays associated with your coverage use will be automatically substantiated based on the claims data received from your PEEHIP coverage. If the charge cannot be automatically substantiated, you will receive a request to provide documentation to substantiate the card swipe. If a charge is not properly substantiated or if it is otherwise determined to be for an expense not eligible for reimbursement under the Health FSA, you will be required to repay the amount of the charge. Failure to provide requested documentation or to return funds for ineligible charges will result in the card being deactivated. You are responsible for all charges on your HealthEquity Flex debit card, including any charges on a card issued to your dependent.

Use of the card is encouraged but not required. A Manual reimbursement request must be completed and submitted with proper documentation to receive reimbursement of qualifying expenses not paid at point-of-sale using the HealthEquity Flex debit card.

Manual Reimbursement

For reimbursement of eligible expenses not paid for using your Flex debit card you will need to request a Manual Reimbursement through the HealthEquity Online Member Portal or mobile app and upload the proper supporting documentation and receipts. In some cases, the claims data will automatically be available on your HealthEquity online account. Just login and select pay me, or if you prefer, pay my provider. The funds can be sent to you by check or direct deposit or directly to the healthcare provider.

You may also submit a paper Reimbursement Form. Forms can be located at www.healthequity.com/peehip or on the PEEHIP website, www.rsa-al.gov. Simply fill out the Reimbursement Form and attach Explanation of Benefits (EOB) forms, bills, invoices, receipts, or other supporting statements showing the amount of the health-related expenses for which you are claiming reimbursement. For over-the-counter drugs you must also attach a copy of the physician's prescription for the drug.

Mail or fax the Reimbursement Form and attachments to:

HealthEquity, Inc.
Attn: Reimbursement Accounts
15 W. Scenic Pointe Drive, Suite 100
Draper, UT 84020

Fax number: 801 999-7829

Once approved, your reimbursement will be sent to you by check or direct deposit. If HealthEquity receives a submission that does not contain the proper documents for substantiation, you will be notified of the additional information needed. Requests for reimbursement for eligible expenses incurred in a plan year must be submitted by the close of the timely filing period. After the timely filing period, any money in the account is forfeited and used by the Plan to help cover the Plan's administrative cost.

Orthodontia Claims

For reimbursement of Orthodontia expense, you must complete an Orthodontia Reimbursement Form and provide the supporting documentation. A copy of your Orthodontia contract must be received by HealthEquity before any related expenses can be reimbursed to you. Contact HealthEquity Customer Service for additional information and to obtain the proper form.

Processing of Requests for Reimbursement

Even if all of the information has been received that is needed in order to treat a submission as a Reimbursement request, from time to time additional information might be needed in order to determine whether the Reimbursement Form is payable. If additional information of this sort is needed, you will be asked to furnish it, and further processing of your Reimbursement Form will be suspended until the information is received. You will have 45 days to provide the information.

Ordinarily, you will be notified of a decision within 30 days of the date on which your Reimbursement Form is filed. If it is necessary to ask for additional information, you will be notified of that decision within 15 days after the requested information is received. If the information is not received, your Reimbursement request will be denied at the expiration of the 45-day period you were given for furnishing the information.

In some cases, you can be asked for additional time to process your Reimbursement Form. If you do not wish to give the additional time, your Reimbursement Form will be processed based on the information already provided. This may result in a denial of your request.

Payment of Requests for Reimbursement

Your Reimbursement request will be reimbursed in full, up to the total amount you agreed to contribute to the Health FSA for the year less previous reimbursements, regardless of the amount that has been deducted from your paycheck when the expense is submitted. Your payroll deductions throughout the year will be used to repay your account if your account does not have sufficient funds at the time to pay the reimbursement request. You can view your processed reimbursements and account balance by logging on to your online account at www.myhealthequity.com or the HealthEquity mobile app.

Direct Deposit

You can register at the web site www.myhealthequity.com, or through the HealthEquity mobile app, to have your reimbursement direct deposited in your bank account. Direct deposit can also be set up by completing a direct deposit form available on the HealthEquity website and at www.rsa-al.gov.

How the DCRA Works

The DCRA allows you to set aside up to $5,000 a year ($2,500 a year if you and your spouse file separate tax returns), before-tax, for dependent care expenses. You then use those before-tax dollars to reimburse yourself for eligible out-of-pocket dependent care expenses.

Reimbursement Limits

There is a limit on the amount of reimbursement you can receive each calendar year that is not subject to federal income tax. If you are single on the last day of the year, you can receive reimbursement up to the amount of your earned income (generally, your compensation not including reimbursement you receive from your account) for that year.

If you are married on the last day of the year, you can receive reimbursements up to the amount of your earned income or your spouse's earned income for that year, whichever is less (but not exceeding the amount in your account). For example, if your earned income is $25,000 for the year, but your spouse's earned income is only $1,500, you can receive reimbursements of up to $1,500 during that year. If you were to receive reimbursements of more than $1,500 for the year, you may have to pay federal and state income taxes on the amount you are reimbursed in excess of $1,500.

If you are married and use the DCRA, your spouse must work, be a full-time student, or be disabled. In cases where a spouse is a student or disabled, DCRA calculations can be made as if that spouse earned an income of $250 per month if you have one eligible dependent, and $500 per month if you have two or more dependents.

Note: PEEHIP reserves the right to limit the contributions of and reimbursements payable to highly compensated employees, if necessary, for the plan to satisfy certain nondiscrimination tests under federal tax law.

Eligible Expenses

Your DCRA can be used to reimburse you for your dependent expenses, as long as the expenses are:

- incurred so that you and your spouse can work or attend school full-time;
- incurred for services relating to the care of a dependent qualifying child under the age of 13 or your dependent or spouse who is physically or mentally incapable of caring for himself and who lives with you for more than one-half of the year; and
- incurred for services provided during the plan year. However, if your membership with PEEHIP terminates during the plan year, expenses must be incurred before your termination date.

Following are some examples of dependent care expenses that are reimbursable by the account. Eligible dependent care expenses include:

- expenses incurred for dependent day care that allow you (and if married, your spouse) to work or attend school full-time;
- licensed nursery school or day care center for children; to qualify under plan rules, the day care center must:
- comply with all applicable state and local laws and regulations;
- provide care for seven or more individuals; and
- receive a fee for providing day care services;
- costs for dependent care services in or outside your home; and
- costs for household services which are in part attributable to the care of the dependent.

For expenses to be eligible for reimbursement, the person you pay to provide care for your eligible dependents cannot be your spouse, another dependent, or a child of yours under the age of 19.

For more information about eligible dependent care expenses, refer to IRS Publication 503, Child and Dependent Care Credit. This publication can be obtained through your local IRS office or from www.irs.gov.

What the Plan Doesn't Cover

Certain dependent care expenses are not covered under the DCRA. Examples of ineligible expenses include but are not limited to:

- any amounts you pay to an immediate family member under the age of 19 or any person you claim as a dependent on your federal income tax return;
- costs for any person caring for your dependents when you or your spouse are not working, except in cases of short temporary absences or part-time employment where the dependent care expenses are required to be paid on a periodic basis that includes both days worked and days not worked;
- transportation expenses not provided by your dependent care provider;

- child support payments;
- education expenses for kindergarten and above or overnight camp expenses;
- food, clothing and entertainment; and
- cleaning and cooking services not provided by the care provider.

Also, note that money you direct into your DCRA cannot be used to pay for health care expenses. Nor can funds in the Health FSA be used to pay for dependent care expenses. In addition, funds assigned to one account cannot be transferred to the other under any circumstances.

Eligible Dependents

As defined by the IRS, an eligible dependent may be a qualifying child (as defined in Internal Revenue Code Section 152) who is under the age 13, or a dependent who is physically or mentally incapable of self-care, who lives with you for more than one-half of the year and who qualifies as a dependent for federal income tax purposes. The dependent must live in your home at least eight hours a day.

Tax Effects

By paying dependent care expenses through the DCRA, you can help reduce your taxes, which in turn can increase your annual take home pay.

Tax Savings

The DCRA lets you set aside a certain amount of money from your paycheck before you pay taxes. You are taxed only on the part of your pay remaining. The result is lower income, which means lower federal income taxes, lower Social Security taxes, and in many cases, lower state income taxes as well.

IRS Requirements

The Dependent Care Accounts of all employees participating in the plan are required to satisfy certain nondiscrimination rules under Sections 125 and 129 of the Internal Revenue Code. PEEHIP is responsible for testing the plan to see whether it complies with these rules. If necessary, the plan administrator may suspend or curtail your contributions to or reimbursements from the plan to the extent determined necessary by the plan administrator to satisfy these rules.

Effect on Other Benefit Plans

Because account contributions reduce Social Security taxes, your Social Security benefits could be slightly less than if you had not contributed to the plan. Consult with your employer's Benefits Office to determine the impact, if any, that your participation in the DCRA may have on any other benefit plans offered by your employer.

Tax Credits

Under current tax regulations, you cannot claim a tax deduction for child care expenses that are reimbursed through the DCRA. You can, however, take a tax credit for any expenses in excess of your dependent care account contribution, up to the allowable limits under the law. Keep this in mind when determining whether or not to participate in the DCRA, and contact your personal tax advisor if you have questions.

Your employer is required to report the amount you contributed to the DCRA on your annual W-2 form. It is your responsibility to determine if the amounts reimbursed to you for dependent care expenses are excludable from your income under Internal Revenue Service rules. Again, contact your personal tax advisor, or your local IRS office, if you have any questions.

How to File a Request for Reimbursement for DCRA

The DCRA is designed to reimburse you for eligible dependent care expenses you already have paid. To receive DCRA reimbursements, follow the steps outlined in this section.

When you have an eligible dependent care expense, you pay it. Then, submit expense for reimbursement either through the HealthEquity member portal, or by completing a DCRA Reimbursement Form. Bills, invoices, receipts, or other supporting statements from your dependent care provider must accompany the online request or Reimbursement Form.

Mail or Fax the Reimbursement Form and supporting statements to:

HealthEquity, Inc.
15 W Scenic Pointe Drive, Suite 100
Draper, UT 84020

Fax number: 801 999-7829

Your DCRA Reimbursement Form will be reimbursed in full, up to the balance available in your DCRA at the time you submit the request for reimbursement. If your account does not have enough money to pay the expense for which you are seeking reimbursement, the Reimbursement Form will be held until funds are available in your account.

If the amount of your dependent care expenses are consistent each month, recurring DCRA claims can be scheduled for the duration of the plan year. Reimbursement will then be sent out to you automatically each month as funds become available.

Reimbursement checks are processed daily. You can register at the web site www.myhealthequity.com or through the HealthEquity mobile app, to have your reimbursement direct deposited to your bank account.

Requests for Reimbursement for eligible expenses incurred in a plan year must be submitted by the close of the timely filing period set forth above. After the close of that period, any unused funds in the account are forfeited.

Appeals

You or your authorized representative may appeal any adverse benefit determination. An adverse benefit determination occurs when reimbursement of your expense has been denied in whole or in part. You cannot file a claim for benefits under the plan in federal or state court (or in arbitration if provided by your plan) unless you exhaust these administrative remedies.

You have 180 days following an adverse benefit determination within which to submit an appeal.

How to Appeal Adverse Benefit Determinations

In order to file an appeal you must send the HealthEquity Customer Service Center a letter or complete the HealthEquity Reimbursement Account Claims Appeal form that contains at least the following information:

- your name;
- your contract number;
- sufficient information to reasonably identify the Request for Reimbursement being appealed; and,
- a statement that you are filing an appeal.

You must send your appeal to the following address:

HealthEquity, Inc.
Attention: Reimbursement Accounts
15 W. Scenic Pointe Drive, Suite 100
Draper, Utah 84020

Conduct of the Appeal

Your appeal will be assigned to one or more persons within HealthEquity who are neither the persons who made the initial determination nor subordinates of those persons.

If more information is needed, you will be asked to provide it. If the information is not received, denial of your appeal may be necessary.

Time Limits for Consideration of Your Appeal

You will be notified of the decision on your appeal within 60 days of the date on which you filed your appeal.

In some cases, additional time may be requested to process your appeal. If you do not wish to give additional time, your appeal will be decided based on the information already received. This may result in a denial of your appeal.

When Participation Ends With Your Health FSA and DCRA

Your participation in the Health FSA usually ends if your membership with PEEHIP ends. If you terminate employment or retire before the end of the plan year, your Health FSA will terminate the first day of the following month or when you have exhausted your employer paid insurance contributions.

Membership ends when an employee terminates employment, retires, goes on leave of absence or dies. You must use the money in your Health FSA on qualified expenses by the flexible spending termination date and file for reimbursement before the 105 day filing limitation.

Your participation in the DCRA will end when your PEEHIP membership ends, you go on a leave of absence, retire or die. Coverage will also end if you no longer meet the eligibility rules of the plan.

Any money remaining in your account at plan year end will be forfeited.

While on a Leave of Absence (Health FSA Only)

Based on enrollment selections, if you take a leave, including leave in which you receive short-term disability benefits, you may continue to have contributions deducted from your benefit pay for your participation to continue.

If you take an unpaid leave of absence, coverage continuation will be handled according to PEEHIP policy. You will be responsible for continuing your account contributions on an after-tax basis.

Please contact PEEHIP for more information. If your leave qualifies under the Family and Medical Leave Act of 1993 (FMLA), you may revoke your existing election as described previously in the section on “Permitted Election Changes.”

Continuation of Your Health FSA under COBRA

If you are no longer an actively employed member of PEEHIP, you can exercise your right to continue participation in the Health FSA for a certain length of time. However, before-tax funding will no longer be available, and your Health FSA contributions will be made on an after-tax basis. Refer to the next section, "Continuation of Coverage under COBRA." PEEHIP will provide you with the appropriate information and application forms for this type of coverage.

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 requires that most employers sponsoring health plans offer employees the opportunity for a temporary extension of that coverage when it ends or changes. Since your Health FSA is considered to be a health plan, COBRA entitles you or your spouse or dependent to extend participation in the Health FSA for the remainder of the plan year in which a COBRA qualifying event occurs. However, this COBRA continuation coverage is only available if, on the date of the COBRA qualifying event, your remaining potential annual benefits under the Health FSA are greater than your remaining contributions for the year (including the additional 2% described below).

COBRA Qualifying Events

The right of you or your spouse or dependent to elect the COBRA continuation coverage described above is permitted if coverage under the Health FSA for you or your spouse or dependent is lost because of:

- a reduction in your work hours;
- the termination of your employment (for reasons other than gross misconduct);
- your death;
- your divorce or legal separation; or
- your dependent child ceases to be a dependent under the terms of the Health FSA.

Notification Responsibilities

You or your spouse or dependent, as the case may be, are responsible for notifying the PEEHIP Office, within 60 days of the occurrence of a COBRA qualifying event resulting from divorce, legal separation, or a dependent child ceasing to be a dependent under the terms of the program. If this 60-day notice is not provided, then the program is not required to provide the option of COBRA continuation coverage as a result of the qualifying event. After receiving notice of the qualifying event, or when the qualifying event is from death, reduction in work hours, or termination of employment, PEEHIP will notify you and your spouse and dependents of the right to choose COBRA coverage. Under the law, you have 60 days from the later of the following two dates to inform PEEHIP that you want COBRA coverage:

- the date coverage would be lost; or
- the date the COBRA election form is sent to you from PEEHIP.

If You Do Not Want COBRA Coverage

If you do not want the extended COBRA coverage, no action on your part is necessary, and your participation in the Health FSA will stop on your last date of employment. However, expenses incurred after that date will not be eligible for reimbursement from the Health FSA.

If You Elect COBRA Coverage

If you elect COBRA coverage, PEEHIP is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Health FSA to similarly situated actively employed members. PEEHIP - not HealthEquity - is responsible for providing COBRA coverage to you if you elect it.

If a COBRA qualifying event causes a loss of coverage under the program, the type of COBRA coverage available to a qualified beneficiary (i.e., individual or family) will generally be the same as the type of coverage in effect on the date of the loss of coverage, subject to any additional adjustments specified by us or PEEHIP or allowed for by law. If more than one qualified beneficiary is entitled to purchase COBRA coverage, all such qualified beneficiaries will be covered under one family Health FSA. If claims are received and processed by us with incurred dates preceding the loss of coverage under the Health FSA but following the date on which we have established the COBRA-FSA, we will not go back and recalculate the opening balance of the COBRA-FSA. Instead, we will process any such claims against the FSA of the member who did not have a qualifying event (usually the subscriber), or in some cases we may process the claims against the COBRA-FSA.

Payment of COBRA Contributions

If you or your spouse or dependent elect COBRA continuation coverage, the remaining contribution payments for the period of continuation coverage will be charged to you, your spouse, or dependent, as the case may be, in an amount equal to 102% of your payroll deduction amount. Payment for the additional 2% charge will be treated as an administrative charge and will not be credited to your account or the account of your spouse or dependent, as the case maybe.

PEEHIP will notify you of the amount and timing of your contributions. Your contributions will be after- tax. You should send your contributions directly to PEEHIP. Failure to contribute to your account on a timely basis will result in termination of COBRA coverage.

Termination of COBRA Coverage

COBRA coverage can be terminated if:

- the company no longer provides a health care flexible spending account to any of its employees;
- the contribution for your continuation coverage is not paid on a timely basis; or
- you become covered under another group health plan.

Premium Conversion Plan

Participation in the Premium Conversion Plan

PEEHIP offers their benefits under the Premium Conversion Plan to provide eligible members with certain tax-free benefits allowed by the Internal Revenue Service ("IRS") in lieu of taxable compensation. Tax-free benefits are provided under the Premium Conversion Plan for all PEEHIP sponsored benefit plans. Premiums are excludible from income under Sections 105 (b) or 106 of the Internal Revenue Code.

Under the Premium Conversion Plan, PEEHIP medical, dental, vision, cancer and hospital indemnity product premiums will be paid with pre-tax dollars. Additionally, other products qualifying for pre-tax deductions pursuant to Internal Revenue Code Section 125 offered to PEEHIP members by third-party vendors with authorized payroll slots shall be included in the Premium Conversion Plan with the exception relating to long term disability products and life insurance explained below.

The Premium Conversion Plan **excludes** short term and long term disability plans and life insurance from inclusion as pre-tax benefits regardless of whether they qualify under Internal Revenue Code Section 125.

Under the Premium Conversion Plan, your paycheck is reduced by the amount needed to pay your premium under a qualified PEEHIP sponsored benefit plan. You do not need to make a separate election to participate in the Premium Conversion Plan. By electing to participate in a qualified PEEHIP sponsored plan, you are automatically enrolled in the Premium Conversion Plan. You will be permitted to change your election as and when you are permitted to make enrollment or disenrollment decisions related to the underlying PEEHIP sponsored plans.

Premium Conversion Plan Administrator

PEEHIP Board has general responsibility for the operation and administration of the Premium Conversion Plan. PEEHIP Board has the discretion and authority to interpret the Premium Conversion Plan and determine eligibility for participation. Such interpretations and determinations by the PEEHIP Board are final and conclusive unless they are arbitrary or capricious.

Respecting Your Privacy

Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices

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.

The Public Education Employees' Health Insurance Plan (the "Plan") considers personal information to be confidential. The Plan protects the privacy of that information in accordance with applicable privacy laws, as well as its own privacy policies.

The Plan is required by law to take reasonable steps to ensure the privacy of your health information and to inform you about:

- the Plan's uses and disclosures of your health information
- your privacy rights with respect to your health information
- the Plan's obligations with respect to your health information
- a breach of your PHI
- your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services
- the person or office to contact for further information about the Plan's privacy practices

Effective Date of Notice: This notice was effective as of September 23, 2013.

How the Plan uses and discloses Health Information

This section of the notice describes uses and disclosures that the Plan may make of your health information for certain purposes without first obtaining your permission as well as instances in which we may request your written permission to use or disclose your health information. The Plan also requires their business associates to protect the privacy of your health information through written agreements.

Uses and Disclosures related to payment, health care operations and treatment

The Plan and its business associates may use your health information without your permission to carry out payment or health care operations. The Plan may also disclose health information to the Plan Sponsor, PEEHIP, for purposes related to payment or health care operations.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, review for medical necessity and appropriateness of care and utilization review and preauthorization). For example, the Plan may tell an insurer what percentage of a bill will be paid by the Plan.

Health care operations include but are not limited to underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts, disease management, case management, conducting or arrangement for medical review, legal services and auditing functions, including fraud and

abuse programs, business planning and development, business management and general administrative activities. It also includes quality assessment and improvement and reviewing competence or qualifications of health care professionals. For example, the Plan may use medical benefit claims information to conduct a review of the accuracy of how benefit claims are being paid. However, in no event will Benefit Staff use PHI that is genetic information for underwriting purposes.

The Plan will only disclose the minimum information necessary with respect to the amount of health information used or disclosed for these purposes. In other words, only information relating to the task being performed will be used or disclosed. Information not required for the task will not be used or disclosed.

The Plan may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures that do not require your Written Authorization

The Plan may disclose your health information to persons and entities that provide services to the Plan and assure the Plan they will protect the information or if it:

- Constitutes summary health information and is used only for modifying, amending or terminating a group health plan or obtaining premium bids from health plans providing coverage under the group health plan
- Constitutes de-identified information
- Relates to workers' compensation programs
- Is for judicial and administrative proceedings
- Is about decedents
- Is for law enforcement purposes
- Is for public health activities
- Is for health oversight activities
- Is about victims of abuse, neglect or domestic violence
- Is for cadaveric organ, eye or tissue donation purposes
- Is for certain limited research purposes
- Is to avert a serious threat to health or safety
- Is for specialized government functions
- Is for limited marketing activities

Additional Disclosures to Others without your Written Authorization

The Plan may disclose your health information to a relative, a friend or any other person you identify, provided the information is directly relevant to that person's involvement with your health care or payment for that care. For example, the Plan may confirm whether or not a claim has been received and paid. You have the right to request that this kind of disclosure be limited or stopped by contacting the Plan's Privacy Official.

Uses and Disclosures Requiring Your Written Authorization

In all situations other than those described above, the Plan will ask for your written authorization before using or disclosing your health information. If you have given the Plan an authorization, you may revoke it at any time, if the Plan has not already acted on it. If you have questions regarding authorizations, contact the Plan's Privacy Official.

Your Privacy Rights

This section of the notice describes your rights with respect to your health information and a brief description of how you may exercise these rights. To exercise your rights, you must contact the Plan's Privacy Official at 877-517-0020.

Restrict Uses and Disclosures

You have the right to request that the Plan restricts uses and disclosure of your health information for activities related to payment, health care operations and treatment. The Plan will consider, but may not agree to, such requests.

Alternative Communication

The Plan will accommodate reasonable requests to communicate with you at a certain location or in a certain way. For example, if you are covered as an adult dependent, you may want the Plan to send health information to a different address than that of the Employee. The Plan must accommodate your reasonable request to receive communication of PHI by alternative means or at alternative locations, if you clearly state that the disclosure of all or part of the information through normal processes could endanger you in some way

Copy of Health Information

You have a right to obtain a copy of health information that is contained in a "designated record set" – records used in making enrollment, payment, claims adjudication, and other decisions. The Plan may provide you with a summary of the health information if you agree in advance to the summary. You may also be asked to pay a fee of $1.00 per page based on the Plan's copying, mailing, and other preparation costs.

Amend Health Information

You have the right to request an amendment to health information that is in a "designated record set." The Plan may deny your request to amend your health information if the Plan did not create the health information, if the information is not part of the Plan's records, if the information was not available for inspection, or the information is not accurate and complete.

Right to access electronic records

You may request access to electronic copies of your PHI, or you may request in writing or electronically that another person receive an electronic copy of these records. The electronic PHI will be provided in a mutually agreed-upon format, and you may be charged for the cost of any electronic media (such as a USB flash drive) used to provide a copy of the electronic PHI

List of Certain Disclosures

You have the right to receive a list of certain disclosures of your health information. The Plan or its business associates will provide you with one free accounting each year. For subsequent requests, you may be charged a reasonable fee.

Right to a Copy of Privacy Notice

You have the right to receive a paper copy of this notice upon request, even if you agreed to receive the notice electronically.

Complaints

You may complain to the Plan or the Secretary of HHS if you believe your privacy rights have been violated. You will not be penalized for filing a complaint.

The Plan's Responsibilities

The Plan is required by a federal law to keep your health information private, to give you notice of the Plan's legal duties and privacy practices, and to follow the terms of the notice currently in effect.

This Notice is Subject to Change

The terms of this notice and the Plan's privacy policies may be changed at any time. If changes are made, the new terms and policies will then apply to all health information maintained by the Plan. If any material changes are made, the Plan will distribute a new notice to participants and beneficiaries.

Your Questions and Comments

If you have questions regarding this notice, please contact PEEHIP's Privacy Official at 877- 517-0020.

Definitions

“Active Status” means the member is currently employed with a PEEHIP participating employer. Member cannot be on unpaid leave or in retirement status.

"Claims Administrator" see HealthEquity, Inc.

"Code" means the Internal Revenue Code of 1986, as amended or replaced from time to time.

"Compensation" means the amounts received as compensation by the Participant from the Employer during a Plan Year.

"Dependent" An individual who is properly covered for the purposes of Internal Revenue Code Sections 105(b) and 106 (a).

"Election Period or Open Enrollment Period" means the period, established by the Administrator, immediately preceding the beginning of each Plan Year, such period to be applied on a uniform and nondiscriminatory basis for all Employees and Participants. Generally, July 1 through September 30.

"Eligible Member" means any Employee who has satisfied the provisions of the Section titled: "Eligibility".

"Employer" The school or other educational institution for whom you work and through whom you are eligible to participate in any qualified PEEHIP sponsored program.

"HealthEquity" The third party administrator contracted through Blue Cross and Blue Shield of Alabama to perform the administrative duties for the flexible spending accounts.

"Participant" means any eligible PEEHIP member who has elected to participate in one or more features of the Public Education Flexible Employees’ Benefits Plan.

“PEEHIP” Public Education Employees’ Health Insurance Plan.

"Plan" means the PEEHIP Flexible Employees’ Benefits Plan described in this instrument, including all amendments thereto.

"Plan Year" means the 12-month period beginning October 01 and ending September 30. The Plan Year shall be the coverage period for the Benefits provided for under this Plan. In the event a Participant commences participation during a Plan Year, then the initial coverage period shall be that portion of the Plan Year commencing on such Participant's date of entry and ending on the last day of such Plan Year.

"Run-out Period or Timely filing Period" means the set number of days after the plan year ends that allows you to submit claims for eligible expenses incurred during the Plan Year.

Public Education Employees' Health Insurance Plan

10/2019