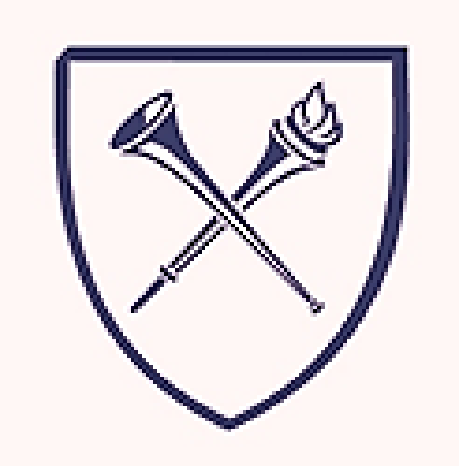


Emory Summary Plan Description Flexible Spending Accounts



Effective January 1, 2025

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Important Notice

The Flexible Spending Accounts (FSA) plan is established by Emory voluntarily and may be amended or terminated at any time by Emory, in its sole discretion. Amendments may, among other things, affect eligibility, contribution rates, benefits coverage, reimbursement rates, procedures, participation, etc., at any time, regardless of whether the individual is participating in the benefit plans at the time of amendment. The Plan Administrator has the discretionary authority to interpret the provisions of the Plan and SPD, and its decisions are final and binding. Nothing in the SPD or the Plan gives, or is intended to give any person the right to be retained in Emory's employment or to interfere with Emory's right to terminate the employment of any person.

Eligibility

You are in an eligible class for coverage under this Plan if you are:

- A regular full-time or half-time (at least 20 hours per week) employee of Emory (including its affiliated employers in the same controlled group).
- A temporary full-time employee on an assignment at Emory University scheduled for at least six consecutive months.

You can sign up for the Healthcare FSA, the Dependent Care FSA, both FSAs, or neither FSA. Participation is completely voluntary; it is up to you to decide which FSA (if any) meets your needs. Only employees can enroll in the Flexible Spending Accounts, but the FSAs can be used to reimburse your dependents' eligible expenses, as well as your own.

Special rules apply to employees who enroll in the HSA Health Plan:

If you are enrolled in the HSA Health Plan and you enroll in the Healthcare FSA during annual enrollment or you enroll for the first time mid-year, you are not eligible for the standard Healthcare FSA and will be enrolled in a Limited Healthcare FSA.

If you are enrolled in the Healthcare FSA and you change your medical coverage option during the middle of the year, the type of health care spending account that you have (e.g., standard Healthcare FSA or Limited Healthcare FSA) will not change.

For Example:

- During annual enrollment, if you elect the HSA Health Plan and the Healthcare FSA, you will be enrolled in a Limited Healthcare FSA. If you get married during the year and you change your medical plan election from the HSA Health Plan to the POS Health Plan, you will remain enrolled in the Limited Healthcare FSA until the end of the year.
- As a new hire, if you elect the POS Health Plan and the Healthcare FSA, you will be enrolled in the standard Healthcare FSA. If you add a newborn, adopt a child, place an adopted child, or divorce during the year, and you change your medical plan election from the POS Health Plan to the HSA Health Plan, you will remain enrolled in the standard Healthcare FSA until the end of the year, and you will not be eligible for HSA contributions.

- During annual enrollment, you elect the HSA Health Plan, but you **do not** elect the Healthcare FSA. If you get married during the year and you change your medical plan election from the HSA Health Plan to the POS Health Plan and you enroll in the Healthcare FSA, you will be enrolled in the standard Healthcare FSA.
- As a benefits eligible employee, you enroll in the POS Health Plan but **do not** elect the Healthcare FSA. If you get married mid-year and you change your medical plan election from the POS Health Plan to the HSA Health Plan, you may enroll in the Health Savings Account provided you complete any required steps for enrollment. You may also enroll in the Limited Healthcare FSA.

The employers participating in these FSAs are: Emory University, Emory Healthcare, Inc., The Emory Clinic Inc., Emory Specialty Associates, LLC, and Emory + Children’s Pediatric Institute, Inc.

Important Note: At the end of the plan year, if you have a balance in the standard Healthcare FSA as of December 31, you will not be able to *contribute to* a Health Savings Account (HSA) or *receive* Emory’s HSA contributions until April 1 of the following year.

Transfers between Entities

Employees cannot change their elections, including their Healthcare and/or Dependent Care FSA election(s) when transferring employment between companies (i.e. Emory University to Emory Healthcare, or vice versa). This rule, however, does not apply to an employee’s election to contribute to a Health Savings Account which can be changed at any time during the year on a prospective basis.

For Example:

- If you are enrolled in the HSA Health Plan, the POS Health Plan or the Kaiser Permanente Plan **with or without** a Healthcare FSA or Dependent Care FSA, you will **not** be able to make any FSA election changes (neither increase, decrease, elect to participate or elect to cancel) when you transfer between entities.
- If you are enrolled in the HSA Health Plan with a Health Savings Account, you will be able to increase, decrease, or stop your Health Savings Account contributions mid-year.

How to Enroll

Enrolling is easy and available 24 hours a day via Employee Self-Service or e-Vantage through your Employer’s homepage. You must enroll within 31 days of your eligibility date. Your completed enrollment authorizes your employer to withhold a portion of your earnings before taxes are deducted and credit that same amount into your FSA(s). Federal law requires that whatever election you make is locked in throughout the applicable calendar year unless you have a “family status change.” Federal law also requires that any amounts you do not use for eligible reimbursements be forfeited, so it is important to plan carefully.

New Employees

You must enroll within 31 days of your date of hire (or the date you became eligible to participate) in order to participate in a FSA(s).

Annual Enrollment

The annual enrollment period is your opportunity to review your benefit needs for the upcoming year and to change your benefit elections, if necessary. The elections you make will be in effect for the following year.

If you are already enrolled in a FSA(s) and wish to continue participating, you must re-enroll each year to continue your participation.

When Participation Begins

New Employees

For a newly hired employee, you are eligible to participate on your date of hire. You must complete the enrollment process within 31 days to participate. If you become eligible to participate mid-year, you must enroll within 31 days of the date you become eligible.

Annual Enrollment

Your annual election will go into effect on January 1 and will remain in effect through December 31, unless you experience an event that permits you to make an election change or which terminates your coverage, as described below.

Making Changes

The IRS requires that your FSA elections stay in effect throughout the full Plan year. Once made, you cannot change your election during the year unless you experience a “qualified family status change.”

Defining a Qualified Family Status Change

The following are examples of qualified family status changes for the FSA:

- Marriage
- Divorce
- Birth or adoption of a child
- Death of a spouse or child
- Termination of your spouse’s employment
- Commencement of your spouse’s employment affecting eligibility
- Transition from part-time to full-time work, or from full-time to part-time work, by you or your spouse that affects eligibility
- An unpaid leave of absence taken by you or your spouse affecting eligibility
- Change in provider or cost for Dependent Care FSA (does not apply if the provider is your relative)

- A child ceasing to qualify as a dependent (such as turning age 13 with respect to the Dependent Care FSA elections)

If You Have a Family Status Change

You have 31 days from the qualified family status change to change your Healthcare and/or Dependent Care FSA election. **The change in your FSA election must be due to and consistent with the change in your family status and otherwise be allowed by the Plan Administrator.**

For Example:

- Upon the birth or adoption of your child, you could increase the amount you are contributing to your Healthcare FSA, but you could not decrease or stop your FSA contributions.
- If you divorce, you could term or decrease your Healthcare FSA contributions, but you could not increase the amount you elect for the year.
- You elect the POS Plan or the Kaiser Permanente Plan, and the Healthcare FSA; then marry and change to the HSA Health Plan mid-year. You will not be able to contribute to *or* receive employer contributions to the Health Savings Account. However, your enrollment in the standard Healthcare FSA will continue until the end of the year.

You should contact the Benefits Department immediately after the change takes place to make sure you allow yourself enough time to take the appropriate action. If you have questions about what changes are allowed following a family status change, please contact the Benefits Department.

If you do not report the family status change and submit the election change request within the 31-day period, you will not be allowed to make the change until the next annual enrollment period.

If You Take a Leave of Absence

Paid Leave of Absence

Your participation in a FSA(s) will not be affected if you are granted a paid leave of absence. Payroll deductions will continue, and you can still use your FSA(s) to reimburse yourself for eligible expenses. However, you could choose to decrease or stop your contributions to the Dependent Care FSA.

Note: You can continue to be reimbursed from your Dependent Care FSA for eligible expenses you incurred while you were actively at work; but you will *not* be reimbursed for expenses incurred while on paid leave. Any balance in your Dependent Care FSA account from contributions made before your leave can be used for claims incurred upon your return to work.

Unpaid Leave of Absence – Healthcare FSA

While on an unpaid leave of absence:

1. You can continue your Healthcare FSA by making payments on an after-tax basis (contact your Benefits Department for details). If you fail to make the required payments during your leave, you will be required to pay the missed payments when you return to work in the same calendar year of the Healthcare FSA election.

2. If you elect to discontinue your participation in the Healthcare FSA during your unpaid FMLA leave of absence or military (USERRA) leave of absence and you return to work during the same plan year, you may either have your same pay period withholding apply (with a corresponding reduction in the total amount available to reflect the period during which no contributions were made) or you can choose to have your pay period withholding increased as necessary to make up the contributions you missed while out on leave. If you elect to discontinue your participation in the Healthcare FSA during your unpaid FMLA leave of absence, you will not be eligible to be reimbursed for expenses incurred during your leave. If you have had a change in status, you may be eligible to make changes to your election within 31 days of your return from the unpaid leave of absence.

Contact the Benefits Department for more information.

Unpaid Leave of Absence – Dependent Care FSA

If you are on an unpaid leave of absence, your contributions and participation in the Dependent Care FSA will end. You can continue to be reimbursed from your Dependent Care FSA for eligible expenses you incurred while you were actively at work; you will *not* be reimbursed for expenses incurred while on unpaid leave. Any balance in your account from contributions made before your leave can be used for claims incurred upon your return to work.

When you return from an unpaid leave, it is considered a family status change and you may elect to participate in the Dependent Care FSA so long as you complete the family status change within 31 days of your return to work. Contact the Benefits Department for more information.

When Your Employment Ends

Healthcare FSA

If you terminate employment during the year or lose benefit eligibility for another reason, you have two choices for your Healthcare FSA:

- You can cease to participate, in which case you will have until May 15th of the next year to submit claims for expenses incurred before your termination of employment date; or
- You can continue your contributions on an after-tax basis by electing COBRA coverage, provided you are eligible for COBRA. [See *Continued Participation in the Healthcare FSA COBRA* for more information.] In this case, you can still claim reimbursements from your account for expenses incurred after you terminate through the end of the year (or, if earlier, through the date your COBRA coverage continues), provided you continue your after-tax contributions.

Dependent Care FSA

If you terminate employment during the year or lose benefit eligibility, your contributions to your Dependent Care FSA will end. However, you can still be reimbursed for eligible expenses you incur through your last day worked. You have until May 15 of the following year to submit claims.

If You Are Rehired

If you terminate employment with Emory and you are rehired as an eligible employee, the following special rules apply to your FSA elections.

- If you are rehired within 30 days or less and during the same calendar year that you terminated employment, your prior FSA election(s) will be reinstated upon reemployment with Emory.
- If you are rehired by Emory after 30 days, you will be treated like a new hire. This means you will be given 31 days to enroll in the FSA. If you do not enroll during that period, you will not participate in the FSA for the remainder of the year.
- If you are rehired by Emory during a different calendar year, you will be treated like a new hire. This means you will be given 31 days to enroll in the FSA. If you do not enroll during that period, you will not participate in the FSA for the remainder of the year.

Expenses incurred while you were not participating in the FSA are not reimbursable. These rules do not apply to transfers between Emory entities. The rules that apply to transfers are discussed earlier in this SPD.

These same rules apply if you lose or gain eligibility to participate in the FSAs during the same year for another reason (meaning a reason other than termination of employment).

Continued Participation in the Healthcare FSA (COBRA)

Under some circumstances, you and/or your eligible dependent(s) can still participate in the Healthcare FSA even after your coverage ends. This continued coverage is available if coverage ends due to a qualifying event, such as:

- Your employment terminates for any reason other than gross misconduct;
- Your scheduled work hours are reduced;
- You retire;
- You divorce;
- Your child ceases to be eligible; or
- You die.

This extended coverage is provided through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, and **applies to the Healthcare FSA only, not to the Dependent Care FSA.**

COBRA Coverage

If coverage terminates due to a qualifying event, you and your dependent(s) if applicable, can still contribute to the Healthcare FSA on an after-tax basis through the end of the calendar year, provided you have a positive account balance at the time of the qualifying event. In certain cases (such as following termination of employment), Emory's COBRA Administrator will notify you or your dependent(s) when

you (or they) are eligible for continued coverage. In other situations, such as divorce, you have the obligation to provide written notice of a qualifying event to Emory at the address provided in this SPD for the Plan Administrator – no later than 60 days following the date of the event - so that COBRA can be offered. Even though the COBRA rules allow you to take up to 60 days to notify Emory about a divorce, remember that you have only **31 days to modify your election** during the year. If you fail to notify Emory within 31 days of a divorce (or other pertinent event), then you will not be able to change or revoke your election under the Healthcare FSA for the remainder of the Plan Year. Of course, this will not affect your dependent’s right to elect COBRA. If you or your dependents do not provide the required notice on time, you or your dependent, as applicable, will not have the right to elect COBRA.

Once you are notified of your right to elect COBRA, you have 60 days to respond and submit your election if you want to continue coverage. If COBRA is elected, the entire cost of coverage plus a 2% administrative fee must be paid for the duration of the COBRA continuation period. In addition, you will have 45 days from the date of your election to submit your required contribution for the first month. Future payments are due each month. Please refer to your COBRA notice for additional important information.

Losing Continued Coverage

Continued participation will end prior to year-end if the Healthcare FSA is discontinued, or if you do not make your contributions on time. If COBRA is not timely elected, or if the required payments are not made when due, the right to COBRA coverage will terminate and cannot be reinstated.

Summary of Benefits

A Flexible Spending Account (FSA) allows you to set aside a portion of your salary on a pre-tax basis, which is reflected, in a special bookkeeping account. You can then use the money in your account(s) to reimburse yourself for qualified healthcare and/or dependent care expenses (but you cannot use money in your Healthcare Account for dependent care expenses or vice versa). Your taxable salary is reduced by the amount you contribute to your account(s), so you pay lower income taxes and Social Security taxes. Participation in a FSA(s) is voluntary. You decide whether you would like to participate and how much money you would like to contribute based on the minimums and maximums shown below.

Contribution	Healthcare Account*	Dependent Care Account
Annual Maximum	\$3,200	\$5,000**
Annual Minimum	\$200	\$200

* Please refer to the enrollment material for any changes to the maximum amount that may be contributed to the Healthcare Account.

** Please see below for additional limits that apply, such as if you are married but file taxes separately or based on your or your spouse’s earned income.

How the Flexible Spending Account Works

You decide how much you want to contribute to one or both of the FSA(s) through pre-tax payroll deductions. These amounts can only be used to pay for qualifying expenses incurred while you participate in the account(s). These are bookkeeping accounts only (there is no actual account in your name, and the

account does not earn interest). You cannot deposit cash directly into your account(s). Once you decide how much you will contribute for the year, you cannot change your election unless you have a qualified family status change, nor can you transfer money from one FSA to another.

How Much You Can Contribute

You can contribute from \$200 to \$3,200 (or such other amount indicated in the enrollment material) to your Healthcare FSA each year.

In general, you can contribute from \$200 to \$5,000 a year to your Dependent Care FSA. However, there are a few additional rules that may affect the maximum available to you. For highly compensated employees (those making \$155,000 or greater per year in 2024), the Dependent Care FSA annual contribution will be limited to \$1,800 (or such other amount as determined by Emory to satisfy the IRS nondiscrimination rules). Please see the section below entitled “Additional Limits on Dependent Care FSAs” for other rules that may affect the maximum you can contribute to the Dependent Care FSA.

Carefully calculate the amount you contribute to your Flexible Spending Account(s). The IRS imposes a “use it or lose it” rule on FSA plans; you forfeit any money that remains in your account after reimbursement of your eligible expenses for the year. In addition, you cannot transfer amounts from one account to the other. See *Limits and Restrictions* for more information.

Limits and Restrictions

To preserve the favorable tax treatment of your contributions, there are several important limitations that you should understand before participating in the FSA(s).

- A FSA is what is known as a “use it or lose it” arrangement, which means if you do not spend all of the money in your account, you lose the unspent balance. You must decide how much to deposit for the year *before* each year begins. Once you decide your contribution amount, you cannot change it during the year unless you experience a qualified family status change; so you should plan to contribute only as much as you expect to spend in the current (if new hire) or upcoming year.
- Having a **Healthcare FSA** limits your tax deductions for healthcare expenses. However, keep in mind that you can deduct unreimbursed healthcare expenses from your federal income tax only if they exceed the threshold established by the Internal Revenue Service.
- To be eligible for reimbursement from the **Healthcare FSA**, the expenses must be for you, your child or a tax-qualified dependent. A tax-qualified dependent is someone for whom you can claim a tax exemption, such as a spouse.
- Having a **Dependent Care FSA** limits the tax credits you may be able to take for dependent care expenses. You can use both the Dependent Care FSA and tax credit, provided you do not claim the same expenses for both. However, federal regulations require that your dependent care tax credit be reduced dollar for dollar, by whatever you put into your FSA.
- You should ask your tax advisor to help you choose the right alternative for your tax bracket.

- You cannot transfer funds between the Healthcare and Dependent Care FSAs.
- You cannot carry over any unclaimed Dependent Care FSA balances from one year to the next. Any funds remaining in your Dependent Care FSA on December 31 will be forfeited unless they are used to cover expenses incurred during that calendar year and Aetna/Inspira Financial (formerly PayFlex) receives your claim for reimbursement by the following May 15.
- The risk of forfeiting money from your Healthcare FSA is reduced by a grace period. You can use your remaining balance available on December 31 to pay for expenses incurred through March 15 of the following year, if you are a participant on December 31. To avoid forfeiture, claims must be filed by May 15. For example, claims incurred between January 1 and March 15 will have to be received by the following May 15.
- Remember that if you participate in the standard Healthcare FSA in 2025 and you want to contribute to a Healthcare Savings Account (HSA) in 2026, you may want to use up your entire balance by December 31, 2025. Due to IRS rules, if you have any balance in a standard Healthcare FSA on December 31 that provides for a grace period, you cannot contribute to a Health Savings Account *or* receive Emory's HSA contributions until the following April 1, even if you do not submit expenses for reimbursement after the end of the year.

Additional Limits on Dependent Care FSA Contributions

If Your Spouse Also Contributes to a Dependent Care FSA, You File Taxes Separately or Based on Earned Income

The IRS sets additional limits on your contributions if you are married and your spouse has a Dependent Care FSA through his or her employer:

- You are limited to a **combined** Dependent Care FSA contribution of \$5,000 in a calendar year. This limit applies whether you have one or more dependents receiving care.
- If you file **separate** federal income tax returns, the most you can contribute is \$2,500 a year.
- If you file a **joint** return, you cannot contribute more than you earn (or what your spouse earns, if it is less than what you earn for the year, with a \$5,000 limit).

If Your Spouse Is Either Disabled or a Full-Time Student

If your spouse is disabled or a full-time student, the IRS considers your spouse's earnings to be \$250 a month if you have one eligible dependent, and \$500 if you have more than one eligible dependent.

How Participating in the FSA(s) Affects Taxes and Other Benefits

Establishing a FSA can also affect your tax strategy when you file your income tax return. You should consult with a tax advisor *before* signing up for a FSA(s) – you cannot change your election once you have made it, unless you have a qualified family status change (as explained in *Making Changes*).

The Tax Advantages

The Internal Revenue Code Section 125 allows your employer to take the money you direct to your FSA(s) out of your pay before federal income, state income, and Social Security (FICA) taxes are deducted. In turn, your taxable income is lower, and you pay less federal, state, and FICA taxes. Emory has the right to adjust elections as it deems reasonable to comply with IRS nondiscrimination rules.

Any reimbursements you receive from your FSA(s) are exempt from federal tax as long as you have not taken (or do not intend to take) a tax deduction or credit for related expenses when you file your federal tax return.

Impact on Other Benefits

Employer-Sponsored Benefits

While you are “reducing” your pay for tax purposes, your pay-related benefits (for example, any employer-sponsored life and disability insurance, and retirement benefits) are not reduced. Your benefits from these plans will be based on your compensation before any amounts are deducted.

Social Security

Since your Social Security (FICA) taxes are based on your reduced pay, your future Social Security benefits may be slightly lower.

Your Flexible Spending Account Statements

The Explanation of Payment (EOP) that Aetna/Inspira Financial (formerly PayFlex) issues with each reimbursement is also a good source of information. The EOP details the amount reimbursed and your current balance.

You can also access information about your FSA account status 24 hours a day, 7 days a week by registering and logging in to Aetna Navigator at www.aetna.com/individuals-families.html. Once logged in you can see your account information under Your Accounts & Funds.

Your Healthcare FSA

The Healthcare FSA lets you pay many of your otherwise unreimbursed healthcare expenses with tax-free dollars. Since not every healthcare expense you incur is eligible for reimbursement through your FSA, it is important to know which are reimbursable and which are not.

If an expense is covered under any other plan(s), you cannot submit it for reimbursement under your Healthcare FSA until the expense has been considered by the other plan(s).

Eligible Healthcare Expenses

You can use your Healthcare FSA to reimburse yourself for certain expenses that are considered “medical care” under Section 213(d) of the Internal Revenue Code, as long as the expenses are not reimbursed by any other medical, dental or vision plan. Tax rules change, so you should check with your tax advisor about the

eligibility of specific expenses. You can get additional information about eligible healthcare expenses from IRS Publication 502, “Medical and Dental Expenses,” which is available from your local IRS office and the IRS website at <http://www.irs.gov/>. Keep in mind that not all expenses listed in the Publication are eligible for reimbursement (such as premiums for coverage).

Limited Healthcare FSA

If you are participating in the Limited Healthcare FSA, you may be reimbursed for your dental and vision expenses that you incur on or following the effective date of your coverage, but your medical expenses are not reimbursable until you have met your medical plan deductible.

Eligible healthcare expenses include medically necessary:

- Acupuncture
- Auto equipment such as special hand controls to assist the physically disabled
- Braille books and magazines
- Crutches
- Dental treatment
- Eye exams, lenses, frames and contact lenses
- Fertility enhancement procedures such as in vitro fertilization (including temporary storage of eggs or sperm), and infertility surgery, including an operation to reverse a prior sterilization procedure
- Guide dog or other animal used by a visually-impaired or hearing-impaired person
- Healthcare and pharmacy co-payment, deductible and coinsurance amounts
- Healthcare expenses that are above the customary charge or healthcare plan maximums
- Hearing exams and hearing aids
- Laser eye surgery
- Lead-based paint removal to protect a child who has, or who has had, lead paint poisoning from continued exposure
- Legal fees directly related to committing a mentally ill person
- Lodging while you receive medical care away from home. Care must be provided by a doctor in a licensed hospital or treatment facility, and the lodging must be primarily for, and essential to, medical care
- Long term care services required by a chronically ill person, if provided in accordance with a plan of care prescribed by a licensed Healthcare practitioner
- Medical information plan that maintains your medical information so it can be retrieved from a medical data bank for your medical care
- Medical services and supplies not covered by your medical plan, provided they are medically necessary (expenses for most cosmetic procedures are not eligible)
- Menstrual care products
- Osteopathic services
- Over-the-Counter medications
- Smoking cessation programs
- Specialized equipment for the disabled, including:
 - Cost and repair of special telephone equipment that allows a hearing-impaired person to communicate over a regular telephone, and equipment that displays the audio part of television programs as subtitles for hearing-impaired people.
- Transportation expenses if primarily for, and essential to, medical care
- At-Home COVID-19 tests

If you have any questions about what is considered an eligible expense under the Healthcare FSA, you may call Aetna/Inspira Financial (formerly PayFlex) Member Services at 1-888-678-8242. You may also contact your local IRS office or visit the IRS website at <http://www.irs.gov/>.

Ineligible Healthcare Expenses

Just as important as understanding what is eligible for reimbursement through your Healthcare FSA, is knowing what is not generally eligible, including the following:

- Expenses for which you have already been reimbursed by other healthcare plans or for which you could be reimbursed from those plans, if you submitted a claim (including Medicare, Medicaid, and Emory's or any other Medical, Dental, or Vision Plan)
- Expenses incurred by anyone other than you or your qualified dependents
- Expenses that are not excludable from federal income tax
- Babysitting, childcare and nursing services for a normal, healthy baby. This includes the cost of a licensed practical nurse (L.P.N.) to care for a normal and healthy newborn.
- Controlled substances
- Cosmetic dental work
- Cosmetic surgery (any procedure to improve the patient's appearance that does not meaningfully promote the proper function of the body, or prevent or treat illness or disease)
- Custodial care in an institution
- Diaper service
- Electrolysis
- Funeral and burial expenses
- Healthcare plan contributions or premiums, including those for Medicare, your spouse's employer's plan, COBRA, or any other private coverage
- Health club dues
- Household help, even if such help is recommended by a physician
- Illegal medical services or supplies
- Maternity clothing
- Medical savings account (MSA) contributions
- Medical plan expenses prior to meeting the deductible, if you are enrolled in a Limited Healthcare FSA
- Over-the-counter health aids or medication, not for medical care (example: vitamins, weight loss aids)
- Nutritional supplements
- Personal use items, unless the item is used primarily to prevent or alleviate a physical or mental defect or illness
- Prescription drugs for cosmetic purposes
- Weight-loss programs not prescribed by a doctor for a specific disease
- Special schooling for a child, even if the child may benefit from the course of study or disciplinary methods
- Transportation to and from work, even if a physical condition requires special means of transportation
- Up-front patient administration fees paid to a physician's practice
- Vitamins or minerals taken for general health purposes

Your Dependent Care FSA

You can use the Dependent Care FSA to reimburse yourself with tax-free funds for certain employment-related dependent care expenses.

Eligibility

If you are married, you may be reimbursed for expenses from the Dependent Care FSA only for expenses incurred while your spouse works or is actively looking for work, or if your spouse:

- Has no earned income for the year; and
- Is a full-time student for at least five months of the year; or
- Is incapable of caring for himself or herself or for the dependent.

Who Qualifies as a Dependent

You can use your Dependent Care FSA to cover the expenses of dependents who are defined as:

- Children who are under age 13 when the care is provided and for whom you can claim an exemption on your federal income tax return;
- Your spouse or other dependent who is mentally or physically incapable of self-care, who lives with you for more than half of the year, and whom you claim as a dependent on your federal tax return (or who you could have so claimed except such individual's earnings exceed the amount permitted for IRS tax exemption purposes).

You can use your Dependent Care FSA to pay expenses for a qualifying child for whom you have joint custody if you pay more than half of the child's support and have custody during the year longer than the other parent. The costs associated with caring for the elderly also may qualify for reimbursement if they live in your home at least eight hours a day and are completely incapable of caring for themselves.

Eligible Dependent Care Expenses

The Dependent Care FSA is strictly monitored by the IRS, and only those expenses that comply with Section 129 of the Internal Revenue Code of 1986 are covered. Keep in mind that the expenses must be work-related to qualify as eligible expenses. The IRS considers expenses "work-related" only if they meet *both* of the following rules:

- They allow you (and your spouse) to work or look for work; and
- They are for the care of a qualified dependent.

You can pay the following work-related expenses through your Dependent Care FSA:

- Wages paid to a babysitter, unless you or your spouse claims the sitter as a dependent.
- Care can be provided in, or outside of, your home.
- Services of a Dependent Care Center (such as a daycare center or nursery school) if the facility provides care for more than six individuals (other than those who reside there), receives a fee,

payment or grant for providing its services, and complies with all applicable state and local laws and regulations.

- Cost for adult care at facilities away from home, such as family daycare centers, as long as your dependent spends at least 8 hours at home.
- Wages paid to a housekeeper for providing care to an eligible dependent. Household services, including the cost to perform ordinary services needed to run your home that are at least partly for the care of a qualifying individual, are covered as long as the person providing the services is not your dependent under age 19 or anyone you or your spouse claim as a dependent for tax purposes.

If you have any questions about what is considered an eligible expense under the Dependent Care FSA, you may call Aetna/Inspira Financial (formerly PayFlex) member services at 1-888-678-8242. You may also contact your local IRS office or visit the IRS website and review Publication 503 at <http://www.irs.gov/>.

Ineligible Dependent Care Expenses

You cannot use your Dependent Care FSA to reimburse yourself for services that:

- Allow you to participate in leisure-time activities;
- Allow you to attend school part-time;
- Enable you to attend educational programs, meetings or seminars; or
- Are primarily medical in nature (such as in-house nursing care).

In addition, expenses for education (such as kindergarten fees) cannot be reimbursed from this account, nor can expenses for overnight camp.

Claiming Reimbursement

When You Can File Claims

Expenses must have been incurred during the Plan Year (or portion of the year during which you participate in that particular account). An expense is incurred when the service that gives rise to the expense is provided. When the expense is billed, charged or paid is irrelevant.

You may not be reimbursed for any expenses arising before the plan becomes effective or for any expenses incurred after the close of the plan year (other than due to the grace period), or after a separation from service or other loss of coverage (unless COBRA coverage is elected).

For example, orthodontia payments, even if billed, will not be considered a healthcare expense under this plan until after the service has been provided. Orthodontia expenses will be reimbursed by this plan only if the expense has been incurred within the plan year. Lump sum payments or services paid in advance of the service being rendered are not reimbursable under this plan, except as provided below.

Orthodontia expenses may also be reimbursed if a reasonable payment schedule or service contract with expense detail is provided with the claim. A reasonable payment schedule or service contract must be prepared by your dentist and must illustrate what orthodontia services are to be provided, when the services

are planned to be provided (identified by month and year), and the corresponding projected expenses associated with those services. An example of a reasonable payment schedule or service contract may include a down payment for initial services provided, and subsequent proportional payments in anticipation of follow-up services. Lump sum payments or services paid in advance of the services being rendered are not reimbursable under this plan in absence of a reasonable payment schedule or service contract.

Aetna/Inspira Financial (formerly PayFlex) Card

Participants will automatically receive an Aetna/Inspira Financial (formerly PayFlex) debit card in the mail. Please activate the card when you receive it so that you will be able to use the card to pay for qualified expenses. Use of the card is subject to Aetna/Inspira Financial's procedures. By using the card you are certifying that you will only use the card for eligible medical expenses, that the expense has not been reimbursed or cannot be reimbursed from a medical plan, that you will not seek reimbursement from any other plan for any expenses for which you use this card and that you will retain sufficient documentation for expenses paid with the card. Each time you use the card, you are reaffirming these requirements.

Use of the Aetna/Inspira Financial card is purely for convenience only. IRS regulations still require participants to retain receipts for any eligible expense they pay using the card and to provide a copy of those receipts when requested. Failure to provide the required documentation may result in the deactivation of your card. You must obtain and retain the documentation necessary to substantiate your Healthcare FSA claim. Please note that a payment receipt may not be sufficient for medical and dental services, so check with Aetna/Inspira Financial to determine what supporting documentation is required.

There are a few circumstances where healthcare expenses purchased with a debit card will be substantiated automatically. For example, payments to a healthcare provider that match the medical plan copay amount and certain recurring charges that were previously approved do not have to be substantiated. However, you should always keep documentation necessary to support any transactions made with your debit card (such as an itemized bill or an Explanation of Benefits (EOB) form) even if you think your expense will not require substantiation.

The FSA plan administrator, Aetna/Inspira Financial (formerly PayFlex), will request verification of most expenses which are purchased using the Aetna/Inspira Financial card. When you receive a request for substantiation of an expense, you must submit appropriate supporting documentation. If you do not have the required documentation or the expense is not eligible, you may submit a different eligible and previously unreimbursed Healthcare FSA expense or you may repay the expense. If you do not timely respond to the request for substantiation, your privileges under the Aetna/Inspira Financial card may be suspended or terminated.

If an expense reimbursed by the Health FSA is later determined to not be eligible for reimbursement, or you do not provide the required documentation substantiating the expense and do not take other corrective steps within the required timeframe, the excess reimbursements may be recovered by:

- Offsetting the excess against other eligible Healthcare FSA expenses submitted for reimbursement (if any are available); or
- Withholding such amounts from your pay as an after-tax deduction (to the extent permitted under applicable law).

If the Plan Administrator is unable to recoup the excess reimbursement as described above, it may take other permitted actions, such as reporting additional taxable income to you, or may treat the excess reimbursement as it would any other bad business debt. This could result in adverse income tax consequences to you.

Documenting Your Claim

Healthcare Expenses

If you do not use your debit card, you can file a claim for reimbursement by completing the “FSA / Limited Purpose FSA” claim form. Copies of the form are available on the benefits website at <https://www.hr.emory.edu/eu/benefits/index.html>. You may also file a claim by logging in to Aetna at <https://www.aetna.com>.

When you submit a claim for reimbursement from your Healthcare FSA, you must provide a copy of:

- The Explanation of Benefits (EOB) you received from your healthcare plan showing how much, if any, of your claim was paid; or
- Itemized bills from suppliers for expenses not covered by any healthcare plan. The itemized bill should include the following information:
 - Patient name;
 - Provider name;
 - Diagnosis;
 - Service or service provided;
 - Charge; and
 - Date of service

Your claim will not be accepted if the required information is not provided. You may use the “FSA / Limited Purpose FSA” claim form to ensure that your claim submission contains all of the required information.

Dependent Care Expenses

To file a claim for reimbursement, complete the “FSA / Limited Purpose FSA” claim form. Copies of the form are available on the benefits website at <https://www.hr.emory.edu/eu/benefits/index.html>. You must provide the following information in your claim submission:

- Dependent’s name;
- Provider’s name, address and tax ID (or Social Security) number;
- The cost, nature and place of the service(s) performed;
- Proof of payment; and
- An indication of whether the provider is related to you and, if so, how (if the provider is your child, you must also include the child's age)

You may ask your dependent care provider to sign the claim form as verification of payment. Detailed bills or receipts are also considered acceptable documentation for dependent care expenses. You are also required to report your provider's taxpayer identification number or Social Security number when you file your tax return.

Reimbursement

Aetna/Inspira Financial (formerly PayFlex) processes FSA claims as they are received, and issues FSA claim payments.

You can be reimbursed through your Healthcare FSA for qualifying healthcare expenses up to the annual pledge amount you elected at enrollment – even if not all of it has been deducted from your paychecks.

You can be reimbursed for dependent care expenses only up to the amount in your Dependent Care FSA when you file a claim. Any unpaid amounts still due you will be processed in the next claim cycle when (and if) you have enough money in your Dependent Care FSA to cover them.

You will receive an Explanation of Payment (EOP), which reflects the status of your account, each time you submit a request for reimbursement (for example, the amount of the claim, how much of it is eligible for reimbursement, what has been paid to date from your FSA, any amounts still payable, and any balance remaining in your Account). Contact information for claim submission and customer service for Aetna/Inspira Financial (formerly PayFlex) is as follows:

Inspira Financial (formerly PayFlex)
P.O. Box 2495
Omaha, NE 68103
Fax: 1-888-238-3539

For the hearing impaired, call 1-877-703-5572

Customer Service: 1-888-678-8242

How to Appeal a Denied Claim

If your claim is entirely or partially denied, the reason(s) for the denial will appear on the Explanation of Payment (EOP) you receive from Aetna/Inspira Financial (formerly PayFlex). See below for more information on claim denials and your right to appeal a denial. If you would like your claim reconsidered, you must submit a written appeal within the required deadline to:

Inspira Financial (formerly PayFlex)
P.O. Box 2495
Omaha, NE 68103

Healthcare FSA Claims and Appeals

If a claim for Healthcare FSA benefits is denied in whole or in part, Aetna/Inspira Financial (formerly PayFlex) will notify you of an adverse benefit determination within a reasonable period of time but in no event later than 30 days after receipt of a claim. An adverse benefit determination is any denial, reduction or termination of a benefit, or a failure to provide or make a payment, in whole or in part, for a benefit. A 15-day extension may be allowed to make a determination, provided Aetna/Inspira Financial determines that the extension is necessary due to matters beyond its control and it notifies you of the need for an extension.

The denial notice will include:

- The specific reasons for the adverse benefit determination.
- References to the specific plan provisions on which the benefit determination is based.
- A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary.
- A description of the plan's appeal procedures and the time limits applicable to those procedures, including a statement of your right to bring a civil action under ERISA Section 502 after an appeal of an adverse benefit determination.

- Any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request.
- If the adverse benefit determination was based on a health care necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the plan to your health care circumstances, or a statement that such explanation will be provided free of charge upon request.

If you have filed a claim for Healthcare FSA benefits and that claim has been denied in whole or in part, and you think your claim has been wrongfully denied, you have 180 days after receiving the written denial to request a review. Your request for a review, called an appeal, must be submitted to Aetna/Inspira Financial in writing. Be sure to explain why you think you are entitled to reimbursement and attach any documentation that will support your claim. Aetna/Inspira Financial must respond to your written request for a review within 60 days of receiving it, explaining the reasons for their decision in clear, understandable language. Aetna/Inspira Financial appeal determination decision is final and binding. You can also follow this procedure if you do not receive any response to your claim within 30 days after you have initially filed it with Aetna/Inspira Financial. You will lose any right to bring legal action if you do not appeal in a timely manner.

You have the right to:

- Submit written comments, documents, records, and other information relating to the claim for benefits.
- Request, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.
- A review that takes into account all comments, documents, records, and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination.
- A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination, nor by that person's subordinate.
- A review in which the named fiduciary consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment.
- The identification of health care or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision.

If your appeal is denied, you will receive the following information:

- The specific reasons for the adverse benefit determination.
- References to the specific plan provisions on which the benefit determination is based.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.
- A statement describing any voluntary appeal procedures offered by the plan and your right to obtain the information about such procedures, and a statement of your right to bring legal action under ERISA Section 502.
- Any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination; or a statement that a copy of this information will be provided free of charge to you upon request.

- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Dependent Care FSA Claims and Claims Relating to Eligibility under the Plan

If you submit a claim regarding eligibility under the Plan or a claim under the Dependent Care FSA and it is denied in whole or in part, you will be notified of the adverse determination within a reasonable period of time, but not later than 90 days after receiving the claim. This 90-day period may be extended in certain circumstances require.

If you think your claim has been wrongfully denied, you have 60 days after receiving the written denial to request a review. Your request for a review, called an appeal, must be submitted to Aetna/Inspira Financial (formerly PayFlex) in writing (or, if it relates to eligibility, to the Plan Administrator). Be sure to explain why you think you are entitled to reimbursement and attach any documentation that will support your claim. Aetna/Inspira Financial will respond to your written request for a review within 60 days of receiving it. If a longer response time is required, Aetna/Inspira Financial will notify you. Aetna/Inspira Financial's decision is final and binding. You can also follow this procedure if you do not receive any response to your claim within 90 days after you have initially filed it with Aetna/Inspira Financial. You will lose any right to bring legal action if you do not appeal in a timely manner.

If your claim relates to eligibility or otherwise does not relate to reimbursement or benefits under the FSA, you must submit the claim, appeal and information supporting your claims and/or appeal to the Plan Administrator (not to Aetna/Inspira Financial). The Plan Administrator has wide and absolute discretion to interpret and apply plan provisions and determine facts, benefits, and eligibility. All interpretations, decisions, and determinations of the Plan Administrator are intended to be final, conclusive, and binding on all parties having an interest in the plan. Also, please refer to the section below regarding bringing legal action.

Non-Assignment of Benefits

You cannot assign, pledge, borrow against, or otherwise promise any benefit payment provided by the Plan before receipt of that benefit payment. However, benefits will be provided to your child if required by a Qualified Medical Child Support Order. In addition, subject to your written direction, all or a portion of benefit payments provided by the Plan may, at the option of the Plan, and unless you request otherwise in writing, be paid directly to the provider rendering a service to you. Any benefit payment made by the Plan in good faith pursuant to this provision fully discharges the Plan to the extent of such payment.

In addition, you may not assign your rights to bring a lawsuit under the Plan to any providers or other persons who may provide or render any treatment or services to you or your dependents.

Legal Action and Exhaustion of Appeals

You must use and fully exhaust all of your actual or potential rights under the Plan's administrative claims and appeals procedures by filing an initial claim and then filing a timely appeal of any denial before filing suit in court. This relates to claims for benefits, eligibility and to any other issue, matter or dispute (including any plan interpretation or amendment issue). Any such suit must be filed within one year after receiving a final adverse benefit determination on appeal or two years after the date the claim arose. Failure

to follow the Plan's administrative claims and appeals procedures in a timely manner will cause you to lose your right to bring legal action.

Restriction of Venue

Any claim, suit or action filed in court or any other tribunal in connection with the Plan by or on behalf of a Claimant shall only be brought or filed in the United States District Court for the Northern District of Georgia.

Discretionary Authority

The Plan Administrator and Aetna/Inspira Financial (with respect to any matters delegated to it) have the exclusive discretionary authority to construe and to interpret the Plan, to decide all questions of eligibility for benefits and to determine the amount of such benefits, and their decisions on such matters are final and conclusive. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect. Benefits under the Plan will be paid only if the Plan Administrator or Aetna/Inspira Financial, as applicable, decides in its discretion that a participant is entitled to them.

Plan Information

Your ERISA Rights: Healthcare FSA

The Employee Retirement Income Security Act of 1974, known as ERISA, guarantees your rights as a Plan participant in the Healthcare FSA. ERISA provides that all Plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and the latest annual report (Form 5500 Series), and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified medical child support order (QMCSO).

Continue Group Health Plan Coverage

Continue healthcare coverage for yourself, spouse and/or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Action by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to \$110 a day (as indexed) until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court, but only after you have exhausted the administrative remedies available under the Plan, including following the appropriate claims procedure as described above. In addition, if you disagree with the Plan’s decision or lack thereof concerning the status of a medical child support order, you may file suit in a federal court.

If it should happen that Plan fiduciaries misuse the Plan’s money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

General Information about the Plan

Plan Administrator: Emory University
Attn: Sr. VP & Chief HR Officer
1599 Clifton Road, First Floor
Atlanta, GA 30322
(404) 727-7613

Agent for Service of Legal Process: Emory University
Office of the General Counsel
201 Dowman Drive
101 Administration Building
Atlanta, GA 30322

Plan Sponsor: Emory University
1599 Clifton Road, First Floor
Atlanta, GA 30322

Employer Identification Number: 58-0566256

Plan Name: Emory University Beneflex Plan

Plan Number: 507

Type of Plan: Welfare

Plan Year: January 1 – December 31

Type of Administration/Funding: Administrative Services Contract with Aetna/Inspira Financial
(formerly PayFlex)

Benefits are paid solely from the general assets of the Employer

Amendment or Termination of the Plan

Emory has the right to amend or terminate the Plan, in whole or in part, at any time. If a change is made, you will be notified. The establishment of an employee benefit plan does not imply that employment is guaranteed for any period of time or that any employee receives any non-forfeitable right to continued participation in any benefits plan.

Plan Documents

This plan description covers the major features of the Flexible Spending Account program administered by Aetna/Inspira Financial (formerly PayFlex), as in effect January 1, 2025. The plan description has been designed to provide a clear and understandable summary of the Plan, and serves as the Summary Plan Description (SPD), as required for plans subject to ERISA.

HIPAA Privacy and Security

For important information about how the Healthcare FSA can use and disclose protected health information, and about your rights under the HIPAA privacy rule, please refer to the Plan's Notice of Privacy Practices. This notice also sets out the Plan's legal obligations concerning your protected health information and describes your rights to access and control your protected health information.

Definitions

Aetna/Inspira Financial (formerly PayFlex) Card – A debit card that you may use electronically to access your flexible spending account to pay for eligible expenses. You may use the card at qualified merchants including doctor and dental offices, hospitals, pharmacies, and hearing/vision care centers.

Benefits – Your right to payment for Covered Flexible Spending Account Services that are available under the Plan. Your right to benefits is subject to the terms, conditions, limitations and exclusions of the Plan.

Claims Administrator – The companies (including affiliates) that provide certain claim administration services for the Plan including Aetna/Inspira (formerly PayFlex).

Claim Determination Period – The calendar year.

Dependent Care FSA – A flexible spending account that may be used to pay for eligible child or adult care expenses. This includes childcare for children under the age of 13 and day care for an individual of any age who is incapable of self-care, lives with the taxpayer for more than one-half of the tax year, and is either the taxpayer's spouse or dependent.

Documentation – IRS regulations require that claims and certain card transactions be substantiated with appropriate documentation. Documentation includes the insurance carrier Explanation of Benefits (EOB), provider itemized statement or pharmacy receipt, and detailed cash register receipt with the merchant name, product name, date, and amount of purchase.

Eligible Medical or Dental Expenses – Expenses incurred by the Employee or the Employee's Spouse or Dependents that are eligible for reimbursements.

Expense Incurred – an expense is treated as having been incurred when the medical or dependent care that give rise to the expense has been provided, and not when you are formally billed, charged for, or pay for the expense. To "give rise" means to cause to happen.

Grace Period – The 2 ½-month period after the end of the Plan Year. During this period, unused account balances that remain at the end of a Plan Year may be used for incurred expenses.

Limited Healthcare FSA – A flexible spending account that may be used to pay for qualified dental and vision expenses. Eligible medical and prescription drug expenses incurred *after meeting* the medical plan deductible are also reimbursable.

Participant – A person who is an Eligible Employee and who is participating in the Plan.

Plan Year – The annual accounting period of the Plan.

Standard Healthcare FSA – A flexible spending account that may be used to pay for eligible medical, dental, vision, and prescription drug expenses.

Use It or Lose It– Rule pursuant to Section 125 of the Internal Revenue Code. Under this rule, any money left unspent at the end of the coverage period is forfeited.