The Pension Boards
United Church of Christ, Inc.

2026 Highlights

Flexible Benefit Plan

for UCC Ministries

The Pension Boards
United Church of Christ, Inc.

History

Since 1914, the Pension Boards-United Church of Christ, Inc. (PBUCC) has been a partner in ministry with those who serve the United Church of Christ (UCC). PBUCC offers comprehensive employee benefits programs for active and retired UCC clergy and lay employees and their eligible dependents, providing the highest standards of service, access, and options.

PBUCC assists those who serve the church in achieving health and economic security through:

- thought leadership regarding faith-based, socially responsible investing;
- professional investment expertise that enhances returns;
- a comprehensive mix of products and services that meet diverse needs;
- innovative application of technology; and
- outreach to all settings of the UCC and the greater church

Health Plan Mission

To provide the highest standard of service, access to care and options to active, inactive, and retired UCC clergy and lay employees.

January 2026

Dear UCC Colleague,

We are pleased to provide you with this copy of **Highlights of Your Flexible Benefit Plan for UCC Ministries** (also known as a "Flexible Spending Account" or "FSA" Plan).

One of the most important features of the FSA Plan is that the benefits offered are generally ones that you are already paying for, but normally with money that has first been subject to federal income and Social Security taxes. Under the FSA Plan, these same expenses are paid for with a portion of your pay before federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save. You can easily manage your FSA Plan by using the Highmark Blue Shield Spending App. Please follow the instructions provided in this booklet to register.

The FSA Plan consists of:

- a Health Care Reimbursement Account, which can help with expenses related to medical, pharmacy, dental, and vision care;
- a Dependent Care Assistance Account, which can help with work-related dependent day care costs;
- a Debit Card for payment of eligible expenses; and,
- a Premium Payment Plan, which enables you to pay eligible insurance premiums on a pre-tax basis.

You are encouraged to read this booklet carefully to learn about the FSA Plan's benefits. If you have any questions, please contact us at **1.800.642.6543**.

We hope that you continue to be pleased with the benefits available to Plan participants, and we covenant to work with you to provide the best possible benefits at the most effective cost.

May you enjoy good health and abundant blessings.

Best regards,

Health Plan Operations

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Introduction

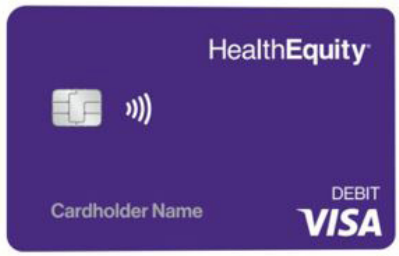
The Flexible Benefit Plan for UCC Ministries (also known as a "Flexible Spending Account" or "FSA") was established for you and other eligible UCC employees. Under this Plan, you will be able to choose among certain benefits. The benefits you may choose are outlined in this **Highlights** booklet. We will also provide other important information concerning the Plan, such as the rules you must satisfy before you can join.

One of the most important features of the Plan is that the benefits offered are generally ones that you are already paying for, but normally with money that has first been subject to federal income and Social Security taxes. Under the Plan, these same expenses will be paid for with a portion of your pay before federal income or Social Security taxes are withheld. This means that you will pay less tax and have more money to spend and save.

The FSA Plan consists of:

- a Health Care Reimbursement Account that can help with expenses related to medical, pharmacy, dental, and vision care;
- a Dependent Care Assistance Account, which can help with work-related dependent day care costs;
- a Debit Card for payment of eligible expenses;
- a Premium Payment Plan, which enables you to pay eligible insurance premiums on a pre-tax basis.

You can manage and check up on your account through HealthEquity online via the **HealthEquity** website at **https://participant.wageworks.com**. Please read this **Highlights** booklet carefully so that you understand the provisions of our Plan and the benefits you will receive. You should direct any questions to the Plan Administrator, the Pension Boards. There is a Plan document on file, which you may review if you desire. In the event there is a conflict between this booklet and the Plan document, the Plan document will take precedence.



Your Flexible Spending Account Card

I. Eligibility

1. When Can I Become a Participant in the Plan?

In order to participate in the Plan, you must first meet the eligibility requirements. Contact the Pension Boards-United Church of Christ, Inc. ("Pension Boards") with questions about the eligibility rules that apply. Then you will be required to complete the application form (**FSA Election and Compensation Reduction Agreement Form**) in order to enroll in the Plan.

2. What Are the Eligibility Requirements for Our Plan?

If you are currently an employee, you may enroll only during the open enrollment period at the end of each year for an effective date of coverage of January 1 of the following year.

If your employer adopts the Plan during the year or if you become eligible during the year, you will be given 30 days to elect to participate in the Plan. If you elect to participate in the Plan, your election will be prospective only.

3. What Must I Do to Enroll in the Plan?

To enroll in the Plan, you must complete the **The Lifetime Retirement Income Plan and Other Benefits Membership form**. This Form must include your personal choice for each of the benefits offered under the Plan. You also must authorize your employer to set aside some of your earnings to pay for the benefits you have elected.

II. Operation

1. How Does This Plan Operate?

Before the start of each year, you will be able to elect to have some of your upcoming pay contributed to the Plan. You must make new elections each year. These amounts will be reserved for the benefits you have chosen. The portion of your salary that is paid to the Plan is not subject to federal income or Social Security taxes. This allows you to use tax-free dollars to pay for certain kinds of benefits and expenses that you normally pay for with out-of-pocket, taxable dollars. However, if you receive a reimbursement for an expense under the Plan, you cannot claim a federal income tax credit or deduction.

III. Contributions

1. How Much of My Pay May My Employer Redirect?

Each year, you may elect to have your employer redirect enough of your compensation to pay for the benefits that you elect under the Plan. These amounts will be deducted from your pay over the course of the year. For the Health Care Reimbursement Account and Dependent Care Assistance Account, the Plan will allow deferrals up to the maximum allowable amounts as designated by the IRS. Contribution limits are typically announced by the IRS in late fall of the prior Plan Year. Contact the Pension Boards with questions about the annual limits that apply.

2. What Happens to Contributions Made to the Plan?

Before each Plan Year begins or when you first become eligible, you will select the account(s) you want and determine how much of your contributions should go toward each account. It is very important that you make these choices carefully based on what you expect to spend on each covered benefit or expense during the Plan Year. (See Section IX, **General Information About The Plan** (p. 11), for the definition of Plan Year.) Contributions to the Plan will be used to pay for the expenses as they arise during the Plan Year.

3. When Must I Decide Which Accounts I Want to Use?

Federal law requires that during the election period, before the Plan Year begins or when you first become eligible, you decide on the benefits you want and how much you want to contribute to each account. All Plan elections apply on a prospective basis.

4. When Is the Election Period for Our Plan?

Your election period will start on the date you first meet the eligibility requirements and end after 90 days. Then, for each following Plan Year, the election period will be the month of November prior to the start of the next Plan Year.

5. May I Change My Elections During the Plan Year?

Generally, after the beginning of the Plan Year you cannot change the elections you have made. However, updates to federal guidelines may allow for authorization of mid-year election changes. Additionally, there are certain limited situations in which election changes are allowed. You are permitted to change elections if you have a change in status and you make an election change that is consistent with the change in status. (**Change in Status Election Form**) Currently, federal law considers the following events to be "changes in status":

- marriage, divorce, death of a spouse, legal separation, or annulment;
- change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;
- any of the following events for you, your spouse, or dependent:
  - □ termination or commencement of employment,
  - □ a strike or lockout,
  - □ commencement or return from an unpaid leave of absence (FMLA),
  - □ a change in worksite, or
  - □ any other change in employment status that affects eligibility for benefits (e.g., from part-time to full-time status);
- one of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, or any similar circumstance; and
- a change in the place of residence for you, your spouse, or dependent.

For Dependent Care Assistance Accounts, the following qualifies as a change in status:

- If your dependent no longer meets the eligibility qualifications for dependent care.
- If the cost of dependent care increases during the year, you may change your elections; however, you may not change your election under the Dependent Care Reimbursement Account if the cost change is imposed by a dependent care provider who is your relative.
- Contact the Pension Boards for additional information and to learn whether your event is eligible for a mid-year election change.

Please note: If you are a working participant, and you will be enrolling in Medicare sometime during the Plan Year after you have enrolled in the FSA Plan, you cannot reduce your election for the year based on your reduced out-of-pocket medical expenses. It is, therefore, very important to calculate your estimated out-of-pocket expenses, including a possible reduction in expenses if you become eligible for Medicare during the Plan Year, prior to submitting your election for the Plan Year. Retired participants are no longer eligible to participate in the FSA plan.

6. Must I Make New Elections in Future Plan Years?

Yes, a new election must be made for each separate Plan Year. This allows you to change the elections that you previously made. You may also choose not to participate in the Plan for the upcoming Plan Year. If you do not make new elections during the election period before a new Plan Year begins, we will consider that to mean you have elected not to participate for the upcoming Plan Year. A new enrollment form must be submitted prior to each new Plan Year for future elections.

IV. Benefits

1. What Benefits Are Available?

Under our Plan, you can choose to receive your entire compensation or use a portion to pay for the following benefits or expenses during the year:

Health Care Reimbursement Account

The Health Care Reimbursement Account enables you to pay for expenses that are not covered by the UCC Medical, Dental, Prescription, or Vision Plans and save on federal income taxes at the same time. The account allows you to be reimbursed by the Plan for out-of-pocket medical, dental, prescription, and vision expenses incurred by you and your dependents. The expenses that qualify are those permitted by Section 213 of the Internal Revenue Code of 1986, as amended.

Dependent Care Assistance Account

The Dependent Care Assistance Account enables you to pay for out-of-pocket, work-related dependent day care costs with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time. Single employees may also use the account.

An eligible dependent is any member of your household for whom you can claim expenses on federal income tax Form 2441, *Child and Dependent Care Expenses*. Children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent care arrangements that qualify include:

- a dependent (day) care center, provided that, if care is provided by the facility for more than six individuals, the facility complies with applicable state and local laws;
- an educational institution for preschool children (for older children, only expenses for non-school care are eligible);
- an individual who provides care inside or outside your home. The individual may not be a child of yours under age 19 or anyone you claim as a dependent for federal tax purposes.

You should make sure that the dependent care expenses you are currently paying for qualify under our Plan. The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care Assistance Account. Generally, your reimbursements may not exceed the lesser of:

(a) $7,500 (if you are married filing a joint return or you are head of a household) or $3,750 (if you are married filing separate returns);

(b) your taxable compensation;

(c) your spouse's actual or deemed earned income. (A spouse who is a full-time student or incapable of caring for himself/herself has a deemed monthly earned income of $250 for one dependent or $500 for two or more dependents).

Also, in order to have the reimbursements made to you from this account be excludable from your income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider on your tax form for the year, as well as the amount of such expense, as proof that the expense has been incurred. In addition, federal tax laws permit a tax credit for certain dependent care expenses you may be paying for, even if you are not a participant in this Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care Assistance Account under our Plan. Consult with your tax adviser to find out which is better for you.

2. Are Costs Incurred by My Domestic Partner Eligible for Reimbursement?

In order to determine whether your domestic partner qualifies as your dependent and is eligible to have their medical claims reimbursed through the FSA Plan, **all three** of the following criteria, based on federal guidelines, must be met:

- The domestic partner must be an individual who, for the taxable year of the employee, has the same principal place of residence as the employee.
- The domestic partner must be an individual who, for the taxable year of the employee, is a member of the employee's household.
- Over one-half of the domestic partner's support is provided by the employee for the employee's tax year.

If one or more of the criteria listed above is not met, then your domestic partner does not qualify as your dependent for benefit plan purposes and you will not be reimbursed for their out-of-pocket medical expenses through the FSA Plan.

If you will be covering your domestic partner's out-of-pocket claims through the FSA Plan, please contact the Pension Boards so that you can complete the required forms: **Statement of Domestic Partnership and Financial Interdependence and Certification of Domestic Partner as a Dependent or Non-Dependent.**

V. Benefit Payments

1. When Will I Receive Payments for My Expenses?

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid.

Participants will be issued a debit card that can be used to pay for qualifying out-of-pocket expenses.

The Internal Revenue Code (IRC) requires that you use your FSA debit card only for eligible expenses. You may need to provide documents to prove that your medical claim is an eligible expense. You can upload these receipts to your member website when you submit a claim, or when you get a request for documents. To ensure compliance with IRS regulations:

- Retain all itemized receipts and documentation as HealthEquity or the IRS may request validation of any account withdrawals.
- If requested, you are obligated to submit receipts to prove expenses are eligible under your specific plan and applicable IRS regulations.
- Itemized receipts should include: provider name, date of service, type of service, and cost to you.

Failure to provide requested substantiation of debit card use may result in suspension or cancellation of your debit card. If your FSA debit card is suspended, please contact HealthEquity at **1.877.924.3967** for details.

Participants may file a claim by **logging in here**.

The HealthEquity website and mobile app can also be used to assist in the management of your FSA by allowing you to:

- Request additional cards for qualified dependents
- Report a card lost or stolen
- Obtain up-to-date account balance
- View account activity
- View alerts such as receipt requests

You may request forms by contacting the Pension Boards toll-free at **1.800.642.6543**, or by email at **info@pbucc.org**.

If the request qualifies as a benefit or expense under the provisions of the Plan, you will receive a reimbursement payment soon thereafter. Remember,

reimbursements made from the Plan are not subject to federal income tax or withholding, nor are they subject to Social Security taxes. Reimbursement for medical expenses is limited to the annual amount you elect. You will only be reimbursed from the Dependent Care Assistance Account to the extent that there are sufficient funds in the account to cover your request. Reimbursement checks are mailed directly to your address or you may select to set up direct deposit via the **View Claims and Payments** tab on the **HealthEquity** website.

2. What Happens If I Don't Spend All Plan Contributions?

The IRS generally requires that the FSA accounts under the Plan be maintained on a "use it or lose it" basis. This means that any unused amounts are subject to forfeiture. The Health Care Reimbursement Plan allows for the maximum carry-over amounts as designated by the IRS for expenses in the next year.

It is important to note that for any remaining balance over the maximum allowable carry over amount, the "use or lose" rule applies and that money must be used by December 31 of the following year. Any money remaining will be forfeited. Employees have until March 31 of the following year to submit expenses that were incurred prior to December 31.

Carryover of health FSA funds will become available after the claims filing deadline of March 31 has passed.

The Dependent Care Assistance Account offers a grace period of 2.5 months and does not offer carry-over of unused funds from the prior year. You may file claims using amounts of the prior year's funds for expenses incurred through March 15. Claims must be filed by March 31.

Because it is possible that you might forfeit amounts in the Plan if you do not fully use the contributions that you have made, it is important that you carefully and conservatively decide how much to place in each account. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins or within 90 days of your first eligibility. You want to be sure that the amount you decide to place in each account will be used up entirely. Forfeited amounts are used to help pay Plan administration expenses and claims.

3. Family and Medical Leave Act (FMLA)

If you take leave under the Family and Medical Leave Act, you may revoke or change your existing elections for the Health Care Reimbursement Account. If your coverage in these benefits terminates due to your revocation of the benefit while on leave, or due to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return. For the Health Care Reimbursement Account, you may continue your coverage or you may revoke your coverage and resume it when you return. You can resume your coverage at its original level and make payments for the time that you were on leave.

For example, if you elect $1,200 for the year and are out on leave for three months, then return and elect to resume your coverage at that level, your remaining payments will be increased to cover the difference–from $100 per month to $150 per month. Claims incurred during the three months when you were on leave can be submitted for reimbursement.

However, if you elect $1,200 for the year and after the three months of leave you opt to continue paying the remaining payments at $100 a month, at the end of the year your annual election will be only $900. In this situation, the expenses you incur during the months that you are on leave are ineligible for reimbursement from the Health Care Reimbursement Account.

You can continue your coverage during your unpaid leave by:

- pre-paying for the coverage;
- paying for your coverage on an after-tax basis while on leave; or
- arranging with your employer a schedule for you to "catch up" on your payments when you return.

4. Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are going into or returning from military service, you may have special rights to health care coverage under your Health Care Reimbursement Account under the Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994. These rights can include extended health care coverage. If you may be affected by this law, please ask the Administrator for further details.

5. What Happens If I Terminate Employment or Retire During the Plan Year?

If you leave your employment or retire during the Plan Year, your right to benefits will be determined in the following manner:

Dependent Care Assistance Account

- You will still be able to request reimbursement for qualifying dependent care expenses for the remainder of the Plan Year from the balance remaining in your Dependent Care Assistance Account at the time of termination of employment. However, no further salary redirection contributions will be made on your behalf after you terminate or retire. *Example: If you terminate employment on August 31, 2026, you will have until March 31, 2027, to file a claim for expenses that were incurred through March 15, 2027, using your remaining 2026 balance funds.*

Health Care Reimbursement Account

- Upon retirement, or termination of employment, you may submit claims only for expenses incurred prior to the last day of the month following your termination or retirement. *Example: If you terminate employment on August 31, you have 90 days to file a claim for expenses that were incurred on or before August 31.*

It is your responsibility to notify the Pension Boards of a divorce, legal separation, or other change in marital status, change in a spouse's address, or a child losing dependent status under the Plan, within sixty (60) days of the event. We will notify the Claims Administrator of any changes that are made.

6. Will My Social Security Benefits Be Affected?

Your Social Security benefits may be slightly reduced because tax-free benefits received under the FSA will reduce the amount of contributions that you make to the Social Security system as well as employer contributions to Social Security on your behalf.

VI. Premium Payment Plan

Your employer must adopt the Plan in order to withhold premiums from your salary as pre-tax money. Once the Plan is adopted, your employer can withhold each month, from your salary before taxes, the premiums that you are paying. If you elect to participate in this Plan, you must agree to have the premiums paid on a pre-tax basis instead of an after-tax basis. Your employer may make monthly payments using the employer portal available on The Pension Boards website, **www.pbucc.org**.

If you are currently paying all or a portion of the premiums for your Health, Dental, and/or Vision Plans, your employer can—if they adopt the Flexible Benefit Plan - withhold the premium payments from your pay on a pre-tax basis. Please note that premium payments made under this Plan will only cover the premiums paid for your spouse and dependents while you are participating in the UCC Health, Dental, and Vision Plans.

VII. Participation In the Plan While Receiving Short-Term Disability (STD) Benefits

If you are participating in the FSA Plan and have been approved to receive Short-Term Disability (STD) benefits, you have one of the two options shown below:

(1) Elect to continue making contributions to the Plan on an after-tax basis and continue participation in the Plan until such time that you are approved for Long-Term Disability (LTD) benefits. Once you begin receiving LTD benefits, you will cease to be a participant in the Flexible Benefit Plan. You will be able to make claims only for expenses incurred during the portion of the Plan Year before you started your LTD benefits.

(2) Elect not to continue participation in the Plan, in which case you will cease to be a Plan participant. You will be able to make claims only for expenses incurred during the portion of the Plan Year preceding the date that your compensation and deferrals to the Flexible Benefit Plan ended.

A disabled member can resume participation in the Plan when compensation resumes. However, this member would not be permitted to submit claims for expenses incurred during the period of non-participation in the Plan.

VIII. Plan Accounting

1. Periodic Statements

You may access a summary of your account online by **logging into your account here** and clicking the **View Claims and Payments** tab or via the HealthEquity app. Remember, you want to claim all the money you have designated for a Dependent Care Assistance benefit and for a Health Care Reimbursement per plan guidelines.

IX. General Information About Our Plan

This Section contains some general information about the Plan that you need to know.

1. General Plan Information

The Plan's records are maintained on a 12-month basis. This is known as the "Plan Year." The Plan Year begins on January 1, and ends on December 31, except for the first Plan Year, which began when the Plan was adopted. In addition, an employer that adopts the Plan on a day other than January 1, may have an initial "Short Plan Year" of less than 12 months.

2. Sponsor Information

Your employer who has adopted the Flexible Benefit Plan for United Church of Christ Ministries prototype document is the plan sponsor for your Plan.

3. Plan Administrator Information

The name, address, and business telephone number of your Plan Administrator are:

The Pension Boards–United Church of Christ, Inc.
475 Riverside Drive, Room 1020
New York, NY 10115-0059
1.800.642.6543

The Administrator keeps the records for the Plan and is responsible for its administration. Therefore, please feel free to contact the Administrator for any further information about the Plan.

4. Service of Legal Process

The name and address of the Plan's agent for service of legal process are:

The Pension Boards–United Church of Christ, Inc.
475 Riverside Drive, Room 1020
New York, NY 10115-0059

5. Claims Submission

File claim online: Submit claim online for faster service. **Log in to your account here** to file your claim electronically and upload your documentation.

Paper claims for expenses should be submitted to:

CLAIMS ADMINISTRATOR
PO Box 14053
Lexington, KY 405126

Fax: 877-353-9236

Please visit www.pbucc.org to obtain a **claim form**.

X. Additional Plan Information

1. Claims Process

Expenses incurred during the Plan Year (January 1 through December 31) may be submitted for reimbursement throughout the year. In order to be eligible for reimbursement of any expenses for a given Plan Year, you must submit your claim by March 31, following the Plan year. Any claims submitted (postmarked, faxed, or emailed) after that time will not be considered for reimbursement. This provision will be in effect for all Plan Years.

2. Appeals

If a claim under the Plan is denied in whole or in part, you or your dependent(s) will receive written notification. The notification will include:

- the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based;
- a description of any additional information needed to process the claim;
- an explanation of the claims.

To Appeal A Denied Claim:

If you feel your claim was denied in error, you have the right to file an appeal by writing a letter that explains why you believe the claim should be approved.

Your appeal may be submitted in writing and mailed to:

HealthEquity Claims Appeal Board
PO Box 14034
Lexington, KY 40512

Or your appeal may be faxed to:

Fax Number: **1-877-220-3248**

Your appeal must be received within 180 days of the date you receive this notice of your claim being denied.

You will be notified of the decision regarding your appeal in writing by HealthEquity within 30 days of receipt of your written appeal.

XI. Summary

The money you earn is important to you and your family. You need it to pay your bills, enjoy recreational activities, and save for the future. The Plan will help you keep more of the money you earn by lowering the amount of taxes you pay. The Plan is the result of our continuing efforts to find ways to help you get the most for your earnings. If you have any questions, please contact the Pension Boards.

Qualifying Medical Care Expenses

Qualifying medical expenses include only those expenses incurred for:

1. yourself;
2. your spouse/domestic partner - refer to Section X
3. all dependents you list on your federal tax return.

Under the Health Care Reimbursement Plan, you will be reimbursed only for those types of medical expenses which are normally deductible on your federal income tax return (without regard to the 10% of adjusted gross income limitation). **Please review a list of eligible expenses here**. Expenses under this Plan are treated as being "incurred" when you are provided with the care that gives rise to the expenses—not when you are formally billed, charged, or when you pay for the medical care.

Qualifying medical expenses include expenses you have incurred for:

a. medicine, drugs, and vaccines that your doctor prescribed;

b. certain over the counter products that are for medical care;

c. medical doctors, dentists, eye doctors, orthodontists, chiropractors, osteopaths, podiatrists, psychiatrists, psychologists, physical therapists, acupuncturists, and psychoanalysts (medical care only);

d. medical examinations, X-ray and laboratory services, insulin treatment, and whirlpool baths prescribed by a physician;

e. nursing help (if you pay someone to do both nursing and housework, you can be reimbursed only for the cost of the nursing help);

f. hospital care (including meals and lodging), clinic costs, and lab fees;

g. medical treatment at a center for substance abuse;

h. medical aids such as hearing aids (and batteries), dentures, eyeglasses, contact lenses, braces, orthopedic shoes, crutches, wheelchairs, guide dogs, and the cost of maintaining them;

You cannot obtain reimbursement for:

a. the basic cost of Medicare insurance;

b. life insurance or income protection policies;

c. accident, health, or indemnity/chronic condition insurance for you or members of your family;

d. the hospital insurance benefits tax withheld from your pay as part of the Social Security tax or paid as part of Social Security self-employment tax;

e. nursing care for a healthy baby;

f. illegal operations or drugs;

g. travel your doctor told you to take for rest or change;

h. cosmetic surgery;

i. long-term care expenses.

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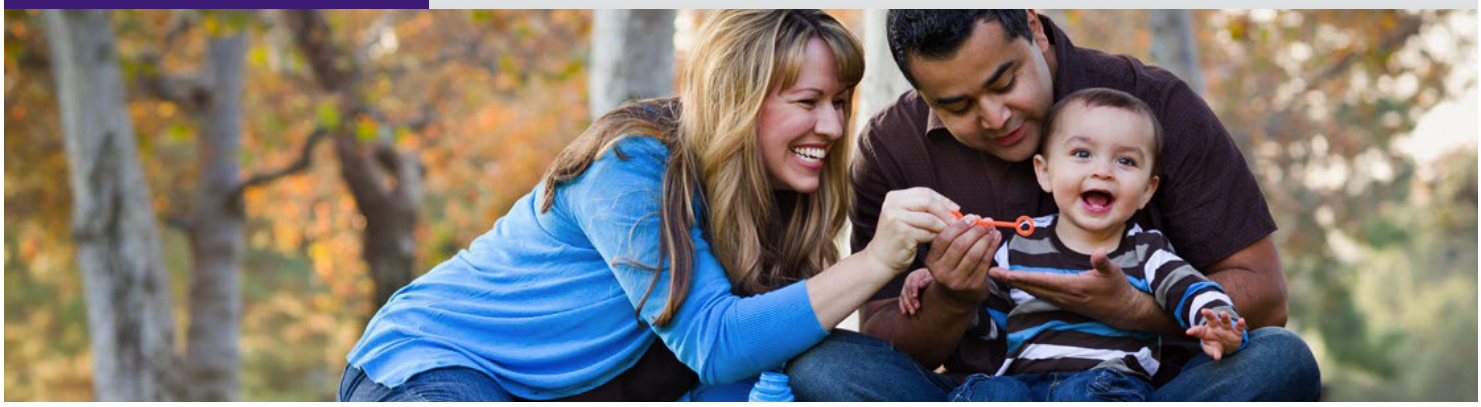
QUICKSTART GUIDE

Your Flexible Spending Account



At-a-Glance

Register online now!

If you haven't registered online yet, please do so today. To register, just visit **www.healthequity.com/wageworks**, select "LOG IN/REGISTER" and then "Employee Registration." You'll need to answer a few simple questions and create a username and password.

Questions?

HealthEquity makes it easy for you to get the help you need now. Please call us at 877.924.3967 or visit the Support Center at **www.healthequity.com/wageworks** where you will find answers to frequently asked questions, important forms, videos and other useful resources.

Download the EZ Receipts® mobile app!

Use your mobile device to file claims and take care of your account paperwork from anywhere[1]. Go to **www.healthequity.com/wageworks** to learn more.

Welcome to HealthEquity. Start Saving. Here's How.

Welcome to your healthcare flexible spending account (FSA) sponsored by your employer and brought to you by HealthEquity.

Your FSA is a great way to save on hundreds of eligible expenses like prescriptions, copayments and over-the-counter (OTC) items.

Your FSA: The Essentials

Your FSA is governed by your employer's applicable plan provisions regulations that detail who is eligible to use the account and where and how the money in it is to be used. Your FSA was designed to be simple. To keep it that way, it's important to comply with the Internal Revenue Service (IRS) regulations that govern the program. The following guidelines will help you avoid any inconvenience.

- **Make sure account funds are only spent on expenses for those who are eligible.** Typically, those eligible are you, your spouse and your dependents.
- **Know what expenses are eligible.** Log in to your account at **www.healthequity.com/wageworks** for a list of eligible healthcare expenses. Generally, eligible healthcare expenses include services and products that are medically necessary to treat a specific condition.
- **Keep your receipts.** Save receipts that describe exactly what you paid for. Make sure the amount and service date—not the payment date—are included.
- **Over-the-counter (OTC) medications, drugs and menstrual care products.** You can use your HealthEquity® Visa® Card[2] (Card) for OTC medications and drugs, including menstrual care products. Alternatively, you can pay for the item out of pocket and use Pay Me Back to submit your claim to HealthEquity for reimbursement. Pay Me Back claims can be submitted online, or with your smartphone or mobile device. (FSA plans vary by employer, and these changes do not necessarily change the benefits under your employer's plan.)
- **Watch where you shop.** If using your HealthEquity Card, shop only at general merchandise stores or pharmacies that have an IRS-approved inventory system in place. Visit **www.sigis.com** for the most updated list of approved merchants. The Card will not work at a non-certified merchant.
- **Verify all Card transactions.** If a transaction is not automatically verified at checkout or by a third-party system, you will be notified by email or upon login to your account. Failure to verify an outstanding transaction may result in Card suspension.
- **Register for an online account at www.healthequity.com/wageworks.** When you register online and provide a current email, you ensure that you will have 24/7 access to your account and will be automatically signed up to receive important updates and alerts. You also must have an account to use the mobile app and take advantage of features like Submit Receipt or Claim and Card usage requests.
- **Keep track of your FSA balance.** Plan ahead to make sure you spend the full amount of your balance.

QUICKSTART GUIDE

Managing Your Account

You can manage and check up on your account through HealthEquity online or over the phone. The "Claims and Activity" page online details all your account activity and will even alert you if any Card transactions are in need of verification.

For the latest information, visit **www.healthequity.com/wageworks** and log in to your account 24/7. In addition to reviewing your most recent FSA activity, you can:

- Update your account preferences and personal information.
- View your transactions and account history.
- Schedule payments to healthcare providers.
- Check the list of eligible expenses for your FSA program.
- Order additional HealthEquity Cards for your family.
- Download the EZ Receipts app to file claims and Card use paperwork.

Using Your FSA Dollars

When you pay for an eligible healthcare expense, you want to put your FSA to work right away. HealthEquity gives you several options to use your money the way you choose.

Using your HealthEquity Visa Card

Use your HealthEquity Visa Card (Card) instead of cash or credit at healthcare providers and pharmacies for eligible services, goods and prescriptions. You can also use the Card at general merchants and drug stores that have an industry standard (IIAS) checkout system that can automatically verify if the item is eligible for purchase with your account.

- Go to **www.sigis.com** to review a list of eligible merchants, like drug stores, supermarkets and warehouse stores, that accept the Card.
- When you swipe your Card at the checkout, choose "credit" (even though it isn't a credit card). No PIN is required.
- Consider paying for items or services on the day you receive them. If your health plan covers a portion of the cost, make sure you know what amount you need to pay before using the Card, by presenting your health plan member ID card first, so the merchant can identify your copay or coinsurance amount and ensure the service is claimed to your healthcare, dental, or vision insurance plan.
- Save your receipts or digital copies. You will need them for tax purposes. Plus, even when your Card is approved, a detailed receipt may still be requested.
- If you've lost or can't produce a receipt for an expense, your options may range from submitting a substitute receipt to paying back the plan for the amount of the transaction.
- If you use your Card at an eye doctor's or dentist's office, we will most likely ask you to submit an Explanation of Benefits (EOB) or other documentation for verification. Failure to do may result in your Card being suspended.
- If you lose your Card, please call HealthEquity immediately and order a new one. You will be responsible for any charges until you report the lost Card.

Using your Mobile Device

With the EZ Receipts mobile app, you can file and manage your reimbursement claims and Card usage paperwork on the spot, with a click of your mobile device camera, from anywhere.

To use EZ Receipts:

- Download at **www.healthequity.com/wageworks/employees/go-mobile**.
- Log in to your account.
- Choose the type of receipt from the simple menu.
- Enter some basic information about the claim or Card transaction.
- Use your mobile device camera to capture the documentation.
- Submit the image and details to HealthEquity.

Paying online

You can pay many of your eligible healthcare expenses directly from your FSA with no need to fill out paper forms.* It's quick, easy, secure and available online at any time.

To pay a provider:

- Log in to your FSA at **www.healthequity.com/wageworks**.
- Select "Submit Receipt or Claim."
- Request "Pay My Provider" from the menu and follow the instructions.
- Make sure to provide an invoice or appropriate documentation. When you're done, HealthEquity will schedule the checks to be sent in accordance with the payment guidelines. If you pay for eligible, recurring expenses, follow the online instructions to set up automatic payments.

* You must, however, provide documentation. For more information about the documentation requirements and payment guidelines, visit **www.healthequity.com/wageworks**.

Filing a claim

You also can file a claim online to request reimbursement for your eligible healthcare expenses.

- Go to **www.healthequity.com/wageworks**, log in to your account and select "Submit Receipt or Claim."
- Select "Pay Me Back."
- Fill in all the information requested on the form and submit.
- Scan or take a photo of your receipts, EOBs and other supporting documentation.
- Attach supporting documentation to your claim by using the upload utility.
- Make sure your documentation includes the five following pieces of information required by the IRS:
  - Date of service or purchase
  - Detailed description
  - Provider or merchant name
  - Patient name
  - Patient portion or amount owed

Most claims are processed within one to two business days after they are received, and payments are sent shortly thereafter.

If you prefer to submit a paper claim by fax or mail, download a Pay Me Back claim form at **www.healthequity.com/wageworks** and follow the instructions for submission.

HealthEquity®

The Pension Boards
United Church of Christ, Inc.

09/17/25