Benefits Handbook Date January 1, 2025

Health Care Flexible Spending Account

Marsh McLennan

Health Care Flexible Spending Account

The Health Care Flexible Spending Account (Plan) allows you to put aside money before taxes are withheld so that you can pay for eligible medical, dental and vision expenses that are not reimbursed by any other coverage you and your qualifying family members have.

A Note about ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that governs many employer-sponsored plans including this one. Your ERISA rights in connection with this Plan are detailed in the *Administrative Information* section.

SPD and Plan Document

This section provides a summary of the Health Care Flexible Spending Account Plan (Plan) as of January 1, 2025.

This section, together with the *Administrative Information* section and the applicable section about participation, forms the Summary Plan Description and plan document of the Plan.

In this section references to Marsh & McLennan Companies mean Marsh McLennan.

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The Plan at a Glance

Plan Feature	Highlights
How the Plan Works	▪ You may contribute to the Plan through payroll deductions on a before-tax basis. ▪ When you have reimbursable health care expenses, you can receive your money back tax-free, up to the amount that you elect to contribute for the year and any carryover amount.
Eligibility	▪ You are eligible if you are an employee classified on payroll as a US regular employee of Marsh & McLennan Companies or any subsidiary or affiliate of Marsh & McLennan Companies (other than Marsh & McLennan Agency LLC or any of its subsidiaries (MMA)). ▪ You are eligible if you are an employee classified on payroll as a US regular employee of Marsh & McLennan Agency LLC – Corporate (MMA-Corporate), Marsh & McLennan Agency LLC – Alaska (MMA-Alaska), Marsh & McLennan Agency LLC – Northeast (MMA-Northeast) or Marsh & McLennan Agency LLC, Private Client Services – National Region (MMA PCS – National). ▪ See “Participating in the Plan” on page 2 for details.
Enrollment	▪ You are eligible to enroll: – within 30 days of the date you become eligible – during Annual Enrollment. ▪ You must elect to participate each PLAN YEAR in order to participate in the Health Care Flexible Spending Account. ▪ You are not eligible for this plan if you enroll in the Marsh & McLennan Companies Health Savings Account.
Contributions	▪ You can contribute between $120 and $3,200 per plan year.
Reimbursements	▪ In general, the Plan will reimburse: – eligible health care expenses that are not covered by another plan, including copayments, deductibles, coinsurance and costs after your dental, vision or medical plan paid a benefit, – that generally would be qualified medical expenses under federal tax law, and – that are INCURRED in the plan year for which you make contributions.
Unused Contributions	▪ Up to a maximum balance of $640 will be carried over for eligible expenses incurred in the next plan year. ▪ Any account balance over $640 will be forfeited after the CLAIMS FILING DEADLINE of March 31 following the plan year. ▪ You have until March 31 of the following year to submit claims for reimbursement of eligible expenses you incur during the plan year.

Plan Feature	Highlights
Contact Information	For more information, contact: Spending Account Service Center (Claims Administrator) P.O. Box 350 Conshohocken, PA 19428 Phone: +1 866 324 4087 Fax: +1 888 788 1928 Website: https://trion.lh1ondemand.com Marsh McLennan does not administer this plan. The Spending Account Service Center's decisions are final and binding.

Participating in the Plan

You are eligible to participate in the Health Care Flexible Spending Account if you meet the eligibility requirements described in the *Participating in Spending Accounts* section.

If you participate in this plan, or are covered by another health care flexible spending account (e.g., through your spouse's employer), you are not eligible for the Marsh & McLennan Companies Health Savings Account.

You can enroll in this plan even if you are not enrolled in any Company medical plan.

My spouse contributes to a health savings account (HSA); can I participate in the Health Care Flexible Spending Account?

Under IRS rules, your spouse will not be eligible to contribute to a health savings account if you participate in the Health Care Flexible Spending Account.

Enrollment

To participate in this Plan, you must enroll for coverage. You may enroll:

- within 30 days of the date you become eligible to participate
- during Annual Enrollment
- within 30 days following a qualifying change in family status that makes you eligible to enroll.

You must enroll each PLAN YEAR in order to participate in the Health Care Flexible Spending Account.

Enrollment procedures are described in the *Participating in Spending Accounts* section.

Contributions

How do I decide how much to contribute?

You select an amount to contribute for the plan year. You can contribute between $120 and $3,200 per plan year.

Since you will forfeit amounts that exceed the $640 carryover maximum that you do not use for expenses INCURRED by December 31 and you cannot change the contribution election once you make it (unless you have a qualified family status change), you should carefully estimate your expenses before deciding on an amount to contribute.

You cannot be reimbursed for services that are provided before your coverage begins or after your coverage ends except for reimbursements provided through carryover funds in a subsequent plan year, as described under “How the Plan Works” regarding the carryover feature.

Once you make your election for the year, you cannot make any changes, unless you have a qualified family status change and then any changes must be due to, and consistent with, the qualified family status change.

If your projected expenses change during the year, you will not be able to change your contribution election unless you have a qualified family status change. For example, if your health care provider tells you during the year that you are no longer a candidate for the LASIK eye surgery for which you had been contributing to the Health Care Flexible Spending Account or is postponing a procedure to a subsequent year, you cannot reduce or stop your contributions.

Does the Company contribute to my Health Care Flexible Spending Account?

No, the Company does not make contributions to your account.

What is the minimum amount I can contribute?

You can contribute a minimum amount of $120 per plan year to the Plan.

What is the maximum amount I can contribute?

You can contribute a maximum amount of $3,200 per plan year to the Plan.

My spouse or domestic partner contributes to his/her employer’s health care flexible spending account; is there a limit to how much I can contribute to my Health Care Flexible Spending Account?

You and your spouse or domestic partner are each limited to the maximum contribution allowed by your respective employer. You can submit a claim only once and only to one health care flexible spending account. If you and your spouse each contribute to a health care flexible spending account, you can only be reimbursed once for any eligible expense.

My spouse or domestic partner and I both work for the Company; how much can we put in the Plan?

You and your spouse or domestic partner can each contribute up to $3,200 per plan year to this plan.

You can submit a claim only once and only to one health care flexible spending account. If you and your spouse each contribute to a health care flexible spending account, you can only be reimbursed once for any eligible expense.

How are contributions credited to my account?

Your contributions will be deducted on a before-tax basis each pay period and will be credited to your account. The total amount elected for the plan year is available for reimbursement at the start of the year, regardless of your contributions at the time of reimbursement.

When will contributions start to come out of my paycheck?

When you first enroll as a newly eligible employee or as a result of a qualified family status change, your contributions will begin in the next available pay period after your enrollment is processed.

If you enroll during the Annual Enrollment period, your contributions will begin with the first pay period of the new plan year.

Can I transfer contributions between my Dependent Care and Health Care Flexible Spending Accounts?

No, the IRS requires that this Plan and the Dependent Care Flexible Spending Account remain separate. You cannot transfer money between accounts or use money in one account to pay expenses related to the other account.

What happens to contributions in my Health Care Flexible Spending Account that I haven't used by the end of the plan year?

The Plan allows a maximum of $640 of your Health Care Flexible Spending Account balance to be carried over into the next plan year. In accordance with IRS rules, you will forfeit any account balance over $640 that is not used to pay eligible expenses incurred between January 1 and December 31 of the plan year if they are not submitted by March 31.

Example: If you have a $700 balance in your Health Care Flexible Spending Account on December 31, 2025, $640 of the $700 balance will be carried over for you to use in 2026. The remaining $60 of the $700 balance will be forfeited unless you submit by March 31, 2026 claims for eligible expenses incurred in 2025 to use the $60 balance.

If your participation ends during the plan year, you will not be reimbursed for expenses incurred after the date your participation ends (for example, after your employment ends,

unless you continue participation through COBRA). You will, however, have until March 31 of the following plan year to submit for reimbursement eligible expenses you incurred during the plan year while you were participating.

If you were participating in the HEALTH FSA solely from the prior plan year's carryover funds, you are not eligible to continue participation through COBRA. You will, however, have until March 31 of the following plan year to submit reimbursement for eligible expenses you incurred during the plan year while you were participating.

Taxes

See the *Participating in Spending Accounts* section for more information about taxes.

How the Plan Works

You may contribute to the Plan through payroll deductions on a before-tax basis. When you have reimbursable health care expenses, you can receive your money back tax-free, up to the amount you elect to contribute for the year. You are reimbursed for eligible expenses that are not covered by another plan.

You contribute to the Health Care Flexible Spending Account over a 12-month PLAN YEAR, from January 1 to December 31 (or fewer months, if you start or stop participating during the plan year as the result of a qualified family status change). You may use your Health Care Flexible Spending Account to pay for eligible expenses INCURRED during the plan year. You have until March 31 of the following plan year to submit for reimbursement eligible expenses you incurred during the plan year.

The Plan generally allows a maximum of $640 of your Health Care Flexible Spending Account unused balance to be carried over into the next plan year to be used for eligible expenses. **In accordance with IRS rules, you will forfeit any amount that exceeds the maximum $640 carryover amount that is not used to pay eligible expenses incurred by December 31 (and submitted by March 31).**

Example: You can use your 2025 Health Care Flexible Spending Account to be reimbursed for eligible expenses incurred between January 1 and December 31, 2025 (the plan year). You must submit claims for those expenses no later than March 31, 2026. If you have a $700 balance in your Health Care Flexible Spending Account on December 31, 2025, $640 of the $700 balance will be carried over for you to use in 2026. The remaining $60 of the $700 balance will be forfeited unless you submit by March 31, 2026 claims for eligible expenses incurred in 2025 to use the $60 balance.

For examples of IRC Section 213 qualified medical expenses, see IRS Publication 502, which is available at www.irs.gov or by calling the IRS at +1 800 829 3676. Note that certain items listed in Publication 502 may not qualify for Health Care Flexible Spending Account reimbursement, such as premiums for dental or vision insurance (see "Examples of Eligible Expenses" on page 17 and "Examples of Ineligible Expenses" on page 19 for more information). You may also contact the Claims Administrator, for information about reimbursable qualified medical expenses.

Impact on Benefits

Can I change my Health Care Flexible Spending Account election during the year?

You may be able to make a change to your Health Care Flexible Spending Account election during the plan year if you have a qualified family status change. All changes must be made within 30 calendar days following the qualified family status event, and the effective date of the change will be the date of the qualified family status event. Refer to the *Life Events* section of the Benefits Handbook for information on qualified events.

Mid-year increases in your annual contribution amount must be due to, and consistent with, the qualified family status change and then only used for eligible health care expenses incurred on or after the effective date of the change. You may not increase your annual contribution amount to request reimbursement for expenses that were incurred prior to the effective date of the change.

Reimbursements

In general, the Plan will reimburse:

- eligible health care expenses that are not covered by another plan, including copayments, deductibles, coinsurance and costs after your dental, vision or medical plan paid a benefit,
- that generally would be qualified medical expenses under federal tax law, and
- that are INCURRED in the PLAN YEAR for which you make contributions

For examples of IRC Section 213 qualified medical expenses, see IRS Publication 502, which is available at www.irs.gov or by calling the IRS at +1 800 829 3676. Note that certain items listed in Publication 502 may not qualify for Health Care Flexible Spending Account reimbursement, such as premiums for dental or vision insurance. You may also contact the Claims Administrator, for information about reimbursable qualified medical expenses.

Who are the qualifying family members whose expenses may be reimbursed?

According to the IRS, a qualifying family member includes any person who qualifies for tax-free health plan benefits, including any of the following individuals:

- your spouse
- a person for whom you can claim an exemption on your federal taxes
- a person who meets all of the following criteria:
  - is your child (by birth or adoption), stepchild or foster child; your sibling or, step-sibling; or the descendant of your child, stepchild, foster child or sibling

  - lives with you for more than half the year
  - doesn't provide more than half his or her own support for the year
  - has not reached or will not reach the age of 27 at the end of the Plan Year
  - is either a US citizen, national, or resident; a resident of Canada or Mexico; or a child being adopted by a US citizen or national who shares that individual's home as a member of the household.
- another person (e.g., relative, domestic partner, same-sex spouse) who meets all of the following criteria:
  - receives more than half of his or her support from you during the calendar year
  - can't be claimed as anyone's "qualifying child" dependent
  - is your relative or, if the person is not your relative, he or she must live with you for the entire calendar year as a member of your household (except for temporary reasons such as vacation, military service or education) and the relationship cannot be in violation of local law
  - is either a US citizen, national, or resident; a resident of Canada or Mexico; or a child being adopted by a US citizen or national who shares that individual's home as a member of the household.

You can be reimbursed for eligible expenses for you, your spouse or your qualifying family members.

Unless your domestic partner or his or her children qualify for tax-free health plan benefits (as described above), the federal government does not permit you to use health care flexible spending accounts for eligible expenses incurred by your domestic partner or his or her children.

How do I get Health Care Flexible Spending Account reimbursements?

There are several ways for you to be reimbursed for eligible Health Care Flexible Spending Account expenses:

- you can use the Prepaid MasterCard® at point of service for eligible expenses without needing to submit claims. When you use the Prepaid MasterCard® at a qualifying provider, the funds are automatically deducted from your Health Care Flexible Spending Account for payment. Using the Prepaid MasterCard® reduces out-of-pocket payments and paperwork, as well as the need to wait for reimbursement checks; or
- you can submit a claim for reimbursement either online at the Spending Account Service Center, mobile app (Spending Account Mobile Center for your Android or iPhone, also compatible with iPad® and iPod touch®), by fax at +1 888 788 1928, by email at mmc@marshmma.com or by mail.
  - Please note that eligible expenses at a provider who is not a qualifying provider cannot be reimbursed using the Prepaid MasterCard®. Instead, you must submit a claim for reimbursement.

Claims Submission by Mail:

Spending Account Service Center
P.O. Box 350
Conshohocken, PA 19428

What is the Prepaid MasterCard®?

The Prepaid MasterCard® is a special-purpose MasterCard® that gives you a way to pay for eligible expenses without needing to submit claims. The Prepaid MasterCard® lets you electronically access the amount you elected to contribute to your Health Care Flexible Spending Account at qualifying providers.

The Spending Account Service Center will provide two (2) Prepaid MasterCards®, which will be loaded with your Health Care Flexible Spending Account election. Additional or replacement cards are available for a $10.00 fee (come in packages of 2 cards) charged directly to your account. If you participate in more than one account, the fee would be charged first to your Health Care Flexible Spending Account, then your Dependent Care Flexible Spending Account.

How does the Prepaid MasterCard® work?

The Prepaid MasterCard® works like a debit card, with your account balance stored on it. When you use the Prepaid MasterCard®, the amount of the eligible expenses will be deducted automatically from your Health Care Flexible Spending Account and payment will be electronically transferred to the provider/merchant. There are no monthly bills and no interest. The total amount you elected for the plan year is available for reimbursement at the start of the year, regardless of your contributions at the time of reimbursement.

Who issues the reimbursements?

Reimbursements are issued by the Claims Administrator. You can submit your eligible expenses for reimbursement at any time after you incur the expense, provided that you submit your claim for reimbursement before the claims submission deadline of March 31of the following plan year.

Where can I get a Health Care Flexible Spending Account Claim Form?

Forms can be found on the Claims Administrator's website or be requested from the Claims Administrator by calling +1 866 324 4087.

How is the reimbursement paid from my account?

For eligible expenses that are not reimbursed by using the Prepaid MasterCard®, such as eligible expenses at a provider who is not a qualifying provider, you must submit a claim for reimbursement. The Claims Administrator will reimburse eligible expenses directly to you from your Health Care Flexible Spending Account. The Claims Administrator will do one of the following:

- deposit your reimbursement amount directly into your checking or savings account. To establish direct deposit of your reimbursement, you will need to provide your direct deposit information to the Claims Administrator by completing a Direct Deposit Authorization Form, accessible online through the Spending Account Service Center.
- send your check to your home address if you do not have direct deposit on file with the Claims Administrator.

Your first reimbursement may be paid by check while the Claims Administrator authenticates your bank information for direct deposit.

How long does it take for claims to be processed?

Reimbursements are processed within three to four business days of the Claims Administrator's receipt of the completed claim form and required documentation.

Do I need a minimum amount of expenses before I can be reimbursed?

No. There is no minimum amount of expenses when submitting a claim for reimbursement.

How much can I be reimbursed?

The total amount elected for the plan year and any carryover amount is available for reimbursement at the start of the year, regardless of your contributions at the time of reimbursement. You can be reimbursed up to your account balance, which is the total amount you elected for the plan year minus the amount you have already been reimbursed.

What if the amount of my expense is more than I currently have in my account?

Eligible expenses are reimbursed from your account balance, which is the total amount you elected for the plan year minus the amount you have already been reimbursed.

Can I be reimbursed before I pay my provider?

Yes, but you must submit documentation confirming that services were rendered including dates of service, services rendered and your cost for these services (such as an itemized statement from your provider or an EXPLANATION OF BENEFITS from the insurer) before you can be reimbursed for eligible expenses.

Can I pay my provider directly if my provider does not accept the Prepaid MasterCard® as a form of payment?

Yes, but you must submit documentation confirming that services were rendered including dates of service, services rendered and your cost for these services (such as an itemized statement from your provider or an EXPLANATION OF BENEFITS from the insurer) before you can be reimbursed for eligible expenses. When you submit your claim, you may opt to have your payment sent to “Someone Else” and submit your providers name, address, the patient’s full name and your account number at the provider’s office during the transaction. Once your claim is approved, the reimbursement process will send a check from your Health Care Flexible Spending Account directly to your provider’s office to pay for your eligible item or service.

Can I be reimbursed for expenses incurred before participation in the Plan?

No, expenses incurred before your participation begins cannot be reimbursed.

How often can I request reimbursement?

You can submit your expenses for reimbursement as often as you would like, provided that you submit your claim for reimbursement before the claims submission deadline of March 31 of the following plan year.

If I use the Prepaid MasterCard® for a health care expense(s), am I required to prove that my expenses qualify as eligible health care expenses?

Yes, all purchases with the Prepaid MasterCard® are required to be “substantiated,” or verified as an eligible health care expense. There are some ways in which your eligible health care expense(s) are automatically substantiated in compliance with IRS regulations. These include co-pay matching SUBSTANTIATION, claims auto-substantiation, and IIAS-Certified Merchant pharmacies.

If a Prepaid MasterCard® purchase cannot be verified by one of the automatic substantiation methods, the IRS requires that you submit itemized receipts to verify that the purchase was eligible for reimbursement under the HEALTH FSA.

What happens if I use the Prepaid MasterCard® for a health care expense that was incurred in the prior plan year when I have carryover funds in my account?

All purchases with the Prepaid MasterCard® are applied to the plan year in which the Prepaid MasterCard® was swiped at the merchant. The debit card does not receive information to validate the date of service in which your claim was incurred. In order to reverse your carryover funds and transfer your expense to the prior plan year, a request must be made to the Spending Account Service Center along with adequate substantiation to show the correct plan year to which the card swipe should be applied. The Spending Account Service Center will not automatically apply any transaction to a previous plan year without consent from the accountholder to do so.

What happens if my Prepaid MasterCard® expense is not automatically substantiated?

You will receive a Receipt Request letter from the Claims Administrator, the Spending Account Service Center, requesting you to submit an itemized receipt or Explanation of Benefits (EOB) for each unsubstantiated expense. Documentation must include the merchant or provider name, service received or item purchased, date of service or date of purchase, description of the expense and the amount of the expense.

You will have 30 days from the date of the letter to submit your documentation to the Spending Account Service Center. If you fail to submit documentation within the 30 day period, you will be sent a second Receipt Request letter from the Spending Account Service Center. You will then have 60 days to submit your documentation to the Spending Account Service Center.

What happens if I submit documentation to substantiate my Prepaid MasterCard® expense(s) and more information is requested?

If you submit documentation to substantiate the expense(s) and the Spending Account Service Center requires more information to make an eligibility determination, you will be sent a Request for More Information (RMI) letter from the Spending Account Service Center. You will then have an additional 30 days to submit your additional documentation to the Spending Account Service Center.

What happens if I submit documentation to substantiate my Prepaid MasterCard® expense(s) and the expense is determined to be ineligible?

If you submit documentation to substantiate the expense(s) and the Spending Account Service Center determines the expense(s) is ineligible, you will be sent an Ineligible Notice letter from the Spending Account Service Center. You will then have 30 days to submit a repayment check to the Spending Account Service Center. If you fail to repay the expense to the Plan, the expense will be reported to the Internal Revenue Service as taxable income to you.

What happens if I do not have documentation to submit for my Prepaid MasterCard® expense?

If documentation is not available, you may send a check payable to the Spending Account Service Center for the expense amount. These monies will be applied to your Health FSA for future reimbursement of eligible expenses. Alternatively, if you have a different eligible expense that was paid out of pocket, you may submit an itemized receipt for it to offset the payment for the expense for which you do not have the necessary documentation.

What happens if I am not able to substantiate or repay my Prepaid MasterCard® expense(s) within the specified timeframe?

Your Prepaid MasterCard® will be temporarily suspended (i.e., cannot be used for further purchases) until the required documentation or repayment check is received and the claim(s) have been verified by the Spending Account Service Center.

Once your Prepaid MasterCard® has been suspended, you won't be able to use your Prepaid MasterCard® for purchases. However, if you need to purchase items during this suspension period, you can still submit a claim reimbursement request form, either online at the Spending Account Service Center, on the mobile app, by fax, by email at mmc@marshmma.com or by mail.

If you fail to substantiate an expense or otherwise repay the expense to the Plan, the expense will be reported to the Internal Revenue Service as taxable income to you.

What happens if my Prepaid MasterCard® is suspended and then I submit documentation to substantiate my Prepaid MasterCard® expense(s)?

If your Prepaid MasterCard® has been suspended, and you then send in the necessary documentation to prove the expense's eligibility and it is deemed to be an eligible expense, your Prepaid MasterCard® will be reactivated and available for use.

What happens if my Prepaid MasterCard® is suspended and then I submit a check to repay the Prepaid MasterCard® expense(s)?

If your Prepaid MasterCard® has been suspended, and you then send in a repayment check for the ineligible expense(s), your Prepaid MasterCard® will be reactivated and available for use.

Can I carryover any 2025 plan year Health Care Flexible Spending Account balance?

Yes, the carryover feature for the 2025 plan year will allow a maximum balance of $640 to be carried over from your Health Care Flexible Spending Account for use in the 2026 plan year.

How does the carryover work?

Any claims for eligible expenses incurred in 2025 that are submitted between January 1, 2026 and March 31, 2026 will be reimbursed from your 2025 balance. After March 31, 2026, any 2025 balance over $640 will be forfeited. Up to $640 of your 2025 account balance will be available on January 1, 2026 for eligible expenses incurred in 2026.

Note: The carryover amount for the 2025 plan year has increased to $640 (2024 plan year maximum carryover amount is $610). If you contribute to a Health Care FSA in 2025 and have a balance as of December 31, 2025, the maximum amount carried over into 2026 will be $640. Any amount over $640 that is not used for eligible expenses incurred during 2025 will be forfeited. You may contribute up to the maximum amount ($3,200 in 2025) each year, regardless of whether any amount is carried over from the prior year.

An example of plan year 2025 carryover (maximum amount carried over into 2026 is $640):

- In November 2025, you elect to contribute $3,200 to a 2026 HEALTH FSA.
- On December 31, 2025, you have a balance of $1,200 in your 2025 Health FSA.
- In March 2026, during the RUN-OUT PERIOD, you submit a claim for $560 for eligible expenses incurred in 2025.
  - Your 2025 Health FSA carryover balance is reduced to $640 ($1,200 minus $560).
- If no other 2025 claims are submitted by March 31, 2026, the $640 balance will be the remaining carryover balance in your 2026 Health FSA.
- You have $3,840 available for reimbursement in 2026 ($3,200 plus $640).
- You incur $3,400 in eligible expenses on July 15, 2026 and submit a claim for reimbursement.
- You are reimbursed for the $3,400 claim ($3,200 from your 2026 Health FSA plus $200 from your 2025 balance that was carried over).
  - Your 2026 balance is now reduced to $440 ($3,840 minus $3,400).
- If no other 2025 claims are submitted by March 31, 2026, your $440 Health FSA balance will be your carryover balance in 2026.

Based on the current plan terms and applicable law, for the 2025 plan year (and subsequent plan years), after March 31, 2026, any 2025 balance over $640 will be forfeited at that time. Up to $640 of your 2025 account balance will be available on January 1, 2026 for eligible expenses incurred in 2026.

Does the carryover impact the amount I may contribute to the Health Care Flexible Spending Account in subsequent years?

No. The 2025 carryover (up to a maximum of $640) does not affect the maximum amount of contributions that you may contribute to your Health FSA. You may contribute up to the maximum amount each year, regardless of whether any amount is carried over from the prior year. The maximum contribution amount for 2025 is $3,200.

Which plan terms apply to my carryover funds if I elect to contribute to a Health FSA for 2025 and have a 2024 balance that is carried over?

The 2024 carryover funds are subject to the plan terms of the Health FSA applicable to you as a result of your medical plan and the Spending Account Service Center Health Savings Account election for 2025, as shown in the chart below:

2025 Medical Coverage and HSA Elections	Applicable Plan Terms
Surest Copay Plan	Health Care Flexible Spending Account
$1,650 Deductible Plan with Health Savings Account	Limited Purpose Health Care Flexible Spending Account
$1,650 Deductible Plan without Health Savings Account	Health Care Flexible Spending Account
$3,300 Deductible Plan with Health Savings Account	Limited Purpose Health Care Flexible Spending Account
$3,300 Deductible Plan without Health Savings Account	Health Care Flexible Spending Account
HMSA Hawaii HMO Plan	Health Care Flexible Spending Account
HMSA Hawaii PPP Plan	Health Care Flexible Spending Account
Marsh McLennan Medical Coverage Waived	Health Care Flexible Spending Account

Do I have to elect to contribute to a Health FSA in the following year for the carryover funds?

No. If you do not elect a HEALTH FSA in the following year, a HEALTH FSA will be established for you for the carryover funds.

What type of Health FSA will be established for me if I don't elect to contribute to a Health FSA in 2025 and have a 2024 balance?

The type of Health FSA established for you depends solely on your 2025 medical coverage election, as shown in the chart below:

If you Do Not elect a Health FSA for 2025 and have a 2024 balance	
2025 Medical Coverage Election	**Health FSA Established for 2025**
Surest Copay Plan	Health Care Flexible Spending Account
$1,650 Deductible Plan	Limited Purpose Health Care Flexible Spending Account
$3,300 Deductible Plan	Limited Purpose Health Care Flexible Spending Account
HMSA Hawaii HMO Plan	Health Care Flexible Spending Account
HMSA Hawaii PPP Plan	Health Care Flexible Spending Account
Marsh McLennan Medical Coverage Waived	Limited Purpose Health Care Flexible Spending Account

What is the deadline for using the carryover funds?

You have until December 31 of the plan year into which funds are carried over to incur eligible expenses. The deadline to submit claims is March 31 of the following year.

For example, $610* is carried over from 2024 to your 2025 Health FSA. You have all of 2025 to incur expenses and submit claims against any 2025 election amount plus the 2024 carryover funds. You then have until March 31, 2026 to submit claims for reimbursement for claims incurred in 2025.

* The maximum carryover amount for plan year 2025 (balance as of December 31, 2025 that can be carried over into 2026) has increased to $640.

Does the carryover affect my eligibility to contribute to a Health Savings Account?

No. Your eligibility to contribute to a Health Savings Account is not impacted by the carryover feature, and you can contribute to a Health Savings Account starting on January 1, as long as you meet the eligibility requirements. Please note that if you are covered by a Health Care Flexible Spending Account, you are not eligible to contribute to a Health Savings Account.

If my participation ends during the year, can I be reimbursed for expenses incurred after my participation ends?

If your participation ends during the year, you will not be reimbursed for expenses incurred after the date your participation ends (for example, after your employment ends, unless you continue participation through COBRA). You will, however, have until

March 31 of the following plan year to submit for reimbursement eligible expenses you incurred during the plan year while you were participating.

If you were participating in the Health FSA solely from the prior plan year's carryover funds, you are not eligible to continue participation through COBRA. You will, however, have until March 31 of the following plan year to submit reimbursement for eligible expenses you incurred during the plan year while you were participating.

What happens to my Health Care Flexible Spending Account when I am on an authorized unpaid leave of absence?

Your before-tax contributions cease. (In some circumstances, COBRA participation may be available.)

Upon return to work, your before-tax contributions will resume. The amount of your before-tax contributions will be recalculated for the remainder of the year to "catch-up" for your missed contributions while on leave. The balance of your annual election will be divided by your remaining pay dates, spreading the balance over the remaining pay periods through the end of the year. This will increase your per pay period contribution upon return from your authorized unpaid leave.

For example, suppose your annual election to the Health Care Flexible Spending Account is $1,200 and you are on an authorized unpaid leave from July 1 through November 1. You will have contributed $600 before you began leave and your contributions will stop while you are on leave. When you return to work, the remaining $600 of your annual election will be spread out over the November and December pay periods. You can submit claims for reimbursement for any eligible expenses you incur while on an authorized unpaid leave.

How do I appeal a benefit determination or denied claim?

There are special rules, procedures and deadlines that apply to appeals of benefit determinations and denied claims and you have special legal rights under ERISA. Please refer to the *Administrative Information* section for a description of the appeal process.

How can I get a copy of IRS Publication 502?

Go to www.irs.gov and enter "502" in the "Search" box for more information about IRC Section 213 qualified medical expenses. Note that certain items listed in Publication 502 may not qualify for Health Care Flexible Spending Account reimbursement, such as premiums for dental or vision insurance (see "Examples of Eligible Expenses" on page 17 and "Examples of Ineligible Expenses" on page 19 for more information).

You may also contact the Claims Administrator for information about reimbursable qualified medical expenses.

Examples of Eligible Expenses

Expenses reimbursed by the Plan include:

- medical services provided by medical practitioners and that are not covered by another plan
- charges for medically necessary services not covered by another plan, including but not limited to the following:
  - deductibles
  - out-of-pocket expenses
  - copayments
  - coinsurance
  - charges exceeding reasonable and customary amounts
  - charges exceeding plan limits
  - prescription drug charges
  - other non-covered charges
  - all medically necessary prescription drugs and certain other prescription drugs permitted by the IRS (e.g., contraceptives and pre-natal vitamins)
  - over-the-counter non-prescription medicines, such as allergy and cold medications, aspirin and antacids
  - eye exams, glasses (frames and lenses), contact lenses and solutions for contact lenses, lubricant eye drops, eye patches and reading glasses
  - LASIK eye surgery
  - dental implants
  - dental treatment, routine dental care (cleaning, X-rays, fillings, etc.), and over-the-counter products such as denture adhesive, temporary filling and temporary relief (if accompanied by a Letter of Medical Necessity)
  - orthodontia (braces)
  - mouth guards
  - hearing exams, hearing aids
  - cost differences between semi-private and private hospital rooms

  - cost for special medical equipment installed in your home, or for home improvements for purposes of medical care, e.g., ramps, support bars, railings, etc. (if accompanied by a Letter of Medical Necessity)
  - fees for special schools on the recommendation of a physician, including schools for the mentally impaired, physically disabled or individuals with severe learning disabilities
  - transportation (amounts paid for travel primarily for, and essential to, medical care)
  - personal use items if primarily used to prevent or alleviate a physical or mental defect or illness, e.g., Braille books, hearing aids
  - private nursing services rendered in your home or elsewhere
  - smoking cessation programs
  - weight loss programs (if you have a letter from your treating physician indicating medical necessity)
- periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine examinations, such as annual physicals
- routine prenatal and well-child care
- flu shots (if not covered by the Marsh & McLennan Companies $1,650 Deductible Plan, $3,300 Deductible Plan, the Surest Copay Plan or any other plan)
- vaccinations
- child and adult immunizations
- screenings for conditions such as:
  - cancer
  - heart and vascular diseases
  - infectious diseases
  - mental health conditions
  - substance abuse
  - metabolic, nutritional, and endocrine conditions
  - musculoskeletal disorders
  - obstetric and gynecological conditions
  - pediatric conditions
  - vision and hearing disorders

- preventive over-the-counter expenses, such as:
  - home diagnostic tests or kits for blood pressure, cholesterol screening, diabetes (e.g., glucose monitor), colorectal, HIV
  - smoking-cessation relief, such as patches and gum
  - pre-natal vitamins.

For examples of IRC Section 213 qualified medical expenses, see IRS Publication 502, which is available at www.irs.gov or by calling the IRS at +1 800 829 3676. Note that certain items listed in Publication 502 may not qualify for Health Care Flexible Spending Account reimbursement, such as premiums for dental or vision insurance. You may also contact the Claims Administrator for information about reimbursable qualified medical expenses.

Examples of Ineligible Expenses

You cannot be reimbursed for certain health care expenses, such as:

- contributions to other employer-sponsored dental, vision or medical plans, including plans sponsored by your spouse’s employer (contributions to the Company’s dental, vision and medical plans are already made on a before-tax basis)
- premiums paid for any health care plan, including COBRA, Medicare, plans sponsored by your spouse’s employer, and individual health insurance offered through a Health Insurance Marketplace Exchange
- costs you deduct as health care expenses on your federal income tax return
- expenses not eligible to be deducted under federal tax law
- expenses reimbursed by any other health plan
- health/gym/fitness club membership fees (unless you have a letter from your treating physician indicating medical necessity)
- elective cosmetic surgery, electrolysis, hair removal or transplants, liposuction, etc.
- vitamins and other dietary supplements, toiletries and cosmetics that are not medically necessary
- medications purchased merely to maintain your or your family’s health
- prescription drugs that are not medically necessary and not permitted by the IRS (such as Rogaine)
- cosmetic dental work (including bleaching, bonding and veneers)
- undocumented travel to or from your physician’s office or other medical facility
- weight loss programs (unless you have a letter from your treating physician indicating medical necessity)
- long-term care premiums and services

About Your Account

How can I find out my unused account balance and other account information?

You can access the Spending Account Service Center's online website, https://trion.lh1ondemand.com, the Spending Account Service Center, 24 hours a day, 7 days a week. The Spending Account Service Center provides you with helpful tools and information such as:

- account elections and balances, year-to-date contributions, submitted/paid claims and issued reimbursements,
- online claim submission,
- direct deposit form, claim forms, and eligible expenses listings.

When will I receive my account statement?

A statement showing your account activity will be issued twice per year, in October and December, and with each reimbursement check. Note: if you do not have an account balance at the time the statement is issued, you will not receive an account statement.

What information can I find on my account statement?

You will find the following:

- annual election
- your balance as of the statement date
- year to date reimbursements
- CLAIMS FILING DEADLINE.

Do I earn interest on my account?

No, your account does not earn interest.

Glossary

Claims Filing Deadline

The claims filing deadline is March 31 following the end of the plan year. For example, for the 2025 plan year, your eligible expenses must be incurred no later than December 31, 2025 and must be submitted to the Claims Administrator by March 31, 2026 (the claims filing deadline).

Explanation of Benefits

An Explanation of Benefits is a statement that the Claims Administrator sends to you after you, one of your covered family members or your health care provider files a claim for benefits. The Explanation of Benefits shows the charges that were submitted, the amount paid and not paid, if any, and the amount you may need to pay, if any.

Health FSA

A spending account that reimburses health care expenses, such as the Health Care Flexible Spending Account and the Limited Purpose Health Care Flexible Spending Account.

Incurred

Expenses are treated as having been incurred when the care or service is provided, not when you are billed or pay for it.

Plan Year

The plan year is January 1 through December 31.

Run-out Period

The run-out period is the time period allowed after the end of the plan year during which you can submit claims for reimbursement of eligible expenses incurred during the plan year. The run-out period for the 2025 plan year is January 1, 2026 through March 31, 2026.

Substantiation

Substantiation means to prove or support that a purchase made with the Prepaid MasterCard® is a qualified health care expense in compliance with IRS rules. Substantiation consists of providing documentation such as an Explanation of Benefits or itemized statements/receipts to verify that your purchases were eligible expenses.