

University of Chicago

# **Flexible Spending Accounts (FSAs)**

Summary Plan Description

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# Your FSA Benefits

The University of Chicago Flexible Spending Plan (the “Plan”) offers Benefits-Eligible Employees the opportunity to pay certain health care and dependent care expenses with tax-free dollars. You can decide whether or not to participate every year. The Plan has two kinds of Flexible Spending Accounts (FSAs):

- The **Health Care FSA** can be used to pay for most out-of-pocket medical, vision and dental care expenses for yourself and your Dependents as long as these expenses are not covered by your medical or dental plan.
- The **Dependent Care FSA** can be used to pay for eligible day care expenses for a dependent child or adult relative while you or your spouse work, or while your spouse is a full-time student or disabled.

You contribute tax-free dollars to your FSAs through payroll deductions. When you have an eligible medical, vision, dental or dependent care expense, you are reimbursed from the appropriate FSA.

If you have questions about your benefits, call the Benefits Office at 773-702-9634 or send an e-mail to [benefits@uchicago.edu](mailto:benefits@uchicago.edu).

The capitalized terms in the Summary Plan Description have special meaning. Please refer to the [Glossary](#) for the definition of those capitalized terms.

## Participating in FSAs

### Eligibility

Participation is voluntary. You are eligible to participate in an FSA if you are a Benefits-Eligible Employee of the University of Chicago (the “University”).

### Enrolling

You may enroll in an FSA:

- Within 31 days of your date of hire as a Benefits-Eligible Employee, provided you complete and submit an enrollment form within that 31-day period.
- If you do not enroll within 31 days, you must wait until Open Enrollment, unless you have a Qualifying Change in Status (see “[Changing Your Elections](#)”).

Enrollment materials are available online at <http://hr.uchicago.edu> or from the Benefits Office.

### During Open Enrollment

You have the opportunity to enroll or re-enroll in a Health Care FSA, Dependent Care FSA or both during the University’s annual Open Enrollment in November. The benefits you elect during Open Enrollment take effect on the following January 1. **You must make a new election every year.**

## Cost

The Internal Revenue Service (IRS) limits the amount you can contribute to an FSA as shown in the table below.

Type of FSA	Minimum Annual Contribution	Maximum Annual Contribution
Health Care	\$250	\$5,000
Dependent Care	\$0	\$5,000*

If you are married, you and your spouse are limited to a maximum annual contribution of \$5,000 if you file a joint return or \$2,500 each if you file separate returns. If you are single, legally separated, divorced or in a domestic partner relationship, you may contribute the full \$5,000 if you claim the child on your tax returns.

\*If you are a Highly Compensated Employee, your dependent care contribution is limited to a lower amount. Contact the Benefits Office regarding this lower limit.

## When Participation Begins

Your participation begins on the first day of the month following the receipt of your election form, provided you return your completed enrollment form to the Benefits Office within 31 days of your date of hire as a Benefits-Eligible Employee.

If you enroll during the annual Open Enrollment, your coverage begins on the following January 1.

Only expenses incurred after your participation begins will be reimbursed from your FSA.

## Changing Your Elections

Once you enroll in an FSA, you cannot increase, decrease or stop your contributions, unless you have a Qualifying Change in Status.

**A Qualifying Change in Status** under the Health Care FSA occurs upon:

- Child ceases to be a Dependent Child.
- Marriage, divorce or legal separation.
- Registration or termination of a Domestic Partnership.
- Death of a Dependent.
- Birth, adoption or placement for adoption of a Dependent Child.
- The start or end of your spouse's or Domestic Partner's employment.
- A change in your, your spouse's or your Domestic Partner's employment status.

**Please note, in order for any of the above provisions to apply to you and your Domestic Partner, your Domestic Partner must qualify as a dependent under Internal Revenue Code section 152. See the [Glossary](#) for more information.**

**A Qualifying Change in Status** under the Dependent Care FSA occurs upon:

- Child ceases to be a Dependent.
- Marriage, divorce or legal separation.
- Registration or termination of a Domestic Partnership.
- Death of a Dependent.
- Birth, adoption or placement for adoption of a Dependent Child.
- The start or end of your spouse's or Domestic Partner's employment.
- A change in your, your spouse's or your Domestic Partner's employment status.
- Dependent Child enters kindergarten.
- Change in dependent care coverage.
- Change in cost of dependent care, except when a relative provides the service.

**Please note, in order for any of the above provisions to apply to you and your Domestic Partner, your Domestic Partner must qualify as a dependent under Internal Revenue Code section 152. See the [Glossary](#) for more information.**

You are able to change an existing FSA election during a calendar year only when you have a Qualifying Change in Status. Any change in your elections must be consistent with the qualifying change in your circumstances. You must complete and submit the request for a Change in Status form to the Benefits Office within 31 days of the qualifying event. Your new election takes effect on the first of the month following the date the Qualifying Change in Status is received by the Benefits Office.

## **When Participation Ends**

Your participation automatically ends on December 31 each year. You must re-enroll during Open Enrollment to maintain a FSA for the following calendar year. Your participation also ends on the day:

- You are no longer employed as a Benefits-Eligible Employee of the University.
- You are no longer eligible to participate – see [Coverage During a Leave](#)
- The University terminates the Plan.

When your participation ends, contributions to your FSA will stop as of the end of the pay period in which your participation ended. You can file for reimbursement of any balance in your Health FSA for any expenses incurred on or before your termination date. You can file for reimbursement of any balance remaining in your Dependent Care FSA for any expenses incurred through December 31 of that calendar year. You have until March 31 of the following year to file for reimbursements for such expenses.

If you die, your surviving spouse or estate can file these claims as if a participant in the Plan.

## **Coverage During a Leave**

There are four types of leaves of absence that you can take from the University and still be treated as an employee of the University while on that leave. The four types of leave are:

1. Short-Term Disability (not available to academic employees)
2. An Unpaid Leave of Absence (including Family and Medical Leave)
3. Long-Term Disability
4. Military Leave of Absence

## **Participation in FSAs while on Short-Term Disability**

***For bi-weekly employees.*** If you are on short-term disability leave and are paid on a bi-weekly basis, your Health Care FSA and Dependent Care FSA remain intact. The same amount will be deducted from your short-term disability paycheck as was being deducted before this leave and you may claim reimbursement for claims incurred while you are on short-term disability.

***For Monthly Paid Employees.*** If you are paid on a monthly basis and go on a short-term disability leave, your short-term disability paycheck is paid on a bi-weekly basis. Therefore, it is important to notify the Benefits Office of this leave so that your FSA contributions can be adjusted to reflect the change in pay periods. Otherwise, the monthly amount will be deducted from each bi-weekly short-term disability check.

If your short-term disability paycheck is insufficient to allow for the deduction of your entire FSA contributions, no deduction will be made so that claims incurred during this time would not be eligible for reimbursement under your Health Care FSA. You may however claim the balance in your Dependent Care FSA as of the end of a calendar year regardless of when the claim was incurred during that year.

If you return to work during the same calendar year in which your short-term disability leave began, you will again need to adjust your FSA contributions consistent with a monthly payroll cycle. You may increase your Health FSA to make up for the missed contributions during your leave, but you may never increase it beyond your original election for that year. If you make up missed contributions, you may claim expenses incurred during the period in which no deductions were made. You must complete a Change in Status form within 31 days of your return to work to make up the missed contributions. The new election becomes effective as of the first day of the month following receipt of the form.

If you return to work as a Benefits-Eligible Employee in a subsequent calendar year, you may elect a Health FSA and/or Dependent Care FSA for the remaining calendar year within 31 days of your return to work. Your participation will be effective as of the first of the month following the receipt of the completed enrollment form.

## **Participation in FSAs While on Unpaid Leave of Absence (including FMLA), Long-Term Disability or Military Leave of Absence**

If you are not actively at work due to an approved unpaid leave of absence, long-term disability leave or military leave of absence, the FSA rules governing these types of leaves are basically the same. With each of these leaves, you are not receiving a paycheck from the University; therefore no pre-tax contributions can be made to your FSAs while on such leave.

If you return to work during the same calendar year in which such unpaid leave of absence began, contact the Benefits Office to make sure that your contributions resume properly. Generally, health care expenses incurred during the leave cannot be reimbursed from your Health Care FSA. If however, you return to active work during the same calendar year, you may amend your Health Care FSA to make up the missed contributions in order to claim expenses incurred during your leave up to the amount of your original election for the year. Such change must be done within 31 days of your return to work and the increase will go into effect as of the first day of the month following receipt of the Change in Status form.

You may claim dependent care expenses up to the amount in your Dependent Care FSA regardless of when the claim was incurred. If you return to work as a Benefits-Eligible Employee in a

subsequent calendar year, you may elect a Health FSA and/or Dependent Care FSA for the remaining calendar year within 31 days of your return to work. Your participation will be effective as of the first of the month following the receipt of the completed enrollment form.

Special Rule for FMLA and Military Leaves.

Because these types of leaves are generally involuntary, the University treats this as a qualifying event under the COBRA rules for FSAs. You may continue or reduce your contributions to a Health Care FSA while on such leave. If you make such an election, such contributions are made on an after-tax basis because there is no paycheck from which a pre-tax contribution can be taken. (See [COBRA](#)).

**Workers' Compensation and FSAs**

If you are not actively at work while you are receiving workers' compensation benefits, but are still receiving a payroll check from the University, your contributions to the Health Care FSA and/or Dependent Care will remain in effect at the same deduction amount as before your leave, provided the amount of the payroll check is sufficient to cover the full deduction. The same amount will be deducted from your University check and you can claim expenses incurred while receiving workers' compensation benefits.

If the payroll check is not sufficient to cover the elected deductions, your contributions to the Health Care FSA and/or Dependent Care FSA will be suspended. You will not be able to claim medical expenses from your Health Care FSA incurred during that time period. However, you may claim the balance in your Dependent Care FSA as of the end of the calendar year regardless of when the claim was incurred during that year.

If you return to active employment during the same calendar year, contact the Benefits Office to ensure that FSA payroll deductions resume for the same amount in effect prior to suspension. Your annual Health Care and Dependent Care election amounts will be reduced by the amount of the missed contributions unless you elect to make up the missed contributions to restore the annual election amounts. If you elect to make up the missed contribution, eligible health care expenses incurred during the suspension period are reimbursable from Health Care FSA. You must then fill out a Change in Status form within 31 days of your return to work. The revised deduction amount will be in effect the first of the month following receipt of the Change in Status form.

If you return to active work in a new calendar year as a Benefits Eligible Employee, you may elect a Health FSA and/or Dependent Care FSA for the remaining calendar year within 31 days of your return to work. Your participation will be effective as of the first of the month following the receipt of the completed enrollment form.

# How FSAs Work

## Your Options

The University offers two types of FSAs:

- The **Health Care FSA** can be used to pay for eligible medical, vision and dental care expenses that are not covered by your medical or dental plan.
- The **Dependent Care FSA** can be used to pay for eligible day care expenses for a Dependent Child or adult relative to allow you or your spouse to work, or while your spouse is a full-time student or disabled.

Each year, you have to make a new contribution election for each FSA within the limits permitted by the Internal Revenue Service. The amount you elect to contribute is automatically deducted from each paycheck before taxes are withheld.

The contributions accumulate in your account until you file a claim. When you have at least \$5 in qualifying expenses, you may submit a claim along with the bill, Explanation of Benefits or receipt for reimbursement.

## Saving Money on Income Taxes

The money deducted from your paycheck as contributions go directly into your FSA before taxes are withheld. Therefore, you do not pay taxes on this money. Reimbursements from your FSA are also tax-free.

Here's an example of how a spending account can help save you money you would otherwise pay in taxes. This example assumes you are married and have two children, your combined annual income is \$50,000 and you contribute \$1,500 to a health care spending account.

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### Example

John earns \$50,000 a year. If he contributes \$1,500 to an FSA, he could save \$340 on his income taxes.

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	With FSA	Without FSA
Gross Annual Base Pay	\$50,000	\$50,000
FSA Contributions	- <u>\$1,500</u>	- <u>\$0</u>
Taxable Income	\$48,500	\$50,000
Income Taxes*	- \$7,408	- \$7,748
After-Tax Expenses	- <u>\$0</u>	- <u>\$1,500</u>
Spending Income	\$41,092	\$40,752
FSA Tax Savings	\$41,092 - 40,752 = <b>\$340</b>	

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\* *Estimates are based on 2002 tax tables and assume you are filing a joint tax return, take the standard deduction, and claim four exemptions. State taxes have not been included but could represent additional savings if you would have otherwise paid state tax on the money you contribute to your spending account. The actual amount you save in taxes will depend on your personal situation.*

## IRS Rules

Because FSAs give you a tax reduction, they are regulated by federal tax rules. For example:

- You can only claim expenses for dependents that you claim on your income taxes. **Note: For a Domestic Partners to qualify as a dependent under IRS rules they must:**
  - Receive over 50% of their support from the employee for the calendar year.
  - Have the employee's home as their principal residence for the entire calendar year; and
  - Be a member of the employee's household. A Domestic Partner will not be considered a member of the employee's household if the relationship between the employee and the Domestic Partner violates local law.
- The money you set aside each calendar year must be used for that calendar year's expenses. **If contributions exceed incurred expenses, the excess contributions will be forfeited.** This is often called the "use it or lose it" rule.
- Any leftover balance in your FSA cannot be carried over into the next year or used to prepay bills for treatment that has not yet been provided. Expenses must be incurred (not billed) during the calendar year.
- You can change your annual contribution elections only during Open Enrollment unless you have a [Qualifying Change in Status](#).
- Any expenses paid through an FSA cannot be taken as a deduction on your income taxes. For example, if you use an FSA to pay for childcare, you cannot claim childcare expenses on your income taxes as well.
- Funds from a Medical FSA cannot be transferred to a Dependent Care FSA or vice versa.

## Health Care FSA

### What Is Covered

The money in your Health Care FSA can be used to pay for most medical, vision and dental care expenses incurred by you and your Dependents as long as these expenses are not covered by your medical or dental plan. Eligible Medical Expenses that meet the Internal Revenue Code Section 213(d) and that you may deduct from your federal income taxes qualify for reimbursement from your Health Care FSA, such as:

- Medical insurance deductibles and copayments.
- Prescription medication.
- Over-the-Counter medication purchases on or after September 3, 2003.
- Mental health care (psychiatric and psychological) services not covered by insurance.
- Dental expenses not covered by insurance.
- Eye care, including exams, glasses, contact lenses and laser surgery.
- Hearing aids.
- Routine medical exams.
- Well-baby care.
- Immunizations.
- Transportation primarily for and essential to medical care.
- Special education or treatment for a disabled Dependent.

This list only provides a few examples. The plan intends to follow current IRS reimbursement guidelines. If you are not sure whether an expense is covered, contact the [FSA Administrator](#).

## What Is Not Covered

You cannot use a Health Care FSA to pay for:

- Medical or dental insurance premiums.
- Vitamins, herbal and dietary supplements.
- Marriage counseling fees.
- Health club memberships or physical therapy for general health.
- Cosmetic surgery.
- Long-term care services or premiums.

This list only provides a few examples. The plan intends to follow current IRS reimbursement guidelines. If you are not sure whether an expense is covered, contact the [FSA Administrator](#).

## Health Care FSA or Income Tax Deduction

You can pay for health care expenses through your Health Care FSA **or** claim the expenses as a health care expense on your income tax return. **You cannot do both.**

To deduct health care expenses on your income tax return, your health care expenses for the year must exceed the current allowable deduction amount as determined by the IRS.

When you use a Health Care FSA, all eligible health care expenses, up to \$5000 per year, are paid with tax-free dollars. **However, you cannot take a tax deduction for any expenses reimbursed through your Health Care FSA. Please consult a tax advisor to determine whether you should participate in a FSA or use the income tax deduction.**

## Dependent Care FSA

### What Is Covered

The money in your Dependent Care FSA can help pay for eligible day care expenses for your Dependent Children or an older dependent relative.

Your dependent care expenses must meet the following requirements:

- The care of your Dependent Child or other eligible dependent must be necessary so you can work. If you are married, both you and your spouse must be employed, or your spouse must be a full-time student or disabled, and not available to care for the dependent.
- Care must be for your child who is under age 13 or for an adult you claim as a dependent on your income tax return. A dependent adult may be an elderly parent or spouse who cannot be left alone while you are at work.
- Expenses can be for a caregiver; before-school and after-school care programs, or for a licensed day care center or day camp.
- Your day care provider must have a Social Security number or taxpayer identification number.
- The cost of this care cannot exceed the annual earnings of the lower-paid spouse.

## What Is Not Covered

You **cannot** use a Dependent Care FSA to pay for:

- School tuition beginning with kindergarten.
- Overnight summer camp fees.
- Nursing home expenses for an elderly relative.
- Fees paid to someone you claim as a dependent on your or your spouse's income tax return, such as one of your children.
- Expenses for care provided while you or your spouse are not at work, such as expenses for a baby-sitter while you go out to dinner.
- Fees paid to someone who does not report the money as income.

This list provides only a few examples. The plan intends to follow current IRS reimbursement guidelines. If you are not sure whether an expense is covered, contact the [FSA Administrator](#).

## Dependent Care FSA or Federal Tax Credit

You can pay for dependent care expenses through your Dependent Care FSA **or** claim the expenses as a dependent care credit on your income tax return. **You cannot do both.**

As a general rule, if your adjusted gross family income tax bracket is higher than 15%, you will probably save more by using the Dependent Care FSA. As with any tax matter, consult your tax adviser before making a decision.

# Receiving Your Benefits

## Filing a Claim

The University has outsourced the processing and payment of FSAs to the FSA Administrator.

When you incur an eligible health care or dependent care expense, you pay that expense out-of-your-pocket. You then submit a claim to be reimbursed with the tax-free money in your FSA. You must accumulate at least \$5 in expenses before submitting a claim, unless it is the end of the year. You have until March 31 of the following year to submit your claims. If your claim is not received by then, you will not be reimbursed from your FSA(s). Claim forms are available online at <http://hr.uchicago.edu> or from the Benefits Office or the [FSA Administrator](#).

## Health Care FSA Claims

If you or your Dependents are covered under a medical or dental plan:

1. File your claim for coverage under the medical or dental plan.
2. The insurance company will send you an Explanation of Benefits (EOB) form indicating how much of the bill they will pay. Submit a copy of the EOB form along with an FSA claim form to the FSA Administrator.
3. You will be reimbursed for the portion of the bill not paid by insurance, up to the amount of your total annual election.

For health care services that are not covered by insurance, send the bill with the FSA claim form directly to the FSA Administrator.

### **Dependent Care FSA Claims**

Submit a receipt along with the completed FSA claim form and the provider's Social Security or taxpayer identification number to the FSA administrator. You will be reimbursed up to the amount currently in your account. If your claim is for more than your current account balance, a partial payment will be made until more money is contributed when pre-tax deductions are made from your paychecks each pay period.

## **If Your Health Care FSA Claim Is Denied**

### **Health Care FSA Claims and Appeals Procedures**

The Claims Administrator will decide upon your claim for reimbursement within a reasonable time, but not longer than 30 days after the Health Care FSA receives the claim. This time period may be extended for an additional 15 days if the claim does not contain sufficient information on which to base a decision, or an extension is required for other reasons beyond the Health Care FSA's control. The insurance company will comply with shorter time limits if required by the state in which the policy was issued.

If an extension is required, you will be notified before the end of the original 30-day period of the circumstances requiring the extension and the date by which a decision is expected. If additional information is required, the Claims Administrator will specifically describe it in the notice and give you a period of at least 45 days to provide it.

The Claims Administrator may secure independent medical advice or other advice and require such other evidence, as it deems necessary to decide your claim.

### **Notification of Denial**

If the Claims Administrator issues an Adverse Benefit Determination, you can request to have your claim reviewed and reconsidered. An "Adverse Benefit Determination" includes:

- Coverage denial,
- Denial because the service is experimental, investigational or not medically necessary, or
- Reduction or termination in an ongoing course of treatment (except due to Health Plan amendment or termination).

The written explanation of the denial will be provided by the Claims Administrator and it will state:

- The specific reasons for the denial,
- A reference to the specific Plan provision on which the denial is based,
- If the Claims Administrator relied on an internal rule, guideline, protocol, or other similar criterion in making its decision, a description of the specific rule, guideline, protocol, scientific or clinical judgment, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request,
- A description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary, and
- Appropriate information as to the steps to be taken if you wish to appeal the Claims Administrator's determination, including your right to submit written comments and have them considered, your right to review (on request and at no charge) relevant documents and other information, and your right to file suit under ERISA with respect to any adverse determination after appeal of your claim.

## **Appealing Denied Claims**

You may appeal an Adverse Benefit Determination. Your appeal must be made in writing within 180 days of the Plan Administrator's initial notice of an Adverse Benefit Determination (or claim denial), or else you will lose the right to appeal your denial. If you do not appeal on time, you will also lose your right to file suit in court, as you will have failed to exhaust your internal administrative appeal rights, which is generally a prerequisite to bringing suit.

Your written appeal should include the following:

- The reasons you feel your claim should not have been denied.
- Any additional facts and/or documentation that you feel support your claim.

You can also ask additional questions and make written comments, and you may review (at no charge) documents or other information relevant to your appeal.

All written comments and documents you submit with your appeal, whether or not considered in the initial claim determination, will be reviewed and considered on appeal.

## **Review of Appeal**

An independent fiduciary will review and render a decision on your appeal within the time frames outlined below and will notify you of its decision in writing. The independent fiduciary will not be an individual who participated in or decided your original claim nor be a subordinate to the original decision maker. No deference shall be given to the initial decision. The independent fiduciary may consult with a physician or other licensed health care professional to receive advice or other such evidence as it deems necessary to decide your claim, except that any medical expert consulted in connection with your appeal will be different from any expert consulted in your initial claim. (The identity of a medical expert consulted in connection with your appeal will be provided.)

The Claims Administrator will notify you of its decision on appeal, adverse or not, but not later than 60 days after the Health Plan received appeal.

## **Notification of Appeal Denial**

If the decision on appeal affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

- The specific reason(s) for the denial,
- the specific Health Care FSA provisions on which the decision is based,
- a statement of your right to review (on request and at no charge) relevant documents and other information,
- if the Claims Administrator relied on an internal rule, guideline, protocol, or other similar criterion in making its decision, a description of the specific rule, guideline, protocol, scientific or clinical judgment, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request, and
- a statement of your right to bring suit under ERISA § 502(a).

## **How and When Benefits Are Paid**

Reimbursements are issued weekly. You can either make arrangements with the [FSA Administrator](#) for direct deposit into your bank account or have a reimbursement check mailed to your home address. Notify the FSA administrator of any address change immediately.

# Administrative Information

## Your ERISA Rights

As a participant in the Flexible Spending Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). 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, such as worksites and union halls, all documents governing the plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) 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 documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The 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.

### Continue Group Health Plan Coverage

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

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

### Prudent Actions 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, your union, 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 copies of 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 a copy of plan documents or the latest annual report 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 you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in 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 in 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 the 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 publication hotline of the Employee Benefits Security Administration.

### **Discretionary Authority**

The Plan Administrator has discretionary authority to grant or deny benefits under the contract. Benefits under the contract and plan will be paid only if the Plan Administrator decides in its discretion that you, the applicant, are entitled to them. The decision of the Plan Administrator shall not be overturned unless determined by a court of law to be arbitrary and capricious.

### **Service of Legal Process**

Service of legal process on any administrative matter should be directed to the Plan Administrator.

### **Plan Amendment and Termination**

The University has reserved the right, in its sole discretion under circumstances that it deems advisable (including, but not limited to, a need to address cost or plan design considerations), to terminate the Plan or to amend or eliminate benefits. In the event of termination or amendment or elimination of benefits, the rights and obligations of participants prior to the date of such event shall remain in effect, and changes shall be prospective, except to the extent that the University's action and applicable law permit otherwise.

### **Collective Bargaining**

Certain provisions of the Plan may be subject to collective bargaining agreements between the University of Chicago and certain unions.

If you are a member of a collective bargaining unit affected by these agreements, you can obtain a copy of the unit's agreement by writing to the plan administrator, or you may obtain it at the Office of Employee and Labor Relations.

## **Privacy Information**

During the administration of the dental plan, the plan and claims administrators may come into contact with what is considered “protected health information” under the Health Insurance Portability and Accountability Act (HIPAA). The University has taken specific steps to protect and limit access to this information. For example, the University has:

- Designated a privacy Office.
- Developed privacy policies and procedures
- Implemented safeguards to protect against improper disclosure
- Provided a complaint resolution process
- Developed sanctions for employees and business partners that violate privacy policies
- Established confidentiality agreements with business associates

As part of our compliance efforts, we must provide a privacy notice to employees. If you would like to review the privacy policies and procedures, receive another copy of the privacy notice or just need more information, please contact the Benefits Office.

## **Continuing Participation Under COBRA**

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that requires employers to allow former employees to continue health care coverage for a limited time. Under COBRA, you may be eligible to continue contributing to a Health Care FSA for a limited time after your contributions would otherwise stop.

It does not allow you to continue contributing to a Dependent Care FSA.

### **Eligibility**

Under COBRA, you will become eligible to continue contributing to your Health Care FSA after your participation would otherwise end because:

- Your employment with the University of Chicago ends (except for gross misconduct) or
- Your scheduled work hours drop below 20 hours per week.

### **Enrolling**

To elect COBRA coverage for your Health Care FSA, return the election forms you received from the FSA Administrator, within 60 days of notification.

### **Cost of Coverage**

If you elect to continue participation through COBRA, your contributions to the Health Care FSA will be made at the same rate as when you were an active employee, but with after-tax dollars. Therefore, your contributions are no longer tax-free. In addition, you must pay a 2% administrative fee.

The advantage of continuing to contribute to your Health Care FSA after you eligibility ends is that the pre-tax contributions already in your FSA Account can be used to pay for health care expenses incurred after you are no longer eligible if necessary.

### **When Coverage Begins**

If you decide to continue your participation through COBRA, your COBRA coverage begins on the first day of the following month. You will be billed retroactively from that date. For example, if you leave the University or become benefits-ineligible on August 14, you can be reimbursed for claims incurred through August 31 and, if necessary to use up your account balance, for claims you incur during that calendar year.

### When Coverage Ends

Your COBRA coverage for the Health Care FSA ends at the end of the calendar year or when you stop paying the premiums, whichever occurs first.

### Other Plan Information

You will need this information for future reference or if you have any questions about your benefits.

<b>Plan Name</b>	The University of Chicago Flexible Spending Plan
<b>Funding and Administration</b>	The plan is funded by participating employees. The plan is administered in accordance with an administrative contract the University has with FlexBen Corporation.
<b>Employer, Plan Sponsor &amp; Administrator</b>	The University of Chicago Benefits Office 956 East 58th Street Chicago, IL 60637 773-702-9634
<b>Agent for Service of Legal Process</b>	<b>For the University:</b> The University of Chicago Benefits Office 956 East 58th Street Chicago, IL 60637  <b>For the claims administrator:</b> FlexBen Corporation 10404 North Baehr Road Mequon, WI 53092
<b>Plan Year</b>	January 1 to December 31 for fiscal record purposes.
<b>Employer Identification Number</b>	36-2177139
<b>Plan Number</b>	516
<b>Type of Plan</b>	The Plan is a cafeteria plan subject to Internal Revenue Code Section 125. Only the Health Care FSA is a welfare benefit plan, which reimburses participants for certain medical expenses.

# Glossary

<b>Benefits-Eligible Employee</b>	<p>Generally, you are Benefits-Eligible if you are:</p> <ul style="list-style-type: none"><li>• <b>Full-time:</b> your position is anticipated to exist for one year or longer and you are scheduled to work at least 35 hours per week.</li><li>• <b>Part-time:</b> your position is anticipated to exist for one year or longer and you are scheduled to work 20 - 35 hours per week.</li></ul> <p>You are not Benefits-Eligible if you are scheduled to work fewer than 20 hours per week or if your position is expected to exist less than one year.</p>
<b>Coinsurance</b>	The portion of covered medical bills that you pay for necessary care, after you meet your deductible.
<b>Copayment</b>	A flat dollar amount you pay for a specific service.
<b>Deductible</b>	The portion of your medical expenses you pay before a plan begins to pay benefits.
<b>Dependents</b>	Under the Health Care FSA, dependents include your spouse, Domestic Partner and Dependent Children. Under the Dependent Care FSA, dependents include your spouse, Domestic Partner, Dependent Children and dependent elderly relatives living with you (see " <a href="#">What Is Covered</a> ").
<b>Dependent Child(ren)</b>	This includes natural, step- and legally adopted children and children placed in the home for adoption. This also includes grandchildren if you or your domestic partner is the legal guardian, claims the child for income tax and legal purposes, and lives with the child in a parent/child relationship. Coverage continues up to the child's 23rd birthday if he or she is unmarried. If you have a mentally or physically disabled child who was covered under the plan before age 23, you can generally continue coverage for that child indefinitely. You are responsible for notifying the Benefits Office when your dependent child marries or reaches age 23. If you do not, your child may lose his or her coverage, and you may pay for coverage at a higher rate than you should.
<b>Domestic Partner</b>	<p>For purposes of the FSAs, the University's definition does not apply. In order for your domestic partner to have expenses reimbursed under either FSA, he or she must be a dependent as defined in Internal Revenue Code section 152.</p> <ul style="list-style-type: none"><li>• You can only claim expenses for dependents that you claim on your income taxes. <b>Note: For a Domestic Partner to qualify as a dependent under IRS rules they must:</b><ul style="list-style-type: none"><li>– Receive over 50% of their support from the employee for the calendar year.</li><li>– Have the employee's home as their principal residence for the entire calendar year; and</li><li>– Be a member of the employee's household. A Domestic Partner will not be considered a member of the employee's household if the relationship between the employee and the Domestic Partner violates local law.</li></ul></li></ul> <p>Please contact a tax adviser for a determination on these eligibility criteria.</p>
<b>Eligible Medical Expenses</b>	The Internal Revenue Code defines "medical care" as any amounts incurred to diagnose, treat or prevent a specific medical condition or for purposes of affecting any function or structure of the body. This includes, but is not limited to, prescription drugs and over-the-counter drugs purchased on or after September 3, 2003. Not every health-related expense you or your eligible dependents incur will constitute an expense for "medical care." For example, as defined by the Code, an expense is not for "medical care" if it is merely for the beneficial health of you and/or your eligible dependents (e.g. vitamins or

	nutritional supplements that are not taken to treat a specific medical condition). Expenses for cosmetic purposes are also not reimbursable unless they are necessary to correct an abnormality caused by illness, injury or birth defect.
<b>Highly Compensated Employee</b>	A Highly Compensated Employee is defined by current IRS guidelines.
<b>Open Enrollment</b>	Open Enrollment is the stated period of time designated by the University each calendar year in which Benefits-Eligible Employees may make changes to their benefits for the next calendar year.
<b>Qualifying Change in Status</b>	The specific situations, defined by current Internal Revenue Code, when you may change your coverage level after Open Enrollment.

## A Final Note

This summary is written in everyday language and provides a general summary and serves as your summary plan description. We have tried to make it as complete and accurate as possible. If there are any discrepancies between this summary and the formal plan documents, those documents will determine how the plan works and the benefits that are paid. The University has the authority to interpret the terms of the plan and to address questions arising under the plan and may delegate some or all of this authority to other entities, such as insurance companies or claims payors. FlexBen makes determinations of benefits under its operating guidelines.

Participating in this plan does not guarantee employment.