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 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.

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 or within 31 days of the date that you become a Benefits-Eligible Employee, provided you enroll on-line through Employee Self Service (ESS) 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").

Enroll online at https://ess.uchicago.edu/ess/.

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 a 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 your election, provided you enroll on-line through Employee Self Service (ESS) 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. Any change in your elections must be consistent with the qualifying change in your circumstances. You must complete and submit a Benefits Change 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.

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
- 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 Service Code Section 152. Please consult with a tax professional 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
- 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 Service Code Section 152. Please consult with a tax professional for more information.

When Participation Ends

Your participation automatically ends on December 31 each year. You must re-enroll during Open Enrollment to maintain an 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 **on or before your termination date.** 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 five 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 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

If you are on short-term disability leave 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 eligible expenses incurred while you are on short-term disability.
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.

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 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 eligible 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 Benefits Change 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.

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.

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 eligible 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.

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 the suspension of the payroll deductions. 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 contributions, eligible health care expenses incurred during the suspension period are reimbursable from Health Care FSA. You must then fill out a Benefits Change 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 Benefits Change 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 Benefits Change 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.

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 is an example of how a flexible spending account can help save you money that you would otherwise pay in taxes. This example assumes that your annual income is $50,000 and you contribute $2,000 to a health care spending account.

Example

	With FSA	**Without FSA**
Gross Annual Base Pay	$50,000	$50,000
FSA Contributions	- $2,000	- $0
Taxable Income	$48,000	$50,000
Income Taxes*	- $13,440	- $14,000
Post-Tax Income	$36,560	$36,000
FSA Tax Savings	$36,560 – $36,000 = **$560**	

IRS Rules

Because FSAs give you a tax reduction, they are regulated by Internal Revenue Service (IRS) rules. For example:

- You can only claim expenses for dependents that you claim on your income taxes. **Note: For a Domestic Partner to qualify as a dependent please consult with the IRS or a tax professional.**
- The money you set aside each calendar year must be used for that calendar year's eligible expenses
- However, you can use money remaining in your Health Care and Dependent Care FSAs as of December 31 of each year for qualified expenses incurred in the first two and one-half months of the next year. This means you have until March 15 (the run-out period) to use your previous year's remaining account balance before it is forfeited. This is often called the "use it or lose it" rule. The claim submission deadline is June 30. . 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 additional information regarding this matter, contact a tax professional.
- Funds from a Health Care 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 (OTC) medication purchases; **if prescribed by a doctor or another individual who is legally authorized to issue a prescription in the state in which the OTC drug expense is purchased**
- 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 expenses not covered by insurance
- Hearing aids
- Routine medical exams
- Well-baby care
- Immunizations

This list only provides a few examples. The Plan follows current IRS reimbursement guidelines. If you are not sure whether an expense is covered, contact the University's FSA Administrator – CONEXIS at 877-822-9091.

What Is Not Covered
You cannot use a Health Care FSA to pay for:

- Medical or dental insurance premiums
- Vitamins, herbal and dietary supplements
- 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 follows current IRS reimbursement guidelines. If you are not sure whether an expense is covered, contact the University's FSA Administrator – CONEXIS at 877-822-9091.

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.** For additional guidance contact a tax professional.

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 that 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 whom you claim as a dependent on your income tax return. A dependent adult may be a spouse or an elderly parent 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 follows current IRS reimbursement guidelines. If you are not sure whether an expense is covered, contact the University's FSA Administrator - CONEXIS at 877-822-9091.

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 with any tax matter, consult your tax professional before making a decision.

Receiving Your Benefits

Filing a Claim Healthcare FSA

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

You have two reimbursement options under the Healthcare FSA. You can complete and submit a written claim for reimbursement. Alternatively, you can use an electronic payment card to pay the expense. In order to be eligible for the Electronic Payment Card, you must agree to abide by the terms and conditions of the Electronic Payment Card Program (the "Program") and in the Electronic Payment Cardholder Agreement (the "Cardholder Agreement") including any fees applicable to participate in the program, limitations as to card usage, the Plan's right to withhold and offset for ineligible claims, etc. The following is a summary of how both options work:

Traditional Paper Claims: When you incur an Eligible Medical Expense, you may file a claim with the FSA Administrator - CONEXIS by completing and submitting a Request for Reimbursement Form. You may obtain a Request for Reimbursement Form from the FSA Administrator - CONEXIS. You must include with your Request for Reimbursement Form, a written statement from an independent third party (e.g., an itemized statement, EOB, etc.) associated with each expense that indicates the following:

a) The nature of the expense (e.g. what type of service or treatment was provided). If the expense is for an over-the-counter drug, the written statement must indicate the name of the drug;
b) The date(s) of service;
c) The name of the provider;
d) The amount of the expense; and
e) The patient's name

The FSA Administrator - CONEXIS will process the claim once it receives the Request for Reimbursement Form from you. Reimbursement for expenses that are determined to be Eligible

Medical Expenses will be made as soon as possible after receiving the claim and processing it. If the expense is determined to not be an "Eligible Medical Expense", you will receive notification of this determination. You must submit all claims for reimbursement for Eligible Medical Expenses during the Plan Year in which they were incurred or during the run-out period.

Electronic Payment Card: The Electronic Payment Card allows you to pay for Eligible Medical Expenses at the time that you incur the expense. Here is how the Electronic Payment Card works.

a) In order to be eligible for the Electronic Payment Card, you must agree to abide by the terms and conditions of the Program as set forth herein and in the Electronic Payment Cardholder Agreement (the "Cardholder Agreement"), limitations as to card usage, the Plan's right to withhold and offset for ineligible claims, etc. You must agree to abide by the terms of the Program both during the Initial Election Period and during each Annual Enrollment Period. A Cardholder Agreement will be provided to you. The card will be turned off effective the first day of each Plan Year if you do not affirmatively agree to abide by the terms of the Program during the preceding Open Enrollment Period. The Cardholder Agreement is part of the terms and conditions of your Plan.

b) The card will be turned off when you terminate employment or coverage under the Plan. You may not use the card during any applicable COBRA continuation coverage period.

c) As specified in the Cardholder Agreement, you certify during the Open Enrollment Period that the amounts in your Healthcare FSA will only be used for Eligible Medical Expenses (i.e. medical care expenses incurred by you, your spouse, and your tax dependents) and that you have not been reimbursed for the expense and that you will not seek reimbursement for the expense from any other source. Failure to abide by this certification will result in termination of card use privileges.

d) Use of the card for Eligible Medical Expenses is limited to merchants who have a health care related merchant category code (doctors, pharmacies, etc.) or who utilize the Inventory Information Approval System described below. The FSA Administrator - CONEXIS has sole discretion to determine whether the merchant has a health care related merchant category code. NOTE: MANY PHARMACIES IN RETAIL AND DISCOUNT STORES WILL NOT QUALIFY AS MERCHANTS WITH A HEALTH CARE RELATED MERCHANT CATEGORY CODE.

e) . When you incur an Eligible Medical Expense at an eligible merchant, such as a co-payment or prescription drug expense, you swipe the card at the merchant's office much like you would a typical credit or debit card. The merchant is paid for the expense up to the maximum reimbursement amount available under the Health Care FSA (or as otherwise limited by the Plan) at the time that you swipe the card. Every time you swipe the card, you certify to the Plan that the expense for which payment under the Health Care FSA is being made is an Eligible Medical Expense and that you have not been reimbursed from any other source nor will you seek reimbursement from another source.

f) ***You must obtain and retain a receipt/third party statement each time you swipe the card.*** **You must obtain a third party statement from the healthcare provider (e.g., receipt, invoice, etc.) that includes the following information each time you swipe the card:**

- **The nature of the expense (e.g. what type of service or treatment was provided). If the expense is for an over the counter drug, the written statement must indicate the name of the drug;**
- **The date(s) of service;**
- **The name of the provider;**
- **The amount of the expense; and**
- **The patient's name**

<u>You must retain this receipt for one year following the close of the Plan year in which the expense is incurred.</u> Even though payment is made under the card arrangement,

a written third party statement is required to be submitted. You will receive a letter from the FSA Administrator - CONEXIS that a third party statement is needed. You must provide the third party statement to the FSA Administrator - CONEXIS within 45 days (or such longer period as is provided in the letter from the FSA Administrator - CONEXIS) of the request.

Dependent Care FSA Claims

If you have elected to participate in the Dependent Care FSA, you will have to take certain steps to be reimbursed for your Eligible Expenses. When you incur an Eligible Expense, you may file a claim with the FSA Administrator - CONEXIS by completing and submitting a Request for Reimbursement Form. You may obtain a Request for Reimbursement Form from the FSA Administrator - CONEXIS. If there are sufficient funds in your Dependent Care Account, you will be reimbursed for your Eligible Expenses on the next scheduled processing date.

If your claim was for an amount that was more than your current Dependent Care Account balance, the excess part of the claim will be carried over into following months, to be paid out as your balance becomes adequate. Remember, you cannot be reimbursed for any total expenses above the available funds in your Dependent Care Account.

If Your FSA Claim Is Denied

FSA Claims and Appeals Procedures

Step 1: If your claim is denied, you will receive written notice from the FSA Administrator - CONEXIS that your claim is denied as soon as reasonably possible but no later than 30 days after receipt of the claim. For reasons beyond the control of the FSA Administrator - CONEXIS, the FSA Administrator - CONEXIS may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the FSA Administrator - CONEXIS must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

Step 2: Once you have received your notice from the FSA Administrator - CONEXIS, review it carefully. The notice will contain:

a) The reason(s) for the denial and the Plan provisions on which the denial is based;
b) A description of any additional information necessary for you to provide to process your claim, why the information is necessary, and your time limit for submitting the information;
c) A description of the Plan's appeal procedures and the time limits applicable to such procedures; and
d) A right to request all documentation relevant to your claim.

Step 3: If you do not agree with the decision of the FSA Administrator - CONEXIS and you wish to appeal, you must file your appeal no later than 180 days after receipt of the notice described in Step 1. You should submit all information identified in the notice of denial as necessary to process your claim and any additional information that you believe would support your claim.

Step 4: . If the claim is again denied, you will be notified in writing as soon as possible but no later than 30 days after receipt of the appeal by the FSA Administrator - CONEXIS.

Step 5: You should take the same action that you took in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the FSA Administrator - CONEXIS.

Step 6: If you still do not agree with the FSA Administrator - CONEXIS's decision and you wish to appeal, you must file a written appeal with the Plan Administrator within the time period set forth in the first level appeal denial notice from the FSA Administrator - CONEXIS. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe would support your claim.

If the Plan Administrator denies your 2nd Level Appeal, you will receive notice within 30 days after the Plan Administrator receives your claim. The notice will contain the same type of information that was referenced in Step 1 above.

How and When Benefits Are Paid

You can either make arrangements with the FSA Administrator - CONEXIS for direct deposit into your bank account or have a reimbursement check mailed to your home address. Notify the FSA Administrator - CONEXIS 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 - CONEXIS, 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 COBRA 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.

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.

Plan Name	The University of Chicago Flexible Spending Plan
Funding and Administration	The plan is funded by participating employees. The plan is administered in accordance with an administrative contract the University has with CONEXIS.
Employer, Plan Sponsor & Administrator	The University of Chicago HRS - Benefits Office 6054 South Drexel Avenue Chicago, IL 60637 773-702-9634
Agent for Service of Legal Process	**For the University:** The University of Chicago HRS - Benefits Office 6054 South Drexel Avenue Chicago, IL 60637 **For the claims administrator:** CONEXIS P.O. Box 227197 Dallas, TX 75222
Plan Year	January 1 to December 31 for fiscal record purposes.
Employer Identification Number	36-2177139
Plan Number	516
Type of Plan	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

Benefits-Eligible Employee	Generally, you are Benefits-Eligible if you are: • **Full-time:** your position is anticipated to exist for one year or longer and you are scheduled to work at least 35 hours per week. • **Part-time:** your position is anticipated to exist for one year or longer and you are scheduled to work 20 - 35 hours per week. 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.
Coinsurance	The portion of covered medical bills that you pay for necessary care, after you meet your deductible.
Copayment	A flat dollar amount you pay for a specific service.
Deductible	The portion of your medical expenses you pay before a plan begins to pay benefits.
Dependents	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.
Dependent Child(ren)	This includes natural, step- and legally adopted children and children placed in the home for adoption. This also includes grandchildren if you, your spouse 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 26th birthday.. If you have a mentally or physically disabled child who was covered under the plan before age 26, you can generally continue coverage for that child indefinitely. You are responsible for notifying the Benefits Office when your dependent child reaches age 26. If you do not, your child may lose his or her coverage, and you may pay for coverage at a higher rate.
Domestic Partner	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. **Please contact a tax adviser for a determination on these eligibility criteria.**
Eligible Medical Expenses	The Internal Revenue Service Code defines "medical care expenses" 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.
Highly Compensated Employee	A Highly Compensated Employee is defined by current IRS guidelines.
Open Enrollment	Open Enrollment is the stated period of time designated by the University each calendar year during which Benefits-Eligible Employees may make changes to their benefits for the next calendar year.
Qualifying Change in Status	The specific situations, defined by current Internal Revenue Service Code, when you may change your coverage level outside of the Open Enrollment period.

A Final Note

This document is written in everyday language, provides a general summary and serves as your summary plan description.

While this document is intended to be accurate, if there are any discrepancies between this summary plan description and the formal plan documents or legislation and/or regulations, the plan documents and/or the legislation or regulations 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. CONEXIS makes determinations of benefits under its operating guidelines.

Participating in this plan does not guarantee employment.