Health Flexible Spending Account Summary Plan Description

UNIVERSITY
OF
CALIFORNIA

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KEY DEADLINES

APRIL 15 ANNUALLY

- Submit your claims for reimbursement; when the deadline is over, you forfeit any unused funds

OCTOBER/NOVEMBER ANNUALLY

- Enroll/re-enroll in the Health FSA for the plan year that begins Jan. 1

Health-related expenses can come in many forms—and not all of them are covered by your medical, dental and vision plans. Fortunately, the university's Health Flexible Spending Account allows you to set aside pre-tax money each year for such expenses, helping you budget for these costs and saving you money on taxes.

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How the Health FSA Works

You decide each year how much you want to contribute to your Health Flexible Spending Account (Health FSA). The amount you specify is taken in monthly installments from your paycheck, before federal, Social Security (FICA) and most state taxes are calculated.

You have until Dec. 31 to incur expenses for reimbursement in your account and you may carryover up to $500 in unused funds from one year to the next. You need to file claims by April 15 of the following year.

Because your FSA contributions reduce your taxable income, participation will lower your taxes. For example, if you're in a 20 percent tax bracket, each $100 you contribute to the FSA can save you $20 in taxes. Check with your tax advisor for details. **Choose your contribution level carefully; any money left in your account will be forfeited.** You can use the online FSA calculation tool at www.conexismarketing.com/employees/tools/fsa-calculator to estimate your expenses. (CONEXIS is the company that handles FSA claims for UC.)

ELIGIBILITY

If you are eligible for any level of UC benefits, you may participate and both you and your dependents are covered. The exception is if you're enrolled in the Blue Shield Health Savings Plan; because that plan includes its own Health Savings Account, participants may not enroll in the Health FSA.

WHEN TO SIGN UP

You need to enroll each year if you want to participate. You may enroll when you first become eligible, usually during your first 31 days as a newly eligible employee. After that, you may sign up each year during Open Enrollment, usually in November.

You may also enroll during the year if you have a family or employment status change. See the chart, "Midyear Changes Allowed for the Health FSA," on page 7 for details on allowable changes.

Use It or Lose It
Remember that you may carry over up to $500 of unused funds from the previous plan year into the next year. You'll lose any money in excess of $500 if you don't use it during the year. You can't receive the unused portion in cash. So it's important to estimate your expenses carefully. Check out the online calculator at www.conexismarketing.com/employees/tools/fsa-calculator to estimate your expenses.

HOW TO ENROLL

As a new employee and during Open Enrollment, you may enroll by logging in to your account on At Your Service Online, at https://atyourserviceonline.ucop.edu/ayso/. If you do not have access to the internet, you should complete the UPAY 850 form, available from your benefits office.

WHEN COVERAGE BEGINS

If you enroll when you're first eligible or after a family or employment change, your coverage starts the first day of the month following your enrollment, subject to payroll deadlines. If you sign up during Open Enrollment in the fall, the effective date is the following Jan. 1.

WHO IS COVERED

Your Health FSA can be used to cover eligible expenses incurred by you, your spouse or your eligible dependents. The list of eligible dependents includes:

- Your children up to age 26
- Your spouse
- Your domestic partner, if he or she is your tax dependent*
- Your registered domestic partner's children if you are considered their stepparent under state law
- Your tax dependent*

The eligibility rules for spouses and dependents are established by the IRS and are different from UC rules for eligibility for other plans.

* "Tax dependent" means your dependent for federal income tax and/or health coverage purposes.

HOW MUCH YOU CAN CONTRIBUTE

The minimum annual contribution is $180; the maximum is $2,550. If you and your spouse are both UC employees, you may each contribute up to $2,550 per year.

ELIGIBLE AND INELIGIBLE EXPENSES

The Internal Revenue Code, section §213(d), and your UC plan set the rules determining which expenses can be paid with your FSA funds. Generally, eligible expenses are those not covered by your medical, dental or vision plans. They must be meant to diagnose, cure, mitigate, treat or prevent illness or disease. Some eligible expenses include:

- Co-payments and deductibles
- Payments for prescription drugs
- Contact lenses and eyeglasses
- Durable medical equipment like crutches and wheelchairs
- Transportation for medical care

Expenses reimbursed under the Health FSA can't be deducted on your tax return. And you can't use the Health FSA to be reimbursed for expenses that are eligible for reimbursement through another plan or program.

Some examples of ineligible expenses include:

- Insurance premiums
- Personal use items like toothpaste and cosmetics
- Over-the-counter medications that are not prescribed by a doctor or other legally prescribing provider
- Family or marriage counseling

For a detailed list of eligible and ineligible expenses, please see the CONEXIS website at uc.conexisfsa.com; select "Health FSA" under "Plan Rules."

CONEXIS's acceptance of an expense doesn't assure IRS approval of the expense. It's your responsibility to make sure that any expenses you submit are eligible under the IRS rules.

WHEN YOU CAN USE THE FUNDS

Your entire annual contribution is available to you beginning the first day of the plan year. That means you may withdraw funds—up to the total amount you elect to contribute for the plan year—to cover eligible expenses at any time during the year.

For example, say you've elected to contribute $2,400 for the year, so that $200 is deducted from your paycheck each month. In April you have surgery, which requires a $1,500 co-payment. You can be reimbursed the full $1,500 in April even though you've only contributed $800 to the plan between January and April.

Expenses are considered to have been incurred when you (or your spouse, partner or dependents) are provided with the care—not when you are billed, charged or pay for it.

How the Health FSA Works

HOW THE CARRYOVER PERIOD WORKS

If you have funds left over at the end of the plan year, you may carry over $500 to the following year, even if you do not re-enroll for the next plan year. However, those funds will not be available to use until after April 15 of the next plan year, referred to as the run-out period.

The carryover balance will be determined after the April 15 run-out period from the previous year is closed and all outstanding claims have been processed and paid. If you have remaining carryover dollars, the funds will be credited to your account in early May. You are eligible to receive the carryover funds automatically as long as you are an active UC employee and are eligible to participate in the Health FSA.

The current plan year funds are available first since the carryover amount cannot be determined until after the claims run-out period. This gives you time to submit reimbursement requests for eligible expenses incurred during the previous plan year. It also reduces the risk of forfeiting money if you have more than the allowed carryover amount when the plan year ends.

The IRS "use-it-or-lose-it" rule still applies. To avoid forfeiting any funds, it is important to spend down your account by Dec. 31. After the end of the run-out period you lose any money left in your account in excess of the carryover limit of $500. Per IRS rules, forfeited funds will not be returned or transferred to another account.

For example, you contributed $1,200 to your Health FSA, but claimed only $600 of eligible expenses by Dec. 31 of the plan year. You have until April 15 of the following plan year to request additional reimbursement for $600 of eligible claims incurred prior to Dec. 31. If you don't claim the remaining $600 unused balance, only $500 may be carried over in early-May. The extra $100 balance will be forfeited.

The carryover does not count towards the annual contribution limit of $2,550. You may choose to contribute up to $2,550 even if you carry over $500 from the previous year.

HOW TO TRACK YOUR BALANCE

You can check your balance anytime online at mybenefits.conexis.com, or with CONEXIS's automated phone service at 800-482-4120. Each time a reimbursement is issued, you'll receive an Explanation of Benefits, either posted to your online account (if reimbursed by direct deposit) or via U.S. mail (if reimbursed by check), that reflects your current account balance. Toward year's end, you'll receive a statement of year-to-date account activity to ensure you are aware of your remaining balance.

HOW TO CHANGE OR CANCEL CONTRIBUTIONS

Certain changes to your family or employment status may allow you a new 31-day window during which you may start or cancel participation or change your contribution amount. The chart, "Midyear Changes Allowed for the Health FSA," on page 7 shows the details. The changes you make to your participation in the plan must be made on account of, and consistent with, the change(s) in your family or employment status. You can't make changes retroactively. And if you stop participating, you can't be reimbursed for expenses incurred after the coverage end date.

To make a change, complete the UPAY 850 form, available at ucal.us/UPAY850. Fill out "Section 6, Health and DepCare FSA" and return the form to your Payroll or Benefits Office.

Midyear Changes Allowed Under Health FSA

In this chart:

- "Dependent" means anyone who is your tax dependent, such as a child, domestic partner, parent, sibling or in-law
- "Health plan" includes a medical, dental or vision plan; "Health FSA" means a health flexible spending account

Event	Actions Allowed			
	Enroll	Increase Contribution	De-enroll	Decrease Contribution
Change in your marital status				
You marry	Yes	Yes	No	No
You marry and either: You and/or your dependent become eligible under and enroll in your new spouse's employer's health plan, or Your spouse is enrolled in his or her employer's health FSA	No	No	Yes	Yes
You lose your spouse through death, divorce, legal separation or annulment	No	No	No	Yes
You lose your spouse through death, divorce, legal separation or annulment, and you/your dependents lose coverage under your spouse's employer's health plan or health FSA.	Yes	Yes	No	No
Gain or loss of a dependent				
You gain an eligible dependent (for example, through birth, adoption or your eligible child moves in with you)	Yes	Yes	No	No
You lose an eligible dependent or a dependent loses eligibility (for example, through death, or when an individual is no longer financially supported by you, or your child no longer satisfies the age requirements for health coverage)	No	No	Yes	Yes
Change in employment status				
You, your spouse or dependent gains eligibility for and enrolls in own employer's health FSA, or enrolls self and you in own employer's health plan, because you/he/she starts employment or has an employment status change	No	No	Yes	Yes
Your spouse or dependent loses eligibility for own employer's health FSA or health plan because you/he/she ends employment or has an employment status change	Yes	Yes	No	No

Questions?
Contact CONEXIS at 800-482-4120.

How to Get Reimbursed

When you incur an eligible expense, you can be reimbursed in one of two ways.

- Use the CONEXIS benefit card. It works like a debit card, deducting the expense from your FSA balance automatically. You can use it to pay for eligible expenses right away and submit any required documentation later, if required. (See the "Documentation" section on page 9 to learn more about what may be required.)
- Pay with cash or by check and then submit a claim form to CONEXIS, along with an Explanation of Benefits statement or other appropriate documentation of the eligible expense. (You can download claim forms at mybenefits.conexis.com.) CONEXIS will then reimburse you, either by direct deposit to your bank account or by check.

Either way, remember that you'll need to file all your claims and documentation by April 15 of the year following the plan year. Mailed claims must be postmarked by April 15; you may also fax claims to the number on the form.

REIMBURSEMENT VIA THE CONEXIS BENEFIT CARD

When you enroll in the Health FSA, CONEXIS will send you one benefit card. If you need more, you can request them by logging on to your account at the CONEXIS website at mybenefits.conexis.com, or calling CONEXIS at 800-482-4120. You can use the card at locations where the provider or merchant has a health care-related merchant category code, such as physicians, dentists and vision care providers, as well as hospitals and clinics.

You may also use it at grocery stores, discount stores and pharmacies that use an Inventory Information Approval System (IIAS). If a provider does not have a health care merchant category code, you can't use the card for reimbursement unless the provider uses an IIAS.

At IIAS locations, you can use the card to pay only for items identified on a list of eligible health care expenses kept by the merchant. You'll need to use another form of payment for any non-eligible items. You can find a list of merchants using an IRS-approved IISA at uc.conexisfsa.com.

While some prescribed over-the-counter (OTC) medications are eligible FSA expenses, you can't use the benefits card for them; you must pay for them another way and then file for reimbursement.

REIMBURSEMENT VIA A CLAIM FORM

If you pay for your expenses with cash, check or a credit card, you'll need to fill out a claim form and provide appropriate documentation to substantiate your expense. (See the "Documentation" section for more about this.) You may file your claim form and documentation in one of three ways:

ONLINE

Log in to your account at mybenefits.conexis.com, download and complete a reimbursement form, then scan and upload the form and your supporting documentation.

BY FAX

Submit your completed reimbursement form and supporting documentation using the fax number listed on the form.

BY MAIL

Send the completed reimbursement form and supporting documentation to the address on the form.

Whichever method you use, don't forget to sign the claim form yourself; claims signed by your spouse or another family member will be returned. And you should request and save all receipts for at least one year after the end of the plan year. If any questions arise about a claim, you may be required to provide supporting documentation.

Once CONEXIS receives your claim form and documentation, they will reimburse you via check or direct deposit. (To set up direct deposit, log in to your account at mybenefits.conexis.com.) Usually, CONEXIS will process your claim within three business days. CONEXIS has the authority to deny a claim that is not consistent with the terms of the plan; for example, if the claim if for an ineligible expense or if the claim is submitted after the deadline.

DOCUMENTATION

If you use your benefits card, certain categories of expenses are substantiated automatically, so you don't need to submit documentation. However, you should keep your receipts in case CONEXIS asks for them. The IRS requires every benefit card transaction be validated as a qualifying expense. These categories include:

- **Copay matching,** in which the expense matches your copayment for your employer's medical, dental, vision or other eligible health-related plan. For example, if your doctor requires a $20 co-pay for office visits and you make a payment to a physician's office for $20, you don't need to submit documentation of the visit.
- **Recurring expenses,** in which an initial expense with a provider is followed by other expenses of the same amount and duration with the same provider. You'll need to provide substantiating documents for the first expense, but once that's been approved, not for the subsequent ones.
- **IIAS-approved expenses,** in which you purchase an FSA-eligible item from a merchant who uses an IIAS.
- **Electronic filing,** in which your insurer or other provider sends your claim information directly to CONEXIS and the electronic file includes the provider's confirmation of the amount and nature of the expense.

If your expense isn't automatically substantiated via one of the methods above, CONEXIS will notify you that documentation is required. You'll need to provide appropriate documentation within the time requested or your claim will be denied, Additionally, your benefit card could be deactivated and your transaction amount reclassified as taxable income.

If you don't use your benefits card to pay an expense and you submit it for reimbursement, you'll need to submit documentation from an independent third party (for example, an insurance carrier's Explanation of Benefits form or a detailed statement from the service provider) to substantiate the claim.

Here are some examples of appropriate documentation. (Note that credit card receipts, cancelled checks and balance forward statements aren't acceptable.)

- **For office visits:** Your insurance plan's Evidence of Benefits statement, or an itemized receipt or bill from the provider. It should include the provider's name, the patient's name, a description of the service, the original date of service and your portion of the charge.
- **For over-the-counter expenses:** An itemized cash register receipt showing the merchant's name, the name and cost of the item purchased and the date. For some over-the-counter medications, a medical determination form completed by a doctor may be required.
- **For prescription drugs:** A pharmacy statement showing the patient's name, the prescribing physician, the prescription number, the name of the drug, its cost and the date the prescription was filled.

ORTHODONTIC EXPENSES

Because orthodontic treatment often requires that you pay some or all of the full cost upfront, these expenses are treated differently than other health care expenses. You may be reimbursed in one of two ways:

LUMP SUM PAYMENT

If your provider requires you to pay much or all of the treatment cost up front, you may be reimbursed for all eligible orthodontic expenses you pay for in the current plan year, even if some of the treatment will take place later. You'll need to provide documentation, which includes:

- The treatment start date and anticipated end date;
- Proof that you've made payment during the current plan year
- A completed claim form

MONTHLY PAYMENTS

You may be reimbursed for the initial payment and file a monthly claim after that. For the initial payment, you'll need to provide documentation, which includes:

- The amount of the initial payment
- The treatment start date and anticipated end date
- A completed claim form

For the monthly payments after that, you'll need to provide an itemized statement or payment coupon from the provider and a completed claim form.

For additional information, please see conexismarketing.com/employees/eligible-expenses/orthodontia.

How to Get Reimbursed

HOW TO APPEAL A CLAIM

If CONEXIS denies a claim in whole or in part, a written explanation will be sent within three business days of receiving your request for reimbursement. If the claim was denied because it is not consistent with the terms of the plan—for example, because the expense was ineligible or the claim submitted after the deadline—CONEXIS handles the appeal. You'll need to request an appeal within 180 days of receiving the denial by writing to:

CONEXIS
Attn: Claims Appeals
P.O. Box 223565
Dallas, TX 75222-3565

You should state all the reasons and supporting facts upon which your appeal is based, along with any other information you consider relevant. Generally, CONEXIS will respond within 30 days of receiving your request or (if later) within 30 days of receiving any additional materials requested from you, your UC location or another relevant party. It's possible, however, that CONEXIS may require a longer period of review. CONEXIS's decision on appeal is final.

If your claim is denied because CONEXIS finds that you or a family member doesn't meet the eligibility requirements, the Plan Administrator will handle the appeal. Under these circumstances, your request for an appeal should be directed to:

University of California Plan Administrator
Attn: Eligibility Appeal
P.O. Box 24570
Oakland, CA 94623-1570

Generally, the Plan Administrator will respond to your request within 60 days of receiving your request or (if later) within 60 days of receiving any additional materials requested from you, your UC location or another relevant party. It's possible, however, that the Plan Administrator may require a longer period of review. The Plan Administrator's decision on appeal is final.

Important Things to Know

IMPLICATIONS FOR SOCIAL SECURITY, RETIREMENT PLANS AND UNEMPLOYMENT

Because your contributions to the Health FSA are made on a pretax basis, they lower the earnings on which your Social Security taxes are based. This means your future Social Security earnings may be reduced. (If your earnings after your Health FSA contributions are above the Social Security wage base—for 2015, $118,500—there will be little to no effect on your benefits.) Your pretax Health FSA contributions may also reduce the earnings used to calculate your unemployment insurance benefits.

Your Health FSA contributions don't affect the wages used to calculate your UC Retirement Plan contributions or benefits; nor do they affect your Tax-Deferred 403(b) Plan or 457(b) Deferred Compensation Plan maximum annual contribution amounts.

LEAVING UC EMPLOYMENT

If you leave UC employment, your participation in the Health FSA will end at the end of the month in which you separate, unless you continue your participation through COBRA. (See "Continuing Participation Through COBRA," on page 11.) For instance, if you leave UC employment April 15, your coverage ends April 30.

If you retire immediately after leaving your job, your participation ends the month in which you retire, unless you continue under COBRA. For instance, if you retire effective April 1, your coverage ends April 30.

You may submit claims for eligible expenses incurred through the last day of participation in the plan. Expenses incurred after this date aren't reimbursable.

LEAVES WITHOUT PAY

When you begin a leave without pay (other than Family and Medical Leave), your contributions to the Health FSA stop. Your participation ends as of the last day of the pay period following the pay period during which you go on leave. For instance, if you begin a leave without pay in February, and your March paycheck (for February earnings) is large enough to make your monthly Health FSA contributions, then your participation ends March 31. (If it's not large enough, then your participation would end on the last day of February.)

If your leave was for less than 120 days and you return in the same plan year, you may enroll in the Health FSA with the same annual contribution as before you went on leave. If your leave was 120 days or longer, or you return in a new plan year, you may choose a new annual contribution.

FAMILY AND MEDICAL LEAVE

When you go on Family and Medical Leave, your Health FSA contributions stop with your last paycheck unless you choose to continue participation during your leave. If you do, eligible expenses you incur while on leave are reimbursable.

You'll need to fill out the UPAY 850 form **before your leave begins** in order to continue participation. If you don't, your participation will end, and only expenses incurred through the end of the last pay period in which you contributed will be reimbursable.

You'll also need to choose a payment option for when you return to work. You may either keep the same monthly contribution, which will reduce the annual amount you put in, or increase your monthly contribution to make up for your time off pay status. Contact your Benefits Office for details.

TEMPORARY LAYOFF

When you begin a temporary layoff, your contributions to the Health FSA stop. Your participation ends on the last day of the pay period following the pay period during which you go on leave. You may, however, continue participation through COBRA.

CONTINUING PARTICIPATION THROUGH COBRA

If you leave UC employment, you'll receive a "Qualifying Event Notice" explaining how you may continue your participation in the Health FSA through COBRA through the end of the plan year (Dec. 31). If you continue participating, you'll make after-tax payments to your account.

By authority of the Regents, University of California Human Resources, located in Oakland, administers all benefit plans in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations, group insurance contracts, and state and federal laws. No person is authorized to provide benefits information not contained in these source documents, and information not contained in these source documents cannot be relied upon as having been authorized by the Regents. Source documents are available for inspection upon request (800-888-8267). What is written here does not constitute a guaranteeof plan coverage or benefits—particular rules and eligibility requirements must be met before benefits can be received. The University of California intends to continue the benefits described here indefinitely; however, the benefits of all employees, retirees, and plan beneficiaries are subject to change or termination at the time of contract renewal or at any other time by the University or other governing authorities. The University also reserves the right to determine new premiums, employer contributions and monthly costs at any time. Health and welfare benefits are not accrued or vested benefit entitlements. UC's contribution toward the monthly cost of the coverage is determined by UC and may change or stop altogether, and may be affected by the state of California's annual budget appropriation. If you belong to an exclusively represented bargaining unit, some of your benefits may differ from the ones described here. For more information, employees should contact their Human Resources Office and retirees should call the Retirement Administration Service Center (800-888-8267).

In conformance with applicable law and University policy, the University is an affirmative action/equal opportunity employer. Please send inquiries regarding the University's affirmative action and equal opportunity policies for staff to Systemwide AA/EEO Policy Coordinator, University of California, Office of the President, 1111 Franklin Street, 5th Floor, Oakland, CA 94607, and for faculty to the Office of Academic Personnel, University of California, Office of the President, 1111 Franklin Street, Oakland, CA 94607.

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