

UNIVERSITY OF CALIFORNIA

Health Flexible Spending Account (Health FSA)

Table of Contents

How the Health FSA Works	1
How the Health FSA Can Save You Money.....	1
How the Health FSA Affects Social Security and Unemployment Insurance Benefits.....	1
The Health FSA Does Not Affect UCRP and UC Retirement Savings Program.....	2
Who Can Participate.....	2
What Dependents Are Eligible.....	2
When You May Enroll and When Coverage is Effective.....	2
You Must Enroll Every Year.....	2
How to Enroll.....	2
What Expenses Are Eligible	3
If You Participate in the Health FSA and the Anthem Lumenos PPO with HRA.....	4
How Much You Can Contribute to Your Health FSA	4
Important Deadlines	4
How to Keep Track of Your Account Balance.....	5
Using the CONEXIS Benefit Card	5
Using a Claim Form.....	6
CONEXIS's Acceptance of Card Purchases or Claims Does Not Assure IRS Acceptance	7
Claims Appeal Procedures	7
Changing or Cancelling Contributions.....	7
If You Go on Leave or Separate from the University	8
Those on FMLA Can Continue Health FSA Participation.....	8
Electing COBRA if You Stop Working for UC	8
If You Have Problems or Questions	8
Midyear Election Actions Allowed Under Health FSA	9

The University's Health Flexible Spending Account (Health FSA) allows you to pay, on a pretax, salary reduction basis, eligible health care expenses not covered by your medical, dental, or vision plans. Because you use pretax dollars, your tax liability is reduced—but your actual tax savings depends on your individual circumstances. The program is established under Internal Revenue Code (IRC) Sections 125 and 105.

HOW THE HEALTH FSA WORKS

After you enroll, your Health FSA works like this:

- ▶ The amount you specify when you enroll is taken from your paycheck each month during the calendar year and deposited in your Health FSA.
- ▶ You pay your health care expenses in one of two ways:
 - You can use the CONEXIS Benefit Card that you received after enrolling. (CONEXIS is the company with which UC has contracted to administer the Health FSA.) You can use the card to pay for eligible expenses electronically, like a debit/credit card, and submit any required documentation later.
 - Or, you can pay for your eligible expenses with cash or by check, and then submit to CONEXIS a claim form and an Explanation of Benefits (EOB) statement or detailed provider or pharmacy statement as proof of services rendered. CONEXIS will then send you a reimbursement payment, either by direct deposit to your bank account or by check.
- ▶ You have access to up to the total annual amount you elected as soon as eligible expenses are incurred.
- ▶ You must file all claims and documentation by April 15 of the year following the plan year.

The “**use it or lose it**” rule is a provision in the IRS regulations that requires that all money contributed to your FSA must be used to reimburse qualified expenses incurred during that plan year or during a grace period (January 1 through March 15) immediately following the plan year. Money not used to reimburse eligible expenses is forfeited. The unused portion of your Health FSA may not be paid to you in cash or other benefits, nor may funds be transferred to another FSA. For example, you could not transfer funds from your Health FSA to your DepCare FSA account so they could be used for childcare. To reduce the risk of forfeiture, it

is critical that you carefully estimate your expenses when choosing your annual election amount.

HOW THE HEALTH FSA CAN SAVE YOU MONEY

Your savings are strictly on income taxes. Your Health FSA contributions are deducted from your taxable pay on a pretax basis—before federal, state, and Social Security (FICA) taxes are taken out. For example, if you earn \$3,000 a month and contribute \$200 to your Health FSA, you pay taxes on \$2,800 a month.

The tax savings are reflected in your paycheck each month, all year.

The Health FSA can help you save on your taxes, but only if you:

- ▶ **Carefully estimate your Health FSA expenses.** (Any funds you do not use must be forfeited.)
- ▶ **Recalculate and re-enroll in the Health FSA annually during Open Enrollment or within a new 31-day period of initial eligibility (PIE) because of a change in family or employment status.**
- ▶ **Submit claims and other required documentation on time.** The final deadline for the Health FSA year is **April 15 of the following year.** (See page 6, “Using a Claim Form”)

The savings depend on your particular tax situation. Consult your tax advisor for more information.

HOW THE HEALTH FSA AFFECTS SOCIAL SECURITY AND UNEMPLOYMENT INSURANCE BENEFITS

As discussed in the previous section, your Health FSA contributions lower your earnings. **Because your Social Security and unemployment insurance benefits are based on earnings, these benefits might be lower, depending on the amount you earn.**

If your earnings after your contributions to the Health FSA are above the Social Security wage base (\$106,800 in 2011), there will be little or no effect on your Social Security benefits. However, if your earnings are below the wage base, your future Social Security benefits may be reduced if earnings from your years of participation in the Health FSA are used to calculate your Social Security benefits.

The amount of your Health FSA contribution also reduces the earnings used to calculate your unemployment insurance benefits.

THE HEALTH FSA DOES NOT AFFECT UCRP AND UC RETIREMENT SAVINGS PROGRAM BENEFITS

Your contributions to the Health FSA do not reduce the wages used to calculate your University of California Retirement Plan (UCRP) contributions or benefits, nor do they affect your Tax-Deferred 403(b) Plan or 457(b) Deferred Compensation Plan maximum annual contribution amounts.

WHO CAN PARTICIPATE

You may participate if

- ▶ You are in an appointment type that is eligible for benefits, **and**
- ▶ You're appointed to work at least 43.75 percent time, **or**

You're not appointed to work at least 43.75 percent time, but you have worked 1,000 hours in a 12-month period.

WHAT DEPENDENTS ARE ELIGIBLE

You can be reimbursed for your own health care expenses, plus the health care expenses of those who qualify as your tax dependents.

Qualifying dependents are:

- ▶ A legal spouse, as defined under federal law.
- ▶ Your child/children up to age 26.
- ▶ A dependent such as a parent, sibling or in-law, if claimed as a tax dependent on your federal tax return.
- ▶ A domestic partner or domestic partner's children, or a legal spouse who does not meet the federal law definition of "spouse" if claimed as a tax dependent on your federal tax return.

Note that these rules are established by the IRS and are different than UC rules for other plans.

WHEN YOU MAY ENROLL AND WHEN COVERAGE IS EFFECTIVE

You may enroll only at the following times:

- ▶ **When you first become eligible for the Health FSA.** (See above, "Who Can Participate") You may enroll for the current calendar year during your period of initial eligibility (PIE), which begins the day you become eligible and ends 31 days later. If you enroll by paper form, your PIE ends on the

last working day of that 31-day period. **The effective date is the first day of the month following your enrollment, subject to payroll deadlines.**

- ▶ **During Open Enrollment.** If you sign up during Open Enrollment (usually held in November), the effective date is January 1 of the following year.
- ▶ **When you have a family or employment status change.** You may be eligible to enroll, cancel or change the amount of your Health FSA contribution during the plan year if your circumstances change and qualify as an "eligible change in status." An eligible change creates a new PIE. The effective date of the change is the first day of the month following your enrollment, subject to payroll deadlines. (See the chart on page 9.)

YOU MUST ENROLL EVERY YEAR

You can enroll in the Health FSA for only one year at a time. Enrollment is for the current plan year (January 1 through December 31) only, subject to the grace period. To participate in the Health FSA for the following year, you must enroll during Open Enrollment.

HOW TO ENROLL

- ▶ **When you become eligible.** If you're a newly eligible employee, you may enroll on UC's At Your Service website (atyourservice.ucop.edu).
- ▶ **During Open Enrollment.** You use UC's At Your Service website to enroll. The Health FSA requires annual enrollment; it does not continue from one year to the next.
- ▶ **When your family or employment status changes.** If you're a current employee and have an eligible change in status, you should complete the *Enrollment, Change, Cancellation, or Opt Out—Employee Only* form (UPAY 850), available on the At Your Service website, to process any transactions you are eligible to make. (See page 7, "Changing or Cancelling Contributions.") Send the form to your Payroll or Benefits Office.

WHAT EXPENSES ARE ELIGIBLE

Health care expenses must meet the statutory requirements of IRC Section 213(d). More general information about eligible expenses can also be found in IRS Publication 502. **Please note, however, that while an expense listed in those documents may be an eligible tax deduction, it may not be an eligible expense under the Health FSA (for example, insurance premiums). You are responsible for making sure all expenses submitted for reimbursement under this plan are eligible.**

Keep in mind that if expenses for any of the items listed below are covered under your medical, dental, or vision plan, they are not eligible for reimbursement under the Health FSA.

- ▶ Expenses must be incurred during the Health FSA plan year and grace period: January 1 through March 15 of the following year. You incur expenses when the care is provided, rather than when you are billed or when you pay for the care.
- ▶ If you enroll midyear, expenses incurred before your effective date are not eligible. **The effective date is the first day of the month following your enrollment, subject to payroll deadlines.**
- ▶ Expenses incurred after your participation ends, including any applicable grace period, aren't eligible. (Also see page 8, "If You Go on Leave or Separate from the University.")

NOTE: Expenses reimbursed under the Health FSA may not be deducted on your income tax return. For more information, consult your tax advisor.

Eligible Expenses

The Health FSA is used for health care expenses not paid by insurance.

Only qualified expenses are eligible for reimbursement through the Health FSA. Qualified expenses must be for out-of-pocket medical care provided to you, your spouse or tax dependent. IRC Section 213(d)(1)(A) and (B) define medical care as amounts paid for:

- ▶ The diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body
- ▶ Transportation primarily for and essential to medical care as defined above

Generally, out-of-pocket expenses such as copayments and deductibles under your major medical plan; prescription drugs; dental expenses, including exams and cleanings; vision expenses, including exams, contact lenses and supplies, and laser eye surgery are eligible under a Health FSA. A comprehensive list of eligible expenses is available online at uc.conexisfsa.com.

- ▶ Expenses reimbursed under your Health FSA may not be reimbursed under any other plan or program. Only your out-of-pocket expenses are eligible.
- ▶ Expenses must be incurred during the period of coverage. As outlined in Proposed Treasury Regulation Section 1.125-2, Q/A-7(b)(6), "expenses are treated as having been incurred when the participant is provided with the medical care that gives rise to the medical expenses, and not when the participant is formally billed or charged for, or pays for the medical care." Therefore, the date of service must be during the current plan year or grace period.
- ▶ Expenses reimbursed under the Health FSA may not be used to claim any federal income tax deduction or credit.

Ineligible Expenses

As mentioned above, only qualified expenses can be reimbursed through the Health FSA. Expenses that do not qualify as medical care cannot be paid for through the Health FSA, including:

- ▶ Over-the-counter medications, unless prescribed by a doctor or another individual who can legally issue a prescription
- ▶ Cosmetic surgery and procedures, including dental whitening
- ▶ Expenses for services rendered outside the coverage period
- ▶ Expenses reimbursed by an insurance provider or another health plan
- ▶ Herbs, vitamins, supplements, or over-the-counter medications used for general health
- ▶ Insurance premiums
- ▶ Family or marriage counseling
- ▶ Personal use items (e.g., toothpaste, shaving cream, cosmetics)
- ▶ Prescription drugs imported from another country

This list is not complete. A comprehensive list of eligible and ineligible expense is available online at uc.conexisfsa.com.

Be aware that expenses submitted for reimbursement must meet IRC regulations. Expenses must be substantiated by an independent third party (for example, an insurance carrier EOB (evidence of benefits) or a detailed statement from the service provider). "Self-substantiation," such as a cancelled check or a credit card or cash receipt, is not sufficient. If your health care expenses are not clearly eligible, CONEXIS may ask you to submit additional information to determine whether the reimbursement is allowed.

Special Rules Associated with Orthodontia Expenses

Services associated with orthodontia generally are provided over an extended period of time and often are impossible to match with actual costs. As a result, orthodontic expenses are processed differently than any other type of health care expense. The two reimbursement methods used for orthodontic expenses are as follows:

1. **Lump Sum Approach.** You may be reimbursed up front for all qualified expenses paid in the current plan year or in the grace period for that plan year. Documentation must include treatment start date, anticipated treatment end date, proof of payment, and a completed claim form. If payment for orthodontia is made in full, the full contract amount, not exceeding your annual election, will be reimbursed. To receive reimbursement for the full contract amount:
 - a. Payment must be made within the applicable plan year or grace period.
 - b. Proof of payment must be provided with your claim.
2. **Monthly Approach.** You may be reimbursed for the initial payment usually associated with banding fees. Thereafter, you may file a monthly claim for the monthly payment amount. Please note a treatment plan or itemized statement is required with the initial contract/banding claim. The documentation should include the amount of the initial down payment (usually associated with banding fees), the treatment start date, and anticipated treatment end date. For ongoing monthly claims, an itemized statement or payment coupon from the provider and a signed claim form are required.

IF YOU PARTICIPATE IN THE HEALTH FSA AND THE ANTHEM LUMENOS PPO WITH HRA

The Anthem Lumenos PPO with HRA includes a Health Reimbursement Account (HRA) funded by UC. If you incur expenses that are eligible for reimbursement under the Health FSA and the HRA, **IRS rules require that amounts available under the HRA must be exhausted before reimbursements may be made from the Health FSA.** However, if you incur an eligible Health FSA expense which is not reimbursable by the HRA, you may claim reimbursement from your Health FSA account, regardless of your HRA balance. In no event may you be reimbursed for the same medical care expense by both the HRA and the Health FSA.

HOW MUCH YOU CAN CONTRIBUTE TO THE HEALTH FSA

You may contribute up to \$5,000 per plan year (\$416.67 per month) from your salary. If both you and your spouse are UC employees, you may each contribute up to \$5,000.

To participate in the Health FSA, you must contribute a minimum of \$180 per year (\$15 per month).

It's important that you estimate your health care expenses carefully, because **the IRS requires you to forfeit any unclaimed money in your Health FSA after the closing date for the plan year subject to IRS "grace period" guidelines.** Under these guidelines, you are permitted to use any funds that remain in your Health FSA account as of December 31 for eligible expenses that you incur through March 15 of the following year.

In accordance with IRC regulations, UC uses forfeited funds to pay administrative costs of the Health FSA program.

IMPORTANT DEADLINES

You may use funds in your Health FSA account for eligible expenses incurred from January 1, **through March 15, of the year following the plan year.** Any paper claim forms for reimbursement of account funds must be received by CONEXIS **by April 15 of the year following the plan year.**

IMPORTANT: All paper claim forms and required documentation for services received during the plan year must be received by CONEXIS, by April 15 of the following year, or you will forfeit any unclaimed balance in your Health FSA. Claims and documentation must be postmarked by the deadline. CONEXIS also will accept faxes. The fax number is 1-800-482-4147.

HOW TO KEEP TRACK OF YOUR ACCOUNT BALANCE

CONEXIS maintains a website where you can check your balances (mybenefits.conexis.com).

You can also get balance information by calling CONEXIS' toll-free automated phone system: 1-800-482-4120.

Each time a reimbursement is issued, you will receive an Explanation of Benefits reflecting your current account balance. At the end of the year, you will receive a statement with a complete summary of your account balance.

USING THE CONEXIS BENEFIT CARD

You have two options for accessing the money in your account: using the benefit card or filing a paper or online claim form.

The CONEXIS Benefit Card is a stored-value card that simplifies the process of paying for qualified health care expenses. As an alternative to the traditional method of filing claims, the CONEXIS Benefit Card lets you electronically access the funds in your Health FSA. You may use the CONEXIS Benefit Card at qualifying medical merchant locations where MasterCard® is accepted. Examples of qualified FSA locations and providers include hospitals, physician offices, dental offices, vision service providers, and some pharmacies.

The CONEXIS Benefit Card allows you to pay for qualified medical expenses at the point of service by providing:

- ▶ Immediate access to your FSA account—you avoid paying out-of-pocket with cash or check
- ▶ Immediate payment of your expense—you avoid waiting for a reimbursement check as funds are transferred immediately from your FSA at the time you incur the expense.
- ▶ Ease-of-use at the point of sale.

Note: Your benefit card can't be used to purchase prescribed over-the-counter (OTC) medicines and drugs. If you need to buy OTC medicines, you will need to pay for the items using another form of payment and then submit the expense for reimbursement along with your prescription.

Using Your Benefit Card

Initially, one card is issued to the employee. If additional cards are needed, you can log on to your account through the CONEXIS website or call CONEXIS directly at 1-800-482-4120.

The CONEXIS Benefit Card may only be used at health care providers who have a health care related merchant category code (such as physicians, dentists, vision care offices, hospitals, and other medical care providers) or at grocery stores, discount stores, and pharmacies that utilize an Inventory Information Approval System (IIAS). You may not use your benefit card at any merchant that does not have a health care-related merchant category code unless that merchant utilizes an IIAS.

As you incur qualified health care expenses, simply present your benefit card for payment. The amount of the qualified expense is automatically deducted from your FSA, and the funds are electronically transferred to the provider/merchant for immediate payment. If the provider/merchant you use cannot accept the CONEXIS benefit card, you should pay for your expense by other means and then file a claim form for reimbursement.

You may use your benefit card for qualified expenses only. A list of eligible and ineligible items is available online at uc.conexisfsa.com.

If you enroll two years in a row and have a balance left from the first year on December 31, your first year balance will be used automatically before your second year balance when you use your benefit card to pay for services during UC's "grace period," (from January 1 through March 15 of year two).

Inventory Information Approval System (IIAS)

Merchants who use an IIAS will only allow the benefit card to be used to purchase those items identified on a list of eligible health care expenses maintained by the merchant. For example, when purchasing eligible health care-related items and ineligible non-health care-related items, the merchant will only accept the benefit card as payment for the health-care related items. You must pay for the ineligible items with another form of payment (cash, personal credit or debit card, etc.) A list of merchants utilizing an IRS-approved IIAS is available online at uc.conexisfsa.com.

Supporting Documentation—SAVE YOUR RECEIPTS

The required documentation for benefit card transactions is the same documentation required for traditional paper claims. You must retain copies of all itemized receipts for each benefit card transaction. Keep all of your documentation for at least one year following the close of the plan year.

If your expense(s) is not automatically substantiated through the IIAS process or one of the methods listed

below (see “Supporting Documentation Not Required in Certain Scenarios”), you will be required to submit documentation to CONEXIS to substantiate your expense(s). You will receive notification from CONEXIS when this is required and you must submit appropriate documentation within the time frame outlined in the notification. Failure to provide appropriate documentation may lead to the deactivation of your benefit card and could eventually result in recategorization of the transaction amount as taxable income.

Appropriate documentation includes:

- ▶ **For office visits**—Your insurance plan’s EOB statement or an itemized receipt or bill from the provider that includes 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 eligible over-the-counter expenses**—An itemized cash register receipt with the merchant name, name of the item/product, date, and amount
- ▶ **For prescription drug purchases**—A pharmacy statement or printout from your pharmacy including the patient’s name, the prescribing physician’s name, the Rx number, the name of the drug, the date the prescription was filled, and the amount

In some cases, a letter of medical necessity from a medical practitioner may be required. Credit card receipts, cancelled checks, and balance forward statements do not meet the requirements for acceptable documentation.

Supporting Documentation Not Required in Certain Scenarios

In many cases, your transaction will be automatically substantiated by the card system using one of the IRS-approved methods outlined below:

- ▶ **Copay Matching.** The expense matches a specific copayment you have under your employer’s medical, pharmacy, behavioral health, and vision or dental plan. For example, you may not be required to submit a receipt if you are subject to a \$15.00 copay for physician office visits and a payment was made to a physician’s office in the amount of \$15.00.
- ▶ **Recurring Expense.** Recurring expenses will not result in a request for documentation as long as the expense equals the same amount, duration, and provider as a previously approved expense.

Recurring transactions will be processed and approved without documentation only after substantiating receipts or other documentation is provided and the initial transaction is reviewed and approved.

- ▶ **IIAS-Approved.** You purchase your FSA-eligible items at a merchant utilizing an IIAS.

NOTE: In rare circumstances, purchases made at merchants utilizing an IIAS may fail to process appropriately. In those cases, you will be required to submit receipts or other substantiating documentation.

- ▶ **Electronic File.** In limited scenarios, your claim information may be provided through an electronic file from your insurance carrier or other provider. In these scenarios, expense substantiation may not be required if the electronic claim file is accompanied by an electronic or written confirmation from the health care provider that identifies the nature of your expense and verifies the amount.

Important: You must still obtain and retain third-party receipts whenever you use your benefit card even if you believe the transaction will not require review. All receipts should be retained for at least one year following the close of the plan year in which the expense is incurred. If the card system is unable to automatically substantiate your transaction, you will be required to provide supporting documentation to substantiate the expense.

Lost Receipts and Ineligible Transactions

Missing or lost receipts will result in a denied claim. You may request a replacement receipt from the service provider or merchant. If you are unable to obtain a replacement receipt, or if you use your card to pay for ineligible expenses, your claim will be denied and you will be required to reimburse the plan with post-tax dollars. If you do not reimburse the plan accordingly, your benefit card will be deactivated.

In situations where you cannot use the card, or if you prefer not to use the card at all, you can file claim forms for reimbursement, as explained below.

USING A CLAIM FORM

You can get a copy of the claim form at the CONEXIS website (mybenefits.conexis.com). You can complete the form online, print and sign it, and then mail, fax or scan and submit online, along with the appropriate documentation.

If you don't have access to the internet, you can get a claim form by calling CONEXIS's toll-free number: 1-800-482-4120.

You must sign claim forms yourself; claims signed by a spouse or other family member will be returned. With your claim, include a **copy** of the health plan's EOB or other required information. Be sure to submit copies only; CONEXIS does not return copies of bills or receipts. CONEXIS will not accept cancelled checks in lieu of a bill or receipt.

You must certify on the claim form that your expenses are eligible under the program.

If your claim exceeds your existing Health FSA account balance, CONEXIS will reimburse you up to your annual election since the Health FSA annual election is available to you in its entirety.

For example, assume that your March expenses total \$600, but your account balance is only \$400. You file a claim for \$600 and attach a copy of the receipt showing the full \$600 expense. You will be reimbursed \$600.

CONEXIS'S ACCEPTANCE OF CARD PURCHASES OR CLAIMS DOES NOT ASSURE IRS ACCEPTANCE

It is your responsibility to make sure that expenses you pay with the card or submit for reimbursement are eligible under the program. You are responsible for taxes and penalties associated with any ineligible expenses if the IRS audits you.

Note that eligible expenses reimbursed from your Health FSA cannot be included in itemized deductions on your income tax return.

CLAIMS APPEAL PROCEDURES

Claims for reimbursement should be submitted to CONEXIS, which serves as third party administrator of the FSA program. CONEXIS will generally process your request for reimbursement within three business days of receipt. CONEXIS has the authority to deny a claim that is not consistent with the terms of the plan (for example, the claim is for an ineligible expense or the claim is submitted after the deadline). If your claim is denied in whole or in part, CONEXIS will issue a written explanation of the reason within three business days. You can appeal a denial of a claim for reimbursement by submitting your request to CONEXIS, Attn: Claims Appeals, P. O. Box 226407, Dallas, TX 75222-6407 within 180 days of receiving the denial. An appeal should state all the reasons and supporting

facts upon which the appeal is based and include any issues or comments that you deem relevant to the appeal. CONEXIS will respond to your request for an appeal within 30 days of submission or receipt of any additional materials reasonably requested from you, CONEXIS, the campus/laboratory location or other relevant party, whichever occurs later.

CONEXIS may determine that circumstances require a longer period for review. CONEXIS's decision on appeal is final.

If your claim for reimbursement is denied because CONEXIS finds that you or a family member does not meet the eligibility requirements, the Plan Administrator rather than CONEXIS will handle the appeal. The request should be directed to Plan Administrator, Attn.: Eligibility Appeal, P.O. Box 24570, Oakland, CA 94623-1570 within 60 days of receiving the denial. The appeal should state all the reasons and supporting facts upon which the appeal is based and include any issues or comments that you deem relevant to the appeal. The Plan Administrator will respond to your request for an appeal within 120 days of submission or receipt of any additional materials reasonably requested from you, the Plan Administrator, the campus/laboratory location or other relevant party, whichever occurs later. The Plan Administrator may determine that circumstances require a longer period for review. The Plan Administrator's decision on appeal is final.

CHANGING OR CANCELLING CONTRIBUTIONS

Once you have specified an annual salary reduction, that amount is taken from your pay and deposited in your Health FSA each month. Federal rules limit adjustments.

However, certain changes in your family or employment status may provide a new 31-day PIE during which you may start or stop participating or change the amount of your contribution during the plan year. See the chart on page 9 for the type(s) of changes that may be allowed. IRS rules indicate that changes to participation and/or to contribution amounts during the plan year must be made on account of and consistent with an eligible change in status. **Your new annual contribution amount applies to all expenses incurred during the calendar year, less any reimbursements that were already made before the change. No retroactive changes are allowed.**

IF YOU GO ON LEAVE OR SEPARATE FROM THE UNIVERSITY

Your monthly contribution continues only as long as you remain on active pay status. If you leave UC, your participation ends as of the last day of the pay period that follows the pay period in which you leave unless you continue participation under COBRA (at right). For example, if you are paid monthly and you leave UC employment in February, your last contribution to your Health FSA is taken from your final paycheck and your participation ends March 31.

If you leave or separate from the University, you may submit claims for eligible expenses incurred through the last day of participation in the plan. Expenses incurred after this date are not eligible for reimbursement.

If you go on leave without pay (other than Family and Medical Leave Act leave) or are temporarily laid off, your contributions to Health FSA stop. Your participation ends as of the last day of the pay period that follows the pay period in which you leave or separate. For example, if you go on leave without pay in February, and your March paycheck (for February earnings) is large enough to make your monthly Health FSA contribution, then your participation ends on March 31. While on leave, you may continue to submit claims, but expenses incurred during the leave after your participation ends are not eligible unless you continue participation under COBRA (at right).

If you stop working at UC for 120 days or longer and are then rehired, if you return from a leave without pay of 120 days or longer, or if you are rehired or return from a leave without pay in a new plan year, regardless of the length of your absence or leave, you have the same re-enrollment options as a new employee (see page 2, "How to Enroll"). If you are rehired or return from a leave without pay of less than 120 days and choose to re-enroll in the Health FSA for the remainder of the same plan year, your annual contribution must be the same as before you left UC.

THOSE ON FMLA CAN CONTINUE HEALTH FSA PARTICIPATION

If you are on an approved FMLA leave (FMLA is the federal Family and Medical Leave Act), you may choose to continue participation during your leave. In this case, eligible expenses incurred during your leave would be reimbursable. In order to continue participation during your FMLA leave, you must complete the *Enrollment, Change, Cancellation, or Opt Out—Employee Only* form (UPAY 850) before your leave begins. Otherwise, your participation will end as described above. The form requires you to select one of three options for continuing or cancelling your contributions upon return to work. See your local Benefits Office for details.

ELECTING COBRA IF YOU STOP WORKING FOR UC

If you leave UC employment during the plan year, you will receive a "Qualifying Event Notice" explaining the procedure for continuing your participation under COBRA, the Consolidated Omnibus Budget Reconciliation Act of 1985. With COBRA, you can continue your participation through the end of the current plan year (December 31) by making direct, after-tax payments to your Health FSA.

You might consider COBRA if, for instance, you have an account balance when you leave UC employment and you have planned a surgery for later in the year. Remember, you can claim only those expenses you incur while participating in the plan. So, in this example, continuing participation through COBRA would allow you to claim eligible surgery-related expenses.

IF YOU HAVE PROBLEMS OR QUESTIONS

If you have questions about your account, you can call the CONEXIS toll-free number (1-800-482-4120) to speak with one of their customer service representatives. You can access your account information through the CONEXIS website—mybenefits.conexis.com—or by calling the CONEXIS automated telephone service at 1-800-482-4120.

MIDYEAR ELECTION ACTIONS ALLOWED UNDER HEALTH FSA

In this chart:

- ▶ “spouse” means your legal spouse (as defined under federal law).
- ▶ “dependent” means anyone you claim as a federal tax dependent, such as a child, domestic partner, parent, sibling, in-law, or spouse who does not meet the federal law definition.
- ▶ “health plan” includes a medical, dental or vision plan; “health FSA” means a health care flexible spending account.

Event	Action Allowed			
	Enroll?	Increase Contribution?	De-enroll?	Decrease Contribution?
Change in your marital status				
You marry	yes	yes	no	no
You marry and either <ul style="list-style-type: none"> • you and/or your dependent become eligible under and enroll in your new spouse’s own employer’s health plan, or • your spouse is enrolled in his or her own employer’s health FSA 	no	no	yes	yes
You lose your legal spouse through death, divorce, legal separation or annulment	no	no	no	yes
You lose your legal spouse through death, divorce, legal separation or annulment and you and/or your dependent 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 plan coverage)	no	no	no	yes
Change in employment status that affects benefits eligibility				
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 <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • ends employment, or • has an employment status change 	yes	yes	no	no

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 (1-800-888-8267). What is written here does not constitute a guarantee of 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 your Human Resources Office and retirees should call the UC Customer Service Center (1-800-888-8267).

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides for continued coverage for a certain period of time at applicable monthly COBRA rates if you, your spouse, or your dependents lose group medical, dental, or vision coverage because you terminate employment (for reasons other than gross misconduct); your work hours are reduced below the eligible status for these benefits; you die, divorce, or are legally separated; or a child ceases to be an eligible dependent. Note: The continuation period is calculated from the earliest of these qualifying events and runs concurrently with any other UC options for continued coverage. See your Benefits Representative for more information.

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, CA 94607, and for faculty to Associate Director of Academic Personnel, University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.

Website address: atyourservice.ucop.edu



University of California
Human Resources
P.O. Box 24570
Oakland, CA 94623-1570

