Columbia University in the City of New York
Flexible Spending Account

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Introduction
Columbia University in the City of New York ("the University") is pleased to provide you\(^1\) with this Benefit Summary, which describes the Flexible Spending Account benefits available to you under the Columbia University in the City of New York Group Benefits Plan (the "Plan"). This Benefit Summary provides information about:

- Who is eligible to enroll in the Flexible Spending Account
- Eligible Health Care Expenses
- Eligible Dependent Care Expenses
- How benefits are paid

Together, this Benefit Summary and the Wrap Document constitute the official Plan Document and Summary Plan Description for the Plan.

This Benefit Summary is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). This Benefit Summary supersedes any previous printed or electronic Benefit Summary for the Plan – including previously released Benefits in Brief, and Benefits Highlights. You are responsible for using this Benefit Summary and other resources provided to you to understand your benefits.

The rest of this summary provides details about how the coverage works as well as information about who is eligible, processes and events that can affect coverage, administrative information, and your rights as a participant in the Plan.

If there is a conflict between this Benefit Summary and any summaries provided to you and/or any verbal representations, this Benefit Summary will govern in every respect and instance.

How To Use This Benefit Summary
- Please read the entire Benefit Summary and share it with your family.
- Many of the sections of this Benefit Summary are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your Benefit Summary and any future Amendments at [www.hr.columbia.edu](http://www.hr.columbia.edu) or request printed copies by contacting the Columbia Benefits Service Center at 212-851-7000.

\(^1\) The terms “you” and “your” as used in this Benefit Summary refer to an employee of the University who is otherwise eligible to participate in the Plan and is actually participating in the Plan pursuant to its terms. Your receipt of this Benefit Summary is not an indication that you are in fact a participant in the Plan.
Overview of the Flexible Spending Account

The University offers two Flexible Spending Accounts ("FSAs"). These accounts let you make before-tax contributions from your pay, which you can then use to reimburse yourself for Eligible Expenses. Money is taken out of your paycheck before federal, Social Security and some state and local taxes are taken out.

The Health Care Spending Account ("HCSA") is a type of FSA that may be used for reimbursement of Eligible Health Care Expenses (defined in the Health Care Spending Account section), including certain medical and dental expenses for you, your spouse, your dependent children, and any other dependents you can claim on your federal tax return.

The Dependent Care Spending Account ("DCSA") is a type of FSA that may be used for reimbursement of Eligible Dependent Care Expenses (defined in the Dependent Care Spending Account section), such as day care and Elder care.

You can elect to participate in either the HCSA, the DCSA, or both.

Each Plan year (January 1 through December 31) you can choose to contribute to your HCSA and/or DCSA, and then, during the Plan year, you can receive reimbursement from the appropriate account for Eligible Expenses that are not otherwise reimbursed. Contribution levels are set forth as described under Section, Contributions.

Eligibility for Benefit Coverage

Eligibility for Full-Time Officers of Administration
If you are a full-time active Columbia University Officer, you and your family are eligible for the Flexible Spending Account under the Plan.

Eligibility for Part-Time Officers of Administration
As a regular part-time Officer of Administration, you are eligible to participate for the Flexible Spending Account under the Plan, provided you meet the following requirements:

- You are a regular Officer of Administration
- Your scheduled work week must be at least 20 hours per week but less than 35 hours per week
- You are a Grade 10 position or higher at Morningside, Lamont or Nevis
- You are a Grade 103 or higher at Columbia University Medical Center

Regular part-time positions are those without a planned employment end date.

Temporary part-time employees are not eligible for part-time benefits. Temporary positions are those approved for a temporary period of time and have an employment end date.
Eligibility for Support Staff

If you are a full-time active Columbia University Support Staff, you are eligible for the Flexible Spending Account under the Plan.

Eligibility for Part-Time Support Staff

As a regular part-time Support Staff, you are eligible to participate in the Flexible Spending Account under the Plan, provided you meet the following requirements:

- You are a regular Support Staff
- Your scheduled work week must be at least 20 hours per week but less than 35 hours per week

Regular part-time positions are those without a planned employment end date.

Temporary part-time employees are not eligible for part-time benefits. Temporary positions are those approved for a temporary period of time and have an employment end date.

When Your Benefits Start - Officers

You are eligible for Benefits on your date of hire. In order for your Benefits to be effective on your date of hire, you must enroll within 31 days of your date of hire. If you do not enroll within 31 days of your date of hire, you will not participate in the FSA for the remainder of the calendar year. You will have to wait until the Benefits Open Enrollment period held annually in the fall. The benefit choices you make at that time take effect the following January. See the section, How To Enroll.

When Your Benefits Start – Support Staff

The benefits of eligible full-time and part-time Support Staff are effective the first day of the month following completion of the applicable waiting period as defined by your collective bargaining agreement. In order for your Benefits to be effective on your earliest enrollment date, you must enroll within 31 days of your date of hire. If you do not enroll within 31 days of your date of hire, you will not participate in the FSA for the remainder of the calendar year. You will have to wait until the Benefits Open Enrollment period held annually in the fall. The benefit choices you make at that time take effect the following January. See the section, How To Enroll.

The term “employee” in this document does not include:

- Officers whose appointments are incidental to their educational program at the University.
- Officers who are classified as non-benefited or casual employees in accordance with University personnel policies and procedures.
- Officers whose terms of employment are subject to a collective bargaining agreement unless the agreement specifically provides for their participation in the FSA
- Any individual who has entered into an oral or written agreement with the University whereby such individual acknowledges his or her status as an independent contractor and that he or she is not entitled to participate in the University’s employee benefit plans, notwithstanding that such person is later determined by a court of competent jurisdiction or the Internal Revenue Service (IRS) to be a common law employee for tax purposes.
- Any individual who is performing services for the University under a leasing arrangement entered into between the University and some other person, notwithstanding the fact that he or she is later
determined by a court of competent jurisdiction or the IRS to be a common law employee or a leased employee;

- An employee who is a non-resident alien who received no earned income from the University that constitutes income from sources within the United States (as defined by the IRS).
- Temporary employees.

**You Are Responsible for Covering Only Eligible Dependents**

You are responsible for ensuring that you submit expenses only for your eligible Dependents. An Employee who covers an individual whom he or she knows does not meet the definition of an eligible dependent will be subject to disciplinary action up to and including dismissal and may be liable for other punishment under the law. If the University learns that you have submitted expenses for an ineligible dependent (such as a former spouse or a child over the age limit), the dependent’s expenses will not be covered by the Plan.

You will be required to repay all costs to the University of providing coverage and any Benefits paid to you or on behalf of your ineligible dependent.

**Report Changes in Dependent Eligibility**

When a dependent is no longer eligible, it is your responsibility to report any changes in the status of your dependents within 31 days of the change. Examples of changes include, but are not limited to, divorce, child reaching the limiting age under the Plan, etc. Go to the CU Benefits Enrollment System at www.hr.columbia.edu/benefits and update any changes in the status of your Dependents online. If you need assistance, call the Columbia Benefits Service Center at 212-851-7000.

**Proof of Eligibility**

The Plan Administrator has a responsibility to ensure that only Eligible Expenses are paid from the benefit Plans. This is a requirement of the Internal Revenue Service (IRS) regulations that govern qualified benefit plans.

You must be prepared to provide satisfactory proof that your enrolled Dependents meet the eligibility requirements. Audits are conducted periodically each year to ensure that all Dependents continue to meet the eligibility requirements of the benefit plans. If you are selected for an audit, you will receive a letter detailing the audit process. Examples of proof of dependent eligibility include, but are not limited to, birth certificates for each covered child, a marriage certificate, etc. **If you cannot provide proof that your dependent is eligible for coverage, his or her coverage will be terminated.**

**Enrollment**

**How to Enroll**

**Newly Eligible Employee**

*If you are newly hired, you must enroll for benefits within 31 days of your date of hire.* If you do not make your benefit elections during your first 31 days of employment, you will not be entitled to have an HCSA nor a DCSA opened for you under the Plan for the remainder of the calendar year.
You will be notified of your benefits on-line enrollment opportunity via email. If you do not receive this notice within 3 weeks of your date of hire, please contact the Columbia Benefits Service Center at 212-851-7000.

**Annual Enrollment Opportunities**

After your initial enrollment, you have the opportunity to elect to participate in the FSA feature of the Plan during the coming calendar year each fall during the Benefits Open Enrollment period. You will receive notification from the Plan Administrator about this opportunity to elect the FSA feature for the coming calendar year. An active election must be made each year to participate in the FSA. The selections you make during annual Benefits Open Enrollment are effective the following January 1.

Each year, you must decide on the amount of before-tax dollars you want to contribute to the accounts. Please note that these accounts are not "funded". Rather, the amount you elect to "contribute" remains in the University’s general assets until claims are reimbursed. You may contribute to the HCSA or DCSA, or both, however, amounts contributed to one account cannot be used to reimburse expenses under the other account. You should carefully estimate your Eligible Health Care and Dependent Care Expenses, collectively referred to throughout this booklet as “Eligible Expenses”, for the upcoming Plan year. IRS regulations require that you forfeit any unused funds in the DCSA and any unused funds in excess of $500 remaining in the HCSA after the end of the Plan year.

You have until March 31 of the next year to request reimbursement for Eligible Expenses incurred during the Plan year. For both Accounts, if your employment terminates you can continue to request reimbursement for Eligible Expenses incurred until the earlier of the date your DCSA or HCSA balance is exhausted or your employment termination date. Any such Eligible Expenses must be submitted on or before March 31 of the Plan year following your termination.

For the Health Care Spending Account, you may elect to contribute between $0 and $2,550 a year. The full $2,550 election is available to you, even if you enroll after the beginning of the plan year. Contributions to your Health Care Spending Account will be limited to your elective contributions, unless otherwise required by law or the terms of a collective bargaining agreement governing your employment with the University. If your employment is subject to the terms of a collective bargaining agreement between the University and a union, you will be required to elect coverage under the Group Medical Feature of the Plan in order to have a Health Care Spending Account established under the Plan, and the University’s contribution to your Health Care Spending Account will be determined in accordance with the applicable collective bargaining agreement.

For the Dependent Care Spending Account, you may each elect to contribute between $120 and $5,000, or if you are married and filing separately for federal income tax purposes, you may each elect to contribute up to $2,500 a year. If you or your spouse’s earned income is less than $5,000 per year, the amount that you can contribute is reduced to the amount of your or your spouse’s earned income. The full $5,000 election is available to you, even if you enroll after the beginning of the plan year.

**Limited Changes During the Year— Qualified Life Status Changes**

The IRS restricts when you can add coverage for a dependent or make changes to your Flexible Spending Account (FSA) elections during the year.
After your initial enrollment when you are hired, or after annual Benefits Open Enrollment, you will only be able to change most benefits for the remainder of the calendar year if you experience a Qualified Life Status Change.

A. Examples of a Qualified Life Status Change include:

- Marriage, divorce or the beginning or end of a same-sex domestic partnership;
- Birth, adoption or placement for adoption or foster care;
- Death of a dependent (Spouse, same-sex domestic partner, child);
- A dependent losing eligibility for coverage, such as a child reaching maximum age;
- Losing coverage under another plan, such as a Spouse/partner losing coverage from his or her employer;
- A Spouse or eligible dependent being called to military duty in the U.S. Armed Forces;
- Job promotions and/or transfers that change the benefit offerings.

If you experience a Qualified Life Status Change, you must go to [www.hr.columbia.edu/benefits](http://www.hr.columbia.edu/benefits) and make your changes within 31 days of the event. If you need assistance, please contact the Columbia Benefits Service Center at 212-851-7000 and a specialist will help you with your changes. Please remember that you must provide proper documentation for your change, such as a birth certificate, marriage certificate or divorce decree. Your benefit changes must be consistent with the nature of your Qualified Life Status Change. If you have Qualified Life Status Changes after mid-November, you may not be able to make changes to certain benefits for the remainder of the current calendar year.

B. For individuals who participate in a HCSA, the following additional events will enable you to change your election:

- If you become entitled to Medicare or Medicaid, you may elect to revoke your HCSA coverage. If you lose coverage under Medicare or Medicaid, you may increase your coverage.
- If the University receives a judgment, decree or order resulting from your divorce, legal separation, annulment or change in legal custody that requires group health coverage for your dependent child then the University may:
  - Change your election to provide coverage for that child, if the order requires you to provide coverage for the child under the HCSA, or
  - Permit you to cancel your child's coverage under the HCSA, if the order requires your former spouse to provide coverage.

C. For individuals who participate in a DCSA, the following events, in addition to those in (A.) above will enable you to change your election:

- A change in your dependent care provider.
- A significant increase or decrease in the cost of the dependent care, but only if the dependent care provider that imposes the cost change is not related to you.

The above rules are intended to be consistent with the IRS regulations under Sections 125 and 129 of the Internal Revenue Code, and to the extent there is any inconsistency, those regulations shall control.

Any new election hereunder must be on account of and correspond with the change in status event that affects eligibility for coverage. This means that there must be a logical relationship between the event that occurs and the election change you are requesting (i.e., if you divorce, it would not be logical to increase your HCSA election).
Changes in contribution amounts made during the Plan year are effective as of the first payroll following the date that you timely notify the Plan Administrator of the change in status and make the change.
HEALTH CARE SPENDING ACCOUNT

Eligible Health Care Expenses

To be eligible for reimbursement from your HCSA, the health care expenses must be:

- Incurred for medical care, defined in Section 213(d) of the Internal Revenue Code for 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 including prescription medicine and drugs and over-the-counter medicine and drugs prescribed by a health care provider.
- Incurred while you are participating in the HCSA
- Incurred by you, your spouse, your child who has not attained age 26*, or the employee's tax dependent (under Section 152 of the Internal Revenue Code)
- Incurred during the Plan year

* Health care expenses must be incurred by your child prior to the end of the month within which your child turns age 26 in order to be eligible for reimbursement from your HCSA.

Please note
Any reimbursement you receive through your HCSA cannot be reimbursed under any other plan covering health benefits, including a spouse's or dependent's plan.

Below is a partial list of the types of health care expenses eligible for reimbursement from your HCSA. Generally, Eligible Health Care Expenses are those for which you could have claimed a tax deduction on an itemized federal income tax return (without regard to any threshold limitation) including any copayment, coinsurance or deductible amounts.

A more comprehensive list of Eligible Expenses are available at www.myuhc.com. Some guidance regarding what constitutes eligible medical expenses (including additional examples) is provided in IRS Publication 502 which is available from any regional IRS office, the IRS website www.irs.gov or by phone at 1-800-TAX-FORM (1-800-829-3676). However, there are certain exceptions, e.g. over-the-counter medicine or drugs prescribed by a health care provider may be reimbursable from your HCSA, but insurance premiums are not.

Eligible Medical Expenses

- Copayments, Coinsurance and Deductible amounts;
- Routine physical exams;
- Routine lab and x-rays performed for medical reasons;
- Birth control items prescribed by your doctor;
- Childbirth classes;
- Cardiac rehabilitation classes;
- Drug abuse treatment centers;
- Sterilization unless prohibited by law;
- Other qualified 213(d) medical expenses not covered by the underlying medical plan.
Eligible Vision Expenses
- Routine eye examinations;
- Eye glasses;
- Contact lenses, including all necessary supplies and equipment.
- Lasik eye surgery

Eligible Hearing Expenses
- Routine hearing examinations;
- Hearing aids and repairs;
- Cost and repair of special telephone equipment for the deaf.

Eligible Dental Expenses
- Copayments, Coinsurance and Deductible amounts;
- Preventive Care;
- Exams, cleanings, x-rays, root canals and bridges;
- Dentures and fillings.

Eligible Prescription Drugs
- Copayment and Deductible amounts;
- Cost for allowable prescription drugs.
- Over-the-counter medicines (must be prescribed)

Ineligible Expenses
The partial list below includes examples of expenses that are not eligible for reimbursement:

- Expenses incurred for cosmetic surgery or other similar procedures, unless the procedure is necessary to improve deformities directly related to a congenital condition, a personal injury or a disfiguring disease.
- Expenses for custodial care in a nursing home.
- Insurance premiums, including Medicare Part B premiums, long term care premiums, and other payments or contributions for health coverage (such as contributions for coverage under an employer-sponsored group health plan or HMO or other health plan).
- Expenses incurred for general good health (such as vitamins and other dietary supplements, and toothpaste).
- Expenses incurred before the effective date of your account.
- Over the counter non-prescription drugs and medicines incurred for medical care (such as allergy medicines, antacids, cold medicines and pain relievers), unless prescribed by a health care provider.

In addition, as with any other expense reimbursed under an employer-sponsored medical or dental plan, health expenses reimbursed through your HCSA cannot be claimed as deductions on your income tax return.
Qualified Reservist Distribution

In accordance with the "Heroes Earning Assistance and Relief Tax Act of 2008" ("HEART Act") a qualified reservist distribution (QRD) is permitted of all or part of any unused HCSA amounts if you are a reservist called to active duty provided that: (1) you are called up for a period of 180 days or more or for an indefinite period of time, and (2) the request for a distribution is made during the period of time between when the order or call is made and the last day that a reimbursement could be made from the HCSA for that Plan year.

To receive a QRD of all or part of any unused HCSA amounts, you must give notice to The University by contacting the Columbia Benefits Service Center at 212-851-7000, as soon as you receive your orders or are called to active duty. For additional details on how to request a qualified distribution, refer to Section, Requesting a Reimbursement or Qualified Distribution from your Flexible Spending Account.
Eligible Dependent Care Expenses

Eligible Dependent Care Expenses that can be reimbursed from your DCSA are expenses incurred for household and dependent care services that enable you and (if married) your spouse to be gainfully employed, which generally means working or actively looking for work.

If your spouse has no earned income, you cannot use a DCSA unless your spouse is physically or mentally incapable of caring for himself or herself, is looking for work or is a full-time student for at least five months during the Plan year.

To qualify for reimbursement, Dependent Care Expenses cannot exceed your earned income or, if married, the earned income of the lesser earning spouse. Earned income (including any self-employment earnings) is generally the remaining salary after all pre-tax salary reductions have been made. If you are married and your spouse is physically or mentally incapable of caring for himself or herself or is a full-time student, the IRS considers your spouse to have a monthly income of $250 (as adjusted from time to time) if you have one dependent, or $500 (as adjusted from time to time) if you have two or more dependents, for each month that your spouse is incapable of caring for himself or herself or is a full-time student.

Dependent Care Expenses must be incurred for a qualified dependent. Qualified dependents are:

- A dependent under federal tax law who is a child under age 13; or
- A spouse of a participant, if the spouse is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the taxpayer for more than one-half of such taxable year; or
- A dependent under federal tax law who is physically or mentally incapable of caring for himself or herself; provided that such dependent lives in your home for more than one-half of the year, if you provide over one-half of the individual's support for the taxable calendar year.

Eligible Dependent Care Expenses include, but are not limited to, the following expenses if not otherwise excluded:

- Expenses for care at a day care center and day care transportation that complies with all applicable state and local regulations.
- Expenses for licensed nursery school fees.
- Expenses for care provided by a housekeeper, babysitter or other person in your home who primarily cares for eligible children or an eligible adult dependent.
- Expenses for care provided by a relative who cares for your qualified dependents, so long as that relative is over the age of 19 and is not your dependent under federal tax law.
- Expenses for care, such as Adult day care center, Elder care or Senior day care, for a qualified dependent age 13 or over, including a spouse or adult dependent, who is physically or mentally incapable of caring for himself or herself. If you are claiming reimbursement for care outside your home for such dependent, the dependent must spend at least 8 hours each day in your home.
- Expenses for care at a day camp to which you send your children (under age 13) during school vacations so that you and your spouse, if you are married, can be gainfully employed or attend school full-time.
Dependent Care Tax Credit vs. Dependent Care Spending Account

Some employees may be eligible to claim a dependent care tax credit on their federal income tax return. This credit is available for the same types of expenses as the DCSA. However, the IRS requires that the dependent care tax credit be reduced, dollar for dollar, by the amount reimbursed under a Dependent Care Flexible Spending Account. In other words, you cannot use expenses reimbursed through the DCSA to claim the tax credit.

For more information about how the dependent care tax credit works, see IRS Publication No. 503. In addition, because each employee's situation is different, you may want to consult with a tax advisor before deciding whether to use the tax credit or the DCSA.
**Health Care Spending Card**

You will be provided with two Health Care Spending Cards that may be used to pay for certain Eligible Expenses directly from your HCSA and/or DCSA. The Health Care Spending Card allows for direct payment to qualified locations and providers and can be used at any approved location that accepts MasterCard®. Use of the Health Care Spending Card is voluntary.

**Important**

You should familiarize yourself with the specific products and services that are eligible for card use based on this Plan. Go to [www.myuhc.com](http://www.myuhc.com) to learn how to get the most out of your Health Care Spending Card.

**Receiving Your Health Care Spending Card**

You will automatically receive two Health Care Spending Cards in the name of the employee member. Read the terms and conditions found on the card insert and sign the back of your card. You may call the customer service number listed on the back of the Health Care Spending Card to order additional cards.

**Activating Your Health Care Spending Card**

If you choose to activate the Health Care Spending Card you will need to call the toll-free number indicated on the sticker affixed to the card and follow the voice prompts to activate. The card will be ready to use one (1) business day following activation.

If you decide not to activate the Health Care Spending Card, simply destroy and discard both cards. However, you can be reimbursed for Eligible Expenses by completing a paper reimbursement form available from [Http://hr.columbia.edu/forms-docs/forms](http://hr.columbia.edu/forms-docs/forms) or found on [www.myuhc.com](http://www.myuhc.com) and as described under Section, Requesting a Reimbursement or Qualified Distribution from Your Flexible Spending Account or for Eligible Health Care Expenses by using the automatic reimbursement (auto-rollover) feature described under the Section, Automatic Reimbursement (Auto-Rollover).

**Please note**

You will need to wait until your Plan's effective date before attempting to activate your card.

**Qualified Locations and Providers**

The Health Care Spending Card may be used at any UHC network provider or Express Scripts Pharmacy with a Point-of-Service (POS) bankcard terminal that accepts MasterCard® or your Health Care Spending Card number can be entered online or on an order form, similar to using a credit card number. Examples of qualified locations and providers include network hospitals, physician, vision care providers, retail pharmacy counters. If an expense has been authorized on your card it has been verified as an Eligible Expense and you will not need to submit any further documentation. Generally UHC and Express Scripts network expenses should be approved on the card while non-UHC medical, vision and dental claims will not be authorized on the card. Child and Adult day care Facilities that are set up for Mastercard will generally have the proper coding to identify the expenses as Eligible Dependent Care Expenses. This allows the Expenses to be authorized on the card.

You may choose to use your Health Care Spending Card for mail order prescriptions or for over-the-counter items by going to an online pharmacy at Drugstore.com via [www.myuhc.com](http://www.myuhc.com). Additionally, your
Health Care Spending Card can be used at Walgreen’s retail stores or at participating retailers as described under the Section, Retailers with Inventory Information Approval System (IIAS).

**Using the Health Care Spending Card**

In order to use the Health Care Spending Card, you may enter “credit” on the POS bankcard terminal just as if you were purchasing an item using a credit card. You may also enter “debit” but you need to obtain a PIN from UHC. Call the number on the back of the card to obtain your PIN number. Each time the card is used for payment, you will sign a receipt. Your FSA and card are regulated by the IRS, therefore you should retain all itemized receipts generated from the Health Care Spending Card for your tax records.

Once you swipe the Health Care Spending Card through the POS bankcard terminal, your available benefit balance is verified. The card validates your purchases real-time and automatically debits your FSA account based on the guidelines established by the IRS and your specific plan design as described under Section, Health Care Spending Account and Dependent Care Spending Account. A claim number is assigned to the transaction.

**Partial Payment Authorization**

Partial authorization capability allows you to use your Health Care Spending Card with transactions amounts greater than the funds available in your HCSA for a portion of the transaction at providers or merchants that accept partial authorization. For example, if you purchase an item that costs $20 and you only have $10 remaining in your HCSA, the HCSA balance of $10 will be authorized towards the purchase and you are responsible for paying the remaining balance of $10 with another form of payment. **Note:** not all providers or merchants accept partial authorization.

**Retailers with Inventory Information Approval System (IIAS)**

IRS regulations require that retailers comply with IRS Inventory Information Approval System (IIAS) swipe technology as a method to identify and substantiate Eligible Health Care Expenses, per Section 213(d) of the Internal Revenue Code. The IIAS allows you to use your Health Care Spending Card to pay for 213(d) Eligible Health Care Expenses without having to provide any additional documentation or request reimbursement after a purchase is made, as transactions will be verified at the point of sale and payment will be made right from your HCSA. Additionally, IIAS compatibility allows you to use your Health Care Spending Card at participating retailers to pay for both Ineligible Expenses and Eligible Health Care Expenses on the same transaction with Eligible Health Care Expenses being approved via the Health Care Spending Card and remaining Ineligible Expenses may be paid using another form of payment. When you use your card at participating retailers, Eligible Health Care Expenses will be identified and noted on your receipt. You will not have to submit receipts for reimbursement as long as the purchases are made at a participating retailer and you use your Health Care Spending Card. IRS guidelines still require you to save your itemized receipts as part of your tax records. You can see a full list of participating retailers at [www.sig-is.org](http://www.sig-is.org). If you go to a non-Participating retailer you can still buy Eligible Health Care Expenses that don't provide itemized sales receipts, however you will need to pay using another form of payment, and then submit receipts for reimbursement as described under the Section, Requesting a Reimbursement or Qualified Distribution from your Flexible Spending Account.

**Monthly Health Statements and FSA Yearly Statements**

Explanation of Benefits (EOBs) will not be issued for card transactions. Instead, you will receive monthly health statements and a FSA yearly statement which will include your card activity. You will also be able to view card transactions on [www.myuhc.com](http://www.myuhc.com). If you note a discrepancy on the monthly health statement or FSA yearly statement, call the number on the back of your Health Care Spending Card to resolve the issue.
Contacting a Customer Care Professional is easy.
Simply call our toll-free number at 1-866-755-2648 available 24 hours a day.

- Order Additional cards
- Report a lost or stolen card
- Get answers concerning Eligible Expenses or your account balances
REIMBURSEMENT OR A Qualified Distribution FROM YOUR FLEXIBLE SPENDING ACCOUNT

Automatic Reimbursement (Auto-Rollover)

The University has elected to have Eligible Expenses for medical, Express Scripts pharmacy, Aetna dental and UHC vision claims automatically submitted to your HCSA for reimbursement. This eliminates extra paperwork and makes it more convenient for you to use your HCSA. Automatic Reimbursement (Auto-rollover) is turned "on" at the start of the Plan year. You can turn automatic reimbursement (auto-rollover) of claims "off" or back "on" by going on to www.myuhc.com.

In addition, if you have dental other than with Aetna and vision coverage through another carrier, the automatic reimbursement (auto-rollover) feature does not apply. Further, the automatic reimbursement (auto-rollover) feature does not apply to your domestic partner covered under your employer's group health plan, unless your domestic partner is your federal tax dependent for health coverage purposes, as defined under Section 105(b) of the IRS Code. An FSA withdrawal request must be submitted for any other types of expenses such as dependent care expenses and any health expenses not submitted to your health benefits carrier.

If you do not activate your Health Care Spending Card or choose not to use your card, and the expense is not part of the Auto-Rollover, you will need to submit a claim either on line or by submitting a paper reimbursement form.

Claim Submission on line:
As long as the expense is eligible, you can be reimbursed by submitting your claim online in 3 easy steps which saves you time and money on postage.

1. Log in to myuhc.com
2. Select Claims & Accounts
3. Select Submit FSA Claims Forms

Paper Claim Submission
A Paper Submission form is called a request for withdrawal, to be reimbursed from your HCSA and/or DCSA for the Eligible Expenses that have been incurred. A request for withdrawal form is available at http://hr.columbia.edu/forms-docs/formsor can be found on www.myuhc.com. Remember, if the automatic reimbursement (auto-rollover) feature as described under Section, Automatic Reimbursement (Auto-Rollover) is turned "on" you will not have to submit a reimbursement form for UHC medical and vision claims, Express Scripts copays, and Aetna Dental Claims.

For reimbursement from your HCSA, you must include proof of the expenses incurred. Proof can include a bill, invoice, or an Explanation of Benefits (EOB) from any group medical/dental/vision plan under which you are covered. An EOB will be required if the expenses are for services usually covered under group medical, dental and vision plans, for example, charges by surgeons, doctors and hospitals. In such cases, an EOB will verify what your out-of-pocket expenses were after payments under other group medical/dental/vision plans are made.

For reimbursement from your DCSA, you must submit proof of the services rendered, such as a bill, receipt, or invoice and Social Security or Tax Identification Number of the care provider.
To receive a qualified reservist distribution (QRD), you must give notice to The Columbia Benefits Service Center at 212-851-7000 as soon as you receive your orders or are called to active duty and request a QRD.

The amount available as a QRD will be the amount contributed to the HCSA as of the date of the QRD request, less any HCSA reimbursements received as of that date.

Once the University has determined your eligibility for a QRD, you will see your qualified distribution included as part of your paycheck, subject to taxation, within 60 days of the request.

You should call the Columbia Benefits Service Center at 212-851-7000 if you have questions about your rights to receive a QRD under the Plan.

Only expenses which are incurred while you are a participant in the Plan may be reimbursed from your Flexible Spending Account. In addition, expenses which are incurred during one Plan year cannot be reimbursed from funds contributed to your HCSA or DCSA during another Plan year (except for amounts not exceeding $500, as explained below). An expense is considered incurred when services are provided, not when you are billed or when you pay for care.

You will be reimbursed for Eligible Expenses as long as the amount requested from either account is at least $25, except for reimbursement with respect to the last month of the Plan year. Amounts below $25 will be accumulated and processed with future payments. However, if the automatic reimbursement (auto-rollover) feature as described under Section, Automatic Reimbursement (Auto-Rollover) is turned "on" you will not have to submit a reimbursement form for certain HCSA expenses.

If you have established a HCSA, your total annual contribution amount is available immediately. You can request reimbursement for Eligible Expenses up to your annual contribution amount as soon as such Eligible Expenses have been incurred.

If you have established a DCSA, only the amounts you have actually contributed to the account are available for reimbursement. If you request reimbursement for more than what you have in your account, you will receive only the amount in your account. As additional contributions are made to your account, outstanding reimbursements will be processed automatically.

Requests for withdrawal will be accepted and processed through March 31 of the following year for expenses incurred during the Plan year. If you terminate service or participation, the dates of service must fall within the Plan year while you are an active participant. Any such Eligible Dependent Care expenses must be submitted on or before March 31 of the Plan Year.

In accordance with IRS regulations, amounts above $500 contributed to your HCSA during the Plan Year or any amounts in your DCSA contributed during the Plan year but remaining in your account at the end of the processing period (March 31 of the following year) cannot be returned to you or used to reimburse expenses incurred in a subsequent Plan year. These amounts are forfeited. Amounts equal to or below $500 in your HCSA will be rolled over to your HCSA to be used for reimbursements for the following year.

**Important**

Myuhc.com includes many features such as the options to:
- View Explanation of Benefits/Health Statements
- Utilize a savings calculator for FSA
- View your FSA summary page detailing contributions and amount left in your FSA
- View your FSA Claims Summary including claim transaction details
WHEN PARTICIPATION ENDS

You will cease to participate in the FSA under the Plan as of the earlier of:

- The date on which the Plan terminates.
- The date your employment with the University ends.
- The date you cease to be an eligible employee.
- The date you retire,
- The date you go on an any unpaid leave
- For the DCSA, the date you go on any paid leave

Health Care Spending Account

You may submit a claim for reimbursement of Eligible Expenses which were incurred during the Plan year in which your employment terminates, as long as those expenses were incurred prior to the date of your termination. Any such claims must be submitted on or before March 31 of the next Plan year.

The requirements of the Consolidated Omnibus Budget Reconciliation Act ("COBRA") may apply to the Health Care Spending Account Plan. see "Optional Continuation Coverage under your Health Care Spending Account (COBRA)".

LEAVES OF ABSENCE

Paid Leaves of Absence:

- **Healthcare FSA:** contributions continue to the FSA on a pre-tax basis. Employees continue to participate in the Healthcare FSA and can submit claims incurred while on leave. However, if you are on paid leave you cannot elect to participate in the Healthcare FSA for the next calendar year during Open Enrollment until you return to active service.

- **Dependent Care FSA:** contributions and participation stop as of the first day of the paid leave. Thus, employees cannot submit for reimbursement, dependent care claims incurred while on leave. If the employee returns to active service during the same calendar year, the remaining election amount to be funded will be prorated over the number of payrolls left in the calendar year. Increased contributions will commence until the end of the calendar year. However, an employee may change the amount of contributions at the end of the leave, but never reducing them below what has already been contributed.

If an employee returns from leave after the end of the calendar year in which the leave began, the employee will have to re-elect the DCSA.

Unpaid Leaves of Absence:

- **Healthcare FSA:** contributions and participation stop as of the first day of the unpaid leave. Thus, employees cannot submit for reimbursement, health care claims incurred while on leave. If the employee returns to active service during the same calendar year, the remaining election amount to be funded will be prorated over the number of payrolls left in the calendar year. Increased contributions will commence until the end of the calendar year. However, an employee may change the amount of contributions at the end of the leave, but never reducing them below what has already been contributed.
• **Dependent Care FSA**: contributions and participation stop as of the first day of the unpaid leave. Thus, employees cannot submit for reimbursement, dependent care claims incurred while on leave. If the employee returns to active service during the same calendar year, the remaining election amount to be funded will be prorated over the number of payrolls left in the calendar year. Increased contributions will commence until the end of the calendar year. However, an employee may change the amount of contributions at the end of the leave, but never reducing them below what has already been contributed.

If you are on unpaid leave you cannot elect to participate in the Healthcare and/or Dependent Care FSA for the next calendar year during Open Enrollment until you return to active service.

**Uniformed Services Employment and Reemployment Rights Act**

An Employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Employee and the Employee’s Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms “Uniformed Services” or “Military Service” mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Employees may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution (i.e., contributions to the account) for HCSA. If an Employee’s Military Service is for a period of time less than 31 days, the Employee may not be required to pay more than the regular contribution amount, i.e. contributions to the account), for continuation of the HCSA.

An Employee may continue Plan coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date of the Employee's absence from work; or
- the day after the date on which the Employee fails to apply for, or return to, a position of employment.

Regardless of whether an Employee continues the HCSA, if the Employee returns to a position of employment, the Employee's HCSA and that of the Employee's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on an Employee or the Employee's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Columbia Benefits Service Center at 212-851-7000 if you have questions about your rights to continue HCSA coverage under USERRA.

**Optional Continuation Coverage Under Your Health Care Spending Account**

**COBRA**

COBRA continuation coverage is offered with respect to a participant's HCSA if the participant has a positive balance in such account at the time of a qualifying event such as termination of employment (other than by reason of gross misconduct) or reduction in work hours. A "positive balance" for this purpose generally means that the contributions made to the account prior to the qualifying event exceed
the eligible claims for reimbursement submitted prior to the qualifying event. A participant who experiences a qualifying event and elects HCSA continuation coverage will have such coverage cease at the end of the Plan year in which the qualifying event occurs and coverage cannot be continued beyond such date. Premiums for such continuation coverage (i.e., contributions to the account) will be paid by the participant on an after-tax basis monthly plus a 2% administrative fee or other cost as permitted by law.

Important
Please refer to the Benefit Summary for Medical coverage for further information regarding COBRA continuation coverage.
PLAN ADMINISTRATION

Claim Filing Deadline
This Plan will only reimburse Eligible Health and Dependent Care Expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no benefits are payable for health expenses incurred before coverage has commenced or after coverage has terminated; even if the expenses were incurred as a result of an accident, Injury, or disease which occurred, commenced, or existed while coverage was in force. An expense for a service or supply is “incurred” on the date the service or supply is furnished.

You have until March 31 of the following year to submit a claim for an Eligible Expense to your FSA covered service to your health plan.

Interpretation of Benefits
The Plan Administrator has full power and discretion to resolve all issues concerning eligibility, status, entitlement to Benefits, and any other interpretations under the Plan. Such interpretations or rulings will be binding on all parties. The Plan Administrator has the right to delegate some of these duties to third party providers, such as the Claims Administrators for the medical plans. As the Plan Administrator’s delegates, the Claims Administrators have the authority to make decisions relating to benefit claims.

The University has delegated the claim fiduciary responsibilities of the Plan to UnitedHealthcare (“UHC”). As such, the University and UHC have the sole and exclusive discretion to:

- interpret Benefits under the Plan;
- interpret the other terms, conditions, limitations and exclusions of the Plan, including this Benefit Summary and any Riders and/or Amendments; and
- make factual determinations related to the Plan and its Benefits.

Statement of the University’s Rights
This document is not a contract or agreement for employment. Employment with the University is “at-will”—nothing in this document changes your right and the University’s right, to end your employment at any time and for any reason. Employment at the University is not guaranteed for any period of time.

The University intends that the terms of the Plan described in this Benefit Summary, including those relating to coverage and Benefits, are legally enforceable, and that the Plan is maintained for the exclusive benefit of participants, as defined by law.

To the extent this Benefit Summary provides a general description of the tax results that may be applicable to coverage under the Plan, the University assumes no responsibility for your own personal tax status, or for any tax consequences resulting from any claims made contrary to current tax law. Please consult your tax advisor for further information on the tax treatment of your Benefits.

Future of the Plan
Although the University expects to continue the Plan indefinitely, it reserves the right in its sole discretion to terminate, alter or modify the Plan in whole or in part at any time and for any reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. No oral or written communication will be effective in amending the Plan.
If the Plan is terminated, Covered Persons will not have the right to any further Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. The amount and form of any final benefit you receive upon termination of the Plan will depend on the Plan’s provisions applicable to you as determined by the University and/or the Claims Administrator. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the University and others as may be required by any applicable law.

If the Plan is amended, Covered Persons may be subject to altered coverage and Benefits; provided, however, that no amendment that materially modifies the benefits provided under the Plan may take effect prior to at least 60-days advance written notice being provided to Participants as required under applicable federal law.