

# **New York University Health Care Flexible Spending Account**

**Summary Plan Description**

**Participants**

**Faculty**

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## Preface

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This summary plan description (SPD) provides a concise description of plan coverage available for you.

While this SPD contains detailed and important information about your benefit plan, every attempt has been made to communicate that information clearly and in easily understandable terms.

Benefits are determined under the terms of the plan in effect at the time you become eligible for the benefits in question. The University reserves the right to suspend, modify or terminate these benefits at any time to the extent permitted by law. This SPD does not constitute a contract of employment or guarantee any particular benefit.

In the event of a discrepancy between this SPD and the plan document, the plan document will govern.

## Introduction

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A Health Care Flexible Spending Account allows you to set aside pretax dollars in an account to pay for eligible out-of-pocket health care expenses incurred by you, your spouse or eligible dependents during the course of a calendar year. The IRS allows you to deduct medical expenses on your income tax return if they exceed 7.5% of your adjusted gross income. Most people do not reach this threshold. With a Health Care Flexible Spending Account you can save money in taxes on your health care expenses whether or not they are significant enough to deduct on your federal income tax return. Note: If you have medical expenses which exceed 7.5% of your adjusted gross income for federal tax purposes, you can still use a Health Care Flexible Spending Account, but you must subtract the amount you contribute to such an account from the amount you can deduct on your federal tax return. You will need to satisfy the requirements described in this SPD to participate in the Health Care Flexible Spending Account (FSA).

## Eligibility

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### Eligible employees

You are eligible for the Health Care Flexible Spending Account if you are:

- a full-time member of the Faculty

If you begin employment during the plan year, you must return your enrollment form to the NYU Benefits Office within 31 days of your date of hire (or 31 days from the date you receive a benefits enrollment kit if later). If you miss this enrollment deadline, the IRS requires that you wait until the next annual enrollment period, unless you have a qualifying change in status (see **Changes in election**).

## Eligible Dependents

You may use the Health Care Flexible Spending Account to reimburse eligible health care expenses for yourself, your spouse, or your eligible dependents. An eligible dependent must meet all of the following requirements:

- is claimed as an exemption on your federal income tax return
- receives more than half of their financial support from you
- lives with you for the entire year as a member of your household

## Enrollment

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### Enrolling in the plan

#### If you are a new employee

If you begin employment at NYU during the plan year, the NYU Benefits Office must receive your completed enrollment form within 31 days after your date of hire or the date you receive benefits information, whichever is later. If you miss your deadline, the IRS requires that you wait until the next annual open enrollment period to participate in an FSA, unless you have a **qualifying status change**. Refer to the **Changes in election** section for more information.

Note: Participation in the FSA program will begin on the first day of the month following your enrollment deadline. You may be reimbursed from your FSA for eligible expenses incurred on or after the date you begin participation.

#### Open enrollment

The plan year is January 1 through December 31. You can elect to participate in an FSA during the annual open enrollment period, which will be announced and designated for a specified period each year, usually in the fall. After the open enrollment deadline, you cannot make any new elections or changes, unless you have a qualifying change in status. Each year, you must re-enroll during the designated open enrollment period to continue your participation. If you do not re-enroll, you will not be eligible to participate in the FSA for the year, unless you have a **qualifying status change**.

#### When participation begins

As a new employee, participation in the FSA begins on the first day of the month following your enrollment deadline. When you enroll during an annual open enrollment period, participation begins on the January 1st following the open enrollment period. You may be reimbursed through your FSA for eligible expenses incurred on or after the effective date of your participation.

#### Making changes

You may change your participation in the Health Care Flexible Spending Account if you have a **qualifying status change**; otherwise you may only make changes during **open enrollment**. After a qualifying status change, you can increase, decrease or stop your contributions.

#### Changes in election

If you have a qualifying status change, you can change your existing Health Care Flexible Spending Account or enroll in coverage for the first time. A change in election due to a qualifying status change must be consistent with the qualifying status change. You must make changes to your coverage within 31 days of your qualifying status change. The effective date of the change is the date of your status change. You must submit a written request and provide appropriate documentation of the date of the event to the NYU Benefits Office.

The following is a list of events that are each considered to be a qualifying status change:

- Your marital status changes (or you register or revoke a same-sex domestic partnership).

- You increase or decrease your number of dependents (birth, death, adoption or placement for adoption).
- Your dependent child is no longer eligible for coverage according to the terms of the plan(s) (exceeds age 19 or 25 if a full time student or marries).
- You or your dependent's work site changes.
- You or your dependent's residence changes.
- Your spouse's/partner's employer's plan has a different plan year and open enrollment period than NYU's.
- You or your spouse's employment status changes (full-time to part-time or vice versa).
- Coverage under your spouse's/partner's plan is significantly curtailed or ceases.
- Your spouse's/partner's employer adds new health plan options.
- NYU adds new health plan options.
- A court decree orders you to provide health coverage for your dependent.
- Your dependent's Medicare/Medicaid status changes.
- You or your spouse/partner commences or returns from an FMLA leave.

Changes you make after a qualifying status change become effective on the date of your change in status.

## Changes during open enrollment

Health Care Flexible Spending Account elections do not carry over from year to year. You must open a new account each year during open enrollment if you want to participate, even if you had one before.

If you do not elect to participate during open enrollment you will not have an account in the following year and you will not be able to elect to participate until the next open enrollment period, unless you have a qualifying status change that allows you to open one during the year. Refer to the **Changes in election** section for more information.

All Health Care Flexible Spending Account elections made during open enrollment will become effective on the first day of the new plan year. The plan year is January 1 through December 31.

## Cost

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### Contribution amounts

You must contribute at least \$120, up to a maximum of \$8,000 per year to the Health Care Flexible Spending Account.

If you become eligible for a Flexible Spending Account during the **plan year** and elect to participate in the plan, you may contribute a pro rata portion of the maximum contribution amount allowed for the remainder of the plan year.

The Health Care Flexible Spending Account and the Dependent Care Flexible Spending Account are separate. Money you set aside for the Health Care Flexible Spending Account cannot be used to pay for dependent care expenses. Similarly, any money set aside for the Dependent Care Flexible Spending Account cannot be used to reimburse any health care expenses. Furthermore, transferring money between the two accounts is not allowed.

### Contribution limits for married couples

If you are married, and you and your spouse both work and are each enrolled in a Health Care Flexible Spending Account offered by your employer, you may each contribute up to the maximum contribution amount allowed by each plan.

If both you and your spouse each have a Health Care Flexible Spending Account, you can submit a specific claim to only one spending account.

## **Changes in contributions**

You may change the amount of your Health Care Flexible Spending Account contributions during the **open enrollment** period.

If you have a **qualifying status change**, you may also make changes to the amount of your contributions during the year provided your change is consistent with the **qualifying status change**. If you are increasing the amount of your contributions, you can contribute a pro rata portion of the maximum contribution amount for the remainder of the plan year. If you decrease your contributions, you cannot decrease your contributions below the amount of expenses for which you have already been reimbursed.

Refer to the **Changes in election** section for more information.

## **When contributions are credited**

Your contributions will be deducted from your paycheck on a pretax basis throughout the year and credited into your account.

## **Account statements**

You will receive an account statement twice a year (in October and January). You can log on to UnitedHealthcare's web site at [www.myuhc.com](http://www.myuhc.com) at any time for current information about your FSA.

## **Tax information**

Your contributions to the Health Care Flexible Spending Account are deducted on a **pretax** basis. Also, in certain situations, the IRS tax rules allow you to deduct some health care expenses on your federal income tax return.

If you are eligible for the deduction on your tax return, you may use this tax deduction, choose to participate in the Health Care Flexible Spending Account, or decide to use a combination of the two to pay for your health care expenses. If you choose to use both, you must subtract your annual Health Care Flexible Spending Account contribution from the amount specified under the IRS tax rules.

The IRS provides information about the tax deduction and qualifying expenses. You cannot, however, submit a claim for reimbursement to the Health Care Flexible Spending Account and claim the same expenses on your federal income tax return.

## **Effect on tax withholding, social security taxes and social security benefits**

When you contribute pretax dollars from your salary to an FSA, you reduce not only the amount of federal income taxes withheld from your paycheck, but Social Security taxes as well. (NYU's Social Security tax payment is also lower). If you are below the Social Security maximum taxable wage base and your Social Security taxes are reduced, there could be an impact on the amount of Social Security benefits you ultimately receive when you retire or if you become disabled and qualify for Social Security disability benefits. Typically, the impact is small - usually a reduction of between 1% and 5%. You must decide if this impact affects your decision to participate in an FSA.

## **Forfeiting unused contributions**

Under IRS requirements, you will forfeit any unused balances in your account at the end of the **plan year**. You have until June 30 of the following year to submit expenses for any claims incurred during the previous plan year and the grace period.

Any amount you forfeit will be used to offset the administrative costs of the HCFSA Program at NYU.

# How the plan works

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## Eligible expenses

The Health Care Flexible Spending Account will reimburse eligible health care expenses incurred by you, your spouse or dependents, during your period of coverage, which would generally be an eligible deduction on your tax return and in accordance with IRS Code 213. These expenses cannot be covered by any other benefit plan. Following is a partial list of examples of expenses which are reimbursable if they are not covered by a health care plan:

- plan deductibles, co-payments and co-insurance
- vision care and eyeglasses or contact lenses
- hearing care and hearing aids
- orthodontia
- dental care, excluding cosmetic treatment
- equipment for the mentally or physically disabled
- alcohol and drug rehabilitation treatment
- chiropractor fees for medical care
- routine physical examinations and immunizations

You may also request tax-free reimbursement for medicines and/or drugs you purchase without a prescription. These over-the-counter medicines and drugs must be for the treatment of illness or injury (as defined by the Internal Revenue Code), not merely to advance your general good health.

For a list of reimbursable expenses, see **IRS Publication 502**.

## Ineligible expenses

You **cannot** be reimbursed for expenses:

- that do not qualify as a federal income tax deduction
- that are payable under any other benefit plan
- for services that occurred before your participation in the plan began or after your participation in the plan ends

The following are some examples of expenses that **are not** eligible for reimbursement:

- custodial care in a nursing home
- elective cosmetic surgery
- dancing lessons, swimming lessons, etc. (even if your doctor recommends them for general improvement of your health)
- diaper service
- diet pills or appetite suppressants
- funeral expenses
- health club membership fees
- health plan premium contributions
- household help
- maternity clothes
- vitamins
- premiums for life insurance policies, or policies that provide payment for loss of earnings or for an accidental loss of life, limb, sight, etc.

For a list of ineligible expenses, see **IRS Publication 502**

# Filing a claim

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## How to file for reimbursement

First, make sure that you or your provider submits the expense to any benefit plan in which you are covered for the same services.

If you are enrolled in one of the NYU Point-of-Service plans and the NYU Dental Assistance Plan, your expenses are processed using automatic reimbursement and you will be reimbursed without taking further action. Any portion of the eligible expenses not covered under the benefit plan will automatically be forwarded to your spending account, and you will receive reimbursement as long as the claim is filed and processed by the claims administrator by the June 30 of the following calendar year deadline.

Note: If you are enrolled in one of the NYU Point-of-Service plans and the NYU Dental Assistance Plan and you and your dependents are also covered under other insurance, you will need to coordinate the total benefits paid to you and your dependents with that other plan before you can file for reimbursement from your Health Care FSA. Therefore, you should contact the NYU Benefits Office to cancel automatic reimbursement. Refer to both of your plans' Summary Plan Descriptions for information about Coordination of Benefits.

If you choose not to use the automatic reimbursement feature or if it is not available to you because you are not enrolled in the above plans, complete a Spending Account Claim Form and send it to UnitedHealthcare with the following documentation:

- the Explanation of Benefits (EOB) statement you received with your reimbursement check (for health care expenses that were partially reimbursed by the health plan or not covered by the health plan), or
- bills or receipts for health care expenses that are not covered under any health plan

These must show when the health care services were provided, for whom the services were provided, and the types of service.

Claim forms are available online at [www.myuhc.com](http://www.myuhc.com), [www.nyu.edu/hr](http://www.nyu.edu/hr) or the Benefits Resource Center web site.

You have until June 30 of the following calendar year to submit claims for expenses from January 1 through March 15 (the plan year plus the grace period).

You can submit a claim as often as necessary. The minimum claim payment is \$25, except for the final claim payment at the end of the year. If the amount of unreimbursed expenses is less than \$25, the claim will be held until additional claims are received, processed, and the total accumulates to \$25.

Your reimbursement will be directly deposited into the same checking account as your NYU paycheck is deposited or will be mailed to your home address if you so elect with UnitedHealthcare.

Claims for reimbursement are processed weekly.

## Your right to appeal a denied claim

If your claim for benefits is denied, you will be notified of the reason for the denial. The notice will include:

- the reasons for the denial
- a description of any materials necessary to complete the request
- an explanation of why this material is necessary

If you believe you are being denied any rights or benefits under the plan, you may file a claim in writing with the Plan Administrator. If any such claim is wholly or partially denied, the Plan Administrator will notify you of its decision in writing within 90 days of the date you filed your claim (or within 180 days, if special circumstances require an extension of time for processing the claim, and if written notice of such extension and circumstances is given to you within the initial 90 day period). This notification will include:

- the reasons for denial,
- the plan provisions on which the denial was based, and
- if needed, a request for further information.

Also included will be additional information you may need if you choose to submit an appeal and an explanation of the claim procedure.

If notification is not given within the specified period, the claim will be considered denied as of the last day of such period and such person may request a review of his or her claim.

If you or your beneficiary wishes to contest the denial, you (or your legal representative) may request a review of the decision in writing within 60 days of the date you received the denial. Your appeal should include a description of the benefits you're claiming and the reasons for your claim. Also, supporting documents and records should accompany your appeal. You should send your appeal to the Plan Administrator.

The Plan Administrator will notify you of its decision in writing within 60 days after your request for review is received by the Plan Administrator (or within 120 days, if special circumstances require an extension of time for processing the request, such as an election by the Plan Administrator to hold a hearing, and if written notice of such extension and circumstances is given to you within the initial 60 day period). If the decision on review is not made within such period, the claim will be considered denied. Any action or decision made in the appeal process is final.

## About your participation

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### When participation ends

You will no longer be eligible to participate in the FSA if you:

- Terminate employment;
- Retire;
- Become permanently and totally disabled;
- Go on an unpaid leave of absence;
- Transfer to an ineligible employment category; or
- Reduce your hours to part-time status;
- Die.

If you become ineligible to participate in the FSA, your pretax contributions to your FSA will automatically stop with the last paycheck you received while eligible to participate. In addition, your FSA contributions will be suspended for any pay periods in which your salary does not at least equal your FSA contributions. You may not submit claims to the FSA which were incurred during the time you were ineligible to participate. You have until June 30 of the following year to file a claim for an eligible expense you incurred in the previous year. Any amounts left in your accounts after this date will be forfeited.

If you are no longer eligible to participate in the Health Care FSA, you may be able to continue contributing to your Health Care FSA on an after-tax basis for up to the remainder of the calendar year under COBRA.

### If the University ends the benefit

The University has established the plan with the bona fide intention and expectation that it will be continued indefinitely, but the University shall not have any obligation whatsoever to maintain the plan for any given length of time, and may at any time amend or terminate the plan, in whole or in part, with respect to any or all of its participants and/or beneficiaries. Any such amendment or termination shall be effected by a written instrument signed by an officer of New York University, or an authorized delegate. No vested rights of any nature are provided under the plan.

# COBRA

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This section is intended to comply with the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 as amended, which requires continuation of coverage to certain eligible employees whose coverage would otherwise terminate. If this section is incomplete or in conflict with the law, the terms of the law will govern.

## Continuation of coverage

You may continue your participation in the Health Care Flexible Spending Account if it ends because of one of the following:

- you terminate (except for gross misconduct) or because you are no longer eligible for coverage
- your dependent becomes ineligible to participate because he or she no longer meets the age requirement under the plan or gets married, or you die
- your spouse becomes ineligible to participate because you become legally separated or divorced or you die

## Duration of coverage

If your employment terminates or you or your dependents otherwise have a COBRA qualifying event at a point where you have more cumulative balance in your Health Care Flexible Spending Account (total monthly contributions exceed expenses that have been submitted for reimbursement), you may be eligible for COBRA continuation coverage. If you choose to elect COBRA continuation for the Health Care Flexible Spending Account, coverage extends through the end of the **plan year** in which your participation as an active employee ended.

For this purpose, the "cost of coverage" is equal to the sum of your contributions plus a 2% administration fee.

## Electing COBRA

You will receive election forms and more information about COBRA from EBPA - the COBRA Administrator. In the case of divorce, legal separation, annulment of your marriage or the ineligibility of a dependent child, you must notify the NYU Benefits Office within 60 days of becoming eligible to elect COBRA.

If you wish to elect COBRA coverage, you must do so no later than 60 days after the date your University coverage ends or 60 days after the date of the notice of COBRA rights and your election is mailed to you by EBPA, whichever is later. You must pay any cost necessary to avoid a gap in coverage within 45 days of the date you elect COBRA.

## When COBRA ends

COBRA continuation coverage will generally end at the end of the **plan year** in which your termination of employment or other qualifying event occurs. It may also end if NYU discontinues the Health FSA plan, NYU stops providing group health care benefits, you do not pay the monthly contribution amounts, or you or a dependent obtains new coverage under another group health plan.

## Administrative information

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If there is any inconsistency between the SPD and the plan document, the plan document governs.

## Right of recovery

If a benefit is paid that is larger than the amount allowed by the Health Care Flexible Spending Account, the plan has a right to recover the excess amount from the person or agency who received it.

## **Your rights under ERISA**

As a participant in the Employee Spending Account Plan of NYU (Plan number 507) you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

### **Receive information about your plan and benefits**

ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available in the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

### **Prudent actions by plan fiduciaries**

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

### **Enforce your rights**

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance:

- If you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.
- If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.
- If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees. For example, if it finds your claim is frivolous.

## **Assistance with your questions**

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## **Plan sponsor**

New York University  
c/o NYU Benefits Office  
7 East 12th Street, 2nd Floor  
Campus Mail Code: 8923  
New York, NY 10003-4475  
Phone: (212) 998-1270 (M-F 9am-5pm)  
Email: [benefits@nyu.edu](mailto:benefits@nyu.edu)

## **Plan name**

New York University Health Care Spending Account Plan, a component of the New York University Employee Spending Account Plan

## **Type of administration**

Third Party Administration

## **Plan administrator**

UnitedHealthcare  
P.O. Box 981178  
El Paso, TX 79998-1178  
Phone: (877) 311-7849  
Web site: [www.myuhc.com](http://www.myuhc.com)

## **Employer identification number (EIN)**

The EIN is 13-5562308.

## **Plan number**

The plan number is 175399.

## **Plan year**

The plan year is January 1 through March 15 (the plan year plus the grace period).

## **Source of benefits funding**

You pay the cost.

## **Agent for service of legal process**

Office of Legal Counsel  
New York University  
Elmer Holmes Bobst Library  
11th Floor  
70 Washington Square South

New York, NY 10012

**Claims administrator**

UnitedHealthcare

P.O. Box 981178

El Paso, TX 79998-1178

Phone: (877) 311-7849

Web site: [www.myuhc.com](http://www.myuhc.com)

## Contacts

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### **For sending a reimbursement request**

UnitedHealthcare  
P.O. Box 981178  
El Paso, TX 79998-1178  
Phone: (877) 311-7849  
Web site: [www.myuhc.com](http://www.myuhc.com)

### **For a reimbursement form**

NYU Benefits Resource Center: [www.home.nyu.edu](http://www.home.nyu.edu)  
by clicking on the "FSA Claim Form" link located to the right  
Email: [benefits@nyu.edu](mailto:benefits@nyu.edu)

### **For appealing a denied reimbursement**

UnitedHealthcare  
P.O. Box 981178  
El Paso, TX 79998-1178  
Phone: (877) 311-7849  
Web site: [www.myuhc.com](http://www.myuhc.com)

### **For COBRA coverage**

EBPA  
P.O. Box 1150  
Exeter, NH 03833-1150  
Phone: (800) 258-7298 x1680

The following terms are highlighted throughout the SPD as having definitions. In this section, you will find the definitions for these terms to help clarify their meaning and to provide information to better help you understand the provisions of your benefit plans.

## Definitions

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### **Adverse benefit determination**

Any of the following that results in the denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a benefit:

- Based on determination of a participant's or beneficiary's eligibility to participate in a plan
- Resulting from the application of any utilization review
- Failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate
- Restrictions on reimbursements for services because classified as nervous or mental

### **Annual maximum**

The total amount of expenses the plan will pay each year for each eligible person.

### **Base salary**

Compensation you receive -- usually paid weekly, bimonthly or monthly -- for work you do. Your base salary is determined by the pay rate in your primary job and excludes any additional compensation. If your base salary changes and causes you to shift into a higher or lower salary tier, your monthly contributions will change accordingly. Also, if you are not paid your salary for any month, your contribution will be based upon the lowest salary tier for that month.

### **Consolidated Omnibus Budget Reconciliation Act (COBRA)**

Federal law that allows eligible people covered by a group health plan to temporarily extend coverage when their coverage would otherwise end, such as when they get divorced or leave employment.

### **Coinsurance**

A percentage of expenses that you are responsible for paying after you meet your deductible.

### **Deductible**

The amount of out-of-pocket expenses you must pay for service before the plan pays any expenses.

### **Effective date**

The earliest of:

- the date coverage begins
- the first day after the plan's waiting period

### **Employee**

A person the University hires to do a job or activities that are controlled by the University (when, where and how to do the job).

### **Explanation of benefits**

A statement you receive from your plan whenever you file a claim, giving specific details about how and why benefit payments were or were not made. It summarizes the charges submitted and processed, the amount allowed, the amount paid and the balance, if any.

### **Family and Medical Leave Act (FMLA)**

Job protection and limited benefits for up to 12 weeks if you are seriously ill or injured, for the birth, adoption or foster care placement of a child, to care for the child, or to care for a sick spouse, child or parent.

### **Forfeit**

To lose a benefit or have a benefit taken away.

### **Full-time**

Employees who are scheduled to work for the University for the full, normal work week.

### **Grace period**

The period during which participants may incur qualified expenses immediately following the plan year and have such expenses reimbursed from unused contributions remaining at the end of such plan year. The grace period is from the period January 1 through March 15 immediately following the preceding plan year.

### **Gross income**

Your total earnings before any deductions or taxes are withheld.

### **Highly compensated employees**

Defined by IRS regulations to make sure the plan doesn't provide benefits that unfairly benefit certain employees. The IRS has determined that employees making more than \$100,000 per year are considered "highly compensated."

### **Internal Revenue Service Publication 502**

Describes medical and dental expenses that qualify for deductions on your federal income tax return.

### **Open enrollment**

The period of time each year designated by the University when you may generally make changes to your benefit elections, if allowed by the plan.

### **Part-time**

Employees who are scheduled to work less than the normal work week.

### **Pay period**

The period of time an employer pays wages to an employee, such as weekly, biweekly or monthly.

### **Plan year**

The 12-month period, or policy or fiscal year on which the plan's records are kept.

### **Pretax salary reductions**

Contributions taken from your paycheck before applicable federal, New York State, New York City and other taxes are withheld.

### **Pro rata**

To divide proportionately based on the period of time you are eligible to participate in the FSA vs. the maximum contribution allowed.

### **Qualified Medical Child Support Order (QMCSO)**

A judgment, decree or order that meets all of the following criteria:

- is issued by a court pursuant to a domestic relations law or community property law
- creates or recognizes the right of an alternate recipient to receive benefits under a parent's employer's group or health plan
- includes certain information relating to the participant and alternate recipient

## **Qualifying status change**

A qualifying status change occurs when: your marital status changes (or you register or revoke a domestic partnership), you increase or decrease your number of dependents (birth, death, adoption or placement for adoption, guardianship, temporary or permanent custody of a child), your dependent child is no longer eligible for coverage according to the terms of the plan(s) (exceeds age 19 or 25 if a full-time student or marries), a court decree that orders you must provide health coverage for your dependent, your or your dependent's work site changes, your or your dependent's residence changes, your dependent's Medicare/Medicaid eligibility status changes, your spouse's/partner's employer's plan has a different plan year and open enrollment period than NYU's, coverage under your spouse's/partner's plan is significantly curtailed or ceases, your spouse's/partner's employer adds new health plan options, NYU adds new health plan options, your provider of dependent care changes, your cost for dependent care significantly increases or decreases, or you or your spouse/partner commences or returns from an FMLA leave.

The term "dependent" refers to any of the following as defined by the plan: your spouse, your domestic partner that you have registered with the NYU Benefits Office, your child, your step-child, your adopted child or child placed with you for adoption, the child of your registered domestic partner, a child for whom you have been appointed legal guardian or a child for whom you have been awarded permanent or temporary custody.

## **Regular employee**

An exempt or non-exempt employee who works on an ongoing basis instead of a temporary basis.

## **Reimburse**

When you are paid back for money you spend on approved expenses.

## **Social Security**

A federal program you can apply for that may pay disability benefits to you, your spouse and your dependent children if you become totally and permanently disabled.

## **Spouse**

Your husband or wife, married to you in a civil or ecclesiastical ceremony.

## **Taxable income**

Your total earnings that are subject to taxes, like base pay, bonuses, commissions and overtime pay.

## **Temporary employee**

Someone who is hired, usually through an agency on a per diem basis, for a short period of time. May or may not have a contract for the specific work period.

## **Termination date**

The last day you are scheduled to work.

## **Total disability**

An illness or injury that prevents you from continuously performing every duty pertaining to your job or from engaging in any other type of work for pay.

## **Waiting period**

The amount of time you must wait before being able to participate in a plan.