



**FLEXIBLE BENEFITS PROGRAM &
FLEXIBLE SPENDING ACCOUNTS**

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he Flexible Benefits Program offers you a substantial tax savings opportunity. It allows you to pay for eligible expenses using pretax dollars—money taken out of your paycheck before income or Social Security taxes have been deducted.

The Flexible Benefits Program has three components:

- *Automatic Before-Tax Health Care and Accident Insurance Contributions* If you enroll in the Boston University Health Plan, the Boston University Dental Health Plan, or elect coverage under the Personal and Family Accident Insurance Plan, your share of the cost for these plans will automatically be deducted from your paycheck on a before-tax basis.
- *Flexible Spending Account—Dependent Care* This account allows you to set aside before-tax dollars to help pay for day care services for your eligible dependents.
- *Flexible Spending Account—Health Care* This account allows you to set aside before-tax dollars to help pay for certain uninsured health care expenses. (If you are enrolled or enrolling in the BU Health Savings Plan, you should NOT enroll in the Flexible Spending Account plan of another employer, e.g., an employer of a spouse.)

Because of its tax-exempt features, the Flexible Benefits Program is strictly regulated by the federal government. If you would like to participate in the program, please read this section carefully, and also discuss how the program may benefit you with your own tax advisor or financial planner.

Eligibility

You are eligible to participate in the Flexible Benefits Program if you are a regular employee of the University and your annual base salary from Boston University is \$10,000 or more.

How the Program Works

The Flexible Benefits Program allows you to use your annual base salary to your best advantage.

It offers the following components:

- **Automatic Before-Tax Health, Dental, and Accident Insurance Contributions** If you participate in the Boston University Health Plan, the Boston University Dental Health Plan, or elect coverage under the Personal and Family Accident Insurance Plan, you will automatically pay your insurance premiums with before-tax dollars. The Flexible Benefits Program does not change the eligibility, benefits, or other features of those plans; it just offers a way to pay the required employee premiums on a before-tax basis. (For information concerning these plans, read the “Health Plan,” “Dental Plan,” and “Survivor Insurance” handbooks.)
- **Flexible Spending Account—Dependent Care** This voluntary reimbursement account is designed to help you pay for the cost of care for your eligible dependents.
- **Flexible Spending Account—Health Care** This voluntary reimbursement account is designed to help you pay for the cost of healthcare expenses not covered by a group insurance plan.

Under current tax laws, contributions to the Flexible Benefits Program are free from federal income taxes, state income taxes, and Social Security taxes.

Special Temporary COVID-19 Relief for 2020 and 2021

In response to the novel coronavirus outbreak (COVID-19), the federal government enacted laws and issued guidance that provides additional flexibility and enhanced benefits for employees of the University. Below is a summary of the additional flexibility available to employees who are eligible to participate in the Flexible Benefit Program. **Please note the announced end of the National Emergency took effect as of May 2023.**

Outbreak Period Extensions

During the Outbreak Period, the federal government extended deadlines for taking certain actions under the employee benefit plans sponsored by the University (the “Outbreak Period Relief”). The duration of the Outbreak Period Relief was determined on an individual basis and ended on the earlier of:

- (1) one year from the date you were first eligible for Outbreak Period Relief, or
- (2) 60 days after the announced end of the National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak which took effect in May 2023.

(3) The following deadlines that occurred on or after March 1, 2020, had been delayed by the federal guidance and ended 60 days after the announced end of the National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak which took effect in May 2023.:

- (4)
- the 30-day deadline for exercising your HIPAA special enrollment rights for a group health plan,
 - Filing a claim for benefits under the Flexible Spending Account – Health Care claims procedure,
 - Appealing an adverse benefit determination under the Flexible Spending Account – Health Care,
 - Filing a request for external review following receipt of an adverse benefit determination from the Flexible Spending Account – Health Care, and
 - Filing a request to perfect a request for external review upon a finding that the initial request was incomplete by the Flexible Spending Account – Health Care,
 - Notifying a group health plan of a COBRA qualifying event or determination of disability,
 - Electing COBRA continuation coverage under a group health plan, and
 - Beginning COBRA premium payments and/or making ongoing, monthly COBRA premium payments.

Flexible Spending Account – Health Care

For the 2020 and 2021 Plan Years, you had the option to elect to increase or reduce your annual contribution amount to your FSA – Health Care account for any reason, at any time.

Please note that in both the 2020 and 2021 Plan Years you could not reduce your contribution amount below the amount you had already contributed to your FSA – Health Care.

Grace Period Extension for 2020 and 2021:

If you were not able to use all your FSA – Health Care funds contributed in 2019 and you had funds remaining in your account in 2020, you could use those funds to reimburse FSA – Health Care expenses incurred at any time in 2020. This same rule applied to the use of FSA – Health Care funds contributed in 2020, which could be used to pay expenses incurred in 2021, and the use of FSA – Health Care funds contributed in 2021 which could be used to pay expenses incurred in 2022.

Claim Submission Period Extension for 2020 and 2021:

Ordinarily you had until March 31 following the end of a plan year to submit claims for reimbursement of expenses incurred during that plan year. For the 2020 and 2021 plan years, however, you had until December 31 of the following year to seek reimbursement of expenses incurred during each of those plan years. For example, you had until December 31, 2022 to seek reimbursement for expenses incurred in 2021.

Dependent Care Flexible Spending Account (DCFSA)

Mid-Year Election Changes:

For the 2020 and 2021 Plan Years, you could elect to increase or reduce your annual contribution amount to your FSA – Dependent Care account for any reason, at any time.

Please note that in both the 2020 and 2021 Plan Years you could not reduce your contribution amount below the amount you had already contributed to your FSA.

Grace Period and Extension for 2020 and 2021:

If you were not able to use all your FSA – Dependent Care funds from your account in 2020, you could use those funds for your 2021 FSA – Dependent Care expenses. Also, if you could not use all FSA – Dependent Care funds contributed in 2021 for FSA – Dependent Care expenses incurred in 2021, any remaining funds remained available for FSA – Dependent Care expenses incurred in 2022.

Claim Submission Period Extension for 2020 and 2021:

Ordinarily you had until March 31 following the end of a plan year to submit claims for reimbursement of expenses incurred during that plan year. For the 2020 and 2021 plan years, however, you had until December 31 of the following year to seek reimbursement of expenses incurred during each of those plan years. For example, you had until December 31, 2022 to seek reimbursement for expenses incurred in 2021.

Dependent Maximum Age Increase

For the 2020 Plan Year, the age limit for qualifying children for whom qualifying dependent care expenses could be reimbursed increased from 13 to 14. Accordingly, you could be reimbursed from your 2020 Plan Year FSA – Dependent Care balance for qualifying dependent care expenses incurred for a child who attained age 13 in 2020 until the child attains age 14 in 2021.

FSA - Dependent Care Maximum Contribution Amount for 2021

For the 2021 plan year, the maximum contributions to the FSA – Dependent Care was increased from \$5,000 to \$10,500 (for employees who are married and filing jointly) and from \$2,500 to \$5,250 (for employees who are married and filing separately for 2021).

Requesting Benefit Election Changes:

Changes to your FSA contribution amounts were made through Human Resources, and all other changes described above must have been requested by contacting the P&A Group customer service department at 800-688-2611.

Participation

Automatic Before-Tax Health, Dental, and Accident Insurance Contributions

If you elect coverage under any of the previously mentioned health, dental, and survivor insurance plans, your participation in this component of the Flexible Benefits Program is automatic. This means that your premium

payments will be deducted from your paycheck using before-tax dollars.

Dependent and Health Care Flexible Spending Accounts (FSAs)

Participation in these accounts is voluntary. You can choose to enroll in one or both. After you enroll, a dependent care Flexible Spending Account and/or a health care Flexible Spending Account will be established in your name and your contributions will be taken from your salary, using before-tax dollars.

Enrollment

Automatic Before-Tax Health and Accident Insurance Contributions

You enroll in the Automatic Before-Tax Health, Dental, and Accident Insurance Contributions component of the Flexible Benefits Program at the same time you enroll in group coverage under the eligible health, dental, and accident insurance plans. Enroll through Employee Self-Service at www.bu.edu/buworkscentral. Select BU Benefits Center.

Flexible Spending Accounts (FSAs)

The open enrollment period for these accounts will be held each year during the Fall semester or such other period as the Plan Administrator may specify.

If you enroll during an open enrollment period, your participation will become effective on the following

January 1. If you are hired after the close of an open enrollment period, you will have 30 days from your benefit orientation date to enroll.

In both cases, participation will continue through the following plan year:

- FSA—Dependent Care Plan Year—January 1 to December 31
- FSA—Health Care Plan Year—January 1 to December 31 with claims incurred until March 15 of the following year

When you complete a Flexible Spending Account enrollment, you must indicate the total amount of money you wish to put into the account during the plan year.

Once you have enrolled, your choices remain in effect until the next open enrollment period, unless:

- You experience a Life or Career Event (examples of Life or Career Events are listed under “Changing or Stopping Your Contributions”), *or*
- You become ineligible to participate in the Flexible Benefits Program for any reason.

Contributions

Before-Tax Health, Dental, and Accident Insurance Contributions

Your contributions are your portion of the cost for your coverage under the health, dental, and accident insurance plans you elect. Maximum contributions under this component of

the Flexible Benefits Program are the sum of your monthly premiums for the plan year.

Flexible Spending Account (FSA) Contributions

For the 2025 Plan Year you may contribute up to \$5,000 to the FSA—Dependent Care and up to \$3,300 to the FSA—Health Care. However, tax law rules may limit your FSA—Dependent Care maximum (see the heading “Maximum Contributions” heading in the “Flexible Spending Account— Dependent Care” section for more information). Boston University will contribute to the FSA—Health Care if you are enrolled in the BCBS PPO health plan and your BU annual base salary is less than \$100,000. The following table shows the University contribution amounts.

Salary Tier	2025 FSA Contribution from BU	
	Single	Family
< \$70,000	\$500	\$1000
\$70,000– \$100,000	\$250	\$500
> \$100,000	No contribution	

Changing or Stopping Your Contributions

Under current IRS regulations, you may change your participation status in the Flexible Benefits Program *only* during the annual open enrollment period or as the result of a Life or Career Event.

Life or Career Events include:

- Marriage
- Birth or adoption of a child
- Start or loss of your spouse’s employment
- Change in employment status (for you or your spouse) from part-time to full-time or from full-time to part-time or other change in percent time worked
- Change in your daycare provider or the cost of care (Dependent FSA)
- Divorce
- Death of your spouse or other dependent
- Your death
- Your dependent turning age 26
- Unpaid leave of absence or sabbatical for you or your spouse

The change in your participation or contributions must be because of and consistent with the Life or Career Event and must meet all IRS requirements for changing your election. You may not change from one health plan option to another at any time other than the annual Open Enrollment Period.

Normally, when you experience a Life or Career Event, you have 30 days from the date of your life or career event to submit your request to make a change to your benefit plan enrollment, and generally the effective date of the change is retroactive to the date of the life or career event, except as otherwise required by law.

In response to the novel coronavirus outbreak (COVID-19), the federal government had previously extended deadlines for taking certain actions under the employee benefit plans sponsored by the University. This extension applied to the 30-day deadline for changing your election under the Health Plan as the result of: the loss of other health coverage, addition of a new spouse or dependent by birth, marriage, adoptions, or placement for adoption, the loss of Medicaid or CHIP coverage, and new eligibility for state premium assistance through Medicaid or CHIP. The announced end of National Emergency took affect May 2023. Therefore, these provisions are no longer available.

Tax Advantages of the Program

The Flexible Benefits Program provides an opportunity for you to pay eligible health and dependent care expenses on a before-tax basis.

- **Advantages for Dependent Care Expenses** Under the Internal Revenue Code, you can obtain a tax advantage for dependent care expenses by paying for them with the tax-free dollars you put into your FSA— Dependent Care or by claiming them as a tax credit on your federal income tax return forms.

You Cannot Use Both Methods for the Same Expenses The amount you contribute to a FSA —Dependent Care will reduce, dollar-for-dollar, the amount you may claim as a tax credit. Consult a tax advisor for details.

If You Pay Federal Income Taxes, Social Security Taxes, and Massachusetts State Income Taxes In some cases, the FSA— Dependent Care will be more advantageous than the federal dependent care tax credit, depending upon income level and number of dependents.

We encourage you to talk to a tax advisor to help you determine whether the FSA— Dependent Care or the federal dependent care tax credit is more advantageous to you.

- **Advantages for Health Care Expenses** The FSA—Health Care may be appropriate for you if you expect to have eligible uninsured medical expenses below 7.5% of your adjusted gross income in the coming calendar year. Expenses below this level are not deductible for federal income tax purposes. As a result, the FSA—Health Care may offer you an advantage which you cannot duplicate on your tax return.

Of course, your own tax situation will dictate exactly what the Flexible Spending Accounts can do for you. For more specific information about how these Flexible Spending Accounts may apply to you, we encourage you to talk to a tax advisor.

Potential Impact on Your Social Security Income

Your participation in the Flexible Benefits Program will have the effect of reducing your Social Security taxable wages by the value of your designated salary reduction amount. This results in an immediate tax savings to you. It could also serve to reduce your future Social Security benefits.

How Flexible Spending Accounts Work

- You estimate what your uninsured medical and/or dependent care expenses will be for the coming year and designate that amount on the appropriate enrollment form.
- The amount you elect to contribute will come out of your paycheck in equal installments for the remaining pay periods of the calendar year.
- The portion of your salary that is credited to an account will not count as taxable income, so you have an immediate tax savings.
- When you have an eligible expense, you file a claim to get reimbursed. You are responsible for paying providers; reimbursement checks will be made out in your name.
- Under federal law, if you make contributions to a Flexible Spending Account which are not used to pay for eligible expenses incurred during that plan year, you will forfeit the unused balance after the end of the plan year. An expense is "incurred" when the services relating to that expense are provided.
- If you are considered to be a Non-Resident Alien for tax purposes, you are generally eligible to use the Flexible Spending Accounts as an

individual. However, expenses for your spouse and children may not be claimed for reimbursement unless they can be claimed as a dependent when you file your taxes. To be considered a dependent for tax purposes, your spouse and/or dependent child must be a citizen, national, or resident of the United States, Canada, or Mexico. We encourage you to speak to a tax advisor regarding your eligibility for tax savings in a Flexible Spending Account.

- Also, as a general rule, expenses incurred before your participation commences or after you cease participation cannot be reimbursed.

Filing Claims with P&A Group

Claims for reimbursement may be filed at any time during the claims period, from January 1st of the current plan year through March 31st of the following year.

For the Dependent Care FSA, the claims must represent expenses incurred during the current plan year (January 1st to December 31st) while you were participating in the Plan. For the Health Care FSA, the claims must represent expenses incurred during the current plan year plus the grace period (January 1 of the current plan year through March 15 of the following year) while you were participating in the Plan. Expenses incurred before you enroll cannot be reimbursed. A claim or expense is "incurred" when the services relating to that claim or expense were provided.

For FSA Dependent Care Claims Only—
You must submit a

Dependent Care Documentation Form each year for each of the Dependent Care providers you use. Once this form is on file with P&A Group, claims submitted with receipts that include the dates of service will suffice for reimbursement.

The Flexible Spending Account Claim Form can be found in the Forms & Documents section under Quick Links at www.bu.edu/hr. When you complete a claim form, include any information required for the verification of health or dependent care expenses. You must include an itemized invoice or receipt indicating the dates of service, the services performed, and the cost.

P&A Group customer service representatives are available Monday through Friday, 8:30 a.m.–8:00 p.m. EST. Call 800-688-2611.

How to Register with P&A Group and Submit Claims

Register with P&A Group

You can register to set up an online account with P&A Group. Among other things, registering will allow you to submit your claims online and use the website to check account balances and the status of claims.

- Go to the P&A Group website at www.padmin.com and select the tab for Employee Participants.
- On the right-hand side of the web page there will be a section titled, "Account Login." Select the link "First time logging in, click here."
- When prompted to enter your Social Security #, you should provide your University ID# instead. Then follow the instructions to set

up your account and your preferences.

Submitting Claims Use your Benefits Card as a debit card purchase wherever MasterCard® is accepted. The money is automatically transferred from your Health FSA account to the merchant.

- **QuikClaim Mobile Feature** Submit a claim and supporting documentation of your eligible expense directly from your smartphone. Go to www.padmin.com on your smartphone and log into your account.
- **Online Claim Upload** After making a purchase, log in to your My Benefits account at www.padmin.com and fill out the online reimbursement form.
- **Fax** Submit a claim form via tollfree fax: 877-855-7105.
- **Mail** Mail a claim form to P&A Group, 17 Court St., Suite 500, Buffalo, NY 14202.

When submitting a claim, you must include a receipt/proof of purchase or insurance statement. To receive reimbursement faster, sign up for direct deposit to have your money directly deposited into your designated checking or savings account.

How do I receive my reimbursement money?

The quickest way to receive your money is by direct deposit to your personal checking or savings account. Direct deposit enrollment forms are available at www.padmin.com. Once enrolled in a direct deposit, all deposits are made via direct deposit until P&A is otherwise notified. You can also receive your money via a check mailed to your home.

How do I get up-to-date account information? Access your account balance and other information anytime, anywhere with the text message feature. Simply update your P&A account profile with your mobile number. Text “BAL” to the number 70626 and receive a text message with your account balance. You can also text “CLM” to the number 70626 to receive the status of your claims.

You can also log in to your P&A account to access your real-time account information or call the customer service department at 800-688-2611 for your latest account information. This system is available in English and Spanish.

- **For dependent care expenses**, you will be reimbursed up to the remaining balance in your account at the time your claim is submitted. Your account balance is reduced by any reimbursements you receive, up to the remaining balance in your account. If the expenses you submit are greater than your account balance, you will be reimbursed up to your account balance. Qualified expenses that were submitted but not paid will be carried over to the next month, and an additional payment will be issued to you during the next regular processing cycle.
- **For health care expenses**, you can be reimbursed up to the amount you choose to contribute (reduced by any prior reimbursements for the plan year).

Treatment of Year-End Expenses You have until March 31 following the end of a given plan year to submit claims for reimbursement of expenses incurred during that plan year.

Account balances remaining after that date will, by law, be forfeited. (You may not use current plan year account balances to pay for expenses incurred in a prior plan year. Prior plan year expenses must be paid with prior plan year account balances. Also, unused amounts cannot be carried over and used to reimburse expenses incurred in a later year.)

If You Should Leave Boston University:

- **FSA—Dependent Care** You may continue to submit claims for reimbursement of eligible dependent care expenses incurred through the last day of your employment at Boston University, up to the remaining balance in your account. Such claims must be submitted no later than March 31 following the end of that calendar year. Any account balances remaining after that date will, by law, be forfeited.
- **FSA—Health Care** In certain circumstances, you may elect to continue your participation in your account through federal health care coverage continuation provisions under COBRA but only to the extent required by COBRA. If you elect to continue your participation, your contributions will be made with after-tax dollars.

If you elect to discontinue your participation, your account balance will be frozen as of the date your employment ends. You may continue to submit claims for reimbursement of expenses incurred through the last day of your employment. Such claims must be submitted no later than March 31 following the end of that calendar year. Any account balance

remaining after that date will, by law, be forfeited.

If You Should Become Totally Disabled or Die

You or your survivors may continue to submit claims for expenses incurred before the time of total disability or death, up to the remaining balance in your account. Such claims must generally be submitted no later than March 31 following the end of that calendar year and account balances remaining after that date will, generally, be forfeited.

Use of Forfeitures

Forfeited account balances will remain part of the University's assets. Under no circumstances may any forfeitures be used to directly benefit any individual plan participant.

Information to Remember

Flexible Spending Accounts have some limitations. These limitations are based on federal regulations required because of the tax-exempt feature of the accounts. For example:

- You must re-enroll in the accounts during each annual open enrollment period. You do this by completing new enrollment forms. If you do not complete a new enrollment, your participation in the accounts will cease at the end of the plan year, and you will not be able to enroll again until the next open enrollment period unless you experience a Life or Career Event or you are requesting a change during the 2020 or 2021 Plan Year (see the "Special Temporary COVID-19 Relief for 2020 and 2021" section above for more information).

- Flexible Spending Accounts can be used only for the purposes for which they are set up—that is, dependent care expenses or health care expenses, respectively.
- Your decisions regarding how much money you will contribute to the accounts for the plan year are fixed (unless there is a Life or Career Event). You cannot choose to stop, reduce, or increase your contributions during the plan year.
- If the full values of the accounts are not used up during the plan year, including the grace period for the FSA-Health Care, you forfeit the remaining balances..

Because of the requirement to forfeit any unused account balances, Flexible Spending Accounts should be used only for predictable expenses. You should, therefore, estimate conservatively.

Following are specific details concerning the Dependent and Health Care Flexible Spending Accounts.

Flexible Spending Account— Dependent Care

The FSA—Dependent Care is designed to help you pay for the cost of eligible expenses for the care of qualified dependents incurred in the calendar year during which and while you participate in this plan. An expense is "incurred" when the services relating to that expense were provided.

Because your individual situation determines whether or not the account is appropriate for you, we urge you to consult a tax advisor before enrolling in an FSA Dependent Care.

Eligible Expenses cover Qualifying Services to Qualifying Individuals.

Qualifying Services are work-related dependent care services performed in order for you and your spouse, if you are married, to remain employed or look for work. Qualifying Services can be provided:

- In your home
- Outside of your home, provided the dependent regularly spends at least eight hours per day in your household, or the dependent is under 13 years of age
- By a dependent care center or facility if it provides care to six or more individuals (excluding residents of the center) and receives a fee, payment, or grant for the services. These services qualify only if the center complies with all the applicable state and municipal laws and regulations.

You must make payments for child and dependent care to someone you (and your spouse) cannot claim as a dependent. If you make payments to your child, he or she cannot be your dependent and must be age 19 or older by the end of the year. You cannot make payments to:

- a. Your spouse
- b. The parent of your qualifying individual if your qualifying individual is your child and under age 13 (

Child and dependent care expenses must be work-related to qualify. Expenses are considered work-related only if both of the following are true:

- They allow you (and your spouse if you are married) to work or look for work.

- They are for a qualifying individual's care.

Qualifying nursery school expenses can be reimbursed, but kindergarten and grade school tuition expenses and the cost of overnight camp cannot be.

If qualifying care is provided in your home, the provider could be a housekeeper, nanny, live-in, or other individual, as long as his or her primary job is to provide qualifying dependent care services.

Qualifying Individuals are:

1. Your qualifying child who is your dependent and who was under age 13 when the care was provided (see the "Special Temporary COVID-19 Relief for 2020 and 2021" section above for a special exception to the under age 13 requirement),
2. Your spouse who was not physically or mentally able to care for himself or herself and lived with you for more than half the year; or
3. A person who was not physically or mentally able to care for himself or herself, lived with you for more than half the year, and either:
 - a. Was your dependent, or
 - b. Would have been your dependent except that:
 - i. He or she received gross income of \$4,300 (2020 limit) or more,
 - ii. He or she filed a joint return, or
 - iii. You, or your spouse if filing jointly, could be claimed as a dependent on someone else's income tax return.

If You Are Divorced or Separated If you are divorced or legally separated, or if you and your spouse lived apart for

the last six months of the calendar year, your children under the age of 13 will generally be considered your dependents if you had custody of them for the greater portion of that calendar year. Consult your own tax advisor for more information.

Maximum Contributions

Federal tax laws place limitations on the amount you can contribute to an FSA—Dependent Care each plan year.

If you are:	Your maximum contribution is:
Single or married filing jointly	\$5,000
Married filing separately	\$2,500

The University elected to implement the increases allowed under the American Rescue Plan Act (ARPA) from \$5,000 to \$10,500 (for employees who are married and filing jointly) and from \$2,500 to \$5,250 (for employees who are married and filing separately for 2021). See the "Special Temporary COVID-19 Relief for 2020 and 2021" section above for special limits that apply in 2021.

Other Contribution Limitations

1. If you are married, your contributions are limited to the least of the following:
 - Your earned income (after reductions in pay for contributions to other benefit plans) for the plan year; or your spouse's earned income for the plan year.

Under federal law, if your spouse is not employed during a month that you incur eligible dependent care expenses,

because he/she is a full-time student or is totally incapacitated, your spouse's earned income for that month will be treated as being either:

- \$250 if you incurred eligible expenses for one Qualifying Individual, or
- \$500 if you incurred eligible expenses for two or more Qualifying Individuals.

2. If you are single, your contributions may not be in excess of your earned income (after reductions in taxable pay for contributions to other benefit plans) for the plan year.
3. The federal maximum contribution limit applies to contributions made to this and other dependent care reimbursement accounts you or your spouse participate in during a given year. For example, if your spouse is contributing \$10,500 under the FSA—Dependent Care of his or her employer in 2021, you would not be eligible to make any contribution under this FSA—Dependent Care. Therefore, if you start working at Boston University after the beginning of the plan year and would like to participate in the Dependent Care Reimbursement Account, you must consider any contributions made to your previous employer's dependent care plan when determining your maximum contribution limit for this account.

Filing Claims

You can be reimbursed from your account by filing a claim with P&A Group.

You do not have to pay for eligible dependent care expenses before being reimbursed for them, but those expenses must be incurred by you. However, P&A Group may ask you to verify your claims and can withhold payment if you do not forward the requested information.

Note: IRS regulations require substantiation of claim.

When you file claims for eligible dependent care expenses, you must include a Taxpayer Identification Number (TIN) for each provider. An individual's TIN is typically his or her Social Security number. Also, when you file your tax return, you will have to include a special form that will include the name(s) and TIN(s) of your caregiver(s). For additional information concerning TINs, contact Human Resources.

You must submit a Dependent Care Documentation Form each year for each of the Dependent Care providers you use. Once this form is on file with P&A Group, claims submitted with receipts including dates of service will suffice for reimbursement.

If you file a claim and it is denied, in whole or in part, you have a right to appeal the denial. Information about a denial of benefits is included in the "Administrative Information" section of this handbook. ERISA does not apply to the FSA— Dependent Care.

Flexible Spending Account— Health Care

The FSA—Health Care is designed to help you pay for eligible health care expenses incurred by you and your dependents in the plan year during which and while you participate in this plan. A claim is "incurred" when the services relating to that claim were provided.

Eligible Health Care Expenses

Before opening an FSA—Health Care, you should be reasonably certain you will have eligible health care expenses during the year. As a guideline for the amount you should budget, you may wish to consider your health plan deductibles and the out-of-pocket expenses you might have to pay during the year.

Eligible expenses are those that are medically necessary and that are not covered by insurance; these generally include:

- Acupuncture
- Chiropractor services
- Convalescent home expenses for medical treatment
- Deductibles and coinsurance
- Drug treatment center expenses
- Feminine Products
- Hearing aids and hearing care expenses
- Institutional care required for a health condition (not custodial care only)

- Kidney donor expenses
- Laboratory examinations and tests
- Medical equipment
- Nursing care
- Organ transplants
- Orthodontic treatment
- Osteopath services
- Over-the-counter medications
- Podiatry services
- Prescription drugs
- Routine physical exams
- Seeing Eye dog expenses
- Special expenses for physically and mentally handicapped children
- Unreimbursed dental care expenses
- Vision care expenses, including eyeglasses and exams

In addition, other health care expenses considered tax deductible under Section 213 of the Internal Revenue Code may be eligible for reimbursement through your account (but health insurance premiums are not eligible for reimbursement). However, any health care expenses you have deducted or intend to deduct on your income tax return cannot be submitted for reimbursement.

Maximum Contributions

You may elect to set aside any amount in your FSA—Health Care up to \$3,300 in the 2025 plan year.

Filing Claims

You can be reimbursed from your account by filing a claim with P&A Group.

Note: *IRS regulations require substantiation of claim.* If you file a claim and it is denied in whole or in part, you have a right to appeal the denial. Information about appealing a denial of benefits is included in the “Administrative Information” section of this handbook.

Leaves of Absence

If you leave work for any reason for a prolonged period of time, you should always contact Human Resources to ask what effect your absence may have on your participation in this and other University sponsored benefit plans.

- **Leave of Absence with Pay** If you are granted a leave of absence with pay, your participation will continue, provided your usual payroll deductions continue.
- **Leave of Absence Without Pay** If you are granted a leave of absence without pay, you may continue your participation during your leave with limitations. Human Resources will provide you with the necessary information and forms to either continue or discontinue participation in this program during an unpaid leave of absence.

When Your Program Participation Ends

Your participation in the Flexible Benefits Program ends the day your employment with the University terminates. It will also end when your status as a regular employee ends or, for the reimbursement accounts, if you do not re-enroll during the annual open enrollment period.

At that time, you can be reimbursed for eligible expenses that were incurred before your date of

termination of employment or other termination of participation.

Closing Thoughts

The Flexible Benefits Program can be a valuable tool in your financial planning. You can realize significant tax savings by paying for eligible benefit expenses with before-tax dollars.

Every effort will be made to help you identify eligible expenses for reimbursement; however, Boston University cannot provide you with legal or tax advice. Also, the University will not be responsible if the treatment of a reimbursement amount is later challenged by the IRS.

The Flexible Benefits Program is intended to qualify under Section 125 of the Internal Revenue Code and other applicable Code Sections. Boston University reserves the right to modify or terminate the program at any time (including a change in the applicable tax laws).

Administrative Information

Sponsor for This Plan

This plan is sponsored by the employer, Boston University, Boston, Massachusetts, which is also the Plan Administrator. Eligibility for the benefit plan described in this handbook applies to those University employees on the US payroll.

Boston University’s Employer Identification Number

For identification purposes, the Internal Revenue Service has assigned number 04-2103547 to Boston University. You will need to know this number if you write to a government agency about

any of the plans.

Type of Plan, Plan Number, and Plan Year

In addition to the University’s Employer Identification Number, you need to know the following information:

- **Type of Plan:** The Flexible Benefits Plan is characterized by the federal government as a Welfare Plan.
- **Plan Number:** Boston University has assigned Plan Number 702 to The Flexible Benefits Plan.
- **Plan Year** The financial records of this plan are kept on a Plan Year basis. The Plan Year for The Flexible Benefits Plan is January 1 to December 31.

Administrator for This Plan

The day-to-day administration of this plan is handled by Human Resources. However, if you have a question or a problem that cannot be resolved by Human Resources, you should contact the Plan Administrator.

The Plan Administrator can be reached by contacting:

Plan Administrator
The Trustees of Boston University
25 Buick Street Boston, MA 02215
Phone: 617-353-4489

Boston University pays the entire cost of many of the benefit plans described in this handbook. In some cases, you and the University share the cost. In others, you pay the entire cost.

Funding and Administration of the Plan

Dependent Care and Health Care Flexible Spending Account claims are processed by P&A Group through a contract it has with the University. The address and telephone number of P&A Group are:

P&A Group
17 Court Street, Suite 500
Buffalo, NY 14202-3204
1-800-688-2611

Agent of Legal Service

The agent for the service of legal process for this plan is:

University Counsel
125 Bay State Road
Boston, MA 02215

Legal process may be served on the Plan Administrator.

Fraudulent Claims

Submission of a claim for benefits under any of the plans described in this handbook includes a representation that the claim is bona fide and, to the best knowledge of the employee, dependent, or other claimant, proper for payment. Submission of a fraudulent or knowingly false claim by an employee or an employee's dependent participating in a plan will be grounds for disciplinary action against the employee, including termination of participation by the employee and/or covered dependent(s) under the plan.

Claims for Benefits/Appealing a Denial of Claims for Benefits

Claims Determinations

Flexible Spending Account - Dependent Care

If your claim under the FSA – Dependent Care is denied in whole or in part, you or your beneficiary will receive a written notice providing:

- the specific reason or reasons for the denial;
- reference to the specific provisions of the plan on which the denial was based;
- a description of any additional information needed to process the claim; and
- an explanation of the claims review (appeals) procedure and the time limits applicable to such procedure, including your right to bring a civil action under Section 502(a) of ERISA if your claim is denied on review.

The notice will be furnished to you within 90 days after receiving your claim. However, if special circumstances require more time for processing your claim, you will be notified in writing before the initial 90 days is up. The notice will explain why an extension is necessary and the date a decision is expected. In no event will an extension go beyond 90 days after the end of the initial 90 days.

Flexible Spending Account – Health Care

If your claim under the FSA- Health Care is denied in whole or in part, the following procedures will apply, depending upon the type of claim:

Post-Service Claims are those claims that are filed for payment of benefits after medical care has been received. Claims for benefits under the FSA – Health Care will always be Post-Service Claims. If your Post-Service Claim is denied, you will receive a written notice from P&A Group within 30 days of receipt of the claim, so long as all

necessary information was provided with the claim. If circumstances beyond the control of the Plan require more time for processing your claim, federal law permits one extension of up to 15 days. You will be notified of any extension before the initial 30 days are up. The notice will explain why an extension is necessary and the date a decision is expected.

If an extension of the decision period is necessary because additional information is needed to decide your claim, then the notice of extension will specifically describe the required information and you will have 45 days to provide it. If all needed information is received within the 45-day time frame, P&A Group will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

If your claim is denied in whole or in part, you will receive written notice of:

- the specific reason or reasons for the denial;
- specific reference to the plan provisions on which the denial is based;
- if a plan rule or guideline was relied on in making the initial benefit decision, either the specific plan rule or a statement that a copy of the rule will be provided to you free upon request;
- the additional information, if any, needed to approve your claim and an explanation of why such information is necessary;
- the plan claims review procedure, including a statement of your right to bring an action under Section

502(a) of ERISA, following an adverse determination appeal; and

- if the initial benefit decision was based on a plan exclusion or limit (such as medical necessity or experimental treatment), either an explanation of the basis for the determination or a statement that such explanation will be provided to you free upon request.

How to Appeal a Claim Determination

If you disagree with a claim determination, you can contact P&A Group in writing to formally request an appeal. Your first appeal request must be submitted to P&A Group within 60 days after you receive the claim denial. In the case of a FSA- Dependent Care claim and within 180 days after you receive the claim denial in the case of a FSA – Health Care claim.

Appeal Process

An appropriate, named plan fiduciary who did not make the initial decision and who is not a subordinate of the individual who made the initial decision will decide the appeal. The review will show no deference to the initial decision. As part of the review, you or your authorized representative may submit written comments, documents, records, or other information relating to the claim for benefits, and, upon request and free of charge, you or your authorized representative will be provided reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits. You may also request the identity of any medical experts consulted by the plan in connection with the initial benefit decision. The Plan fiduciary who considers your appeal will take into account all

information you submit, regardless of whether it was submitted or considered in the initial decision. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. P&A Group and the Plan Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process.

Appeals Determinations

Flexible Spending Account – Dependent Care

P&A Group will notify you of its decision on review not later than 60 days after receiving your request for review. If special circumstances require more time to reach a decision, it will be made as soon as possible, but not later than 120 days after receiving your request. If an extension of time is necessary, you will receive a written notice explaining why an extension is necessary and the date by which a decision is expected. A denial on review will be in writing and include:

- the specific reason or reasons for the denial;
- reference to the specific Plan provisions on which the denial is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to your claim for benefits; and
- a statement of your right to bring a civil action under Section 502(a) of ERISA.

Flexible Spending Account – Health Care

You will be provided written or electronic notification of decision on your appeal within 60 days for the appeal of a Post-Service Claims. Prior to receiving a final adverse benefit determination based on new or additional evidence or rationale, you will be provided with any new or additional evidence considered, relied upon, or generated in connection with your claim, and any new or additional rationale, and you will have an opportunity to respond prior to the date the final adverse benefit determination is due. If the appeal is denied, you will receive a notice providing -

- the specific reason or reasons for the denial;
- specific reference to the Plan provisions on which the denial is based;
- if a plan rule or guideline was relied on in making the initial benefit decision, either the specific plan rule or a statement that a copy of the rule will be provided to you free upon request;
- the additional information, if any, needed to approve your claim and an explanation of why such information is necessary;
- the Plan claims review procedure, including a statement of your right to bring an action under Section 502(a) of ERISA, following an adverse determination appeal;
- if the benefit decision was based on a Plan exclusion or limit (such as medical necessity or experimental treatment), either an explanation of the basis for the determination or a statement that

such explanation will be provide to you free upon request; and

- the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Exhausting Administrative Remedies

If your claim is denied on review, then you may bring a civil action in federal or state court. You may not commence such an action, however, until you have exhausted your administrative remedies under the Plan. Unless otherwise expressly stated in the plan document for the applicable plan, you must initiate any civil action on a claim for benefits under the Flexible Benefits Program within 12 months after exhaustion of your administrative remedies under the Plan.

Documents and Laws Governing This Plan

The plan description contained in this handbook was written from the documents that legally govern how the plan works.

In the event of any discrepancy between the plan description in this handbook and the controlling contracts or plan documents, the language in the controlling contracts or plan documents will govern. If you would like a copy of any of these documents, please contact Human Resources.

The plan is also regulated by applicable provisions of applicable laws, which will govern in the event of any conflict between the law and the terms of the plan as described in either the

documents or in this summary plan description.

Equal Opportunity/Affirmative Action Policy

Since its founding in 1839, Boston University has been dedicated to equal opportunity and has opened its doors to students without regard to race, sex, creed, or other irrelevant criteria. Consistent with this tradition, it is the policy of Boston University to promote equal opportunity in educational programs and employment through practices designed to extend opportunities to all individuals on the basis of individual merit and qualifications, and to help ensure the full realization of equal opportunity for students, employees, and applicants for admission and employment. The University is committed to maintaining an environment that is welcoming and respectful to all.

Boston University prohibits discrimination against any individual on the basis of race, color, religion, sex, age, national origin, physical or mental disability, sexual orientation, genetic information, military service, or because of marital, parental, or veteran status. This policy extends to all rights, privileges, programs, and activities, including admissions, financial assistance, educational and athletic programs, housing, employment, compensation, employee benefits, and the providing of, or access to, University services or facilities. Boston University recognizes that that equal opportunity is a reality. Accordingly, the University will continue to take affirmative action to achieve equal opportunity through

recruitment, outreach, and internal reviews of policies and practices.

The coordination and implementation of this policy is the responsibility of the Director of Equal Opportunity. The officers of the University and all deans, directors, department heads, and managers are responsible for the proper implementation of equal opportunity and affirmative action in their respective areas, and they are expected to exercise leadership toward their achievement. It is expected that every employee of Boston University will share this commitment and cooperate fully in helping the University meet its equal opportunity and affirmative action objectives.

Boston University has developed detailed procedures, described in its *Complaint Procedures in Cases of Alleged Unlawful Discrimination or Harassment* (www.bu.edu/eeo/policies-procedures/complaint), by which individuals may bring forward concerns or complaints of discrimination and harassment. Retaliation against any individual who brings forward such a complaint or who cooperates or assists with an investigation of such a complaint is both unlawful and strictly prohibited by Boston University.

Inquiries regarding this policy or its application should be addressed to the Director of Equal Opportunity, Equal Opportunity Office, 888 Commonwealth Avenue, Suite 303, Boston, MA 02215, or call 617-358-1796.

Amendment or Termination of the Plan

Boston University intends to continue maintaining the plan described in this

handbook for the exclusive benefit of its employees.

However, the University reserves the right to change or discontinue it, and to implement changes as required by federal, state, or local laws.

You will be informed of any material changes that are made to the plans. If a plan is terminated, your rights, on the date of the termination, would be governed by the provisions of the plan document.

Your Rights Under ERISA

The FSA – Health Care benefit is subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides the participants in these plans with certain rights and protections. The following statement is included here so that you will be aware of your rights under the law.

Under ERISA:

You may examine, without charge, at Human Resources and at other specified locations, during normal business hours, all plan documents relating to the plans in which you participate. The documents that must be available for your review include insurance contracts, plan and trust documents, collective bargaining agreements, and all documents filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration, for example, detailed annual reports.

If you wish, you may request your own copies of these plan documents by writing to Human Resources. Where permitted by law, you may have to pay

a reasonable charge to cover the costs of copying.

You will receive summaries of the plans' annual financial reports each year, free of charge. The administrator for the plans is required by law to furnish each participant with a copy of these summary annual reports.

Continue Health Coverage

You may continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Flexible Benefits Plan as a result of a qualifying event. You or your dependents will have to pay for such coverage. Review this handbook and the documents governing the Flexible Benefits Plan - Health Care on the rules governing your COBRA continuation coverage rights.

Plan Fiduciaries

Besides giving you certain rights as a participant, ERISA places certain duties upon the people who are responsible for the management of the above-mentioned plans. These people are called "fiduciaries" under the law, and they have the duty to act prudently and in your best interests.

Under ERISA, no one may fire you or discriminate against you to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

Enforcing Your Rights

If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to obtain copies, without charge, of documents relating to the decision, and to appeal any denial all within certain time schedules.

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 for each day's delay until you receive the materials, unless the materials were not sent for reasons beyond the administrator's control. If you have a claim for benefits that 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 a plan's decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse plan money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or file suit in a federal court.

In a lawsuit, the court normally decides who pays the court costs and legal fees. If you are successful, the other party might have to pay. But, if you lose, the court might order you to pay these costs and fees, especially if the court finds your claim to be frivolous.

Assistance with Questions

If you have any questions about this statement of your rights under ERISA, contact Human Resources. 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 visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. You

may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

A Final Note

This handbook presents a summary of Boston University's benefits for faculty and staff and is intended to serve as the summary plan description for the

FSA- Health Care Plan. It is designed as a quick reference source and is not intended to cover every point of policy. In certain instances, the University may exercise discretion, with respect to the administration of the plans described in this handbook. For more in-depth information, contact Human Resources.

Periodically, the University may make changes in policy that may not be reflected immediately in this handbook.

Again, for complete and up-to-date information about any policy or benefit, you should contact Human Resources.

Please note: The policies described in this handbook are not intended to create an employment contract between Boston University and its employees. Therefore, they do not alter the University's rights regarding discharges and layoffs.