UNIVERSITY OF MISSOURI

# Flexible Benefits SPD

Effective January 1, 2025

This summary plan description (SPD) is designed to provide an overview of the University of Missouri's Flexible Benefits Plan (Plan). While the University hopes to offer participation in this Plan indefinitely, it has the right to amend or terminate any benefit plan. In addition to this SPD, the University plans to continue to use other methods of communication such as memos, meetings, newsletter articles or electronic media to help you stay informed.

The University is the Plan Administrator with the authority to control and manage the operation and administration of the Plan. The University has delegated certain administrative duties of the Plan to ASIFlex. The Plan Administrator and other fiduciaries of the Plan have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to benefits in accordance with the terms of the Plan. Any interpretation or determination pursuant to this discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary or capricious.

This SPD serves as both the Plan document and SPD. This SPD is designed to meet your information needs. It supersedes any previous printed or electronic SPD for this Plan. The terms of this Plan may not be amended by oral statements made by the Plan Sponsor, the Claims Administrator, or any other person. In the event an oral statement conflicts with any term of the Plan, the Plan terms will control.

It's important for you to have a good understanding of all this Plan has to offer. Please review this SPD carefully. If you have questions, contact your HR Generalist (umurl.us/CBR) or HR Service Center (umurl.us/HRSC).

## Table of Contents

You enjoy two important advantages under the University of Missouri's Flexible Benefits Plan:

- Unless you specifically elect otherwise your share of the cost of certain benefits will be taken from your pay on a *before-tax* basis. This means you pay no federal, state or Social Security taxes on those benefit premiums.
- If you like, you can choose to participate in the Health Savings Account, Health Care Flex Spending Account (FSA) or Dependent Care Flex Spending Account (FSA). These special accounts allow you to pay for many typical health or dependent care expenses with *tax-free* money.

## Am I eligible to participate?

You are eligible to pay premiums for Medical, Dental, Vision, Basic Group Term Life, Short-Term Disability and Long-Term Disability insurance on a before-tax basis under this Plan if you are eligible to participate in the component of the Plan to which you wish to make before-tax contributions. For example, in order to pay Medical Plan premiums on a before-tax basis under this Plan, you must be eligible to participate in the Medical Plan.

You are eligible to make contributions to a Health Savings Account under this Plan provided you meet the following conditions:

- You are enrolled in the University's qualified high-deductible health plan (Healthy Savings Plan) on the first day of the month
- You are not covered by another health plan or any other disqualifying non-high deductible health plan coverage
- You are not enrolled in any part of Medicare
- You may not be claimed as a dependent on someone else's tax return
- You, or your spouse, may not be enrolled in a general-purpose Health Care Flexible Spending Account

If you are an active employee of the University, you are eligible for coverage under a Health Care FSA or a Dependent Care FSA, provided you also meet the following conditions:

- you are classified 75% FTE or more
- you have an appointment duration of at least nine months
- you are regularly scheduled to work an average of 30 hours a week
- you are not enrolled in the Healthy Savings Plan (this requirement is only necessary if you wish to enroll in the Health Care FSA)

For the purpose of this section any individual who is simultaneously employed by the University and the Harry S. Truman Veterans Administration Hospital pursuant to an agreement between said organizations, and whose joint appointments, combined, otherwise meet the requirements of this section, shall be considered an Employee.

Per diem employees are excluded as an Employee under this Plan. Variable hour employees are not eligible for coverage under a Health Care or a Dependent Care FSA under this Plan.

## When does my participation begin?

Unless you submit a benefit election form (via online or paper), you will be automatically enrolled in the Healthy Savings Plan portion of the Medical Plan and contributions towards such coverage will be withheld from your pay, on an after-tax basis. If you do not submit a benefit election form (via online or paper), you will also be automatically enrolled in the plans listed below:

- Basic Group Term Life Insurance, Option A
- Short-Term Disability, Base Plan
- Long-Term Disability, Option A

If you submit a benefit election form (via online or paper) within 31 days of your date of hire or benefit eligibility, you can elect to pay for any or all of the coverages offered under this Plan (Medical, Dental, Vision, Basic Group Term Life, Short-Term Disability and Long-Term Disability) for which you are eligible and make contributions to any account (Health Savings Account, Health Care FSA or Dependent Care FSA) for which you are eligible, on a pre-tax basis, unless after-tax is elected and/or applicable.

*Health Savings Account:*

- You may elect to make before tax contributions to a Health Savings Account by submitting an enrollment form (via online or paper) to participate in this plan at any time, provided you meet the HSA eligibility requirements noted above. If your hire date or benefit effective date begins on the first day of the month, coverage will begin on that day. If your date of hire or eligibility is on any day other than the first day of the month, coverage will begin on the first day of the month next following your hire or eligibility date.
- You may also make changes to your HSA election at any time during the Plan year by submitting an enrollment change form (via online or paper).

*Health Care and Dependent Care FSA:*

- If you are newly benefit hired or become newly benefit eligible during the Plan year, you may elect to make before-tax contributions to the Health Care and Dependent Care FSAs for the Plan year in which you are newly hired or newly eligible by submitting an enrollment form (via online or paper) to participate in the Plan within 31 days of your date of hire or eligibility. If your hire date or benefit effective date begins on the first day of the month, coverage will begin on that day. If your date of hire or eligibility is on any day other than the first day of the month, coverage will begin on the first day of the month next following your hire or eligibility date, provided you enroll within 31 days of becoming newly eligible.
- If you are rehired within 30 days (in the same calendar year), you will continue with the same FSA elections you previously had in place unless you experience a qualified status change (other than the change in employment within the past 30 days).
- You can begin participation in the Health Care FSA or Dependent Care FSA on any January 1, provided you enrolled during the preceding annual enrollment period and you are in an active pay status as of January 1 of the Plan year.

- You may also make a mid-year enrollment in the Health Care FSA or Dependent Care FSA during the Plan year if you experience a qualifying change in status event, provided you enroll within 31 days of the event. Your mid-year enrollment in the Health Care FSA election or Dependent Care FSA election will become effective on the first day of the month coinciding with or following the date of your change in status event, or the date on which you provide notice of the event, whichever is later. When does my participation end?

Your participation in the Plan continues until the date in which you no longer meet the eligibility requirements as described above or the date this Plan is terminated, if earlier. Once you are no long eligible or your employment is terminated, you may not make any more contributions to the Plan. Please note, however, that coverage of Medical, Dental, Vision, Basic Group Term Life, Short-Term Disability and Long-Term Disability benefits will terminate as of the date specified in those plan documents.

For information about reimbursement of expenses from your Health Care and Dependent Care FSAs after you cease to be eligible, see the section titled "How do I get reimbursed?" under "Health Care and Dependent Care FSAs". For information about obtaining distributions from your HSA at any time, including after you cease to be eligible under the Plan, contact the trustee/custodian of your HSA established and maintained outside the Plan.

## Continuation Coverage

You will be notified by mail if you are eligible for Health Care FSA COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will come from the University's COBRA Administrator and will give you instructions for electing COBRA coverage. If you elect COBRA coverage for any health benefits, contributions for those benefits will be paid on an after-tax basis.

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to the federal Uniformed Services Employment and Reemployment Rights Act (USERRA). More information about coverage under USERRA is available from the Plan Administrator.

## How will a leave of absence affect my benefits?

In the event of unpaid leave, your before-tax deposits to the accounts will stop as of the last day of the month in which your pay or eligibility ends. Your coverage will stop at the end of that month as well unless you make arrangements to continue coverage with the UM Office of Human Resources. You will be billed for the contributions during your unpaid leave. So long as contributions are timely paid, your coverage will continue.

During paid leave, your before-tax deposits to the accounts will continue so long as there is sufficient pay from which to deduct the contributions. So long as contributions are timely paid, your coverage will continue.

## Before-tax payments

You and the University share in the cost of certain benefits. If you like, you can pay your share of this cost on a before-tax basis. This means your contribution for medical, dental, basic group term life, short-term disability and long-term disability insurance can be paid with money on which you will not have to pay Social Security, federal and state income taxes. As a result, you pay less in taxes.

This before-tax method is a major advantage of your Flexible Benefits Plan. Under the program, your premium payment sequence works like this:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Your pay | - | Your share of benefit costs | = | Taxable pay | - | Taxes | = | Take-home pay |

Your benefit costs are deducted before your taxable pay is calculated. As a result, your taxable pay is reduced. Lower taxable pay means lower taxes.

If you choose to participate, you'll also be able to pay for some typical health and dependent care expenses with before-tax money through Health Care and Dependent Care FSAs.

**Do before-tax contributions affect my benefits?**

Although your taxable salary is reduced when you make before-tax contributions, your total base annual earnings will be used to determine the amount of your coverage under the Retirement, Group Term Life, Short-Term Disability and Long-Term Disability Plans.

However, before-tax contributions can affect the tax treatment of benefits you receive from the Plans. When you pay for a benefit coverage on a before-tax basis, the IRS views the entire cost of the benefit as being paid by your employer. In other words, the amount of your before-tax contributions is considered a contribution by the University for your benefits,

For those who pay for benefit costs on a before-tax basis, here are examples of how tax laws affect your benefits:

- If you elect more than $50,000 in group term life insurance coverage under our Plan, the value of the life insurance amount in excess of $50,000 is taxed as additional income. In other words, if you receive $75,000 of life insurance coverage, you would be taxed on the value of $25,000 ($75,000-$50,000) of group term coverage. The "value" of this coverage is determined according to a table used by the IRS and is called "imputed income". The value then will appear on your W-2 form at the end of the year. A before-tax premium contribution may not be used to reduce this imputed income.
- If you file your federal or state income tax returns on an itemized deduction basis you cannot use the amount of your before-tax contributions for medical or dental benefits as part of your medical expense deduction.

- Under the law, monthly income benefits received from a short-term or long-term disability plan are subject to federal and state income taxes to the extent that an employer has paid the cost of the coverage. This means that if you become disabled, the full amount of the monthly benefits you receive from the Short-Term Disability or Long-Term Disability Plan would be taxable. Of course, because your contributions are made on a before-tax basis, you will pay lower taxes while you are working.
- Because Social Security taxes are not paid on the portion of your salary used to make before-tax contributions, your salary base used for calculating Social Security retirement benefits is also decreased. The end result is a slight decrease in the amount of Social Security benefits to which you are entitled. However, the decrease in Social Security benefits is generally more than offset by the immediate tax savings. The impact of such a decrease is determined by your salary level and the cost of the Plans in which you participate.

## When can I change my decision?

Because of the tax advantages you enjoy under this benefit Plan, the IRS has issued restrictions as to when and what changes you may make during the year. In general, once you elect or waive coverage under the Plan, your election is binding throughout the year and you may only make changes to your elections during the annual open enrollment period. Different restrictions may apply, however, depending on the type of change and your specific enrollment.

If you are eligible to contribute to the Health Savings Account, you may elect to make contributions to the Health Savings Account at any time on a prospective basis. You may also change the amount of your Health Savings Account contributions on a prospective basis at any time.

You cannot make new elections or change an existing election outside the annual open enrollment period under Basic Group Term Life or Long Term Disability for which contributions are being paid before taxes, or under a Dependent Care FSA, unless your needs are affected by a "change in family status". In addition, you cannot make new elections or change an existing election outside the annual open enrollment period for Medical, Dental, or Vision, or under a Health Care FSA, unless your needs are affected by a "qualified family/employment status change".

Changes to your Short-Term Disability coverage may only be made during the annual open enrollment period.

**What is a "change in family status"?**

The following events are changes in family status, and impact your ability to make changes in Basic Group Term Life, Long Term Disability and Dependent Care FSA elections:

- Marriage or divorce.
- Birth or adoption of a child, or assuming legal guardianship of a child.
- Death of your spouse or your dependent.
- A change in your or your spouse's employment from full-time to part-time or vice versa.
- The termination of, or commencement of, you or your spouse's employment.

- You or your spouse taking an unpaid leave of absence.
- A significant change in your health coverage as a result of your spouse's employment.
- If your child no longer qualifies for dependent care because they turned 13, then that is a loss of a dependent under the Dependent Care FSA, but not under any of the other plans.

The Internal Revenue Service allows changes in your Dependent Care FSA if you experience a change in cost due to a change in providers. Similarly, you may reduce your election when your child starts school or you no longer require dependent care. If you stop future contributions or decrease your annual election to less than the minimum required amount ($50), your coverage will terminate at the end of the month in which your last contribution was made. Claims incurred after coverage termination are not eligible for reimbursement.

**What is a "qualified family/employment status change"?**

Unless otherwise provided in the applicable underlying plan document, the following events are qualified family/employment status changes and may impact your ability to make new elections or changes in existing Medical, Dental, Vision benefit elections as well as your Health Care FSA elections due to specific requirements or restrictions and must be consistent with the qualified family/employment status change

- Change in marital status as a result of marriage, divorce, legal separation, annulment or death of spouse
- Change in the number of dependents as a result of death, birth, adoption or placement for adoption, or a child ceasing to be eligible or becoming eligible as a dependent
- Change in the employment status of you or your spouse that involves the commencement or termination of employment
- Change in the work schedule of you or your spouse which involves an increase or decrease in work hours, a strike, a lockout or an unpaid leave of absence that affects your eligibility for benefits
- A change in residence or worksite of you or your spouse that affects your eligibility for benefits
- A loss of coverage under certain group health coverage sponsored by a governmental or educational institution, including CHIP, a state's children's health insurance program, a medical program of an Indian Tribal government, the Indian Health Service or tribal organization, a state health benefits risk pool or a foreign government group health plan
- A change in entitlement to Medicare or Medicaid for you, your spouse or a dependent
- A significant change in health coverage of you or your spouse attributable to your spouse's employment
- A significant change in the cost of coverage under a health plan
- Addition of a new benefit package option or coverage option offered by the University
- Elimination of a benefit package option or coverage option during a period of coverage
- A FMLA leave of absence
- Loss of coverage due to exhaustion of another employer's COBRA benefits, provided you were paying contributions on a timely basis
- Certain court administrative order, judgement or decree requires your child to be covered under a group health plan

- Contributions were no longer paid by the employer
- For purposes of Medical coverage benefit elections only, a change in your employment status that results in the number of hours per week you are expected to work, on average, changing from more than 30 hours per week to less than 30 hours per week after the change. You only experience a "qualified family/employment status change" for purposes of the above change if:

    1) You had been in an employment status under which you were reasonably expected to average at least 30 hours of service per week and there is a change in your status so that you will be reasonably expected to average less than 30 hours of service per week after the change, even if that reduction does not result in you ceasing to be eligible under the Plan; AND
    2) The revocation of the election of coverage under the Plan corresponds to your, and any related individuals who cease coverage due to the revocation, intended enrollment in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.
- For purposes of Medical coverage benefit elections only, you become eligible for a special enrollment period to enroll in a health plan through a health insurance marketplace established by the Patient Protection and Affordable Care Act (a "Marketplace"), or you seek enrollment in a health plan through a Marketplace during the Marketplace's annual open enrollment period. You only experience a "qualified family/employment status change" for purposes of the above change if:
    1) You are eligible for a special enrollment period to enroll in an insurance plan that is certified by the Marketplace, provides essential health benefits, follows established limits on cost-sharing, and meets other requirements (a "Qualified Health Plan") through a Marketplace pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or you seek to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; AND
    2) The revocation of the election of coverage under the Plan corresponds to your, and any related individuals', intended enrollment in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

In order for you to make a change, your benefit needs must change as a result of one of those occurrences and the change you wish to make must be consistent with the status change event. For example, a change in your spouse's employment status does not allow you to change options unless there is a significant change in the coverage of yourself or your spouse as a result of the change in employment status—such as loss of coverage.

Experiencing a "qualified family/employment status change" may allow you to change your existing Health Care FSA election or to newly enroll in the Health Care FSA.

If you have a "change in family status" or "qualified family/employment status change and wish to make a change in your election under this Plan, you must submit your change (via online or paper) within 31 days of the event. The Plan Administrator will administer any benefit

election changes in accordance with the applicable regulations and IRS guidance. You will be notified if the change is acceptable. Your election will become effective in accordance with the rules governing the effective date of participant elections in the component plan for which you are changing coverage. For example, if you experience a "qualified family/employment status change" and wish to change your Medical Plan coverage as a result, the date your change in coverage becomes effective will be determined by the rules governing participant elections under the Medical Plan. A change in your Health Care FSA election or Dependent Care FSA election will become effective on the first day of the month coinciding with or following the date of your change in status event, or the date on which you provide notice of the event, whichever is later.

Other conditions that apply to changing your benefit plan coverage are described in each Summary Plan Description (SPD).

## Special Enrollment Rights

If you, your spouse, or your dependent does not enroll in the Plan when first eligible, you may have a right to a "special enrollment" during the plan year. A special enrollment right allows you to elect to make before-tax contributions to a Health Savings Account, Health Care FSA or Dependent Care FSA or elect coverage under the Medical, Vision, Dental, Basic Group Life, or Long Term Disability component of this Plan. If you wish to enroll in the Group Life or Long Term Disability component of this Plan after your initial eligibility, you will be required to provide evidence of insurability within 31 days after the event that gives rise to your special enrollment right. The special enrollment rights are as follows:

### If You Lose Other Coverage

You have special enrollment rights if all of the following conditions are met:

- You were covered under a group health plan or had other health insurance at the time you declined coverage under this Plan; and
- You lost your former coverage because you stopped being eligible for that coverage (or the employer stops contributing toward your or your spouse's other coverage).

If you lose other coverage under the circumstances described above, you may request coverage under this Plan by submitting a completed benefit change form (via online or paper) within 31 days of the other coverage ending. Your coverage under this Plan will become effective on the first of the month following the date coverage ends.

### If You Lose Coverage Under Medicaid

If you declined coverage for yourself or your dependents while Medicaid coverage or coverage under a state children's health insurance program is in effect, you or your dependents are entitled to special enrollment rights when your, or your dependents', coverage under a Medicaid plan or under a state children's health insurance program is terminated as a result of a loss of eligibility for such coverage and you submit a completed benefit change form within 60 days after your or your dependents' coverage ends.

**If You Acquire a Spouse or a Dependent**

If you get married, have a child, adopt a child, or place a child for adoption, you may enroll yourself, together with your spouse, your newly acquired dependents, or both, in this Plan, provided you submit a completed benefit change form (via online or paper) within 31 days of the marriage, birth, adoption, or placement for adoption, unless otherwise provided in the Medical Plan. If you request coverage by submitting a completed benefit change form (via online or paper), your coverage will become effective on the date of the event in the case of birth, adoption, or placement for adoption, and in the case of any other event, on the first of the month following the date of the event, unless the event occurs on the first day of the month, the coverage will become effective on that date.

**If You Become Eligible for State Premium Assistance**

If you or your dependents become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this Plan, you are entitled to special enrollment rights under this Plan when you or your dependents become eligible for such a premium assistance subsidy, provided that you submit a completed benefit election form within 60 days after you or your dependents are determined to be eligible for such assistance. Coverage under this Plan will become effective on the first of the month following the date of the event.

## Health Savings Accounts (HSAs)

If you are eligible, you may make pre-tax contributions to an HSA, up to the statutory maximum. An HSA is established and maintained outside the Plan with the HSA custodian and may be used to reimburse certain eligible medical expenses. The Plan Administrator's role is limited to allowing you to contribute to your HSA on a pre-tax basis and it has no control or authority over the funds you deposit in your HSA. If you have questions about your HSA, you should contact the HSA custodian. The University may make contributions to your HSA. Any contribution provided by the University will count toward your annual statutory maximum. You are responsible for determining your maximum annual contribution.

## Health Care and Dependent Care FSAs

One of the key advantages of your benefits plan comes in the form of these two special accounts which offer you an opportunity for real tax savings.

The Health Care FSA provides a before-tax method of paying for certain health care expenses that aren’t covered by your Medical, Dental, or Vision Plan. The Dependent Care FSA allows the payment of expenses such as day care for a child or a dependent adult in the same tax-saving manner.

In order to participate, you must re-enroll each year in the Health Care FSA and Dependent Care FSA and designate an annual amount that will be deducted from your paycheck in equal installments each pay period to be deposited to your account.

The University Health Care FSA and Dependent Care FSA have a 2.5-month Grace Period (through March 15 of the following year), which allows you extra time to incur expenses to use your flexible spending balance after the close of the plan year.

According to Internal Revenue Service (IRS) regulations, any money left in your accounts at the end of the Plan year or at the end of the Grace Period must be forfeited. This is called the "use it or lose it" rule—it's the IRS's way of making sure you use the accounts as they were intended. Keep this rule in mind when you're considering how much to deposit to either account.

**The Health Care FSA**

The Health Care FSA allows you to pay certain health care expenses—such as deductibles, copayments, coinsurance, eyeglasses and physicals—with before-tax dollars. In the process, your taxable income is reduced and you pay less in income taxes.

If you choose to participate in this account, you'll designate an annual dollar amount—up to $3,050 to be deducted from your paycheck on a before-tax basis and deposited to your account. If two employees are married and each one enrolls for a Health Care FSA, each employee may enroll for the maximum amount. The annual minimum deposit is $50. When you incur an eligible health care expense, you are reimbursed from your account with these tax-free dollars.

The Health Care FSA can be used to reimburse you for the cost of certain expenses you or your eligible dependents incur. For purposes of your Health Care FSA, your eligible dependents include (a) your son, daughter, stepchild, legally adopted child, or eligible foster child who is under the age of 27 at the end of the taxable year; and (b) your tax dependents under the Internal Revenue Code, except that an individual's status as a tax dependent is determined without regard to the gross income limitation for a qualifying relative and certain other provisions of the Internal Revenue Code's definition. See IRS Publication 969 for more details.

Your dependents need not be covered by the Medical Plan to have their expenses reimbursed through the Health Care FSA.

Eligible expenses include, but are not limited to, the following:

- Deductibles, copayment, and coinsurance amounts for your medical and dental plan and for your spouse's plan (as long as you are not reimbursed for these expenses through coordination of benefits between the two plans).
- Medical, dental and orthodontia expenses not covered under any health plan.
- Eye examinations, lenses (including contact lenses), frames, and laser eye surgery.
- Hearing examinations and hearing aids.
- Birth control.
- Other expenses allowed as medical deductions by the IRS on your federal tax return that are not reimbursable under any other Plan.

Some expenses that are not eligible include the following:

- Health spa and club memberships, unless you obtain a letter of medical necessity from a medical provider and you provide a statement that you would not have joined but for the medical necessity
- Cosmetic surgery or other similar procedures, unless used to correct a deformity caused by a congenital abnormality, personal injury from accident or trauma, or to restore proper function of the body related to another medical diagnosis or condition
- Non-medical expenses such as electronic air filters and hot tubs, unless you obtain a letter of medical necessity from a medical provider. In addition, if the expense is a capital improvement to your home then only a portion will be reimbursed. Please see www.asiflex.com for further information
- Insurance premiums (individual or group)

Expenses for which you have been reimbursed from your Health Care FSA cannot be claimed as an itemized deduction on your federal income tax return. A detailed list of expenses can be found at www.asiflex.com.

**The Dependent Care FSA**

If you're paying for care for your child or a dependent adult, you probably know what those costs will be each year—normally they're quite predictable. That predictability makes it easy to determine how much to put into your account. The Dependent Care FSA works in much the same way as the Health Care FSA, but it is a completely separate account with its own rules and procedures.

You decide how much to deposit to your Dependent Care FSA — as much as $5,000 per year per household or $2,500 if you are married and file a separate federal income tax return. If two employees are married and each one enrolls for a Dependent Care FSA, the maximum enrollment between both employees is $5,000. The annual minimum deposit is $50. When you submit an eligible expense, you will be reimbursed with the tax-free dollars you've deposited to your account, provided your balance is large enough to cover it.

The rules for determining eligible expenses under the Dependent Care FSA are the same as those that apply to the federal child care tax credit (Section 21 of the Internal Revenue Code).

In order to be eligible for reimbursement, dependent care expenses must meet the following requirements:

- The care must be necessary in order for you to work and for your spouse (if married) to work or attend school full-time (unless your spouse is disabled).
- The amount to be reimbursed must not be greater than your annual income or your spouse's annual income, whichever is lower. If your spouse is a full-time student or is mentally or physically incapacitated (and does not have a regular job), his or her financial status will be based on an assumed monthly income of $250 if you have one eligible dependent, or $500 if you have two or more eligible dependents.
- If the dependent is a child:
  a. He or she must be younger than age 13 and dependent upon you for at least 50% of his or her financial support. (There is no age limit for handicapped children.)

b. You must be entitled to claim the child as a dependent on your federal tax return and you must be the child's custodial parent. The custodial parent is defined to be the parent with custody a greater length of time during the year than the other parent. If custody is split exactly 50% for one parent and 50% for the other, the custodial parent is the parent with the higher adjusted gross income. Please see IRS Publication 504 for further details (this publication may also be found at www.asiflex.com).
c. Care may be provided either inside or outside your home, but it may not be provided by anyone considered your dependent, such as one of your older children.
d. If the care is provided by a facility that cares for more than six children, the facility must be licensed, if applicable, by the state in which it is located.

- If the dependent is an adult:
  a. He or she must be physically or mentally incapable of caring for himself or herself.
  b. He or she must be dependent upon you for at least 50% of his or her financial support.
  c. Care may be provided either inside or outside your home. However, expenses outside your home (such as a nursing home) are eligible only if the dependent regularly spends at least eight hours each day in your home.

The law requires that you identify the provider of dependent care on your federal tax return. When identifying the provider, you must include the provider's name, address and Social Security number or taxpayer identification number (TIN). These same requirements apply to the federal child care tax credit. Additionally, the University is required to report the amount of your annual account deposit on your W-2 form.

Expenses reimbursed from the Dependent Care FSA may not be used as a federal income tax credit. The maximum dollar limit under the tax credit is reduced by the amount you have been reimbursed from the Dependent Care Account.

**How much can I deposit to each account?**

There are limits on the annual amounts you may deposit to the Health Care and Dependent Care FSAs:

| | **Minimum** | **Maximum** |
|---|---|---|
| Health Care FSA | $50 | $3,050 (per employee) |
| Dependent Care FSA | $50 | $5,000 (per household) ($2,500 if you are married and file a separate federal tax return) |

Careful planning is the key to making the most of your savings through the two accounts. Together or separately, they provide an effective way of paying certain health and dependent care expenses while reducing your taxes. However, keep in mind that you will forfeit any unused money left in your accounts at the end of the reimbursement period so plan your deposits carefully.

**How do I get reimbursed?**

The process of putting money into your Health Care FSA or Dependent Care FSA and getting it back out is pretty simple. It can be broken down into these steps:

- Indicate the amount you want to deposit to your accounts on the correct line on your enrollment form. This amount will be deducted from your paycheck before taxes in equal installments each pay period throughout the next year.
- Once you have incurred eligible expenses, the next step is to complete a request for reimbursement. There are numerous ways to receive reimbursement:
  - You can file a claim using your smartphone or mobile device. It is very simple. Just download the free app available in the App store or the Google play store. Search for the ASIFlex mobile app.;
  - You can file a claim online at www.asiflex.com;
  - You can use the ASIFlex Debit Card (see below); or
  - You can file a claim by completing a paper form (available at www.asiflex.com) and either:
    - Fax it to 877-879-9038;
    - Bring it to the ASI office located at 201 W. Broadway, Suite 4-C, Columbia, MO 65203; or
    - Mail it to: ASI, P.O. Box 6044, Columbia, MO 65205-6044.
- To expedite your reimbursement, the claims administrator can arrange for direct deposit to your checking or savings account. Typically, this would take no longer than two working days from the day the claim is received by the administrator.
- The administrator then uses the money in your account to reimburse your expense.

You can only be reimbursed for expenses you incur while you are participating in the accounts. The claim period for the Health Care and Dependent Care FSA is January 1 of the Plan year until March 15 of the following year. Only qualified expenses incurred during this time period are eligible for reimbursement. The deadline for submitting requests for reimbursement for Health Care and Dependent Care FSA claims incurred is April 30. After April 30, your prior year's Health Care and Dependent Care FSA is closed and you will forfeit any money remaining in it.

If the claims you submit for the Dependent Care FSA are more than the amount you have accumulated in it, you will be paid only as much as is in your account. The remainder of the claim will be held in a pending state until your balance is large enough to pay it and then it will be processed.

You will be reimbursed for an eligible Health Care FSA claim as long as your claims do not exceed the amount of your total annual deposit.

If your employment terminates or you become ineligible to participate in a Health Care or Dependent Care FSA, you will have until April 30 of the year following your termination of participation to submit expenses for the Health Care or Dependent Care FSA. For the Health Care FSA, you may include any expenses incurred up to the end of the month in which your Health Care FSA deduction terminates. For Dependent Care FSA claims, you may include any expenses incurred prior to the date you become ineligible or your employment terminates. You may not be reimbursed for expenses incurred after this date.

However, if you are eligible for, and timely elect, COBRA, you may be able to continue your Health Care FSA deposits on an after-tax basis by making direct payments to the University's

COBRA Administrator on a post-tax basis. The Dependent Care FSA is not eligible for continued coverage through COBRA.

**ASIFlex Debit Card** – The ASIFlex Debit Card provides a convenient method to pay for out-of-pocket health care expenses for you, your spouse and/or any tax dependents. The IRS has stringent regulations regarding appropriate use of the ASIFlex Card, such as **where the card can be used, and when follow-up documentation is required. Use of the ASIFlex Debit Card is not paperless and DOES NOT eliminate paperwork.** The ASIFlex Debit Card is a great benefit, but it is important that you take a moment and understand how it works.

**Where can the ASIFlex Debit Card be used?**

Per IRS regulations, the ASIFlex Debit Card can only be used at Health Care Providers (based upon the Merchant Category Code) and at stores that have implemented an Inventory Information Approval System (IIAS).

1) **Health Care Merchant Category Codes (MCC)**: Every merchant that accepts credit cards has an MCC, which is a general category that is assigned when the merchant applies for the right to accept credit cards. The ASIFlex Card will work to pay providers that have an MCC that indicates the merchant is a health care provider (hospital, doctor, dentist, optometrist, chiropractor, etc.).

2) **Inventory Information Approval System (IIAS)**: The IRS also allows the ASIFlex Card to be used at retail stores that have IIAS in place. IIAS restricts purchases with your ASIFlex Card to eligible expenses, and you will never be prompted for follow-up documentation for purchases at these stores. Please note that if you have a medical condition that allows you to claim expenses that are not normally eligible, the ASIFlex Card will not be able to pay for these expenses at these stores. You will have to pay with a separate form of payment and submit a claim. The ASIFlex Card will work at these stores, even if the MCC does not indicate it is a health care provider.

   A list of stores with this system in place now (and some expected in the future) is available online, at www.asiflex.com/debitcards. **Purchases at these stores will never require follow-up documentation provided the merchant has identified the product as FSA eligible!**

**Do I have to turn in documentation when paying with the ASIFlex Card?**

If you use the ASIFlex card, you are only required to submit backup documentation if the transaction is unable to be electronically substantiated.

**Which claims can be electronically substantiated?**

ASIFlex Debit Card transactions can be accepted by the FSA administrator without any follow up if the merchant is an acceptable merchant type such as a physician's office or hospital and at least one of three other criteria are met. Transactions are electronically substantiated if:

- ✓ The dollar amount of the transaction at a health care provider equals the dollar amount of the co-payment or any combination of any known co-pays up to five times the highest known co-pay, for the **employer-sponsored** health, vision or dental plan that participant has elected;

- ✓ The expense is a recurring expense that matches expenses previously approved as to amount, provider, and time period (e.g., for an employee who pays a monthly fee for orthodontia at the same provider for the same amount); or

- ✓ The merchant maintains a compliant Inventory Information Approval System (IIAS) for over-the-counter supplies (e.g., Band-Aids, contact lens solution, etc.) and prescription medication (this system restricts purchases with the ASIFlex Card to FSA-eligible expenses).

Any transaction that does not meet the above criteria will prompt a request for follow-up documentation.

**What happens if I don't submit requested documentation?**

As detailed above, there are times when you may use the ASIFlex Debit Card to purchase FSA eligible items or services and additional documentation will be required to substantiate the transaction, in accordance with IRS Regulations. When follow up documentation, or a statement of services is required, ASIFlex will send you an e-mail or letter requesting this documentation. The requested information should include the following information: name of provider, name of member (or member's spouse or dependent), date the service was provided, brief description of the service(s) provided, and the amount that was your responsibility.

ASIFlex will send the initial request for follow up documentation within a few days of the ASIFlex Card transaction. Should you not comply with the request, ASIFlex will make a second request in approximately three weeks. Should you not comply with the second request, a third notice will be sent to you stating that the ASIFlex Card has been "suspended" because the requested documentation was not received by ASIFlex. **When you use the ASIFlex Card for a transaction requiring documentation, those dollars are identified as "overpaid" within your FSA account until the transaction is substantiated.**

If you submit a manual claim before the ASIFlex Card transaction is substantiated, the dollars associated with the manual claim will be used to offset the overpaid dollars from the ASIFlex Card transaction. This will prevent the manual claim from being reimbursed in part, or in full, depending upon the dollar amount of the manual claim. Once the ASIFlex Card transaction is substantiated, the manual claim used to offset the ASIFlex Card transaction will be reimbursed in full. See the following examples for further explanation:

***Example 1***: *John goes to the dentist and pays $200 for a root canal with his ASIFlex Card. He then receives a notice from ASIFlex requesting follow up documentation. John submits the statement of services from his dentist along with the notice received from ASIFlex. ASIFlex reviews and processes the follow up documentation to substantiate the claim. John's FSA account will no longer be showing as "overpaid "since all follow up documentation was submitted.*

***Example 2****: Lisa pays her eye doctor $250 for contacts using her ASIFlex Card. ASIFlex sends Lisa a notice asking for follow-up documentation for the $250 purchase. Prior to submitting the detailed statement from her eye doctor, Lisa submits a manual claim to ASIFlex for a $100 prescription which she paid for out-of-pocket. ASIFlex will process the $100 claim but no payment will be issued that day. Instead, the amount of the manual claim will be used to offset the ASIFlex Card transaction. This will result in ASIFlex showing Lisa's' overpaid amount reduced from $250 to $150. Two weeks later Lisa submits the follow up documentation for the ASIFlex Card transaction used to purchase the contacts to ASIFlex. ASIFlex will then process the supporting documentation for $250 and Lisa will be issued a payment of $100 for her manual prescription claim.*

If you are unable to provide documentation for an ASIFlex Card transaction in question, you may submit expenses incurred out-of-pocket to offset the ASIFlex Card transaction. The expenses that are incurred out-of-pocket must not also be paid for using the ASIFlex Card.

Should you neglect to submit the requested documentation and the plan year comes to an end (following the Plan's provision for documentation to be submitted by April 30), ASIFlex will provide notice to the University that the claim was not substantiated within the plan year as required by IRS Regulations. **If you are actively employed by the University and do not repay your claims, a wage attachment will be processed to deduct the amount of the unsubstantiated claim/s from your pay.**

If you do not provide requested documentation and leave University employment or retire, a W-2 will be provided to you for the year in which the funds were not repaid and these funds will be reported to the IRS as earnings for which taxes must be paid. See the following example for further explanation:

***Example***: *Lori's daughter Carrie goes to the dentist to receive a crown in 2024. Lori uses her ASIFlex Card for the $750 expense. Lori terminates employment the following week. ASIFlex sends Lori three notices requesting follow up documentation, and receives no response or repayment from Lori. At the end of the plan year (following the grace period provision to April 30, 2025) ASIFlex will notify the University of the overpayment. The University will then issue a W-2 for 2025 in January, 2026, to the member and to the IRS, which will report the $750 overpayment as taxable income.*


While the ASIFlex Debit Card provides a convenient method to pay for out-of-pocket health care expenses, the ASIFlex Debit Card is **NOT** a paperless option and **DOES NOT** eliminate paperwork. There are times when you may use the ASIFlex Debit Card to purchase FSA eligible items or services and additional documentation **will still be required** to substantiate the transaction in accordance with IRS Regulations.

Concerns and questions regarding this process should be directed to ASIFlex at asi@asiflex.com or 1-800-659-3035.

**Is there a cost for the ASIFlex Card?**

The first set of two (2) cards is provided at no cost. There is, however, a $5 replacement card or additional card fee.

**Can I request additional ASIFlex Cards?**

Yes. Everyone who requests a card will receive two ASIFlex Cards in the mail. If you would like additional cards, complete the ASIFlex Card application form and submit to ASIFlex. There is a $5 fee for each additional ASIFlex Card request. Please note that all ASIFlex Cards will be in the name of the FSA participant.

**Special rules to remember**

While the accounts are a good way for you to reduce your taxes, you should be aware of several important rules:

- The IRS requires that any money not used for eligible expenses incurred during the year be **forfeited**. This means you should put aside money only for those expenses you feel certain you will incur during the Plan year. (An expense is "incurred" on the date the service is provided—not when you pay for it.)
- Dependent Care FSA elections may be made during the plan year as well as an existing election can be changed during the plan year if your benefit needs are affected by a "change in family status".
- Health Care FSA elections may be made during the plan year as well as an existing election can be changed during the plan year if your benefit needs are affected by a "qualified family/employment status change".
- The accounts are completely separate, so you may not use deposits to your Health Care FSA to fund dependent care expenses, or Dependent Care FSA funds to pay health care expenses.

**What if I elect the wrong plan on accident?**

If the Plan Administrator determines that there has been an error, such as a clerical or administrative error or an election in which the participant is clearly unable to benefit, then the Plan Administrator may make an adjustment to correct such error. Such error must be based on clear and convincing evidence that a mistake was made. An example of a participant clearly being unable to benefit would be an election for dependent care when the participant has no dependents.

Any misstatement or other mistake of fact shall be corrected as soon as reasonably possible upon notification to the Plan Administrator, and any adjustment or correction attributable to such misstatement or mistake of fact shall be made by the Plan Administrator as he/she considers equitable and practicable."

**Claim questions**

If any portion of a claim is not paid, or if you do not understand or do not agree with the handling of a claim, there are several things that you can do to appeal the decision. Most of your questions can be answered quickly by either calling or writing the University (Plan Administrator).

If the University determines that all or part of your claim is not eligible for reimbursement, you will receive a notice that gives the following information:

- the specific reason for the denial
- a specific reference to the provision of the Plan on which the denial is based
- a description of any additional information that may be needed and the reason for it
- an explanation of the Plan's claim review procedure

If you believe that your claim has been processed incorrectly, you have 60 days following the receipt of the claim denial to file a petition for review with the University. You need to state in writing the specific reasons for which you believe you are entitled to different or greater benefits.

Within 60 days after the University receives your petition for review, the University will give you the opportunity to present your position orally or in writing. You will also have the opportunity to review pertinent documents. The University will notify you of the final decision within 60 days following the receipt of your specific request for review. If, because of special circumstances the 60-day period is not sufficient, the final decision may be extended for another 60 days at the election of the University. You will be informed at the onset of the extension if this becomes necessary.

Exhaustion of the claims and appeals procedures is mandatory for resolving every claim and dispute arising under this Plan. This means you must exhaust the available administrative remedies before you may bring an action in a court of law. Under this Plan, the plan participant or beneficiary must first seek one administrative review of an adverse claim decision. No such legal action may be brought more than three years after the date written proof of claim is required, unless other timeframes apply under law.

The Plan Administrator and all persons determining or reviewing claims have full discretion to determine benefit claims under the Plan. Any interpretation, determination or other action of such persons shall be final, conclusive and binding on all persons having an interest under the Plan, shall be given deference in the event the determination is subject to judicial review, and shall be overturned by a court of law only if it is arbitrary or capricious.

## Privacy and Security of Health Information

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in this section and the Plan's privacy notice. This Section shall apply to the Health Care FSA portion of this Plan.

**Definitions**

All terms not specifically defined in this Section shall have the meaning ascribed to them in the Privacy Rule and the Security Rule.

a) Breach Notification Rule: the regulations issued under HIPAA set forth in subpart D of 45 CFR Part 164.
b) Business Associate: a person or entity who performs services for the Plan involving the use or disclosure of individually identifiable health information, as defined in 45 CFR Section 160.103.
c) HIPAA: the Health Insurance Portability and Accountability Act of 1996, as amended.
d) Plan Participant: an individual who meets the eligibility requirements specified in the Plan.
e) Plan Sponsor: The Curators of the University of Missouri.
f) Privacy Rule and Security Rule: HIPAA's implementing regulations at 45 CFR Parts 160, 162, and 164.
g) Protected Health Information ("PHI"): individually identifiable health information as defined in 45 CFR Section 160.103.
h) Summary Health Information: information that summarizes the claims history, expenses, or types of claims by individuals for whom the Employer provides Benefits under the Plan, as such information is defined in the Privacy Rule.
i) Workforce Members: means UM System HR's employees, volunteers, trainees, students, and other persons whose conduct, in the performance of work for the Plan Sponsor, is under the direct control of Plan Sponsor, whether or not they are paid for that work by the UM System HR.

**Plan Sponsor's Certification of Compliance**

Neither the Plan nor any Business Associate servicing the Plan will disclose Plan Participants' PHI to the Plan Sponsor unless the Plan Sponsor certifies that the Plan Documents have been amended to incorporate this Section and agrees to abide by this Section.

**Purpose of Disclosure to Plan Sponsor**

a) The Plan and any health insurance issuer or Business Associate servicing the Plan will disclose Plan Participants' PHI to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions for the Plan not inconsistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing Regulations (45 CFR Parts 160-164). Any disclosure to and use by the Plan Sponsor of Plan Participants' PHI will be subject to and consistent with the provisions of this Section.
b) Neither the Plan nor any health insurance issuer or Business Associate servicing the Plan will disclose Plan Participants' PHI to the Plan Sponsor unless the disclosures are explained in the Notice of Privacy Practices distributed to the Plan Participants by the Plan.
c) Neither the Plan nor any health insurance issuer or Business Associate servicing the Plan will disclose Plan Participants' PHI to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
d) The Plan may disclose Summary Health Information to Plan Sponsor.

e) The Plan may disclose to Plan Sponsor information on whether an individual is participating in the Plan, or is enrolled or has disenrolled from a particular coverage option within the Plan.

**Restrictions on Plan Sponsor's Use and Disclosure of PHI**

a) The Plan Sponsor will neither use nor further disclose Plan Participants' PHI, except as permitted or required by the Plan Documents, as amended, or required by law.
b) The Plan Sponsor will ensure that any agent, including any subcontractor, to whom it provides Plan Participants' PHI agrees to the restrictions and conditions of the Plan Documents, including this Section, with respect to the Plan Participants' PHI.
c) The Plan Sponsor will not use or disclose PHI that is Genetic Information about an individual for underwriting purposes. The term "underwriting purposes" includes determining eligibility for Benefits, computation of premium or contribution amounts, or the creation, renewal, or replacement of a contract of health insurance.
d) The Plan Sponsor will not use or disclose Plan Participants' PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
e) The Plan Sponsor will comply with the requirements of the HITECH Act and its implementing regulations to provide notification to affected individuals, HHS, and the media (when required) if the Plan Sponsor or one of its Business Associates discovers a breach of unsecured PHI.
f) The Plan Sponsor will report to the Plan any use or disclosure of Plan Participants' PHI that is inconsistent with the uses and disclosures allowed under this Section promptly upon learning of such inconsistent use or disclosure.
g) The Plan Sponsor will consider requests by a Plan Participant to restrict uses and disclosures of the Participant's PHI to carry out treatment, payment, or health care operations, or restrict uses and disclosures to the Participant's family members, relatives, friends or other persons identified by the Participant who are involved in care or payment of care. Except as otherwise provided, the Plan Sponsor is not required to agree to the Plan Participant's request; however, if the Plan Sponsor does agree to the request, the request will be honored until the Plan Participant revokes it, or until the Plan Sponsor notifies the individual that the Plan Sponsor will no longer honor the request. The Plan Sponsor must comply with the restriction request if: (1) except as otherwise provided by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and is not for the purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the Health Care Provider involved has been paid out-of-pocket in full.
h) The Plan Sponsor will make PHI available to the Plan Participant who is the subject of the information in accordance with 45 CFR Section 164.524.
i) The Plan Sponsor will make Plan Participants' PHI available for amendment, and will on notice amend Plan Participants' PHI, in accordance with 45 CFR Section 164.526.
j) The Plan Sponsor will track disclosures it may make of Plan Participants' PHI so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 CFR Section 164.528 and the HITECH Act and its implementing regulations.

k) The Plan Sponsor will make available its internal practices, books and records, relating to its use and disclosure of Plan Participants' PHI, to the Plan and to the U.S. Department of Health and Human Services to determine compliance with 45 CFR Parts 160-164.

l) The Plan Sponsor will, if feasible, return or destroy all Plan Participant PHI, in whatever form or medium, including any electronic medium under the Plan Sponsor's custody or control, received from the Plan, including all copies of any data or compilations derived from and allowing identification of any Participant who is the subject of the PHI, and retain no copies of such information when the Plan Participants' PHI is no longer needed for the purpose for which the disclosure was made. If it is not feasible to return or destroy all Plan Participant PHI, the Plan Sponsor will limit the use or disclosure of any Plan Participant PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

**Adequate Separation Between the Plan Sponsor and the Plan**

a) The following classes of employees or other Workforce Members under the control of the Plan Sponsor may be given access to Plan Participants' PHI received from the Plan or a health insurance issuer or Business Associate servicing the Plan:
   1) any employee who serves as the Plan Administrator;
   2) any employee who serves as a Plan fiduciary; and
   3) any employee who performs functions related to the Plan, including but not limited to human resources, audit, legal, accounting and systems personnel.

   This list includes every class of employees or other Workforce Members under the control of the Plan Sponsor who may receive Plan Participants' PHI relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business.

b) The classes of employees or other Workforce Members identified in paragraph 5(a) of this Section will have access to Plan Participants' PHI only to perform the plan administration functions that the Plan Sponsor provides for the Plan.

c) The classes of employees or other Workforce Members identified in paragraph 5(a) of this Section will be subject to the Plan Sponsor's disciplinary policies and procedures up to and including termination of employment or affiliation with the Plan Sponsor, for any use or disclosure of Plan Participants' PHI in breach or violation of or noncompliance with the provisions of this Section to the Plan Documents. Plan Sponsor will promptly report any such breach, violation or noncompliance to the Plan, as required by paragraph 4(d) of this Section, and will cooperate with the Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any Plan Participant, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance.

**Disclosures by Others to the Plan Sponsor**

The Plan Sponsor shall be entitled to receive PHI from:

a) the Plan;
b) any Business Associate of the Plan;

c) any person or entity that contracts with such Business Associate;
d) any person or entity that contracts with the Plan Sponsor to provide services to or on behalf of the Plan;
e) any health insurer or health insurance issuer or HMO that provides health Benefits coverage or services to or on behalf of the Plan;
f) any health care clearinghouse that provides services to or on behalf of the Plan or with respect to Plan Participants; and
g) any other person or entity that maintains, or has the authority to direct the disclosure of, PHI related to any Plan Participant.

**Permitted and Required Uses and Disclosures of PHI**

a) Permitted Uses and Disclosures. The Plan Sponsor is and shall be entitled to use and disclose any PHI obtained pursuant to this Section only for the purposes of plan administration functions.
b) Required Uses and Disclosures of PHI. The Plan Sponsor shall be required to use and/or disclose PHI:
    1) to an individual, when requested under, and required by 45 CFR Section 164.524, in order to provide an individual with access to their own PHI;
    2) to an individual, when requested under, and required by 45 CFR Section 164.528, in order to provide an individual with an accounting of disclosures of that individual's PHI; and
    3) when required by the Secretary of the Department of Health and Human Services or those acting under the authority or at the direction of the Secretary to investigate or determine the Plan's compliance with the Privacy Rule, Security Rule, or Breach Notification Rule.

**Prohibited Uses and Disclosures of PHI**

The Plan Sponsor shall not be entitled to use or disclose PHI for any purpose for which use and disclosure is not expressly allowed under this Plan Document, including but not limited to:

a) using or disclosing PHI other than as permitted or required under this document or applicable law, or in a manner inconsistent with the Privacy Rule or Security Rule; and
b) taking adverse employment action against any Plan Participant who is an employee of Plan Sponsor, except with respect to any fraud or unlawful act related to the Plan and committed or reasonably suspected to have been committed by such person; and
c) using or disclosing PHI that is genetic information for underwriting purposes.

**Minimum Necessary**

When using or disclosing PHI or when requesting PHI from another party, the Plan Sponsor must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure, and limit any request for PHI to the minimum necessary to satisfy the purpose of the request.

**Security Provisions**

a) Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
b) Plan Sponsor will ensure that the adequate separation required by Section 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
c) Plan Sponsor will ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
d) Plan Sponsor will report to the Plan any security incident of which it becomes aware.

**Mitigation**

a) In the event of noncompliance with any of the provisions set forth in this Section, the HIPAA Privacy Officer or Security Officer, as appropriate, will address any complaint promptly and confidentially. The HIPAA Privacy Officer or Security Officer, as appropriate, first will investigate the complaint and document the investigative efforts and findings.
b) If PHI, including Electronic PHI, has been used or disclosed in violation of the Privacy Policy or inconsistent with this Section, the HIPAA Privacy Officer and/or the Security Officer, as appropriate, shall take immediate steps to mitigate any harm caused by the violation and to minimize the possibility that such a violation will recur.

**Breach Notification**

Following the discovery of a Breach of unsecured PHI, the Plan shall notify each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed as a result of a Breach, in accordance with 45 CFR § 164.404, and shall notify the Secretary of Health and Human Services in accordance with 45 CFR § 164.408. For a breach of unsecured PHI involving more than 500 residents of a State or jurisdiction, the Plan shall notify the media in accordance with 45 CFR § 164.406.

"Unsecured PHI" means PHI that is not secured through the use of a technology or methodology specified in regulations or other guidance issued by the Secretary of Health and Human Services.

## Other Information

**Contrary Representations**

No employee, officer or agent of the University, Plan Administrator, or Claim Administrator has the authority to alter, vary, or modify the terms of this Plan except by an authorized written amendment to the Plan. No verbal representations contrary to the terms of the Plan and its written amendments are binding on the Plan, Plan Administrator, or University. The terms contained within this Plan document control.

**Applicable Law**

The Plan shall be governed by the laws of the State of Missouri.

**No Funding**

This Plan is a considered an unfunded benefit plan. No individual shall acquire, by reason of this Plan, any right in or title to any assets, funds, or property of the University. No employee, officer or agent of the University guarantees payment of benefits under the Plan.

**No Employment Guarantee**

The establishment of this Plan and the granting of benefits under the Plan shall not give any employee or other person the right to continued employment with the University or limit the right of the University to dismiss or modify the terms of employment of a person.

**Right to Amend or Terminate Plan**

The University has the right, in its sole and absolute discretion, to amend, modify, or terminate, in whole or in part, any or all provisions of the Plan at any time and for any reason or no reason.