Flexible Spending Account Participant Handbook

Provided by
Aflac Benefit Services
for your Employer's Plan

Aflac™

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Welcome to Aflac Benefit Services!

We are dedicated to providing superior service to our customers and are delighted to serve as your cafeteria plan service provider. Our role is to process your Requests for Reimbursement according to the plan designed by your employer, who is the plan sponsor and plan administrator. All benefits are funded by your employer through your salary redirection. Flexible Spending Account (FSA) benefits are paid by your employer and not insured or paid by Aflac Benefit Services.

- There are two types of FSAs: The first is **unreimbursed medical (URM)** and the second is **dependent day care (DDC).**
- Your participation in an FSA program allows a portion of your salary to be redirected to provide reimbursement for these types of expenses.
- At the beginning of each plan year, you elect a specific dollar amount for each FSA you wish to participate in.
- Participation in one or both FSAs can save you money by reducing your taxable income. This is because taxes will be calculated after the elected amount is deducted from your salary.
- Your taxable income will be reduced for Social Security purposes; therefore, there may be a corresponding reduction in Social Security benefits.

Use of Personal Information

Your privacy is important to us. Aflac Benefit Services will follow applicable law with regard to the use and disclosure of your personal information. As set forth in your claim form, by enrolling in the FSA, you authorize us to use and disclose your personal information in connection with administering the plan and for other purposes permitted by law.

*Use discretion when faxing your medical information to us. You bear full responsibility for any inappropriate use or disclosure that may arise as a result of your transmission of information to Aflac Benefit Services.

Quick Tip 1
Requesting Services (toll-free)

For Inquires
1.877.353.9487
For Claim Forms
1.877.353.9487, Option 2
To Submit Claims by Fax*
1.877.353.9256

Quick Tip 2
Filing a Claim

Before submitting your claim, make sure you have had the service(s).

To File Your Claim

1. Complete a claim form, and be sure to sign and date it.

2. Attach a legible receipt(s) from the service provider or an EOB showing:
- **A description of the service or a list of supplies furnished.**
- **The charge(s) for each service.**
- **The date(s) of service.**
- **The name of the person(s) receiving the service.**

Please note: Your service provider's signature on the claim form can be substituted for a receipt.

Quick Tip 3
Redi-Flex® Convenient Direct Deposit

No Waiting in Line to Sign Up
1.877.353.9487

General Guidelines: URM

To be eligible for reimbursement, an expense must be for medical care.

Medical Care

- Medical care means diagnosis, cure, treatment, or prevention of disease.
- Medical care does not include cosmetic surgery or similar procedures. Cosmetic surgery means any procedure to improve your appearance. Procedure may also include medicines or drugs. A surgery or procedure necessary to correct a deformity resulting from a disfiguring disease, an accident, or trauma may be eligible.
- Expenses for medical care will be limited to expenses incurred primarily for the prevention or improvement of a physical or mental defect or illness. An expense that is merely beneficial to your general health is not an eligible expense.

Substantiation of Medical Care

If you submit a claim that contains an expense that is not clearly for medical care, the plan sponsor and/or Aflac Benefit Services may request additional information from you to substantiate that your expense is for medical care. You can normally provide substantiation by submitting a physician's statement of medical care. The physician's statement should contain the following information and may only be applied to the plan year in which it is used:

- Physician's name (The letter will need to be *from the prescribing physician,* not the caregiver, unless it is the same person.)
- Patient's name
- Specific medical condition for which treatment is prescribed
- Description of the treatment and how it treats the medical condition
- Length/frequency of the treatment program (if related)

Claims Incurred

Medical expenses reimbursed under a health FSA must be incurred during your coverage period. Expenses are incurred when you receive medical care and not when you are billed, charged for, or pay for them.

Dependent Care FSA or Dependent Care Tax Credit?

Before making an election, you should consult with your tax advisor to determine which of the available dependent care tax exemption programs will be the most beneficial to you. For more information, see IRS Publication 503 on the IRS' Web site at www.irs.gov.

General Guidelines: DDC

DDC expenses may be reimbursed for work-related expenses for any Qualifying Individual described below who resides with you:

- A dependent age 12 or under who entitles you to a personal tax exemption
- A spouse or other tax dependent who is physically or mentally unable to care for himself/herself

Expense Requirements

DDC expenses must meet all of the following conditions to be eligible for reimbursement:

- **Qualifying Individual:** Expenses must be incurred for a Qualifying Individual (see above).
- **Work-related:** Expenses must be incurred to allow you to work. If you are married, expenses must be incurred to allow you and your spouse to work unless your spouse is a full-time student or incapable of self-care.
- **Claims incurred:** Expenses must be incurred for services performed after the date of your DDC election and during your current plan year. An expense cannot be reimbursed until the service has been fully incurred (for example, if the service is a week of care, the expense cannot be reimbursed until that week's end).

Note: You may only be reimbursed up to the amount actually contributed to your DDC benefit account for the plan year less any prior reimbursements.

Eligible DDC Expenses for Qualifying Individual:

- **Care outside the home:** Expenses incurred for services outside of your household for the care of a dependent (for example, a baby sitter). If the dependent is age 13 or older, he/she must be disabled and spend at least eight hours per day in your home.
- **Dependent care center:** Expenses incurred for services provided by a dependent care center (i.e., a facility providing care for more than six individuals not residing at the facility).
- **Payments to relatives:** Expenses incurred for services provided by a relative who is not your dependent (even if he or she lives in your household). However, you may not claim any amounts paid to:
  - ❖ An individual for whom you or your spouse is entitled to receive a personal tax exemption as a dependent, or
  - ❖ Any of your children who are under age 19 at the end of the year in which the expenses were incurred (even if he or she is not your dependent).
- **Summer day camp:** Expenses incurred for a day camp that is primarily custodial in nature rather than educational. However, expenses for overnight camps are not considered work-related and are ineligible.

General IRS Rules & Information

The following rules apply to both DDC and URM FSAs.

Election Irrevocability

You may not make changes before the beginning of the next plan year unless there is a qualified change in status (as permitted by your plan) that affects eligibility.

Qualified changes in status may include:

- Change in employee's legal marital status
- Change in number of tax dependents
- Change in employment status that affects eligibility
- Dependent satisfies or ceases to satisfy eligibility requirements
- Change in residence that affects eligibility
- Judgment, decree, or court order dictating provision of coverage
- Entitlement to Medicare or Medicaid (URM only)
- Change in cost of the benefit (DDC only)
- Change in coverage: (DDC only)
  - Addition or elimination of benefit option
  - Change in coverage of spouse or dependent under his/her employer's plan
  - Significant curtailment of coverage

If a change in status occurs, you may make changes consistent with the qualifying event or as otherwise defined by your Plan Document. See your plan sponsor for further details about making changes.

Dollar Limits

DDC Account:

This reimbursement (when aggregated with all other dependent care reimbursements during the same calendar year) may not exceed the least of the following:

- $5,000, or
- $2,500, if married but filing separate tax returns, or
- Participant's Earned Income (after participant's pre-tax contributions have been deducted under the plan), or
- If married, the participant's spouse's Earned Income (after pre-tax contributions have been deducted)

URM Account:

Your plan sponsor determines the maximum benefit that may be elected. Please see your employer for the maximum benefit amount allowed under your plan.

No Transfer

You may not transfer money between your DDC and your URM FSA accounts.

Use-It-or-Lose-It Rule

Money remaining in your FSA account(s) will not be returned to you at the end of the plan year. Any amount remaining after the end of the runoff or grace period will be forfeited. Because of the use-it-or-lose-it rule, it is important for you to carefully estimate your out-of-pocket URM and DDC expenses for the upcoming plan year.

Termination of Employment

DDC Account:

If you have not received reimbursement for all contributions made to your DDC account upon your termination, you may continue to incur expenses during the plan year and submit claims for reimbursement. Generally, you may submit claims through the plan year and runoff period until all of your contributions are used.

URM Account:

When you terminate employment, your participation in the plan ends and you will no longer be able to incur expenses for reimbursement. Your salary redirections will end; however, you may still file claims for dates of service that were incurred before your termination as long as they are within your eligible plan year.

COBRA:

COBRA does not apply to DDC. However, COBRA may apply to your URM account and allow you to continue participation in your URM, thus allowing you to receive reimbursement for medical expenses incurred after your employment termination, if:

- The plan sponsor is subject to COBRA, and
- When you terminate employment and you have contributed more for URM than you have received in URM benefits.

Note: Under COBRA you must elect coverage within 60 days and continue to submit contributions to your employer to continue coverage under your URM account for the current plan year.

Other Rules

Additional rules apply. These rules are described in the Plan Document and the Summary Plan Description (SPD).

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Examples of Eligible Medical Care Expenses

The following lists are examples of the types of expenses that may or may not be reimbursed. These lists are not intended to be complete, as other expenses may also be eligible or ineligible under federal tax law or under your employer's plan. To be eligible under an FSA URM account, the medical expense(s) must be incurred for medical care that is not reimbursed from any other source. Medical care means the drug or service is needed to treat a medical condition. Aflac Benefit Services may request additional information from you to substantiate that an expense is for medical care.

Eligible

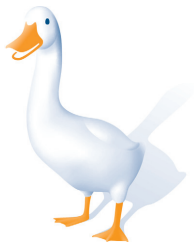
- Artificial limbs and reconstructive breast implants
- Counseling, if for medical care (psychological, psychotherapy, family counseling for patient only, etc.)
- Dental care, if for medical care (examinations, cleanings, fillings, crowns, bridges, etc.)
- Diabetic supplies (blood sugar monitor, syringes, test strips, etc.)
- Drugs, legally obtained by prescription (insulin or medicines)
- Drugs, over-the-counter, if for medical care
- Fertility enhancement (*in vitro* fertilization, reverse vasectomy, etc.)
- Guide/leader or hearing-assisting animal
- Hearing devices (hearing aids, hearing aid batteries, and repair, etc.)
- Insurance copayments and deductibles
- Nursing care
- Orthodontia
- Oxygen equipment
- Rental of medical equipment
- Service fees for medical care (consultations, diagnostic lab work, etc.) provided by physicians, surgeons, specialists, or other medical practitioners, including holistic and Christian Science practitioners
- Smoking cessation programs, aids, devices, and medications
- Support or corrective device (crutches, braces, etc.)
- Medically prescribed therapy treatments (must be *primarily* for individual's medical care)
- Vision care (eye exams, prescription eye glasses/contact lenses, or contact lens solution)
- Vision correction surgery (including RK and Lasik)
- Weight loss programs (physician-prescribed for a specific condition)

Ineligible

- Medical insurance premiums
- Counseling (nonmedically related) (anger management, behavior counseling, marriage counseling, etc.)
- Dietary supplements (including vitamins) that are merely beneficial to general health
- Drugs, prescribed or over-the-counter (*primarily* for personal, cosmetic, and/or for the benefit of the individual's general health)
- Elective cosmetic surgery/procedure
  - Anti-aging treatments (chemical peels, laser therapy, anti-aging drugs, etc.)
  - Breast implants (nonreconstructive)
  - Cosmetic dental veneers/teeth whitening
  - Electrolysis/hair transplants
  - Treatment for varicose veins or spider veins
- Funeral expenses
- Health club membership fees
- Household help
- Maternity clothing
- Toiletries and personal care items (shampoo, deodorant, soap, etc.)
- Weight loss foods that substitute for normal foods or nutritional needs

Quick Tip 4
Eligible Drugs & Medicines

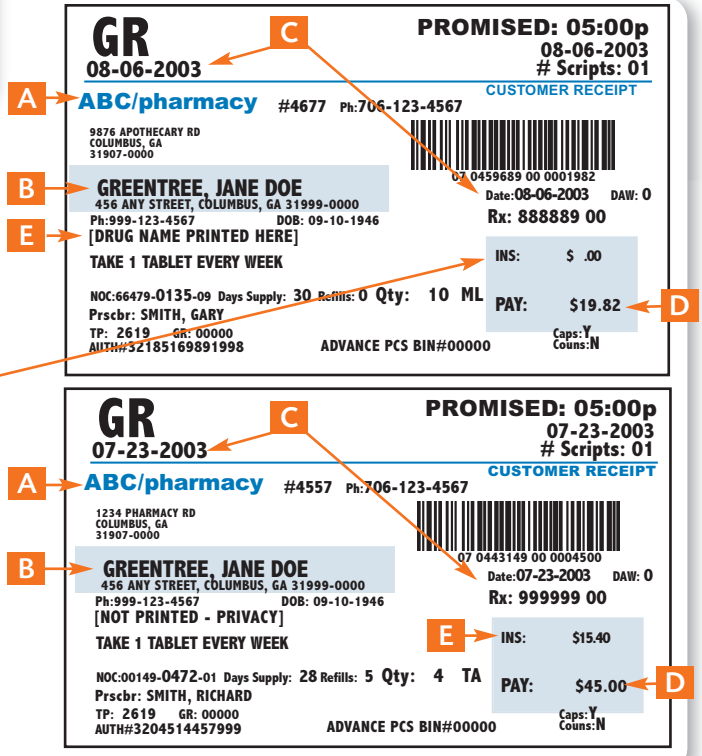
- **Over-the-counter drugs purchased for personal/cosmetic reasons or simply for good health do not qualify as eligible expenses. This includes drugs such as anti-aging treatments, vitamins, and nutritional supplements.**
- **Documentation must identify the name of the over-the-counter drug. Aflac Benefit Services may ask for substantiation showing the reason the drug was purchased. This occurs in situations where an over-the-counter drug could be taken for both general health and to treat a specific medical condition.**
- **Prescription drug receipts reflecting an insurance copayment or deductible will be considered eligible.**



Quick Tip 5
Acceptable Prescription Drug Receipts

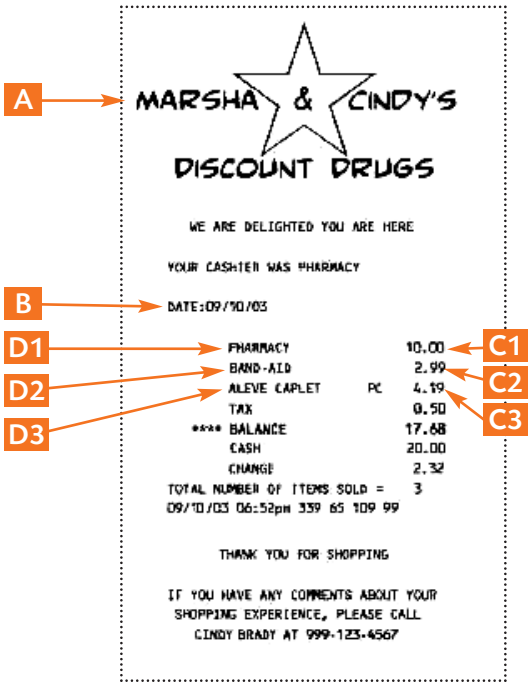
- **A** Provider Name
- **B** Patient Name
- **C** Date of Service
- **D** Expense Amount
- **E** Insurance Approval
  (Copay, Co-ins, Applied Deductible)
  and/or
  Prescription Drug Name

Note: Appearance of "Ins: $.00" does not meet Requirement E for Insurance Approval. However, since this receipt also includes the Drug Name, Requirement E is fulfilled and this is an acceptable receipt.



Quick Tip 6
Acceptable Over-the-Counter Medicine Receipt

- **A** Provider Name
- **B** Date of Service
- **C** Expense Amount
- **D** Drug Name
  (Drug name must be clearly indicated on register receipt.)

D1 not acceptable:

Pharmacy is not an acceptable description. If the expense was for a prescription drug purchase, please see examples for prescription drugs.