What is a health care flexible spending account?

A health care flexible spending account (FSA) is an employer-sponsored plan that allows you to set aside a portion of your income on a pre-tax basis and then use that money to pay for qualified out-of-pocket medical expenses.

What is the advantage of participating in a health care FSA?

Participating in a health care FSA can significantly reduce your taxes and increase your take-home pay by allowing you to use pre-tax dollars to pay for qualified medical expenses including co-pays and deductibles, prescriptions, and many over-the-counter drugs and items. A comprehensive list of eligible expenses is available online at https://www.conexis.com/solutions/expenses_EE.asp#health care.

What expenses are covered under a health care FSA?

Qualified expenses must be for out-of-pocket medical care provided to you, your spouse or dependent. Code §213(d)(1)(A) and (B) define medical care as amounts paid for:

- The diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body.
- Transportation primarily for and essential to medical care as defined above.

Typically, out-of-pocket expenses such as co-payments and deductibles under your major medical plan; prescription drugs; dental expenses, including exams and cleanings; vision expenses, including exams, contact lenses and supplies, and laser eye surgery are eligible under a health care FSA. A comprehensive list of eligible expenses is available online at https://www.conexis.com/solutions/expenses_EE.asp#health care.

Over-the-counter medications used to treat a specific medical condition, including antihistamines, allergy medications and cold medicine also are qualified expenses under your health care FSA. “Stockpiling” of over-the-counter medications is not permitted and expenses resulting from stockpiling are not reimbursable (i.e. there must be a reasonable expectation that such items can be used during the plan year).

Please note the following:

- Expenses reimbursed under your health care FSA may not be reimbursed under any other plan or program. Only your out-of-pocket expenses are eligible.
- Expenses must be incurred during the period of coverage. As outlined in Prop. Treas. Reg. § 1.125-2, Q/A-7(b)(6), "expenses are treated as having been incurred when the participant is provided with the medical care that gives rise to the medical expenses, and not when the participant is formally billed or charged for, or pays for the medical care." Therefore, the date of service must be within the current plan year.
- Expenses reimbursed under a health care FSA may not be used to claim any federal income tax deduction or credit.

What expenses are not covered under a health care FSA?

- Cosmetic surgery and procedures, including dental whitening
- Expenses for services rendered outside the coverage period
- Expenses reimbursed by an insurance provider or another health plan
- Herbs/Vitamins/Supplements/OTC medications used for general health
- Insurance premiums
- Family or marriage counseling
- Personal use items (e.g., toothpaste, shaving cream, cosmetics)
- Prescription drugs imported from another country

This list is not complete. A comprehensive list of eligible and ineligible expenses is available online at https://www.conexis.com/solutions/expenses_EE.asp#health care.

Are there any special rules associated with orthodontia expenses?

Services associated with orthodontia generally are provided over an extended period of time and often are impossible to match with actual costs. As a result, orthodontic expenses are processed differently than any other type of health care expense. The two reimbursement methods used for orthodontic expenses are as follows:

1. **Lump Sum Approach** – You may be reimbursed up front for all qualified expenses paid in the current plan year. Documentation must include treatment start date, anticipated treatment end date, proof of payment and a completed claim form. If payment for orthodontia is made in full, the full contract amount, not exceeding your annual election, will be reimbursed. To receive reimbursement for the full contract amount:

    a. Payment must be made within the applicable plan year.
    b. Proof of payment must be provided with your claim.

2. **Monthly Approach** – You may be reimbursed for the initial payment usually associated with banding fees. Thereafter, you may file a monthly claim for the monthly payment amount. Please note a treatment plan or itemized statement is required with the initial contract/banding claim. The documentation should include the amount of the initial down payment (usually associated with banding fees), the treatment start date and anticipated treatment end date. For ongoing monthly claims, an itemized statement or payment coupon from the provider and a signed claim form are required.

How much can I contribute to my health care FSA?

Your employer determines the maximum annual election amount for your plan. Refer to your enrollment materials or summary plan description for this information.

What amount is available for reimbursement at any particular time during the plan year?

Provided that your coverage is in force, your full annual election amount (reduced by the amount of any previous reimbursements received during the year) is available to you at any time during the plan year.

How often are reimbursements made?

Reimbursements are issued on a schedule chosen by your employer.

Where can I get a reimbursement request form?

Reimbursement request forms are available from the participant section of the CONEXIS Web site. You must first log in to your account to access these forms.

Is there a deadline for submitting claims?

Your plan may include a "run-out period" which is a pre-determined period after the end of a plan year during which you may file claims for expenses incurred during the plan year. After that period has expired, any unused dollars are forfeited. To verify the time limit for filing claims, please refer to your summary plan description.

How do I keep track of my account activity?

Your account information is available 24/7 from the participant section of our Web site. Additionally, each time a reimbursement is issued from your account you will receive an Explanation of Benefits (EOB) reflecting your current account balance. At the end of the plan year, CONEXIS will send you an annual statement with a complete summary of your account balance.

Can I change my election amount?

Your election is irrevocable for the plan year unless you have a change in status or other qualified event as defined in the IRS Regulations and your employer's plan permits such qualified changes. Qualified changes in status include:

- A change in marital status (such as marriage, divorce or death of your spouse)
- A change in the number of your dependents (such as birth or adoption of a child, or death of a dependent)
- A change in employment status of you, your spouse or dependent
- An event causing your dependent to satisfy or cease to satisfy an eligibility requirement for benefits
- A change in residence of you, your spouse or dependent

Your requested change must be on account of and consistent with the event. In general, the change in status must affect eligibility for the coverage. In other words, there are two parts to determining if a change in election should be permitted. First, you must experience a change in status or other qualified event. Second, your requested change must be consistent with the event. Please see your summary plan description for more information regarding other qualified changes, consistency requirements and exceptions that may apply.

Please Note: The information above is provided under the assumption that your employer's plan allows all changes permitted under the IRS Regulations. An employer may restrict mid-year election changes through plan design. Please see your summary plan description for specific rules governing your plan. If you experience a change in status or other qualified event, please contact your human resources or benefits representative to obtain the appropriate paperwork for completion.

What is the "use-it-or-lose-it" rule?

The "use-it-or-lose-it" rule is a provision in the IRS regulations that requires that all money contributed to your FSA must be used to reimburse qualified expenses incurred during that plan year. Money not used to reimburse eligible expenses is forfeited. The unused portion of your health care FSA may not be paid to you in cash or other benefits, including transferring money between FSAs. To reduce the risk of forfeiture, it is critical that you carefully estimate your expenses when choosing your annual election amount.

What happens if I terminate my employment?

If you terminate your employment during the plan year or you otherwise cease to be eligible under the plan, your active participation in the plan as well as your pre-tax contributions will end automatically. Expenses for services rendered after your termination date are not eligible for reimbursement.

Please Note: You may be entitled to elect COBRA continuation coverage under the health care FSA and receive reimbursement for qualified expenses incurred after your termination, provided you continue to make your required contributions on a post-tax basis. However, you generally do not have the right to elect COBRA continuation coverage if the cost of COBRA continuation coverage for the remainder of the plan year equals or exceeds your remaining account balance. Please see your summary plan description for specific rules governing your plan.