What is a health flexible spending account?
A health 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 FSA?
Participating in a health 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 qualified dental and vision services. A complete list of eligible expenses is available online at www.anthem.com.

What expenses are covered under a health FSA?
Qualified expenses must be for out-of-pocket medical care provided to you, your spouse or eligible 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 include (but are not limited to): co-pays 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 FSA. A complete list of eligible expenses is available online at www.anthem.com.

Please note: Per IRS rules:
- Expenses reimbursed under your health 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. § 1.125-6(a)(2), "expenses are incurred when the employee (or the employee’s spouse or dependents) is provided with the medical care that gives rise to the medical expenses, and not when the employee is formally billed, 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 FSA may not be used to claim any federal income tax deduction or credit.

Are over-the-counter medicines eligible for reimbursement?
As part of the changes introduced by the recent health care reform acts, beginning January 1, 2011, over-the-counter (OTC) medicines and drugs will no longer be eligible for reimbursement under your health FSA unless prescribed by a doctor (or another individual who can issue a prescription) in the state in which you purchase the OTC medicines. Any claim you submit for reimbursement that includes an OTC medicine expense incurred on or after January 1, 2011 must be accompanied by a Request for Reimbursement Form and appropriate supporting documentation, which must include one of the following:

- A written OTC prescription along with an itemized cash register receipt that includes the merchant name, name of the OTC medicine or drug, purchase date, and amount
- A printed pharmacy statement or receipt from a pharmacy that includes the patient’s name, the Rx number, the date the prescription was filled, and the amount

*If you are not enrolled in an Anthem medical plan, you will need to log on to your Reimbursement Benefit Account at www.benefitadminsolutions.com/anthem. You will need your Anthem Reimbursement Account Number or Social Security Number and Date of Birth to log-in to the Web site for the first time.

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Examples of reimbursable OTC medicines and drugs now requiring a prescription include (but are not limited to):

- Allergy and sinus: Actifed, Benadryl, Claritin, Sudafed
- Antacids: Mylanta, Pepcid AC, Prilosec, TUMS
- Aspirin and pain relievers: Advil, Excedrin, Motrin, Tylenol
- Cold and flu: Nyquil, Theraflu, Tylenol Cold & Flu
- Diaper rash ointments: Balmex, Desitin
- First aid creams, sprays, and ointments: Bactine, Neosporin
- Sleep aids: Sominex, Tylenol PM, Unisom Sleep Tabs

“Stockpiling” of OTC 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: Prescription medicines and insulin (including over-the-counter insulin) are not affected by this change. You can follow the same process when purchasing these items and submitting FSA claims.

**What over-the-counter items are still eligible expenses?**
The rules for over-the-counter items health care-related expenses have not changed. These items are still eligible for reimbursement through your health FSA. You may use your benefit card to purchase these items. Examples include (but are not limited to):

- Bandages, band-aids, and gauze
- Batteries (for hearing aids, blood glucose monitors, etc.)
- Diabetic supplies and test kits
- First aid kits
- High blood pressure monitors
- Thermometers

**What expenses are not covered under a health FSA?**
Ineligible expenses include:

- 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 used for general health
- Non-prescribed OTC medicines (except insulin)
- 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 complete list of eligible and ineligible expenses is available online at [www.anthem.com](http://www.anthem.com).

**Are there any special rules associated with orthodontia expenses?**
Generally, services associated with orthodontia are provided over an extended period of time and are often impossible to match with actual costs. As a result, orthodontic expenses are processed differently than any other type of health 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 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 through the Anthem Blue Cross and Blue Shield (Anthem) Web site. You must first log in to your account to access these forms.

**What do I need to submit in addition to a reimbursement form?**
You must retain copies of all itemized receipts and other documentation for each FSA-related transaction. We recommend you keep all documentation in a separate envelope at home or work.

Appropriate documentation includes:

- For office visits – Your health plan's Explanation of Benefits (EOB) statement or an itemized receipt or bill from the provider that includes the patient's name, a description of the service, the original date of service, and your portion of the charge.
- For prescription drug purchases – A pharmacy statement or printout from your pharmacy including the patient's name, the Rx number, the name of the drug, the date the prescription was filled, and the amount.
- For over-the-counter medicines – A written OTC prescription along with an itemized cash register receipt that includes the merchant name, name of the OTC medicine or drug, purchase date, and amount, OR a printed pharmacy statement or receipt from a pharmacy that includes the patient’s name, the Rx number, the date the prescription was filled, and the amount.
- For over-the-counter health care-related products – An itemized cash register receipt with the merchant name, name of the item/product, date, and amount.

In some cases, a letter of medical necessity from a medical practitioner may be required. Credit card receipts, canceled checks, and balance forward statements do not meet the requirements for acceptable documentation.
My plan offers a run-out period, 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.

My plan offers a grace period, is there a deadline for incurring claims?
Your plan may include a “grace period” extension. This feature creates a grace period that immediately follows the end of the plan year during which unused funds remaining in your health care FSA may be used to reimburse eligible expenses incurred during the grace period.

The grace period begins on the first day immediately following the last day of the plan year, and in most cases, ends two months and 15 days later. For example, if the plan year ends December 31, 2010, the grace period will begin January 1, 2011, and end March 15, 2011.

The grace period ensures that you have the opportunity to maximize the funds in your account and avoid forfeiting those funds through the “use-it-or-lose-it rule.” You should still carefully estimate your planned expenses based on a 12-month period and make a conservative election based on that estimate. Remember, the grace period is meant to help you when your expenses fall a little short of expectations; it is not an extension of the plan year that requires an increase in your election amount.

Please note: Not all FSA plans include a run-out period or grace period extension, and the time allotments are pre-determined by employers. For example, your employer may choose to shorten the grace period. To find out if your plan includes these features, and to verify the time limit for incurring and filing claims under your plan, please refer to your summary plan description.

Can I change my election amount?
Your election is irrevocable during 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 legal marital status (marriage, divorce or death of your spouse)
- A change in the number of your dependents (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. For example, if you have a baby, you could increase your FSA contribution. 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 FSA may not be paid to you in cash or other benefits, including transferring money between FSAs. To reduce the risk of losing money at the end of your plan year, 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 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.

How do I keep track of my account activity?
Your account information is available anytime day or night from the Anthem Web site. Simply log in to your personal account at www.anthem.com for real-time account information including account balance, claims status, and payment history.