



Flexible Spending Account Participant Resource Guide

PROVIDED BY AFLAC BENEFIT SERVICES
FOR YOUR EMPLOYER'S PLAN

WINGSPAN | Cafeteria Plans



WELCOME TO AFLAC BENEFIT SERVICES!

We are delighted to serve as your cafeteria plan service provider. Our role is to process your flexible spending account (FSA) claims according to the plan designed by your employer, who is the plan sponsor and plan administrator. FSA benefits are paid by your employer and not insured or paid by Aflac Benefit Services. All benefits are funded by your employer through your salary redirection.

- There are two types of FSAs:
 - 1 Unreimbursed Medical (URM)
 - 2 Dependent Day Care (DDC)
- Your participation in an FSA program allows a portion of your salary to be redirected to provide reimbursement for eligible FSA expenses.
- At the beginning of each plan year, you elect a specific dollar amount for each type of FSA you wish to participate in.
- Participation in one or both FSAs can save you money by reducing your taxable income. 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 reduction in future Social Security benefits.

GENERAL GUIDELINES: URM

To be eligible for reimbursement, an expense must be for medical care incurred during the period of coverage by you, your spouse, or your eligible dependents as defined by your plan. Generally, this means your dependent children or other qualifying relatives.

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; this may also include medicines or drugs prescribed by a physician. A surgery or procedure necessary to correct a deformity resulting from a disfiguring disease, 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

When you submit a claim for reimbursement, you will be required to make a statement that you have neither received nor will seek reimbursement elsewhere for the expense. 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.

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.

Quick Tip **1** *Filing a Claim*

Before submitting your claim, make sure the service(s) has been incurred.

1. Complete a claim form, and be sure to sign and date it.
2. Attach a legible receipt(s) or service statement showing:
 - Patient's name
 - Service provider's name

- Description of the service or a list of items received
- Charge(s) for each service or item
- Date(s) of service

Please note: Your service provider's signature on the claim form can be substituted for a receipt, but all service-related information must be completed on the form.

THE AFLAC NOW CARD® IS AN ELECTRONIC METHOD FOR ACCESSING YOUR MEDICAL FSA BENEFITS!

THE AFLAC NOW CARD® IS AN ELECTRONIC METHOD FOR ACCESSING YOUR MEDICAL FSA BENEFITS.

- It looks like a credit card and can be reused for up to three years. It is reloadable each year with your election; no new card is issued unless it is lost, stolen, or expired.
- When using the Aflac Now Card at self-service merchant terminals, select the credit option.
- The card will be accepted at the following health care providers:
 - Doctor's office
 - Dental provider
 - Pharmacy
 - Vision care provider
 - Hospital

Note: Your card may not work at discount stores and grocery store pharmacies.

- It works like a credit card, requires no PIN, and is activated upon first use.
- Benefits are deducted from your FSA account immediately at the point of sale or at the time of service.
- It can be used to pay for eligible medical, dental, or prescription expenses.
- You get 24-hour access to the card Web site at www.benefitspaymentsystem.com to obtain your balance for the current benefit year.
- The card does not eliminate the need for receipt substantiation. IRS regulations require that you retain documentation to substantiate expenses. If you need to provide receipts for after-the-fact review, you will be notified by mail.

HOW YOUR AFLAC NOW CARD WORKS

With your Aflac Now Card, transactions will be processed immediately at the point of sale or at the time of service. When the merchant uses an inventory information approved system (IIAS), transactions will automatically

be entered based upon the eligible FSA information contained in the merchant's system. When transactions are not automatically approved, you will be required to provide proof of service. A letter will be sent to you if additional information is required. **Save your receipts.** Keep all receipts and documentation related to your Aflac Now Card transactions.

SUBMITTING PROOF FOR AFLAC NOW CARD TRANSACTIONS

Complete a claim form and mark the Aflac Now Card box or submit the letter requesting additional information. Then attach a legible receipt(s) or an Explanation of Benefits showing:

- The patient's name,
- The service provider's name,
- A description of the service or a list of items purchased,
- The charge(s) for each service or item, and
- The date(s) of service.

Note: Credit card receipts typically do not have all information required. This may result in the denial of your transaction if no other form of acceptable proof is provided.

Fax claim form to: 1.877.353.9256

Mail claim form to: Aflac Benefit Services
1932 Wynnton Road, Columbus, GA 31999

To manage your account, view transactions, and check your balance, log on to www.benefitspaymentsystem.com.

POSSIBLE MISUSE OF THE CARD CAN RESULT IN TEMPORARY DEACTIVATION OF THE CARD:

- Not providing proof when requested
- Paying for ineligible nonmedical services
- Paying the balance on an account or bill received for service dates outside the current plan year

Quick Tip 2

Acceptable Prescription Drug Receipts

- A** Provider Name
- B** Patient Name
- C** Date of Service
- D** Expense Amount
- E** Insurance Approval
(Copayments, Coinsurance, 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.

This is a sample prescription drug receipt from ABC/pharmacy. It includes the following information:

- Header:** GR 10-06-2010, PROMISED: 05:00p, 10-06-2010, # Scripts: 01.
- Pharmacy Info:** 9876 APOTHECARY RD, COLUMBUS, GA 31907-0000, #4677, Ph: 706-123-4567.
- Patient Info:** GREENTREE, JANE DOE, 456 ANY STREET, COLUMBUS, GA 31999-0000, Ph: 999-123-4567, DOB: 09-10-1976.
- Prescription:** TAKE 1 TABLET EVERY WEEK, NDC: 66479-0135-09, Days Supply: 30, Refills: 0, Qty: 10 ML, Prscrib: SMITH, GARY, TP: 2619, GR: 00000, AUTHN: 32185168692008, ADVANCE PCS BIN#00000.
- Insurance:** INS: \$.00, PAY: \$19.82, Caps: Y, Coums: N.
- Barcode:** 01459889 00 0001982.

This is a sample prescription drug receipt from ABC/pharmacy. It includes the following information:

- Header:** GR 10-23-2010, PROMISED: 05:00p, 10-23-2010, # Scripts: 01.
- Pharmacy Info:** 1234 PHARMACY RD, COLUMBUS, GA 31907-0000, #4557, Ph: 706-123-4567.
- Patient Info:** GREENTREE, JANE DOE, 456 ANY STREET, COLUMBUS, GA 31999-0000, Ph: 999-123-4567, DOB: 09-10-1976.
- Prescription:** TAKE 1 TABLET EVERY WEEK, NDC: 00149-0472-01, Days Supply: 28, Refills: 5, Qty: 4 TA, Prscrib: SMITH, RICHARD, TP: 2619, GR: 00000, AUTHN: 3204514457999, ADVANCE PCS BIN#00000.
- Insurance:** INS: \$15.40, PAY: \$45.00, Caps: Y, Coums: N.
- Barcode:** 01443149 00 0001500.

EXAMPLES OF ELIGIBLE AND INELIGIBLE URM 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. Additional information may be requested from you to show that an expense is for medical care.

EXAMPLES OF ELIGIBLE MEDICAL EXPENSES

- Amounts applied to insurance copayments, coinsurance, or deductibles for services received within the coverage period
- Chiropractic care
- Dental care, if for medical care (e.g., exams, cleanings, fillings, root canals, bridges, and dentures)
- Diagnostic services (e.g., X-rays, MRIs, and cancer screenings)
- Hearing devices (e.g., hearing aids and hearing aid batteries)
- Lamaze birthing classes, for mother only
- Orthodontia (e.g., braces and retainers)
- Smoking cessation programs, aids, and products
- Vision care (e.g., eye exams, prescription glasses/contact lenses, and contact lens solution)
- Vision corrective surgery (e.g., LASIK, RK, and PRK)

OVER-THE-COUNTER (OTC) EXPENSES

(Medical Supplies, Drugs, and Medicines)

Effective January 1, 2011, all over-the counter medicines and drugs will require a physician's prescription to be eligible for reimbursement under unreimbursed medical (URM) spending accounts. This change is effective regardless of any grace period under the plan.

EXAMPLES OF POTENTIALLY ELIGIBLE EXPENSES (DUAL-PURPOSE SERVICES AND ITEMS)

Additional medical proof is required for all dual-purpose expenses. Dual-purpose expenses are items or services that can be used for medical or nonmedical reasons.

- Acne medications/treatments and Retin-A
- Crowns on multiple incisor teeth
- Massage therapy – must treat injury/trauma or related medical condition; when services are not performed by a chiropractor, medical proof will be required from the prescribing physician
- Snoring cessation aids
- Vitamins and supplements (excluding foods) prescribed to treat a specific medical condition or deficiency, for example:
 - Dietary supplements
 - Fiber supplements

- Glucosamine/chondroitin
- Herbal or holistic supplements
- Hormone supplements

- Weight loss/dietary supplements (excluding foods) needed to treat obesity or a related medical condition

Note: Submitting a physician's statement of medical care for an expense does not guarantee the expense's eligibility under the plan. Each claim is examined for eligibility under the plan based on the facts and circumstances specific to the claim. The physician's statement may only be applied to the plan year in which it is used.

You can normally provide proof 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
- Date of service, description of the treatment, and how it treats the medical condition
- Length/frequency of the treatment program (if related)

INELIGIBLE EXPENSES

Expenses prohibited from reimbursement or not for medical care:

- Medical insurance premiums
- Long-term care services for chronically ill individuals
- Counseling, when not for medical care (e.g., marriage counseling, anger management, behavioral counseling)
- Dietary supplements (including vitamins) taken for general health or well-being
- Drugs and medicines used for general health, well-being, or for personal or cosmetic reasons (e.g., Propecia, Botox, etc.)
- Elective cosmetic surgery/procedures
- Personal living expenses (e.g., food, clothing, furniture, mattresses, vacuums, hot tubs, etc.)
- Toiletries and personal care items (e.g., shampoo, deodorant, soap, toothbrushes, toothpaste, and skin moisturizers)
- Weight loss foods that substitute for normal foods or nutritional needs

GENERAL GUIDELINES: DDC

EXPENSE REQUIREMENTS

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

- **Qualifying Individual:** Expenses must be incurred for a qualifying individual. A *qualifying individual* is someone who resides with you for more than half the year and is:
 - An individual age 12 or under who entitles you to a personal tax exemption,* which usually means that such individual (1) does not provide over half of his/her own support and (2) is your child (son, daughter, grandchild, stepchild, brother, sister, niece, and nephew) or
 - A spouse or other tax dependent who is physically or mentally unable to care for himself/herself and spends at least eight hours per day in your home.

***Special rule for children of divorced parents:** A child of divorced or separated parents who resides with one or both parents for more than half the year and receives over half of his/her support from one or both parents may only be the qualifying individual of the custodial parent without regard to which parent claims the child on his or her tax return.

- **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. Expenses may also qualify if incurred while you or your spouse is unemployed but are actively looking for work.
- **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 requested is a week of care, the expense cannot be reimbursed until that week's end. Similarly, if the requested service is a full month, the reimbursement will not be issued until after the last day of the month has passed.

Please note: You may only be reimbursed up to the amount actually contributed to your DDC benefits account for the plan year, less any prior reimbursements. Eligible expenses in excess of this amount will be carried over and reimbursed as contributions accumulate.

ELIGIBLE DDC EXPENSES FOR QUALIFYING INDIVIDUAL

The following expenses are eligible for reimbursement from your DDC account so long as you neither receive nor seek reimbursement for such expenses from another source:

- **Care outside the home:** Expenses incurred for services outside of your household for the care of a dependent (i.e., a baby sitter).
- **Dependent care center:** Expenses incurred for services provided by a dependent care center (i.e., a facility that complies with all applicable state and local laws and regulations, and that provides care for more than six individuals who do not reside at the facility).
- **Payments to relatives:** Expenses incurred for services provided by a relative who is not your dependent (even if he/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;
 - Any of your children who are under age 19 at the end of the year in which the expenses were incurred even if he/she is not your dependent; or
 - Your spouse or the parent of the child for whom care is provided.
- **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.

Quick Tip 3

**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.

Quick Tip 4

Filing a DDC Claim

Before submitting your DDC expense request, make sure it is complete.

- DDC claims must be submitted on a Request for Reimbursement Form signed and dated by the DDC participant.
- All fields in the Dependent Care Claim Information section should be completed, including the dependent's age when the care was provided.
- All DDC expenses must be substantiated by the third-party dependent care provider. This can be done in one of two ways:
 1. Include a printed statement of services from the dependent care provider that includes:
 - Name of the dependent care provider
 - Name of the qualifying individual receiving care
 - Date(s) care was provided – must match the dates provided on the Request for Reimbursement Form
 - Amount charged for the services provided
 - OR-
 2. Have the provider complete and sign the Provider Information area within the Dependent Care Claim Information section.

Please note: When using the provider signature certification option, a new form should be completed and provider signature obtained for each subsequent service in order for the provider's certification to be deemed valid.

Quick Tip 5

Convenient Direct Deposit

Expedite reimbursement of your claims by using direct deposit.

- You only have to enroll once (remains active unless terminated upon your written request).
- There is no waiting on checks, no lost checks, and no waiting in long bank lines.

Sign up for direct deposit today! Just go to aflac.com and type "direct deposit" in the search box. Fill out the form, and fax or mail it in. It's that easy!

Direct Deposit Option for Flexible Spending Account Participants



Authorization Agreement for Direct Deposit

I authorize Aflac Benefit Services to initiate credit entries and, if errors occur, I authorize the correction of entries to my account as indicated. This authorization is to remain in force until I terminate it in writing.

Type of Account:

☐ Checking ☐ Savings

Bank Routing Number:

(This nine-digit number is usually found in the bottom left corner of your check.)

Bank Account Number:

(The exact location and number of digits varies from bank to bank, but this number is usually found in the bottom middle of your check.)

Financial Institution Information

- Name: _____
- City/State: _____

Employee Information

- Your Name: _____
- Employer: _____
- SSN: _____
- Employee Phone: _____
- Signature: _____

Signing up is easy ...

1. Complete and sign the Authorization.
2. Fax the signed form to (706) 317-0149 or mail it to:
Aflac Benefits Services
1932 Wynnton Road
Columbus, GA 31999-1131

After your claim is paid ...

- Mailed reimbursements can take 5 - 7 days to reach your home.
- Direct deposits take only 2 - 3 days to reach your bank.

Remember ...

- Allow approximately ten business days for direct deposit to become effective.
- Call your bank to verify that your payment has been deposited before making a withdrawal or writing a check.
- Notify Aflac Benefit Services immediately if you change financial institutions.

You can get claim status information or assistance by calling us toll-free at ...

1.877.353.9487

A90108B

GENERAL IRS RULES AND INFORMATION

THESE RULES APPLY TO BOTH URM AND DDC 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)
 - Change in provider
 - Change in DDC 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 Documents. See your plan sponsor for further details about making changes.

NO TRANSFER BETWEEN FSAS

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 to your employer. 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.

DOLLAR LIMITS

URM Account

Unreimbursed Medical Maximum Effective January 1, 2013, health FSA salary reductions are limited to \$2,500 per individual per calendar year. Check with your employer to determine the maximum for your plan.

DDC Account

This reimbursement (when totaled 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)

TERMINATION OF EMPLOYMENT

URM Account

When you terminate employment, your participation in the plan ends, and you will no longer be able to incur expenses for reimbursement from the URM account. 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.

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.

COBRA

COBRA does not apply to your DDC account. COBRA may apply to your URM account and allows 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, you have contributed more for URM than you have received in URM reimbursements.

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.

GRACE PERIOD

FSAs are not required to offer a grace period. Check with your employer to determine if a grace period applies to your FSA plan.

In some cases, your employer may have chosen to include an additional grace period for your URM and/or DDC benefits. This grace period provides a temporary extension of coverage that allows qualifying participants to continue to incur and submit eligible expenses under the FSA for a limited period of time beyond the end of the normal plan year, usually two months and 15 days, but check with your employer.

QUALIFYING FOR GRACE PERIOD

In order to take advantage of the grace period, you must be:

- A participant in the FSA on the last day of the plan year to which the grace period relates, or
- A qualified beneficiary who is receiving COBRA coverage under the URM on the last day of the plan year to which the grace period relates.

GRACE PERIOD CLAIMS AND OVERLAPPING COVERAGE PERIODS

If your plan offers a grace period and you qualify to take advantage of the grace period and also sign up for FSA benefits for the following plan year, there will be a time when your expenses may qualify under both FSA plan years. In these situations, the FSA plan will generally first reimburse the expense from any remaining benefits in the older plan year and then reimburse any remaining eligible amounts from the newer plan year. However, you may not be reimbursed for the expense twice.

***Please note:** Grace period expenses may be handled differently, depending on the plan's methods of reimbursement. If participating in an FSA plan with a grace period, please check to see how these claims will be handled by your plan.*

OTHER RULES

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

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 purposes permitted by law.

IMPORTANT NUMBERS

FOR IVR ASSISTANCE

1.877.353.9487

FOR CUSTOMER SERVICE

1.800.323.5391

FOR CLAIM FORMS

1.877.353.9487, Option 2

TO FAX* CLAIM FORMS

1.877.353.9256

FOR DIRECT DEPOSIT FORMS

1.877.353.9487, Option 2

Visit our Web site www.aflac.com or www.aflacny.com for claim forms or direct deposit forms.

For information on your Aflac Now Card® account, go to www.benefitspaymentsystem.com.

**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.*

WINGSPAN SM | Cafeteria Plans



We've got you under our wing.®