Flexible Spending Account (FSA) Informational Guide

GENERAL INFORMATION

WHAT IS A FLEXIBLE SPENDING ACCOUNT?

A Flexible Spending Account (FSA) is a tax-favored program that allows employees to pay for eligible out-of-pocket health care and dependent care expenses with pre-tax dollars. By using pre-tax dollars to pay for eligible health care and dependent care expenses, an FSA gives you an immediate discount on these expenses that equals the taxes you would otherwise pay on that money.

There are two types of FSAs – health care and dependent care.

- The Health Care Flexible Spending Account (HCFSA) – used to pay for qualified medical costs and health care expenses that are not paid by your Health Benefits plan or any other insurance.

- The Dependent Care (Day Care) Flexible Spending Account (DCFSA) – used to pay for eligible dependent care expenses such as child care for children under age 13 or day care for anyone who you claim as a dependent on your Federal tax return who is physically or mentally incapable of self-care so that you (and your spouse, if you are married) can work, look for work, or your spouse can attend school full-time.

The Air Force FSA Program includes a 2 ½ month grace period for both accounts. During the grace period, eligible expenses incurred from January 1st through March 15th of the following year can be applied towards your prior year's balance. You must be actively participating as of December 31st to be eligible for the grace period. The intent is to help account holders avoid forfeiting any of the funds they deposited in FSA accounts. It is important to carefully consider the amount you choose to elect. Refer to the FSA calculator at http://www.spendingaccounts.info/calculator.htm to estimate the amount that is right for you.

HOW CAN A HEALTH CARE (HCFSA) AND DEPENDENT CARE (DCFSA) HELP ME?

An FSA offers tax savings by allowing you to pay for out-of-pocket expenses with pre-tax money. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after federal (and often state and local) taxes are deducted.

WHAT IS THE MAXIMUM/MINIMUM AMOUNT I CAN ELECT ON MY HEALTH CARE (HCFSA)?

The maximum you can elect for a Benefit Period is $2,550 for HCFSA. The minimum is amount is $100.

WHAT IS THE MAXIMUM/MINIMUM AMOUNT I CAN ELECT ON MY DEPENDENT CARE (DCFSA)?

The maximum you can elect for a Benefit Period is $5,000 for DCFSA per household. The minimum is amount is $100.

HOW DOES A FSA WORK?

You first need to determine how much money you want to elect for your account(s) for the upcoming Benefit Period. The maximum you can elect for a Benefit Period is $5,000 per DCFSA account, and, $2,550 per HCFSA. However, the household limit for a DCFSA is $5,000 ($2,500 if you are married, but filing separately). The minimum annual amount you can elect is $100 per account.

Most people review their current year expenses, and take into account changes that will occur in the coming year when making their annual elections. However, you will also forfeit any monies you don’t use within the Benefit Period, so plan carefully.

Second, you actually enroll in the program.

Once you have decided on your annual election, you formally enroll in a HCFSA, a DCFSA, or a combination of, and you specify your annual election(s) — that is, how much money you want to have deducted from your pay and deposited into your account(s) for you to use during the upcoming Benefit Period.

ADP Benefit Services KY, Inc. is the Third Party Administrator that oversees the day-to-day administration. You can enroll online during Open Enrollment at https://AirforceNAF.adp.com or if you have questions you may contact the Air Force FSA Service Center, toll-free, at 1-844-842-1400, Monday through Friday, from 8:00 a.m. until 8:00 p.m., Central Time.

Next, your annual election(s) is deducted from your pay in allotments. After you make your election for the Benefit Period, ADP will deduct your annual election(s) in installments, called

deductions. The deductions are spread evenly over the number of pay dates remaining in the Benefit Period.

You are now ready to incur expenses and submit claims. You will pay for your out-of-pocket expenses upfront then submit your health and dependent care expenses to ADP for processing. You have several options for submitting claims: mail, fax and online. Refer to "How Do I Submit Claims" FAQ for details.

WHAT IS THE "USE OR LOSE" RULE?

Under IRS tax rules, you forfeit any money for which you did not incur an eligible expense under your FSA account(s) during the Benefit Period. This is known as the "use or lose" rule. When you contribute to an FSA, you agree to reduce your salary by a specified amount and your employer contributes that amount to an FSA for you. Since you never received that money, you can't be taxed on it. If you were to receive the unused amount at the end of the Benefit Period, the IRS would consider this "deferred compensation". Section 125 of the IRS Code prohibits deferred compensation, thus the "use or lose" rule. The "use or lose" rule is why you should plan carefully when making your annual FSA election. Also remember that reimbursement for expenses are generally based on when an expense is incurred, not when it is paid.

ENROLLMENT

WHEN IS OPEN ENROLLMENT?

Open Enrollment for the 2016 Benefit Period will be November 2nd – November 27th, 2015.

WHAT IF I DON'T ENROLL DURING OPEN ENROLLMENT?

You can only enroll outside of Open Enrollment if you experience a Qualifying Life Event (QLE). You may not change your election unless you have a QLE. Refer to the "What is a Qualifying Life Event" for more details.

WHO IS ELIGIBLE TO ENROLL?

Most Air Force NAF employees are eligible to enroll. You may refer to the Air Force NAF FSA Program Plan Document for specific details. In addition, after you enroll and by January 1st, you must provide your banking information for claim reimbursements. This is required to participate in the program. Simply log in to your secure, online account, select "Collect EFT" and provide and follow the instructions. Please note that reimbursements may be held until your banking information is provided.

CAN I CHANGE MY ELECTION OUTSIDE OF OPEN ENROLLMENT?

Yes, if you experience a Qualifying Life Event (QLE), you may change your election. A QLE is an event defined by the Internal Revenue Service in Section 125 that allows you to change your FSA election outside of Open Enrollment. These QLEs defined by the IRS include:

- Change in your legal marital status (i.e., marriage, legal separation, divorce, or death of your spouse)
- Change in employment status (for you, your spouse, or dependent) that affects eligibility for health insurance benefits
- Change in your number of tax dependents
- Birth or date you adopt a child, or placement for adoption
- Death of your spouse or dependent
- Change in your dependent's eligibility (for example, your child reaches age 13 where he/she is no longer eligible under a DCFSA)
- Change in your child care/elder care provider or cost or coverage, such as a significant cost increase charged by your current day care provider, or a change in your day care provider. This applies to a DCFSA only. It does NOT apply to a HCFSA.

Note: A dependent is anyone you claim on your federal income tax return or someone with whom you jointly file a federal income tax return.

If you or your dependents experience a QLE, you may enroll or change your current election(s) in the program; however, your requested change must be consistent with the event that prompted the election change. For example, if you adopt a baby, you may want to increase your HCFSA and/or DCFSA elections to accommodate the added medical expenses and/or day care costs you may incur for this adopted child. However, in general, you could not decrease your DCFSA elections for that QLE. You may wish to decrease your DCFSA, for example, if your spouse decided to stay home with your child and you no longer had eligible day care costs.

If your requested change is due to the birth or adoption of a child, the change will be retroactive to the child's date of birth, date of adoption, or placement for adoption, consistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Otherwise, your QLE will be effective the first day of the following pay period.

Additionally, you cannot reduce your HCFSA or DCFSA election(s) below the amount already reimbursed or already in your account.

QLEs can be submitted for approval through October 31st of each year. No changes for the current Benefit Period will be allowed from November 1st through December 31st.

WHEN WILL MY NEW HIRE ENROLLMENT BECOME EFFECTIVE?

If you enroll as a new hire during the 2016 Benefit Period your effective date will be the first day of the following pay period and continue through December 31st, or until you separate from service, whichever comes first. Enrollments can be submitted for approval through October 31st of each year. No changes for the current Benefit Period will be allowed from November 1st through December 31st.

Only expenses incurred on or after your effective date through the end of the Benefit Period, or your last day of service, are eligible for reimbursement.

CLAIMS ADMINISTRATION

WHAT IS THE AIR FORCE NAF BENEFIT PERIOD?

The first Benefit Period runs from January 1st, 2016 – March 15th, 2017. This includes a 2 ½ month grace period from January 1st through March 15th of the following year for all accounts. During the grace period, eligible expenses incurred from January 1st through March 15th of the following year can be applied towards your prior year's balance. You must be actively participating as of December 31st to be eligible for the grace period. If you enroll during Open Enrollment, your effective date will be January 1st, 2016.

HOW DOES THE GRACE PERIOD WORK?

First, you must have a remaining balance as of December 31st. If you do not have a balance, the grace period will have no effect on your account.

Secondly, you must be actively participating as of December 31st to be eligible for the grace period.

If you have a balance as of December 31st and you incur eligible expenses during the grace period (January 1st thru March 15th), simply submit those expenses in the same manner as you normally would. Your claims will automatically be paid from the appropriate year. If you have a remaining balance in your prior year account and you submit eligible grace period claims before the claims deadline of March 31st, the claims will be applied towards your prior year account until it is depleted.

After your prior year account is depleted, claims will process from the current year account. For example, if you happen to find claims with 2016 dates of service, after you have depleted your 2016 account balance, you can still submit those. The system will automatically adjust both of your accounts to ensure you do not lose money.

Below are two scenarios to help you understand how the Grace Period works.

Example: Let's say you have a remaining FSA balance of $100 as of December 31st, 2016 and have re-enrolled for a 2017 FSA account.

- You incur $100 in expenses on February 1st, 2017 and submit a claim before the March 31st, 2017 claim submission deadline. Your claim will be paid from the prior year account taking your 2016 account balance to zero.

- Since submitting the claim above, you find an additional expense from March 1st, 2016 totaling $60. You submit this claim before the March 31st, 2017 deadline.
    - ADP will adjust your account balances to allow the $60 claim to be paid from your prior year account.
    - That same amount ($60) from the original $100 claim will be applied to your 2017 account.

WHEN ARE EXPENSES ELIGIBLE?

Expense eligibility is determined by your effective date in the plan. If you enroll during Open Enrollment, your effective date will be January 1st of the following year. For enrollments outside of Open Enrollment (i.e. QLEs or new hires), your effective date will be the first day of the following pay period. Expenses incurred from your effective date in the plan through March 15th of the following year are eligible to be considered for reimbursement. Please note eligibility for expenses is generally based on when an expense is incurred, not when it is paid.

HOW DO I SUBMIT MY CLAIMS?

There are several ways to submit claims for reimbursement:

- Online Claim Submission – To submit online claims, you will log into your secure, online account by clicking "Reimbursement Accounts" and "Online Claim Submission". You must upload an image of your supporting documentation in PDF, .TIF or .JPEG with your claim information.
- Toll-free Fax: 1-866-376-7415
- Mail: PO Box 34700, Louisville, KY 40232

When you fax your claim, you can receive confirmation by email that your claim has been received. To take advantage of this free, convenient service, include your email address during the enrollment process when prompted and/or include your email address on the claim form when submitting your information for reimbursement. If your claim is received prior to 3:00 p.m. Central Time on any given business day, you will receive your confirmation email on the same day ADP receives your claim. If your claim is received after 3:00 p.m. Central Time, your confirmation email will be sent on the following business day. Please note during high claims volume periods it may take up to 48 hours to receive your confirmation email.

WHAT IS REQUIRED FOR MY CLAIM TO BE REIMBURSED?

For a manually submitted claim, you must file a claim form with ADP to be reimbursed for an eligible expense. The claims forms are available at the Air Force FSA Service Center web site at https://AirforceNAF.adp.com. Note: you must accrue a minimum reimbursement of $10 before funds will be released.

With your completed claim form, you must submit one of the two items below to document your claim:

- **Explanation of Benefits Statement (EOB)** – This is the statement that you typically receive each time that you, or a health care provider, submit a claim for payment to your health, dental, or vision care plan. The EOB shows the expenses paid by the plan and the amount you must pay. For expenses that are partially covered by your health care plan, your spouse's, or other dependent's, you must attach the EOB.

- **Supporting Documentation** – For expenses that are not covered at all by you, your spouse's or other dependent's health care plans, or that you elect not to submit to your plan or any other insurance you may have, you must sign the claim form verifying that the expense is not covered and/or has not been reimbursed by Aetna or any other insurance. Claims will not be processed without supporting documentation of your expenses. A cancelled check alone is not acceptable. An EOB is the preferred documentation type as it contains all information necessary to process your claim.

  Supporting documentation includes detailed receipts or an itemized statement which contains the following information:

  - Type of service or name of product purchased
  - Date expense was incurred
  - Your name or your dependent's name for whom the service/product was provided
  - Person or organization providing the service/product
  - Amount of the expense

IMPORTANT NOTE: ADP cannot reimburse you for any type of expense until the actual service is incurred. This means you should submit your expenses only after the dates of service have passed. If you submit them before the dates of service have passed, ADP will deny your claim and you will need to resubmit. This is also true for the signature date on the claim. If your signature date is **before** the dates of service submitted on the claim, it will be denied because you cannot validate an expense before it's actually provided.

If your receipt does not clearly show the name of the product, you will need to submit copies of the front of the box/container for over-the-counter (OTC) products (which are not medicines or

drugs) with your claim form. Copies of the packaging, as well as your receipt are required for all OTC medicines or drugs.

Please note: All OTC medicines or drugs (excluding insulin) will require a physician's prescription in order to be considered for reimbursement.

It should take 5 to 7 business days from the time ADP receives your claim until it is processed and another 2 to 3 days until the funds reach your bank via Electronic Funds Transfer (EFT). As a reminder, if you do not have EFT set up, reimbursement will be held until this has been completed. You can update your EFT information at any time at https://AirforceNAF.adp.com through your secure online account.

WHAT EXPENSES ARE ELIGIBLE FOR REIMBURSEMENT?

Many of your typical out-of-pocket health care expenses may be reimbursed by a HCFSA. Some common reimbursable expenses not covered by most plans are listed below. All of these items meet IRS criteria for a covered medical expense. For more complete listings of eligible medical expenses, please refer to the Eligible Expense Guide, and IRS Publication 502. You may also contact the Air Force FSA Service Center at 1-844-842-1400, Monday through Friday, from 8:00 a.m. until 8:00 p.m., Central Time.

- Chiropractic services
- Co-insurance, co-pay amounts and deductibles
- Contact lenses and cleaning solutions
- Dental care and procedures not covered under another plan (including crowns, endodontic services, implants, oral surgery, periodontal services and sealants)
- Eye surgery not covered under another plan (cataract, LASIK, corneal rings, radial keratotomy, etc.)
- Eyeglasses not covered under another plan (including prescription sunglasses and over-the-counter reading glasses)
- Hearing aids and batteries
- Infertility treatments
- Orthodontia not covered under another plan
- Over-the-counter (OTC) items (including sunscreen, bandages and contact lens solution)
- Over-the-counter (OTC) medicines and drugs (including antacids, allergy medicines, cold medicines and pain relievers) when accompanied by a prescription. Please note: All OTC medicines/drugs (excluding insulin) will require a physician's prescription in order to be considered for reimbursement.

WHAT EXPENSES ARE ELIGIBLE FOR REIMBURSMENT ONLY IF MEDICALLY NECESSARY?

Some expenses are eligible for reimbursement only when a doctor or other licensed health care practitioner certifies that they are medically necessary. Your doctor’s certification must indicate your specific medical disorder, the specific treatment needed, how this treatment will alleviate your medical condition, and the length of treatment required. Examples include:

- Air conditioners, central air, heaters, and humidifiers installed in your home for allergy relief
- Cosmetic surgery following an accident, disease or other surgery
- Home Medical Equipment (e.g., reclining chairs, bed boards, special mattress)
- Hydrotherapy
- Water fluoridation units
- Weight loss program for treatment of a specific disease (e.g., heart disease), not including cost of food
- Wigs for hair loss due to chemotherapy or radiation treatment

A Letter of Medical Necessity (LMN) form is available for you and your health care provider to use. A personal letter from your provider will also suffice as long as it includes all the information necessary to determine medical necessity. Please note: if the treatment extends beyond the time period listed, you need to submit a new certification/physician letter covering the new time period. You must also submit a new LMN each year that you participate - the length of time cannot be indefinite. If the letter or note does not contain all of the information listed below, your letter may be denied.

- Date
- Employee Name
- Patient Name
- Diagnosis (specific medical condition or disorder)
- CPT Code assigned to your diagnosis
- Specific treatment prescribed by the provider
- How the treatment will alleviate the condition
- Duration of the treatment
- Provider signature, license number, state and telephone number

WHAT EXPENSES ARE NOT ELIGIBLE FOR REIMBURSEMENT?

The following is a list of common medical expenses not eligible for reimbursement. For more complete listings of eligible medical expenses, please refer to the Eligible Expense Guide, and IRS Publication 502. You may also contact the Air Force FSA Service Center at 1-844-842-1400, Monday through Friday, from 8:00 a.m. until 8:00 p.m., Central Time.

- Insurance premiums, including those for health insurance, dental and/or vision insurance, life insurance, long-term care insurance, and Temporary Continuation of Coverage.
- Cosmetic surgery or procedures
- Exercise and fitness programs for general health, including health club membership dues*
- Expenses that have been reimbursed elsewhere
- Expenses not incurred during your period of coverage
- Fees paid to a health care provider in advance of services being rendered (this includes health maintenance fees but excludes braces)
- Personal use items (items ordinarily used for personal, living or family purposes such as household disinfectants)

- Physician charges for services that are not direct medical care, such as monthly fees for guaranteed access and quicker appointments (so-called "boutique practice or pre-paid physician fees")

  * Fees paid for a fitness program may be an eligible expense if prescribed by a physician and substantiated by his or her statement or Letter of Medical Necessity that treatment is necessary to alleviate a medical problem.

HOW LONG AFTER THE END OF THE BENEFIT PERIOD DO I HAVE TO SUBMIT MY CLAIMS?

You have until March 31st of the following year to submit claims for expenses incurred during the Benefit Period. Your claim must either be postmarked or faxed by 11p.m. Central Time on March 31st.

Claim Processing Examples:

1. You choose to enroll in both a HCFSA and DCFSA for the 2016 Benefit Period and are set to retire on July 1st, 2016. You may only submit claims for health care expenses which are incurred prior to the July 1st, 2016 separation date, but you can continue to incur dependent care expenses through December 31st, 2016 or until the balance is depleted. Note: you will not be eligible for the grace period under the DCFSA.

2. You enroll in Air Force NAF program on February 1st, 2016 and elect to participate in a HCFSA. Your effective date would be February 11th. You cannot receive reimbursement for any eligible expense prior to your effective date, but you may submit claims for expenses purchased after that date.

3. You elect bi-weekly DCFSA deductions of $400 and pay your day care provider $500 every two weeks. At the time you submit a claim, you will have $400 in your account. ADP will process the claim and reimburse $400. When the next deduction is received, ADP will release the additional $100 without you having to complete an additional claim form.

4. You elect $2,000 for HCFSA for the Benefit Period. On January 15th, your spouse incurred $1,000 in dental expenses. Although you have not yet contributed $1,000 into your health care account (as of January 15th), you can still receive a reimbursement for $1,000.

5. Let's say you elected $1,300 for the Benefit Period to be deducted over 26 pay periods, resulting in a per pay date deduction of $50. Then, your payroll provider fails to withhold your scheduled deduction on pay period 9 ($400 already deducted). That leaves $900 of the $1,300 to be deducted from your pay for the rest of the year. ADP would recalculate your deduction by spreading the remaining $900 over the remaining 17 pay periods. Your "new" allotment would be $52.94 per pay period so that your account is funded in full by the last payday of the year.

APPEAL PROCESS

You have the right to appeal any denial that involves your Health Care and/or Dependent Care Flexible Spending Account, including items such as:

- A claim or request for reimbursement that is not paid in full
- A product or service determined to be ineligible that you believe is eligible
- Your request to change your election due to a Qualifying Life Event (QLE) that is not approved

If you disagree with the decision, or do not understand why your claim for reimbursement was denied in part, or in full, you may contact a Benefit Counselor to request a more detailed explanation. The Air Force FSA Service Center is open Monday through Friday, 8:00 am – 8:00 pm, Central Time. You may contact us toll-free at 1-844-842-1400, or via email at AirForceNAF@adp.com.

ADP will respond within 30 days of receipt of the appeal across all levels.

First Level Appeal

If you are still not satisfied with the decision, you may request a formal appeal in writing for reconsideration within 30 calendar days of the denial. Include in your appeal request:

- An explanation as to why you disagree with the denial based on specific provisions outlined in the Frequently Asked Questions, Internal Revenue Service regulations that govern all pre-tax benefit programs, or other written documentation.
- Copies of documents that support your claim, such as a physician's letter of medical necessity, Explanation of Benefit (EOB) from Aetna or detailed bills from your provider. At your discretion, you can also submit information such as operative reports, medical records, or other medical information that supports your claim.

Second Level Appeal

If you do not agree with the decision to uphold the denial through the first level appeal, you may file a second level appeal for reconsideration, in writing, within 30 days of the first level appeal decision. Your appeal will be reviewed again to ensure that it was handled properly.

Third Level Appeal

If you do not agree with the decision to uphold the denial through the second level appeal, you may file a third level appeal for reconsideration, in writing. This must be sent within 30 days of the second level appeal denial. Your appeal will be reviewed by the Air Force NAFI for a final decision. Please note the third level appeal is final and binding on all parties and cannot be reviewed further.