

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.empireblue.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.empireblue.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 Empire medical plan, you will need to enter your Social Security Number and Date of Birth on the Empire Web site to register.

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: Somnex, 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.empireblue.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 Empire BlueCross BlueShield (Empire) 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 Empire Web site. Simply log in to your personal account at www.empireblue.com for real-time account information including account balance, claims status, and payment history.

What is a dependent care flexible spending account?

A dependent 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 eligible, employment-related dependent care expenses incurred for a qualifying individual.

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

Participating in a dependent 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 dependent care expenses including childcare, after school care and day camp. A comprehensive list of eligible expenses is available online at www.empireblue.com.*

Who is a qualifying individual?

A qualifying individual is:

- Your dependent child under the age of 13 who lives with you for more than half the year.
- Your spouse or other qualifying dependent that is physically or mentally incapable of self-care and lives with you for more than half the year.

What if I am divorced?

If you are divorced and you are the custodial parent, your child is a qualifying individual even if you do not claim the child as a tax dependent. A divorced, non-custodial parent cannot be reimbursed under a dependent care FSA, even if the divorced, non-custodial parent claims the child as a tax dependent.

What constitutes an "employment-related" expense?

To be eligible for reimbursement under your dependent care FSA, an expense must be incurred to enable you (and your spouse, if married) to work or look for work. For this purpose, "work" may include actively looking for work but does not include unpaid volunteer work or volunteer work for a nominal salary. Your spouse is considered to have worked if he or she is a full-time student for at least five calendar months during the tax year or if he or she is physically or mentally incapable of self-care.

Expenses you pay for dependent care while you are off work due to illness generally are not eligible for reimbursement. However, temporary absences from work may be disregarded if you are required to pay for dependent care expenses during the absence. Whether an absence is short and temporary depends on the facts and circumstances of the situation; however, IRS regulations stipulate that an absence of up to two consecutive weeks due to illness or vacation is a short-term or temporary absence.

What if I work part-time?

In general, if you work part-time you must allocate expenses between days worked and days not worked. However, if you work part-time but are required to pay for dependent care expenses on a periodic basis (including non-working days), you do not have to allocate expenses between days worked and days not worked. These two scenarios are illustrated in the following examples.

Allocation Required. You work three days a week and have voluntarily placed your child in day care five days a week so you may remain gainfully employed. Your cost for the childcare is \$50 per day and \$250 for the week. Because you work part-time and are not required to pay the full \$250 expense, you must allocate your expenses according to your days worked. In this case, your allocated expenses equal \$150 (\$50 per day for the three days worked).

Allocation Not Required. The facts are the same as above, but in this scenario your dependent care provider requires that you pay the full \$250 fee regardless of the number of days that care is actually provided. In this case, the full \$250 expense may be considered an employment-related expense and allocation of the expense based on days work is not required.

What expenses are covered under a dependent care FSA?

A dependent care FSA covers qualified dependent care expenses incurred for the care of one or more qualifying individuals as described above. Typical eligible expenses include:

- Before school and after school care
- Expenses for preschool/nursery school
- Extended day programs
- Au pair services (amounts paid for the actual care of the dependent)
- Babysitter (in or out of the home)
- Nanny services (amounts paid for the actual care of the dependent)
- Summer day camp for your qualifying child under the age of 13
- Elder day care expenses of a qualifying individual

This list is not complete. You may view a comprehensive list of eligible expenses online at www.empireblue.com.

What expenses are not covered under a dependent care FSA?

Ineligible expenses include the following:

- Amounts paid to your spouse, your child under age 19, a parent of your child who is not your spouse or an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent
- Expenses attributable to a disabled spouse or tax dependent living outside your household
- Educational expenses
- Tuition for kindergarten and above
- Food expenses (unless inseparable from care)
- Incidental expenses (e.g., extra charges for special events or activities unless inseparable from care)
- Overnight camp

This list is not complete. You may view a comprehensive list of eligible and ineligible expenses online at www.empireblue.com.

How much can I contribute to my dependent care FSA?

Your election may not exceed the maximum amount specified in Section 129 of the Internal Revenue Code. Currently, the maximum annual amount is \$5,000 per year (\$2,500 if you are married and file separate returns).

Although the general annual maximum is currently set at \$5,000, your maximum annual contribution amount may not exceed the earned income limitation. If you are single, the earned income limitation is your salary (excluding your contributions to the dependent care FSA plan). If you are married, the earned income limitation is the lesser of your salary (excluding your contributions to the dependent care FSA plan) or your spouse's salary.

My spouse also participates in a dependent care FSA. Can we both elect up to \$5,000?

No. If you are married and file a joint tax return, your combined maximum election amount is \$5,000. The maximum amount available to you if you are married but filing separate returns is \$2,500. Expenses reimbursed under your dependent care FSA may not be reimbursed under your spouse's dependent care FSA and vice versa (i.e. no “double-dipping”).

Is tuition an eligible dependent care expense?

No. Fees associated with tuition for kindergarten or children in first grade and above are not eligible for reimbursement under a dependent care FSA. However, expenses related to before school care, after school care and nursery school expenses are eligible if the care is primarily custodial in nature.

I pay my neighbor to watch my 13-year-old after school. Is this an eligible expense?

No. To be an eligible expense, the care must be provided to a qualifying individual. A child age 13 or above is not a qualifying individual.

My 16-year-old daughter cares for my 8-year-old son after school. Can I pay my daughter and be reimbursed for those expenses through my dependent care FSA?

No. You may not be reimbursed for payments made to a dependent for which you (or your spouse) can claim an exemption or for payments made to your child who is under age 19 at the end of the year.

If I participate in the dependent care FSA plan, do I need to report anything on my personal income tax return at the end of the year?

Yes. You must identify all persons or organizations that provide care for your child or dependent by filing IRS Form 2441 - Child and Dependent Care Expenses, along with your Form 1040 each year (or Schedule 2 for Form 1040A). Please note that filing requirements are subject to change by the IRS. Consult your tax advisor for more information.

If I participate in the dependent care FSA, will I still be able to claim the household and dependent care credit on my federal income tax return?

No. You may not claim any other tax benefit for the tax-free amounts received by you under the dependent care FSA, even though the balance of your eligible, employment-related dependent care expenses (if any) may be eligible for the dependent care credit. In limited situations, it may be to your benefit to take advantage of the tax credit rather than participate in the dependent care FSA. Consult your tax advisor for more information.

I elected to contribute \$400 per month into my dependent care FSA. My actual expenses are closer to \$500 per month. Should I submit my claim form for \$400 or for \$500?

You should file your claim for the actual amount of the expense (in this case, \$500). The maximum reimbursement you may receive is equal to the current account balance in your dependent care FSA. If your request for reimbursement exceeds the available balance in your dependent care FSA, the remaining amount will be placed in pending status and paid when additional contributions are posted to your account.

What if my eligible dependent care expenses during the plan year are less than the annual amount I have elected?

All money contributed to your dependent care 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 dependent 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 for you to be conservative when choosing your annual election amount. Our online savings calculator can help you estimate your annual expenses.

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 on the employee section of the Empire BlueCross (Empire) 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?

If the employee and provider certifications on the reimbursement request form are completed and signed, no additional documentation is required. If the provider certification is not completed and signed, you must submit an itemized statement from your provider including the date(s) of service, the name(s) and date(s) of birth of your dependent(s), an itemization of charges and the provider's name, address and Tax ID/SSN number.

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 and/or dependent 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 ends two months and fifteen days later.¹ For example, if the plan year ends December 31, 2009, the grace period will begin January 1, 2010, and end March 15, 2010.

The grace period ensures that you have the opportunity to maximize the funds in your account and avoid forfeiture of 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.

Not all plans include a run-out period or grace period extension. To determine if your plan includes these features, and to verify the time limit for filing claims under your plan, please refer to your summary plan description.

What if I decide to change the amount I elected?

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 (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 that causes 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. With respect to your dependent care FSA, you may change or terminate your election only if:

¹ In some instances your employer may choose to shorten the grace period. Please refer to your summary plan description for specific rules governing your plan.

- Such a change or termination is on account of, and corresponds with, a change in status that affects eligibility for coverage under the Plan.
- Your election change is on account of, and corresponds with, a change in status that affects the eligibility of dependent care assistance expenses for the available tax exclusion.

You may also change your dependent care FSA election when an independent, third-party provider (other than a relative) significantly increases or decreases the cost of dependent care or when there is a coverage change (e.g., a change in providers).

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 which 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 dependent 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.

In limited scenarios, your dependent care FSA plan may include a "spend-down" provision that allows you to submit dependent care expenses incurred after your termination, assuming you continue to meet all other participation requirements. This feature is not available in all plans. 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 24/7 from the employee section of our Web site. Simply log in to your account and you have access to real-time account information including account balance, claims status, and payment history.

**If you are not enrolled in an Empire medical plan, you will need to enter your Social Security Number and Date of Birth on the Empire Website to register.*

Services provided by Empire HealthChoice HMO, Inc. and/or Empire HealthChoice Assurance, Inc., licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

When can I enroll in the plan?

There will be an open enrollment period determined by your employer prior to the beginning of the plan year. You may call Empire BlueCross BlueShield (Empire) to verify your plan year. Your election is irrevocable, except under certain conditions.

How often are reimbursements made?

Claims are reimbursed on the schedule chosen by your employer. You may call Empire to verify the reimbursement schedule your employer has chosen.

Where can I get a reimbursement form?

You may log on to the participant Web site at www.empireblue.com* or obtain a form from your human resources representative.

What do I need to submit in addition to a reimbursement form?

Health FSA – You must retain copies of all itemized receipts 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 insurance 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 over-the-counter medications and expenses – An itemized cash register receipt with the merchant name, name of the item/product, date and amount.
- For prescription drug purchases – A pharmacy statement or printout from your pharmacy including the patient's name, the prescribing physician's name, the Rx number, the name of the drug, the date the prescription was filled and the amount.

In some cases, a letter of medical necessity from a medical practitioner may be required. Credit card receipts, cancelled checks and balance forward statements do not meet the requirements for acceptable documentation.

Dependent Care – If both the employee and provider certifications are completed and signed, additional documentation is not required in most cases. It is important to note that dependent care services must have already been provided, thus the provider's signature must be on or after the end service date for which you are requesting service.

Commuter Benefits – You should send the receipt from the service provider(s), complete with dates and amounts. If the receipt is not obtainable, the front and back copy of a cancelled check made payable to the service provider or a credit card receipt is acceptable.

Where do I submit my claims?

Empire provides three methods of claim submission:

1. Online claim submission through the participant Web site at www.empireblue.com. You must have access to a scanner to use this method.
2. Fax claims to the attention of Cafeteria Plan Services at the number listed on your claim form.
3. Mail claims to the mailing address listed on your claim form.

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.

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 and/or dependent 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 ends two months and fifteen days later.¹

The grace period ensures that you have the opportunity to maximize the funds in your account and avoid forfeiture of 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.

Not all plans include a run-out period or grace period extension. To determine if your plan includes these features, and to verify the time limit for filing claims under your plan, please refer to your summary plan description.

What if I decide to change the amount I elected?

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 (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. 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.

¹ In some instances your employer may choose to shorten the grace period. Please refer to your summary plan description for specific rules governing your plan.

Can unused account balances roll over to the next plan year?

For health care and dependent care accounts, unused account balances will not roll over to the next plan year; however, in the case of commuter benefits, unused amounts may be rolled over from each consecutive year that you choose to participate in the commuter program. Under no circumstance may unused account balances be reimbursed back to you.

How do I keep track of my account activity?

Your account information is available 24/7 from the employee section of our Web site. Simply log in to your account and you have access to real-time account information including account balance, claims status, and payment history.

**If you are not enrolled in an Empire medical plan, you will need to enter your Social Security Number and Date of Birth on the Empire Website to register.*

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The Elite Visa® Benefit Card

The Easiest, Fastest, Most Secure Way to Use Your FSA

The Elite Benefit Card provides instant access to the money in your health flexible spending account (FSA) by automatically deducting funds from your account when you make a qualified purchase.



Key Benefits of Using the Card

- Easy to use – just swipe and go!
- It works at most health care-related merchants where Visa is accepted.
- You spend only the pre-tax dollars in your FSA. There's no need to pay out of pocket. There are no claims to submit. And best of all, there's no waiting for reimbursement!

Common Purchases and Uses for the Card

- Co-pays, deductibles, and co-insurance
- Qualified dental and vision care expenses
- Prescription medicines, insulin and eligible over-the-counter (OTC) health care items, like bandages and first aid kits. Find a list of eligible expenses at www.empireblue.com.

Where You Can Use Your Card

You may use your card at merchants that have a health care-related merchant category code (such as doctors, dentists, vision care offices, hospitals, and other medical care providers) or at grocery stores, discount stores, and pharmacies who utilize an Inventory Information Approval System (IIAS).

A merchant category code is an electronic identifier that categorizes the type of merchant where you are using your card. During the purchase process, the category information determines if your card can be used at that location.

Using Your Card to Pay for Over-the-counter Items

You may use your card to pay for eligible over-the-counter (OTC) health care items, such as blood pressure monitors, thermometers, bandages, and first aid kits. However, due to new rules that take effect January 1, 2011, your benefit card cannot be used to purchase OTC medicines and drugs. If you need to purchase OTC medicines, you must pay for the items using a form of payment other than your benefit card and then submit the expense for reimbursement along with the prescription from your doctor.

When using your card at an IIAS vendor, your card may be used to pay for only those items identified on a list of eligible expenses maintained by the vendor. When purchasing eligible, health care-related items AND ineligible, non-health care-related items, you may use your benefit card to pay for the health care-related items only. You must use another form of payment (cash, personal credit or debit card, etc) to purchase the ineligible items.

A list of merchants using an IIAS is available online at www.empireblue.com*. Some merchants, including Walgreens, have implemented a custom IIAS solution and do not appear on this list. You may use your benefit card at these merchants as well. If a vendor does not appear on this list, ask them if they use an IIAS before using your card.

Save Your Receipts

Please keep receipts for all purchases made with your benefit card. Per IRS regulations, Empire BlueCross BlueShield (Empire) may be required to request itemized receipts to verify card purchases.

All itemized receipts or other proofs of purchase must include the dollar amount, date of service, provider's name, patient's name, and a description of the purchased service or product. For over-the-counter health care items, an itemized cash register receipt must have the merchant name, product name, date, and amount. Any receipt that does not contain this information is not acceptable, such as credit card receipts and cancelled checks. If the requested receipt is lost or not available, most providers can provide a detailed statement documenting FSA eligible purchases.

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

Verifying Card Purchases

You will receive a monthly card activity statement any time you have new – resolved or outstanding – card transactions on your account. The statement includes an activity summary and a Return Form that is used to resolve outstanding transactions. If one or more of your transactions requires further action, you must submit the completed Return Form along with your itemized documentation within the noted timeframe. Examples of acceptable forms of documentation include your insurance carrier's Explanation of Benefits (EOB), a provider's statement of work, and an itemized receipt.

Failure to submit proper documentation will result in the deactivation of your card. If you do not provide acceptable documentation or repay the plan for the ineligible transaction within the allotted timeframe, any subsequent non-card (paper) claims will be used to resolve the balance due (by reducing the amount of your reimbursement by the amount of the balance due).

To ensure timely notification, we will send all notices to you via e-mail. Please take time to register and log in to your account at www.empireblue.com to submit or update your e-mail address.

When Receipts Are Not Necessary

- The expense matches a specific co-pay you have under your employer's medical, pharmacy, vision, or dental plan. For example, you may not be required to submit a receipt if you have a \$20 co-pay for physician office visits, and the payment was made to a physician's office in the amount of \$20.
- Recurring expenses will not result in a request for documentation as long as the expense equals the same amount, duration, and provider as a previously approved expense. These recurring transactions will be processed and approved without documentation only after you submit receipts or other documentation and the initial transaction has been reviewed and approved.
- You purchase your FSA-eligible items at a merchant utilizing an Inventory Information Approval System (IIAS). In the unlikely event that an IIAS transaction fails to process correctly, you will receive a request for documentation. You must verify these transactions as outlined above.
- In limited situations, your claim information may be provided through an electronic file from your health insurance carrier or other provider. In these situations, verifying expenses may not be required if the electronic claim file is accompanied by an electronic or written confirmation from the health care provider (like your prescription benefits manager) that identifies your expense and verifies the amount.

Helpful Habit - Save all receipts for purchases made with your card, even if you believe the transactions meet the requirements outlined above.

Co-pay Tips

You may swipe your card for an amount up to five times the maximum co-pay amount to include:

- Single co-pay for a specific benefit – If the transaction equals a multiple of a specific co-pay, then no additional documentation is required. However, the transaction will fall outside of this automatic approval category if the transaction amount exceeds five times the applicable co-pay amount.
- Different co-pay for a specific benefit – If the transaction equals a multiple of a co-pay for a particular benefit, or a combination of the co-pays for a particular benefit then no additional documentation is required. However, this transaction will fall outside the automatic approval category if the transaction amount exceeds five times the maximum co-pay for a particular benefit.

Example: You and your two children visit the doctor and there is a \$20 co-pay amount per person for the office visit. You only have to swipe your card once. The \$60 transaction will match as a multiple of your co-pay amount.

What is the Elite Visa Benefit Card?

The Elite Benefit Card is a stored-value card that simplifies the process of paying for qualified health flexible spending account (FSA) expenses. As an alternative to the traditional method of filing claims, the Elite Benefit Card lets you electronically access the pre-tax contributions you set aside in your health FSA. You may use the Elite Benefit Card at qualifying health care providers and medical merchant locations where Visa® is accepted. As you incur qualified health care expenses, you simply present your benefit card for credit payment. The amount of the qualified expense is automatically deducted from your FSA, and the funds are electronically transferred to the provider or merchant for immediate payment. The card system will validate your coverage status, the status of your benefit card, the merchant category code, and the available funds in your account.

What is the advantage of using the Elite Benefit Card?

The Elite Benefit Card allows you to pay for qualified medical expenses at the point of service by providing:

- Real-time access to your FSA - you avoid paying out-of-pocket with cash or check
- Immediate payment of your expense - you avoid waiting for a reimbursement check as funds are transferred immediately from your FSA at the time you incur the expense
- Reduced paperwork and ease of use at the point of sale when you purchase an eligible FSA expense

Where can I use my benefit card?

You may use your benefit card at health care providers that have a health care-related merchant category code (such as doctors, dentists, vision care offices, hospitals, and other medical care providers) or at grocery stores, discount stores, and pharmacies that utilize an Inventory Information Approval System (IIAS) .

A merchant category code is an electronic identifier that categorizes the type of merchant where you are using your card. During the purchase process, the category information determines if your card can be used at that location.

You must save all receipts or other itemized documentation for all benefit card transactions, as you may be required to substantiate purchases made using your benefit card. We recommend keeping all documents in a separate envelope at home or work.

You may use your benefit card for qualified expenses only. A list of eligible and ineligible items is available online at www.empireblue.com.*

What is an Inventory Information Approval System?

An Inventory Information Approval System (IIAS) is a point-of-sale system that compares the items you are purchasing against a list of FSA-eligible items maintained by the merchant. When using your benefit card at an IIAS merchant, you may only use your benefit card to pay for those items identified on the list of eligible expenses maintained by the merchant. For example, when purchasing eligible, health care-related items AND ineligible, non-health care-related items, the merchant will only accept the benefit card as payment for the health care-related items. You must pay for the ineligible items with another form of payment (cash, personal credit card, debit card, etc.).

**If you are not enrolled in an Empire medical plan, you will need to enter your Social Security Number and Date of Birth on the Empire Website to register.*

Services provided by Empire HealthChoice HMO, Inc. and/or Empire HealthChoice Assurance, Inc., licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

Please Note: You may not use the benefit card at any merchant that does not have a health care-related merchant category code unless that merchant utilizes an IIAS. Pharmacies, grocery stores, and discount stores will not qualify as merchants with a health care-related merchant category code.

Some merchants, including Walgreens, have implemented a custom IIAS solution and do not appear on this list. You may use your benefit card at these merchants as well. If your chosen vendor does not appear on this list, ask them for confirmation prior to using your card.

In rare circumstances, purchases made at merchants utilizing an IIAS may fail to process appropriately. In those cases, you will be required to submit receipts or other supporting documentation. A list of merchants utilizing an IIAS is available online at www.benefitadminsolutions.com/IASvendors.

What if my preferred merchant does not utilize an IIAS?

You may pay for your eligible expenses using another method of payment and then submit a reimbursement form along with appropriate documentation. All documents are subject to review and approval prior to reimbursement. You can find a reimbursement form through your personal online account.

How do I activate my card?

There is an activation sticker on the front of your Elite Benefit Card. To activate your card, simply call the number on the sticker attached to the front of your card and then follow the prompts. Once activated, sign the back of the card and your Elite Benefit Card is ready to use.

Do I have to use my benefit card for all expenses that I incur?

No. You may choose to pay for eligible expenses using another form of payment and then reimbursement Request for Reimbursement Form along with your supporting documentation. If you choose not to use your benefit card, we recommend that you keep your benefit card in a safe and secure place in case you want to use it in future plan years.

Please Note: The Elite Benefit Card is the easiest, fastest, and most secure way to pay for your eligible health FSA expenses. Using your card allows you to pay for eligible expenses without the need to pay out of pocket and wait for reimbursement. We encourage you to find out just how easy and convenient participating in the plan can be by using your card to pay for eligible expenses.

Can I use my benefit card to purchase over-the-counter medicines after January 1, 2011?

No. 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 our health FSA unless prescribed by a doctor (or another individual who can legally 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 have an Elite Benefit Card, you will not be able to use it to purchase OTC medicines beginning on January 1, 2011 because of these changes. If you need to purchase OTC drugs, you must pay for the items using a form of payment other than your benefit card and then submit the expense for reimbursement along with the appropriate documentation listed above.

Examples of 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
- First aid creams, sprays, and ointments: Bactine, Neosporin
- Nicotine gum and patches: Nicoderm CQ, Nicotrol
- Sleep aids: Sominex, Tylenol PM, Unisom Sleep Tabs

To be eligible under a health FSA, over-the-counter medicines and other eligible items must be for "medical care" as defined by the Internal Revenue Code. An over-the-counter medicine is for "medical care" if it is needed to treat a medical condition and is generally accepted as falling within the category of "medicine or drugs." Items that are merely beneficial to the general health of an individual are not for "medical care" and are not reimbursable (e.g., vitamins, nutritional supplements).

Please Note: Prescription medicines and insulin (including over-the-counter insulin) are not affected by this change and can be purchased using your benefit card.

What over-the-counter items are still eligible expenses without a prescription?

The rules for OTC health care-related expenses have not changed, and 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
- Contact lens solution
- Condoms and other OTC contraceptives
- Diabetic supplies and test kits
- First aid kits
- Hearing aid batteries
- High blood pressure monitors
- Thermometers
- Wheelchairs, crutches, canes, and walkers

For a complete list of eligible health FSA expenses, including many over-the-counter health care related items and medical supplies, go to www.empireblue.com.

When using my benefit card, can I purchase eligible and ineligible items at the same time?

When using your benefit card at an IIAS vendor, your card may be used to pay for only those items identified on a list of eligible expenses maintained by the vendor. You do not have to worry about which expenses qualify or splitting up your purchase – the IIAS process will do that for you.

For example, at an IIAS-participating grocery store you have a prescription filled and also want to buy bandages, gauze, aspirin, and first aid cream. When paying for these items, the merchant will accept your benefit card for the prescription medication and the FSA-eligible items that do not require a prescription (the bandages and gauze), but you will need to use another form of payment (cash, personal credit or debit card, etc.) for the aspirin and first aid cream. If you have a prescription for these items, you can be reimbursed through your health FSA by submitting a Request for Reimbursement Form along with your supporting documentation – the itemized receipt and the prescription from the doctor.

Should I select “debit” or “credit” when checking out?

You should select “credit.” Benefit card transactions are signature-based and processed in the same manner as a credit card transaction. The Elite Benefit Card does not require (or include) a PIN for authorization and there is no “cash back” option.

Is the benefit card process paperless?

Generally, yes. However, in some cases you may be required to submit additional documentation, per IRS guidelines. Therefore, you must keep copies of all receipts and itemized statements (not the credit card receipt) for each purchase.

How will I know if I need to submit additional documentation?

You will receive a monthly card activity statement any time you have new, resolved, or outstanding card transactions on your account. The statement includes an activity summary and a Return Form that is used to resolve outstanding transactions. If one or more of your transactions requires further action, you must submit the completed Return Form along with your itemized documentation within the noted timeframe. (Examples of acceptable forms of documentation are noted below.)

Failure to submit proper documentation will result in the deactivation of your card. If you do not provide acceptable documentation or repay the plan for the ineligible transaction within the allotted timeframe, any subsequent non-card (paper) claims will be used to resolve the balance due (by reducing the amount of your reimbursement by the amount of the balance due). Failure to repay the plan could result in adverse tax consequences.

To ensure timely notification, we will send all notices to you via e-mail. Please take time to register and log in to your account at www.empireblue.com to submit or update your e-mail address. We encourage you to log in to your account each month to check out your card activity.

What is acceptable documentation?

The required documentation for benefit card transactions is the same documentation required for traditional paper claims. Therefore, **you must retain copies of all itemized receipts for each benefit card transaction.** We recommend you keep all documentation in a separate envelope at home or work.

You must submit appropriate documentation to upon request. Appropriate documentation includes:

- **For office visits** – Your insurance 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 and drugs** – 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 (see page 3 for additional details).
- **For over-the-counter health care-related items** – An itemized cash register receipt with the merchant name, name of the item/product, date and amount (see page 3 for examples of OTC health care-related items).

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.

Will I receive a request for documentation for every benefit card transaction?

No. In many cases, your transaction will be automatically verified by the card system using one of the IRS-approved methods outlined below:

- **Co-pay matching** –The expense matches a specific co-payment you have under your employer’s medical, pharmacy, vision, or dental plan. For example, you may not be required to submit a receipt if you have a \$20 co-pay for physician office visits, and a payment was made to a physician’s office in the amount of \$20.
- **Recurring expense** – Recurring expenses will not result in a request for documentation as long as the expense equals the same amount, duration, and provider as a previously approved expense. These recurring transactions will be processed and approved without documentation only after you submit receipts or other documentation and the initial transaction is reviewed and approved.
- **IIAS-approved** – You purchase your FSA-eligible items at a merchant utilizing an Inventory Information Approval System (IIAS). In the unlikely event that an IIAS transaction fails to process correctly, you will receive a request for documentation. You must verify these transactions as outlined above.
- **Electronic file** – In limited situations, your claim information may be provided through an electronic file from your insurance carrier or other provider. In these situations, verifying expenses may not be required if the electronic claim file is accompanied by an electronic or written confirmation from the health care provider (that identifies your expense and verifies the amount).

***Please Note:** You must still obtain and retain the third-party receipt when you incur the expense and use your benefit card, even if you believe it will not be needed. If the card system is unable to automatically substantiate your transaction, you will receive a request for supporting documentation.*

What are instances when supporting documentation is needed?

In most circumstances, using your benefit card to pay for dental and vision expenses will result in a request for additional documentation (such as an EOB or itemized receipt) from Empire BlueCross and BlueShield (Empire) because the amount will rarely match your insurance co-pay amount and these transactions are not part of the IIAS process. This may also occur if you are covered under your spouse’s plan when a co-pay does not match the plan’s claims data. For example:

- If you visit the eye doctor and in addition to paying for an eye exam, you purchase eyeglasses or contacts with your benefit card. Your total does not match your insurance co-pay amount; therefore, your transaction cannot be automatically approved, and you will receive a request for additional documentation.
- When paying for dental services with your benefit card, the co-insurance amounts for the various services will differ – the cost of a routine cleaning is different than the amount for a cavity filling. Since the amounts are often inconsistent with each visit, you will receive a request for supporting documentation.
- If you are covered under your spouse’s health plan and the co-pay for your physician visit does not match up with the data provided by the plan, Empire will ask for documentation to verify the benefit card transaction. The co-pay must match your specific co-pay under your employer’s plan. It is not sufficient if the transaction amount matches a co-pay amount under any health plan option provided by your employer or provided by your spouse’s employer.

What if I do not have a copy of my itemized receipt?

If you do not have a copy of your itemized receipt and receive a request for documentation, request a copy from the provider (pharmacy, doctor, dentist, etc.). Additionally, many health insurance providers offer statements and/or Explanation of Benefits (EOB) statements on their Web sites. It is important for you to retain your receipts for over-the-counter purchases, as cash register receipts typically cannot be reproduced.

What if I accidentally use my benefit card for ineligible or non-qualifying expenses?

Before using your benefit card, you should review the list of eligible and ineligible expenses available online at www.empireblue.com. As an added convenience, Inventory Information Approval System (IIAS) merchants will split FSA-eligible and non-FSA eligible items at the point of sale and prompt you to pay for non-FSA items with another form of payment.

If your benefit card is misused, you will be required to reimburse the plan with a personal check. If you do not reimburse the plan within the allotted timeframe, any subsequent traditional paper claims you submit will be used to resolve your balance due. Additionally, your employer will be notified and your benefit card will be deactivated.

What should I do if I want to pay for multiple co-pays in one transaction?

You swipe your benefit card for an amount up to five times the maximum co-pay amount to include:

1. **Single Co-pays for a Specific Benefit** – If the transaction equals a multiple of a specific co-pay, then no additional documentation is required. However, the transaction will fall outside of this automatic approval category if the transaction amount exceeds five times the applicable co-pay amount.

Example: You and your two children visit the doctor and there is a \$20 co-pay amount per person for the office visit. You only have to swipe your card once. The \$60 transaction will match as a multiple of your co-pay amount.

2. **Different Co-pays for a specific benefit** – If the transaction equals a multiple of a co-pay for a particular benefit or a combination of the co-pays for a particular benefit, then no additional substantiation is required. However, this transaction will fall outside of the automatic approval category if the transaction amount exceeds five times the maximum co-pay for a particular benefit.

Example: Assume your health plan requires a \$15 co-pay for generic drugs and a \$25 co-pay for brand name drugs. You use your benefit card at the pharmacy to purchase three generic drugs and two brand name drugs for a total of \$95. No additional documentation is required because the \$95 total is a multiple of a combination of the co-pays for the particular benefit, and the total does not exceed five times the maximum co-pay amount.

Please Note: *If the transaction amount exceeds the maximum transaction amount (i.e., five times the maximum co-pay for that type of benefit) or it is not a multiple of the co-pay or combination of co-pays for a benefit, additional documentation is required for the entire transaction.*

Example: Assume your health plan requires a \$20 co-pay for prescription drugs. You use your benefit card to purchase seven prescriptions for a total of \$140. The \$140 transaction exceeds the five times maximum co-pay amount for that particular benefit. Therefore, you must provide substantiation for the entire \$140 transaction.

The co-pay must match your specific co-pay under your employer's plan. It is not sufficient if the transaction amount matches a co-pay amount under any other health plan option provided by your employer or provided by your spouse's employer; it must equal a multiple of the specific co-pay that is applicable to you.

What if I have a \$1,000 limit on my benefit card, but I have a \$1,500 transaction?

The Visa authorization process does not allow for partial approval of transactions. For instance, a \$90 expense against a \$50 account balance cannot be partially approved for \$50 and rejected for the remaining \$40. Therefore, transactions exceeding your benefit card limit or available balance will be rejected. For this reason, you should check your available balance on the Empire Web site throughout the plan year. If you know your available account balance, you can ask the merchant to charge up to the available balance on your benefit card and use an alternative form of payment for the difference.

What if my benefit card is declined?

If your benefit card is declined, you may pay for the expense out-of-pocket and submit a manual claim for reimbursement. There are several reasons your benefit card may be declined, including insufficient account balance or ineligible merchant type. You may contact Empire to verify the reason your benefit card was declined.

Will I receive a cardholder agreement?

Yes. The cardholder agreement will be sent along with your Elite Benefit Card. Carefully read the cardholder agreement and the back of your Elite Benefit Card. By signing the back of your Elite Benefit Card, you agree to abide by the terms and conditions of the cardholder agreement. You further certify you will use your benefit card for qualified medical expenses only and will not seek reimbursement under any other health plan. Each time you use your benefit card, you reaffirm your agreement to abide by the provisions of the cardholder agreement.

Will I receive a statement or accounting information of my benefit card transactions?

You can view detailed account information including benefit card payments by logging in to your account at www.empireblue.com.

Will I receive a new Elite Benefit Card for each plan year?

No. Your Elite Benefit Card is valid for three years from the issue date. Upon annual reenrollment in the health FSA plan, your benefit card balance is reset to reflect your new election amount.

If I terminate employment, can I continue to use my benefit card?

No. Your benefit card is deactivated upon termination of your employment. If you have qualified expenses to submit after your termination of employment, you may use the traditional method of submitting a reimbursement form with appropriate documentation. However, your qualified expenses must be incurred during your period of coverage.