

What is the CONEXIS Benefit Card?

The CONEXIS Benefit Card is a stored-value card that simplifies the process of paying for qualified medical expenses. As an alternative to the traditional method of filing claims, the CONEXIS Benefit Card lets you electronically access the pre-tax contributions you set aside in your health flexible spending account (FSA). You may use the CONEXIS Benefit Card at qualifying medical merchant locations where MasterCard® is accepted.

What is the advantage of using the CONEXIS Benefit Card?

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

- Immediate access to your FSA account - 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

Where can I use my Benefit Card?

The CONEXIS Benefit Card may only be used at health care providers who have a health care-related merchant category code (such as physicians, 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) as described below. As you incur qualified health care expenses, you simply present your Benefit Card for payment. The amount of the qualified expense is automatically deducted from your FSA, and the funds are electronically transferred to the provider/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.

You must retain itemized documentation for all Benefit Card transactions, as you may be required to substantiate purchases made using your Benefit Card.

You may use your Benefit Card for qualified expenses only. A list of eligible and ineligible items is available online at www.conexis.com/solutions/expenses_EE.asp.

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.).

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.

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 substantiating documentation. A list of merchants utilizing an IIAS is available online at www.conexis.com/IIASvendors.

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 traditional paper claim to obtain reimbursement. Remember, all paper claims must be accompanied by appropriate supporting documentation and are subject to review and approval prior to reimbursement.

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 file traditional paper claims to obtain reimbursement. 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.

Can I use my Benefit Card to purchase qualified over-the-counter medications?

In 2003, the IRS issued a ruling approving reimbursement of qualified over-the-counter (OTC) medications under health FSAs. You may use your Benefit Card to purchase qualified OTC medications at any merchant that utilizes an IIAS. 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 substantiating documentation. Remember, you must obtain and retain receipts for all purchases made using your Benefit Card.

Please Note: To be eligible under a health FSA, over-the-counter medications and other eligible items must be for "medical care" as defined by the Internal Revenue Code. An over-the-counter medication 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). You may view a list of eligible over-the-counter medications and other items online at www.conexis.com/solutions/overthecounter_EE.asp.

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 CONEXIS Benefit Card does not require (or include) a PIN number for authorization and there is no "cash back" option.

Is the Benefit Card process paperless?

No. Although you do not have to complete and submit a claim form, in some cases additional documentation is required, per IRS guidelines. Therefore, **you must keep copies of all receipts and itemized statements** (not the credit card receipt) for each purchase. You should retain your itemized statements for at least one year following the close of the plan year in which the expenses are incurred.

When necessary, CONEXIS will request verification of your card purchases by sending you written notification(s), following the process outlined below:

1. You will receive an initial detailed notification when documentation is required to verify a purchase made with your Benefit Card.
2. If we do not hear from you within 30 days from the date of the initial notice, you will receive a final notice to submit documentation within 30 days to verify your purchase(s). If you do not respond to this notice, your card will be deactivated until your card purchase is verified.
3. If the documentation you submit is incomplete or the expense is ineligible, you will receive a notice allowing you an additional 30 days to submit appropriate documentation or to repay the money (if your purchase is ineligible). Failure to submit proper documentation or payment will result in the deactivation of your card.

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

What constitutes 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 for at least one year following the close of the plan year.

You must submit appropriate documentation to CONEXIS 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 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.

Will I receive a request for documentation for every Benefit Card transaction?

No. In many cases, your transaction will be automatically substantiated 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 \$10.00 co-pay for physician office visits and a payment was made to a physician's office in the amount of \$10.00.
- **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. Recurring transactions will be processed and approved without documentation only after substantiating receipts or other documentation is provided 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).
- **Electronic File** – In limited scenarios, your claim information may be provided through an electronic file from your insurance carrier or other provider. In these scenarios, expense substantiation may not be required if the electronic claim file is accompanied by an electronic or written confirmation from the health care provider (e.g., your prescription benefits manager) that identifies the nature of 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. All receipts should be retained for at least one year following the close of the plan year in which the expense is incurred. If the card system is unable to automatically substantiate your transaction, you will receive a request for supporting documentation.

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.conexis.com/solutions/expenses_EE.asp. 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-payments in one transaction?

You may use your Benefit Card to make a single transaction for up to five times your co-pay amount at qualified health care providers, as outlined below:

1. **Single Co-Pays for a Specific Benefit** – If the transaction equals a multiple of a specific co-pay applicable to you under your employer’s plan, then no additional substantiation is required; however, the transaction will fall outside of the auto-adjudication category if the transaction amount exceeds five times the applicable co-pay amount.

Example: If a participant with a \$20.00 per family member co-pay were to take two children to the doctor at the same time, they may use the Benefit Card once for \$40.00, instead of using the Benefit Card twice (once for each \$20.00 co-pay).

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 auto-adjudication category if the transaction amount exceeds five times the maximum co-pay for a particular benefit.

Example: Assume your health plan requires a \$5.00 co-pay for generic drugs and a \$15.00 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 \$45. No additional substantiation is required because the \$45.00 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 substantiation is required for the entire transaction.

Example: Assume your health plan requires a \$10.00 co-pay for prescription drugs. You use your Benefit Card to purchase seven prescriptions for a total of \$70.00. The \$70.00 transaction exceeds the five times maximum co-pay amount for that particular benefit. Therefore, you must provide substantiation for the entire \$70.00 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 the 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 MasterCard® authorization process does not allow for partial approval of transactions. For instance, a \$90.00 expense against a \$50.00 account balance cannot be partially approved for \$50.00 and rejected for the remaining \$40.00. Therefore, transactions exceeding your Benefit Card limit or available balance will be rejected. For this reason, you should check your available balance on the CONEXIS 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 CONEXIS to verify the reason your Benefit Card was declined.

Will I receive a cardholder agreement?

Yes. You will receive a cardholder agreement when you receive your CONEXIS Benefit Card. Carefully read the cardholder agreement and the back of your CONEXIS Benefit Card. By signing the back of your CONEXIS 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 on your employee page of the CONEXIS Web site at www.conexis.com.

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

No. Your CONEXIS Benefit Card is valid for three years from the issue date. Upon annual reenrollment in the health FSA plan, your Benefit Card balance will be reset to reflect the current plan year's 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 filing a claim form with appropriate documentation. However, your qualified expenses must be incurred during your period of coverage.