Premera Blue Cross

FLEXIBLE SPENDING ACCOUNT

Alaska AIRLINES

HORIZON AIR

Get started

1. Create an account at **premera.com/aag** to access your benefits and manage your flexible spending account (FSA). You can:
   - Pay provider bills
   - Check your balance
   - View transaction history
   - Sign up for direct deposit
   - Request reimbursement
   - View claim status
2. Check your mailbox for your healthcare payment card, issued by UMB, the Bank Custodian for your FSA.
3. Review the list of **eligible expenses**. Remember, preventive care is covered in full if you see in-network doctors. For everything else, you can use your FSA funds.

Using FSA funds

FLEXIBLE PAYMENT OPTIONS

Out-of-pocket expenses

Pay healthcare expenses out of your own pocket. You can reimburse yourself at any time.

Healthcare payment card

Use your card to pay doctor bills and other eligible healthcare expenses. Your card is linked to your FSA, and money is automatically deducted.

Pay online

Pay claims online with FSA dollars or directly from your personal bank account.

ROLL OVER UP TO $500

The healthcare FSA allows you to roll over up to $500 of your balance into the next plan year. You must use any funds over the $500 rollover amount within the plan year and claim it by March 31 of the following plan year; per the IRS “use it or lose it” rule. If you do not, those funds are forfeited.

UMB Bank is an independent company that provides FSA custodial services on behalf of Premera Blue Cross. It does not provide Blue Cross Blue Shield products or services and is solely responsible for their own services.

Have questions about your health plan or FSA? Call customer service at **877-AAG-3525**.

The healthcare payment card

Use your card to pay for eligible products and services directly at the doctor or pharmacy. Or you can use it for over-the-counter[1] items. The money comes right out of your account. FSA funds may even be used for **eligible expenses** for your spouse or tax dependents. When using the healthcare payment card for eligible expenses, you must have enough funds in your account or your transaction will be denied.

Important! If you have available funds to use at the end of the year, it is important that you submit these claims manually so they are deducted from the eligible plan year. If you use your healthcare payment card to pay a provider for an eligible expense after the new plan year begins, funds will be deducted from your new plan year's funds.

- To avoid any error in payment, you will need to pay for the eligible medical expense by using your own personal credit card, check, or cash and keep your itemized receipt as documentation.
- To submit your claims, sign in to your online account, and under Manage My Account, select Personal Funding Account.
- Claims for the previous plan year are only available until midnight Pacific Time on March 31.
- You can also print the claim submission form and submit documentation per the instructions on the form.
- Reimbursement is provided via check or direct deposit.

Need a new or additional healthcare payment card?

In the event your card is lost or stolen, or if you would like to order an additional card for a dependent, you can request a new card online, by calling **877-AAG-3525**, or on the CYC Mobile app.

ConnectYourCare MOBILE

Download the CYC Mobile app to manage your FSA on the go. Available for Android, iPhone, and Windows.

Streamline claims

Claims containing a sensitive diagnosis or procedure are not available for online FSA payment without authorization from the patient. Dependents, including spouses, domestic partners, and children 13 years of age or older may provide authorization to streamline sensitive claims directly to the subscriber's account for viewing and payment.

Additionally, members can manage the visibility of their sensitive claims information to other members on the plan by providing designation. Sign in to your account and select Privacy Settings from the navigation bar to edit preferences.

[1]IRS rules require a doctor's prescription for the reimbursement of over-the-counter drugs and medicines.

Substantiation

When you use your healthcare payment card to pay for services, substantiation of those transactions is required. Substantiation is verification that the purchase was an eligible healthcare expense. The IRS has established specific guidelines that require all FSA transactions—even those made using the healthcare payment card—to be substantiated. Please note that all transactions are subject to substantiation, including claims for services by healthcare providers. Since not all services from a medical provider or pharmacy are eligible healthcare expenses, receipts are required to verify eligibility.

The Inventory Information Approval System (IIAS) is a federal government mandated system used by merchants that identifies eligible healthcare items and limits FSA healthcare payment cards to eligible items only.

This system makes it easier for account holders to manage eligible over-the-counter (OTC) and pharmacy expenses, since the merchants automatically substantiate eligible OTC purchases at the point of sale. All supermarkets, grocery stores, department stores, and wholesale clubs are required to implement the IIAS merchant program or they cannot accept healthcare payment cards.
For a regularly updated list of these stores and pharmacies, visit **premera.com/merchants** and look for retailers that are certified IIAS compliant.

REQUIRED INFORMATION FOR SUBSTANTIATION

All receipts or documentation must include the following information:

- Name of person who incurred the service or expense
- Name and address of the provider or merchant
- Date the service or expense was incurred
- Detailed description of the service or expense
- Amount charged for the service or expense
- OTC medications must be accompanied by a doctor's prescription

EOBs contain all the required information and are excellent sources of documentation. **Credit card receipts, cash register receipts, and cancelled checks are not acceptable**.

REQUESTS FOR SUBSTANTIATION

If a receipt is needed, you will be notified by email or reminder letter. You may also see if a claim requires receipts by signing in to your online account. Claims needing documentation are displayed on the Claims section of the website. If you do not substantiate your claim, a second letter will be sent to you within a few weeks advising you to do so, or your card will be suspended. A third letter will be sent if there is no response, notifying you that you have seven days to substantiate your claim before your card is suspended.

ALWAYS SAVE ITEMIZED RECEIPTS

Save your itemized receipts from every healthcare payment card transaction and your explanation of benefits (EOBs).

TO HELP KEEP YOU ORGANIZED: You can upload receipts and EOBs to your account or use the CYC Mobile app.

ConnectYourCare is an independent company responsible for healthcare funding account administration. It does not provide Blue Cross Blue Shield products or services and is solely responsible for their own services.

SUBSTANTIATION PROCESS

There are two ways purchases may be substantiated in compliance with IRS requirements:

1. **Auto substantiation.** Substantiation may be automatically made through electronic evidence. Examples include:
   - **Copay matching**—charges that exactly match the dollar amount, or up to five times the dollar amount, for a copay under the health plan.
   - **Recurring claims**—charges that exactly match the provider and dollar amount for a previously approved and substantiated transaction. For example, a fixed monthly payment.
   - **Real-time substantiation**—charges that are verified as eligible expenses by the merchant, service provider, or other third-party vendor.
   - **Ready for action**—streamlined claims that do not match a payment card transaction will be flagged as Ready for Action. You can then select from several payment options.
2. **Manual substantiation.** All purchases that do not qualify for auto-substantiation must be manually substantiated with receipts or other documentation. Examples include:
   - Doctor and other provider visits, where the amount paid is not equal to the copay or does not match a file feed from the health plan.
   - Prescription and eligible OTC transactions where the amount paid is not equal to the copay or the store is not IIAS compliant.
   - OTC medications which must be accompanied by a doctor's prescription.

UPLOADING CLAIM DOCUMENTATION

For claims that require documentation, submitting receipts is easy. Upload claim documentation following these simple steps:

1. **Scan documentation.** Make sure documentation includes all the required information, including patient name, product or service description, service date, provider information, and charge.
2. **Upload documentation.** In your account, choose the claim that requires receipts, and then select Upload Claim Documentation. Follow the instructions to select and upload documentation.
3. **Check claim status online.** The claims department will review the documentation and process the claim. Go online at any time to check the status of the claim. The uploaded documentation will be saved with the claim.

For more detailed information, refer to IRS Publication 969, "Health Savings Accounts and Other Tax-Favored Health Plans," which you can download from the IRS website, irs.gov, or order by calling 800-TAX FORM. This material is not intended to be tax or legal advice. The reader should consult with his or her own tax advisor to determine the tax implications of participating in a personal funding account discussed herein. Advice, if any, included in this material was not intended or written by Premera to be used, and it cannot be used, by any taxpayer for the purpose of avoiding penalties that may be imposed on the taxpayer.

IMPORTANT NOTE ABOUT OVER-THE-COUNTER MEDICATION

Many OTC drugs and medicines are not eligible for reimbursement through an FSA, unless accompanied by a prescription. A prescription is a written or electronic order for a medicine or drug that meets the legal requirements of a prescription in the state in which the medical expense is incurred and that is issued by an individual who is legally authorized to issue a prescription in that state.

The OTC limitation is on drugs and medicine only. Other OTC items such as bandages and contact lens solution are still eligible.

The healthcare payment card cannot be used for non-eligible items. If a prescription has been written for these items, a manual claim with the prescription documentation will need to be submitted for eligibility and reimbursement.

Dependent day care FSA

If you have a dependent day care FSA, you need to pay for your eligible dependent care expenses out of pocket; you cannot use the healthcare payment card for your dependent day care funds. The annual contribution maximum for the dependent day care FSA is $5,000. Remember, there is a "use it or lose it" rule with FSAs, so be sure to accurately estimate your annual contributions. You may request reimbursement from your account or pay your provider by selecting Make A Payment. Remember, you can only use your dependent care funds up to the balance in your account. You will need to submit an itemized receipt or a **dependent care claim form** as documentation.

Eligibility requirements

To be reimbursed through your dependent day care account for child and dependent care expenses, you must meet the following requirements:

- You incurred the expense in order for you and/or your spouse to work or look for work, unless your spouse was either a full-time student or was physically or mentally incapable of self-care.
- You cannot make payments to someone you can claim as your dependent on your federal tax return or to your child who is under age 19.
- Your filing status must be single, qualifying widow(er) with a dependent child, married filing jointly, or married filing separately.
- You and your spouse must maintain a home that you live in for more than half the year with the qualifying child or dependent.

Save your receipts

The IRS requires that your charges be verified. Always save your itemized receipts in case they are required to confirm a purchase for tax purposes. Remember, receipts for these expenses must include the name of the dependent. Claims for the plan year must be submitted to Premera by March 31 of the following plan year in order to be reimbursed.

For more information about FSAs,
check out **CYC's FSAs for Dummies**.

Notice of availability and nondiscrimination 800-722-1471 | TTY: 711

Call for free language assistance services and appropriate auxiliary aids and services.
Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
呼吁提供免费的语言援助服务和适当的辅助设备及服务。
呼籲提供免費的語言援助服務和適當的輔助設備及服務。
Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
សូមហៅទូរសព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាកម្ម និងជំនួយចាំបាច់ដែលសមរម្យផ្សេងៗ។
無料言語支援サービスと適切な補助器具及びサービスをお求めください。
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Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.
ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਉਚਿਤ ਸਹਾਇਕ ਚੀਜ਼ਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਵਾਸਤੇ ਕਾਲ ਕਰੋ।
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.
Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.
Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.
Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.
Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.
Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.
اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.
برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

Discrimination is against the law. Premera Blue Cross (Premera) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes. Premera does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Premera provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language assistance services to people whose primary language is not English, which may include qualified interpreters and information written in other languages. If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with: Civil Rights Coordinator ─ Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, TTY: 711, Fax: 425-918-5592, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.