HEALTH CARE SPENDING ACCOUNT FAQ FOR *PLAN MEMBERS*

Contents

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1. What is a Health Care Spending Account?

A Health Care Spending Account (HCSA) is a benefit program provided by your employer to provide top-up coverage for Health, Vision, Dental and other medical expenses that are not covered under your group benefits program but are allowed under the Income Tax Act.

2. Who is eligible for HCSA?

To be eligible for HCSA, Plan Members must be covered for Extended Health or Dental Benefits with Wawanesa Life. If Extended Health and Dental Benefits are waived due to similar coverage under a spouse's plan, they will continue to be considered eligible under this HCSA.

While a dependent can't be enrolled directly to participate, a Plan Member is able to claim expenses for an Eligible Dependent using their HCSA balance. An Eligible Dependent is any person for whom the Plan Member may claim a medical expense tax credit on the federal tax return in the taxation year.

3. How much money do I have to spend?

Your employer determines the amount of contributions (money) to be deposited into the Plan Member's Health Care Spending Account. This is the total amount available to be used to claim eligible expenses incurred by Plan Members and/or their Eligible Dependents.

4. What is covered under a HCSA program?

Only Canada Revenue Agency's Medical Expense Tax Credit program expenses are eligible for reimbursement.

Examples of ***eligible*** expenses:

- Co-insurance, deductibles and any amounts not covered under your group benefits plan
- Payments to medical practitioners, hospitals, orthodontists, etc.
- Artificial limbs, aids and other medical equipment
- Eyeglasses, contact lenses and laser eye surgery
- Rehabilitative therapy
- Dentures

Examples of ***ineligible*** expenses:

- Athletic or fitness club fees
- Over the counter medication
- Organic food
- Supplements
- Cosmetic Procedures aimed at enhancing one's appearance (ie. liposuction, botox injections, teeth whitening)

5. How does it work?

At the beginning of each benefit year, your employer allocates a specified amount of contributions to your HCSA. These contributions are for you to use at your discretion to pay for medically related expenses allowed under the Income Tax Act.

Example:

Under his group benefits plan with Wawanesa Life, John has $300 every calendar year for custom made orthotics. John also has $100 every calendar year under his spouse's plan. John purchased a pair of orthotics at the beginning of the year and used up his $300, he now needs a second pair which will cost him $400.

After John submits his claim to both his and his spouses plans, he is still out of pocket $300 ($0 paid by his plan, $100 paid by his spouse's plan)

At the beginning of the benefit year, John's employer contributed $1000 to John's HCSA program. John can now decide if he wants to use his HCSA to pay for the remaining $300 of his orthotic claim.

If John choses to use his HCSA dollars to pay for the remainder of the orthotics, he will be left with $700 for the rest of the benefit year to use on other expenses.

*In the example above, if the HCSA program is **Rolling Contributions**, and John does not submit any more claims through this HCSA for the rest of the Benefit Year, the $700 remaining contributions will rollover into the next Benefit Year. The $700 will need to be used in the next Benefit Year or it will be forfeited.*

*In the example above, if the HCSA program is **Rolling Claims**, and John did not have enough contributions left in his HCSA program to pay the remaining $300 , he can submit the balance of the claim to be paid through his HCSA plan in the next Benefit Year. Claims can be rolled to the next Benefit Year only.*

*In the example above, if the HCSA program is **No Rolling**, and John did not submit the expense to his HCSA by the end of the Benefit Year he cannot submit it in the next Benefit Year and any contributions not used in the Benefit Year will be forfeited.*

More information on your HCSA program type can found in your Benefits Booklet or by contacting a Customer Service Representative at 1-800-665-7076.

6. What is a Benefit Year?

A Benefit Year is a 12-month period that usually runs from January 1 to December 31. The Benefit Year that applies to your plan can be found in your Benefits Booklet or by contacting a Customer Service Representative at 1-800-665-7076.

7. How do I submit claims?

All Plan Members can sign up for Plan Member Online Claims where they can submit their expenses electronically. Claims can be also be submitted by mailing a completed claim form and supporting documents to Wawanesa Life.

More information on how to submit a claim through Plan Member Online Claims can be found at Wawanesalife.com under Group/Group Forms/How to claim expenses through your Health Care Spending Account.

8. How do I sign up for direct deposit?

Simply log into Plan Member Online claims and sign up for direct deposit for quick payments.

9. How do I coordinate my HCSA with my Health and Dental benefits?

All eligible expenses incurred must be submitted through all group health or dental plans before submitting under HCSA. As a Plan Member you may choose to set up auto coordination to have any unpaid amount from your Health and Dental claims automatically paid under your Health Care Spending Account.

Payment for Eligible Dependents who have other insurance follow the same rules applied to the health and dental benefits under the group plan. More details on coordination of benefits can be found in the employee benefits booklet.

10. What is the claim submission period?

Proof of an eligible expense must be submitted no later than 31 days following the benefit year. Your specific benefit year will depend on the type of plan that has been implemented by your employer. For specific information regarding the claim submission period for your plan please refer to your Benefits Booklet or contact a Customer Service Representative at 1-800-665-7076.

11. What happens to unused contributions?

If the plan type selected by your employer is a No Rolling plan or a Rolling Claims plan, unused contributions will be forfeited at the end of the benefit year. If the plan type selected by your employer is a Rolling Contributions plan, then unused contributions will be carried forward to the next benefit year. Any contributions carried forward will be forfeited at the end of the next benefit year if not used.

For specific information regarding unused contributions for your plan please refer to your Benefits Booklet or contact a Customer Service Representative at 1-800-665-7076.

12. What happens if I leave my employment?

You will have 30 days from when you are no longer an active employee to submit claims for eligible expenses incurred prior to the date your active employment ends, provided that the HCSA remains active. After 30 days any unused contributions will be forfeited.

13. What information can be found on our plan member site?

You can refer to Plan Member Online Claims to:

- Submit Health, Dental and HCSA claims
- Sign up for direct deposit
- View and print Explanation of Benefits (EOB) for any processed claims
- Access claims information
- View balances, including your HCSA balance
- Mock claims to see what is covered
- Use the “is my drug covered” tool for specific drug coverage inquires
- Find dental, paramedical or vision providers
- Print forms
- Update address and print benefit ID cards

14. Where can I get my Benefits Booklet?

You can access your current benefits booklet on Plan Member Online Claims, or by contacting your Plan Administrator.

15. Who do I contact if I have questions?

If you have questions about your HCSA you can contact a Customer Service Representative at 1-800-665-7076.