

Benny

Your card for Better Benefits!



The FSA Benny Card provides a convenient method to pay for out-of-pocket medical expenses for you, your spouse and/or any tax dependents. The IRS has stringent regulations regarding appropriate use of the Benny Card, as far as **where the card can be used**, and **when follow-up documentation is required (use of the card DOES NOT eliminate all of the paperwork)**. The card is a great benefit, but it is important that you take a moment and understand how it works.

Where can the cards be used?

Per IRS regulations, the FSA Debit Card can only be used at Health Care Providers (based upon the Merchant Category Code) and at stores that have implemented an Inventory Control System.

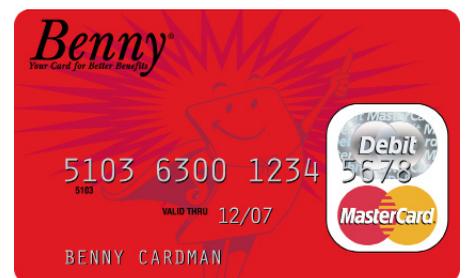
- 1) Health Care Merchant Category Codes (MCC):** Every merchant that accepts credit cards has an MCC, which is a general category that is assigned when the merchant applies for the right to accept credit cards. The FSA debit card will work to pay providers that have an MCC that indicates the merchant is a health care provider (hospital, doctor, dentist, optometrist, chiropractor, etc.).
- 2) Inventory Control System Restriction:** The IRS also allows a card to be used at retail stores that have an FSA Inventory Control System in place that only allows FSA-eligible items to be paid for with your FSA debit card. Please note that if you have a medical condition that allows you to claim expenses that are not normally eligible, the card will not be able to pay for these expenses at these stores. You will have to pay with a separate form of payment and submit a claim. The card will work at these stores, even if the MCC does not indicate it is a health care provider. A list of stores with this system in place now (and some expected in the future) is available online, at www.asiflex.com/debitcards. **Purchases at these stores should never require follow-up documentation!!** Please note that as of 7/1/2009, IRS regulations require all pharmacies to have the Inventory Control System in place, or your card will be declined.

When do I have to turn in paperwork?

Certain situations will allow FSA debit card transactions to be electronically substantiated, meaning that no follow-up documentation will be required. If a transaction cannot be electronically substantiated, you will receive a request for follow-up documentation from ASIFlex. Transactions are considered to be electronically substantiated if they:

- Match a co-payment, or any combination of co-payments up to five times the highest, for the health insurance plan(s) that you have elected through your employer (please note that if you use the card to pay for your spouse's co-payment, you will be required to submit supporting documentation);
- Occur at a retail outlet that has implemented the Inventory Control System; or
- Are recurring expenses for the exact same amount at the same provider and have been substantiated once via a paper claim. An example of this is if you go see a chiropractor once a month and you are assessed a fee of \$23.11 for each visit. This amount does not match a co-payment, so you will be prompted for documentation the first time. When you submit your documentation, please include a note stating that this is a recurring expense. Future transactions at the same provider, for the same amount, will not require follow-up documentation.

All other transactions will prompt a request for a detailed statement of services.



Contact ASIFlex with Questions: **Phone:**
Email:
Web:

(800) 659-3035
asi@asiflex.com
www.asiflex.com

ASIFlex FSA Debit Card Application

Please print all fields clearly to avoid spelling errors.



Employer		Social Security Number (must be included or no card will be issued)	
Last Name:		First Name, Middle Initial	
Mailing Address:	City:	State:	Zip:
Daytime Phone:	Home Phone:	Date of Birth: MM/DD/YYYY (must be included or no card will be issued)	
Email Address (must be included or no card will be issued)		Employee Identification Number (if available)	

- ✓ The debit card is optional to you. It is important to note that there will be times when you will be required to provide follow up documentation to show ASIFlex what item(s) were paid for with the card. ASIFlex will notify you when you need to provide a detailed statement of services to substantiate your purchase(s). **If you do not supply the requested documentation in the timeframe requested, your card will be deactivated.**
- ✓ If you do want a card, you have to complete this application. If you do not apply for the card, you will access your funds by filing claims and ASIFlex will reimburse you by direct deposit or check.
- ✓ Two debit cards, both in your name, will be issued from a processed application. The cards will be mailed to your home address approximately two weeks from ASIFlex's processing of the application. There is a \$5.00 charge for additional or replacement cards.
- ✓ Please note that as mentioned on the reverse side of this application, **you will be required to submit substantiating documentation for some debit card transactions.** ASIFlex will notify you when follow-up documentation is required. **If you do not provide the requested documentation in the timeframe stated in your notification, your card will be deactivated.**
- ✓ **Always select the "credit" option when you present the card** at a merchant or a provider, even though the card is referred to as a "debit card." There is no PIN number associated with this FSA debit card.
- ✓ **There may be an annual fee for the card,** so please review your plan materials.

I hereby state that the above information is accurate, to the best of my knowledge. Additionally, I certify that the FSA debit card will only be used to purchase eligible medical care expenses, as defined in Code §213(d) of the Internal Revenue Code and that I will not seek reimbursement from any other source for the expenses paid for with the FSA debit card. I also acknowledge that if I do not provide requested documentation in a timely fashion, my card will be deactivated, in accordance with Federal regulations.

Participant's Signature: _____ Date: _____

**The application must be sent directly to ASIFlex.
 Please fax application, toll-free, to: 1-877-879-9038 or
 Mail to: ASIFlex, P O Box 6044, Columbia, MO 65205-6044**