



Reimbursement Accounts CLAIM FILING INSTRUCTIONS

The Internal Revenue Service has specific guidelines for administering reimbursement accounts. Please review the following to determine what type of supporting documentation is required for your expenses. For quick claim reimbursement, submit your claim online through **File a Claim**.

Health Care Expenses:

Health care expenses include amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, and for treatments affecting any part or function of the body. The expenses must be primarily to alleviate or prevent a physical or mental defect or illness. Expenses for solely cosmetic reasons generally are not expenses for medical care. Also, expenses that are merely beneficial to one's general health are not expenses for medical care. In some cases, you may be asked to provide a letter of medical necessity from your attending physician to substantiate your claim.

If you have medical, dental or vision insurance, all expenses must be submitted to your insurance company before being submitted for reimbursement—even if you have not met your annual deductible. When you receive the Explanation of Benefits (EOB) statement from your insurance company, submit a copy to PayFlex along with the completed claim form. If you simply make a copayment when you receive medical care or purchase prescription drugs, you may submit the EOB or an itemized statement showing the date of service, a description of the service, service provider name and address, patient name, and the copayment amount.

If you do not have insurance coverage for health expenses, submit an itemized statement from the provider showing the date of service, a description of the service, provider name and address, patient name, and the amount charged along with the completed claim form. Cancelled checks, credit card receipts, or billing statements showing “previous balance”, “balance forward” or “received on account” cannot be accepted.

Documentation for prescription drugs must include the service provider name, the date the prescription was filled, the name of the drug, patient's name and dollar amount. This information is provided on the pharmacy receipt (script), or you can ask your pharmacist for a print-out of your prescriptions for a particular time period. Cash register receipts must clearly indicate it is for prescription co-pay.

Documentation for over-the-counter (OTC) items must clearly identify the merchant name, name of the purchased item, date and amount on the cash register receipt. Quantities purchased must be reasonably able to be consumed during the current plan year. Please note, as of January 1, 2011, OTC drugs and medicines will require a written prescription from your physician in order to get reimbursed. When submitting these expenses for reimbursement, you must include a copy of your prescription, an itemized receipt and a completed claim form. Keep in mind, not all OTC items require a prescription. Items such as band-aids, braces & supports, contact lens solution/supplies, diagnostic tests & monitors, elastic bandages & wraps, first aid supplies, insulin & diabetic supplies, reading glasses, wheelchairs, walkers & canes are reimbursable without a prescription. However, items such as vitamins and supplements still require a Letter of Medical Necessity, since they are generally used to maintain good health and not taken to treat a medical condition.

Orthodontia claims require an itemized statement/paid receipt, the orthodontist's contract/payment agreement, or monthly payment coupons. Reimbursements can be made in one lump sum, or as the services are provided over the expected treatment period as described below:

- **Coupon Payment Option** – You can submit an itemized statement of your orthodontia expenses as the service is provided. Submit this documentation with a completed claim form for reimbursement.
- **Monthly Payment Option** – You can obtain a contract agreement from the orthodontist showing the patient name, the date the service begins and the length of service, charges for the initial banding work and the dollar amount charged each month. Submit your contract with your first claim. Please make sure to check the Automatic Monthly Reimbursement box on the claim form. If the Automatic Monthly Reimbursement box is checked and your contract is submitted with your claim form, PayFlex will automatically reimburse you each month, according to the contract, eliminating the need to submit a claim every month.
- **Total Payment Option** – If you paid the entire amount of treatment when the service began, submit your claim with a copy of your paid receipt and an itemized statement showing the provider name, patient name, date treatment started, dollar amount and amount insurance will pay.

Reimbursement Accounts - CLAIM FILING INSTRUCTIONS (cont.)

Dependent Child or Adult Day Care:

In order to get reimbursed for dependent child or adult day care expenses, the expenses must be work-related, meaning you and your spouse, if married, must be employed, actively seeking employment or a full-time student. When submitting a claim for dependent day care expenses; complete a claim form and provide an itemized statement from your day care provider. **Your provider's signature on the claim form may be used as a substitute for an itemized statement. Remember, either the provider's signature on the claim form OR an itemized statement is required. PLEASE DO NOT SEND BOTH.** If submitting the itemized statement instead of having the provider sign the claim form, the itemized statement must include the provider's name, your dependent's name, as well as the specific dates day care services were provided and the cost of care. Cancelled checks cannot be accepted as a form of documentation. IRS regulations require you to report the provider's name, address and Tax Identification Number (or Social Security Number) on Form 2441 to be filed with your personal income tax return. A dependent is considered eligible if they are under age 13 or otherwise meets the "Qualifying Person Test" as described in Publication 503. Remember, you can only get reimbursed for day care services received, not for services to be provided in the future.

Before Submitting A Paper Claim:

Don't forget, your claim can be submitted online by selecting **File a Claim**. Should you choose to submit a paper claim, you can expedite the process by avoiding these common claim-filing mistakes:

1. Be sure to sign and date the claim form. To download a claim form, go to My HealthHub Resources and click on **Administrative Forms**.
2. Include the appropriate documentation (itemized statement and/or EOB) to substantiate your expenses. If multiple items are on the receipt, be sure to circle the ones for reimbursement.
3. Complete the claim form in full. Be sure that the supporting documentation equals the total you are requesting for reimbursement.
4. Keep a copy of your claim and documentation. Information submitted to the administrator will not be returned to you. If additional information is needed, it is helpful that you have copies you can refer to.
5. Don't wait until the last minute to file your claim! You risk missing the deadline and if you submit incorrect information, there may not be enough time left for you to re-submit your claim for reimbursement.
6. If filing for dependent day care reimbursement, your provider must sign the claim form OR you must submit an itemized statement. Please do NOT send both.

If you are unsure of an expense, please refer to the list of eligible/ineligible expenses on our website. Health care expenses must meet requirements of Section 125 and Publication 502 and not all expenses listed in Publication 502 are eligible for reimbursement. In addition, over-the-counter (OTC) items are eligible for reimbursement even though Publication 502 states that they are not eligible for tax deductions. However, as of January 1, 2011, OTC drugs and medicines will be considered ineligible unless you have a written prescription from your physician. Dependent care expenses must meet requirements of Section 125 and Publication 503.

Using the PayFlex Card®:

Using the PayFlex Card to pay for your eligible expenses is easy! The advantage is that you do not have to pay money out of your pocket when you present the card for payment of qualifying expenses.

Here are some helpful hints when using the card:

1. Use the card only for eligible expenses at qualifying merchants. The merchant must accept MasterCard® in order for the card to work.
2. If you pay for an ineligible expense with your card or do not provide documentation when requested, you'll be required to do one of the following:
 - a. Submit an Explanation of Benefits from your insurance carrier or an itemized receipt from another eligible expense incurred in the current plan year that has not been submitted for reimbursement, OR
 - b. Submit a personal check or money order payable to PayFlex for the amount of the transaction for which you are unable to provide supporting documentation.
3. The card works great for prescription drug or office visit co-pays that match your benefit plans amounts.
4. The card can be used for purchasing contact lens cleaning solutions and eligible over-the-counter (OTC) supplies or items. You may be requested to submit a receipt at a later date during the plan year to verify these expenses. Please note, starting January 1, 2011, OTC drugs and medicines can only be purchased with the PayFlex Card if your pharmacist assigns a prescription (Rx) number to the item and processes the item as a prescription. If no Rx number is assigned to the OTC drug or medicine, the card will be denied. In this case, you must pay with another form of payment and submit a claim for reimbursement. When submitting a claim for OTC drugs or medicines, include a copy of the prescription and receipt.
5. You can also use your card for eligible medical, dental, vision and hearing products and services.
6. Keep copies of all Explanation of Benefits, detailed receipts and itemized statements for each purchase. This will make it easier if you are asked to provide documentation of a certain expense at anytime during the plan year. IRS requires itemized documentation for certain card transactions.

Reimbursement Accounts - CLAIM FILING INSTRUCTIONS (cont.)

Definitions – Things You Need to Know:

Date of Service – The date a service or supply was provided to you, regardless when paid for or when you were billed. Prescription drugs are generally based on the date the prescription is filled, regardless when picked up or paid for. Eyeglasses/contact lenses are based on the date the order is placed, regardless when picked up or paid for.

Documentation – IRS regulations require that claims and certain card transactions be substantiated with appropriate documentation. Documentation includes the insurance carrier Explanation of Benefits (EOB), provider itemized statement or pharmacy receipt, and detailed cash register receipt with the merchant name, product name, date and amount of purchase.

Duplicate Expense – An expense that was previously submitted for consideration.

Expense Incurred – an expense is treated as having been incurred when the medical care or dependent care that gives rise to the expense has been provided, and not when you are formally billed, charged for, or pay for the expense. To “give rise” means to cause to happen.

Explanation of Benefits (EOB) – This statement is provided to you by your insurance carrier after they have processed your claim. It shows the provider name, patient name, date the service was provided, the amount they paid and what you owe.

Ineligible under IRS Guidelines – Expenses that cannot be reimbursed with “pre-tax” dollars or paid for with your PayFlex Card® are considered ineligible. Eligible health care expenses include services for the diagnosis, cure, mitigation, treatment, or prevention of disease, and for treatments affecting any part or function of the body. The expenses must be primarily to alleviate or prevent a physical or mental defect or illness. Expenses for solely cosmetic reasons generally are not expenses for medical care. Also, expenses that are merely beneficial to one’s general health are not expenses for medical care.

Itemized Statement – This is used when an individual does not have insurance coverage and will, therefore, not receive an Explanation of Benefits (EOB) or when you simply make a co-payment when you receive medical care or purchase prescription drugs. An itemized statement is a type of billing receipt that documents the service you have received. This document must include:

- Provider name/address
- Patient name
- Date service was provided (regardless when paid or billed)
- Description of service or supply (should be a detailed description)
- Dollar amount charged

Letter of Medical Necessity – Because health care expenses must be for medical reasons, some expenses may require a letter from your physician confirming the diagnosed condition, the type of treatment, why the treatment is medically necessary, and the duration of treatment. A Letter of Medical Necessity form is available in My HealthHub Resources for your convenience.

Over-the-counter Drugs and Medicines (OTC)– Items that are taken orally or applied to the body to alleviate or treat sickness, pain, injuries, or a medical condition such as allergy and cold medications, pain relievers such as aspirin and antacids, are considered to be OTC drugs and medicines. These items may be in the form of a liquid, pill, or ointment if they contain a drug. As of January 1, 2011, OTC drugs and medicines will be considered ineligible unless you have a written prescription from your physician. Items such as vitamins, herbal and dietary supplements, cosmetic treatments or items that are for maintaining general good health are not included and remain ineligible expenses.

Period of Coverage – This is the time during which you are eligible to receive benefits. Your period of coverage begins when you become eligible and enroll in your employer’s plan, and ends when you are no longer eligible (this may be your employment termination date).

Provider – The doctor, hospital, pharmacy, store that provided the service or supply to you.

Provider Discount – Some health care providers participate in networks under which they agree to charge less than the prevailing fees. This is called a provider discount and although this amount may appear on statements, it is not owed to the provider and is not an eligible expense.

Runout Period – This is a period of time following the close of the plan year during which you can still file claims incurred in the prior year while you were a covered participant and it does vary among employers.

Reimbursement Accounts - CLAIM FILING INSTRUCTIONS (cont.)

RX Script – The pharmacy or prescription receipt received from the pharmacy when they fill a prescription. This shows the pharmacy name/address, patient name, date filled, drug name, and dollar amount charged.

Substantiation – To “substantiate” means to prove or support something; confirming that it is true or valid. With the PayFlex Card™, this means you would provide documentation such as an Explanation of Benefits (EOB) or itemized statement to verify that your purchases were eligible expenses.

Type of Service/Supply – A detailed description of the service being provided. For example, a description of “dental services” is not complete. A description that says “x-rays and crown” is detailed and complete.

Work-Related Expense – Qualifying daycare expenses must be work-related. This means they are incurred to allow you, and if married, your spouse to work. This does not include expenses you pay while doing volunteer work, or expenses you pay while you are on leave, vacation, or out ill.