CLAIM FILING INSTRUCTIONS

The Internal Revenue Service has specific guidelines for administering Flexible Spending Account Programs. To expedite claim reimbursements, please review the following to determine what type of supporting documentation is required for your expenses.

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 us 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. If you submit a cash register receipt for documentation, it must clearly identify the item as a prescription with a prescription copayment.

***Documentation for over-the-counter (OTC) medicine and drug*s** 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.

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 this with your first claim form and we can automatically reimburse you each month, according to the contract. This eliminates the need for you to send a claim form in each month. You do need to send a new claim form with your contract agreement at the beginning of the next plan year if you wish to continue.

- Total Payment Option – If you paid the entire amount of treatment when the service began, attach to the claim form a copy of your paid receipt, along with an itemized statement showing the provider name, patient name, date treatment started, dollar amount and amount insurance will pay. *Under this option, you can only file for this expense once. You cannot submit this expense again in future plan years*.

Dependent Child or Adult Daycare:

Complete the claim form in full, and provide an itemized statement from your provider for work-related expenses. The itemized statement must include the provider's name, your dependent's name, as well as the specific dates daycare services were provided and the cost of care. The claim form can be used as an itemized statement if your daycare provider provides this information and signs the form where indicated. Cancelled checks cannot be accepted. Reimbursements can be made for services that have already been provided. 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. An eligible dependent is under age 13 or otherwise meets the "Qualifying Person Test" as described in Publication 503.

Before Submitting Reimbursement Claim Form:

You can expedite your claim by avoiding these common claim-filing mistakes:

1. Be sure to sign and date the claim form.
2. Include the appropriate documentation 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 refile.

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 drugs and medicines are eligible for reimbursement even though Publication 502 states that they are not eligible for tax deductions. Dependent care expenses must meet requirements of Section 125 and Publication 503.

Using the PayFlex Debit Card:

Using the PayFlex Debit Card to pay for your qualifying 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. In some cases, you may not need to provide additional documentation either. Here are some helpful hints when using the card:

1. Use the card only for eligible expenses at qualifying merchants.
2. If you purchase non-qualifying expenses, you'll be required to write a personal check back to the plan.
3. Keep copies of all receipts and itemized statements, (not the credit card receipt), for each purchase in a separate envelope. This will make it easier if you are asked to provide documentation of a certain expense at anytime during the plan year.
4. The card works great for prescription drug or office visit copays that match your benefit plans amounts. If you are purchasing a prescription drug and other non-qualifying items, ask the merchant to ring up the prescription separately so that you can use the PayFlex Debit Card.
5. The debit card can be used for purchasing contact lens cleaning solutions and eligible over-the-counter medicines and drugs. You **will** be requested to send the receipt in at a later date during the plan year to verify these expenses. If you are making additional purchases of non-qualifying items, ask the merchant to ring up the eligible expenses separately so that you can use the debit card.
6. You can use your card for other health expenses, including medical, dental, vision and hearing. Keep your receipts and itemized statements because, in some cases, we may ask you sometime during the year to send documentation of the expense.

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 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 for over-the-counter drugs/medicines.

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

Expense Incurred – Expenses must be incurred before being considered for reimbursement. Health care and dependent care expenses are treated as having been incurred when you are provided with the health care or dependent care that gives rise to the expense, and not when you are formally billed or charged for, or pay for the expense.

CLAIM FILING INSTRUCTIONS (Cont.)

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 – 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. In some cases, you may be asked to provide a letter from your attending physician to further substantiate your claim.

Itemized Statement – This is used when an individual does not have insurance coverage and will, therefore, not receive an EOB. This can also be used if you simply make a copayment 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. To be considered fully itemized, it 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

Medical Necessity – Because health care expenses must be for medical reasons, some expenses will 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.

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 eligible for reimbursement. These items may be in the form of a liquid, pill, or ointment if they contain a drug. 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.

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.

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.