The Federal FSA Program

# *Quick Reference Guide*

## *Filing your claim for reimbursement*

Under the FSAFEDS Program, you must submit a fully completed and signed FSAFEDS Health Care Claim Form or FSAFEDS Dependent Care Claim Form along with appropriate documentation, as described in this Guide.

Remember, expenses become eligible on the actual *date of service, not the date of payment* - that is, you incur the expense when the service is rendered. Orthodontic treatment is an exception to this rule. FSAFEDS will reimburse pre-paid orthodontia expenses regardless of the date of service. The payment must have been made during the Benefit Period. Eligible expenses and appropriate documentation are described below.

**Health Care**

Many of your typical, recurring, out-of-pocket health care expenses can be reimbursed under your health care FSA. All eligible services must meet IRS criteria as a qualified medical expense. For complete listings of eligible medical expenses, please refer to the FSAFEDS Eligible Expenses Juke Box, FSAFEDS OTC Quick Reference Guide and IRS Publication 502. Please note, however, that insurance premiums are listed in IRS Publication 502 as eligible medical expenses but they are NOT eligible FSA expenses.

| Type of health care expenses: | Examples include, but are not limited to: | In addition to the completed, signed claim form, you need to submit: |
|---|---|---|
| Expenses covered, but not reimbursed in full or in part, by your Federal Employees Health Benefits (FEHB) plan or any other insurance plan, or supplemental insurance, such as Federal Employees Dental and Vision Insurance Program (FEDVIP) dental insurance or (FEDVIP) vision insurance. | ▪ A covered service that goes towards meeting your individual or family annual insurance deductible<br>▪ An office visit to a non-participating (out-of-network) provider<br>▪ A covered service that has enrollee cost sharing, such as a co-payment amount per office visit. | Your Explanation of Benefits (EOB) statement (original or copy) from your FEHB or other insurance plan or an itemized receipt from the provider of the service or item. |
| Eligible expenses not covered by your FEHB or any other health plan, or supplemental insurance such as FEDVIP dental insurance and/or FEDVIP vision insurance. | ▪ Certain treatments for infertility<br>▪ Many alternative therapies<br>▪ Services that your insurance plan determines are not medically necessary, and for which you are still responsible for payment*, although cosmetic services are not generally eligible<br>▪ Services that are potentially eligible but require a Letter of Medical Necessity (LMN) | Bills or receipts that include the date(s) of service, your name or the name of your dependent who received the service, the nature of service(s) rendered, the amount charged, and the name and address of the provider.<br><br>A copy of your LMN for certain expenses, which will be kept on file. Once you've reached |

| Type of health care expenses: | Examples include, but are not limited to: | In addition to the completed, signed claim form, you need to submit: |
|---|---|---|
| | | the end of the length of treatment indicated on the LMN, you must resubmit an updated LMN for continued treatment. |
| Eligible expenses not submitted to your FEHB or any other health plan, or supplemental insurance such as FEDVIP dental insurance and/or FEDVIP vision insurance. | ▪ Mental health services that are covered under your health plan, but you choose to pay for out-of-pocket without submitting to your FEHB plan<br>▪ Prescription drugs that you choose to pay out-of-pocket without submitting to your FEHB plan<br>▪ Services that are potentially eligible but require a Letter of Medical Necessity (LMN) | Same information required above |
| Over-the-counter (OTC) medicines and products | ▪ Services that are potentially eligible but require a Letter of Medical Necessity (LMN)<br>▪ Refer to the FSAFEDS Eligible Expenses Juke Box | A receipt that indicates the date of purchase, the name of the product or supply, and its cost. Please circle the product name and amount you are submitting for reimbursement.<br>If your receipt does not have all this information, you must submit the outer packaging that has this information OR a copy of the product label along with a dated receipt. |

*If your FEHB or other insurance plan's Explanation of Benefits (EOB) does not clearly indicate the service rendered, FSAFEDS may ask you for additional information and/or ask you to provide a Letter of Medical Necessity from your health care provider.

Note: Health plan co-payments do not require an EOB if you submit a receipt from your health care provider for the amount and indicate "co-payment" on the Claim Form.

**Paperless Reimbursement**

If you participate in paperless reimbursement (PR), claims that are processed by your participating FEHB plan and/or FEDVIP plan are automatically forwarded to FSAFEDS for reimbursement of your out-of-pocket costs. You do not need to submit a paper claim. In fact, if you do participate in PR, you should NOT submit paper claims for expenses that are coming across automatically from your FEHB and/or FEDVIP plan.

- To learn more about PR or to find out if your FEHB and/or FEDVIP plan participates in the program, please refer to the Paperless Reimbursement Overview QRG.

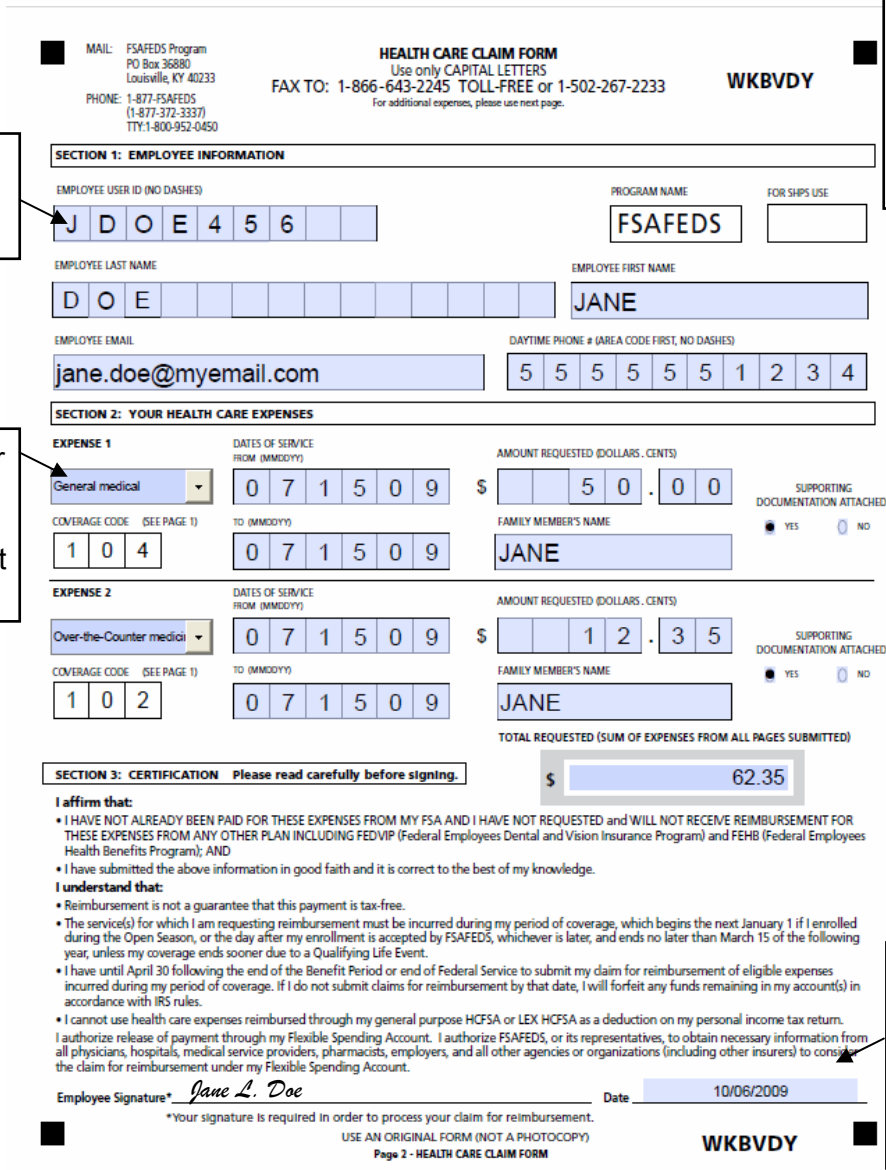
- **IMPORTANT:** If you participate in PR with your FEHB plan and are enrolled in a FEDVIP plan that does not participate in PR, some or all of your dental expenses and/or vision expenses may be covered by FEDVIP. Therefore we cannot automatically process eligible dental claims and/or vision claims from your FEHB plan using PR. Instead, we will email you a reimbursement statement to let you know to submit a manual claim along with your FEDVIP EOB or itemized statement from your dental and/or vision provider to FSAFEDS for reimbursement of your eligible expense(s). If you have used all the benefits available to you through your FEDVIP coverage, you can immediately complete the claim form and submit it to FSAFEDS with the appropriate documentation that supports your remaining out-of-pocket expense.

**Sample Health Care Form**

**Important:**
- Fill in the entire form
- Provide supporting documentation
- Submit your form only once

Be sure to type or print legibly in the form.

Add together similar expenses from the same Coverage Code and place that total on one line.



MAIL: FSAFEDS Program, PO Box 36880, Louisville, KY 40233
PHONE: 1-877-FSAFEDS (1-877-372-3337) TTY:1-800-952-0450

**HEALTH CARE CLAIM FORM**
Use only CAPITAL LETTERS
FAX TO: 1-866-643-2245 TOLL-FREE or 1-502-267-2233
For additional expenses, please use next page.

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**SECTION 1: EMPLOYEE INFORMATION**

EMPLOYEE USER ID (NO DASHES): JDOE456
PROGRAM NAME: FSAFEDS
FOR SHPS USE:
EMPLOYEE LAST NAME: DOE
EMPLOYEE FIRST NAME: JANE
EMPLOYEE EMAIL: jane.doe@myemail.com
DAYTIME PHONE # (AREA CODE FIRST, NO DASHES): 5555551234

**SECTION 2: YOUR HEALTH CARE EXPENSES**

EXPENSE 1: General medical
DATES OF SERVICE FROM (MMDDYY): 071509
TO (MMDDYY): 071509
AMOUNT REQUESTED (DOLLARS . CENTS): $ 50.00
SUPPORTING DOCUMENTATION ATTACHED? YES
COVERAGE CODE (SEE PAGE 1): 104
FAMILY MEMBER'S NAME: JANE

EXPENSE 2: Over-the-Counter medici
DATES OF SERVICE FROM (MMDDYY): 071509
TO (MMDDYY): 071509
AMOUNT REQUESTED (DOLLARS . CENTS): $ 12.35
SUPPORTING DOCUMENTATION ATTACHED? YES
COVERAGE CODE (SEE PAGE 1): 102
FAMILY MEMBER'S NAME: JANE

TOTAL REQUESTED (SUM OF EXPENSES FROM ALL PAGES SUBMITTED): $ 62.35

**SECTION 3: CERTIFICATION Please read carefully before signing.**

**I affirm that:**
- I HAVE NOT ALREADY BEEN PAID FOR THESE EXPENSES FROM MY FSA AND I HAVE NOT REQUESTED and WILL NOT RECEIVE REIMBURSEMENT FOR THESE EXPENSES FROM ANY OTHER PLAN INCLUDING FEDVIP (Federal Employees Dental and Vision Insurance Program) and FEHB (Federal Employees Health Benefits Program); AND
- I have submitted the above information in good faith and it is correct to the best of my knowledge.

**I understand that:**
- Reimbursement is not a guarantee that this payment is tax-free.
- The service(s) for which I am requesting reimbursement must be incurred during my period of coverage, which begins the next January 1 if I enrolled during the Open Season, or the day after my enrollment is accepted by FSAFEDS, whichever is later, and ends no later than March 15 of the following year, unless my coverage ends sooner due to a Qualifying Life Event.
- I have until April 30 following the end of the Benefit Period or end of Federal Service to submit my claim for reimbursement of eligible expenses incurred during my period of coverage. If I do not submit claims for reimbursement by that date, I will forfeit any funds remaining in my account(s) in accordance with IRS rules.
- I cannot use health care expenses reimbursed through my general purpose HCFSA or LEX HCFSA as a deduction on my personal income tax return.

I authorize release of payment through my Flexible Spending Account. I authorize FSAFEDS, or its representatives, to obtain necessary information from all physicians, hospitals, medical service providers, pharmacists, employers, and all other agencies or organizations (including other insurers) to consider the claim for reimbursement under my Flexible Spending Account.

Employee Signature* Jane L. Doe  Date 10/06/2009

*Your signature is required in order to process your claim for reimbursement.

USE AN ORIGINAL FORM (NOT A PHOTOCOPY)

Page 2 - HEALTH CARE CLAIM FORM

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Be sure to read the Certification section, sign and date your form! Unsigned claims will not be paid.

**Dependent Care**

In order to be eligible for reimbursement under FSAFEDS, your dependent care expenses must be incurred so that you and your spouse, if you are married, can work, look for work*, or attend school full-time. Eligible dependent care expenses include:

- child care for your children under age 13,
- child care for your children of any age who are physically or mentally incapable of self-care who you claim on your Federal Income Tax return as a qualified dependent, and
- elder care for adults who you claim on your Federal Income Tax return as a qualified dependent.

Dependent care FSA accounts work differently than health care FSA accounts. With dependent care accounts, you can only be reimbursed up to the amount that is currently in your FSAFEDS account at the time you submit a claim. You may still want to file your expenses as the services are provided, however, rather than waiting until you have that amount in your account. Eligible amounts that you claim in excess of your current account balance will be held until additional deposits are made from your salary. You don't have to resubmit those claims. Once your deposits are posted to your account, your funds will release automatically.

Please note: Expenses cannot be reimbursed before the care has actually been provided for your dependent, even if your provider requires payment in advance. If you submit a claim for expenses to be incurred in the future, it will be denied and you will have to resubmit it after the services are rendered.

*Example: On Monday, March 1, you enroll your son in a daycare that requires pre-payment each month. That day, you pay $800 for the month of March and immediately submit your claim form. FSAFEDS will process your claim, but can only reimburse you for $27 up to the date we receive your claim (March 1, in this case). Any expenses incurred after the date of receipt will be denied and you must resubmit for payment.*

While we can't reimburse your expenses in advance of when the care or service was rendered, FSAFEDS does offer you the opportunity to submit multiple claims to recoup your out-of-pocket expense more timely. For childcare that you must pre-pay a month in advance, we suggest you complete and submit a FSAFEDS Dependent Care claim form once a week. Using the example above, you would fax your first claim to FSAFEDS on March 5 requesting $200 for Week 1. You can then submit the additional charges for reimbursement each week as the services are rendered, thus minimizing your out-of-pocket expense.

* Please note, if either you or your spouse had no earned income for the year, you are not eligible for the Dependent Care FSA. For more information, refer to the dependent care section of the Summary of Benefits and Frequently Asked Questions.

**Dependent Care Expenses – Supporting Documentation:**

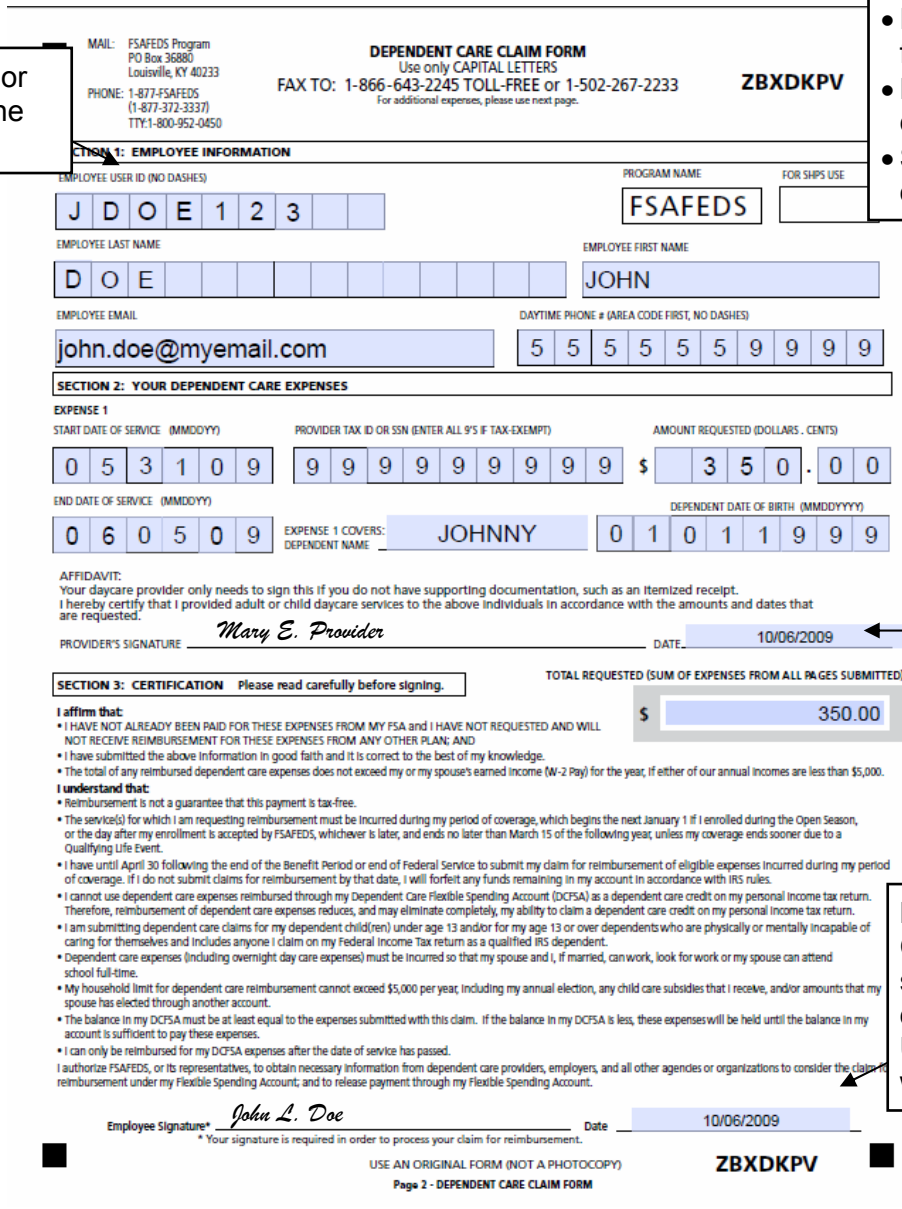
You can either:

- Attach a copy of your dependent care bill or signed receipt to your claim form, OR
- Have your provider sign the Affidavit section of the claim form

## Sample Dependent Care Form

Be sure to type or print legibly in the form.

**Important:**
- Fill in the entire form
- Provide supporting documentation
- Submit your form only once



MAIL: FSAFEDS Program
PO Box 36880
Louisville, KY 40233

PHONE: 1-877-FSAFEDS
(1-877-372-3337)
TTY:1-800-952-0450

**DEPENDENT CARE CLAIM FORM**
Use only CAPITAL LETTERS
FAX TO: 1-866-643-2245 TOLL-FREE or 1-502-267-2233
For additional expenses, please use next page.

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**SECTION 1: EMPLOYEE INFORMATION**

EMPLOYEE USER ID (NO DASHES): J D O E 1 2 3
PROGRAM NAME: FSAFEDS
FOR SHPS USE:
EMPLOYEE LAST NAME: D O E
EMPLOYEE FIRST NAME: JOHN
EMPLOYEE EMAIL: john.doe@myemail.com
DAYTIME PHONE # (AREA CODE FIRST, NO DASHES): 5 5 5 5 5 5 9 9 9 9

**SECTION 2: YOUR DEPENDENT CARE EXPENSES**

EXPENSE 1
START DATE OF SERVICE (MMDDYY): 0 5 3 1 0 9
PROVIDER TAX ID OR SSN (ENTER ALL 9'S IF TAX-EXEMPT): 9 9 9 9 9 9 9 9 9
AMOUNT REQUESTED (DOLLARS . CENTS): $ 3 5 0 . 0 0
END DATE OF SERVICE (MMDDYY): 0 6 0 5 0 9
EXPENSE 1 COVERS: DEPENDENT NAME: JOHNNY
DEPENDENT DATE OF BIRTH (MMDDYYYY): 0 1 0 1 1 9 9 9

AFFIDAVIT:
Your daycare provider only needs to sign this if you do not have supporting documentation, such as an itemized receipt.
I hereby certify that I provided adult or child daycare services to the above individuals in accordance with the amounts and dates that are requested.

PROVIDER'S SIGNATURE: *Mary E. Provider* DATE: 10/06/2009

Be sure to have your provider sign here, unless you prefer to include a receipt.

**SECTION 3: CERTIFICATION** Please read carefully before signing.

TOTAL REQUESTED (SUM OF EXPENSES FROM ALL PAGES SUBMITTED): $ 350.00

**I affirm that:**
- I HAVE NOT ALREADY BEEN PAID FOR THESE EXPENSES FROM MY FSA and I HAVE NOT REQUESTED AND WILL NOT RECEIVE REIMBURSEMENT FOR THESE EXPENSES FROM ANY OTHER PLAN; AND
- I have submitted the above information in good faith and it is correct to the best of my knowledge.
- The total of any reimbursed dependent care expenses does not exceed my or my spouse's earned income (W-2 Pay) for the year, if either of our annual incomes are less than $5,000.

**I understand that:**
- Reimbursement is not a guarantee that this payment is tax-free.
- The service(s) for which I am requesting reimbursement must be incurred during my period of coverage, which begins the next January 1 if I enrolled during the Open Season, or the day after my enrollment is accepted by FSAFEDS, whichever is later, and ends no later than March 15 of the following year, unless my coverage ends sooner due to a Qualifying Life Event.
- I have until April 30 following the end of the Benefit Period or end of Federal Service to submit my claim for reimbursement of eligible expenses incurred during my period of coverage. If I do not submit claims for reimbursement by that date, I will forfeit any funds remaining in my account in accordance with IRS rules.
- I cannot use dependent care expenses reimbursed through my Dependent Care Flexible Spending Account (DCFSA) as a dependent care credit on my personal income tax return. Therefore, reimbursement of dependent care expenses reduces, and may eliminate completely, my ability to claim a dependent care credit on my personal income tax return.
- I am submitting dependent care claims for my dependent child(ren) under age 13 and/or for my age 13 or over dependents who are physically or mentally incapable of caring for themselves and includes anyone I claim on my Federal Income Tax return as a qualified IRS dependent.
- Dependent care expenses (including overnight day care expenses) must be incurred so that my spouse and I, if married, can work, look for work or my spouse can attend school full-time.
- My household limit for dependent care reimbursement cannot exceed $5,000 per year, including my annual election, any child care subsidies that I receive, and/or amounts that my spouse has elected through another account.
- The balance in my DCFSA must be at least equal to the expenses submitted with this claim. If the balance in my DCFSA is less, these expenses will be held until the balance in my account is sufficient to pay these expenses.
- I can only be reimbursed for my DCFSA expenses after the date of service has passed.

I authorize FSAFEDS, or its representatives, to obtain necessary information from dependent care providers, employers, and all other agencies or organizations to consider the claim for reimbursement under my Flexible Spending Account; and to release payment through my Flexible Spending Account.

Be sure to read the Certification section, sign and date your form! Unsigned claims will not be paid.

Employee Signature*: *John L. Doe* Date: 10/06/2009
* Your signature is required in order to process your claim for reimbursement.

USE AN ORIGINAL FORM (NOT A PHOTOCOPY) ZBXDKPV

Page 2 - DEPENDENT CARE CLAIM FORM

### How can I submit my claim form?

- **Fax Your Claim:** 1-866-643-2245 (toll-free) • 1-502-267-2233
- **Mail Your Claim:** FSAFEDS Program • PO Box 36880 • Louisville, KY 40233

### Overseas Claim Submission Process

For participants who live overseas, there are a few additional requirements regarding claim submission:

- Please be sure to submit your claim in English. We will send you a claim receipt in English.
- You can use the non-toll-free fax number for your claims: 1-502-267-2233

## Claim Review and Appeal Process

You have the right to submit an appeal of a claim for benefits that we have denied.

- You may request further explanation of a denied claim from FSAFEDS. You may contact us via phone, email (FSAFEDS@shps.com), fax or mail.
- If you do not agree with the explanation provided by FSAFEDS, you have the right to formally appeal a claim for benefits that has been denied by writing to FSAFEDS and requesting reconsideration. You can submit formal appeals with supporting documentation via fax or mail. For more information, please read the Appeal Process Quick Reference Guide.

If you have questions please visit the FSAFEDS web site at www.FSAFEDS.com or contact an FSAFEDS Benefits Counselor, toll-free, at 1-877-FSAFEDS (372-3337), TTY: 1-800-952-0450, Monday through Friday, 9:00 A.M. until 9:00 P.M., Eastern Time.

## When will I receive payment of my claim?

- In most cases, you should receive payment within 5-7 business days after we receive your claim, as long as it contains all of the required information discussed above. If supporting documentation (for example, a Letter of Medical Necessity if required, legible copy of a receipt, etc.) or your signature is missing, processing will be delayed. We will reprocess your claim after we receive the missing documentation. We will also revise your claim received date to reflect the date we receive the missing documentation and will prepare your claim for payment within 5-7 business days of that revised date.
- If your claim does not total $25.00, it will be processed and you will receive a reimbursement statement, but you will not receive the money until you submit another claim and reach the $25.00 minimum or the end of the quarter, whichever comes first.
- Remember, you will not receive reimbursement for dependent care claims that exceed the current amount in your DCFSA on the date your claim is processed. In this case, your reimbursement will be held until additional funds are deposited.
- You will receive reimbursement for health care claims even if the current amount in your account is less than the claim total.
- The total amount you can be reimbursed for any account cannot exceed your total annual election for that account.