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 claim form along with appropriate documentation outlining the expense(s) you incurred to be reimbursed for eligible health and/or dependent care expenses. Remember, expenses become eligible on the actual *date of service* - that is, you incur the expense when the service is rendered. The exception is orthodontic treatment. FSAFEDS will allow reimbursement for pre-paid orthodontia expenses, up to the elected amount, regardless of the date of service. The payment must have been made during the Benefit Period. For grace period expenses, be sure to select the box at the top of the form for the Plan Year that you want to be reimbursed from. 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.

Type of health care expense:	Examples include:	In addition to the completed, signed claim form, you need to submit:
Expenses covered, but not reimbursed in full or in part, by your FEHB or any other health plan, or supplemental insurance, such as FEDVIP dental and/or vision	■ A covered service that goes towards meeting your individual or family annual deductible ■ An office visit to a non-participating (out-of-network) provider ■ A covered service that has member cost sharing	Your Explanation of Benefits (EOB) statement (original or copy) from your FEHB or other health plan or an itemized receipt.
Eligible expenses not covered by your FEHB or any other health plan, or supplemental insurance such as FEDVIP dental and/or vision	■ Certain treatments for infertility ■ Many alternative therapies ■ Services that your plan determines are not medically necessary, and for which you are still responsible for payment* ■ Services that are potentially eligible but require a Letter of Medical Necessity (LMN)	Bills or receipts that include the date(s) of service, the nature of service(s) rendered, and the amount charged, along with the name and address of the provider. A copy of your LMN for certain expenses, which will be kept on file. Once you've reached the end of the length of treatment indicated, 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 and/or vision	■ Mental health services that are covered under your health plan, but you choose to pay out-of-pocket without submitting to your FEHB Plan ■ Prescription drugs that you choose to pay out-of-pocket without submitting to your FEHB Plan	Bills or receipts that include the date(s) of service, your name or your dependent's name who received the service, the nature of services rendered and the amount charged, along with the name and address of the provider.
Over-the-counter (OTC) medicines and products	Refer to the FSAFEDS OTC Quick Reference Guide	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. 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 health plan's 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" in Part II of the Claim Form.

Paperless Reimbursement

- If you participate in paperless reimbursement, claims that are processed by your FEHB Plan for you (self-only enrollment) and your dependents (self and family enrollment) are automatically forwarded to FSAFEDS for reimbursement of your out-of-pocket costs without having to complete and file a paper claim. We are continually adding plans. To learn more about paperless reimbursement or to find out if your plan participates in the program, please refer to the Paperless Reimbursement Overview QRG.

- **IMPORTANT:** If you are enrolled in a Federal Employees Dental and Vision Insurance Program (FEDVIP) dental and/or vision plan, some or all of your dental and/or vision expenses may be covered by that plan, so we cannot automatically process eligible dental and/or vision claims via the paperless reimbursement program. 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. If you have used all the benefits available to you though your FEDVIP coverage, or you certify via the claim form that you will not be submitting the expense(s) to your FEDVIP plan(s) for consideration, then you can immediately complete the claim form and submit it to FSAFEDS with the appropriate documentation that supports your remaining out-of-pocket expense.

DCFSA

- Eligible Dependent care expenses include child care for your children under age 13 or your child who is physically or mentally incapable of self-care, and, elder care for adults who can be claimed on your Federal Income Tax return as a qualified IRS dependent. Expenses must be incurred so that you and your spouse, if married, can work, look for work*, or attend school full-time.
- Since claims are reimbursed as funds are posted to your account, you may choose to file your expenses as services are provided. Amounts claimed in excess of your current account balance will be held until deposits are made. Once your deposits are posted to your account, your funds will release automatically.
- Expenses cannot be reimbursed in advance of the actual care for your dependent, even if your provider requires payment in advance.

Example: On Monday, March 1, you enroll your son in a daycare that requires pre-payment each month. That day, you pre-pay $800 and immediately submit your claim via fax. FSAFEDS will process your claim, but can only reimburse you 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 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:

- Attach a copy of the bill or signed receipt or have your provider complete Part III, " Dependent Care Expenses" on the claim form
- Read and sign the Employee's Certification for Reimbursement on the claim form

How can I submit my request for reimbursement?

- **Fax Your Claim:** 1-866-643-2245 (toll-free) • 1-502-267-2233
- **Mail Your Claim:** FSAFEDS Program • PO Box 36880 • Louisville, KY 40232

Overseas Claim Submission Process

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

- Please be sure to submit you claim in English. Your claim receipt will be sent in English.
- You will need to utilize the direct number for you claims: 1-502-267-2233

Claim Review and Appeal Process

You have the right to request a review or submit an appeal of a claim for benefits that has been denied.

- You may request a denied claim be **reviewed** by FSAFEDS to determine if the denial should be upheld. You may submit your request for review via email (FSAFEDS@shps.com), fax or mail.
- 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.

If you have questions you may 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 should I expect to receive my reimbursement?

- Typically, it takes us 5-7 business days after we receive your claim to reimburse the expense, as long as your claim 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.) 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.
- 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 in full even if the current amount in your account is less than the claim total. Of course, the total amount you can be reimbursed cannot exceed your total annual election.