



FAQ: FLEXIBLE SPENDING ACCOUNT (FSA)

I am new to Flexible Spending Accounts. How do these plans work?

When you enroll in a Flexible Spending Account (FSA), you will determine the total amount you want to set aside in a pre-tax account to pay for your eligible out-of-pocket healthcare and dependent care expenses. This amount will be deducted from your paycheck throughout the year on a pre-tax basis. In the case of a Healthcare FSA, the full amount you've elected for the plan year is available to you as of your effective date.

As you incur expenses, request reimbursement at any time throughout the plan year by submitting to Acclaim Benefits a Reimbursement Request Form with itemized supporting documentation. Upon approval of that request, Acclaim Benefits will disburse funds from your FSA directly to you.

What is eligible for reimbursement under my Flexible Spending Account?

A Flexible Spending Account (FSA) is designed to reimburse you for out-of-pocket medical expenses and dependent care expenses incurred within your plan year by you, your spouse and tax dependents. Examples of eligible expenses can be found in your Summary Plan Description or on our website at www.acclaimbenefits.com.

How do I complete the Reimbursement Request Form?

Please include your full name and Acclaim Benefits Participant Identification Number to ensure proper identification.

Enter the appropriate Benefit Code for each product or service you are submitting. Similar products and services may be combined on the same line of the Reimbursement Request Form.

Enter a service start date and if the service provided spans more than one day, also enter the service end date. These dates are the date(s) which you actually received the service, not when the charge was billed or paid. For instance, a reimbursement request for dependent care expenses should include the first date and last date the dependent care services were received to account for the total amount requested. For many medical expenses, the patient is charged after the reimbursement request has been processed by insurance however, the date(s) that the actual service took place is what should be listed on the form. It is the service dates that determine eligibility, not billing or payment dates.

If the request cannot be validated by itemized, third-party documentation, a service provider may sign his-her name in the appropriate field on the form (credentials must be included for all healthcare services) along with the provider's Tax ID Number.

Under the "Amount" column, please enter only the amount you wish to be reimbursed. If your insurance coverage will be responsible for a portion of the total charges, you would only include the portion of that charge that is your responsibility to pay.

The participant (not a spouse or dependent) must sign at the bottom of the form.

How do I know which Healthcare Benefit Code to use?

A good rule to follow for any type of Healthcare reimbursement request is to first classify the expense as Medical, Dental, or Vision. If the expense is a product, not a service, determine whether a prescription is required to obtain the product. If no prescription is required, and you can obtain the product anonymously, it is most likely an over-the-counter expense.

Here is a list of the Healthcare Benefit Type Codes and some of the expenses these codes might cover:

01 Medical – Doctor visits, surgery, medical equipment

02 Dental – Cleanings, fillings, crowns, extractions, eligible prescription dental products obtained from a dentist's office

03 Vision – Glasses, contact lenses, eye exams, contact lens fittings

08 Prescription – Any prescription filled by a pharmacist

23 Over-the-Counter – Any eligible product that can be purchased without a prescription from a retail provider. This can include pain relievers, contact lens solution, bandages, etc.

07 Medical Mileage/Parking – You may be reimbursed for mileage to and from any provider from which you receive an eligible medical service. Mileage reimbursement requests should include the provider name and the number of miles round trip. See FAQ regarding travel expenses for further details. Medical parking reimbursement requests should be substantiated by a receipt from a parking lot or ramp, and documentation detailing the corresponding visit.

Products and services that share the same Benefit Code may certainly be listed on the same line of the Reimbursement Request Form, as long as the appropriate dates of service are listed on that line. For instance, if you have three prescriptions filled on three different days, you may enter the fill date of the first prescription under the service "Start Date," the fill date of the last prescription under the service "End Date," and the total of all three under the "Amount."

What does my documentation need to have to be considered “itemized?”

IRS guidelines regarding these types of benefits plans require the following information for any reimbursement request:

- The Service Provider's Name - This could be the name of the doctor, dentist, clinic, retailer etc.
- The Date of Service - This refers to the date on which the charge was incurred/received (except in the instance of on-going services), not a billing or payment date.
- Detailed Description of Service – This should be the specific name of an eligible medical procedure or product. You may use Physician Procedure (CPT) Codes if you have them. Over-the-Counter products must be listed clearly on the register receipt. In the case of an abbreviated description, a representative of the retail provider may indicate the full product name, and print and sign his or her name on the receipt.
- Dollar Amount – This means the amount charged for each specific product or service. Some providers may offer ineligible products or services that they combine with charges for eligible services on an invoice. Without being able to separate the charges for each individual product or service, Acclaim Benefits will be unable to reimburse the entire amount.

In lieu of itemized documentation, service providers may indicate the date, detailed description and charge amount for any medical or dependent care service and put their signatures (credentials included – M.D., D.D.S., etc.) and Tax ID Numbers in the indicated spaces on the Reimbursement Request Forms.

Prescriptions and Over-the-Counter products require third-party documentation – a provider’s signature will not suffice for these types of reimbursement requests.

What do I do if I lost or threw away a prescription receipt? Can I send you the empty prescription bottle?

No, but your pharmacy should be able to provide you with a detailed print out of all prescriptions filled within a requested time period.

What are the hours during which I can fax my reimbursement request?

You may send your fax at any time as our fax line can accept faxes 24 hours a day. Please use the Acclaim Benefits Reimbursement Request Form as the cover page for your fax to ensure proper and timely processing. If you are resubmitting a previously denied request, please use the Denial Letter as your fax cover page.

What will be processed sooner, faxing or mailing my reimbursement request form?

Sending a request by fax will arrive in our offices sooner than by mail. Once received, however, no special priority is given to requests based on the mode they were sent.

All reimbursement requests are processed within 24-hours of receipt (excluding weekends and Acclaim Benefits scheduled holidays). If you have signed up for e-mail notification you should receive the notification within that same 24-hour period.

May I e-mail my reimbursement request form in?

Sending personal health information via e-mail is not advised unless you are comfortable with the security you have on the computer you are sending from. If you wish to e-mail your reimbursement request, you may send it to fsacsr@acclaimbenefits.com.

When will I receive payment?

Funds will be released to you according to a schedule that is specific to your employer sponsored plan. Acclaim Benefits will process your reimbursement request within 24 hours of receipt of the request (excluding weekends and Acclaim Benefits scheduled holidays) . Please refer to your reimbursement schedule for accurate payment release dates.

Why is my request not showing up online?

It may take up to 24-hours from the time we receive your reimbursement request before you can view it online. Acclaim Benefits prides itself on quick turnaround on processing requests. To ensure that your reimbursement is likely to appear online without any delays, please make sure you are using the most current Reimbursement Request Form by downloading it from our website each time you submit a new request. Fill out the form clearly and completely.

I highlighted all the pertinent information on all the receipts that I faxed along with the Reimbursement Request Form. Why was Acclaim Benefits unable to fulfill my request?

If faxed, some highlighted documents become completely illegible. Instead of highlighting expenses, Acclaim Benefits recommends circling, underlining, or using some other method of indicating specific products, services, dates, or amounts on a statement or receipt.

May I send Explanations of Benefits to substantiate reimbursement requests?

You may submit an Explanation of Benefits (EOB) from your insurance company as your itemized documentation. You may request reimbursement for any amount that your insurance company has applied to your deductible, co-pay, or co-insurance.

Does Acclaim Benefits receive information from my healthcare provider or my insurance company?

No, Acclaim Benefits does not receive any information from your healthcare provider or your medical plan carrier directly. You will be required to submit the proper documentation as your medical information is protected and secure information.

How long do I have to submit a reimbursement request after the end of the year?

The amount of time that you have to submit your reimbursement requests after your loss of coverage for that plan year will vary by plan. If you have a balance in your account you will receive a letter in the fourth quarter of the plan year notifying you of your remaining balance and the deadline for reimbursement request submission. You may refer to your Summary Plan Description to obtain your final reimbursement request submission deadline or you may contact Acclaim Benefits [Customer Service](#).

How do I appeal a request that Acclaim Benefits was not able to reimburse?

You will receive notification of any expense for which Acclaim Benefits has determined is ineligible or for expenses which may require additional documentation in order to process. The notice will also provide you with details regarding your rights to appeal the denied expense. You have 180-days from the date printed at the top of that letter to supply Acclaim Benefits with that required information. To guarantee that the request is re-processed correctly, please always include a copy of that notice with any re-submission.

What is my participant ID?

All participants are assigned a Participant Identification Number from Acclaim Benefits as a unique identifier. If you do not know your Participant ID, you may retrieve it online by logging in to your account at www.acclaimbenefits.com and go to User Profile. You may also contact Acclaim Benefits [Customer Service](#) to find out how to obtain it.

How do I request a reimbursement for travel expenses and mileage for medical care received?

The IRS allows a reimbursement of \$50 per night for hotel/lodging for the person receiving treatment, and an extra \$50 for a parent or guardian if the patient is too young to travel alone. This is the maximum allowable amount for reimbursement, regardless of the cost of the hotel room.

How to request a reimbursement for mileage:

- 1) Fill in 07 for the benefit type code
- 2) Calculate the mileage on the line labeled "Detailed Description of Service" write IRS regulated amount (this amount can be found on our eligible expense list) of cents (per mile) times the number of miles roundtrip
- 3) Attach documentation verifying the service ((e.g. bill, statement, itemized receipt, EOB).

Mileage can be reimbursed for round trips from the participant's home address to the medical provider. IRS Publication 502 specifically states that travel to another city for the purpose of medical care with underlying personal reasons is not allowable. This means that mileage may not be reimbursed for travel to see a particular provider if another provider or clinic can perform the same service and is located closer to the participant's home.

Sometimes dependents who live away at college will return home to see a family physician. In cases such as these, the mileage must be calculated from the participant's address. If the dependent chooses to visit a clinic close to campus, the mileage should be calculated from the dependent's temporary residence. Mileage rates may be adjusted periodically. See the list of [eligible expenses](#) for current mileage reimbursement rates.

Airfare, taxi fees, and public transportation expenses incurred for the specific purpose of obtaining medical treatment are eligible. Car rental expenses are eligible for dates of travel to and from the medical provider.

What is a Letter of Medical Necessity? Why do I need one?

A Letter of Medical Necessity (LMN) is required for any item or service that is not typically eligible for reimbursement. The LMN must be provided by a medical practitioner who is qualified to diagnose and treat the stated medical condition, and it must state that the treatment and/or item in question is not merely beneficial for general health, but is primarily for treatment of that specific medical condition. Examples of procedures/items that would require a LMN are: massage therapy, breast pumps, dietary supplements, herbs and/or vitamins, orthotics or shoe inserts, weight loss programs, sperm and/or embryo storage, etc.

What information does Acclaim Benefits require in a Letter of Medical Necessity?

To reimburse an expense that is usually considered ineligible under IRS guidelines, Acclaim must be notified of the following:

- The specific medical condition being treated – the physician writing the Medical Necessity Letter may also include Diagnosis (ICD-9) codes
- The specific product or treatment prescribed for this medical condition
- The proposed start and end date of treatment (most letters will require an annual update)
- The signature and legible, printed name of the physician, including credentials

Any Medical Necessity Letter should be written by a physician qualified to diagnose and treat the listed condition.

What information do I need for a dependent care reimbursement?

The form must be completed in its entirety (See [How Do I complete the Reimbursement Request Form?](#))

In lieu of an itemized statement from your dependent care provider, he/she (or a representative of the daycare center) may indicate the service dates and charge amount in the appropriate fields on the Reimbursement Request Form, and provide a signature and Tax ID number on the line below. **Note:** the reimbursement request should not be submitted until the service has been provided.

I submitted a dependent care reimbursement request and I received reimbursement for a lesser amount. Why did I not receive the full amount I requested?

For your dependent care account, the money must be deducted from your paycheck and reported by your employer to Acclaim Benefits before it is available for reimbursement to you. If you have requested an amount greater than the balance of your account, the remainder of the requested amount will be suspended until additional contributions (payroll deductions) have been applied to your account. Once the funds appear in your account, reimbursement will occur according to your employer's reimbursement schedule.

What is the Acclaim Benefits policy regarding reimbursement for Orthodontia (braces) expenses?

This type of expense is usually reimbursed monthly based upon a provider- contract or payment plan. The regulations allow for ongoing reimbursement throughout the term of the treatment. To calculate your monthly reimbursement amount, and how much should be allocated for each plan year, the following information is needed:

- Treatment start and end date (or the start date and length of treatment in months)
- Total treatment cost
- Down payment required by provider
- Amount covered by Insurance and/or provider discount, if applicable
- Monthly payment amount

If the provider offers a discount for full payment up front, you may choose that option, but be aware that reimbursement must still occur on a monthly basis according to a payment plan. To ensure that Acclaim Benefits has all the information needed to process and approve orthodontia reimbursement, please have the provider complete and sign the Acclaim Benefits [Orthodontia Worksheet](#).

When submitting the Reimbursement Request Form monthly, if we have the Worksheet or a copy of your contract with the provider of file, we will also need a monthly invoice or copy of the payment coupon.

Full reimbursement can be made when the work begins only if the provider is requiring that full payment is due and payable before work can begin. In this scenario this requirement will need to be in writing and submitted to Acclaim Benefits along with the itemized documentation.

I've updated my e-mail address on the Reimbursement Request Form. Why am I still receiving a reimbursement request receipt notification at my old e-mail address?

It may be the case that the representative handling your request was unable to read your new e-mail address. You may update your e-mail address on Acclaim Benefits website under [User Profile](#).

I sent my new address to Acclaim Benefits. Why has it not been updated?

All address changes must be done through your employer. If you have updated your address with your employer and it is still not reflected in our system, please contact [Customer Service](#) so we can verify your information with your employer.

Due to delays in processing my health insurance claim, I received the bill after the final deadline for reimbursement requests had expired. Can I submit the expense for reimbursement in the current plan year?

No, you cannot submit an expense incurred in the prior plan year for reimbursement of the current plan year's funds unless your plan allows for a grace period. Refer to your Summary Plan Description or [Plan Highlights](#) to determine if your plan has a [grace period](#). To be eligible for reimbursement, a service must be incurred during the Plan year and submitted by the final reimbursement deadline. Once the deadline for submission has passed, any funds remaining in your account are forfeited.

I have left or will be leaving the company through which I have my FSA reimbursement account. How long may I continue to incur and submit expenses for reimbursement?

The amount of time you have to incur expenses and submit them for reimbursement after your employment has ended will vary according to your plan specifications. You may also have the opportunity to extend your healthcare reimbursement coverage beyond your termination. Please refer to your Summary Plan Description for additional information. You may also refer to the [Plan Highlights](#) section on Acclaim Benefits website or contact Acclaim Benefits [Customer Service](#).

Why do I need the provider's signature and Tax ID?

The provider's signature and Tax ID number are only required when the provider cannot supply you with proper, itemized documentation.