Live your life, enjoy your life

A guide to using your Flexible Spending Account (FSA)

UnitedHealthcare®

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Your guide to managing your Flexible Spending Account (FSA)

If you are enrolled in a Flexible Spending Account (FSA) from UnitedHealthcare, use this guide to manage your account through uhcservices.com.

FSA checklist

Use this list to make sure you've taken all the first steps to creating
an account on uhcservices.com.

- ☐ Go to **uhcservices.com** and select "New Member Registration"
  (if you haven't already registered).
- ☐ Complete the registration form
  - Check your email for the 'Activation Required' message .
  - Click on the link provided to activate your account.
- ☐ Sign up for direct deposit and other features at **uhcservices.com**.

Once you have registered on uhcservices.com, you can:

- Submit claims*
- View account balance
- Review claim status
- Send an email to Customer Service with Ask the Expert
- Access forms and other resources
- Access payment details

Sign up for eStatus

UnitedHealthcare will automatically send you emails when we've received a claim, issued a reimbursement, or made a system enhancement.

To sign up for eStatus select 'eStatus' during the registration process or click 'change your password' and check the 'Subscribe for eStatus and other information alerts'.

For more information
Please log on to uhcservices.com.

*May not be available for all plans.

Why direct deposit?

Any eligible expenses that you pay out of your own pocket and submit for reimbursement from your FSA are automatically deposited right into your personal checking or savings account.

You can also count on:

- Secure and automatic receipt of reimbursement funds
- Fewer envelopes to open and fewer trips to the bank to deposit your checks

Plus, you are making a decision that is good for the environment. You can cancel direct deposit at any time.

Timeframes

- Online eClaims are processed within one business day.
- Mailed/Faxed claims are processed within 5 business days.
- Reimbursement of approved claims are determined by your employer's plan.

You can submit your claims through:

- eClaims *
- UnitedHealthcare Health Care Spending Card MasterCard®
- Submitting paper claim forms.

Claim forms can be found on your member website at **uhcservices.com**.

Please note: If you do not enroll in the FSA for the new plan year or are terminated you must submit a paper claim form in order to receive prior year expense reimbursements during the grace period.

Website Features

1. Plan Details: Provides an overview of your account including:
   - Election Amount
   - Balance
   - Pending payments
   - Claim detail
2. Enrollment: Our online enrollment tool provides you with your claim information and allows you to estimate your future spending needs to determine your election amounts during open enrollment.

3. eClaims:
   - Submit your claims electronically
   - View your eClaim status
4. Calculate Savings: The FSA Savings Calculator, will help you determine possible savings using an FSA will give you. Your FSA will help you save in the plan year.
5. Resources: Find information and forms needed to use your FSA
6. Ask the Expert: You can send us questions online using Ask the Expert. Turn around time is one to four business days.

Claims:

Submitting Claims

Requests for reimbursement can be submitted on the web (eClaim), mailed, emailed or faxed to our office along with proper documentation.

eClaims: Some clients offer eClaim ability which allows you to submit your claims online for same or next day processing. eClaims are processed and pay out based on the information given on the online claim. Documentation is not required at the time of submission, however is still required. Once you have submitted the eclaim online you will receive a "Documentation Form" that pops up on your screen. If this is not returned in a timely fashion you will receive an email or letter from UnitedHealthcare

To submit an eClaim

- select the eClaim tab
- complete the requested information. Submit using the blue bar above the line detail.
- mail, email or fax your receipts along with your printed claim form to UnitedHealthcare

To submit a mailed or faxed claim

- Complete the appropriate claim form located on the resources tab.
- complete the requested information
- mail or fax your completed form and receipts to UnitedHealthcare

Claim Payments

In most cases, claims pay out once per week. Once your claim is received, approved and processed, your claim will pay out depending on your employer's plan. Depending on the option chosen, the payment will be either mailed to your home, or direct deposited to your checking or savings account.

Claim documentation

Five pieces of information are required to help ensure the approval of your claim. They are:

- Patient: Person who received the service or who the item is for. For retail store purchases, this may be excluded.
- Provider: Who delivered the service or if a purchase, where was the item purchased.
- Date of Service: Date services occurred or date item was purchased.
- Type of Service: Detailed description of what service or product was paid for.
- Financial Responsibility: The amount paid for the service or product and/or the portion not reimbursed through your insurance carrier.

Please ensure that your documentation contains all of the above information when submitting a claim.

See the below grid for information regarding what additional documentation must be included with each claim type:

Weight Loss Reimbursement
Signed dated weight loss reimbursement form and copy of letter from Dr. stating the diagnosis and medical need for weight loss with every submitted claim form.
Capital Expenditure
Signed dated request form by participant and physician
Date of service incurred
Provider name
Description of service
Patient name
$$ Participant is responsible for
Medical Mileage IRS sets the per mile amount
Signed dated claim form including total requested amount
Transit
Signed dated claim form including total requested amount
Medical FSA
Signed dated claim form including total requested amount
Date of service incurred
Provider name
Description of service
Patient name
$$ Participant is responsible for
If the expense incurred is reimbursable by an insurance company, you must submit the expense to the insurance company first / the EOB received would then be required as documentation.
Health Reimbursement account/ Employer Funded Plans
Signed dated claim form including total requested
Date of service
Provider name/type of service
Patient name
Description of services or CPT code
Dollar amount charged
OR
EOB – is required if reimbursed in any part by an insurance company
Orthodontia
A claim must be submitted with documentation regardless of having a contract on file.
Signed dated claim form including total requested amount
Receipt of payment
Description of services - orthodontic/braces enough info
$$ Participant is responsible for
Signature of orthodontist helpful but not required
Private Insurance
Signed dated claim form including total requested amount
Bill or receipt from the insurance company which includes
Type of insurance
Cost of insurance
Dates that the policy has been issued for coverage
Proof of ownership or being covered on the policy
Medicare Part B: A copy of the rate letter would be sufficient as this includes the covered member, and the monthly rates. A new copy can be requested from Medicare.
Parking
Signed dated claim form including total requested amount
Letter of Medical Necessity
Whom needs OTC
The product being prescribed
How it will help the disorder
Year: Example: three months
Note: If it's an item out of the ordinary, or that has a dual purpose (general Health vs. illness) it must state "medically necessary"
Dependent Daycare Account Non demand - can submit one month in advance
Signed dated claim form including total requested amount
Signature of participant and day care provider
Tax ID or SSN
Dates of Care
Dependent Name
Dependent Age
Over 13 need to provide letter of medical necessity. Letter must include diagnosis, and wording such as can not care for self.
Note: The wording: "Tuition" raises a concern on submitted claims: tuition is not an eligible expense. Many providers have begun to use this term. We require the age of the child and the type of care; ie Pre-school, kindergarten

Claim Denials

If a claim is ineligible for reimbursement, our system will generate a denial/pending-payment notice. This notice is sent directly to your home or emailed depending on the communication method you have selected.

See the below table of Claim Denial codes:

Denial Codes

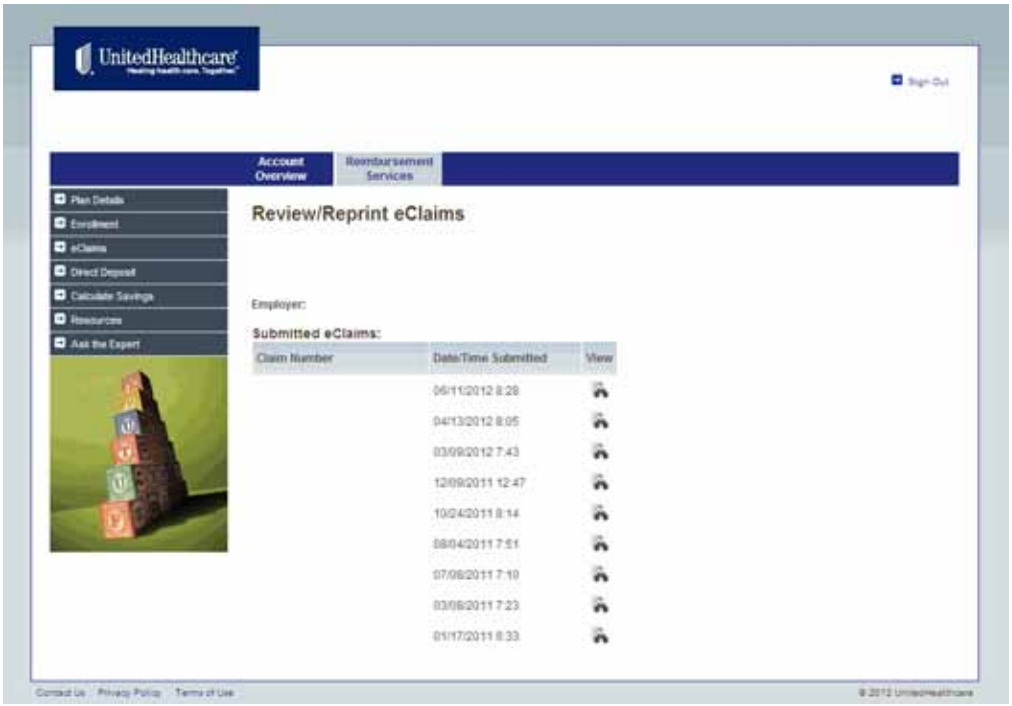
01	**Dates of service needed** –The date of service/ date of purchase were not listed on the documentation submitted.
02	**No documentation received** – The claim submitted did not have documentation/receipt attached
03	**Prior to or after effective date** – the participant submitted a claim for after or before the effective date of the plan. Participants may only submit expenses that incur during the plan year, for example the client's plan year is 1/1/11 – 12/31/12 a participant cannot submit claims for prior to 1/1/12 for the plan year.
04	**Duplicate claim/expense** – the claim submitted is a duplicate of a claim that has already been processed.
05	**Total calculated incorrectly** – If the total requested amount does not add up to the itemized amounts on the bottom of claim form, the claim is denied.
06	**Eligibility requires RX** – some expenses that are ineligible expenses may be eligible with a prescription from a doctor, such as vitamins or supplements.
07	**Duplicates Insurance Payment** – Participants cannot submit claims for amounts paid by an insurance company. Any amount paid by another entity is not eligible.
08	**Sign and date claim form** – the participant must sign and date any claim form submitted for reimbursement.
09	**Claim form needed** – All faxed/Mailed claims must accompany a claim form.
10	**Received after year end period** – this means that the participant did not get the claims submitted in the correct time frame. To determine the year end period applicable locate the grace period and runoff for the client.
11	**Not a participant in account** – Typically used when a participant sends in a claim form for a plan not enrolled in i.e. participant has a Medical account & sends in a Day Care claim
12	**Not an eligible expense** – A participant will receive this denial if they submit a claim for an ineligible expense such as toothbrushes, cosmetic surgery etc…
14	**Provider signatures needed (daycare)** – Daycare claims must be signed by the daycare provider or include a receipt signed by the daycare provider.
15	**Description of services needed** – Documentation must include a description of services, i.e. Medical office visit, daycare services, etc. We cannot accept balance forward charges.
16	**Received after termination date** – The claim was received after the participant's termination date and submit term.
17	**Claim not legible (too light/dark or highlighted)** – If a participant submits a claim that is illegible we will deny the claim.
18	**Ineligible over-the-counter item**
20	**Estimate or Pre-determination** – Not eligible for reimbursement for FSA
22	**Amount claimed needed** – The participant must include the amount of reimbursement they would like from the services submitted for reimbursement.
23	**Wrong Claim Form**

Denial Codes

25	**Invalid service dates (more than 1 month advance)** – Dependent care claims may be submitted up to one month in advance. For example a participant may submit dependent care claims in April for May service dates.
26	**Invalid HSA claim**
80	**Applied towards plan deductible** – When a participant has an HRA, the employer often will have the participant pay part of the deductible before the HRA can pay out. Denial code 80 is used to track the participant responsibility.
81	**EOB required** – Many HRA plans require an explanation of benefits (EOB) from the health insurance company to be submitted as documentation for the participant's claim.
82	**Exceeds individual maximum** – Many HRA plans pay "per person", meaning a participant on the plan may only receive a certain amount individually.
83	**Participant's responsibility** – Many HRAs only pay up to a certain dollar amount maximum. Any HRA claims received over the HRA maximum will be denied as the participant's responsibility.
97	**Debit card denial substitute** – If a participant does not submit documentation to substantiate a debit card claim, we will apply future claims submitted as substitute documentation.
98	**E-claim denial substitute** – If a participant does not submit documentation to substantiate an eClaim, we will apply future claims submitted as substitute documentation.
99	**Exceeds individual plan election** – any claim submitted after the plan year election amount is exhausted will deny.
9A	**Amount paid prior to rollover** – if the participant has both FSA and HRA accounts and FSA is the first payor, any claim submitted towards the FSA that need to roll to the HRA will deny 9A then apply to the HRA. For example, if a participant has a $90 balance in their FSA account and submits a claim eligible for both FSA and HRA in the amount of $100, $90 will pay out of the FSA $10 will deny 9A then the remaining $10 will rollover to the HRA to be paid/applied.
9M	**Amount in excess of monthly maximum** – Due to IRS guidelines transit and parking plans have monthly maximums, any amount over the monthly maximum submitted will be denied.
Z1	**HRA plan rolled over** – must consider under current plan
Z2	**Processing date entry error** – the system creates this denial code is a result of entering a claim dates of service in reverse order, for example date of service 3/1/12 – 1/1/13.

Reviewing/Reprinting eClaims

The participant may view and reprint the eClaim documentation form by clicking on the icon under the View column.



Use an FSA to pay for eligible expenses like these

- Acupuncture
- Ambulance
- Artificial limbs
- Artificial teeth
- Blood sugar test kits for diabetics
- Breast pumps and lactation supplies (newly allowed by the IRS)
- Chiropractor
- Contact lenses and solutions
- Crutches
- Dental treatments including X-rays, cleanings, fillings, braces, and tooth removals
- Doctor's office visits and procedures
- Drug addiction treatment
- Drug prescriptions
- Eyeglasses and vision exams
- Fertility treatment
- Hearing aids and batteries
- Hospital services
- Inpatient alcoholism treatment
- Insulin
- Laboratory fees
- Laser eye surgery
- Over-the-counter medicines and drugs if prescribed by a doctor (see more information below)
- Physical therapy
- Psychiatric care if the expense is for mental health care provided by a psychiatrist, psychologist or other licensed professional
- Special education services, recommended by a doctor, for learning disabilities
- Speech therapy
- Stop-smoking programs (including nicotine gum or patches, if prescribed)
- Surgery, excluding cosmetic surgery
- Vasectomy
- Walker
- Weight-loss program, if it is a treatment for a specific disease diagnosed by a physician
- Wheelchair

Over-the-counter (OTC) medicines and drugs

Because of the health care reform law passed in 2010, over-the-counter medicines and drugs may only be eligible for FSA reimbursement if you have a valid prescription. Those medicines or drugs include:

- Acid controllers
- Acne medicine
- Aids for indigestion
- Allergy and sinus medicine
- Antidiarrheal medicine
- Baby rash ointment
- Cold and flu medicine
- Eye drops
- Feminine antifungal or anti-itch products
- Hemorrhoid treatment
- Laxatives or stool softeners
- Lice treatments
- Motion sickness medicines
- Nasal sprays or drops
- Ointments for cuts, burns or rashes
- Pain relievers, such as aspirin or ibuprofen
- Sleep aids
- Stomach remedies

The Internal Revenue Service, or IRS, publishes information on flexible spending accounts, or FSAs, and qualified expenses. Visit irs.gov

Please see your benefit plan documents to see what expenses are eligible for reimbursement under your FSA.

Over-the-counter supplies

Many OTC medical supplies may be eligible for reimbursement from an FSA, and no prescription is required. Examples include:

- Bandages, adhesive or elastic
- Braces and supports
- Catheters
- Condoms
- Contact lens solution and supplies
- Crutches
- Dentures and denture adhesives
- Diagnostic tests and monitors (such as blood glucose monitors)
- Elastic bandages and wraps
- First-aid supplies
- Insulin
- Ostomy products
- Pregnancy tests
- Reading glasses
- Walkers, wheelchairs and canes

Important note: Insulin does not require a prescription for FSA reimbursement.

These are not the complete lists. The IRS decides which expenses can be paid from an FSA, which also include, but are not limited to, deductibles, copayments and medications. The IRS can modify the list at any time.

These expenses aren't eligible

Here are some common services and expenses that are not eligible for FSA reimbursement.

- Aromatherapy
- Baby bottles and cups
- Baby oil
- Baby wipes
- Breast enhancements
- Cosmetics
- Cotton swabs
- Dental floss
- Deodorants
- Feminine care
- Hair regrowth
- Low-calorie foods
- Mouthwash
- Petroleum jelly
- Shampoo and conditioner
- Skin care
- Spa salts
- Sun-tanning products
- Toothbrushes

What does that mean?

Eligible expense: A medical, dental or vision expense your employer's plan says can be paid for or reimbursed.

Flexible spending account (FSA): A benefit plan that lets people put money aside in special accounts, pre-tax, to help pay for certain medical costs, child care, and other health services.

For more information

- Ask your employer for information about your FSA plan and eligible expenses.
- The IRS publishes information on FSAs and qualified medical expenses. Visit irs.gov.
- Most major grocery, department, retail and drug stores can identify at the cash register what supplies qualify for FSA reimbursement.

The IRS has limitation for FSA Contributions, you can find this information at: http://www.irs.gov/publications/p15b/ar02.html#en_US_2011_publink1000250341*

Health Care Spending Card (Debit Card) Claims

The benefits Health Care Spending Card (debit card) is accepted only at certain merchants whose card reader is set with an approved merchant category code. These codes are designated merchant codes; such as hospitals, doctor offices, vision care providers, and pharmacies. If the Health Care Spending Debit Card is available to you, you may use your debit card to pay for expenses at point of service instead of paying out of pocket, then waiting for reimbursement from your reimbursement account.

> You will need to retain all receipts and documentation from your Health Care Spending Debit Card purchases to verify the expenses are eligible according to Internal Revenue Service regulations. You will receive an e-mail or letter from UnitedHealthcare Benefit Services requesting the documentation, if required. Simply attach the documentation to the printed email request and email, mail or fax it to UnitedHealthcare Benefit Services using our TOLL-FREE fax number. The documentation you send in must include the name of the service provider, the type of service, the date of service, and the dollar amount. Credit card receipts typically do not have all of the required information, so please make sure to ask your provider for a detailed receipt or bill.

Your card will be good until the expiration date, you will not receive a new card every year. **It is important to read the debit card agreement that is attached to card.**

When not to use your debit card:

- Once the plan is within the run off period, please make sure to use the manual claim option if you want to use funds from the previous plan year as any debit card transactions that occur after the end of the plan year and grace period will apply to the new plan year.
- Claims cannot be manually moved from one plan year to the next. If claims submitted during the run off period need to moved to another plan year, a refund must be sent to UnitedHealthcare and a new claim must be submitted.

You will need to send in the required documentation soon after receiving the e-mail from UnitedHealthcare. Delays in sending in the documentation or charging ineligible items could result in deactivation of your debit card, writing a personal check to the plan, or a payroll deduction by your employer of any ineligible amounts.

Qualifying Events - Changing your election

The annual election may be changed at open enrollment with your employer. During the plan year, the election may be changed if you encounter certain qualifying events. Some qualifying events include:

- Change in employee's legal marital status
- Change in number of dependents
- Change in Employment Status of the employee, spouse or dependent that affects eligibility
- Change in Dependent Eligibility Requirements

If you happen to experience a qualifying event, contact your employer for more information about potentially changing your election.

* Refer to SPD for plan specifics.

You have more time to spend your FSA dollars

The Internal Revenue Service (IRS) allows a "grace period," which gives you more time to use your Flexible Spending Account (FSA) dollars. This grace period reduces the worry you may have about the "use it or lose it" rule.*

Q How long is the grace period?

A The grace period begins the first day after your plan year ends and it lasts two and a half (2 1/2) months.

Example: You contribute $1,200 to a health care FSA for a January 1, 2011 to December 31, 2011 plan year. On December 31 you have $200 remaining in your FSA. Instead of losing that money, you have until March 15, 2012 (2 1/2 months) to use it.

Q Does the "use it or lose it" rule still apply?

A Yes, this rule still applies. However, having a grace period gives you an extra 2 1/2 months to use your remaining FSA dollars. If you don't spend your money by the end of the grace period, you will lose it.

Q How do I sign up for the grace period?

A If you were enrolled in the FSA on the last day of the plan year, you will automatically get the 2 1/2 month grace period. There's nothing you need to do. Any eligible expenses that you have during the grace period will automatically be applied to balances remaining in the FSA.

Q If I still have FSA dollars remaining at the end of my plan year, can I re-enroll in my FSA for the new plan year?

A Yes, you can re-enroll in an FSA even if you have dollars remaining in your FSA from the prior year. You may want to take into consideration any money you have remaining in your prior year FSA before making an election for the new plan year.

Q I have dollars remaining in my health care FSA at the end of the plan year. I also re-enrolled in the FSA for the new plan year. If I have remaining eligible expenses from last year, or have new expenses during the grace period, how will they be reimbursed?

A If you have any eligible expenses from the prior year that have not yet been submitted for reimbursement, make sure you submit those first so they will be paid out of your prior year FSA. In addition, if you have eligible expenses during the grace period, the prior year FSA will also pay those first. Once the prior year FSA money has been spent, expenses will then be reimbursed from your new FSA. If you submit new expenses first, you could use up your FSA balance, leaving you with nothing to reimburse your prior year expenses. Keep in mind that once the expenses are submitted to your prior year FSA, they cannot be changed so that they are reimbursed from your new FSA.

Example: You have $200 remaining in your health care FSA at the end of the 2011 plan year (December 31, 2011). You still have an eligible expense from December 15 that you have not submitted for reimbursement. And on January 10, 2012, you have a $250 expense. If you submit the 2012 expense before the 2011 expense, you will spend your remaining $200. You will have no FSA dollars to pay for the 2011 expense.

*See your SPD for exact dates and to see how the grace period applies to you.

Q What happens if I leave my job before the end of the plan year?

A Your plan's normal termination provisions will apply. Some employer plans are subject to COBRA continuation rules, so you may be offered an opportunity to continue participation by agreeing to make additional contributions to the plan through COBRA. Please see your employer's plan information for additional details.

Q Can I submit claims from last year towards my current year balance?

A No, Plan Year, claims can only be reimbursed from the plan year funds in which they were incurred, with the exception of claims submitted towards any applicable grace period. Refer to your SPD for additional information.

Q Can I use the eClaim functionality if I have an HRA

A No, If you have an HRA and and FSA the eClaims feature can not be used.

Q How long are claims viewable on www.uhcservices.com?

A Claims are viewable for the current and previous plan years.

Q What happens to unused funds if employment is terminated?

A Refer to your SPD.

* If you have an HRA and and FSA the eClaims feature can not be used.

Glossary of Reimbursement Terms

Section 125 (medical FSA), Section 105 (Healthcare Reimbursement Arrangement) and Section 129 (Dependent Day Care) of the law, as with any law, have their own special terminology that can quickly become confusing. Based on our comprehension of these laws, we can assist you in understanding the terminology so you will soon sound like a Reimbursement account expert! Please bear in mind that occasionally terminology may differ slightly between sources such as insurance carriers, Third Party Administrators (TPAs), agents, brokers, etc.

The definitions of these Reimbursement terms have been prepared based on UnitedHealthcare's understanding and knowledge of Reimbursement laws. UnitedHealthcare is not engaged in the practice of law. The employer should consult with its own attorney on the legal implications of Reimbursement for the employer's situation.

Dates of Service – The date the service was incurred. This date could be different than the date you are billed or the date you pay for the expense. Prescription drugs are based on the date the prescription is filled and eyeglass/contact lens purchases are based on the date ordered. These dates could be different than the date picked up or the date paid.

Plan Year Election – The amount you wish to put into the corresponding Account Type for the entire Plan Year. This amount will then be divided by the number of paychecks you receive during the Plan Year to equal your Paycheck deduction amount.

Provider Name / Type of Service – Doctor name, store name, dentist, clinic, hospital, etc. along with what service was performed (for example, 'Dr. Smith / Office visit', 'ABC Drug Store / Prescriptions', or 'The Vision Store / Contacts').

Summary plan documents (SPD): The SPD will outline the plan guidelines. A copy can be provided by your employer.

Qualifying event – a life event that triggers the ability to make a change during the plan year to your elections.

Some qualifying events include:

- Change in employee's legal marital status
- Change in number of dependents
- Change in Employment Status of the employee, spouse or dependent that affects eligibility
- Change in Dependent Eligibility Requirements
- Letter of medical necessity
- Prescription: Medicine, drugs, the doctor's order for your medication

Notes

UnitedHealthcare®