

# **FlexMagic® - Flexible Benefit Plan**

## **Third Party Administration Reimbursement Instructions**

Once you have enrolled in the Flexible Benefit Plan, the amounts you have elected on your employee election Form will be taken from your gross wage each pay period for the entire plan year, unless an eligible status change occurs which allows you to modify your original election. These dollars are set aside into two separate spending accounts:

1. **Dependent Care Spending Account:** Expenses must be for eligible children under the age of 13 or for a dependent who has a physical or mental disability requiring supervision. Only expenses, which are necessary to employment for you and your spouse are allowable expenses.
2. **Health Care Spending Account:** This includes out-of-pocket medical, dental and vision expenses not reimbursed to you by insurance or another medical reimbursement plan. Insurance premiums are not an eligible expense through the Spending Account.

**Reclaiming Your Spending Account Dollars:** You may reclaim your spending account dollars by submitting a reimbursement claim form along with copies of your expense receipts (see Claims Documentation). You may only claim reimbursements for expenses that can be proven with receipts. You may claim any eligible expense you have incurred during the plan year while you are an active participant in the Plan. The Spending Accounts are not interchangeable - you may not use money that was set aside for dependent care for health care expenses or vice versa. If the IRS audits your tax return, you must be able to provide original receipts in order to validate the tax-free dollars you received.

Spending account dollars reclaimed by you are tax-free and are not show as earnings on a W-2 Form. You will receive a year-end statement showing the value of your tax-free benefit payments. Dollars reclaimed through the plan cannot be used toward the tax credit or as a deduction on your tax return.

You have a 90-day run-out period after the end of the plan year in which to claim any remaining funds from the spending accounts. However, the expenses must have been incurred during the plan year while you were active in the plan, or if adopted, within the 2 ½ month grace period following the end of the plan year. Following the 90-day run-out period any dollars remaining in the spending accounts will be forfeited, unless the employer, in the employer's sole discretion, returns the experienced gains to plan participants (see Experienced Gains).

**To Reclaim Money from Your Spending Accounts:** Complete the claim form and include a copy of your expense receipt(s) and any required documentation for your claim (Make sure the Claim Form is *signed and dated*).

- Submit the claim form and a copy of your claim documentation to the following:

Mail:	TPA Claims Department, FlexMagic Consulting, Inc. 6450 S. Quebec St. Suite 5-28, Centennial, CO 80111-4681
Fax:	303-649-1925 or 800-889-6260
Questions:	303-649-1922 or 800-888-9084
E-mail:	<a href="mailto:claims@flexmagic.com">claims@flexmagic.com</a>

- You will then receive your tax-free reimbursement as explained under your Plan rules.

### **Health Insurance Portability and Accountability Act (HIPAA)**

Under HIPAA regulations you are assured that certain health information, referred to as Protected Health Information (PHI), will be kept confidential. Disclosure of your PHI for any purpose other than for "Plan Administration" such as quality assurance, claims processing, auditing and monitoring or for the purpose of obtaining payment will be limited and subject to state and federal regulations. To learn more about these Privacy Rules contact your Flexible Benefit Plan Coordinator to receive a complete Notice of Privacy Practices.

# Claims Documentation

## Dependent Care Expenses:

- The receipt must show the cost of the care, the dates of service and the names of the children or dependents for which the care was provided.
- Services must be for eligible children under the age of 13 or for an older dependent that has a physical or mental disability requiring supervision so you can work.
- The care **must be necessary to you and your spouse's employment**. Both spouses must have reportable income and reimbursed expenses are limited to the income of the lesser earning spouse.
- The receipt must show service was incurred during the eligible period.
- You cannot pay a spouse or dependent under age 19 to care for your children or dependents.
- The receipt must be signed by a third-party provider (caregiver) and show the provider's Social Security Number or FEIN. *You are required to put the name, address and Social Security Number or FEIN of the provider on your Federal tax return.*

## Health Care Expenses:

- The receipt must include the provider's name, type of service, date of service, family member for whom the service was provided, proof the service was incurred during the eligible period, and documentation that the expense was not paid by an insurance plan. A copy of the "Explanation of Benefits" (EOB) from your insurance carrier shows the service was not paid by insurance.
- Eligible services cannot be reimbursed by insurance or any other plan.
- Services must be incurred during the Plan Year, while you are an active participant in the Plan.
- Mileage expense reimbursement for medical services is allowed. You must keep a mileage log of the trip with odometer readings, date of visit, reason for the visit and family member name. Parking fees and tolls are also reimbursable expenses, with proof of payment. Check with your Flexible Benefit Plan Coordinator for eligibility.

## Claim Denial Appeal Procedures:

A claim is a request for a Plan benefit by a participant or beneficiary. Except as otherwise described in applicable summaries or booklets describing the benefits provided through this Plan (such as insurance carrier booklets or employer summaries describing your benefits), if you submit a claim for benefits and it is denied, in whole or in part, you or your beneficiary will receive a written explanation from the Administrator within 30 days after filing the claim. If special circumstances require, the Administrator may take up to an additional 15 days to contact you. The Administrator must notify you of this extension before the end of the initial 30-day period.

The Administrator's explanation should state the specific reasons for the denial, references to pertinent sections in the Plan document, additional information you must provide to improve your claim, and the procedure available for further review of your claim.

If you do not agree with the reasons for denial of your claim, you may request an appeal within 180 days of receiving the denial. You should attach any documents or records that will support your appeal. As part of the review procedure, you must be allowed to request and receive copies of pertinent documents, although in some cases, approval may be needed for the release of confidential information, such as medical records. You must submit issues and comments in writing. You may have someone act as your representative in the review procedure, if you wish.

A decision will be made in writing within 60 days following the receipt of your request for review or the date that all information required of you is furnished, whichever date is later. If special circumstances require an extension of time, a written notice of the extension will be sent to you. Notification of the decision on review will be clearly described and will specify the reason for the decision.