HEALTH FSA GUIDE

Provided by Davevic Benefit Consultants

DAVEVIC

Benefit Consultants

DAVEVIC BENEFIT CONSULTANTS

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Paying for health expenses can be stressful, but planning ahead and putting money in a health flexible spending account (FSA) will help you save on taxes while keeping a reserve of money available for health care costs. Although FSAs are a great way to help you pay for medical expenses, they can be confusing if you haven't worked with one before. This guide will walk you through what health FSAs are, what they can pay for and how they work.

What Are Health FSAs?

An FSA is an employer-sponsored savings account for health care expenses. You are not taxed on the money put into the FSA, and you can then use the account to pay for qualified out-of-pocket health care costs, such as your deductible and copays, but not your premium. However, you cannot stockpile money in the account from year to year, and you will lose leftover money in the account at the end of the plan year unless your employer offers an option that allows for either a short extension or a small carry-over into the next year.

FSAs were created in the 1970s to enable employees to use pre-tax dollars for health care expenses that were not otherwise covered by employer-sponsored health coverage. These accounts gained more popularity in the 2000s, and they underwent a few changes with the Affordable Care Act (ACA), including the addition of an annual contribution limit.

Health FSAs can save you money on taxes while helping you regularly put aside money for health care expenses. If carefully planned, using an FSA for health care costs can be an asset to your family's budget.

Why Have a Health FSA?

Health FSAs offer an option for setting aside money to use for qualified medical expenses. These accounts offer a convenient way to prepare for out-of-pocket medical expenses while saving on taxes. In addition, you can use your health FSA to pay not only for your medical expenses, but also for the medical expenses of your spouse and dependents.

Health FSA Advantages

Here are some of the advantages an FSA can provide:

Tax reductions: The amount you contribute to a health FSA is not subject to federal income tax or social security (FICA) tax—effectively adjusting your annual taxable salary. The taxes you pay each paycheck and collectively each plan year can be reduced significantly.

- Your employer can also contribute to your FSA, and this amount is also not considered taxable income to you.
- You can withdraw money from your FSA to pay for qualified medical expenses (see Appendix) and your withdrawals are not taxed.
- You do not have to report FSA amounts on your income tax return.

Convenience: After the initial election at the beginning of the year, your employer will take care of transferring the allotted amount into your FSA through salary deferral.

Flexibility: You can withdraw health FSA funds at any time (for qualified medical expenses), even if the amount has not yet been deposited into the account, as long as the amount is no more than your elected annual deferral amount less any amount already used.

Is a Health FSA Right for You?

FSAs can save you money because you don't have to pay taxes on the amount deferred to the account. However, using an FSA does require careful planning in order to reap the financial benefits.

When you participate in an FSA, you have to decide at the beginning of the plan year how much to contribute for the year. Because you will generally lose what you don't use by the end of the year, determining how much to defer into an FSA can be challenging. While correctly estimating your health care expenses and using an FSA to pay for those expenses will save you money, incorrectly gauging your health costs could cause you to lose money.

How your employer manages the FSA may also affect how much you will benefit from using an FSA. If the employer provides a grace period or carry-over option (see "Grace periods and carry-overs" section), you will have a little more flexibility when using your FSA funds. The largest downside to using an FSA is that if you overfund your FSA and don't use the amount in there, you will lose what you've saved.

How Do Health FSAs Work?

At the beginning of the year, you elect the total amount you want to have withdrawn from your paychecks to put into your FSA, and your employer will deposit the money into the account in equal allotments throughout the year. The IRS has outlined rules guiding eligibility, contributions and reimbursements.

FSA Eligibility

FSAs are employer-sponsored benefit plans, and the employer can choose what other type of group health plan coverage to offer with the FSA. FSAs can be offered with any type of health plan—FSAs are not tied to a high deductible health plan (HDHP) like health savings accounts (HSAs) are. Self-employed individuals are not eligible for an FSA, and restrictions may apply for highly compensated individuals or key employees.

Opening Your FSA

The FSA is sponsored by your employer as one of your employee benefits. You will need to choose how much you want to contribute to your FSA. The amount you elect will be for the entire plan year, and your employer will then deduct the corresponding amount from your paycheck with each pay cycle. This is sometimes referred to as a salary reduction arrangement.

Contributions

After your initial contribution election, you ordinarily cannot change your election for a plan year during the year. Your elected contribution amount can only be changed if you experience a permitted election change event, such as a change in family status and your FSA permits you to change your election.

The amount you choose to transfer into your FSA should be based on the amount of qualifying medical expenses you anticipate your family incurring during the plan year. Start by looking at your family's medical expenses for the past year and then determine whether your family will likely have those same expenses again and whether there will likely be any

new expenses. Use this estimate to help you choose what amount you would like to contribute to your FSA, remembering that it is typically best to underestimate by a little than to overestimate and lose that money at the end of the year.

Limits – In 2023, the maximum amount you can contribute to your FSA is $3,050, which is indexed for inflation and therefore may change year to year. The employer may implement a lower annual limit than the federal maximum.

Who can contribute – Both you and your employer may contribute to your FSA. However, your employer is not obligated to contribute to the account.

Grace Periods and Carry-overs

The FSA operates with a use-or-lose rule, meaning if you don't use the money in your FSA by the end of the plan year, you will lose it. However, the use-or-lose rule was relaxed with two options that employers may choose to offer: a grace period or a carry-over. The grace period can last up to 2 ½ months into the next year, typically March 15 for a calendar year plan. Generally, only expenses you incur during the plan year can be reimbursed from the funds in your FSA, but if your FSA has a grace period, you can use those unused funds in your FSA for expenses incurred during the grace period.

Under the carry-over option, an FSA may allow employers the option of allowing employees to carry over up to $610 of unused funds from one year to the next beginning in 2023. The carry-over does not count toward the annual maximum allowable contribution. Employers are not required to offer either of these options, and they may only offer one of the two options, not both.

If you have funds in your FSA at the end of the year, you might consider scheduling a checkup, dental cleaning or similar appointment before the end of the year in order to use up the leftover funds before they are lost.

Using Your Health FSA

FSAs must comply with a uniform coverage rule. The uniform coverage rule provides that an employee's entire annual FSA election amount, less any amount already used, must be available at any time of the plan year—even if that full amount has yet to be contributed to the account. This means that the entire amount of your election is available for your use at any time of the year. For example, if you elect $1,000 for your annual contribution, and you incur qualified medical expenses of $800 in January, your FSA will reimburse you for the $800 even though that amount has not yet been deducted from your salary.

When you are paying for a qualified medical expense that you would like to use your FSA funds for, you typically have two choices: using a health payment card or requesting reimbursement.

Health Payment Card

Some employers may provide you with a health care payment card, which is very similar to a debit or credit card, and you can pay for eligible medical services or products by swiping the card as you would a debit or credit card. The money will then be deducted from your FSA account.

Health care payment cards may be used only on eligible medical expenses that are not reimbursed or covered by another source. Over-the-counter (OTC) medications are only eligible for reimbursement if they are prescribed to you, and you present the prescription at the time of purchase. The only OTC medication that can be reimbursed without a prescription is insulin. Health care payment cards may not be used to cover more than the maximum dollar amount of coverage available in your FSA.

As a general rule, every claim paid with a health care payment card must be reviewed and substantiated. The IRS guidance allows automatic adjudication for certain card transactions, meaning that receipts do not need to be submitted

for verification of expenses for which a health care payment card is used. This applies in three situations at medical providers and 90-percent pharmacies (drug stores and pharmacies where at least 90% of the store's gross receipts during the prior taxable year consisted of medical expenses):

- When the total cost of the transaction is equal to the standard copayment for the service(s) received
- When the transaction is for recurring expenses that have previously been approved
- When the merchant provides expense verification to the employer when the transaction takes place

Reimbursement
Another way to pay for eligible medical expenses with your FSA funds is to pay out-of-pocket and then submit receipts for reimbursement. Your account will have specific instructions for how to do this. When submitting for reimbursement, you will need your receipts and proof that what you paid for was an eligible medical expense; this is one of the reasons it is important to keep all receipts and related paperwork from your health care provider.

Qualified Expenses

Employees may use their health FSAs to pay for or reimburse themselves for their own eligible medical expenses, as well as their spouses' and dependents' eligible medical expenses. Eligible medical expenses are unreimbursed medical care expenses, as defined under Section 213(d) of the Internal Revenue Code. An employer can more narrowly define the expenses that can be reimbursed from an FSA. Health FSAs cannot be used to pay for non-medical expenses. Your FSA cannot be used to pay for health insurance premiums, long-term care coverage or expenses, or amounts already covered under another health plan. See Appendix for a list of qualified medical expenses.

Life Events

Certain life events may affect your FSA.

Employment status changes – Your employer owns the FSA. Typically, if you leave your job before you've used the FSA funds, the employer will keep the amount left in the account. However, you may be eligible to elect COBRA and continue your FSA until the end of the year.

Death – If you die, the contributions to your FSA will stop, but your survivors can file claims until the filing deadline for any remaining eligible expenses that you or your family members incurred.

FSA Recordkeeping

In most cases, you will have to submit receipts and other proof that you purchased an eligible medical service or product in order to receive reimbursement. Make sure you retain all receipts, Explanation of Benefits (EOBs) and other documents to ensure that you have the necessary proof to obtain reimbursement from your FSA.

Appendix—Qualified Medical Expenses

The qualified medical expenses that can be reimbursed by an FSA on a tax-free basis are limited to expenses for medical care (as defined in the federal tax code) for the employee and his or her spouse and dependents, to the extent those expenses are not reimbursed by any other health coverage. The federal tax code defines medical care expenses as amounts paid for the diagnosis, cure, mitigation or treatment of a disease, and for treatments affecting any part or function of the body. The expenses must be primarily to alleviate a physical or mental defect or illness.

The products and services listed below are examples of medical expenses that may be eligible for payment under your Flexible Spending Account, when such services are not covered by your health plan. This list is not exhaustive; additional expenses may qualify as medical expenses, and the items listed below are subject to change. Also, your FSA plan may have additional restrictions on the types of expenses it will reimburse.

- Acupuncture
- Alcoholism treatment
- Ambulance
- Annual physical exam
- Artificial limb
- Artificial teeth
- Bandages
- Birth control pills
- Body scan
- Breast pumps and supplies
- Breast reconstruction surgery following mastectomy for cancer
- Capital expenses (improvements or special equipment installed to a home, if meant to accommodate a disabled condition)
- Car modifications or special equipment installed for a person with a disability
- Chiropractor
- Contact lenses
- Crutches
- Dental treatment (not including teeth whitening)
- Diagnostic devices
- Disabled dependent care expenses (medical care of the disabled dependent)
- Drug addiction treatment
- Eye exam
- Eye glasses
- Eye surgery
- Fertility enhancement (for example, in vitro fertilization or surgery)
- Guide dog or other service animal

- Hospital services
- Laboratory fees
- Lactation expenses
- Lodging at a hospital or similar institution
- Medical conference expenses, if the conference concerns a chronic illness of yourself, your spouse or your dependent
- Medical information plan
- Medications, if prescribed
- Nursing services
- Operations
- Optometrist
- Osteopath
- Oxygen
- Personal protective equipment used for the primary purpose of preventing the spread of COVID-19
- Physical exam
- Pregnancy test kit
- Prosthesis
- Psychiatric care
- Psychoanalysis
- Psychologist
- Sterilization
- Stop-smoking programs
- Surgery
- Special telephone for hearing-impaired individual
- Television for hearing-impaired individuals
- Therapy received as medical treatment
- Transplants
- Transportation for medical care
- Vasectomy
- Vision correction surgery
- Weight-loss program if it is a treatment for a specific disease
- Wheelchair
- X-rays

Visit FSAstore.com to lookup and shop for other eligible items.

Flexible Spending Accounts

Prior Plan Year Claims

When a claim is submitted under a Flexible Spending Accounts, it is reviewed per IRS Section 125 regulations. Under IRS Section 125, participants are unable to pay for prior plan year claims using current plan year funds. Additionally, the regulations state you should not use your Benny Card to pay for prior plan year claims. If you have funds remaining in the prior plan year, you can still submit a claim using alternative method. For more information please contact Davevic Benefit Consultants, Inc.

Flexible Spending Accounts and the regulations pertaining to prior plan year claims.

1. Prior Plan Year Claims.
2. Exception for Carry Over
3. Exceptions for Grace Periods

Davevic Benefit Consultants, Inc.
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Grove City, Pa 16127

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Exception for Carryovers

Employers with health FSAs may allow rollover of unused funds remaining at the end of a coverage period to be paid or reimbursed to plan participants for qualified medical expenses incurred during the following coverage period. For this purpose, the remaining unused amount as of the end of the coverage period is the amount unused after medical expenses have been reimbursed at the end of the plan's run-out period.

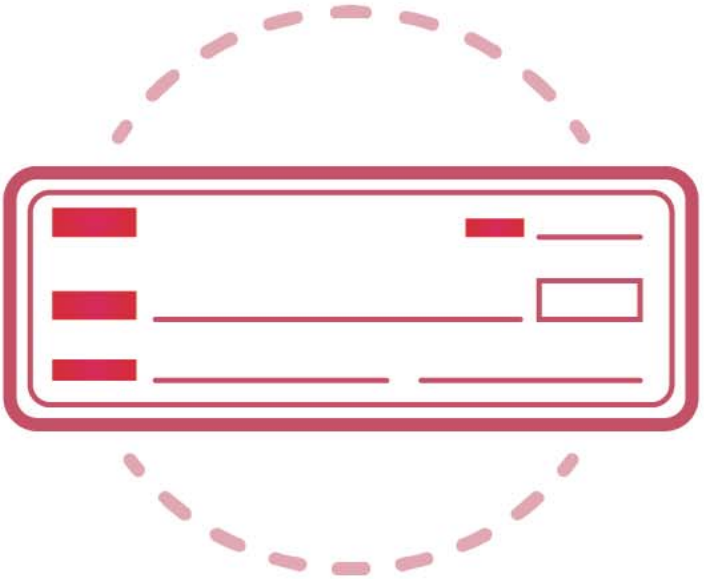
Similar to health FSA grace periods, permitting carryovers is strictly optional, and employers must choose to implement it. Also, the carry-over provision is only available if the plan does not also incorporate the grace period rule.

Exception for Grace Periods – If Your Company Does Not Offer the Carryover

The IRS allows employers to design their health FSA with an extended deadline, or grace period, of **two and a half months** after the end of a plan year to use FSA funds. Thus, for a plan year ending Dec. 31, the employees would have until March 15 to spend the funds in their health FSA.

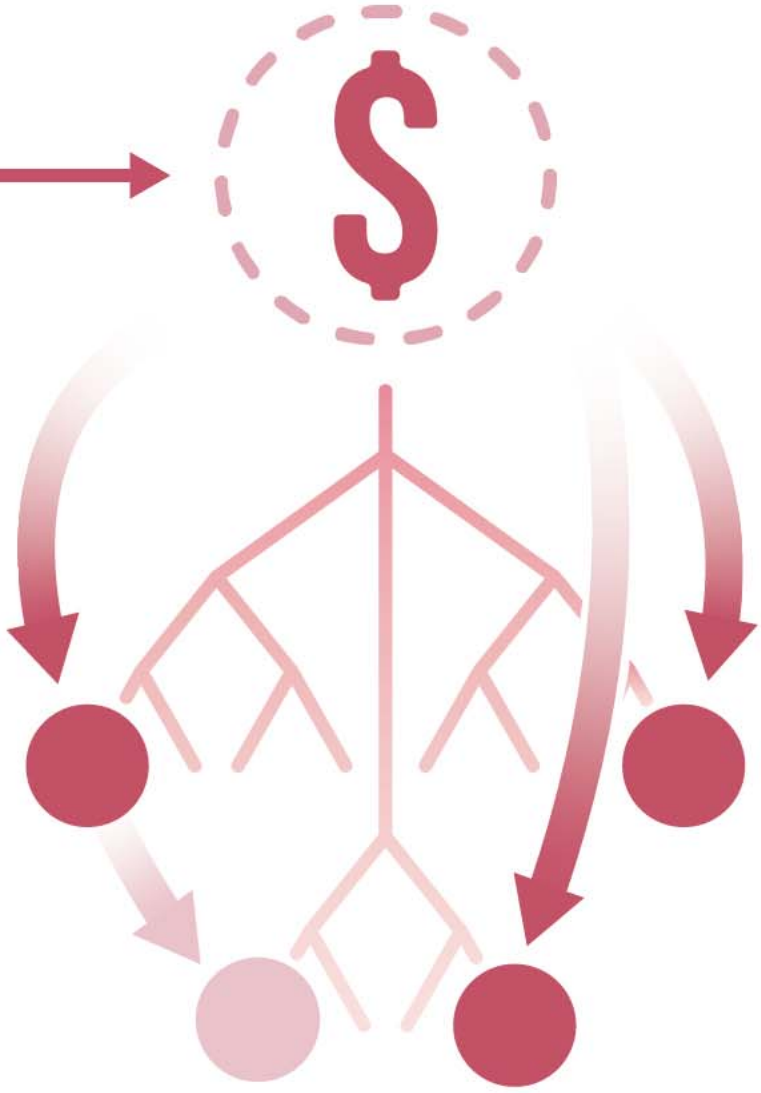
Allowing a health FSA grace period is strictly optional; the employer must choose to implement it as part of its health FSA's design. Also, a grace period under a health FSA is an alternative to offering carryovers—a health FSA that allows carryovers cannot also have a grace period.

Also, a health FSA grace period is different from a "run-out" period for submitting claims. Most health FSAs are designed with a run-out period that gives participants time after the end of the coverage period for submitting claims for medical expenses that were incurred during the coverage period. Unlike a grace period, a run-out period does not allow a health FSA to reimburse claims incurred after the coverage period ended.



What is a Dependent Care FSA?

A dependent care flexible spending account (FSA), or dependent care assistance program, allows you to pay for certain expenses on a tax-free basis. If you care for a dependent, this may be for you!



How It Works

Each pay period, money moves from your paycheck into your dependent care FSA. When you need to pay for dependent care expenses, like elder care or preschool, you can use the money from your account. And as long as you're paying for an eligible expense, the money is tax-free!

Speak with HR to learn more about how our dependent care assistance programs can benefit your family.

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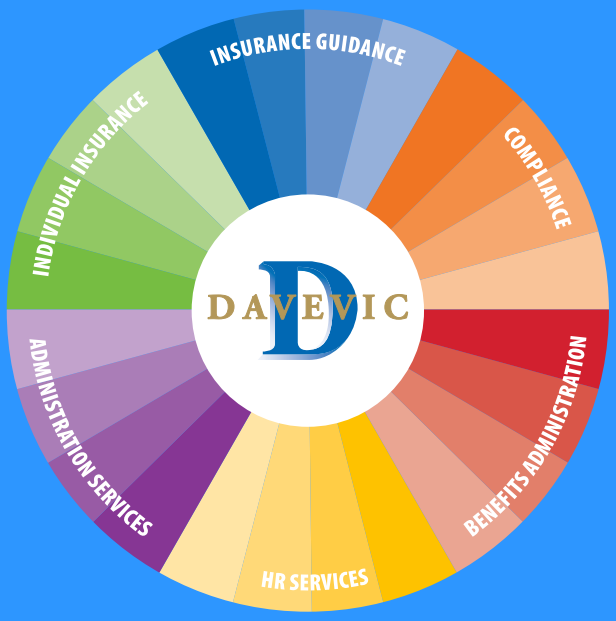
ACRISURE® PARTNER



Davevic Online Portal & Mobile App

DAVEVIC

IMPORTANT BENEFITS ANNOUNCEMENT

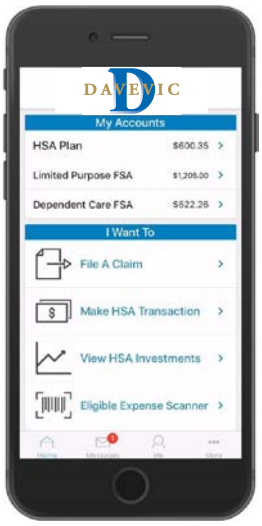
Great News!

Your Employer has contracted with Davevic Benefit Consultants to offer a services platform that makes it easier for you to manage your account-based benefits. Below is information regarding your own consumer portal to upload a claim, check balances, and much more!

The Consumer Portal and Davevic App make managing your benefits easy!

An easy-to-use **Consumer Portal**:

- Secure, 24/7 access to your accounts
- Check your up-to-the minute plan balances
- View all plan, claims, and payment details
- File claims and submit receipts online
- View upcoming reimbursements
- Sign up for direct deposit.. and much more!



The handy **Davevic App**:

- Access available account balances on your iPhone®, iPod Touch®, iPad®, or Android®-powered device
- Submit claims and receipts using your device's camera
- Receive account balances and selected alerts via text message on any mobile device
- Message center that will alert you when a debit card claim requires an invoice, receipt, or Explanation of Benefits (EOB).
- By clicking on the notification, you can take a picture of the documentation being requested.

Verifying purchases made with the **Benny® Prepaid Benefits Card**:

- When you use your Benny Card, only certain services do not require receipt verification
- Doctors office and prescription drug copays are automatically confirmed
- All other services will need proof of purchase (copy of receipt, invoice, or EOB) for your card to be used without issue
- You can upload these receipt requests on the consumer portal

EMPLOYEE & CONSUMER PORTAL GUIDE

Welcome to your Davevic Benefit Consultants Consumer Portal.
This one-stop portal gives you 24/7 access to view information and manage your Flexible Spending Account (FSA) and Health Reimbursement Account (HRA).

Consumer Portal access enables you to:

- File a claim online
- Upload receipts and track expenses
- View up-to-the-minute account balances
- View your account activity, claims history and payment (reimbursement) history
- Report a lost/stolen Card and request a new one
- Update your personal profile information
- Change your login ID and/or password
- Download plan information, forms and notifications

LOGGING ON TO THE HOME PAGE:

1. Go to **www.davevic.com**
2. Under the login center, click FSA/HRA Claims Portal
3. Click Go.
4. Enter the below information as an **Existing User**:

Login ID: **first initial, last name, last 4 digits SSN** (no spaces)
Password: **davevic1**

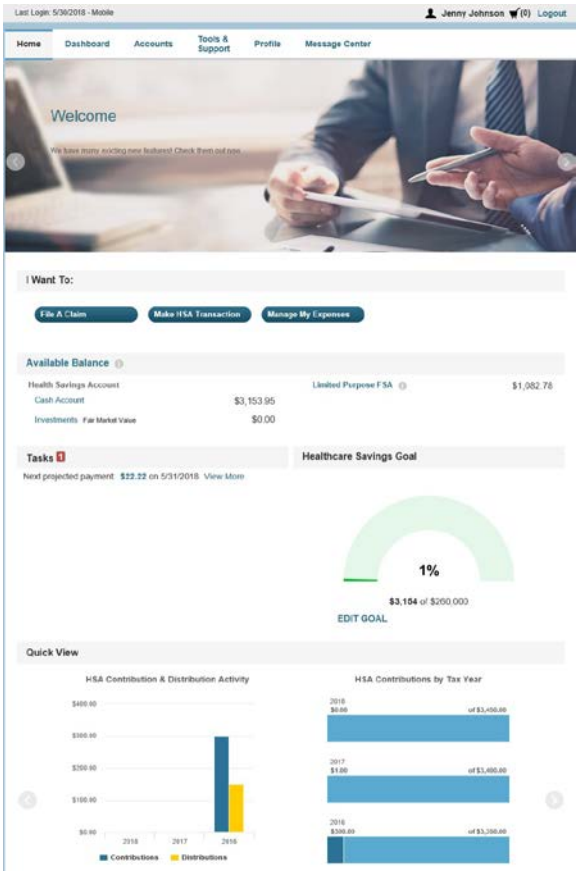
5. Click **Login**

You will be prompted to change your password once you login.
Reminder: Your password is required to be changed every 90 days You can change it by clicking "Forgot Password" on the login page.

The **Home Page** is designed for easy navigation:

- Easily access the **"I Want To"** section which contains the most frequently used features.
- **Available Balance** links to the Account Summary page, where you can see and manage your accounts.
- The **Message Center** section displays alerts and relevant links that enable you to keep current on your accounts. You will also be able to view claim denials and emails sent from Davevic.
- The **Quick View** section graphically displays some of your key account information.

You can also hover over the tabs at the top of the page.



For more information please contact us toll-free 800-854-4099 or checkout our website: www.davevic.com

HOW TO FILE CLAIMS ONLINE

How to File Claims using the Consumer Portal:

1. To get to your consumer portal go to www.davevic.com. At the top of the screen run your cursor over the "Login Center" and a menu will drop down. Click "Go" in the box that says FSA/HRA/HSA Participant. This will take you to your consumer portal login page.

2. Enter your username and password. (See login instructions on other side of page)

3. To file a claim, locate the "Reimburse Myself" button (right below "I want to…" on the left side of the screen).

4. This will take you to the next screen where you will select account paid from which will always be "Medical" and pay to will be "Me."

5. Next screen will have "Upload Valid Documentation", click on this link. Locate the picture(s) of your invoice, receipt or Explanation of Benefits (EOB). Once chosen, click "Next."

6. Complete the online claim form, and continue to click next when you are completed with each page. Important information to know: When uploading claims please upload each claim separately otherwise your claims could be mislabeled and can cause issues with processing. Once complete, you will receive a confirmation on the screen when your claim was successfully submitted.

How to File Claims using the Davevic Mobile App:

1. Log into your 1Cloud app using the passcode you selected.

2. After logging in, a screen will appear with all of your accounts listed along with a "Reimburse Myself" link and an "Expenses" link. Click on "Reimburse Myself" to upload a claim for payment.

3. The next screen that appears will be the online claim form that you will need to complete. Fill in all required fields (provider field and miles driven are not required fields).

4. On the same page, scroll down and you will find "Upload receipt" link. Click on that and it will ask you if you want to take a picture or download one from your library.

5. Choose or take a picture of the correct receipt or EOB for this claim.
   (Note: All pages of the EOB are needed)

6. Important information to know: When uploading claims please upload each claim separately otherwise your claims could be mislabeled and can cause issues with processing.

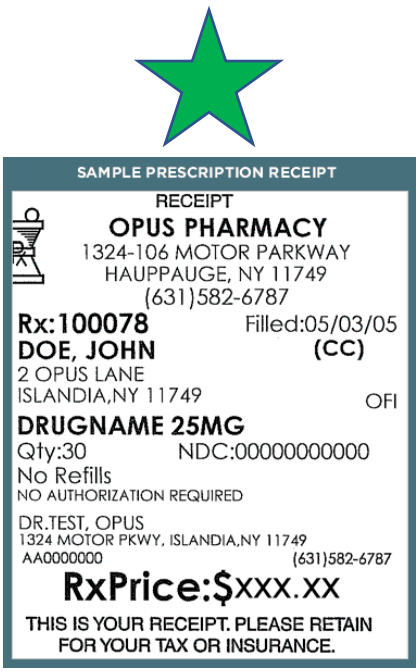
7. Once you have finished all the necessary steps, click on the "Add Claim" button on the top right side of your screen. Now your claim has been submitted to Davevic for review.

Documentation Recommendations

Prescription Drug Receipts

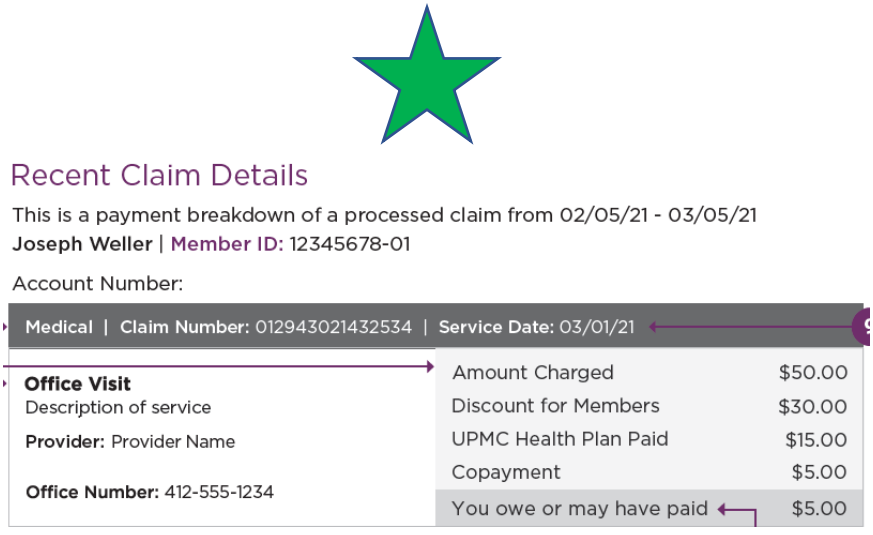
Detailed Prescription Invoice is required – A detailed prescription invoice is recommended in order for the claim to be properly adjudicated.

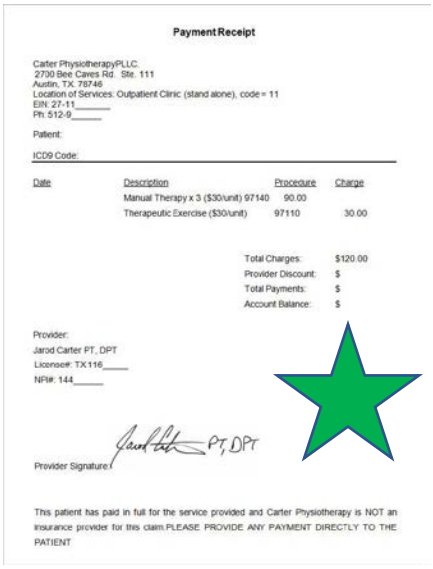
The receipt on the right is an example of a recommended receipt. This is typically stapled to your prescription bag or nearby.



Copays and Other Services Reciept

EOB or Detailed Copay Receipt is recommended– Below are examples of adequate documentation to submit for reimbursement.





Flexible Benefit Plan
Reimbursement Claim Form

Employer: .....

Employee: ..... Social Security #: XXX-XX- .....

Phone: ..... E-mail: .....

Dependent Care Expense Claims

Name of Dependents	Period Covered From	Period Covered To	Name, Address, and Taxpayer Identification Number of Service Provider	Amount Incurred
➡ *Attach a receipt from your daycare provider, or include the daycare provider's signature*			**Provider's Signature:**	
			Total Dependent Care Expense Claim*	$

*NOTE: The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the Plan Year or the earned income of your spouse. (If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earnings of $200 if there is one (1) child or dependent, or $400 if there are two (2) or more.) No payment may be made under the Plan; if the service provider is your dependent for federal income tax purposes; or is your child or stepchild and is under age 19.

Unreimbursed Medical Expense Claims

Date Expense Incurred (mm/dd/yy)	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
➡ *Attach appropriate receipt(s) and submit with this claim form*			**Total Medical Care Expense Claim**	$

Read Carefully: The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company's Cafeteria Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

Employee Signature _____ Date _____

***Note: Form must be signed in order to process the claim.**

Claim Filing Procedures...

How To File A Claim

- Complete **all** information on the claim form for each amount claimed for reimbursement.
- Make sure the claim does not include items for more than one plan year. Use different claim forms for different years.
- You must sign and date the claim form.
- Attach a copy of a bill, invoice or other written statement from a third party which supports each reimbursement request and shows the date the service was incurred.
- Statements showing only a balance forward and copies of cancelled checks or credit card receipts are ***not*** valid receipts.

Claim Form

If you **mail** your claim with receipts, remember to keep a copy of the claim form and supporting documents for your records.

If you **fax** your claim with receipts, please remember to keep the original claim form and supporting documents for your records.

Where To Send A Claim

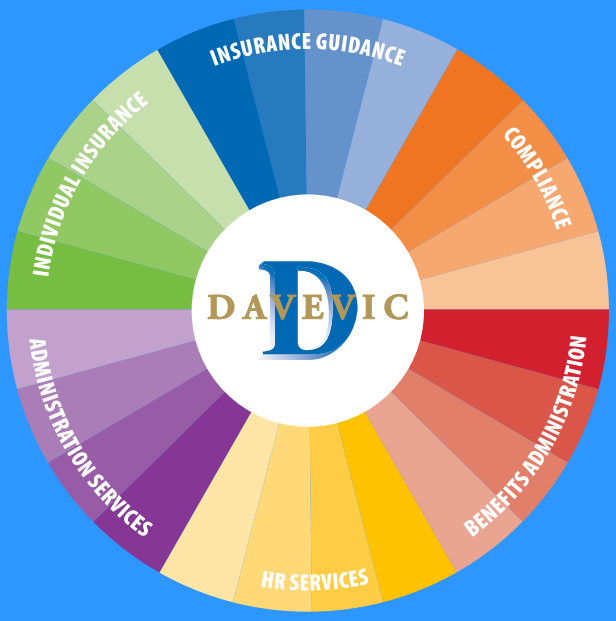
Mailing Address: Davevic Benefit Consultants, Inc.
902 South Center Street
P. O. Box 976
Grove City, PA 16127

Fax: 724-458-4464

E-mail Attachment: flexcontact@davevic.com

Phone: 724-458-7255 or toll free 800-854-4099

Online Account Access: www.davevic.com



Debit Card Reminders

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Benny® Prepaid Benefits Card Substantiation Details

General Questions on the Benny® Prepaid Benefits Card

Employers and employees may have questions about the requirements for submitting receipts when the Benny Prepaid Benefits Card is used to pay for a service. This handout provides an explanation of the receipt substantiation requirements.

IRS Rules Govern Substantiation Requirements

The IRS has established specific guidelines that require all Flexible Spending Account (FSA) and Health Reimbursement Arrangement (HRA) transactions — even those made using a healthcare payment card — to be substantiated (verified that the purchase was an eligible medical expense).

The substantiation process is performed by Evolution1. We are very diligent in the execution of the substantiation process to avoid adverse tax consequences to employees.

Common Misconceptions about Receipt Requirements

1. If the Benny Prepaid Benefits Card is used for an eligible service, no further receipts or documentation are needed to support the expense.
2. Any claim at a doctor, dentist or vision provider will not require receipts.

These misconceptions are NOT TRUE! Since not all services from a medical, dental, vision or a non IIAS pharmacy provider are eligible expenses, itemized receipts are required to verify eligibility. For example, a dentist may perform teeth whitening, which is not eligible for reimbursement.

IIAS and Auto Substantiation

Inventory Information Approval System (IIAS) is a new Federal Government mandated system used by pharmacy merchants that identifies eligible prescription and over the counter items and limits FSA and HRA healthcare payment cards to only those eligible items.

This system makes it easier for account holders to manage eligible over- the-counter and pharmacy expenses, since the merchants automatically substantiate purchases at the point of sale.

All supermarkets, grocery stores, department stores, and wholesale clubs are required to implement the IIAS merchant program or they cannot accept healthcare payment cards. For a regularly updated list of these stores and pharmacies, please choose the IIAS Merchants link on your consumer portal and look for retailers that are certified IIAS compliant.

Substantiation Processes
There are two ways purchases may be substantiated in compliance with IRS requirements:

Auto-Substantiation. A daily process is run to auto-substantiate Benny debit card claims using the specific methods setup for the employer group. These methods include co-pay substantiation, recurring auto-substantiation, and Carrier substantiation. Examples include:

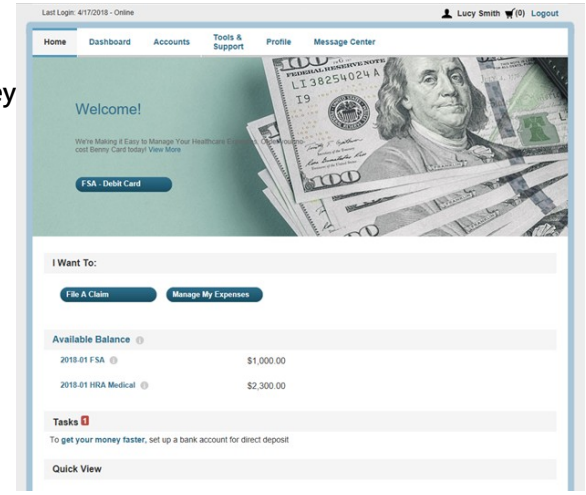
- *Copay matching*: charges that exactly match the dollar amount, for up to 5 times the dollar amount, for a copay under the employer's insurance plan. For example, a $20, $30, or $40 charge at a doctor's office or 5 times those amounts.
- *Recurring claims*: charges that exactly match the provider and dollar amount for 3 previously approved and substantiated transactions. For example, a fixed monthly orthodontia payment.

Manual Substantiation. All purchases that do not qualify for auto substantiation must be manually substantiated with receipts or other documentation. Examples include:

- Doctor, dentist, and other provider visits where the amount paid is not equal to the copay.
- Prescription and over-the-counter transactions where the amount paid is not equal to the copay at a store that is not IIAS compliant.

Always Save Itemized Receipts

Employees should save their itemized receipts from every healthcare payment card transaction and all of the explanation of benefits (EOBs) they receive from health/pharmacy/dental plans.



An easy approach for keeping this information on hand is to upload copies of itemized healthcare payment card receipts and EOBs to the Dashboard page of the consumer portal where they will be stored electronically.
Receipts can also be attached to the expense from the mobile app using the camera on your mobile device! Otherwise, designate an envelope or folder to store documentation in your personal files. Using this process will help employees find documentation if requested.

Information Required on Documentation

All receipts or documentation must include the following information:

- Name of person who incurred the service or expense
- Name and address of the provider or merchant
- Date of service for the amount charged
- Detailed description of the service
- Amount due for the service provided

EOBs contain all of the required information and are excellent sources of documentation. Credit card receipts and cancelled checks are not acceptable!

Receipts for over-the-counter (OTC) and prescription items do not need to include the person's name, but must display the name of the item (e.g. band aids).

Requests for substantiation

If substantiation of a debit card transaction is required, employees will be notified by email or an alert on the Consumer Portal home page. Debit card transactions that require substantiation are displayed through messages in both the Message Center on the home page and their account summary page. Employees may also see if a claim requires substantiation by logging into their online account or mobile app to check the status of the claim.

In Summary

- IRS rules require that all FSA and HRA claims be substantiated.
- If the claim cannot be auto- substantiated, the employee is required to submit documentation to support the claim.
- Employees should save itemized receipts and documentation for all healthcare services—even when they paid using their Benny Prepaid Benefits Card.
- Using IIAS compliant merchants for pharmacy and OTC purchases will significantly cut down on receipt requests.

DAVEVIC

Debit Card Receipt Reminders

How our system works:

1. Davevic claims system generates Debit Card request letters on a daily basis for services requiring proof of an eligible expense. The notices are sent via mail or email based on Consumer preference in their account. Below is the process to review each debit card swipe.
2. After the debit card is used at the point-of-sale it may take 2-3 days for the purchase to appear in the participant account as pending approval.
3. Once the purchase enters the pending cycle, our claims system will begin the substantiation process to determine if the claim meets IRS specific guidelines to Auto-Substantiate the claim.
4. At the end of this process, the system will either accept the claim without further documentation needed or produce a Debit Card request letter stating a receipt is needed.
5. First Receipt Request will be approximately 5 days after the date of the purchase.
6. If the Consumer does not respond to the first request, the Second Receipt Request will be sent 15 days later.
7. Lastly, Consumer does not respond within 15 days an Overdue Final Notice is mailed to the participant providing additional time before suspending the Debit Card.
8. Our system will automatically suspend the Debit Card 15 days after the final notice is sent. The Debit Card will remain suspended until the IRS required receipts are submitted.
9. The complete process provides the Consumer approximately 45 days to respond to the request before their Debit Card is suspended.
10. When receipts/invoices or explanation of benefits have been received, Davevic will verify the information based on IRS regulations and apply to Consumer specific claim. The suspended Debit Card will reactivate within 24 hours.

Timeline Illustration

Date of Debit Card service: March 1			
Step	**Request Letter Title**	**Interval**	**Date Request Sent**
1	First Receipt Request	5 days	March 5
2	Second Receipt Request	15 days	March 20
3	Overdue Final Notice	15 days	April 5
4	No Notice Sent – Card Suspension	15 days	April 20