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:

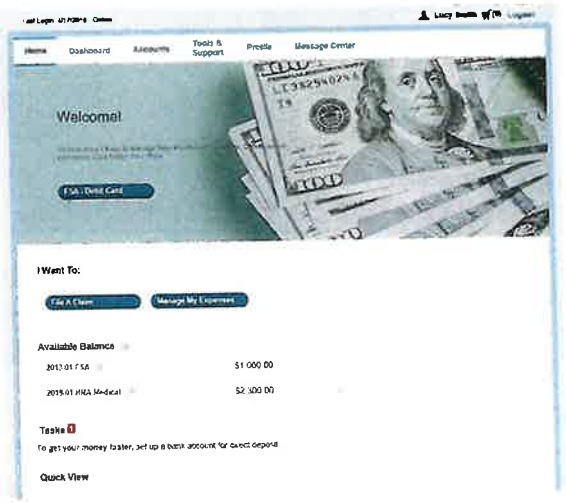
- *Copay matching*: charges that exactly match the dollar amount, for up to 5 times the dollar amount, for a copay under the employer's insurance plan. For example, a $20, $30, or $40 charge at a doctor's office or 5 times those amounts.
- *Recurring claims*: charges that exactly match the provider and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

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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

Flexible Spending Accounts

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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

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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.