2018

Your Flexible Spending Account Plan

Administered by Benefit Allocation Systems, LLC

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BAS
Benefit Allocation Systems

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BAS Benefit Allocation Systems

Welcome to your FSA!

Congratulations! Your employer has offered you the opportunity to participate in a Flexible Spending Account Plan ("FSA"). Your employer has selected Benefit Allocation Systems, LLC as the claims processor for your FSA. BAS works with you and your employer to make your FSA participation as easy as possible.

Here's information about how your FSA works and how you can submit claims for reimbursement from your FSA. Since the FSA is your employer's plan, the terms of your FSA are set by your employer. BAS does not sponsor, fund or determine eligibility for your FSA, but BAS does review your claim reimbursement requests to make sure they are eligible for payment under the terms of your plan.

Introduction to A Flexible Spending Account

A Flexible Spending Account Plan ("FSA") offers an easy and convenient way for you to save money on taxes and make your benefit dollars go further. If you participate in a Health Care and/or Dependent Day Care FSA, your employer puts money aside from your paycheck (before taxes are taken out) and you use that money to pay for eligible health care and/or dependent day care expenses.

When you have an eligible health care and/or dependent day care expense, you must save your receipts and other documentation (such as EOBs). You then submit the proper documentation to BAS for review. If the documentation is approved (it will be approved if it meets IRS and your plan's requirements), you will receive a reimbursement of the amount of the eligible expense. More information about what expenses are eligible to be paid from your FSA is set forth below.

Please note that BAS does not hold any of your FSA contributions. Contributions are held by your employer. When you submit an expense that is eligible for reimbursement, BAS reviews and approves your claim, and then advises your employer on the amount of funds it needs to provide to BAS to send to you for reimbursement.

How to Submit Your Claim for Reimbursement

You must submit your claim to be reviewed in order to receive a reimbursement of your claim amount. BAS offers three easy ways to submit your claim.

Online Claim Submission (*Easiest!*)

You can submit your claim online, from your own computer. You can even take a picture of your documentation and send it to BAS online!

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Visit www.MyEnroll.com and enter your user ID and password. When you are logged in, you will be on your home page. Hover your mouse over the word "Employees" in the top menu bar. Under "Flex Spending Accts," click on "Enter FSA Claims Online." This will take you to the claim submission process where you will describe your claim, who incurred the claim, the date of the claim, and you will upload the supporting claim documentation. BAS has user guides and videos with step-by-step instructions. Go to www.FSA-central.com to view the help videos.

Mail Your Claim Submission (*Easier*)

You will need a claim form to mail your claim submission. You can get a blank claim form by visiting www.MyEnroll.com and selecting "Flexible Spending Account" from the menu bar.

- Use the drop down menu to select "Non-Bar Coded Claim Forms"
- Select the format you prefer (html, PDF, or Word) and the FSA plan (Dependent Care or Health Care)
- Print the form

Complete the claim form, sign it at the bottom and gather your supporting documentation. You can mail your claim form and documentation to

Benefit Allocation Systems
Attn.: FSA Claims Department
PO Box 62407
King of Prussia, PA 19406

Fax Your Claim Submission (*Easy*)

You will need a claim form to fax your claim submission. You can get a blank claim form by visiting www.MyEnroll.com and selecting "Flexible Spending Account" from the menu bar.

- Use the drop down menu to select, "Non-Bar Coded Claim Forms"
- Select the format you prefer (html, PDF, or Word) and the FSA plan (Dependent Care or Health Care)
- Print the form

Complete the claim form, sign it at the bottom and gather your supporting documentation. You can fax your claim form and documentation to 1.888.265.2144.

Documentation Needed with Claim Submission

Health Care FSA

When submitting a claim for reimbursement from the Health Care Flexible Spending Account or Health Reimbursement Account, you must provide documentation of the qualified expense.

An acceptable health care FSA claim should include:

- Appropriate claim form. (Separate claim form for each individual)
- Signed
- Dated
- List Expenses
- List Dates of Service
- Identify whose expenses (participant, dependent)
- Amount of Claim
- Appropriate receipts (see below)

Supporting Documentation

Supporting receipts, EOBs or billing statements must be submitted with the completed and signed claim form. Supporting documentation must contain all of the following elements to be considered an adequate receipt under IRS rules. Credit card receipts and/or cancelled checks are not adequate documentation.

Medical Service – (An itemized statement or an EOB from the insurance company or health care provider that contains the following)

- Patient Name
- Provider Name
- Date of Service
- Description of Service (or procedure code)
- Amount Paid

Medical Item

- Merchant Name
- Date of Purchase
- Description of Item
- Amount Paid

Prescription

- Name of Patient
- Name of Pharmacy
- Date (fill date)
- Prescription Number
- Amount Paid

OTC Drug or Medicine

- Prescription Required
- Doctor's Name
- Doctor's License Number
- Patient's Name
- Date
- Description of Drug (specific description- "cold medicine" or "allergy medicine" not sufficient)

- Receipt Required
- Merchant Name
- Date of Purchase
- Description of Item
- Amount Paid

Dual Purpose Item

If the item has both a medical and a non-medical purpose (a massage, nasal strips, vitamins, or compression socks, for example), a Letter of Medical Necessity from your doctor must be submitted confirming that the item is for medical care. A new Letter of Medical Necessity must be provided each Plan Year. BAS has a form that your doctor can fill out to satisfy the Letter of Medical Necessity Requirements. You can get a LOMN form to give to your doctor at www.fsa-central.com in the "Reimbursement Guide" link.

To be acceptable, a Letter of Medical Necessity must include:

- Patient Name
- Doctor Name
- Date of Issue
- Diagnosis
- Service or Supply Needed
- Statement or support that service or supply is medically necessary to treat diagnosis
- Length of Service (if applicable)

Dependent Day Care FSA

When submitting a claim for reimbursement from the Dependent Day Care Flexible Spending Account, you must submit a completed BAS Dependent Day Care FSA Claim Form, along with appropriate receipts showing the expense was incurred for an eligible dependent.

An acceptable Dependent Day Care FSA claim should include:

- Appropriate claim form. Separate claim form for each individual.
- Signed
- Dated
- Identify Qualified Dependent
- Provider's Signature and Date (or provide receipt)
- Taxpayer Identification Number (or SSN) (or statement that you tried to get the TIN/SSN but couldn't)
- Description of Services
- Amount of Claim
- Appropriate supporting documentation (see below)

Supporting Documentation

If the Provider does not sign and date the completed form attesting to each expense, supporting bills/receipts must be submitted with the completed claim form. A bill/receipt must contain all of the following elements to be considered adequate under IRS rules. Credit card receipts and/or cancelled checks are enough.

- Name of Qualifying Dependent
- Name and Address of Provider
- Date of Service
- Description of Service (if not evident from name on statement)
- Provider's Taxpayer Identification Number/SSN (if not on claim form or if statement not provided that tried to obtain the TIN/SSN)

How to Access Important Plan Dates

There are three important FSA dates you should know. These are:

1. The plan year beginning and end;
2. The grace period end (if applicable to your plan, this will be the last day to incur claims);
3. The runout period end (this will be the last day to submit claims for reimbursement.

To access this information for your FSA, log on to www.MyEnroll.com. Hover over "Employees" in the menu bar, and select Flexible Spending Acct. Then select the FSA Balances and History link. All three dates are conveniently located in one screen. The plan year end date will be displayed across the top. The grace period and claims run-out period will be displayed under each benefit.

How Does the Health Care FSA Work?

The Health Care Flexible Spending Account enables you to be reimbursed with before-tax dollars to pay expenses not covered by your employer's medical plan. The total amount that you elect to contribute to your account for the year can be used immediately to pay eligible reimbursable expenses. Your total reimbursable expenses for the year cannot exceed your total contributions to the account for the year. Your employer sets the exact terms of your plan, so contact your employer for more information.

How much may I contribute to my Health Care FSA?

The IRS places a dollar limit on the amount of contributions you can make to the Health Care Flexible Spending Account Plan each year. In 2018, that dollar limit is $2,650, but the amount may be adjusted for inflation from time to time. Your employer may set a lower maximum contribution. Please refer to information from your employer for the minimum and maximum amount you may contribute to your Health Care Flexible Spending Account each year. The annual contribution is equal to the annual amount you elect, subject to the dollar limitations of the Plan.

Whose expenses may I be reimbursed for under my Health Care FSA?

You may be reimbursed for eligible health care expenses for yourself, your tax dependent for health coverage purposes, and/or your child who is under age 27 as of the end of the taxable year. Certain relatives including your parents, grandparents, grandchildren, nieces and nephews may qualify as dependents if they live in your house and you provide at least half of their support. Consult your personal tax advisor.

To be eligible for reimbursement, the expense must be incurred during the plan year and while you are a participant in the FSA. An expense is incurred when it is actually provided. It is not considered incurred when paid or billed. For a prescription, the incurred date is typically the fill date.

What expenses can be reimbursed from my Health Care FSA?

Only expenses for medical care (which is a term defined by the IRS under section 213(d) of the Internal Revenue Code) that are incurred during the plan year (and grace period, if applicable) may be reimbursed through the Health Care Flexible Spending Account.

An expense is for medical care if it is for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body. Amounts spent for general health or cosmetic purposes are not eligible for reimbursement. If you are a participant in a Health Care FSA sponsored by a religious organization, your eligible expenses may be subject to additional limitations so that they are in keeping with religious directives.

BAS has a table you may use to check if an expense is considered a medical expense. Remember, your plan may limit what can be reimbursed, so the items in the table may or may not apply to you. To access the eligible expense table, log on to **www.MyEnroll.com**. Hover your mouse over the word "Employees" in the top menu bar. Under "Flex Spending Accts.," click on "Eligible Expense Table."

Within the Expense Table, you can scroll through or search alphabetically to locate expenses and read thorough explanations of eligibility.

The expense table identifies expenses as:

a) qualifying expense,
b) potentially qualifying expense, or
c) not a qualifying expense.

Common eligible medical expenses include:

- Routine medical and dental checkups.
- Any amount paid for the purpose of affecting any structure of the body. This includes not only surgery, but also the purchase of equipment that is used to help your body function properly, including prescription eyeglasses.
- The purchase of any prescription drug or insulin.
- Over-the-counter medicines and drugs that are prescribed by a physician.

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- Transportation which is primarily for and essential (not merely convenient) to receiving medical care.

Payment of the portion of any medical expenses that is not reimbursed under your employer's medical plan because of deductibles or co-payment requirements, or other limitations on the amount or nature of benefits covered by the medical plan.

You *cannot* pay any medical or long-term care insurance premiums through the Health Care Flexible Spending Account. You cannot pay for an over-the-counter drug through the Health Care Flexible Spending account Plan unless the over-the-counter drug is a prescribed drug or is insulin. Cosmetic surgery or other similar procedures may not be reimbursed from the plan, unless the surgery is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting form an accident tor trauma, or a disfiguring disease. If your employer's plan follows ethical religious directives, your reimbursements are limited to those expenses that are in keeping with the ethical religious directives.

Can I use my Health FSA for Over the Counter Products?

Over the counter (OTC) medications and drugs require a prescription in order to be eligible for reimbursement from a health care FSA. OTC items include things such as

Acid controllers	Baby rash ointments/creams	Laxatives
Allergy & Sinus	Cold sore remedies	Motion sickness
Antibiotic products	Cough, cold & flu	Pain relief
Anti-diarrheals	Digestive aids	Respiratory treatments
Anti-gas	Feminine anti-fungal/itch	Sleep aids & sedatives
Anti-itch & insect bite	Hemorrhoidal preps	Stomach remedies
Anti-Parasitic treatments		

Please note that insulin is considered an eligible expense with or without a prescription.

You can use your FSA to purchase eligible OTC items for medical care that are not considered a medicine or drug, such as bandages, splints, contact lens solution, etc. without needing a prescription. Items for general good health (such as vitamins) are not eligible for reimbursement from a health FSA, unless your doctor provides a Letter of Medical Necessity for the item (see below for a description of a LOMN).

What is the Use-It-Or-Lose-It Rule?

In order to retain the favorable tax treatment of the Health Care Flexible Spending Account Plan, the IRS generally requires that amounts not used to reimburse eligible expenses incurred by the end of the plan year are forfeited. This means if you do not use it, you lose it.

Your employer determines what it does with the forfeited funds. BAS does not hold any of your FSA contributions and does not keep any forfeited amounts.

What is a carryover or grace period?

Some health FSAs may include a carryover or grace period. These health FSA features allow you to either have additional time to either incur eligible expenses or carry over a limited amount of unused money into the next plan year. A plan may have one of these features but not both. While these features are described here, they may or may not apply to your plan. Contact your employer to determine if your plan has a carryover or grace period or neither.

A carryover feature allows you to carryover up to $500 of unused funds into the next plan year before your unused amounts are forfeited (use it or lose it). The maximum carryover amount may be changed by the IRS or your plan from time to time. Please note that the exact dollar amount that is carried over is determined after the period to submit claims has ended, which may be several months after the end of the prior plan year. You will not have access to the carried over funds until this time.

A grace period feature allows you to continue to incur eligible expenses during the next plan year for a limited period of time (an additional 2 ½ months) before your unused amounts are forfeited.

Check the terms of your plan to determine if either of these features applies to you.

How Does the Dependent Day Care FSA Work?

The Dependent Day Care Flexible Spending Account allows you to be reimbursed with before-tax dollars for expenses you need for caring for your dependents in order to enable you (and your spouse, if you are married) to work or look for work.

The total expenses that you can have reimbursed at any time cannot exceed the total amount that you have contributed to the account up to that time.

Who qualifies as a dependent under the Dependent Day Care Flexible Spending Account?

In order to be reimbursed for dependent care expenses, you must maintain a household that includes at least one “qualifying” dependent. A “qualifying” dependent is a dependent who either is under the age of 13 or is physically or mentally incapable of caring for himself. If a dependent reaches the age of 13 during the year, only expenses incurred prior to reaching that age will qualify.

The definition of “dependent” generally includes your spouse and any person you can claim as a dependent on your tax return. However, there is one difference that applies if you are divorced and your divorce decree specifies whether you or your former spouse can claim your children as dependents for tax purposes. Under the Dependent Day Care Flexible Spending Account rules, only the parent who has custody of the child can treat the child as a dependent, regardless of which parent gets the tax deduction. If the parents have joint custody, the parent with whom the child lives for the larger part of the year can treat the child as a dependent. Consult your personal tax advisor.

How much can I contribute to the Dependent Day Care Flexible Spending Account?

In 2018, you can generally contribute up to $5,000 per year to your Dependent Day Care Flexible Spending Account, provided that you are either single or, if you are married, file a joint tax return with your spouse. If you and your spouse file separate tax returns, you can only contribute up to $2,500 per year. Your employer may set lower contribution limits, and the IRS may adjust these limits from time to time.

If either you *or your spouse* has earned income for the year of less than $5,000, the amount that you can contribute is limited to this lesser amount. This means that if your spouse doesn't work, you cannot contribute to the Dependent Day Care Assistance Plan for that year. There are some special rules that apply if you and your spouse are separated, or if your spouse is a full-time student or is incapable of caring for himself or herself.

What are eligible dependent care expenses?

Whether an expense is eligible for reimbursement is determined by IRS guidelines. You will be required to provide the name, address and Social Security number or tax ID number of the dependent care provider to show the expense is an eligible expense. Your provider cannot be one of your children under age 19 or anyone else who you can claim on your tax return as a dependent.

Some examples of eligible dependent care expenses include:

- Expenses paid for certain household services. Non-essential household services (i.e., a gardener or chauffeur) don't qualify.
- Certain expenses paid to care for the qualifying dependent in your household, such as payment for a nurse who comes to your home.
- Expenses to care for a qualifying dependent outside of the your household, provided that if the dependent is not under the age of 13, the dependent must spend at least eight hours a day in your home. For example, payments to a day care center for a child under the age of 13 generally would qualify. However, payments to a nursing home in which your parent resides on a full time basis would not qualify, because your parent doesn't spend at least eight hours a day in your house.
- Payments to day care centers (must meet all state and local licensing requirements).
- Preschool costs.
- After-school care.
- Dependent care/baby-sitting services in your home or someone else's, as long as the care provider is not one of your own children under age 19 or anyone else for whom you claim a tax exemption on your federal income tax return.
- Certain expenses for a live-in, full-time housekeeper for a disabled dependent.
- Summer day camp.

What dependent care expenses may NOT be reimbursed under the Dependent Day Care Flexible Spending Account?

Examples of expenses that may not be reimbursed from the Dependent Day Care Flexible Spending Account include:

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- Dependent care services provided by a person or facility that does not report the income for tax purposes.
- Dependent care services provided by someone you claim as an exemption on your federal income tax return or by one of your children under the age of 19.
- Housekeeping expenses not related to dependent care.
- Dependent care expenses you claim on your federal income tax return.
- Health care expenses for a dependent.
- Food or clothing for a dependent.
- Transportation costs between your home and the dependent care center.
- Schooling costs for children in kindergarten or older.
- Expenses for day care from a provider that is not a qualified, licensed provider.
- Overnight camp expenses.

Are there any limits on my reimbursements under the Dependent Day Care Flexible Spending Account?

You cannot get reimbursed for expenses in advance. You can only get reimbursed for expenses you already incurred, and only up to the amount you have contributed to your Dependent Day Care FSA.

What is the Use-It-Or-Lose-It Rule?

The IRS requires that amounts not used to reimburse eligible expenses incurred by the end of the plan year are forfeited. This means if you do not use it, you lose it.

Your employer determines what it does with the forfeited funds. BAS does not hold any of your FSA contributions and does not keep any forfeited amounts.

Claim Processing

When you submit a claim form, if BAS has your email address on record, you will receive an email confirming that your claim as been processed.

Payment and Notification

Each week BAS processes approved FSA claims for payment. At that time, BAS will send you an email letting you know your claim has been processed and directing you to go online to view information about the claim payment.

Reimbursement Methods- Direct Deposit

You can arrange, at no cost to you, to receive your health care and/or dependent day care flexible spending account expense reimbursements by direct deposit. The advantages of direct deposit are:

- Faster, more secure access to your reimbursement funds

- Funds are deposited electronically and usually available to you the same day
- No time delay between payment and receiving your check in the mail
- No chance of lost checks or delayed mail
- No need to go to the bank to make a deposit

You can sign up for direct deposit by logging into www.myenroll.com. Hover over the Employees tab. Select Ach Authorization under Flexible Spending Accts.

Denied Claims

If a claim is not approved for payment, you will receive an email directing you to log onto MyEnroll.com and see your explanation of benefits (EOB) identifying the denied claim, along with a denial code for explanation.

Claims can be denied for many reasons, but most claims are denied because the supporting documentation submitted with the claim form does not provide enough detail. For example, the following receipts alone would not provide adequate substantiation for a claim in accordance with IRS rules:

- cash register receipts for prescription copays;
- provider payment receipts that do not contain dates of service or the reason for the expense; and
- receipts for services or items with both a medical and non-medical purpose (also known as dual-purpose items or services) that are not accompanied by a doctor's letter of medical necessity.

Many FSAs offer a period of time for you to fix a denied claim.

Identify the claim that was denied and the reason for the denial. Log on to www.MyEnroll.com. Hover over "Employees" in the menu bar, and select Flexible Spending Acct. Then select the FSA Balances and History link. Locate the claim and review the denial code. Click on the code for a brief description of the reason the claim was denied.

Obtain an Explanation of Benefits or a new itemized receipt to substantiate the denied claim. Resubmit the claim by mail or fax. Include a copy of the email from MyEnrollServices@BASusa.com with your resubmission. This will assist with expediting the claim.

Fax your resubmission to: 888-265-2144 or mail it to BAS P.O. Box 62407 King of Prussia, PA 19406.

Debit Card

If your employer offers a debit card with your health flexible spending account plan, there are certain rules you must follow for using the card. Most importantly, SAVE YOUR RECEIPTS!!!

What is the Debit Card?

The pre-paid Benefits Card is a special-purpose MasterCard® that gives you an easy, automatic way to pay for qualified health care expenses that are eligible to be reimbursed through your Health Flexible Spending Account plan. The Card lets you access the pre-tax dollars you set aside in your FSA and use those dollars to pay for your eligible, reimbursable health care expenses.

How does the Card work?

It works like a MasterCard®, with the value of your health FSA contribution loaded on it. When you have eligible expenses at a business that accepts MasterCard® debit cards, simply use your Card to pay for eligible expenses. The amount of your eligible purchases will be deducted - automatically - from your health FSA and the pre-tax dollars will be electronically transferred to the provider/merchant for immediate payment.

Even though your Card swipe pays for your charge at the provider/merchant, the payment does *not* necessarily mean that the expense is approved as an eligible health FSA expense. In many circumstances, you must submit supporting documentation to verify your Card payment. This is the case even if the charge is processed and the provider/merchant receives payment.

How does the Card change how I am reimbursed for health FSA expenses?

With the debit Card, you simply swipe the Card and the funds are automatically deducted from your FSA. You must retain your receipts (provider documentation, not just credit card receipts) for all of your debit Card purchases. The benefit of the debit Card is that it eliminates most out-of-pocket cash outlays and you do not have to wait to receive reimbursement checks.

Please be sure to use your debit card to pay for eligible expenses incurred within the plan year, only. That means you should not use the card to pay past balances due.

Why should I save receipts and other documentation for all purchases made with my debit Card?

The IRS requires that every transaction made with any type of Flexible Spending Account prepaid debit card must be substantiated in order to confirm that the cardholder is using the Card to pay for an eligible expense. The IRS considers many expenses paid with the Card to be automatically substantiated at the point of sale. For example, if you use your Card to pay a copayment amount for a prescription, the expense may be automatically substantiated if your plan's copay amount is identified in the system. In this instance you do not have to separately submit a receipt for the copayment amount for substantiation.

Many expenses cannot be substantiated at the point of sale, and IRS regulations require you to submit extra documentation to verify the transaction. Examples of expenses that may not automatically substantiate include dental, chiropractor and physician office visits where the amount paid is not equal to an established copay amount that is recognized in the Card System, and situations in which you charge more than on copay expense in the same Card swipe.

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If you use your Card for an expense that cannot be automatically substantiated at the point of sale, the merchant will be paid for the expense, but you MUST provide documentation to verify that the purchase is an appropriate FSA expense.

You will be required to submit substantiation to BAS in order for BAS, on behalf of your plan, to confirm that the expense is eligible in accordance with IRS guidelines.

What is appropriate substantiation?

The Internal Revenue Service places rules on FSAs in exchange for allowing participants to receive the tax-favored benefits of participating in the plan. One of those restrictions is that all claims must be substantiated with supporting documentation that meets certain requirements.

Appropriate substantiation includes the merchant or provider name, the service or item purchase date, and the amount of the purchase. Explanation of Benefits (EOBs) and other provider documentation with the required information may be used as verification of an expense. Cancelled checks, handwritten descriptions of charges, card transaction receipts or previous balance receipts cannot be used to verify an expense.

Medical Service – An itemized receipt/statement or an EOB from the insurance company or health care provider should include: Patient Name; Provider Name; Date of Service; Description of Service (or procedure code); Amount Paid. A credit card receipt from your Card swipe is not sufficient.

Medical Item – Examples of medical items include nonprescription reading glasses, bandages for a current wound, contact lens solution, etc. A proper receipt should include: Merchant Name; Date of Purchase; Description of Item; Amount Paid. A credit card receipt from your Card swipe is not sufficient.

Prescription – Documentation for a prescription should include: Name of Patient; Name of Pharmacy; Date (fill date); Prescription Number or Name; Amount Paid. A credit card receipt from your Card swipe is not sufficient.

How long do I need to save my receipts and other documentation?

You should save all of your receipts for as long as you would save documentation for your tax return. Consider keeping all information in one place so it is readily available upon request.

What if I lose my receipts or I accidentally swipe the Card for something that's not eligible?

Usually the service provider can recreate an account history and provide replacement documentation. Insurers can generally issue a replacement EOB. In the event that documentation cannot be located, recreated, or if the expense is ineligible for reimbursement, you can send a check or money order to BAS for the ineligible amount so BAS can forward the repayment to your employer for it to be credited back to your FSA. If this applies to you, please contact BAS for more information.

How will I know to submit documentation to verify a charge?

If there is a need to submit a receipt or other documentation, you will receive an email from @wexhealth.com. The email will include an attachment with more information. Please DO NOT ignore the emails you receive. You must respond to the emails in order to complete the process for documenting unsubstantiated expenses paid with your Card, as per the Card use agreement you received when you activated the Card. If you do not have an email associated with your account, you will receive the notifications through regular U.S. mail.

The majority of notifications will be sent each month for services rendered the prior month. However, ALL receipts should be saved per IRS regulations, as there may be instances in which you may have to submit documentation outside of the monthly notification.

What if I don't submit documentation to verify a charge?

If you don't submit documents to verify an unsubstantiated charge made with the Card, then the Card will be suspended until proper documentation is received and the charge is substantiated. If it cannot be substantiated, you will be required to repay to your FSA the amount charged. BAS will let you know that your Card has been suspended if the documentation is not received when required. Submitting the appropriate documentation or repaying the amount in question will allow the Card to be reactivated.

What is the Documentation Request Processing Schedule for Unsubstantiated Claims?

If you use your Card for an expense that cannot be automatically substantiated, you will be asked for more information as follows:

Wex Health will send you a First Request for Receipts notice asking for supporting documentation for the unsubstantiated expense. If you have a valid email address entered into MyEnroll, you will receive the letter by email (from @wexhealth.com). If you do not have an email address associated with your account, the letter will be mailed to your home address.

You will have 30 days to respond to the first request for receipts. If your response is not received within 30 days, you will be sent a Second Request for Receipts notice to remind you of the need for supporting documentation. You will have 30 days to respond to the second request. If your response is not received in this time period, your Card will be suspended and you will again be asked for supporting documentation. *Please note that you may continue to submit manual (paper or online) claims while the card is suspended.*

Your card will remain suspended until you provide adequate documentation, or until you repay your account with after-tax dollars.

If you provide additional documentation, that documentation will be reviewed to determine if the expense can be properly paid from your FSA. If it is determined that the expense can be properly paid, the claim will be substantiated and your Card will be reactivated. If after review of the documentation you submit, it is determined that there is not sufficient information to substantiate the claim, you will be sent another notification requesting more information. You will have 30 days to respond to the request for more information.

If, based on all of the information you provide, it is determined that the expense is not an eligible expense, you will receive a notice asking you to send a check in the amount of the

expense to reimburse your FSA. When BAS receives the repayment and forwards it to your employer to reimburse your account for the ineligible expense, your account will be credited and your Card will be reactivated.

If you do not respond to the notifications within the timeframes, or if you do not repay an expense that is determined to be an ineligible expense, your Card may be permanently suspended and will not be reactivated.