

**Virginia United Methodist
Conference**

**Your Flexible Spending
Accounts**

Claims Filing Instructions

FLEXIBLE SPENDING ACCOUNT

Table of Contents

	<i>Page No.</i>
SECTION I: General Information on Flexible Spending Accounts.....	1
SECTION II: List of Eligible and Ineligible Expenses for Your Health Care Spending Account.....	3
SECTION III: List of Eligible and Ineligible Expenses for Your Dependent Day Care Spending Account.....	5
SECTION IV: Claims Filing Instructions.....	6
 APPENDICES:	
A. Sample Completed Claim Form	
B. A Sample Explanation of Benefits Form	
C. A Sample Participant Summary Statement	

FLEXIBLE SPENDING ACCOUNTS

General Information

What Are Flexible Spending Accounts?

Flexible Spending Accounts (FSAs) allow you to set aside a portion of your earnings through payroll deductions to help pay for eligible health and dependent care expenses. Participating in an FSA is like opening up your own savings account, and prepaying for planned health care and dependent care out-of-pocket expenses. Your contribution is made before taxes are withheld. Therefore, your taxable earnings will be lower, and your taxes will also be lower.

Health Care Flexible Spending Account

The health care flexible spending account is designed to help you pay for health care expenses that are not 100% covered, or are ineligible for payment, under your employer provided health care plan. These expenses might include the medical plan deductible, coinsurance, dental, and vision and hearing services.

When you sign up for the health care spending account all of your dependents automatically participate. Therefore, when planning your out-of-pocket medical expenses you should consider all of your eligible dependents.

Dependent Care Spending Account

The Dependent Care Spending Account is designed to help you pay for childcare or elder care services, which make it possible for you and your spouse (if applicable) to work. It also may be used to help pay for the care of a disabled spouse or dependent.

Qualifying dependents include individuals that spend at least eight hours a day in your home and are:

- Your dependent children under the age of 13 for whom you have custody
- Your spouse who is physically or mentally unable to care for himself/herself or
- Your dependent who is physically or mentally unable to care for himself/herself, even if you cannot claim an exemption for the person for income tax purposes.

Filing A Health Care Claim – Health Care Spending Account

When filing a claim, attach your receipt or insurance explanation of benefits. Claims for eligible expenses that are not covered by a health plan can be submitted directly to the health care flexible spending account for payment. If your claim is for a medical condition that is covered by a medical or dental claim, you will need to first file that claim with that plan. After the claim is processed, submit a copy of the Explanation of Benefits (EOB), which shows your out-of-pocket expenses, as part of your health care flexible spending account claim.

When filing a claim for over-the-counter expenses, attach a store receipt that lists the items. The receipt must include the name of the product, the amount paid, and the date purchased.

Claim payment is based on the date you receive health care service, not the date you pay the invoice or the date you are billed. Your claim will be paid from your health care flexible spending account contributions for the year in which you received this service. The payment is made up to the amount of your annual election.

Filing A Dependent Care Spending Account

When filing a claim, attach a bill that shows the charge, dates of service, provider, and the provider's tax identification number or social security number. **Remember to sign your claim form.**

Claim payment is based on the date you received the dependent care service, not the date you pay the invoice or the date you are billed. Your claim will be paid from your spending account contributions for the year in which you received the service. The payment is made up to the amount currently in your dependent care account at the time the claim is processed.

Claim Filing Deadline

Claims incurred during each year must be submitted by March 31 of the following year.

Where to Send Your Claims

Submit your claims to:

Aon Flexible Spending Administration
7325 Beaufont Springs Drive
Suite 300
Richmond, VA 23225
Customer Service 1-800-481-5224

Aon will process claims weekly. Claims received in our office by Friday of each week will be processed and checks will be mailed the following Wednesday.

FLEXIBLE SPENDING ACCOUNTS***List of Eligible and Ineligible Expenses for Your Health Care Spending Account*****Eligible Health Care Expenses**

- Deductible or co-payment amounts you pay under your or your spouse's medical, HMO, dental or vision care plans.
- Any amounts that you pay after any maximum benefit under a medical, dental, or vision plan have been paid.
- Any other health care expenses not covered by a health care plan that otherwise would be eligible for deduction when you file your tax return. These can include fees for:
 - Acupuncture, by licensed practitioner
 - Alcoholism or substance abuse treatment
 - Ambulance hire
 - Anesthetist
 - Artificial limbs
 - Birth control pills and contraceptive devices (prescription)
 - Braille books & magazines
 - Chiropractors
 - Christian Science practitioners
 - Contact lenses, solutions and enzymes
 - Cosmetic surgery to correct a congenital deformity or disfigurement due to an accident or disease
 - Dental expenses
 - Dentures
 - Dermatologists
 - Drug addiction therapy
 - Durable medical equipment, crutches, etc.
 - Eye examinations and eyeglasses
 - Hearing aids
 - Hospital services
 - Insulin
 - Legal abortions
 - Mileage @ 18¢ per mile) to/from physician's office for treatment
 - Note-taker to deaf
 - Nursing home (medically necessary)
 - Nursing care
 - Obstetricians
 - Ophthalmologists
 - Optician
 - Optometrists
 - Orthodontia (for services performed during the plan year)
 - Orthopedic shoes
 - Orthopedists
 - Osteopaths
 - Over-the-counter drugs used to treat a specific medical condition
 - Oxygen
 - Pediatrician
 - Physician's fee
 - Physiotherapist
 - Podiatrist
 - Prenatal care
 - Prescription drugs
 - Programs to stop smoking
 - Psychologists
 - Psychotherapy
 - Sanitarium stays
 - Seeing-eye dogs
 - Special home for mentally disabled
 - Surgical fees
 - Telephone or television equipped for deaf person
 - Therapy by licensed therapist, speech, occupational, etc.
 - Transplants
 - Tuition at special school or specially trained tutor for disabled
 - Vaccines
 - Vasectomy
 - Wheel chair purchase or rental
 - X-ray fees

For these expenses to be eligible, they must be considered medically necessary and prescribed by your physician, dentist, or vision care doctor.

Ineligible Health Care Expenses

Medical and dental premiums cannot be reimbursed through the health care spending account. In addition, elective cosmetic surgery and similar expenses are not allowable expenses according to the Internal Revenue Service. Other common ineligible expenses include:

- Anti-baldness drugs or hair transplants
- Dancing or swimming lessons, even if recommended by your doctor
- Diaper service
- Expense for trips even if for general health improvement
- Health club dues
- Household help
- Illegal operations and treatment
- Maternity clothes
- Over-the-counter products used to improve general health (i.e. vitamins, dietary supplements, mouthwash, etc.)
- Teeth bleaching
- Toothpaste, cosmetics, and toiletries
- Weight loss programs (unless prescribed by a doctor to alleviate a diagnosed medical condition)

FLEXIBLE SPENDING ACCOUNTS

List of Eligible and Ineligible Expenses for Your Dependent Day Care Spending Account

Eligible Dependent Care Expenses

Dependent care expenses that can be reimbursed through your dependent care account include costs you may pay for child care or for care of dependent adults who live with you at least 8 hours a day. However, the tax laws require that this care be necessary so that you and your spouse can work or attend school full-time.

You can be reimbursed through your dependent care account for:

- Payments to licensed nursery schools, day care centers or individuals for care of preschool children.
- Payments for before school care or after school care for children from kindergarten to age 13.
- Payments to providers outside the home for care of disabled dependent(s).
- Services of a housekeeper, maid or cook if services were partly for the care of a child to age 13 or a disabled dependent. This includes meals, lodging and payroll taxes of the housekeeper.
- Payments to relatives for care of qualifying dependent(s); however, the relative cannot be your dependent or your child if under 19 as of the end of the year.
- Payments (in lieu of regular day care) to summer day camp or other summer programs, but not overnight camps.

Ineligible Dependent Care Expenses

You cannot be reimbursed for:

- Expenses for education of qualified dependent(s) including kindergarten.
- Expenses for food, clothing or entertainment for dependent(s)
- Transportation to get dependent(s) to day care outside your home
- Payments to housekeeper while you are home sick
- Payments to a dependent to care for another dependent
- Expenses for overnight camps

Section IV

FLEXIBLE SPENDING ACCOUNTS

Claims Filing Instructions

Claim forms are enclosed for your use. Fill out the form completely according to the instructions on the back of each form. If you need additional forms, please contact Aon or your local benefits office.

Health Care Claims

For medical expenses, attach the documentation that describes the provider of the service, the type of service, the ***incurred*** date (not paid date or billing date), and the amount of the expense. The incurred date is the date you received the service.

Examples of acceptable documentation for medical expenses are:

- An Explanation of Benefits (EOB) from your medical or dental plan administrator. This is necessary even if the charges will be applied to your deductible.
- A physician's or similar statement for expenses not covered by your medical plan (not a receipt for payment).
- Receipts of co-payments from an HMO or managed care plan.

For over-the-counter expenses, submit the receipt which must include the product name, cost, and date purchased.

Dependent Care Claims

For dependent care expenses, you must submit a provider-signed receipt or invoice that itemizes the dates of service and the amount charged. Be sure to include the provider's name, address, and Social Security number or taxpayer identification number with each claim submitted. The taxpayer identification number is not necessary if the provider is a non-profit, religious, charitable, or educational organization.

Please note that your provider may be subject to a fine for not providing you this information.

Canceled checks are not considered acceptable documentation for spending accounts.

Special Claims Filing Instructions

Dependent Care Expenses

- Remember to attach a provider-signed statement for expense showing the dependent's name, the date of service, and the amount of the expense. Include the provider's name, address, and taxpayer identification number.
- IRS Rules define a qualifying dependent and include:
 - (1) Your dependent child under age 13.
 - (2) Your dependent that is physically or mentally unable to care for himself/herself.
- The dependent must spend at least eight (8) hours each day in your household. (For example, nursing home expenses are not eligible although they may be eligible for the Health Expense Spending Account to the extent that they are medically required.)
- Expenses must be incurred to enable you (and, if married, your spouse) to work. They cannot exceed either your earned income or your spouse's earned income. If your spouse is a full-time student or is disabled, your spouse is treated as having an income of \$200 per month (\$400 per month if two or more dependents receive day care). If you are in this situation, you may not contribute more than \$200 (or \$400) into the account each month regardless of your income.

Medical Expenses

- If part of the claim should be filed with your medical plan, submit the claim there first. If you are unsure if the expense is covered, file it with your medical or dental plan or contact Aon Consulting.

After the carrier has paid, submit the balance of the claim, along with the carrier explanation of benefits to Aon.

Virginia United Methodist Conference

Flexible Spending Account Claim Form

This request is for reimbursement of:

- Health Care Expenses (Complete Sections A, B, and D)
- Dependent Care Expenses (Complete Sections A, B, C, and D)

Mail to:

Aon Consulting
 7325 Beaufont Springs Drive, Suite 300
 Richmond, VA 23225
 1-800-481-5224

Name _____	Social Security No. _____
Mailing Address _____	City _____ State _____ Zip _____
If this is a new address, check here: <input type="checkbox"/>	Daytime Phone _____

A. LIST OF EXPENSES (Attach bills, statements, or other evidence of expenses.*)

Health Care	Date of Service	Payment Made To	Service Provided	Amount
<i>TOTAL HEALTH CARE EXPENSES</i>				
Dependent Care				
<i>*Canceled check is not sufficient evidence.</i>				<i>TOTAL DEPENDENT CARE EXPENSES</i>

B. SPOUSE AND DEPENDENT INFORMATION* (If expenses were for your spouse or for a dependent)

FOR AON USE ONLY

Person's Name _____	Date of Birth _____	Relationship _____
Person's Name _____	Date of Birth _____	Relationship _____

*Your spouse is the person to whom you are married at the end of the year. Your dependent is your child, stepchild, parent, other close relative, or a person who lives in your home, if you provide over half of his/her support.

Amounts

\$ _____

\$ _____

\$ _____

\$ _____

Approved By _____

Date _____

C. DEPENDENT CARE PROVIDER INFORMATION (Required unless provider is non-profit organization)

Name _____	Taxpayer ID or Social Security No. _____
------------	--

D. SIGNATURE

I certify that the expenses listed above qualify for reimbursement and have been incurred and paid by me or by eligible members of my family. In claiming reimbursement for health care expenses, I certify that these expenses have not been reimbursed by my health care plan or any other health care plan, such as my spouse's. Bills, statements, or other evidence of these expenses are attached. In claiming reimbursement for dependent care expenses, I certify that my spouse and I will not receive reimbursements in excess of \$5,000 from all employer-sponsored dependent care spending account plans.

Signature _____ Date _____

(SEE REVERSE SIDE FOR INSTRUCTIONS)

FORM COMPLETION INSTRUCTIONS:

1. **Section A.** Complete name and address. Reimbursement checks are sent to your home.
2. **Section B.** Complete the necessary information and attach the written documentation including either the provider bill(s) or a copy of the insurance company's Explanation of Benefits that shows the amounts that went towards the deductible or coinsurance. A canceled check is not sufficient based on the IRS regulations.
3. **Section C.** If the claim is for a dependent spouse or child, complete the name, date, and relationship (i.e., husband, wife, son, or daughter).
4. **Section D.** Read, sign, and date.

HOW TO READ YOUR EXPLANATION OF BENEFITS

When your claim is processed, an Explanation of Benefits (EOBs) are sent to your home. A sample EOB follows this page. The information contained on the EOB includes:

1. The date of service of the claim being reimbursed. The service date must occur during the plan year.
2. The claim amount submitted for reimbursement.
3. The claim amount paid less any ineligible expenses.
4. Describes the services provided that are being reimbursed.
5. & 6. Provides the plan year-to-date summary of claim activity for either your health care or dependent care spending account.

SAMPLE EXPLANATION OF BENEFITS

Aon Consulting
Virginia United Methodist Conference
7325 Beaufont Springs Drive, Suite 300
Richmond, VA 23225

Joan M. Jones
123 Anywhere Street
Anytown, VA 25621

①	②	③	④
Claim Date	Claim Amount	Paid Amount	Description
9/25/07	25.00	25.00	Medical Expenses

⑤
Health Care

Account Balance: \$125.00
Available Funds: \$250.00
Annual Election: \$600.00

⑥
Day Care

Account Balance: \$ N/A
Available Funds: \$ N/A
Pended Claims: \$ N/A

If you have any questions regarding this claim or your account, please call Aon Consulting.

FLEXIBLE SPENDING ACCOUNTS

HOW TO READ YOUR PARTICIPANT STATEMENT

You will periodically receive a statement that summarizes your flexible spending account activity on a year-to-date basis. A sample Participant Statement follows. An explanation of the information contained in this statement is outlined below:

1. **Date of the Statement**

This date indicates the end date of the period of time summarized in the statement. For example, a statement with the date in October reflects the activity in your account from the beginning of the plan year through September.

2. **Employee Name and Address**

This is your name and current mailing address.

3. **Dependent Care**

This column summarizes the activity in your Dependent Care Spending Account from the beginning of the plan year through the date of this statement.

- **Annual Benefit Contributions.** This represents the total amount you enrolled to contribute to your Dependent Care Spending Account for the current plan year.
- **Total Employee Contributions.** This represents the total year to date amount that has been withheld as of the date of the statement.
- **Total Claims Submitted.** These are the total dollars that have been submitted by you for reimbursement.
- **Total Claims Paid.** These are the total dollars that have been paid to you from your Dependent Care Spending Account for eligible claims submitted during the period shown.
- **Current Account Balance.** The Current Account Balance in your Dependent Care Spending Account is calculated by subtracting claims paid from contributions. Eligible claims submitted for reimbursement will be paid up to your contributions at the time the expense is incurred.

4. **Medical Expense Reimbursement**

This column summarizes the activity in your Health Care Spending Account from the beginning of the plan year through the date of this statement.

- **Annual Benefit Contributions.** This represents the total amount you enrolled to contribute to your Health Care Spending Account for the current plan year.

- **Total Employee Contributions.** This represents the total year to date amount that has been withheld as of the date of the statement.
 - **Total Claims Submitted.** These are the total dollars that have been submitted by you for reimbursement.
 - **Total Claims Paid.** These are the total dollars that have been paid to you from your Health Care Spending Account for eligible claims submitted during the period shown.
 - **Current Account Balance.** The Current Account Balance in your Health Care Spending Account is calculated by subtracting claims paid from contributions. Eligible claims submitted for reimbursement will be paid up to your Annual Election at the time the expense is incurred. Once this maximum has been paid, no further reimbursements will be made. This means that your current account balance may be negative until your contributions catch up with or exceed your payments.
5. **Grace Period Notification.** You have until March 31 of the following year to file claims for the current year.
 6. **Questions.** If you have any questions regarding this statement, call the number listed on the statement.

SAMPLE PARTICIPANT STATEMENT

10/01/2007

Joan M. Jones
123 Anywhere Street
Anytown, GA 25621

The following report is a statement of your account(s) in the Virginia United Methodist Conference Flexible Spending Account plan year ending 12/31/2007.

	<u>Dependent Care</u>	<u>Medical Expense Reimbursement</u>
Annual Benefit Contributions	750.00	1250.00
Total Employee Contributions	500.00	1041.70
Total Claims Submitted	600.00	250.00
Total Claims Paid	500.00	250.00
Current Account Balance	.00	791.70

For the Medical Care Reimbursement portion of the Flexible Benefit Plan, you need to request the balance within 90 days of 12/31/2007.

For the Dependent Child Care portion of the Flexible Benefit Plan, you need to request the balance within 90 days of 12/31/2007.

If you have any questions concerning your account(s), please contact Aon Consulting at 1-800-481-5224.