I am new to Flexible Spending Accounts and Health Reimbursement Accounts. How do these plans work?
When you enroll in a Flexible Spending Account (FSA), you will determine the total amount you want to set aside in a pre-tax account to pay for your eligible out-of-pocket healthcare and dependent care expenses. This amount will be deducted from your paycheck throughout the year on a pre-tax basis. In the case of a Healthcare FSA, the full amount you've elected for the plan year is available to you as of your effective date. As you incur expenses, you can request reimbursement at any time throughout the plan year by submitting a claim to Burnham & Flower Insurance Group on an FSA Reimbursement Claim Form with itemized supporting documentation. Upon approval of that request, we will disburse funds from your FSA directly to you.

What is eligible for reimbursement under my Flexible Spending Account?
A Flexible Spending Account (FSA) is designed to reimburse you for out-of-pocket medical expenses and dependent care expenses incurred within your plan year by you, your spouse and tax dependents. An eligible expense list is attached. Some expenses may not be listed but are still covered and may be limited to physician approval or medical necessity.

How do I complete the Reimbursement Claim Form?
Please include your full name and last four digits of your social security number to ensure proper identification. Enter the appropriate services you are requesting reimbursement for. Similar products and services may be combined on the same line of the Reimbursement Request Form. Enter a service start date and if the service provided spans more than one day, also enter the service end date. These dates are the date(s) which you actually received the service, not when the charge was billed or paid. For instance, a reimbursement request for dependent care expenses should include the first date and last date the dependent care services were received to account for the total amount requested.

For many medical expenses, the patient is charged after the reimbursement request has been processed by insurance however, the date(s) that the actual service took place is what should be listed on the form. It is the service dates that determine eligibility, not billing or payment dates. If the request cannot be validated by itemized, third-party documentation, a service provider may sign his/her name in the appropriate field on the form (credentials must be included for all healthcare services) along with the provider’s Tax ID Number.

Under the “Amount” column, please enter only the amount you wish to be reimbursed. If your insurance coverage will be responsible for a portion of the total charges, you would only include the portion of that charge that is your responsibility to pay. The participant (not a spouse or dependent) must sign at the bottom of the form.

What does my documentation need to have to be considered “itemized?”
IRS guidelines regarding these types of benefits plans require the following information for any reimbursement request:

- The Service Provider’s Name - This could be the name of the doctor, dentist, clinic, retailer etc.
- The Date of Service - This refers to the date on which the charge was incurred/received (except in the instance of on-going services), not a billing or payment date.
- Detailed Description of Service – This should be the specific name of an eligible medical procedure or product. You may use Physician Procedure (CPT) Codes if you have them. Over-the-Counter products must be listed clearly on the register receipt. In the case of an abbreviated description, a representative of the retail provider may indicate the full product name, and print and sign his or her name on the receipt.
• Dollar Amount – This means the amount charged for each specific product or service. Some providers may offer ineligible products or services that they combine with charges for eligible services on an invoice. Without being able to separate the charges for each individual product or service, Burnham & Flower Insurance Group will be unable to reimburse the entire amount.

• Patient Name – required on all copay and deductible reimbursements.

In lieu of itemized documentation, service providers may indicate the date, detailed description and charge amount for any medical or dependent care service and put their signatures (credentials included – M.D., D.D.S., etc.), contact information and Tax ID Numbers in the indicated spaces on the Reimbursement Request Forms.

Prescriptions and Over-the-Counter products require third-party documentation – a provider’s signature will not suffice for these types of reimbursement requests.

**What do I do if I lost or threw away a prescription receipt? Can I send you the empty prescription bottle?**
No, but your pharmacy should be able to provide you with a detailed print out of all prescriptions filled within a requested time period. A prescription bottle does not include the necessary information needed to process the claim. You will not be able to request reimbursement with just a copy of your cash register receipt. A cash register receipt does not give the name of the patient, the quantity filled, or other necessary information.

**What are the hours during which I can fax my reimbursement request?**
You may send your fax at any time as our fax line can accept faxes 24 hours a day. Please use the Burnham & Flower Insurance Group Reimbursement Request Form as the cover page for your fax to ensure proper and timely processing. If you are resubmitting a previously denied request, please use the Denial Letter as your fax cover page.

All claims will be processed same-day as long as they are received by 3:00 pm. Any claims received after that time will be processed on the next business day.

**What will be processed sooner, faxing or mailing my reimbursement request form?**
Sending a request by fax will arrive in our offices sooner than by mail. Once received, however, no special priority is given to requests based on the mode they were sent. All reimbursement requests are processed within 24-hours of receipt (excluding weekends and Burnham & Flower Insurance Group scheduled holidays). If you have signed up for e-mail notification you should receive the notification within that same 24-hour period.

**May I e-mail my reimbursement request form in?**
Yes, if you wish to e-mail your reimbursement request, you may send it to TPASupport@bfgroup.com.

**When will I receive payment?**
Burnham & Flower Insurance Group will process your reimbursement request within 24 hours of receipt of the request (excluding weekends and Burnham & Flower Insurance Group scheduled holidays). We advise our clients to allow for 2-3 business days for electronic payments to post to their accounts and 5-10 business days for check mailing.

**Why is my request not showing up online?**
It may take up to 24-hours from the time we receive your reimbursement request before you can view it online. Burnham & Flower Insurance Group prides itself on quick turnaround on processing requests. To ensure that your reimbursement is likely to appear online without any delays, please make sure you are using the most current Reimbursement Request Form by downloading it from our website each time you submit a new request. Fill out the form clearly and completely and make sure to attach all necessary substantiation when submitting your claim.
I highlighted all the pertinent information on all the receipts that I faxed along with the Reimbursement Request Form. Why was Burnham & Flower Insurance Group unable to fulfill my request?

Your claim may have been denied due to an ineligible expense or lack of documentation. You will be notified by email or mail of any denied claims. You will have the opportunity to resubmit this claim. If you choose to do so, please provide us with the necessary substantiation.

May I send Explanations of Benefits to substantiate reimbursement requests?

You may submit an Explanation of Benefits (EOB) from your insurance company as your itemized documentation. You may request reimbursement for any amount that your insurance company has applied to your deductible or copayments as long as it is an eligible reimbursable expense.

Does Burnham & Flower Insurance Group receive information from my healthcare provider or my insurance company?

No, we do not receive any information from your healthcare provider or your medical plan carrier directly. You will be required to submit the proper documentation as your medical information is protected by HIPPA regulations and secure information.

How long do I have to submit a reimbursement request after the end of the year?

The amount of time that you have to submit your reimbursement requests after your loss of coverage for that plan year will vary by plan. If you have a balance in your account you will receive a letter in the fourth quarter of the plan year notifying you of your remaining balance and the deadline for reimbursement request submission. You may contact Burnham & Flower Insurance Group if you have any questions on this.

How do I appeal a request that Burnham & Flower Insurance Group was not able to reimburse?

You will receive notification of any expense for which Burnham & Flower Insurance Group has determined is ineligible or for expenses which may require additional documentation in order to process. The notice will also provide you with details regarding your rights to appeal the denied expense. You have 180-days from the date printed at the top of that letter to supply us with that required information. To guarantee that the request is re-processed correctly, please always include a copy of that notice with any re-submission.

What is a Letter of Medical Necessity? Why do I need one?

A Letter of Medical Necessity (LMN) is required for any item or service that is not typically eligible for reimbursement. The LMN must be provided by a medical practitioner who is qualified to diagnose and treat the stated medical condition, and it must state that the treatment and/or item in question is not merely beneficial for general health, but is primarily for treatment of that specific medical condition. Examples of procedures/items that would require a LMN are: massage therapy, breast pumps, dietary supplements, herbs and/or vitamins, orthotics or shoe inserts, weight loss programs, sperm and/or embryo storage, etc.

As of January 1, 2011, many over-the-counter medications will now require a LMN or prescription to be reimbursed under a participant’s FSA account. A list is attached for your records.

What information does Burnham & Flower Insurance Group require in a Letter of Medical Necessity?

To reimburse an expense that is usually considered ineligible under IRS guidelines, we must be notified of the following:

- The specific medical condition being treated – the physician writing the Medical Necessity Letter may also include Diagnosis
- (ICD-9) codes
- The specific product or treatment prescribed for this medical condition
- The proposed start and end date of treatment (most letters will require an annual update)
- The signature and legible, printed name of the physician, including credentials

Any Medical Necessity Letter should be written by a physician qualified to diagnose and treat the listed condition.
What information do I need for a dependent care reimbursement?
The form must be completed in its entirety (See How Do I complete the Reimbursement Request Form?)
In lieu of an itemized statement from your dependent care provider, he/she (or a representative of the
daycare center) may indicate the service dates and charge amount in the appropriate fields on the
Reimbursement Request Form, and provide a signature and Tax ID number on the line below.

Note: The reimbursement request should not be submitted until the service has been provided.

I submitted a dependent care reimbursement request and I received reimbursement for a lesser amount. Why did I not receive the full amount I requested?
For your dependent care account, the money must be deducted from your paycheck and reported by your employer to Burnham & Flower Insurance Group before it is available for reimbursement to you. If you have requested an amount greater than the balance of your account, the remainder of the requested amount will be suspended until additional contributions (payroll deductions) have been applied to your account. Once the funds appear in your account, reimbursement will occur according to your employer’s reimbursement schedule.

What is Burnham & Flower Insurance Group’s policy regarding reimbursement for Orthodontia (braces) expenses?
This type of expense is usually reimbursed monthly based upon a provider-contract or payment plan. The regulations allow for ongoing reimbursement throughout the term of the treatment. To calculate your monthly reimbursement amount, and how much should be allocated for each plan year, the following information is needed:

- Treatment start and end date (or the start date and length of treatment in months)
- Total treatment cost
- Down payment required by provider
- Amount covered by Insurance and/or provider discount, if applicable
- Monthly payment amount

If the provider offers a discount for full payment up front, you may choose that option, but be aware that reimbursement must still occur on a monthly basis according to a payment plan. To ensure that we have all the information needed to process and approve orthodontia reimbursement, please have the provider complete and sign the Burnham & Flower Insurance Group Orthodontic Service Form. Once this form is received completed by our office, you will be set-up on monthly automatic reimbursements until your balance has been used. Please contact Burnham & Flower Insurance Group for additional information regarding submitting Orthodontia claims.

Due to delays in processing my health insurance claim, I received the bill after the final deadline for reimbursement requests had expired. Can I submit the expense for reimbursement in the current plan year?
No, you cannot submit an expense incurred in the prior plan year for reimbursement of the current plan year’s funds unless your plan allows for a grace period. To be eligible for reimbursement, a service must be incurred during the Plan year and submitted by the final reimbursement deadline. If a claim is submitted by a participant after the deadline, the Employer will be notified and it will be their decision on how to processed.

I have left or will be leaving the company through which I have my FSA reimbursement account. How long may I continue to incur and submit expenses for reimbursement?
The amount of time you have to incur expenses and submit them for reimbursement after your employment has ended will vary according to your plan specifications as determined by your Employer.

This has been provided to you by:

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