

GRACE PERIOD allows you to submit claims for services received between January 1 and March 15, of the new plan year and request reimbursement from any account balance remaining in your medical spending and/or dependent care account from the previous plan year under the following conditions:

- Coverage under the FlexComp Plan must be in effect on the last day of the plan year on December 31.
- You must indicate on the FlexComp Reimbursement Voucher SFN 16868 if you want expenses received during the “grace period” reimbursed from any balance remaining in your account(s) from the previous plan year. If you select this option, expenses incurred during the “grace period” and approved for payment will be reimbursed first from any amount available in the prior plan year. If the expenses exceed the account balance, you will then be reimbursed from your current plan year account(s) if applicable.
- If you do not indicate on the form that you want expenses received during the “grace period” reimbursed from any account balance remaining from the previous plan year, your claim will be processed in the plan year for which expenses have been incurred. No adjustment will be made to your account(s) to reprocess the claim.
- Grace period effect on dependent care expense accounts: There may be taxable income to an individual if reimbursements from a dependent care account exceed IRS permitted amounts in a calendar year. We suggest you consult your accountant or tax advisor with regard to your individual situation.

USE-OR-LOSE deadline to file medical and dependent care claims is four (4) months after the plan year ends on December 31 or April 30. Any unused amounts in a medical spending account cannot be used for dependent care expenses or vice versa. As a reminder, any amounts remaining in these accounts after April 30 are forfeited.

DEPENDENT ELIGIBILITY RULES for employees participating in a medical spending account have been extended to allow you to cover your adult children that no longer meet the requirements of dependent. The extension of coverage applies to your son, daughter, stepson, stepdaughter, legally adopted and eligible foster children. It is not necessary that you child be a student, be financially supported by you, or that he or she reside with you. Both married and unmarried children can now qualify as a dependent, but coverage does not extend to any spouse of your child or to grandchildren. You may now be reimbursed for qualified health care expenses for these individuals through age 26. Eligibility ceases January 1<sup>st</sup> of the calendar year in which the family member will turn age 27.

ACCEPTABLE FORMS OF DOCUMENTATION to submit with your claim to ensure that your health related or day care expenses meet IRS and NDPERS claims processing guidelines:

A copy of the page of the Explanation of Benefits (EOB) that lists the breakdown of charges and benefits indicating the deductible, co-insurance, co-payment, etc. from your health, dental, or vision insurance carrier.

If you do not have insurance coverage, an itemized statement from the provider is required. The itemized statement must include the provider's name, patient name, date, and list services received. Statements with only a balance forward or balance due cannot be accepted.

Orthodontic expenses may be reimbursed as payment is required and paid during the plan year. To be reimbursed for orthodontic expenses paid during the plan year; you must submit a receipt from your orthodontist identifying the payment is for orthodontic services and showing the patient name, date and amount of payment.

For prescription drugs, the documentation (prescription receipt, provider statement, or insurance explanation of benefits) must show the patient name, date, and Rx number or the name of the drug being dispensed.

Drugs & medicines purchased Over-The-Counter (OTC) Effective January 1, 2011, OTC drugs and medicines will be considered ineligible unless you obtain a prescription from your physician. A "prescription" means a written or electronic order for the medicine or drug issued by a licensed health care practitioner. The prescription must be submitted with your first claim. Thereafter, you can include a notation on your claim form that there is a prescription on file. The prescription must be renewed each plan year. In addition to your prescription, you will need to provide a detailed customer receipt showing the item name, date, and amount of purchase. If your receipt does not show the item name, you must also include a copy of the product label or container cover.

Massage therapy, weight loss programs, health club dues will require a letter of medical necessity from your physician. Please review the following guidelines when submitting a [Letter of Medical Necessity](#):

- The patient name must be provided.
- The patient diagnosis must be specific.
- The recommended treatment must be named and described in detail by your physician.
- Your physician must state the specific length of treatment, not to exceed the current plan year.
- Your physician must complete, sign and date the form.

You cannot be reimbursed for costs incurred before coverage is effective or after coverage ends. Provider discounts or pre-payment discounts must be subtracted from the cost of services. Contact lens insurance and maintenance agreements, an eyeglass warranty or clip on sunglasses are not eligible expenses. Services that require pre-payment cannot be reimbursed until after the services have been received. Insurance premiums cannot be reimbursed from a medical spending account.

For Dependent Care claims your provider must complete Part D of the form or provide a receipt with the following information:

- Name of Provider (If provider is a relative, list relationship)
- Tax Identification Number or Social Security Number
- Actual dates on which care was provided (not billing payment date)
- Amount of dependent care expense

**Day care expenses must:**

- Be for the purpose of enabling you or you and your spouse to be employed.
- Be for a child under 13 years of age who is your dependent under Federal tax rules. The child must reside with the employee at least one-half of the taxable year.
- The dependent care account can also be used for the care of a spouse or a dependent over the age of 13 who is incapable of self-care. The adult dependent who is incapable of self care must live with the employee for more than one-half the taxable year and not have more than \$3,200 per year in gross income.
- Be provided by someone other than your spouse or another dependent child. If your day care provider is a relative, list relationship.

**Eligible Expenses may also include:**

- Before or after school care.
- Registration or application fees, if fee must be paid in order to obtain care.
- Day Camp
- Preschool/nursery school
- Transportation expenses, if expenses are for transporting a child to or from place where care is provided and transportation is furnished by day care provider.
- Late “pick-up” fee

You cannot obtain reimbursement for costs incurred before coverage is effective. Services that require pre-payment cannot be reimbursed until after the services have been rendered. Food if billed separately from the dependent care expenses or late payment fees cannot be reimbursed. Kindergarten expenses that are primarily educational in nature are not eligible. However, if your day care provides kindergarten that is run on the order of a nursery school, with the child’s education merely incidental to the care provided and the cost cannot be

separated from the cost of the child care, the entire amount can be considered an eligible expense.

Claims processing guidelines: Every effort is made to process your claim in a timely manner. Claims will be processed within 4-7 business days from January through April. Thereafter, claims are normally processed within 1-3 business days of receipt of your claim.

All supporting documentation sent with your claim form should be copied on 8 ½ by 11 single sided paper and must be legible. Do not use staples, tape or highlighter on your form or receipts. Please do not mail the same form that you have faxed. Be sure your PeopleSoft employee id is correct and your signature on the claim form is legible. Claims received with incomplete or incorrect employee id numbers will be delayed and claims that are not signed cannot be processed and will be returned.