

Participant Claim Documentation Requirements

Introduction

IRS rules require as a third party administrator of a health reimbursement plan, we obtain proper documentation prior to paying reimbursements for participant claims. These documentation requirements are established by the Internal Revenue Service and it is important that our plan is compliant with such rules so that the tax-free status of the program is maintained.

The following is a list of our basic claim documentation requirements (we will accept copies, original receipts are not required):

Office Visit Co-pays

A receipt from the doctor's office is acceptable as long as it identifies the patient, provider, date of service, procedure, and amount of co-pay.

Prescription Drug Co-pays

A receipt from the pharmacy is acceptable as long as it identifies the patient, the drug and amount of co-pay.

Over-the-Counter (OTC) Drugs and Medications

A receipt listing the medication and its corresponding cost is required. If your receipt is from a cash register, it is acceptable as long as the item and its corresponding cost are clearly identified.

Covered items are those OTC drugs, medications and treatments that are intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease or injury. Some items may have a dual purpose; a medical purpose and a personal/cosmetic or general health purpose. In this case, attach a note to your Claim Form from a licensed medical provider stating the person has a specific medical condition for which the item is purchased. Excluded items are those that are used primarily for general health and well being. The amount of the purchased OTC item to be reimbursed should be limited to a reasonable quantity expected to be consumed in a reasonable amount of time. Two bottles of an item in any one reimbursement is the limit. Sales taxes on the OTC item purchases can be included in the reimbursement.

Non-covered Medical, Dental, and Vision Claims (not fully covered by insurance)

For claims partially covered by insurance, the participant should provide a copy of the Explanation of Benefits Form (EOB) provided by the insurance company. The EOB shows the remaining balance of the claim after the insurance has paid its share.

If an EOB is not available, please provide a statement from the provider that identifies the patient, provider, services provided, dates of those services and cost after insurance payments. Please note that balance forward billing statements are not acceptable.

Medical, Dental, Vision or Medicare Part B Insurance Premiums

A billing statement from the insurance company or Medicare identifying the covered individual, the amount of the premium, and the coverage period is acceptable. Premiums paid by an employer or through a pre-tax Section 125 Cafeteria Plan are not eligible for reimbursement.

Tax-Qualified Long-Term Care Insurance Premiums

A copy of the billing statement from the insurance company identifying the covered individual, the amount of the premium, and the coverage period is acceptable.

In addition, documentation that the policy is “tax qualified” is required. Generally, this can be found in the policy’s Declaration’s page.

Tax qualified long-term care premium reimbursements are limited to a guideline amount established in IRS rules and is indexed to inflation. Here are the current limits:

Age 40 or under	\$ 260
Age 41 to 50	\$ 490
Age 51 to 60	\$ 980
Age 61 to 70	\$2,600
Age 71 or over	\$3,250