VitaFlex
Excellence in Pre-Tax Benefits

Health Flexible Spending Account (FSA)
Common Documentation Errors

What happens with a Claim?

Claims are processed in 1–2 business days. A claim could be submitted automatically by using your debit card or manually through one of our many communication methods.

- If your claim is submitted by a debit card, we may ask for additional documentation. Using a debit card does not waive the need for documentation. If documentation is requested, you will have 90 days from the date of the transaction to send us sufficient documentation. If sufficient documentation is not provided by this time, the claim may be denied.
- If you are submitting a claim on the website or the VitaFlex Mobile App, you do not need to submit a claim form. Simply upload your supporting documentation with the claim submission. If additional documentation is needed, you will be notified by email.
- If you are submitting a claim by email, fax, or mail, a claim form is required. You may locate the claim form under the tools and support tab of the portal or on our pre-tax resource page in the document library.

Only certain health claims are eligible for reimbursement. If you are considering a particular cost, you may use our Eligible Claims Guide to verify eligibility. If it is not located in the claims guide, please email Vita Concierge with the product(s) or service(s), and we will look into your request.

The eligible expense(s) must be incurred during the Plan Year and after your participation effective date. Health expenses must be incurred no later than your final date of employment. A health-related expense is "incurred" on the date the participant is provided the health care that gives rise to the expense, not when the participant is formally billed/charged for or actually pays for the health care. All claims must be submitted by the specified claims submission deadline. Please refer to your Summary Plan Description located on your online portal for the claims submission deadline. Expenses must be eligible and must not have been reimbursed by any other source, such as your spouse's insurance plan.

Federal tax law requires that the salary deferrals under your Health FSA plan be a "use it or lose it" arrangement. If claims with complete documentation are not submitted in a timely manner, the balance of your salary deferrals will be forfeited to your employer.

Where to File a Claim?

Claims may be submitted as expenses are incurred, or they may be bundled and filed on a periodic basis. All claims for the current Plan Year must be received by the claims submission deadline. Claims may be submitted using any of the following methods:

Online: www.vitaflex.net
Email: claims@vitamail.com
Fax: (866) 964-3539 (650) 964-3539
US Mail: 900 N. Shoreline Blvd., Mountain View, CA 94043
VitaFlex Mobile App: Log in with same password as VitaFlex Consumer portal

Documentation Requirements

There are six items that are looked for in every claim. Please ensure the documentation submitted contains all six pieces of information.

- Provider Name
- Patient Name
- Insurance Payment (If any)
- Date of Service
- Description of Service
- Amount Charged

There are various types of documents that could be submitted. Some of the most common documents are: Explanations of Benefits (EOBs), medical supply bills, copayment receipts, provider billing statements (must include participant name, date(s) of service, type of service, and, in certain circumstances, a diagnosis code), or other third-party documentation confirming the above required information.

Make sure to keep a copy of your documentation for your personal records. In the event that the IRS would like to request documentation from you, you are responsible for furnishing the documentation.

Changes in Plan Participation

You may only change or terminate salary reductions and plan participation if you have a qualified change in status or experience one of the other exceptions to irrevocability outlined in your Summary Plan Description. Changes in family status include: birth, death, marriage, divorce, change in employment of a spouse, and certain other situations as identified in your Summary Plan Description. If a change in status occurs, a request for a corresponding change in Plan election must occur within 30 days of the date of status change.

Questions

Questions regarding your account may be directed to help@vitamail.com or (650) 966-1492 (toll-free at (800) 424-3052).

This brief summary is provided for your convenience. Please refer to your Summary Plan Description or Plan Detail Document for full Plan details.

Claim Documentation Recommendations and Notes

Dental Claims

Most often a dental office will charge an estimated patient responsibility. The initial receipt will indicate that there is an estimated insurance contribution. We are not able to accept documents with an estimated contribution. The eligible expense amount is the amount you are responsible to pay after any insurance payments. Due to contracted rates and various insurance plans, the amount estimated by the dental office may not be correct. It is suggested that you submit an **Explanation of Benefits** (EOB) after your insurance carrier has processed the expense. This document most often has the necessary information to approve a dental claim.

If there is a discrepancy between the amount charged and the amount determined as "patient responsibility" by the insurance carrier, the dental office may owe a refund. If you used your debit card to pay for the service and there is a partial amount denied, the card will be placed in a suspended status until the repayment is settled.

Examples:
Approved Documentation
Denied Documentation

Vision Claims

There are some items that are not eligible under the FSA guidelines sold at most eye wear shops. We are looking for an **itemized receipt** showing that the items purchased are eligible.

Examples:
Approved Documentation
Denied Documentation

Prescription Claims

Not all medication is eligible under the FSA guidelines, because of this, we require verification of the medication that was purchased. This can be accomplished by submitting a **detailed summary from the pharmacy**. We would also accept a purchase receipt in conjunction with the medication label or description sheet tying the RX code on the purchase receipt to the medication name.

Over the Counter Medication (OTC) Claims

Over the counter medication can only be approved with a prescription or a statement of medical necessity. This generally pertains to an OTC item that has an active ingredient. In this situation a debit card would not work and you would need to file a claim for reimbursement. Prescriptions are kept on file to substantiate claims for a period of one year. There is an OTC form for your physician to sign if you would like to list out commonly purchased medications, such as cough syrup, aspirin, Tylenol, etc. This form can be located under the tools and support tab of the portal or on our pre-tax resource page in the document library.