Substantiation for Healthcare FSAs

University Systems of Georgia

hsabank®

What is substantiation and why is it required?

The IRS requires that reimbursements from the FSA are substantiated or proof that the expense reimbursed or paid from the FSA are eligible.

On slide 6 we will review the items verified when substantiating a reimbursement.

HSA Bank has several methods in place that we use to assist with substantiating FSA reimbursements. These are referred to as auto-substantiation.

When our attempts to auto-substantiate a reimbursement are not successful, you will be requested to submit the documentation.

Auto-substantiation methods

Pharmacies with Inventory Information Approval System (IIAS)
Real time substantiation as 95%+ of pharmacies use IIAS, including all major drug store chains

Copay Matching
More copays captured in the system results in less substantiation required by employees

Recurring Expenses
First Substantiated expense took place within 72 months of recurring expense
Same provider, same amount, same patient

Claims Exchange – NEW as of August 1, 2022
Explained on next page

Claims Exchange between Anthem and HSA Bank began August 8, 2022

What is Claims Exchange?

Claim data (limited to the financial data only) is received daily by HSA Bank from Anthem via file, this allows for virtual EOBs to load to your account as soon as they are processed and matched to substantiate debit card transactions for FSA accountholders for ease in submitting manual claims in lieu of the member submitting a receipt.

You will receive an email notification when a claim from Anthem has been received by HSA Bank.

Why is Integrated Claims File important?

Receiving claims from Anthem can help to auto-substantiate the remaining 23% of FSA transactions not covered by IIAS or other methods.

Why did I receive multiple emails at one time?

If you received multiple emails on or around August 8, 2022 that is the first date we received a Claims Exchange file from Anthem. Going forward the claims will be received as processed by Anthem.

Claims Exchange, continued

Do I need to opt-in?

No, USG employees are automatically opted in at the time of enrollment. If you have an email address on file, you will automatically receive an email each time a claim is received and loaded to the website.

Can I opt-out of my claims information being sent from Anthem to HSA Bank?

Yes, to opt-out you may call the USG dedicated Client Assistance Center at 833-228-9352.

What is required for documentation? FSA reimbursement

Substantiation must include the below items either via itemized receipt or Explanation of Benefits (EOB). Documentation can be submitted through the member website or the mobile app.

Recipient
Name of the person for whom the product or service was rendered

Provider
Name of the provider or merchant of the product or service rendered

Date of Service
Date on which the service was performed or the item was purchased

Type of Service
Detailed description of the service provided or the item purchased

Cost
Amount paid for a product or service and/or the portion not covered by insurance

Debit card substantiation 101

What is required for Debit Card Substantiation?

HSA Bank is focused on making this requirement as member-friendly as possible with 77% of debit card transactions being auto-substantiated through IIAS at pharmacies, copay matching and recurring reimbursement.

How long do members have to provide documentation for Debit Card substantiation?

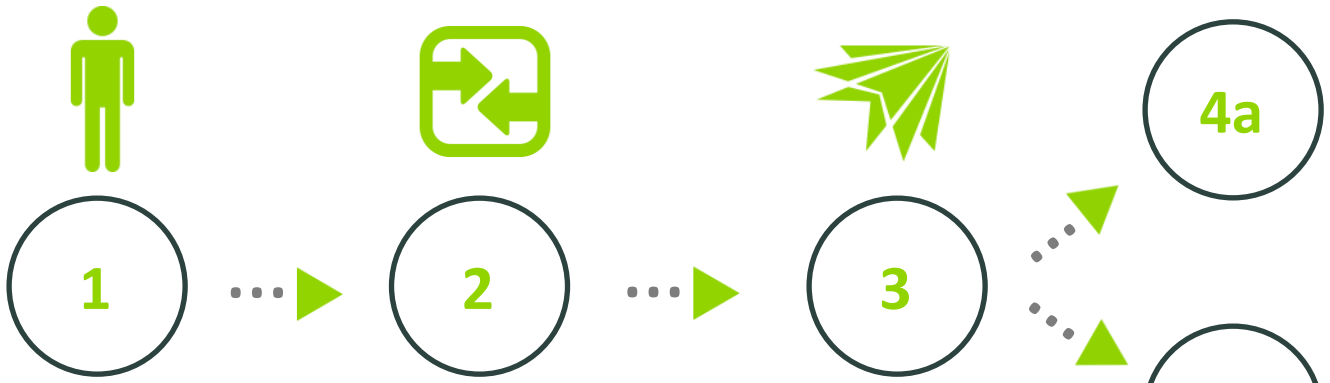
Full substantiation is required within 45 days of the transaction, otherwise the claims will be denied. HSA Bank will continue to request substantiation or repayment of the plan for the transaction amount.

What happens when a claim is denied?

When a claim is denied, it is HSA Bank policy to mail or email a claim denial letter, depending on your communication preference. In either case, the claim denial letter will explain the reason why your claim was denied and provide next steps.

The claims exchange process

Debit card substantiation



Swipes card and merchant/ provider is paid

Auto-substantiation is attempted:

- *IIAS (Rx)*
- *Copay-matching*
- *Recurring*

If not auto-substantiated, 45 days waiting for a health plan claim to substantiate the transaction

Transaction is substantiated

*Transaction is **not** substantiated*

If transaction is not substantiated, HSA Bank asks for documentation from the member

Member provides documentation on member website, mobile app or USPS

Substantiation request timeline with claims exchange

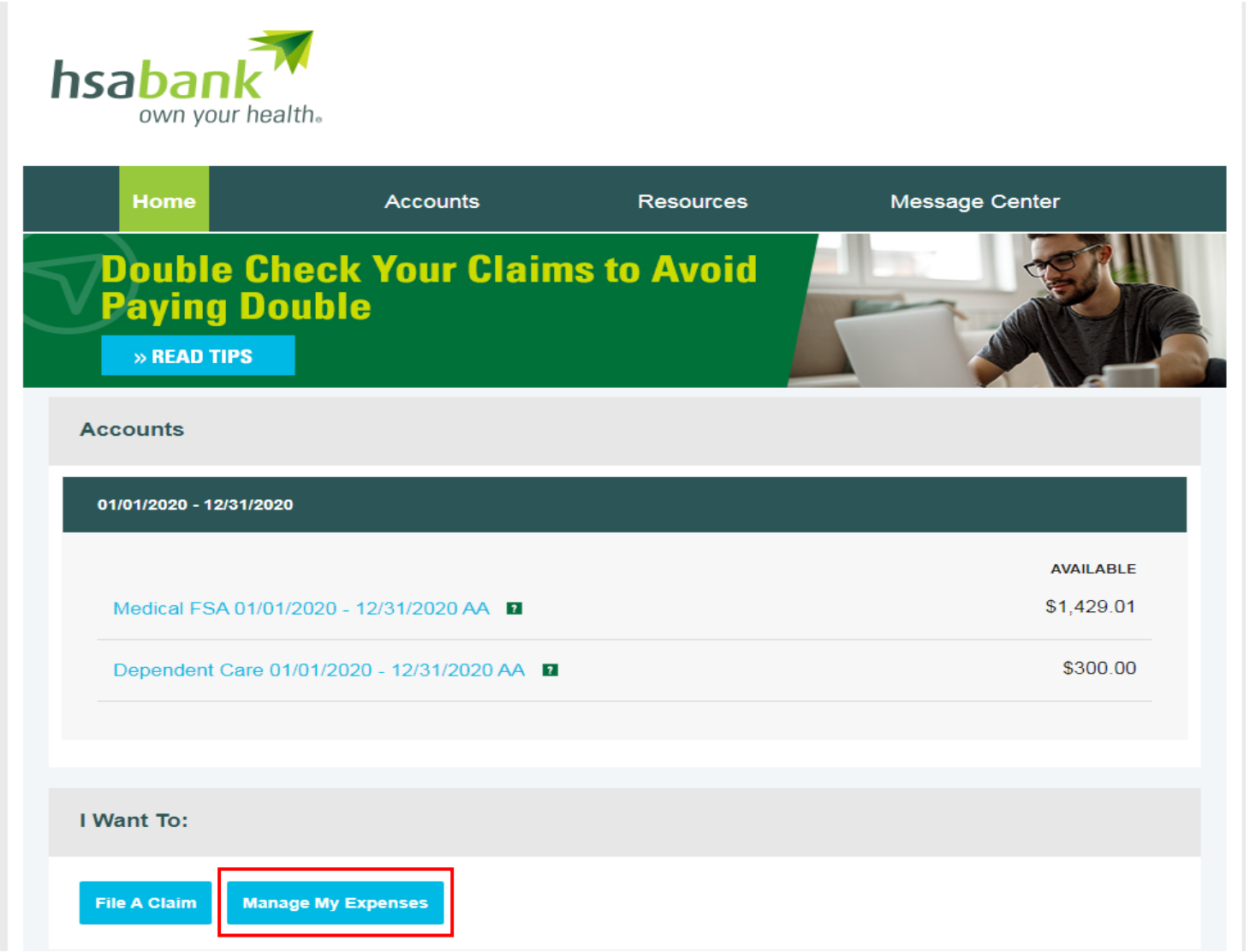
Updated Receipt Request Timeline

- HSA Bank will attempt to substantiate a debit card transaction or manual claim with data from the claims exchange file for 45 days after the transaction.
- Starting at day 46, if the transaction is not substantiated, HSA Bank will initiate a documentation request to the member.
- If not substantiated by day 53, HSA Bank will initiate a second documentation request to the member.
- If not substantiated by day 60, HSA Bank will deny the claim and request repayment.

Denied Claims

When a claim is denied, it is HSA Bank policy to mail or email a claim denial letter, depending on your communication preference. In either case, the claim denial letter will explain the reason why the claim was denied.

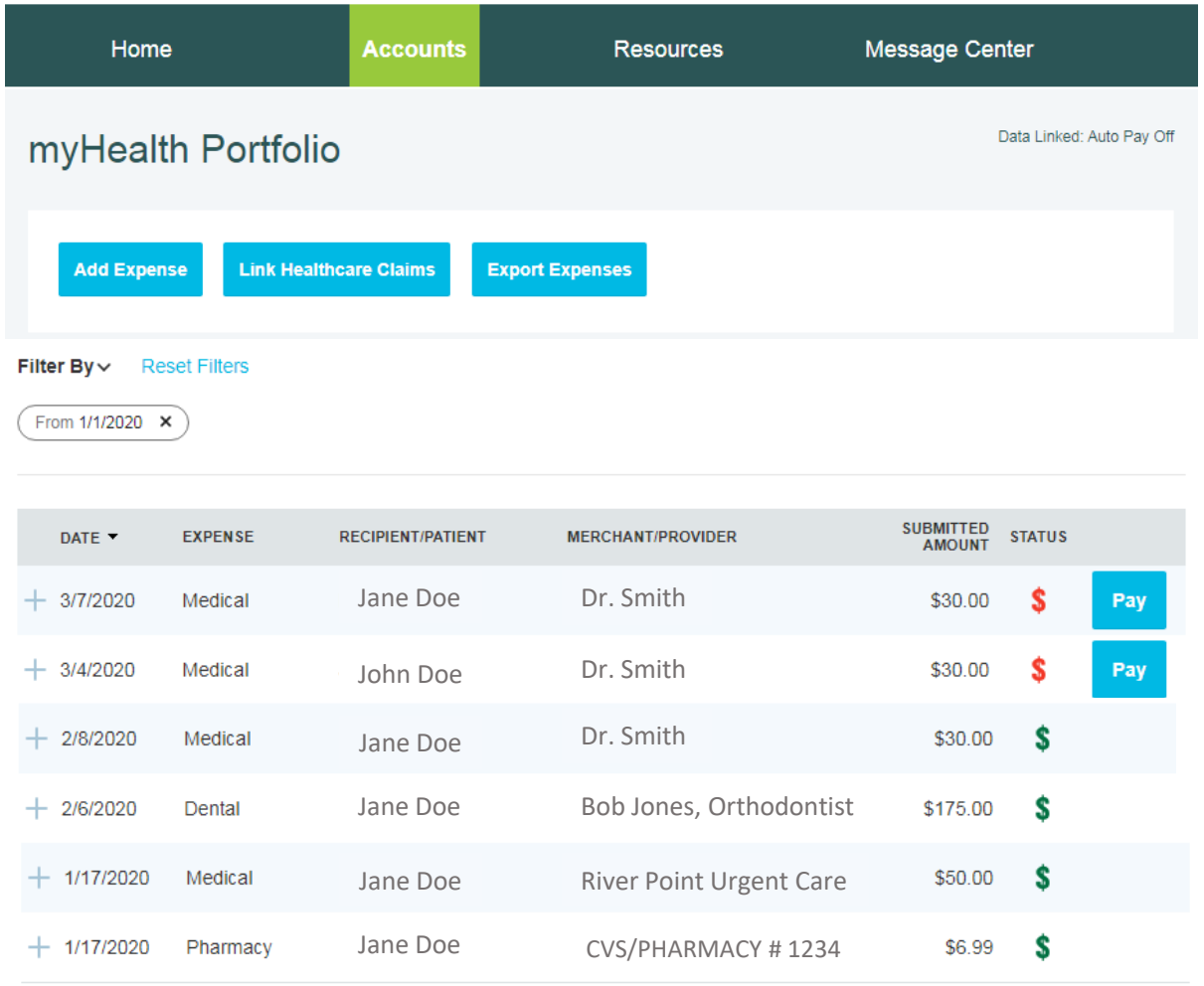
Member Experience



Claims files will load individual claims sent by Anthem to the Member's Dashboard in the member website.

From the main screen click on Manage My Expenses

Member Experience

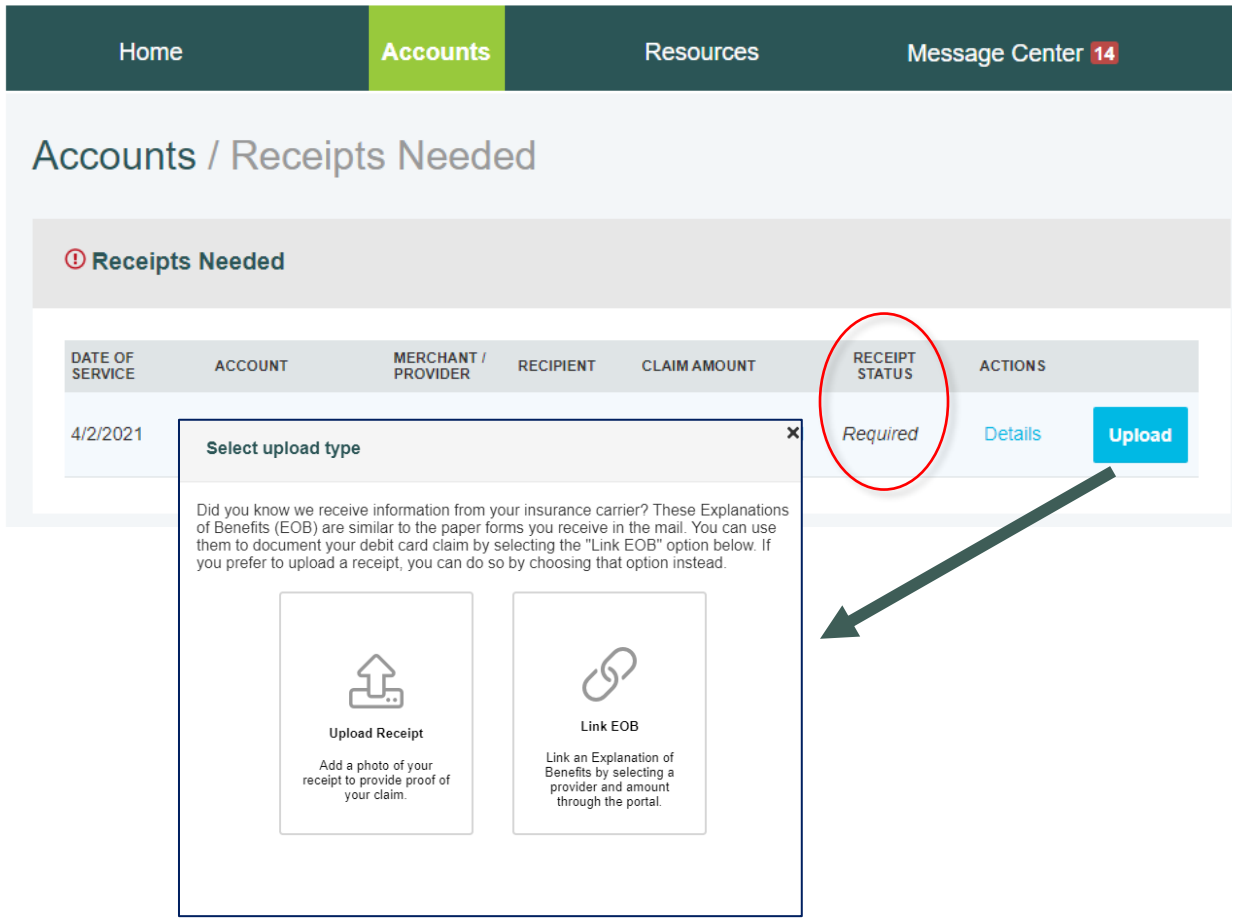


To expand a given claim to see details, click anywhere within that row.

Claims with a green $ and no Pay button are claims that are already in a paid status.

Claims with a red $ and the Pay button are those that may need action. This could be scheduling a payment or marking as paid if you paid with your debit card at the time of service or if it's determined to be a duplicate claim.

Member Experience



When a member has an unsubstantiated debit card transaction, they can match the data with the claims exchange file. On the member website, the member navigates to the "Receipts Needed" page to view their outstanding debit card transactions requiring substantiation.

The member clicks the Upload action. From the pop-up window, they select the "Link EOB" option.

How to Avoid Duplicate Payments – FSA or HSA plan

What the member will see in the portal

If a member uses their debit card, two claims will appear on their account. One will show Debit Card as the source, and the other will have Health Plan.

Two claims, same amounts

If the claims are for the same dollar amount and the member already paid that amount with their debit card, they would simply select “Mark as Paid” or “Remove Expense” for the Health Plan claim that came through automatically.

Two claims, different amounts

If the dollar amounts differ between the two claims -- for instance if the member paid only an office visit copay with their debit card at the provider – they would pay only the difference owed on the Health Plan claim and the Debit Card claim.