An expense for this service is not eligible for reimbursement. Please refer to Q-9 of Appendix I in your Summary Plan Description (SPD). Expenses must be primarily for medical care. For example, expenses that are for your general health or primarily personal or cosmetic in nature are not eligible under the plan.

Your plan indicates that you must file a request for reimbursement on the designated form. We are unable to process your Request as this item does not appear on the required, completed Request for Reimbursement form. Please fill out a Request for Reimbursement form along with any applicable substantiation documentation. See Helpful Tips #1.
This claim item was found to be eligible. However, the requested reimbursement amount has been applied to offset the overpayment you previously received.

Our records indicate you have received your maximum annual election amount for the applicable plan year. No further benefit is payable. If the annual election amount reflected on the first page of this statement is incorrect, please contact your Employer's benefit coordinator so they can update your enrollment information on file.

The receipt provided did not include one or more of the following: (a) name of service provider, (b) date of service, (c) charge amount for OTC expense item and (d) a clear description of the OTC expense item (i.e., OTC drug or product name). Note: The drug or product name must be clearly indicated on the receipt. If unclear (i.e., abbreviated), you can include a copy of the product's packaging that will tie the abbreviations used on the receipt to the actual product purchased.

Additional payment and/or treatment information is required in order to determine the eligibility of your submitted orthodontia-related expense. Your documentation needs to indicate the receipt information listed under Helpful Tips #4 with special attention to (1) date of service or evidence of ongoing orthodontic treatment and (2) proof of orthodontia expenses. Due to the ongoing nature of orthodontia and likelihood that treatment may span beyond your plan year period, the Plan can only remit reimbursement for service(s) incurred during the applicable plan year.

Ineligible expense - over the counter (OTC) medication/supply stockpiling. The quantity purchased cannot be reasonably put into use within the remainder of the applicable plan year. The Medical Care Reimbursement Plan, in accordance with current IRS Code regulations, requires that an eligible expense be incurred, not simply paid for, within the plan year. IRS officials have commented that in regards to OTC medications/supplies, stockpiling of items that cannot reasonably be put into use during the applicable plan year would not qualify as eligible expenses for medical care under IRC Section 213(d). Please refer to Q-9 of Appendix I in your Summary Plan Description (SPD).

Please refer to Helpful Tips #5 for guidance on information required.

This claim item was found to be eligible. However, the requested reimbursement amount has been applied to offset the overpayment you previously received.

The submitted expense has previously been paid or is currently being processed for payment.

Pended for research. This claim item is currently pended for research. *(Doesn't print on EOB)*

As of the statement date, the dates of service of your reimbursement request are not within your coverage period under the Plan Year(s) on file. (See Q-2 and Q-4 of Appendix I of your Summary Plan Description.) Please recheck your eligible coverage period with your Employer and have them contact us directly if there is an error.
Ineligible Claim. The submitted expense was received outside of the applicable Plan Year Run-Off period and is therefore ineligible for reimbursement. In order to be eligible for reimbursement, an expense must be submitted within the Run-off period of the applicable Plan Year in which the expense was incurred. For more information concerning your Plan's Run-off period please refer to Q-8 and Q-11 of Appendix I of your Summary Plan Description, Article 6.06 of the Plan Document, or contact your Employer's Benefit Coordinator.

Please sign and resubmit your completed Request for Reimbursement form. A signed Request for Reimbursement form is required in order to process your Request.

Though your claim was signed by your service provider, a more specific description of the service performed and/or date(s) of service is needed to properly determine the eligibility of your expense. Please resubmit your Request with this additional information. (Example: "Root Canal" rather than "Dental" OR "[name of drug]" rather than "Prescription" or "Rx"). See Helpful Tip #5.

Our records do not show that you are a participant in the Unreimbursed Medical FSA for the plan year applicable to the submitted dates of service. If this is not correct, please contact your Employer's benefit coordinator so they can update your enrollment information on file.

“Helpful Tips” printed on EOBS

1. Send claims on a completed and signed Request for Reimbursement form via either mail to the address at the top of the following page, or fax to 1-877-FLEXCLM (353-9256). Note: Blank forms may be obtained at aflac.com – Get a Claim Form - Flex One, or by calling 1-877-353-9487.

2. Please allow 48 hours for Flex One to receive your faxes.

3. Don’t submit claims in advance of the service being rendered. Claims cannot be paid until after the service is rendered.

4. Submit a legible receipt from the provider showing: (a) name of service provider, (b) name of person receiving service, (c) date of service, (d) description of service, Rx drug name, or a list of supplies furnished (description of service cannot be solely in prescription numbers (e.g., Rx#)), and (e) charge for service. Additional substantiation may still be required.

5. A service provider signature on the Request for Reimbursement form can serve as a substitute for your expense receipt when all blocks of the FSA area are completed in detail. Please make sure you use a detailed service description such as "Root Canal" rather than "Dental" OR "Individual Psychological Counseling" rather than just "Counseling".

6. Most participants have 90 days from the end of the plan year to submit claims with dates of service within the plan year. Check with your employer to be sure.

7. You can only receive DDC reimbursements up to the amount of your Payroll Deductions Made (listed above) less any prior reimbursements.