



RE: Aflac Benefit Services/Flex One® (FSA) Welcome Packet

Dear Plan Sponsor:

Welcome to Aflac Benefit Services/Flex One®. Thank you for choosing Aflac Benefit Services/Flex One as your cafeteria plan service provider. We value you as a customer and look forward to serving you. Attached you will find important information and forms pertaining to your Flexible Spending Account (FSA):

Account Information

Separation of Plan – Leave of Absence Form

Request for Reimbursement Form – Dependent Care and Medical Care FSA

Request for Reimbursement Form – Medical Care FSA only

Direct Deposit Form

Change in Family Status Form

Claim Denial Codes and Explanations

Helpful Tips

Aflac 2008 Holiday Closing Schedule

If there is any way we can assist you further, please call us toll-free at 1-800-323-5391. Our customer service representatives are here to assist you Monday through Friday from 8 a.m. to 7 p.m. Eastern time. We also provide 24-hour access to your plan information through our toll-free IVR system at 1-877-Flex-IVR (1-877-353-9487).

Sincerely,

Aflac Benefit Services/Flex One

Important Bank Account Funding and Claims Information

Thank you for choosing Aflac Benefit Services/Flex One for your Flexible Spending Account (FSA) claims processing needs. The following is information that we think will be helpful to you in the administration and servicing of your FSA plan(s).

- We know that it is important to you that your employees get their FSA reimbursements as quickly as possible – after all, it is their money! Well, you have taken the right step in selecting ACH Debit as your bank account funding method. However, you may want to consider changing your selection to the Local Account Funding Option because the Local Account Funding Option provides the fastest, most flexible way to pay your participants' claims!

Because you have chosen to use the ACH Debit Funding Option, claim payments are sent to participants 48 hours after they are processed.* This delay allows Aflac Benefit Services/Flex One to receive the transferred reimbursement funds in our claims payment system. **If you want claim payments to be automatically released for payment as soon as they are processed,* the Local Account Funding Option may be a better choice for you!** To learn more or to switch to the Local Account Funding Option, call us toll-free at 1-877-353-9487 between 8 a.m. and 7 p.m. EST.

While Aflac Benefit Services/Flex One will provide you with a daily report of reimbursement payments made to participants on the specified day, you will be responsible for any overdraft fees that may occur due to an insufficient balance. **Therefore, be sure that you always have sufficient funds in your Local bank account to be able to pay your employees' FSA claims every day.**

- For you and your employees' convenience, we provide a toll-free fax number for the submission of participant claims and any other claims-related information: **1-877-FLEX-CLM (1-877-353-9256)**.
- Below is an **example timeline** with the ACH Debit Funding Option that explains what happens to a participant's claim when it gets to Aflac Benefit Services/Flex One:**
 1. Monday: Reimbursement request received via fax (before 3 p.m.).
 2. Tuesday: Claim processed* by Account Service Specialist. System initiates employer's ACH funds transfer.
 3. Wednesday: Employer funds received in Aflac Benefit Services/Flex One claims payment system. System initiates claim payment.
 4. If the participant:
 - a. Chooses to receive reimbursements through our direct deposit program, the reimbursement payment is **sent** to the participant by EFT on **Wednesday**. The participant **receives** the reimbursement on **Friday**.**
 - b. Does not sign up direct deposit, then the reimbursement check is **mailed** on **Thursday**. The Participant receives the reimbursement by check by mail on about **Monday of the following week**.
- **Did you notice from the example above how much faster participants receive their reimbursements when they use our direct deposit program?** If you want to offer direct deposit to your employees, just provide them with the attached Aflac Benefit Services Direct Deposit Form. Participants can fax their completed and signed direct deposit forms to (706) 317-0149.
- **In order to avoid overpayments to ineligible FSA participants, please notify Aflac Benefit Services/Flex One as soon as any changes to your payroll (e.g. terminations, leaves of absence, etc.) occur.**
- Visit aflac.com to download current forms, such as the Request for Reimbursement and the Aflac Benefit Services Direct Deposit Form, as well as the most current copy of the sample Aflac Benefit Services/Flex One Cafeteria Plan Packet.

* *The term, "processed," indicates that a claim has been entered into the Aflac Benefit Services/Flex One claims payment system. Before a reimbursement payment can be sent to the participant, the claim must also be "released" in our claims payment system. After a claim is released, the system initiates the actual reimbursement payment to the participant at 12 a.m. EST on the following business day.*

** *This timeline illustrates averages, as claims can be processed within 24 – 48 hours of receipt. In addition, federal law allows banking institutions up to 72 hours to complete electronic funds transfers, so it can take anywhere from 1 – 3 days for participants to receive their claim payments through the our direct deposit program.*

Aflac Benefit Services/Flex One® Flexible Spending Account (FSA)

Separation of Plan – Leave of Absence Form

Please use this form to report FSA changes.

NOTE: All fields must be completed.

FSA SEPARATION OF PLAN

Employer Name:
Employer Tax ID:
Employee Name:
Social Security Number:
Type of Coverage: (Check all that apply) <input type="checkbox"/> Unreimbursed Medical <input type="checkbox"/> Dependent Care
Separation Date:
Type of Separation (Check one.): <input type="checkbox"/> Retirement <input type="checkbox"/> Deceased <input type="checkbox"/> Discontinuation of Employment
Date of Last Deduction:
Total Amount of FSA Deductions:
Will employee continue coverage under COBRA? <input type="checkbox"/> Yes <input type="checkbox"/> No

LEAVE OF ABSENCE

Employer Name:
Employer Tax ID:
Employee Name:
Social Security Number:
Date of Last Deduction Prior to Leave:
Amount of Last Deduction Prior to Leave:
Did employee elect to continue coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate: <input type="checkbox"/> Pre-pay contribution obligations on a pre-tax basis (provided that the leave doesn't straddle two plan years) <input type="checkbox"/> Make monthly contributions (pre-tax if the employee is on a PAID leave of absence) <input type="checkbox"/> Catch-up contributions upon returning from leave If no, indicate separation date:
Total Amount of FSA Deductions:

RETURN FROM LEAVE OF ABSENCE

Employer Name:
Employer Tax ID:
Employee Name:
Social Security Number:
Date of Return From Leave of Absence:
Date Deductions Will Resume Upon Return From Leave of Absence:
Deduction Amount:

Fax this completed form to (706) 320-2432 **OR** e-mail it to Flex FSA at TERMS@aflac.com.
Please notify Aflac Benefit Services/Flex One® whenever these types of changes occur.

EMPLOYER'S SIGNATURE

DATE



Flex One® Request for Reimbursement Form

Instructions: Please print or type the information below.

FLEX ONE CLAIM FAX: 1.877.353.9256

- 1. Sign and date form.
- 2. The Total Dependent Care Reimbursement requested box **must be completed**.
- 3. The Medical Care Total requested box **must be completed**.
- 4. Receipts attached must be clear and legible.
- 5. Allow 48 business hours to check status of reimbursement request.
- 6. **Please maintain copies of all receipts for your records.**

Employee Information Check here if address change

Participant's Social Security Number		Employer Name		
Last Name	First Name	Middle Initial	Participant's E-Mail Address	
Street Address		City	State	ZIP

By submitting this claim form, I request reimbursement from my Flex One account(s) as listed below. I agree to the Terms and Conditions outlined in my employer's Summary Plan Description. I certify and warrant to Aflac that these are eligible medical and/or dependent care expenses that I or my dependents have incurred, are not cosmetic in nature, and cannot be reimbursed from any other source. I will maintain copies of all documentation for my records.

Participant's Signature _____ Date _____

Dependent Care Claim Information

For Dependent Care expenses that allow you and your spouse, if applicable, to work. You may file your claim in one of the following ways:

OPTION 1 must include:

—OR—

OPTION 2 must include:

- 1. Date(s) of service (only services received; no future dates).
- 2. Reimbursement requested (This amt is = to or < than amt charged).
- 3. Name and age of the dependent receiving care.
- 4. Provider name, phone number, and dated signature.

Name/Age of Dependent Receiving Care	Date(s) Services Were Provided	Amount Requested
/	____/____/____ - ____/____/____	
/	____/____/____ - ____/____/____	
/	____/____/____ - ____/____/____	

Total Dependent Care Reimbursement Requested
\$ _____

Dependent-Care Provider Business Name _____ Phone Number _____

Provider's Signature _____ Date _____

Medical Care FSA Claim Information

For Medical Care expenses, an Explanation of Benefits (EOB) from your insurance company or other receipt(s) must be submitted. *The EOB and/or attached bills must contain the following items to be processed and approved:*

- 1. Patient Name
- 2. Service Provider
- 3. Description of Service
- 4. Date(s) Service Was Provided
- 5. Amount/Copay

List each receipt separately in the space(s) below. Use additional forms if necessary. A total **must** be indicated in the Total block below. Use the Provider Certification space below only if no receipt is attached. **Do not** indicate "see attached" in the spaces below.

FSA Card Receipt	Patient Name	Service Provider	Description of Service	Date Service Was Provided	Requested Amount
<input type="checkbox"/>					
<input type="checkbox"/>					
<input type="checkbox"/>					
<input type="checkbox"/>					
<input type="checkbox"/>					
<input type="checkbox"/>					

Provider Certification

TOTAL \$

In lieu of receipts or EOB(s) the provider of the service can certify that the above listed medical care expenses have been incurred and only incurred by either the participant or his/her dependents. Any other expenses must have receipts or a separate completed form. Failure to complete all items will result in an invalid claim request.

Provider Name and Address _____ City _____ State _____ ZIP _____

Provider's Signature _____ Date _____

I certify that the Medical Care expenses listed above were incurred by the patient named above.

Helpful Tips for Filing Your Claim

1. Complete, sign, and date the Flex One® Request for Reimbursement Form. Failure to complete all areas will result in claim rejection and a delay in processing and reimbursement. Do not indicate “See Attached” in any field. Descriptions of service should provide as much detail as possible. If a provider certification is used, the provider must sign and date each new claim form.
2. Submit documentation that is clear and legible. Do not highlight information; these areas often turn black when scanned. In addition, double check to make sure all documentation is clearly visible and not overlapped, written through, or cut off if photocopied.
3. Verify that services received are eligible expenses. See below or refer to your *Participant Handbook* for general guidance.
4. The deadline or run-off period for claims submission is determined by your employer. For more information on the run-off period, refer to your Summary Plan Description or contact your employer. To avoid delays, submit your claims at least two weeks prior to the end of your run-off period.
5. Additional reimbursement forms can be obtained at aflac.com or via the IVR at 1-877-353-9487.

Sample Health FSA Expenses

This list is not all-inclusive; for more detailed information, refer to the *Participant Handbook*. Unreimbursed medical expenses are reviewed according to the regulations of Internal Revenue Code Section 125. All claims must be substantiated, and appropriate documentation must be provided. *Some expenses may require additional documentation from your doctor or health care provider.*

Insurance

Eligible

Deductibles, copayments, and coinsurance for medical care plans

Ineligible

All premiums/contributions for insurance
Long-term care plans
Expenses paid totally by your health plan

Treatments/Therapies

Eligible

Prescribed weight loss programs to treat a medical condition (not including foods)
Diagnostic services (e.g., X-ray and MRI treatments)
Smoking cessation programs
Fertility treatments

Ineligible

Illegal treatments
Physical treatments for general well-being or relaxation (e.g., massage therapy)

Fees/Services

Eligible

Physician consultation fees
Routine office visits
Nursing services for care of a specific ailment
Legal sterilization

Ineligible

Cosmetic procedures that improve appearance but do not meaningfully promote the proper function of the body or treat an illness/disease
Payments to domestic help for nonmedical services
Retainer or concierge fees

Medical Equipment

Eligible

Wheelchairs/crutches
Blood sugar monitors
Oxygen equipment
Hearing aids, batteries, or hearing aid repairs

Ineligible

Equipment replacement insurance and/or warranties
Vacuum cleaners for individuals with dust allergies

Dental/Orthodontic Care

Eligible

Routine exams, cleaning, and X-rays
Artificial teeth/dentures
Braces and orthodontic services

Ineligible

Teeth bleaching/whitening
Tooth bonding that is not medically necessary (e.g., cosmetic veneers)

Miscellaneous Charges

Eligible

Sales tax associated with an eligible item
Transportation expenses primarily for medical care, to include mileage, bus, taxi, parking fees and/or tolls

Ineligible

Divorce, even when recommended by a psychiatrist
Diaper service
Toiletries or cosmetic items (e.g., toothbrush, soap, lotion, etc.)
Maternity clothes

Vision Care

Eligible

Prescription eyeglasses
Contact lenses and cleaning solution
Prescription sunglasses

Ineligible

Lens replacement insurance/warranties
Protection plans
Coatings/tints not used to treat a medical condition

Drugs

Eligible

Prescription and over-the-counter drugs to treat a medical condition
Birth control
Insulin

Ineligible

Dietary supplements for general health, to include vitamins and herbs
Drugs for cosmetic purposes

Key Numbers

Flex One Claims Fax:
1.877.353.9256

Customer Service:
1.877.353.9487

Submission Guidelines

Fax your completed Flex One Request for Reimbursement Form and all documentation to: **1-877-FLEX-CLM (1-877-353-9256)**. **Please allow 48 hours for the receipt of your faxed form before calling to inquire about your reimbursement.**

Note: Please use discretion when faxing your personal information to Aflac. You bear full responsibility for any inappropriate use or disclosure that may arise in connection with your transmission of information to Aflac.

For account information 24 hours a day, 7 days a week, please use our IVR at 1-877-353-9487.

Helpful Tips for Filing Your Claim

1. Complete, sign, and date the Flex One® Request for Reimbursement Form. Failure to complete all areas will result in claim rejection and a delay in processing and reimbursement. Do not indicate “See Attached” in any field. Descriptions of service should provide as much detail as possible. If a provider certification is used, the provider must sign and date each new claim form.
2. Submit documentation that is clear and legible. Do not highlight information; these areas often turn black when scanned. In addition, double check to make sure all documentation is clearly visible and not overlapped, written through, or cut off if photocopied.
3. Verify that services received are eligible expenses. See below or refer to your *Participant Handbook* for general guidance.
4. The deadline or run-off period for claims submission is determined by your employer. For more information on the run-off period, refer to your employer or your Summary Plan Description. To avoid delays, submit your claims at least two weeks prior to the end of your run-off period.
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Insurance

Eligible

Deductibles, copayments, and coinsurance for medical care plans

Ineligible

All premiums/contributions for insurance
Long-term care plans
Expenses paid totally by your health plan

Treatments/Therapies

Eligible

Prescribed weight loss programs to treat a medical condition (not including foods)
Diagnostic services (e.g., X-ray and MRI treatments)
Smoking cessation programs
Fertility treatments

Ineligible

Illegal treatments
Physical treatments for general well-being or relaxation (e.g., massage therapy)

Fees/Services

Eligible

Physician consultation fees
Routine office visits
Nursing services for care of a specific ailment
Legal sterilization

Ineligible

Cosmetic procedures that improve appearance but do not meaningfully promote the proper function of the body or treat an illness/disease
Payments to domestic help for nonmedical services
Retainer or concierge fees

Medical Equipment

Eligible

Wheelchairs/crutches
Blood sugar monitors
Oxygen equipment
Hearing aids, batteries, or hearing aid repairs

Ineligible

Equipment replacement insurance and/or warranties
Vacuum cleaners for individuals with dust allergies

Dental/Orthodontic Care

Eligible

Routine exams, cleaning, and X-rays
Artificial teeth/dentures
Braces and orthodontic services

Ineligible

Teeth bleaching/whitening
Tooth bonding that is not medically necessary (e.g., cosmetic veneers)

Miscellaneous Charges

Eligible

Sales tax associated with an eligible item
Transportation expenses primarily for medical care, to include mileage, bus, taxi, parking fees and/or tolls

Ineligible

Divorce, even when recommended by a psychiatrist
Diaper service
Toiletries or cosmetic items (e.g., toothbrush, soap, lotion, etc.)
Maternity clothes

Vision Care

Eligible

Prescription eyeglasses
Contact lenses and cleaning solution
Prescription sunglasses

Ineligible

Lens replacement insurance/warranties
Protection plans
Coatings/tints not used to treat a medical condition

Drugs

Eligible

Prescription and over-the-counter drugs to treat a medical condition
Birth control
Insulin

Ineligible

Dietary supplements for general health, to include vitamins and herbs
Drugs for cosmetic purposes

Key Numbers

Flex One Claims Fax:
1.877.353.9256

Customer Service:
1.877.353.9487

Submission Guidelines

Fax your completed Flex One Request for Reimbursement Form and all documentation to: **1-877-FLEX-CLM (1-877-353-9256)**. **Please allow 48 hours for the receipt of your faxed form before calling to inquire about your reimbursement.**

Note: Please use discretion when faxing your personal information to Aflac. You bear full responsibility for any inappropriate use or disclosure that may arise in connection with your transmission of information to Aflac.

For account information 24 hours a day, 7 days a week, please use our IVR at 1-877-353-9487.

Direct Deposit Option for Flexible Spending Account Participants



Signing up is easy ...

1. Complete and sign the Authorization.
2. Fax the signed form to (706) 317-0149 or mail it to:

Aflac Benefits Services
1932 Wynnton Road
Columbus, GA 31999-1131

After your claim is paid ...

- Mailed reimbursements can take 5 - 7 days to reach your home.
- Direct deposits take only 2 - 3 days to reach your bank.

Remember ...

- Allow approximately ten business days for direct deposit to become effective.
- Call your bank to verify that your payment has been deposited before making a withdrawal or writing a check.
- Notify Aflac Benefit Services immediately if you change financial institutions.

You can get claim status information or assistance by calling us toll-free at ...

1.877.353.9487

Authorization Agreement for Direct Deposit

I authorize Aflac Benefit Services to initiate credit entries and, if errors occur, I authorize the correction of entries to my account as indicated. This authorization is to remain in force until I terminate it in writing.

Type of Account:

- Checking Savings

Bank Routing Number:

(This nine-digit number is usually found in the bottom left corner of your check.)

Bank Account Number:

(The exact location and number of digits varies from bank to bank, but this number is usually found in the bottom middle of your check.)

Financial Institution Information

- Name: _____
- City/State: _____

Employee Information

- Your Name: _____
- Employer: _____
- SSN: _____
- Employee Phone: _____
- Signature: _____



Change In Status Form

(Fill out only to request a Change in Participation during the year.)

Full Name: _____

Group Account No.: _____

Employer: _____

Adding/Reinstating Benefits

Date of First Deduction: _____

Terminating Benefits

Date of Last Deduction: _____

Instructions

1. Check the appropriate box to indicate a Change In Status or a Change in Cost or Coverage that may qualify you to change your coverage or FSA election for the Plan Year. If you are unsure if an event qualifies, please refer to your plan documents for further information.
2. Fill out a Salary Redirection Form (M-0019) to indicate the change(s) you wish to make in your Total Annual Redirected Amounts or in your participation. Changes you make may include, but are not limited to, increasing or decreasing the deduction amounts for medical/dental and/or dependent care accounts or withdrawing from participation.

Changes in Status

- **Change in Marital Status** Marriage Divorce or Annulment Death of Spouse Legal Separation
- **Change in Number of Tax Dependents** Birth Placement for Adoption Adoption Death of Dependent
- **Change in Employment Status That Affects Eligibility**

	You	Spouse/Dependent
Termination of Employment.....	<input type="checkbox"/>	<input type="checkbox"/>
Part-time to Full-time.....	<input type="checkbox"/>	<input type="checkbox"/>
Full-time to Part-time.....	<input type="checkbox"/>	<input type="checkbox"/>
Commencement of Employment.....	<input type="checkbox"/>	<input type="checkbox"/>
Return from unpaid leave of absence.....	<input type="checkbox"/>	<input type="checkbox"/>
Strike or Lock-Out.....	<input type="checkbox"/>	<input type="checkbox"/>
Commencement of unpaid leave of absence.....	<input type="checkbox"/>	<input type="checkbox"/>
Change in Worksite.....	<input type="checkbox"/>	<input type="checkbox"/>
Other (Salaried to Hourly, etc.).....	<input type="checkbox"/>	<input type="checkbox"/>

- **Change in Spouse or Dependent's Eligibility Under an Employer's Plan**

 - Gains eligibility (age, student status, marital status).....
 - Loses eligibility (age, student status, marital status).....

- **Change in Residence Affecting Eligibility** You Spouse/Dependent

Changes in Cost or Coverage

(Note: Changes in Cost or Coverage do not allow for changes to health FSAs.)

- **Significant Cost Increase of Your/Your Dependent's Coverage**
- **Significant Curtailment of Your/Your Dependent's Coverage**.....
- **Addition or Elimination of Benefit Package Option Under Your/Your Dependent's Employer's Plan**
- **Change in Coverage or Open Enrollment of Spouse or Dependent Under Other Employer's Plan**

Please explain the event(s) marked above and describe how the requested benefit/election change is consistent with the event(s).

I understand that I may be required to provide the appropriate documentation for any of the changes that I have checked above. The status and participation changes must comply with my employer's plan and the Plan Administrator has sole discretion to make this determination. If my change in participation is denied, I will have 60 days to appeal the decision.

I hereby elect the participation change(s) noted on the redirection form attached and attest that the change is made on account of and conforms with the change in status or change in cost or coverage event.

Employee signature: _____ Date: _____

Accepted and agreed to by: _____ Date: _____
(Plan Administrator/Employer Signature)

M00268

Copy Dist.: White-Flex One* Yellow-Associate Pink-Employer Gold-Employee

(8/05)

Denial Code Description Reference Sheet

- LEG** The documentation (receipt, bill, EOB, etc.) received was not legible enough to determine eligibility of your submitted request. Please resubmit a more legible copy of the documentation or have your service provider sign your Request for Reimbursement Form if you are unable to obtain a more legible copy. Please refer to Helpful Tips #4 and #5 for guidance on information required.
- MAX** Our records indicate you have reached 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.
- MRI** The receipt provided did not include one or more of the following: (a) name of service provider, (b) name of person receiving service, (c) date of service, (d) nature of service/drug name and (e) charge for service. Please provide the missing information by submitting a printed bill or receipt from your service provider or an explanation of benefits (EOB) from your insurance company. This information is required in order to determine eligibility of your submitted expense.
- ORT** 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.
- OSP** 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 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 IRS Section 213(d). Please refer to Q-9 of Appendix I in your Summary Plan Description (SPD).
- OTC** The over the counter (OTC) expense receipt provided did not include one or more of the following: (a) name of service provider (i.e., place where purchased), (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.
- OVR** This claim item was found to be eligible. However, the requested reimbursement amount has been applied to offset the overpayment you previously received.
- PPD** The submitted expense has previously been paid or is currently being processed for payment.
- PND** Pended for research. This claim item is currently pended for research.
- PYR** 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.

Denial Code Description Reference Sheet, Continued

- RCT** Substantiation for expense not received. Please have the service provider sign the Request Form **OR** provide a third party statement such as a receipt, bill, or explanation of benefits (EOB) from your insurance. This information is required in order to determine the eligibility of your expense for reimbursement. Please make sure all required information is listed on the Request Form and submitted receipt (Request Form only if Provider signature used). See Helpful Tips#4 and #5 for information required and tips regarding service provider signed Request Forms.
- RUN** 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.
- SIG** Please sign and resubmit your completed Request for Reimbursement Form. A signed Request for Reimbursement Form is required to process your request.
- SVC** 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 Tips #5.
- URM** 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.

EOB Denial Code Description Reference Sheet

- APL** The appeal request for this item has been denied. A letter advising of the denial reason(s) is being sent to you.
- DDC** Our records do not show that you are a participant in the Dependent Care 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.
- DPD** Insufficient substantiation. It is unclear from the documentation provided that this expense is primarily for custodial purposes (as opposed to being educational or medical). An expense for this service may be eligible for reimbursement if it is work-related and the primary purpose of the expense is to provide custodial care for your eligible qualifying child (age 12 or under) or your spouse or other tax dependent who is physically or mentally unable to care for himself/herself. If this is the case, please submit additional documentation from your daycare provider certifying that the expense is primarily custodial in nature. Refer to Q-9 of Appendix I in your Summary Plan Description (SPD) for what constitutes an eligible expense.

EOB Denial Code Description Reference Sheet, Continued

- DPU** Insufficient substantiation. An expense for this service may be eligible for reimbursement if its purpose is primarily to alleviate or prevent a physical or mental defect or illness. If this is the case, please submit a dated physician's statement indicating 1) patient's name 2) specific medical condition for which treatment is prescribed and 3) description of the treatment and how it treats the medical condition. Reoccurring services should include the period and frequency of treatment (cannot span beyond the applicable plan year). Treatments that are of a personal or cosmetic nature with only ancillary medical benefits are generally not eligible – refer to Q-9 of Appendix I in your Summary Plan Description (SPD) for more information.
- DSI** We were unable to determine from the documentation that you submitted that the expense requested was actually incurred. If the expense has been incurred (i.e., the service or treatment was actually provided), please submit additional documentation from your service provider verifying when the expense was incurred. Your Plan and IRS regulations require that service or treatment be actually rendered prior to the time that the expense is reimbursed. Expenses are not considered incurred simply because you are billed, charged for, or pay for them. Please refer to Q-10 in Appendix I of your Summary Plan Description (SPD).
- FRM** We are unable to process your request as the required Request for Reimbursement Form (completed as instructed) was not received with the submitted documentation. Please resubmit your request with a completed Request for Reimbursement Form. See Helpful Tip #1.
- FUT** The expense(s) has not yet been incurred. IRS regulations require the actual service be provided to you, your spouse, or your tax dependent prior to reimbursement of the expense. In accordance with your Plan, resubmit your request(s) to us once the requested service has been provided. (Note that all claims must be filed before the end of the Run-off period.)
- IND** 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 work-related and primarily custodial in nature in addition to being incurred for your qualifying child (age 12 or under) or your spouse or other tax dependent who is physically or mentally unable to care for himself/herself.
- INU** 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.
- ITM** 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.

“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 (1-877-353-9256). 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.

Aflac and Aflac Benefit Services/Flex One

2008 HOLIDAY SCHEDULE

Aflac and Aflac Benefit Services/Flex One Holidays 2008

New Year's Day	Tuesday, January 1
Martin Luther King Day	Monday, January 21
Good Friday	Friday, March 21
Memorial Day	Monday, May 26
Independence Day	Friday, July 4
Labor Day	Monday, September 1
Thanksgiving	Thursday, November 27
	Friday, November 28
Christmas	Thursday, December 25
	Friday, December 26

Please note that Aflac and Aflac Benefit Services/Flex One **will be closed** on the above holidays. If you have any questions, please call our toll-free number at 1-800-323-5391 between 8:00 a.m. and 7:00 p.m. Eastern Time, Monday through Friday.