State of Nebraska

Flex Debit Cards

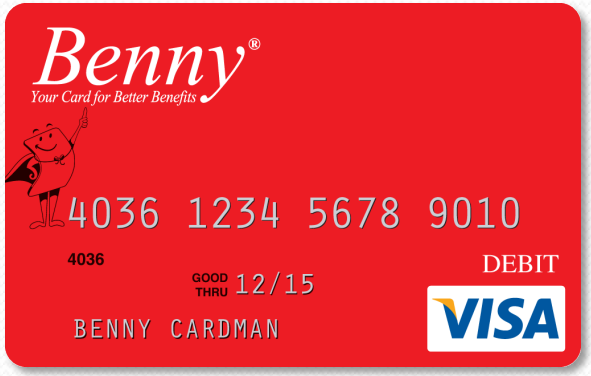
2013

Presented by:

ASI FLEX

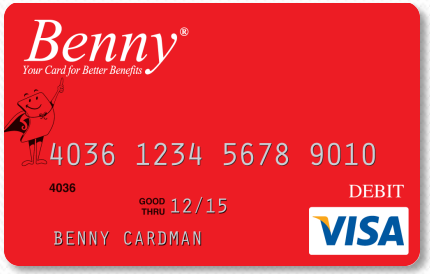
Claim Filing Options 7/1/2013

- Several options from which to choose
  - Mail
  - Fax
  - File online **www.asiflex.com**
  - NEW FSA Debit Card



- The choice is yours at each point-of-sale!

Debit Card – What is it?



- Health Benefit Card
- Allows you to pay directly from your health FSA account
  - Sign for credit transaction
  - Enter PIN for debit transaction
- Accepted at healthcare and retail providers that accept VISA® based on merchant codes
- Not accepted at providers not recognized as health care providers/merchants

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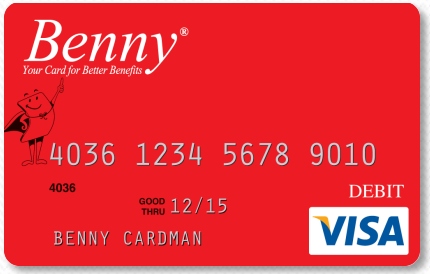
How does it work?



- At point-of-sale, present card for payment
- Advantage is that you don't have to use cash or another credit card
- Merchant will process the transaction
- Card company reports to ASIFlex the provider/ merchant name, date of transaction, dollar amount
- **NOTE: You may need to provide additional documentation showing the patient name and type of service/product**

How do I provide information?

- ASIFlex will notify you if additional information is required
- IRS requires documentation for all transactions **except** if the transaction is for:
  - Co-Pays that match the State plan you are enrolled in
  - Identified recurring expenses at the same provider, same amount each month (e.g. orthodontia)
  - Transactions at certified merchants who maintain an inventory system of eligible items (retail stores, drugstores, pharmacy)
- All other expenses for Rx under non-State plans, and any medical, dental, vision require documentation

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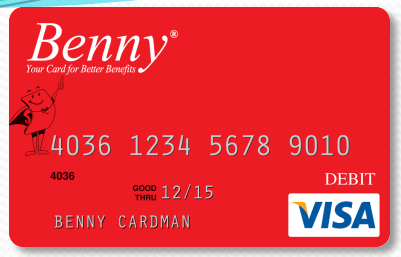
How does ASI notify me?

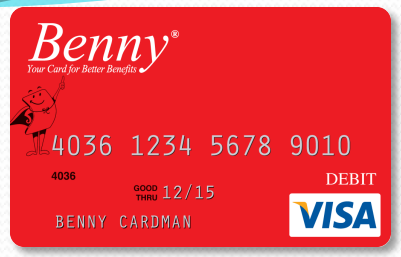


- Up to three requests are sent by mail or email/text
  - Letter 1 – Sent following transaction
  - Letter 2 – Sent after two weeks, advises card may be inactivated
  - Letter 3 – Sent after two weeks, temporary inactivation notice
- To remedy, simply provide documentation and card will be activated
- If documentation lost, you can write a check back to the plan or submit a substitute claim

What type of documentation is required?

Type of Expense	Documentation Needed
If covered by insurance Medical, Dental, Vision	Insurance payer explanation of benefits (EOB) or Itemized statement NOTE: Submit to insurance first
If not covered by insurance	Itemized Statement
Prescriptions	Pharmacy receipt or Printout from pharmacy
OTC Drugs/Medicines	Physician prescription **and** itemized merchant receipt NOTE: Rx must be dated prior to or on the date of purchase.
OTC Medical Supplies/Items	Itemized merchant receipt

How do I get a card?



- Automatically issued to all health care participants
- Mailed to home address
- 2-3 weeks from time order is placed
- 2 cards provided
- Arrives in plain white envelope – do not destroy!
- Read cardholder agreement
- Report lost or stolen cards
- Call to activate and select a PIN if you wish; same PIN for both cards

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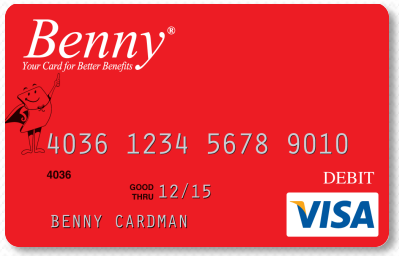
How do I use the card?



- Save all itemized provider/merchant receipts (NOT the credit card receipt)
- Save all insurance payer Explanation of Benefits (EOB)
- Submit documentation upon request – it's the law!
- Know your balance
- Use at health care providers (note that some teaching hospitals, e.g., may not be recognized as they code terminals as "educational")
- Check your messages under your account
- Fax correctly

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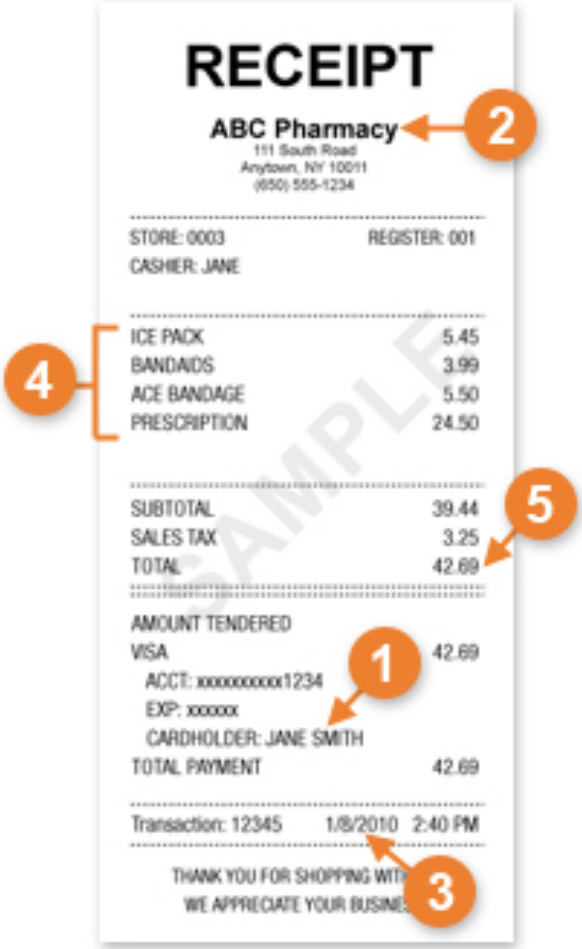
Merchant Receipt



Alegent Health

CRB 111-3

CASH RECEIPT

Date 9-10-12 818936

Received From Timothy Spencer #2016341

Address Dr. Jarzobski's office

ACC Heart & Vascular Dollars $ 50.00

For Copay

ACCOUNT			HOW PAID		
AMT. OF ACCOUNT			CASH	50.	00
AMT. PAID			CHECK		
BALANCE DUE			MONEY ORDER ☐ CREDIT CARD ☐		

By

AH HEART & VASC SPC BM
7500 MERCY ROAD
OMAHA, NE 68124

Merchant ID: 000000000492820
Term ID: 01764150
104029744992

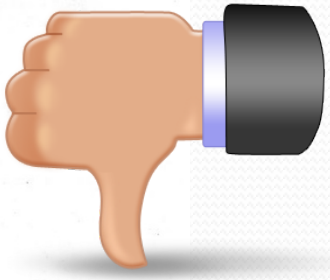
Sale

VISA
XXXXXXXXXXXX3575
Entry Method: Swiped
Apprvd: Online Batch#: 000815
09/10/12 13:54:48

Inv #: 000004 Appr Code: 034821

Total: $ 50.00

Customer Copy



SPEN [redacted] $4.00

Rx# 617206-1472 10/14/12 Verifying Rph:JP*SAFETY CAPS*

Prescriber: QUINLAN, MARK
ENALAPRIL MALEATE 20MG TABS #30
NDC# 64679-0926-02 Days: 30 Mfg: WOCKHARDT USA
AETNA Auth# 30001573505788
U&C: $4.00
10.00 Refills left until 09/06/13

HyVee
(402) 891-0600
17810 WELCH PLAZA
OMAHA, NE 68135
Store# 1472

Price $4.00

PHARMACY RECEIPT • RETAIN FOR TAX OR INSURANCE

HyVee
EMPLOYEE OWNED

17810 WELCH PLAZA
OMAHA, NE 68135
402-896-4168
E-mail comments:
1472director@hy-vee.com

****

Purchase 4.00

Credit # XXXX XXXX XXXX 3575
Auth # 000860
Lane # 22 Checker # 400
10/14/12 11:00 Ref # 2111677880

****

PRESCRIPTION 4.00 P

Sub Total $4.00
VISA $4.00
[S] XXXX XXXX XXXX 3575
Auth# 000860 Ref# 2111677880

BALANCE DUE 4.00

CHANGE $0.00

Total number of items sold = 1

Cashier:0400 Name:PHARMACY
Store:1472 POS:022 Transaction:0013
Oct 14 2012 10:59 AM

Enterprise Pharmacy

Customer Statement

version 1.0

Page

Patient Name: [redacted]
Street Address: [redacted]
City: [redacted] **State:** [redacted] **Zip:** [redacted]
Birthday: [redacted]

Pharmacy Name: OMAHA HY-VEE #9
Street Address: 17810 WELCH PLAZA
City: OMAHA **State:** NE **Zip:** 68135
Phone No: (402) 891-0600 **Fax No:** (402) 891-1239
Federal Tax ID: 42-0325638

Sold	Store #	Rx #	Fill #	Product	NDC #	Qty	Unit	Days	Prescriber Name	TP Total Amt Paid	PT Pay Amt Total	Primary TP Name	Prior Au
05/20/2012	1472	588873	1	VENLAFAXINE HCL 75MG TABS	68382-0021-01	30	EA	30	JENNIFER CZYZ-APRN	4.99	0.00	ANTHEM PRESCRIPTIONS	
06/27/2012	1472	588780	1	SIMVASTATIN 40MG TABS	16729-0006-15	30	EA	30	JENNIFER CZYZ-APRN	4.99	0.00	ANTHEM PRESCRIPTIONS	
06/27/2012	1472	588873	2	VENLAFAXINE HCL 75MG TABS	68382-0021-01	30	EA	30	JENNIFER CZYZ-APRN	0.00	10.00	ANTHEM PRESCRIPTIONS	
07/27/2012	1472	588780	2	SIMVASTATIN 40MG TABS	16729-0006-15	30	EA	30	JENNIFER CZYZ-APRN	0.00	9.99	ANTHEM PRESCRIPTIONS	
07/27/2012	1472	588873	3	VENLAFAXINE HCL 75MG TABS	68382-0021-01	30	EA	30	JENNIFER CZYZ-APRN	0.00	10.00	ANTHEM PRESCRIPTIONS	
08/28/2012	1472	615068	0	VENLAFAXINE HCL 75MG TABS	68382-0021-01	30	EA	30	LISA _APRN_ FAX KOZIOL	4.92	10.00	AETNA	
08/28/2012	1472	588780	3	SIMVASTATIN 40MG TABS	16729-0006-15	30	EA	30	JENNIFER CZYZ-APRN	0.00	9.99	AETNA	

# of Records	Patient Pay	Third Party Pay
7	49.98	14.90

Attested To By: [signature] PharmD 9-9-12
Registered Pharmacist

Disclaimer: "May not reflect all prescription records"

Understanding your Explanation of Benefits (EOB)

Service Center
Address
City, State, Zip
Phone: 1-888-888-8888

Have more questions about your claim?
Visit (name of member website)
for all your claim and benefit information

Date

John Johnson
Address
City, State, Zip

1

Member/Patient Information
Member/Patient: John Johnson
Member ID: 1234567890
Group Name: ABC Company
Group #: 1234567

Explanation of Benefits Statement
This is not a bill. Do not pay. This is to notify you that we processed your claim.

2

Claims Summary Detailed claim information is located on following page(s)

Dollar Amount	Description
$229.00	**Amount Billed** This is the total amount that your provider billed for the services that were provided to you.
$32.23	**Plan Discounts** Your plan negotiates discounts with providers to save you money. This amount may also include services that you are not responsible to pay.
$75.00	**Your Plan Paid** This is the portion of the amount billed that was paid by your plan.
$121.77	**Total Amount You Owe the Provider** The portion of the charges you owe the provider(s). This amount does not reflect any payment you may have already made at the time you received care or any amount that may have been paid to you. This amount may include your deductible, co-pay, coinsurance and / or non-covered charges.

Use this EOB statement as a reference or retain as needed

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Claim detail page

Date

Service Center
Address
City, State, Zip
Phone: 1-888-888-8888

Have more questions about your claim?
Visit (name of member website)
for all your claim and benefit information

Claim Detail *for John Johnson*

Provider: Dr. Martin — Claim Number: 20120111101 — Account Account Number: 9201253-11

Date of Service	Type of Service	Notes*	Amount Billed	(-) Plan Discounts (-)	Your Plan Pays (=)	Your Remaining Responsibility to Provider**				Total Amount You Give the Provider
						Deductible (+)	Copay (+)	Coinsurance (+)	Non Covered (=)	
7/15/12	Office Visit	IX	$150.00	$12.23	$0.00	$66.77	$0.00	$5.00	$0.00	$71.77
7/15/12	DX Services		$125.00	$0.00	$75.00	$25.00	$0.00	$25.00	$0.00	$50.00
Claim Total:			$225.00	$12.23	$75.00	$91.77	$0.00	$30.00	$0.00	$121.77

**This total does not reflect any payment or copay you made at the time of service. Please wait for a provider bill before making a payment.

Notes*

IX- THIS PHYSICIAN OR HEALTH CARE PROVIDER IS NOT A NETWORK PROVIDER BUT HAS ACCEPTED A REDUCTION IN CHARGES ON THIS CLAIM THROUGH MULTIPLAN. THE MEMBER IS RESPONSIBLE FOR THE TOTAL AMOUNT INDICATED IN THE AREA OF THIS STATEMENT SHOWING WHAT THE PATIENT OWES. YOU ARE NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED AND THE AMOUNT ALLOWED. IF YOU ALREADY PAID THE ENTIRE BILL, PLEASE CONTACT THE PHYSICIAN OR HEALTH CARE PROFESSIONAL FOR A REFUND.

Insurance does not always pay the cost of health care. If services are listed which you did not receive or service you were told would be free, call 1-866-611-2[illegible].

You have the right to receive, upon request and free of charge, a copy of the internal rule, guideline or protocol that was relied upon in making the non-coverage decision for your claim.

MEDICAL CLAIMS ONLY

A review of this benefit determination may be requested by submitting your appeal to us in writing at the following address: Health Plan Claims Appeal Department. The request for your review must be received within 180 days from the date you receive this statement. If you request a review of your claim, we will complete our review no later than 30 days after we receive your request for review.

You may have the right to file a civil action under ERISA if all reasonable remedies of your claim have been completed.

Use this EOB statement as a reference or retain as needed

Page 2 of 4

3. **Service Description**
   Description of service provided. Remark code text is listed below the Service Details box.
4. **Your Plan Paid**
   The amount of benefits paid to the employee or provider.
5. **Deductible/Copay**
   Itemized Responsibility - This section shows your responsibility for the services provided.
6. **Notes**
   Section with more details on why claim was paid or not paid. This section also shows your appeals options and other helpful information.

① Provider

Millard Hills Dental Health Center
14202 Y Street
Omaha, NE 68137
(402)895-2085

October 16, 2012

Account Aging	
Current	$0.00
30 Day	$0.00
60 Day	$0.00
90 Day	$0.00
Contract	$0.00
Balance Due	**$0.00**

[redacted]

ID: 1625

Date	Provider	Transaction		Tth	Surface	Fee
10/16/2012	Laura Hermsen	D1110	Prophylaxis - Adult			80.00
	Gerald R. Gemar	D0120	Evaluation - Periodic Oral			47.00
		Acct Pmt	Visa Card Number VISA ending in 3575 Appr#:003783 for ($127.00)			

② Date of Service

③ Description of Service

Subtotal:	127.00
Tax:	0.00
④ **Today's Charges:**	127.00
- VisaToday's Payment:	127.00
+ Previous Balance:	0.00
Balance Due:	$0.00

Dollar Amount

Contract Balance	Estimated Insurance	Previous Balance	Charges Today	Payments Today	Adjustments Today	**Balance Due Now**
0.00	N/A	0.00	127.00	127.00	0.00	**0.00**

⑤ Patient Name

SIGNED
I agree to pay the above payment amount according to my card issuer agreement.

Future Family Appointments:

Patient:	Next Appointment:	Patient:	Next Appointment:	Patient:	Next Appointment:
[redacted]	4/18/2013 @ 8:00 am				

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Unacceptable Documentation

- Credit card receipts
- Balance forward, paid-on-account statements, previous balance due statements
- Cancelled checks
- Pre-treatment estimates; services not yet performed
- Health statements

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Online Resources

- www.asiflex.com
- https://asiflex.com/debitcards
- File Claims
- Access your FSA account detail
- Review messages sent to you
- Extensive eligible/ineligible expense listing
- Frequently Asked Questions
- Expense Estimator
- Tax Savings Calculator
- Helpful videos
- Links to IRS Forms & Publications

Real people! Here to Help!

Website
www.asiflex.com
https://asiflex.com/debitcards

E-Mail
asi@asiflex.com

Phone
1.800.659.3035

Address
PO Box 6044
Columbia, MO 65205