

HCFSA Reimbursement Checklist

Checklist of Requirements	Questions to Ask	Yes	No
Plan Document	Is the type of expenses permitted (and not excluded) under the plan document? Does the reimbursement request exceed the plan's minimum reimbursement amount?	<input type="checkbox"/> <input type="checkbox"/>	
Annual Limit	Is the reimbursement request, together with prior reimbursements, less than the maximum plan limit elected by the participant for the plan year (no carryovers of unused amounts to the next year are allowed)?	<input type="checkbox"/>	
Medical Care	Is the expense for medical care under Code § 213(d)? Is it primarily for a medical purpose? Does the expense have any cosmetic uses? If the expense involves a personal element, would it have been incurred if the medical condition had not existed? Was the method of achieving the medical result unreasonably expensive?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	 <input type="checkbox"/>
Claimant Identity	Has the participant submitted a signed (or electronic) statement that the expense was for the employee, his spouse or his dependent?	<input type="checkbox"/>	
No Other Deduction	Has the employee certified that no other deduction will be taken for the same expense?	<input type="checkbox"/>	
Uniform Coverage	Is the maximum amount of coverage (reduced by prior reimbursements) available to the participant at all times? Is the employee still paying the premium? Are claims being reimbursed at least monthly (or when the claims reach a reasonable minimum amount specified under the plan)?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
12-Month Coverage Period	Has there been a short plan year? Has the participant experienced any changes in status, ceased contributions or separated from service?		<input type="checkbox"/> <input type="checkbox"/>
Incurred During Coverage Period	Has the medical care giving rise to the expense already been provided? Was the medical care received during the plan year? Was the participant covered by the plan when the medical care was provided? Does any portion of the expense represent prepayment for medical care that has not yet been provided? Has the request been submitted in the run-out period specified in the plan? If the employee's coverage has terminated, was a timely COBRA election made?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	 <input type="checkbox"/>
No Insurance Premiums	Does the request involve payment of any insurance premiums for the employee, his spouse or his dependent?		<input type="checkbox"/>
Not Reimbursed or Won't Seek Reimbursement from Other Plan(s)	Has the employee submitted a signed (or electronic) statement that the expense has been incurred, has not previously been reimbursed and that the employee will not seek reimbursement from any other health plan? Has the participant been previously reimbursed for the same expense under this or any other plan?	<input type="checkbox"/>	 <input type="checkbox"/>
Claims Substantiation	Has the employee submitted a written (or electronic) statement from an independent third party providing that the expense has been incurred and the amount of the expense?	<input type="checkbox"/>	
No Discrimination	Is the reimbursement decision consistent with prior decisions involving similar expenses? If a highly compensated employee is making the reimbursement request, does the plan discriminate in favor of such employees with respect to eligibility or benefits?	<input type="checkbox"/>	 <input type="checkbox"/>