

## How to File a Claim

---

The below information will help you understand your HRA VEBA Plan's overall claims process and related IRS rules. After becoming claims-eligible, knowing this information will help you submit "clean" claims that will be processed quickly and hassle-free. To learn more about what types of out-of-pocket medical care expenses and premiums are eligible for reimbursement and who is eligible for coverage under your HRA VEBA Plan, read the **Qualified Expenses and Premiums** and **Definition of Dependent** handouts available online. To get copies, log in at [hraveba.org](http://hraveba.org) and click **Resources**, or contact the customer care center at [customercare@hraveba.org](mailto:customercare@hraveba.org) or **1-888-659-8828**.

---

### Can I submit my claims online?

Yes, online claims submission is available and recommended. Submitting claims online is faster and easier than using a paper **Claim Form**. To submit a claim online, log in at [hraveba.org](http://hraveba.org) and click **Claims**. You will need to scan and upload supporting documentation.

### Where can I get a Claim Form and where do I send it?

To access paper forms, log in at [hraveba.org](http://hraveba.org) and click **Resources**, or contact the customer care center at [customercare@hraveba.org](mailto:customercare@hraveba.org) or **1-888-659-8828**. You can email, fax, or mail your completed Claim Form and required documentation as indicated on the form. Email is recommended and preferred over regular mail. Faxing is sometimes unreliable and is not recommended.

A fully completed and signed Claim Form, with supporting documentation for each expense, is required for reimbursement.

### What type of documentation (proof of expense) do I need to include?

IRS rules require that you include proper proof of each expense. Missing, incomplete, or illegible forms of documentation are the most common reasons claims are denied. You can help avoid denied claims by making

sure the proof you submit is legible and contains all of the following:

1. **Name** of patient or covered individual who received the item or service;
2. **Date** item was purchased or service was provided;
3. **Service Provider** name (e.g. doctor, pharmacy, hospital, etc.)
4. **Description** of the item purchased or service received; and
5. **Amount** of out-of-pocket expense.

Forms of documentation that do not contain all the required information cannot be accepted. Common examples include cancelled checks, credit or debit card receipts, bank statements, and balance-forward or payment-on-account statements. EOBs that indicate an estimated insurance payment, or that indicate final insurance payment has not yet been determined, cannot be accepted. You will need to submit a final EOB, detailed receipt, or itemized statement that reflects your actual out-of-pocket amount. Finally, handwritten receipts are generally not acceptable, unless the qualified out-of-pocket amount is under \$200 and the provider's name has been stamped or pre-printed on the receipt.

Generally, all of the required information is contained on any one of the following types of documents:

1. **Explanation of benefits (EOB)** from your insurance company (recommended);
2. **Itemized statement** of services from your doctor or other service provider;

3. **Stub or “bag tag”** from a prescription (not the cash register receipt); or
4. **Detailed receipt and prescription** for over-the-counter (OTC) medicines.

## What types of claims require additional proof?

Certain types of claims require proof that is slightly different or in addition to the basic information requirements. For example:

- **Insurance premiums**

Proof of qualified insurance premiums must include: (1) name(s) of covered individual(s); (2) premium amount(s); (3) policy period (i.e. coverage month(s)); and (4) insurance provider name and address. This information is typically contained on your premium billing notice, statement of insurance, open enrollment notice, pension benefit direct deposit stub, or similar form of documentation. For long-term care insurance premiums, include a copy of the policy’s Declarations page, which should contain proof that the policy is tax-qualified.

Automatic reimbursement or payment of ongoing (e.g. monthly) insurance premiums is available. Complete and submit an **Automatic Premium Reimbursement** form. To access paper forms, log in at [hraveba.org](http://hraveba.org) and click **Resources**, or contact the customer care center at [customercare@hraveba.org](mailto:customercare@hraveba.org) or **1-888-659-8828**. Or, skip the form and set up your automatic premium reimbursement or payment online after logging in to your account at [hraveba.org](http://hraveba.org).

IRS regulations provide that insurance premiums paid by an employer, deducted pre-tax through a section 125 cafeteria plan, or subsidized by the Premium Tax Credit are not eligible for reimbursement. If requesting reimbursement of premiums deducted from your paycheck, you must include a letter from your employer that confirms a pre-tax option for the deduction of such

premiums is not available. Qualified premiums deducted from your spouse’s paycheck after tax are eligible for reimbursement.

- **Orthodontia**

Reimbursement generally may not exceed the cost of services provided to date. However, full or partial pre-payment of orthodontia services may be reimbursed if you submit proof of having made such payment. In addition, a letter, contract, or similar document from your provider that contains the patient name, service provider name, description of services, and amount of out-of-pocket expense is required.

- **Massage therapy**

Massage therapy claims require a prescription or letter of medical necessity from your doctor, unless you submit (1) an itemized statement of services that contains a diagnosis/condition or (2) an EOB from your primary medical insurance carrier that confirms insurance has paid its portion of the total charge.

- **Weight loss programs**

The cost of a weight loss program may qualify, but only if the program is prescribed or recommended by your doctor to treat a specific medical condition. To prove the expense is primarily for medical care, you must submit a prescription or letter of medical necessity from your doctor recommending the program. Special foods associated with a weight-loss program will not qualify, because such food simply meets normal nutritional needs.

- **Health club or gym fees**

Only in very limited circumstances would fees paid to a health club or gym be eligible for reimbursement. You must submit a prescription or letter of medical necessity from your doctor that contains diagnosis of a specific medical condition (e.g. rehabilitation after surgery). Additionally, the health club or gym fees would be reimbursable only when you would not have incurred the fees “but for” the disease or condition diagnosed by

your doctor. When treatment is no longer needed, the fees would no longer qualify.

- **Personal trainers**

Fees associated with a personal trainer may qualify, but only if your doctor has prescribed or recommended a supervised exercise regimen in order to treat a specific disease or injury, and only if such fees are incurred for a limited time. Additionally, the fees must not have been incurred by you “but for” the disease or medical condition diagnosed by your doctor. In order to prove this expense is primarily for medical care, you must submit a prescription or letter of medical necessity from your doctor.

- **Vitamins, remedies, and supplements**

You must submit a prescription or letter of medical necessity from your doctor. Claims for vitamins, remedies and supplements do not qualify if such products merely benefit your general health. However, the products might qualify for reimbursement if recommended by a medical practitioner to treat a specific medical condition.

- **Over-the-counter (OTC) medicines and drugs**

Federal healthcare reform laws require that claims for OTC medicines and drugs (except insulin and contact lens solution) purchased on or after January 1, 2011 require a prescription or note from a medical professional recommending the item to treat a specific medical condition. OTC medicines and drugs like aspirin, antihistamines, and cough syrup must be prescribed. The prescription requirement applies only to medicines and drugs, not to other types of OTC items such as bandages and crutches.

- **Transportation and lodging for medical care**

Claims for transportation may include car, bus, taxi, train, plane, and ferry fares. A standard mileage rate set by the IRS, not actual car expenses, for use of a car to obtain medical care is allowed, and proof of mileage is required (e.g. printed MapQuest directions). Lodging may be reimbursable up to \$50 per night if certain

conditions are met: (1) lodging is primarily for medical care; (2) care is provided by a licensed physician in a licensed hospital or medical care facility; (3) the lodging is not lavish or extravagant; and (4) there is no significant element of recreation or vacation in the travel. If a parent is traveling with a sick child, up to \$100 per night may qualify.

## How long will it take to process my claim and get my reimbursement?

Standard claims processing time is **five to seven business days** from the day your claim is received by the Plan. If you are not signed up for direct deposit, remember to allow adequate mail delivery time to receive your paper check reimbursements in the mail.

You can check the status of your claim online. Log in to your account at [hraveba.org](http://hraveba.org) and click **Claims**.

To get your money back faster, submit your claims online. Also, sign up for direct deposit. It is faster and more convenient than waiting to receive paper check reimbursements in the mail.

## Will I receive an EOB?

Yes, an EOB will be provided to you after your claim has been processed. If you are signed up for e-communication in lieu of paper (recommended), we will notify you via email when your EOB is available online. To access your EOBs, log in at [hraveba.org](http://hraveba.org) and click **Claims**. A paper EOB will be mailed to you if you are not signed up for e-communication.

The Notes section of your EOB will contain an explanation if any portion of your claim is not paid. In most cases, unpaid claims can easily be reprocessed after we receive additional information from you.