



Participant Reference Guide

A Participant's Guide to DirectPay Reimbursement Plans.

Welcome

Welcome to DirectPay and the benefits of a Section 105 medical reimbursement plan. We hope you will find DirectPay an efficient and easy way to have more choice in your health care planning and more control of your own health costs. This Reference Guide offers only a general description of a DirectPay Plan, and may not accurately reflect your Plan or the benefits available under your Plan. You will receive a Summary Plan Description outlining your Plan within the next 60 days. In the meantime, you can check with your employer for specifics regarding your Plan. Enclosed with this Guide is your Request for Reimbursement Form along with some reimbursement tips. The tips are designed to educate and assist you in accurately and efficiently request reimbursements. Please take time to read this material and become familiar with the operation of your DirectPay Plan. Feel free to contact us with any questions regarding your Plan.

DirectPay - Reimbursement Plan

DirectPay is solely funded by the employer and reimburses employees for qualified expenses as defined by the Plan. Employer contributions are received by the employee completely tax free! Employees may not contribute to this Plan and unused dollars may be rolled over from one Plan Year to the next.

Direct Pay Reimbursements

You may request reimbursements any time a qualifying expense has been incurred. The service related to the expense needs only to have taken place; it does not need to be paid before requesting reimbursement. Simply complete and submit a Request for Reimbursement Form. Non-conforming forms will not be accepted. Qualified reimbursements are limited to: (a) eligible expenses incurred during the applicable Plan Year and pursuant to the Plan design, (b) for eligible Plan Participants, and (c) for expenses not previously reimbursed under this or any other benefit Plan or claimed as an income tax deduction. It is your responsibility to comply with these guidelines and avoid submitting duplicate or ineligible claims. TASC or your employer will not be held responsible for invalid claims for reimbursements made. Participants are responsible to reimburse TASC for any amounts paid to them that they were not eligible for. Reimbursement requests must be accompanied with the appropriate claim substantiation (see below for more details). Failure to comply may delay payment. In some cases, DirectPay may require additional information or documentation.

Once a request is reviewed and approved, a reimbursement check for the full amount of your claim will be mailed directly to your home or processed through your bank if you have elected Direct Deposit. The Plan contribution limit will be factored in. Reimbursement requests that exceed Plan limitations will be maintained by TASC. Communication that you exceeded your Plan limit will not take place. Any balance in the account at the end of the Plan Year will be carried over and applied to the following Plan Year, if offered by the employer.

Web Access

Participants are able to view their claim detail online at www.tasconline.com. This web tool provides to the participant the submitted claim information including claim reimbursed date, pay to information (participant or provider) and check number. Your company's human resources department can provide you with your user name and password.

Plan Design

Below are descriptions of various types of benefit plans and their substantiation requirements. Your company's DirectPay plan may consist of coverage for just one of these benefits or a combination of several. See your company's human resources department for specific plan benefit coverage information.

Deductible and/or Coinsurance – All medical expense that are applied to the deductible and/or coinsurance of the health plan qualify for reimbursement. Qualified expenses are those incurred by the employee or the employee and family. An Explanation of Benefits (EOB) must accompany the Request for Reimbursement evidencing the expense as an expense applicable to the insurance deductible or coinsurance amount.

Copay - All medical expenses that are applied to the copay of the health plan qualify for reimbursement. Qualified expenses are those incurred by the employee or the employee and family. A copy of a receipt, statement or Explanation of Benefits (EOB) identifying the claimant, date of service, the amount of service, the name of the service provider and description of the service must accompany the Request for Reimbursement evidencing the expense as an expense applicable to copay expenses.

Uninsured Medical Expenses and/or Health Insurance Premiums – All out-of-pocket medical expenses (uninsured costs) and/or health insurance premiums qualify for reimbursement. Qualified expenses are those incurred by the employee or the employee and family. A copy of a receipt, statement or Explanation of Benefits (EOB) identifying the claimant, date of service, the amount of service, the name of the service provider and description of the service must accompany the Request for Reimbursement evidencing the expense as an expense applicable to uninsured medical expenses or health insurance premiums.

Dental – Only covered expenses of a dental nature qualify for reimbursement. However, cosmetic dentistry services are excluded. A copy of a receipt or statement from the dental provider identifying the claimant, date of service, amount of service, name of the service provider and description of the service must accompany the Request for Reimbursement evidencing the expense as a dental expense.

Orthodontia - Only covered expenses of an orthodontic nature qualify for reimbursement. However, cosmetic dentistry services are excluded. A copy of a receipt or statement from the dental/orthodontic provider identifying the claimant, date of service, amount of service, name of the service provider and description of the service must accompany the Request for Reimbursement evidencing the expense as a orthodontic expense.

Vision - Only covered expenses of a vision nature qualify for reimbursement. A copy of a receipt or statement from the vision provider identifying the claimant, date of service, amount of service, name of the service provider and description of the service must accompany the Request for Reimbursement evidencing the expense as a vision expense.

Prescription Medication – All prescription expenses that are prescribed by a licensed health provider and are processed through a licensed pharmacy are eligible under the Plan. Covered expenses may or may not apply to the health insurance plan. A copy of a pharmacy receipt must accompany the Request for Reimbursement evidencing the expense as a prescription pharmacy expense. Cash register receipts are not accepted and will be returned to the participant with a request for the pharmacy receipt.

Account Information

Each reimbursement check contains a summary of the claim processed including the claimant, date of service, amount processed and amount paid. If you have questions regarding your account or claim, contact our Customer Service Department at 800-422-4661.

Year End

Near the end of each Plan Year you will have an opportunity to re-enroll for the upcoming Plan Year. At this time your employer may change the parameters of the Plan. The three months following the end of the Plan Year are called the run out period. During this time, you may submit Requests for Reimbursement for expenses from the previous Plan Year if you have a positive balance. The Plan Year is officially closed three month following the end of the Plan Year, or sooner if directed by your employer.