2015
Public Employees Benefits Board (PEBB)
Flexible Spending Arrangement Enrollment Guide

How you can use your pre-tax earnings to pay for health care expenses
Table of Contents

Who is eligible and how can a Flexible Spending Arrangement (FSA) help me? ................................................................. 3

How does the FSA work? ................................................................................................................................. 3

When can I enroll? ........................................................................................................................................ 3

When does my enrollment begin? ................................................................................................................. 4

What are eligible health care expenses? ........................................................................................................ 4
  When is additional documentation required? .............................................................................................. 4
  Orthodontia .................................................................................................................................................. 5
  Stockpiling .................................................................................................................................................. 5
  Ineligible health care expenses ................................................................................................................. 5

How do I get reimbursed? ............................................................................................................................... 5
  Grace period .............................................................................................................................................. 6
  How do I receive information from Flex-Plan Services? ............................................................................ 6
  The Flexi-Card .......................................................................................................................................... 6
  Valid merchants ........................................................................................................................................ 6
  Using your Flexi-Card™ for OTC medicines and drugs ........................................................................ 7
  Additional cards ........................................................................................................................................ 7
  Grace period and the Flexi-Card™ ........................................................................................................... 7

When can I make changes? ............................................................................................................................. 7
  Approved leave of absence (also called Leave Without Pay) ................................................................. 8
  Transfers between state agencies and higher-education institutions ...................................................... 9
  Continuation coverage ............................................................................................................................. 10
  What happens if my employment terminates? ......................................................................................... 10

How do I appeal a denied claim? .................................................................................................................. 10

How to contact Flex-Plan Services
Business hours: Monday – Friday, 6 a.m. – 6 p.m., PST

Phone: 1-800-669-3539
Email: customerservice@flex-plan.com
Fax: 1-425-451-7002 or toll-free fax 1-866-535-9227
Mail: Flex-Plan Services, PO Box 53250, Bellevue, WA 98015
Who is eligible and how can a Flexible Spending Arrangement (FSA) help me?

The Health Care Authority (HCA) contracts with Flex-Plan Services, Inc. to manage the Flexible Spending Arrangement (FSA), also known as a Flexible Spending Account, to process claims, and provide customer service for Public Employees Benefits Board (PEBB) enrollees. The FSA is available to public employees eligible for PEBB benefits who work at state agencies, higher-education institutions, and community and technical colleges as described in Washington Administrative Code (WAC) 182-12-114. A link to WAC is available at [www.hca.wa.gov/pebb](http://www.hca.wa.gov/pebb) under PEBB Rules and Policies.

A Flexible Spending Arrangement is an employer-sponsored benefit that enables you to set aside money from your paycheck on a pre-tax basis to pay for your out-of-pocket health care costs. Here are some of the ways you can benefit from an FSA:

- Setting aside a portion of your pay with an FSA reduces your annual taxable income and helps you pay for out-of-pocket health expenses large and small.
- You can set aside as little as $240 or as much as $2,500 for the calendar year. The full amount you set aside for your FSA election is available on your first day of coverage for expenses.
- Your FSA helps you pay for deductibles, copays, coinsurance, dental, vision, and many other expenses. (See summary of eligible expenses on pages 4 and 5.)
- You can use your FSA for you, your spouse or qualified tax dependent's health care expenses, even if they are not enrolled in your PEBB medical or dental plan.

How does the FSA work?

- You estimate your expenses for the plan year and enroll in an FSA for that amount.
- The money deducted from your pay is divided by the number of paychecks you will receive in the plan year.
- Your election will be deducted from your paycheck throughout the plan year pre-tax, so you don’t pay FICA (7.65%) or federal income tax (10-35%) on your elected dollars.

You may not enroll in an FSA and enroll in a PEBB consumer-directed health plan (CDHP) with an HSA. You cannot cancel participation in the FSA once the plan year starts unless you terminate employment. In addition, you cannot change or revoke your election after the plan year starts unless you experience a “qualifying event.” Common qualifying events include birth, death, adoption, marriage, or divorce. Your election change must be consistent with the qualifying event. See “When can I make changes?” on page 7.

When can I enroll?

You may enroll in the FSA at the following times:

- No later than 31 days after the date you become eligible for PEBB benefits.
- No later than the last day of the PEBB annual open enrollment period, which is usually held in November.
- No later than 60 days after you or an eligible family member experiences a qualifying event that creates a special open enrollment during the plan year. See “When can I make changes?” on page 7.

For each new plan year, you must reenroll to participate in an FSA before the end of the PEBB annual open enrollment period. An FSA election is only valid for the plan year in which you enroll and does not continue automatically. See the enrollment form for instructions on where to submit your form. Some universities may require employees to submit their enrollment forms to their personnel, payroll, or benefits offices for processing.
When does my enrollment begin?

If you enroll during PEBB’s annual open enrollment period, which is usually held in November, your FSA is effective January 1, 2015 through December 31, 2015. If you enroll at any other time, enrollment begins the first of the month after Flex-Plan Services receives and approves your enrollment form.

What are eligible health care expenses?

The health care FSA covers a wide variety of expenses. We’ve assembled a list of common expenses that are eligible for reimbursement. Not all eligible items are on this list. For a more exhaustive list, go to [www.pebb.flex-plan.com](http://www.pebb.flex-plan.com). Items marked with an asterisk (*) are over-the-counter (OTC) medicines or drugs that require a prescription for reimbursement.

<table>
<thead>
<tr>
<th>Acne treatment*</th>
<th>Compression stockings</th>
<th>Incontinence supplies</th>
<th>Prescription glasses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>Contacts &amp; solutions</td>
<td>Individual counseling</td>
<td>Reading glasses</td>
</tr>
<tr>
<td>Allergy &amp; sinus medication*</td>
<td>Contraceptives</td>
<td>Insect bite treatment*</td>
<td>Respiratory Treatments*</td>
</tr>
<tr>
<td>Antacids*</td>
<td>Copays</td>
<td>Lab work</td>
<td>Saline nasal spray</td>
</tr>
<tr>
<td>Antibiotic ointment*</td>
<td>CPAP machine</td>
<td>Lactation consultant</td>
<td>Sleep aids &amp; sedatives*</td>
</tr>
<tr>
<td>Antifungal foot cream*</td>
<td>Crutches</td>
<td>Lactose intolerance pills*</td>
<td>Sleep deprivation treatment</td>
</tr>
<tr>
<td>Anti-gas medication*</td>
<td>Deductibles</td>
<td>Laser eye surgery</td>
<td>Smoking cessation products*</td>
</tr>
<tr>
<td>Anti-itch cream/gel*</td>
<td>Dental services</td>
<td>Laxative*</td>
<td>Smoking cessation programs</td>
</tr>
<tr>
<td>Antiseptic*</td>
<td>Diabetic supplies</td>
<td>Lice treatment products*</td>
<td>Speech therapy</td>
</tr>
<tr>
<td>Asthma treatment*</td>
<td>Diaper rash ointment*</td>
<td>Massage therapy</td>
<td>Sterilization procedures</td>
</tr>
<tr>
<td>Bandages/gauze</td>
<td>Digestive Aids*</td>
<td>Medical records</td>
<td>Stool softener*</td>
</tr>
<tr>
<td>Birthing classes or Lamaze</td>
<td>Drug addiction treatment</td>
<td>Motion sickness relief*</td>
<td>Thermometer</td>
</tr>
<tr>
<td>Blood pressure monitor</td>
<td>Ear wax removal kits</td>
<td>Nasal strips</td>
<td>Throat lozenges*</td>
</tr>
<tr>
<td>Braces (knee, ankle, wrist)</td>
<td>Eye drops</td>
<td>Naturopathic visits</td>
<td>Pain relievers*</td>
</tr>
<tr>
<td>Breast pump</td>
<td>Feminine anti-fungal/anti-itch*</td>
<td>Orthodontia</td>
<td>Physical exams</td>
</tr>
<tr>
<td>Burn cream*</td>
<td>Fertility treatment</td>
<td>Orthotics</td>
<td>Physical therapy</td>
</tr>
<tr>
<td>Chiropractic services</td>
<td>Flu shots</td>
<td>Oxygen and equipment</td>
<td>Vision care</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>Hearing aids &amp; supplies</td>
<td>Pregnancy test</td>
<td>Walker</td>
</tr>
<tr>
<td>Cold / hot pack</td>
<td>Hemorrhoid medication*</td>
<td>Prenatal vitamins</td>
<td>Wart treatment*</td>
</tr>
<tr>
<td>Cold sore treatment*</td>
<td>Hormone therapy</td>
<td>Prescription drugs</td>
<td>Wheelchair &amp; Repair</td>
</tr>
<tr>
<td>Cold/cough medication*</td>
<td>Immunizations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

When is additional documentation required?

Certain medical expenses are not reimbursable under a Health Care FSA unless a licensed health care practitioner states that the service or product is medically necessary. Flex-Plan Services will need a Letter of Medical Necessity (LMN) for these items to be reimbursed. The LMN is available on our website.

<table>
<thead>
<tr>
<th>Air conditioner</th>
<th>Breast reduction</th>
<th>Home medical equipment</th>
<th>Nutritionist expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Air purifier</td>
<td>Chronic disease self-management program</td>
<td>Humidifiers</td>
<td>Vitamins and supplements</td>
</tr>
<tr>
<td>Automobile modifications</td>
<td>(workshop and trainings)</td>
<td>Learning disability fees</td>
<td>Weight loss programs</td>
</tr>
<tr>
<td>Braille books</td>
<td>Cosmetic procedures</td>
<td>Lumbar support</td>
<td></td>
</tr>
<tr>
<td>Breast augmentation</td>
<td>Genetic testing</td>
<td>Mole removal</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Motorized scooter</td>
<td></td>
</tr>
</tbody>
</table>
Orthodontia expenses
Unlike other FSA expenses, which are deemed incurred when the services are rendered, orthodontia expenses are deemed incurred when paid. Therefore, only payments made during your eligibility period or plan year (whichever ends first) may be reimbursed. Proof of payment to an orthodontia provider or a completed Orthodontia Contract is required for reimbursement.

Stockpiling
IRS regulations prohibit you from purchasing a large quantity of any item in any one transaction. Buying more than three items would be considered stockpiling and will not be reimbursed.

Ineligible health care expenses
The following expenses are some that are not eligible under a health care FSA. Please do not submit claims for these items.

<table>
<thead>
<tr>
<th>Airborne</th>
<th>Electrolysis/laser hair removal</th>
<th>Hygiene products</th>
<th>Marijuana</th>
</tr>
</thead>
<tbody>
<tr>
<td>OTC immune support products</td>
<td>Finance charges</td>
<td>Imported OTC items</td>
<td>Massage chair</td>
</tr>
<tr>
<td>Books</td>
<td>Funeral expenses</td>
<td>Imported prescriptions</td>
<td>Mattress</td>
</tr>
<tr>
<td>COBRA premiums</td>
<td>Gym membership</td>
<td>Insurance premiums</td>
<td>Missed appointment fee</td>
</tr>
<tr>
<td>CPR classes</td>
<td>Hair growth products</td>
<td>Late fee</td>
<td>Teeth whitening</td>
</tr>
<tr>
<td>Electric toothbrush/picks</td>
<td>Hair transplant</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How do I get reimbursed?
Flex-Plan Services will send you claim forms when you enroll in the FSA. During the plan year, you may submit requests for reimbursement to Flex-Plan Services for expenses you have incurred.

Please remember:
- For each claimed expense, documentation must show the provider’s name, name of the person receiving the service or expense, date(s) of service, cost, and the type of expense or description of the service(s) you are claiming. You can use bills from your providers or statements from your insurance company as documentation. Do not submit copies of canceled checks or credit or debit card receipts.
- Documentation will not be returned.
- Expenses must be incurred during the plan year and while you are an active participant in the plan.
- Flex-Plan Services will not reimburse any expenses that were incurred before your effective date of enrollment.
- An expense is “incurred” when the health care is provided or the eligible item is purchased – not when you are billed, charged, or when you pay for the medical care.

Flex-Plan Services offers several convenient ways to submit your claim and documentation. Choose one of the following:
- **Online** at [www.pebb.flex-plan.com](http://www.pebb.flex-plan.com) (you will need to create a log in and password)
- **Fax** to 425-451-7002 or toll-free 1-866-535-9227
- **Email**: claims@flex-plan.com
- **Mail** forms and documentation to: Flex-Plan Services, Inc., PO Box 53250 Bellevue, WA 98015-3250
- **Mobile App**: you can submit a claim through their Flexi App, available on both Google Play and the App Store. You can find the app by searching *Flexi App* or *Flex-Plan Services*.

Flex-Plan Services will process your claim within a few days and either make an electronic funds transfer into your bank account if you enrolled in direct deposit, or mail you a reimbursement check.
Flex-Plan Services will provide you with a quarterly statement that shows your account balance. It is important to read these statements carefully so you understand the balance remaining to pay for eligible expenses. Remember, all services should be incurred either by the end of the plan year or before the end of the grace period.

Grace period

The FSA falls under the “use it or lose it” rule. This means you must incur services by March 15 of the following plan year and use all elected funds by the end of that grace period. You must submit your claims to Flex-Plan Services no later than March 31, 2016. After March 31, 2016 you forfeit any money left in your account to the plan administrator, the Health Care Authority. Once the money is forfeited, you will not be able to claim it.

If you reenroll in the following plan year, any claims incurred during the grace period (January 1, 2016 - March 15, 2016) will be applied to any unused funds from the 2015 plan year first.

How do I receive information from Flex-Plan Services?

You can choose your method of communication. For example, if you provide an email address, statements and other communications will be sent automatically to your email until you change your method of communications or opt-out of electronic correspondence.

The Flexi-Card™

The Flexi-Card is a convenient way to pay for eligible out-of-pocket medical expenses for you, your spouse, and your qualified tax dependents. Rather than filing a claim and waiting for reimbursement for your out-of-pocket eligible expenses, you may be able to use the Flexi-Card™ to pay your provider directly.

Valid merchants

The card is accepted at participating merchants using the Inventory Information Approval System (IIAS) and at medical care merchants using the MasterCard® system. This includes:

- Most provider offices
- Dental and vision clinics
- Hospitals
- Mail order Rx programs
- Pharmacies and grocery stores*

*Merchants that have implemented IIAS recognize when participants purchase FSA-eligible expenses. For a list of IIAS participating retailers please visit [http://pebb.flex-plan.com](http://pebb.flex-plan.com) and select IIAS Merchants. When you use your Flexi-Card™ at these merchants you will not be required to submit a claim form or provide documentation for your eligible expense.

Each time you swipe your Flexi-Card™, the provider receives payment and the expense is deducted from your FSA balance. When you use your card for a copayment or at an IIAS retailer, you typically will not be required to substantiate--provide documentation--of your charge. This system allows Flex-Plan Services to electronically verify the eligibility of your expense.

The debit card is a feature that allows participants to use their funds directly out of their FSA, without paying out of pocket or waiting for a reimbursement check. However, the IRS has stringent regulations about where the debit card can be used and when follow-up documentation is required for transactions that can’t be verified electronically. Using the debit card does not eliminate the need to submit follow-up documentation if requested by Flex-Plan Services.
If any of your Flexi-Card™ charges require substantiation, you will receive a summary of your card activity for those charges. Flex-Plan Services will notify you, at the beginning of each month of any transactions that require substantiation. You must provide a valid email address in order to receive the Flexi-Card™ when you enroll.

We recommend you always save your receipts and documentation.

Using your Flexi-Card™ for OTC medicines and drugs

The Flexi-Card™ will not work for purchases of OTC medicines and drugs. To be reimbursed for OTC medicines and drugs, choose one of the following methods:

**Manually**
Submit a prescription along with your claim to Flex-Plan Services in order to be reimbursed for any OTC medications. The receipt or documentation from the store must include the name of the drug printed on the receipt. This information must be provided by the store, not just listed by the participant on the receipt or on the claim form.

**Flexi-Card™**
If you have your prescription on hand, then you can use your Flexi-Card™ at the pharmacy. Show the prescription to the pharmacist and he or she will process your OTC transaction as a prescription drug instead of an OTC medicine or drug. This will not affect the cost of the OTC item, but treat it as a prescription for eligibility purposes. If these steps are taken, the item will be considered fully substantiated at the point of sale and no further documentation will be required.

Additional cards
You may request a Flexi-Card™ when you enroll or through the Flex-Plan website. You may request a second card at no cost. After that, each additional card ordered will incur a $5 fee. If your cards are lost or stolen, Flex-Plan Services charges a $5 fee to replace the card. Fees are deducted from your FSA balance.

Grace period and the Flexi-Card™
If you use your Flexi-Card during the grace period and have a balance available in the previous plan year, your expense will be deducted from that older balance first. Once the balance from a previous plan year is exhausted, the expense will then be deducted from the available balance in your current plan year.

When can I make changes?
Changes require approval by Flex-Plan Services and must follow the rules in Washington Administrative Code 182-08-199. You cannot change or revoke your election after the plan year starts unless you experience a “qualifying event.” The change in enrollment must be allowed under Internal Revenue Code (IRC) and correspond to and be consistent with the event that creates the special open enrollment. If an event occurs and you wish to make a change, you must complete and submit the required forms along with evidence of the event that created the special open enrollment, to your employer no later than 60 days after the event. Forms can be found at [www.hca.wa.gov/pebb](http://www.hca.wa.gov/pebb).

The following events create a special open enrollment for eligible employees who want to make a change to their FSA:

A. Employee acquires a new dependent due to:
   - Marriage;
   - Registering a domestic partnership if the domestic partner qualifies as a tax dependent;
• Birth, adoption, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption;
• A child becoming eligible as an extended dependent through legal custody or legal guardianship; or
• A child becoming eligible as a dependent with a disability.

B. Employee's dependent no longer meets PEBB eligibility criteria due to:
• A change in marital status;
• Dissolution of a domestic partnership, when the domestic partner qualified as a tax dependent;
• A dependent losing eligibility as an extended dependent or as a dependent with a disability;
• A dependent child turning age 26; or otherwise no longer meeting dependent child eligibility; or
• A dependent dies.

C. Employee or the employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);

D. Employee or an employee's dependent has a change in employment status that affects the employee's or a dependent's eligibility for the FSA.

E. A court order or a National Medical Support Notice requires the employee or any other person to provide insurance coverage for an eligible dependent of the employee.

F. Employee or an employee's dependent becomes entitled to or loses eligibility for coverage under Medicaid or a state Children's Health Insurance Program (CHIP).

G. Employee or an employee's dependent becomes entitled to or loses eligibility for coverage under Medicare.

Approved Leave of Absence (also called Leave Without Pay)

You may elect to continue your FSA participation while you are on an approved leave of absence because of one of the following events:
• You are on authorized leave without pay from your agency;
• Your employment ends due to a layoff;
• You are an employee who reverted to a position that is not eligible for the employer contribution toward insurance coverage;
• You are an employee appealing a dismissal action;
• You are receiving time-loss benefits under workers’ compensation;
• You are applying for disability retirement;
• You are called to active duty in the uniformed services, as defined under the Uniformed Services Employment and Reemployment Rights Act (USERRA);
• You are on approved educational leave;
• You are a faculty employee who is between periods of eligibility; or
• You are a seasonal employee during an off season.

If your employer has approved a leave of absence and you will have at least eight hours of pay status as an employee in a given month (or at least 5 percent of full-time for faculty) you may continue your FSA by making FSA contributions to your employer:
• Pay your contributions during the leave to your payroll office, or
• Pre-pay your contributions before you go on leave through your employer.
If you are not using at least eight hours of pay status (or at least 5 percent of full-time for faculty) to maintain your benefits, the PEBB Continuation of Coverage Election Notice will be sent to you and you may elect to continue your PEBB health insurance coverage by self-paying the full premium (LWOP coverage). You may also continue your FSA contributions on a post-tax basis by making FSA contributions to Flex-Plan Services as follows:

- Pay your contributions during the leave directly to Flex-Plan Services, or
- Pre-pay your contributions to Flex-Plan Services before you go on leave. If you select this option, you must arrange this before going on leave by completing the Flex-Plan Change in Status Form, available at www.pebb.flex-plan.com or by calling Flex-Plan services at 1-800-669-3539.

If you are taking a leave of absence that qualifies as an approved Family Medical Leave Act (FMLA) or Uniformed Services Employment and Reemployment Rights Act (USERRA, or military) leave, you may cease all or a portion of required contributions consistent with the requirements of the FMLA or USERRA. This choice will not affect your ability to continue enrollment in PEBB’s other benefits (as provided by PEBB rules).

If you choose to discontinue contributions during the approved FMLA or USERRA leave, upon your return you may elect to:

- Resume participation at the same amount elected at the start of the plan year, with a corresponding increase in contributions for the balance of the plan year; or
- Participate at a reduced amount for the plan year, and resume the per-pay period contribution in effect before the FMLA or USERRA leave.

Important: If you are unable to pay your contributions in full while on approved FMLA or any other benefit eligible leave; you can continue to submit claims for reimbursement for that period. For example, if you are on a benefit eligible leave in September and do not submit your FSA contributions, claims incurred during that month can be submitted for reimbursement. Your future contributions should be recalculated to make sure they meet your annual election total by the end of the plan year.

If you are ineligible for benefits, while on leave, you will not be able to claim services incurred during your leave of absence.

To resume your FSA, you must fill out and send the Flex-Plan Change in Status Form to Flex-Plan Services no later than 60 days after returning to work. If you submit your form more than 60 days after returning to work, Flex-Plan Services will deny your request.

Transfers between State Agencies and Higher-Education Institutions

If you enroll in an FSA and later change jobs and move to another Washington State agency, higher-education institution, or community or technical college that offers PEBB benefits, your enrollment will continue if:

- Your new position is eligible for participation in the PEBB FSA;
- There is no more than 30 days’ lapse in employment; and
- You notify your new personnel, payroll, or benefits office and Flex-Plan Services of your transfer to avoid unnecessary interruptions before the end of the current plan year. Your per-paycheck deductions will increase, if necessary, to meet the annual contribution amount by the end of the plan year.

If your transfer situation satisfies one of the above guidelines, please complete an Agency Transfer Form and submit it to your benefits office for approval and signature within the 30-day period. Your employing agency must submit it to Flex-Plan Services for processing.
Note: An agency transfer is not a qualifying event to change your health plan. You may not participate in an FSA and enroll in a PEBB consumer-directed health plan (CDHP) with an HSA.

Continuation Coverage (including COBRA and Leave without Pay)
A participant, his or her spouse, or qualified tax dependent may choose to continue the FSA if one or more of the following qualifying events occur:

- Death of the participant;
- Termination of the participant’s employment (other than for gross misconduct) or a reduction in hours;
- Divorce of the participant; or dissolution or termination of a state-registered domestic partnership with a domestic partner who qualified as a tax dependent; or
- A dependent child loses eligibility for PEBB coverage.

When any of these occur, you or a family member must notify Flex-Plan Services. If, on the date of the qualifying event, your remaining benefits for the current year are greater than your remaining contribution payments, Flex-Plan Services will give each eligible family member the right to choose FSA continuation coverage. Each person who elects FSA continuation coverage through Flex-Plan Services must do so no later than 60 days from the date Flex-Plan Services provides the notice of this continuation right.

FSA continuation coverage will not extend beyond the current plan year, but may end earlier if you do not pay your contributions within 30 days of the due date. Flex-Plan Services cannot reimburse you for expenses incurred during any period of continuation until Flex-Plan Services receives your contributions for that period.

What happens if my employment terminates?
An FSA is an employee benefit, so except as noted in the section When Can I Make Changes, when your employment ends, or you go on unpaid leave that is not approved FMLA or military leave, you can no longer contribute to your FSA. This means that your participation ends on the last day of the month in which Flex-Plan Services received your last contribution. You will only be able to claim expenses, up to your available funds, incurred while employed unless you are eligible to continue coverage (WAC 182-12-133). Except as stated in the section Continuation Coverage (including COBRA and Leave without Pay), Flex-Plan Services will not reimburse any expenses incurred while you were not actively enrolled in an FSA.

If you cease employment during the plan year, contact your personnel, payroll, or benefits office to find out if you can request some of these options:

- Stop: Your final paycheck will have the normal deduction and your participation will cease. You may be reimbursed only for services incurred on or before the termination date.
- Accelerate: You can authorize your employer to take future deductions from your final paycheck only. This final deduction will be pre-tax and you can participate in the plan to the extent contributions are made.
- COBRA: Under certain circumstances, you may be eligible to continue participation through Flex-Plan Services on an after-tax basis through COBRA. (See Continuation Coverage –including COBRA and Leave without Pay above.)

How do I appeal a denied claim?
You will receive written notice of any denied claims within seven days of receipt of the claim. The notification will include the reasons for the denial, a description of any additional information needed to process the claim, and an explanation of the claims review procedure. You may resubmit your claim to Flex-Plan Services with additional information no later than March 31, 2016. If you wish to file an appeal, Flex-Plan Services must receive your appeal no later than 30 days from the date the denial was issued.
Your appeal must include:
- A statement outlining why you think your request should not have been denied
- Your employer’s name
- The date(s) of the services denied
- A copy of your original claim
- A copy of the denial letter you received
- Any additional documents or information that supports your appeal

Flex-Plan Services will send you a written notice of the resolution of your appeal within 30 days. Appeals are approved only if the extenuating circumstances and supporting documentation are within IRS regulations and the document that governs the PEBB FSAs.

To file a first-level appeal with Flex-Plan Services, use one of the methods below:

Email: claims@flex-plan.com
Fax: 1-425-451-7002 or 1-866-535-9227
Mail: Flex-Plan Services, P.O. Box 53250, Bellevue, WA 98015

If you receive a denial of your appeal from Flex-Plan Services and you disagree with that decision, you may submit a second-level appeal to the PEBB Appeals Committee as described in Washington Administrative Code (WAC) 182-16-036. A link to WAC is available at [www.hca.wa.gov/pebb](http://www.hca.wa.gov/pebb) under PEBB Rules and Policies.

You must file both first-level and second-level appeals by submitting a written request by email, fax, or mail. Indicate in the appeal whether it is a first-level or second-level appeal.

To file a second-level appeal with the PEBB Program, the PEBB appeals manager must receive your appeal no later than 30 days after the date of the Flex-Plan Services decision on your appeal. Include a copy of the denial notice you received from Flex-Plan Services with your appeal along with any supporting documentation. You may complete and submit the Request for Review/Notice of Appeal form with your appeal, which is available at [www.hca.wa.gov/pebb](http://www.hca.wa.gov/pebb). You may send the appeal to:

PEBB Appeals  
Attn: Appeals Manager  
Health Care Authority  
P.O. Box 42699  
Olympia WA 98504-2699

You also may submit the appeal by email to pebappeals@hca.wa.gov or fax to 360-725-0771.

If the PEBB Appeals Committee affirms Flex-Plan Services’ denial and you disagree with that decision, you may request a review by Administrative Hearing as described in WAC 182-16-050. The PEBB appeals manager must receive your written request for an administrative hearing no later than 30 days after the date of the PEBB Appeals Committee’s decision on your appeal. To request an administrative hearing, submit a letter to the address listed above.