

FLEXIBLE BENEFITS PLAN CLAIM FOR REIMBURSEMENT

Your Employer's Name: _____

Your Full Name: _____

Your Social Security Number: _____

LIMITED PURPOSE HEALTH FSA EXPENSE CLAIMS

Only Use This Form If You Also Participate In A Health Savings Account (HSA)

PLEASE LIST EACH EXPENSE ON A SEPARATE LINE IN THE TABLE BELOW. SIGN THE FORM AND ATTACH APPROPRIATE DOCUMENTATION. USE MULTIPLE FORMS AS NEEDED TO RECORD ADDITIONAL EXPENSE ITEMS.

Mark the Box Describing Whether or Not You Paid Each Medical Expense Using Your Benefits Debit Card	Date Medical Expense Incurred	<u>DENTAL & VISION CARE ONLY</u> Expense Description & Merchant or Provider's Name <i>(i.e., Glasses – LensCrafters; Braces – Dr. Jones, etc.)</i>	Amount on Debit Card or Other Receipt if Debit Card Not Used	Put <input checked="" type="checkbox"/> below if this is Recurring **
<input type="checkbox"/> Paid with Benefits Card <input type="checkbox"/> NOT Paid with Card			\$ _____	<input type="checkbox"/>
<input type="checkbox"/> Paid with Benefits Card <input type="checkbox"/> NOT Paid with Card			\$ _____	<input type="checkbox"/>
<input type="checkbox"/> Paid with Benefits Card <input type="checkbox"/> NOT Paid with Card			\$ _____	<input type="checkbox"/>
<input type="checkbox"/> Paid with Benefits Card <input type="checkbox"/> NOT Paid with Card			\$ _____	<input type="checkbox"/>
<input type="checkbox"/> Paid with Benefits Card <input type="checkbox"/> NOT Paid with Card			\$ _____	<input type="checkbox"/>
<input type="checkbox"/> Paid with Benefits Card <input type="checkbox"/> NOT Paid with Card			\$ _____	<input type="checkbox"/>

** An expense is considered recurring if you will use your card to pay the identical expense to the same provider on a regular basis throughout the year.

Attach Documentation For Every Expense – Incomplete Forms Will Be Rejected – See Back Of Form

I certify that: 1) each of the above medical care expenses are for services provided while I was covered under the Medical Care Flexible Spending Account, 2) all medical expenses listed above have not been reimbursed or are not reimbursable from any other source, and 3) all expenses were incurred for the medical care of me, my spouse or qualified dependent. I acknowledge that I am fully responsible for the accuracy and veracity of all information relating to this claim. If an expense for which I am reimbursed is later disallowed by the Internal Revenue Service, I understand that I will be liable for payment of any related income or payroll taxes relating to such improper expense reimbursement.

Employee's Signature _____ Date _____

PLEASE MAKE A COPY OF ALL DOCUMENTATION PRIOR TO SENDING TO ADMIN AMERICA



Fax Claims: 770-992-0723
NEW - Mail Claims:
 Admin America
 P.O. Box 1209
 Alpharetta, GA 30009

Phone: 770-992-5959 or 1-800-366-2961
Email: claims@adminamerica.com
24 Hour Account Information Via The Internet: www.adminamerica.com
(click on Flex Plan Participants)



IMPORTANT INFORMATION ABOUT FILING CLAIMS

ELIGIBLE MEDICAL EXPENSES

In order for any expense to be eligible for reimbursement under this Limited Purpose Health FSA, the expense must both: 1) meet the normal eligibility rules for reimbursement under a traditional unrestricted Health FSA, and additionally 2) must be limited to expenses for services related to vision or dental care. This typically means that deductibles, co-insurance amounts, co-pays for office visits and prescription drugs are not reimbursable by this Limited Purpose Health FSA.

In order for an expense to be eligible under a traditional unrestricted Health FSA, the expense must pass several tests:

1. PRIMARY PURPOSE TEST

Was the primary purpose for incurring the medical expense for the prevention or alleviation of a health or body condition? Was the treatment specific to the medical condition rather than for general physical improvement or general well being? A response of “**no**” to any one question would render the expense **ineligible**.

2. “BUT FOR” TEST

Would the medical expense have been incurred “but for” the disease or illness? Would you have done it (incurred the expense) anyway? In other words, would you have been treated even if you did not have the specific medical condition, disease or illness? A response of “**yes**” to any one of these questions would render the expense **ineligible**.

3. REASONABLENESS TEST

Is the medical expense reasonable? Is the entire expenditure for the treatment of a medical condition and not partially or totally for personal, living, or family expenses? A response of “**no**” to either of these questions would render the expense **ineligible**.

Whether or not an expense is eligible will not always be clearly defined in the regulations. That determination will occasionally be very complex. You are always welcome to call Admin America to get a specific determination over the telephone before you submit your claim.

CLAIM DOCUMENTATION

The IRS requires that all expenses be substantiated. That is, you must provide documentation that proves you or one of your dependents incurred the expense during the respective plan year. If you do not attach acceptable documentation, your claim will be returned to you. Below are some of the ways to document your expenses according to IRS rules.

- In general, for documentation of medical expenses to be acceptable, health services must be described or identified, the date the expense was incurred (i.e., goods or services were received) must be evident and the out-of-pocket expense you are responsible for must be stated clearly.
- Good documentation for most expenses is an Explanation of Benefits (EOB) from your insurance company.
- Unacceptable forms of documentation for medical expenses include copies of checks, credit card receipts (unless also accompanied by additional documentation) and billing statements showing only a prior balance.

CLAIM RETURN POLICY

If you submit a claim for an ineligible expense, for a time when you were not enrolled in the plan, with insufficient documentation, etc., Admin America will return the claim to you by mail, fax or email. If the claim is denied for insufficient documentation, we will include an explanation of what documentation you must provide before your claim can be processed. When we receive your properly documented claim, it will be adjudicated within 2-3 business days. If you are due a reimbursement check, it will be issued on the next date we normally process checks for your group.

END OF THE YEAR REIMBURSEMENT AND GRACE PERIOD

The timing of your expenses is very important and determines the Plan Year period from which your expense is reimbursable. For medical expenses to be reimbursable from a specific Plan Year’s account, you must incur the expense within the defined Plan Year period or during the Grace Extension (if any) established for your Plan. An expense is considered “**incurred**” when services are received, not when you pay for the services.

Your flexible benefits plan may allow up to 90 days after the end of the Plan Year to submit claim documentation for a respective Plan Year’s Flexible Spending Account.

Please refer to your **Summary Plan Description** for the specific plan year, grace period (if any) and other important information regarding your plan.

Please contact Admin America with any questions you may have regarding how your plan operates.