

## VOUCHER INSTRUCTIONS

Health FSA claims will be reimbursed up to the amount elected for the Plan year. Dependent Care claims will be reimbursed according to the amount available in your account at the time your claim is processed.

**CLAIMS MUST BE RECEIVED BY 12:00 P.M. (Noon) Pacific Time- ON WEDNESDAY TO BE PROCESSED THE FOLLOWING MONDAY.**

The statement you receive when the service was provided or an Insurance Company Explanation of Benefits must accompany all Health FSA vouchers. Only expenses properly verified will be reimbursed.

Use the following list as your guide for acceptable and unacceptable documentation for Health FSA expenses.

**Acceptable Documentation** to accompany the Health FSA Reimbursement Voucher:

1. Bill or Receipt that includes:
  - a. Provider of Service
  - b. Type of Service Rendered
  - c. Original Date of the Service
  - d. Charges for the Service; and/or
2. Insurance Company Explanation of Benefits; and/or
3. Pharmacy statement that includes the **name of the prescription**, date of purchase, and amount charged.
4. Cash Register receipts which include the name of the item requesting reimbursement for.

**\*\*Please send COPIES of documentation (as listed above). Keep originals for your records. Faxing your claims will expedite the reimbursement process.**

**Unacceptable Documentation:**

1. Cancelled checks
2. Bill or receipt showing a balance forward or a previous balance
3. Cash Register and/or Credit Card Receipts which do not reflect the name of the item claiming.

### **PLEASE NOTE**

Dependent Care vouchers **must** include the provider's Tax Identification Number or Social Security Number and names and ages of covered dependents.

Orthodontia expenses **must** be submitted with a completed Acordia Orthodontia Contract, and the statement from the provider.

**It is important to note that the date of the service, NOT THE DATE OF PAYMENT, must fall within the dates of the plan year for which you are enrolled.**

## Eligible Health Care Expenses

<p>Acupuncture (excludes remedies and treatments prescribed by acupuncturist)</p> <p>Alcohol and Drug Rehabilitation</p> <p><b>Ambulance</b></p> <p>Artificial Limbs and Teeth</p> <p>Birth Control Pills</p> <p>Chiropractor</p> <p>Christian Scientist Practitioners</p> <p>Co-payments</p> <p>Crutches</p> <p>Deductibles</p> <p>Dental Fees, Oral Surgery</p> <p>Dentures</p> <p>Diagnostic Fees</p> <p>Eye Exam, Prescription Eye Glasses, Contact Lenses, Contact Lens Solution, Enzyme Cleaners</p> <p>Eye Surgery (LASIK, Cataracts, etc.)</p> <p>Gynecologist</p> <p>Hearing Devices and Batteries</p> <p>Hospital Bills</p> <p>Insulin</p> <p>Laboratory Fees</p> <p>Lip Reading Lessons</p> <p>Medical Examinations</p>	<p>Midwife</p> <p>Nursing Care</p> <p>Optometrist</p> <p>Orthodontia Expenses (as treatment is provided) *</p> <p>Orthopedic devices</p> <p>Over the Counter Medications**</p> <p>Oxygen</p> <p>Pediatrician</p> <p>Physical Therapy (provided by a Licensed Therapist with proof of Medical Necessity)</p> <p>Physician (M.D. or D.O.) Fees</p> <p>Podiatrist</p> <p>Prescription Drugs</p> <p>Psychiatrist</p> <p>Psychologist</p> <p>Rental or Purchase of Medical Equipment (including special Equipment for handicapped Persons)</p> <p>Surgery (other than cosmetic, unless deemed medically necessary)</p> <p>Transportation Expenses relative to Illness</p> <p>Obstetrics</p>
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## Eligible Over-the-Counter Expenses

<p><b>Antiseptics</b></p> <p>Antiseptic wash or ointment for cuts or scrapes</p> <p>Benzocaine swabs</p> <p>Boric Acid powder</p> <p>First aid wipes</p> <p>Hydrogen Peroxide</p> <p>Iodine tincture</p> <p>Rubbing Alcohol</p> <p>Sublimed Sulfur powder</p> <p><b>Asthma Medications</b></p> <p>Bronchodilator/Expectorant tablets</p> <p>Bronchial asthma inhalers</p> <p><b>Cold, Flu, and Allergy Medications</b></p> <p>Allergy medications</p> <p>Cold relief syrup</p> <p>Cold relief tablets</p> <p>Cough drops</p> <p>Cough syrup</p> <p>Flu relief tablets or liquid</p> <p>Medicated chest rub</p> <p>Nasal decongestant inhaler</p> <p>Nasal decongestant spray or drops</p> <p>Nasal strips to improve congestion</p> <p>Sinus &amp; allergy homeopathic nasal spray</p> <p>Sinus medications</p> <p>Vapor patch cough suppressant</p>	<p><b>Diabetes</b></p> <p>Diabetic lancets</p> <p>Diabetic supplies</p> <p>Diabetic test strips</p> <p>Glucose meters</p> <p><b>Ear/Eye Care</b></p> <p>Airplane ear protection</p> <p>Ear drops for swimmers</p> <p>Ear water-drying aid</p> <p>Ear wax removal drops</p> <p>Homeopathic earache tablets</p> <p>Contact lens solutions</p> <p><b>Health Aids</b></p> <p>Antifungal treatments</p> <p>Denture adhesives</p> <p>Diuretics and water pills</p> <p>Hemorrhoid relief</p> <p>Incontinence supplies</p> <p>Lice control</p> <p>Medicated bandages</p> <p>Motion sickness tablets</p> <p>Respiratory stimulant ammonia</p> <p>Sleeping aids</p>	<p><b>Pain Relief</b></p> <p>Arthritis pain reliever</p> <p>Bunion and blister treatments</p> <p>Itch relief</p> <p>Orajel</p> <p>Pain relievers, aspirin and non-aspirin</p> <p>Throat pain medications</p> <p><b>Personal Test Kits</b></p> <p>Cholesterol tests</p> <p>Colorectal cancer screening tests</p> <p>Home drug tests</p> <p>Ovulation indicators</p> <p>Pregnancy tests</p> <p><b>Skin Care</b></p> <p>Acne medications</p> <p>Anti-itch lotion</p> <p>Bunion and blister treatments</p> <p>Cold sore and fever blister medications</p> <p>Corn and callus removal medications</p> <p>Diaper rash ointment</p> <p>Eczema cream</p> <p>Medicated bath products</p> <p>Wart removal medications</p>	<p><b>Stomach Care</b></p> <p>Acid reducers</p> <p>Antacid gum</p> <p>Antacid liquid</p> <p>Antacid tablets</p> <p>Anti-diarrhea medications</p> <p>Gas prevent food enzyme dietary supplement</p> <p>Gas relief drops for infants and children</p> <p>Ipecac syrup</p> <p>Laxatives</p> <p>Pinworm treatment</p> <p>Prilosec</p> <p>Upset stomach medications</p>
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\*We cannot accept a claim for the entire contracted amount. We will accept claims for the initial down payment usually associated with the appliances. Monthly payments will also be accepted as the charge for the medical services rendered for that month.

\*\*Only those medications used to treat a medical condition, illness, or disease. Items used for the general health of an individual are not eligible under this Plan.

**Over the counter medications must also be purchased in a quantity consistent with the illness that is being treated- "Bulk" purchases of OTC items will not be covered!**

\*\*\*Plan restrictions may apply



## Acordia Dependent Care Assistance Program (DCAP)

### **Why should I participate in a DCAP when I can take the dependent care credit on my annual tax return?**

If your family income is over \$30,000, you will most likely benefit from this plan rather than taking advantage of the current income tax credit. For your personal tax savings, please check with your tax consultant.

### **Can I change my contribution amount during the Plan Year?**

Only if you have a change-in-status, such as: marriage, birth, adoption, or a change in your or your spouse's employment status. Please see your administrator for more information on the change-in-status rules.

### **What DCAP restrictions are there?**

"Dependent" refers to a dependent under the age of 13, or a mentally or physically disabled dependent of any age, Dependent Care Expenses must be incurred to allow an employee to work or attend school, If married, the employee must work and the spouse must work or attend school full time, \$5,000 maximum contribution per calendar year unless you are married and are filing separate returns in which case the maximum contribution is \$2,500 per calendar year, Dependent care facility, if required, must be State Licensed, Services for care cannot be provided by a dependent, Pre-taxing dependent care precludes you from taking the after-tax child care credit on your annual income tax, Services must be *incurred* during the current plan year or portion of year in which an employee is enrolled, regardless as to when the services were paid for.

### **What expenses are considered not eligible for reimbursement?**

The following list of expenses would not be considered eligible dependent care expenses:

<p><b>KINDERGARTEN FEES</b></p> <p>Elementary School Expenses (For child In First Grade or Higher)</p> <p>Food Transportation Overnight Camp Fees</p>	<p>Incidental Expenses (diapers, activities, etc.) Housekeeper, Maid, Cook Mass transit and Parking Entertainment Expenses Day Care Expenses for Child 13 Yrs or older, unless Physically or Mentally incapable of caring for self. Expenses incurred outside of the participating plan year.</p>
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### **How do I get reimbursed for my expenses?**

Once you have completed the enrollment form, you will receive all necessary forms and instructions on how to file your claim. Simply complete the claim form, have your dependent care provider sign the acknowledgement form, and mail or fax the forms to Acordia. Provided there are funds in your account, you will receive your reimbursement via a check mailed to your home address or direct deposit within 5-10 business days.

### **Do I have to wait for my contributions to be deposited into my account in order to make a claim for reimbursement?**

Yes. The amount available to you for reimbursement is the amount you have contributed to date.

### **What happens to my contributions if I do not incur enough qualified expenses, or neglect to file a claim in the time specified in my SPD?**

Should you not incur enough qualified expenses or neglect to file a claim, you will forfeit any amount contributed to your DCAP account. Also, any DCAP reimbursements that are unclaimed (for example, checks that have not be cashed) by the close of the Plan Year will be forfeited to the Plan. For this reason, please be conservative when estimating your dependent care expenses.

### **What if I terminate employment for any reason?**

You will be able to request reimbursement for dependent care expenses that you incurred to the end of the current employer plan year. Please see your SPD for information on claim filing time limits.

**Dependent Care Assistance Program Reimbursement Voucher**

**Employer:** \_\_\_\_\_ **Employee ID#** \_\_\_\_\_

**Name of Employee (Last, First, M.I.):** \_\_\_\_\_ **Daytime Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

{ } CHECK HERE IF THIS IS A NEW ADDRESS

<u>Name of Dependent(s)</u>	<u>Age of Dependent(s)</u>
_____	_____
_____	_____
_____	_____

**Dependent Care Provider Information:**

Name of Dependent Care Center or Individual Provider	Tax I.D. or Social Security #
Address City State	Zip Code
Period Covered From: To:	Amount Charged
Provider Signature	← Attach a receipt from your dependent care provider, OR include the providers signature

**DEPENDENT CARE EXPENSES:** Dependent Care Expenses will not be reimbursed without a complete form. When a Voucher is received, we reserve the right to request the original expense documentation or further information at anytime. We may not reimburse an expense until the requested documentation is received. Please do not send the originals unless requested.

**NOTE: THE DEPENDENT CARE PROVIDER'S NAME, ADDRESS AND TAX I.D. MUST BE INCLUDED ON YOUR ANNUAL INCOME TAX RETURN BY COMPLETING SCHEDULE 2 OF FORM 1040A OR FORM 2441. EMPLOYEE MAY NOT USE DEPENDENT CARE EXPENSES REIMBURSED UNDER THIS PLAN FOR DEPENDENT DAY CARE TAX CREDIT PURPOSES**

**I HEREBY CERTIFY** that the expense(s) shown above are for dependent care expenses that have been incurred for the main purpose of allowing my spouse and I to work (or allowing my spouse to be currently seeking employment or attending school full time), and not for educational purposes. I have read and understand what expenses are eligible for reimbursement under the plan. The listed expenses have not been, and will not be paid or reimbursed by any other source. I understand that any amounts not used for qualified expenses by the end of the plan year will be forfeited to the plan.

\_\_\_\_\_ Date Signed

\_\_\_\_\_ Signature of Employee

Phone: 800-257-4860  
 Fax: 800-231-3213

# ACORDIA HEALTH FSA ORTHODONTIA CONTRACT

Name of Employer: \_\_\_\_\_

Name of Employee (Last, First, M.I.): \_\_\_\_\_

Employee ID #: \_\_\_\_\_

Name of Patient: \_\_\_\_\_

## Orthodontia Provider Information:

Name of Provider: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Contract Period Covered:  
Begin: \_\_\_\_\_ End: \_\_\_\_\_

<b>Total Contract Amount Charged</b> \$	Down Payment Amount \$	Monthly Charges \$ per month
Provider Signature		← Attach a copy of your contract from your Orthodontia provider, OR include the providers signature

**\*\*Services must be incurred prior to reimbursement. You are only eligible for reimbursement for dates of service within the plan year. You must submit this form along with your Health FSA Claim Voucher each time you wish to be reimbursed for your expenses.**