

CLAIM FOR REIMBURSEMENT

Employer Name: _____ Preferred Email Address _____ Change in Email Address yes no
 Employee Name: _____ Employee Social Security #: _____
 Employee Address: _____ Change in Address yes no

UNREIMBURSED MEDICAL EXPENSE CLAIMS

A	B	C	D	E	F
Line	Date Expense Incurred (Date of Service)	Expense Amount Claimed	Detailed Description of Expense	Person for Whom Expense Incurred (self, spouse, etc.)	Name of Service Provider
1		\$			
2		\$			
3		\$			
4		\$			
5		\$			
6		\$			
7		\$			
8		\$			
	Total Medical Expense Claim	\$			

DEPENDENT DAY CARE EXPENSE CLAIMS (If Applicable)

A	B	C	D	E	F		G	
Line	Period Covered (mo/day/yr.) From To	Expense Amount Claimed	Name of Daycare Provider	Dependent Who Received Service (self, spouse, etc.)		Provider Certification		Tax ID# of Provider
				Age	Name	Amount	Signature	
1		\$				\$		
2		\$				\$		
	Total Daycare Expense Claim	\$						

I, the undersigned participant in the Plan, certify that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while I was covered by the Company's Plan with respect to such expenses and that the expenses have not been reimbursed, or are not reimbursable, from any other source. By signing this form, I certify that the expenses claimed for medical expense reimbursement or payment are eligible for reimbursement under the Plan, and were incurred for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. I also certify that I have obtained a Form W-10 (or shown due diligence obtaining the dependent care provider's TIN or social security number) from any dependent care providers and I intend to file Form 2441 with the Internal Revenue Service with respect to any dependent care expense reimbursements, if any. I certify that I will not take any of such expenses as an income tax deduction or tax credit on my personal federal income tax return. I understand that I alone am fully responsible for the sufficiency and accuracy of all information relating to the claim which is provided by me, and that if an expense for which payment or reimbursement is claimed is subsequently determined to not be a proper expense under the Plan, I may be liable for payment of all related taxes, including federal, state, or local income tax, on amounts paid from the Plan which relate to such expense. Note: Reimbursements from the medical expense reimbursement account are limited if you are covered under a Health Savings Account (HSA) to dental or vision expenses, expenses related to preventative care, and expenses that exceed the health plan deductible.

Employee's Signature

Date

- Attach a copy of bill, invoice or written statement, including the date of service, from a third-party supporting the request. NOTE: Provider Certification in box F may be furnished in place of a copy of a bill.
- Attach a copy of any explanation of benefit statement that shows the deductible, co-insurance or amounts not covered by medical/dental plan.

Mail, fax, or email claim to: OHFS, P.O. Box 728, Anoka, MN 55303-0728 • FAX (763) 767-4700 • EMAIL flexclaims@arcadministration.com • PHONE (763) 772-1380 OR (866) 898-4584

PLAN CLAIM REIMBURSEMENT INFORMATION

Cafeteria, HRA and/or VEBA plans enable you to save taxes and increase your spendable income by converting a portion of your compensation from cash to benefits. Under these plans, you use pre-tax dollars to pay for unreimbursed medical and/or dependent care expenses. Otherwise, you would pay your share of benefit costs with after-tax dollars.

Your election to participate in the plan is made on a plan year basis. However, the IRS allows election changes under certain circumstances, referred to as family status changes. Examples of changes to family status include: marriage, divorce, birth or adoption of a child, death of a spouse or dependent, significant changes in health coverage due to your spouse's employment, the termination or commencement of employment by your spouse. For more detailed information about the relationship of family status changes to this plan, please refer to your Summary Plan Description and your human resources representative.

SUBMITTING CLAIMS

To claim benefits under the plan, complete the claim for reimbursement form, attach appropriate documentation of expenses and forward to OptumHealth Financial Services, PO Box 728, Anoka, MN 55303-0728. **Claims may be faxed to OHFS with documentation to the following fax number - (763) 767-4700.** They may also be emailed to us (with scanned in documentation attached) at flexclaims@arcadministration.com. Faxed or emailed claims that are received by OHFS after 1:00 PM Central Time will be processed on the next business day. Whether you submit claims and documentation by mail, fax, or email it is important that you make sure that the documentation that you submit to OHFS is legible. If OHFS is unable to read any of the following items because of the quality of the copy or the fax, the claim will be denied pending resubmission of legible documentation. The documentation must **clearly** identify -

1. the nature of the service
2. the date the service was incurred
3. the name of the provider
4. the amount of the expense.

You may use one line on the claim form to enter expenses which are identical in nature (i.e. office visit co-pays, RX co-pays, etc.) even if the expenses have been incurred on different dates. However, please make sure to attach documentation verifying each individual expense.

For both medical expenses and dependent care expenses, please identify each piece of documentation with the corresponding line number from the claim form. Sign and date the form and mail or fax it, along with your documentation. Forms that are not signed and dated will result in the denial of the claims. We suggest that you photocopy your form and documentation for your own records before submitting them.

If your claim is denied, in part or in full, you can file an appeal. You can find the appeal procedure in your Summary Plan Description.

Unfortunately, because of IRS regulations, you **cannot** submit claims directly online at OHFS's website because your claims must be accompanied by independent, third party documentation. Therefore, you can only submit claims by mail, fax, or email.

MEDICAL EXPENSE CLAIMS

To be eligible for reimbursement under the plan, you must provide proof the expenses were incurred. Please attach a copy of an itemized statement from the provider. Expenses are only eligible if they are incurred while you are participating in the plan. Expenses may be incurred by you, your spouse or other individuals who qualify as eligible dependents under federal rules governing cafeteria plans. **Note: Reimbursements from the medical expense reimbursement account are limited if you are covered under a Health Savings Account (HSA) to dental or vision expenses, expenses related to preventative care, and expenses that exceed the health plan deductible.**

Examples of eligible expenses include co-payments, deductibles, unreimbursed medical, dental, and vision expenses, therapy you receive as medical treatment, prescription drugs, and, if your plan allows, over-the-counter medication (e.g. aspirin, antacids, pain relievers, cold medication, allergy medicine), hearing aids, guide dogs, transplants, and therapy you receive as medical treatment.

DEPENDENT DAY CARE CLAIMS

Eligible dependents include your children under age 13, or if older, the person receiving care must be physically or mentally incapable of self care. See your SPD for additional information on Qualifying Individuals and certain benefit maximums which apply. Reimbursement for dependent care expenses are eligible if these amounts are paid to permit you to work. If you are married, dependent care expenses are only eligible if your spouse is also working for pay, attending school, or seeking employment while you are at work.

To request reimbursement, complete the dependent care section of the claim form and attach proof the dependent care services were provided by attaching an itemized statement or by having your dependent care provider complete the Provider Certification (Section F) of the form.

According to federal law, you must report the name, address and taxpayer identification number of the dependent care provider when you file your tax return.

To access your account information, log on to www.arcbenefitaccess.com and click on the FSA/HRA/VEBA Participant Login button.