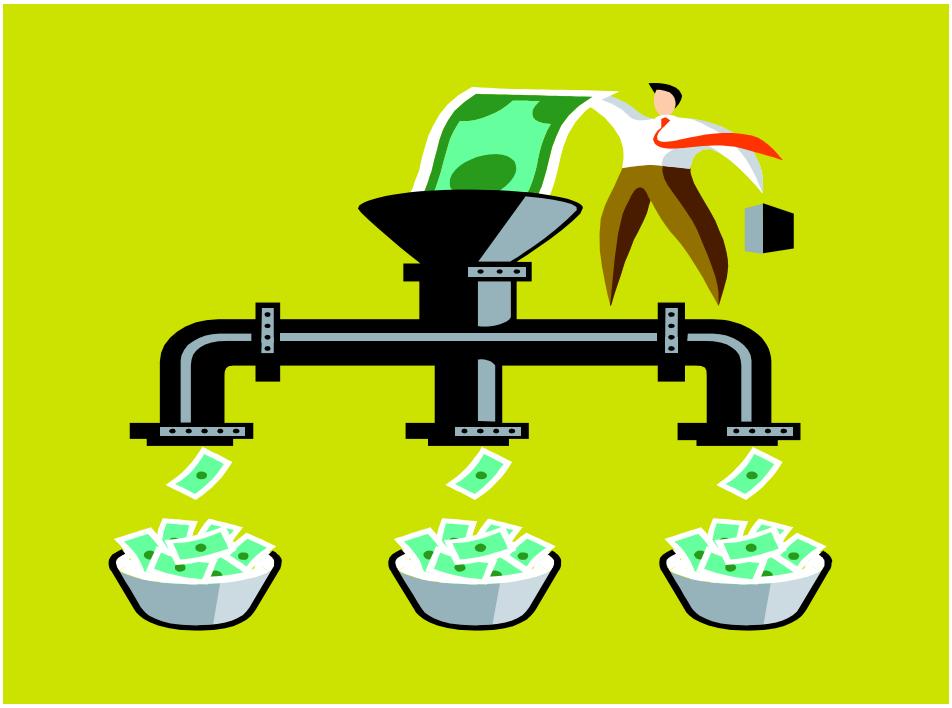
Flexible Spending Account (FSA) & Health Reimbursement Arrangement (HRA/VEBA)

BENEFIT GUIDE

Osseo Area School District #279
2007-2008



Corporate Health Systems, Inc.
[Benefit Communication Solutions]
15153 Technology Drive, Suite B
Eden Prairie, MN 55344-2273
Phone (952) 939-0911 Fax (952) 939-0990

NOTICE

This is a benefit summary only and may not outline all of your benefits. When you enroll, you will receive a summary plan description or certificate of coverage. This booklet does not replace, supplement or change any of the individual benefit product summary plan descriptions or certificates of coverage and should not be used in determining actual benefits available. Remember this is a summary only and the legal plan documents determine actual benefits. Please be aware that if there are differences between the statements in this booklet and actual legal plan documents or laws, the legal course will prevail. Contact the insurance carrier for more information and answers to specific questions, or see your Human Resource Office for a copy of the plan document before making a decision.

This booklet provides an overview of the following insurance benefits:

- Flexible Spending Accounts (FSA)
- Health Reimbursement Arrangement (HRA)

Corporate Health Systems is the Benefit Administrator for the above insurance benefits. For questions concerning these benefits please contact Corporate Health Systems at the number listed below.

Erin Cannon
(952) 939-0911 ext. 24
ecannon@corphealthsys.com

You may also contact your employer's benefit's representative.
Barb Shannon
(763) 391-7009

Revised April 2007

To verify coverage or for questions concerning how a specific claim will be paid, please consult the applicable insurance carrier or plan document of the coverage in question. Neither Corporate Health Systems nor your employer can quote benefits for reasons involving accuracy and confidentiality. When in doubt, contact Corporate Health Systems and you will be directed to the appropriate resource.

FLEXIBLE SPENDING ACCOUNTS

(FSA)

Plan Outline

Administrator:	Corporate Health Systems, Inc. Local Phone: (952) 939-0911 Toll Free Phone: (888) 939-0922 Website: www.corphealthsys.com
Plan Year:	July 1 through June 30
Employee Eligibility:	Refer to the Osseo Area Schools Benefits Booklet or see your Terms and Conditions of Employment.
Waiting Period for Enrollment: *(Time employee must wait before being eligible to enroll)*	You are eligible to join the plan once you have met the eligibility requirements.
Initial Enrollment Period: *(Time frame after the waiting period during which employee must enroll)*	30 days
Coverage Termination Date Upon Loss of Eligibility:	Date of employment termination
Maximum Annual Health FSA Election:	$3,000
Maximum Annual Dependent Care FSA Election:	$5,000 ($2,500 if filing separately)
Pre-Tax Premiums Account: *(For health care and dental insurance premiums)*	Premiums for Employer sponsored insurance plans are automatically withdrawn from your paycheck on a pre-tax basis.
Flex Run-Out Period: (*This is the number of days after the end of a plan year you have to file a claim that was incurred within the plan year.)*	90 days – September 30
Claims Grace Period: *(This is the time period after the end of the plan year during which you may incur claims. Claims incurred during this time period must be submitted for reimbursement before the end of the Flex Run-Out Period.)*	2 ½ months after the end of the plan year – September 15

General Commonly Asked Questions

What is an FSA?

The FSA benefit is a plan that allows you to pay for certain unreimbursed expenses prior to income tax calculations.

What is the advantage of participating in an FSA?

By contributing to the plan you reduce your Federal and State income taxes as well as your FICA or Social Security Taxes. These tax savings mean additional disposable income for you from each of your paychecks.

How are the rules for FSA's determined?

The IRS determines the rules and regulations for FSA's. All FSA's must meet one of the following IRS Code Sections: 125 (Pre-Tax Premiums), 105 (Health FSA), 129 (Dependent Care FSA).

When can I enroll?

You can enroll during your initial enrollment period. You can also enroll during your company's annual open enrollment period, which is typically during the 1-2 months prior to your employer's Plan Year Anniversary Date (you will be notified with exact dates). **Elections are irrevocable**; the ONLY other opportunity you may have to make or change an election is if you experience a Family Status Change.

What is a Family Status Change?

Under the federal government a "change in status" allows you to change your elections during the plan year if the change is due to and consistent with any of the following events:

- Marriage
- Divorce
- Birth or adoption of a child
- Death of a spouse or child
- Commencement or termination of your or your spouse's benefit eligibility
- *A significant change in your or your spouse's healthcare coverage due to your spouse's employer *(applies **only** to your Pre-tax premium deductions)
- Taking an unpaid leave of absence by you or your spouse

Status Change forms are available by contacting either Corporate Health Systems or your employer's benefit contact. When you have a Status Change and wish to make election changes, you MUST return the Status Change form within 30 days of the occurrence of the change in status.

To which of the plans does the Family Status Change rule apply?

The Family Status Change rule applies to the pre-tax plans including but not limited to; *Pre-tax premium deductions, Health FSA and Dependent Care FSA accounts.

Will participating in a pre-tax plan reduce my future Social Security retirement benefits?

Converting pay to a Flexible Spending program may have an effect on the benefits you and your family will receive from Social Security. The formula used in determining your Social Security benefit takes into account your W-2 wages, which are lowered by your pre-tax elections. However, for most people the reduction is minimal, particularly when compared to the tax savings they enjoy through participation in the plan.

How do I get information regarding my Flexible Spending Account?

Go to www.corphealthsys.com to view your account's claim history, account balance and payment history. Claim forms can also be printed from the website. Your user ID and PIN number will be mailed to your home. Your account information can only be accessed with these codes. You can also contact your Corporate Health Systems Benefit Administrator.

General Commonly Asked Questions continued

What are the steps for employee participation in the plan?

1. Once you have made an election, pre-tax payroll deductions will be taken from your paycheck evenly divided by the number of payrolls in a year (or remaining in the year) and applied to the account(s) in which you have chosen to participate. Accounting is maintained separately for each account.
2. You incur an expense (example: you have an office visit co-pay).
3. You submit a claim for the expense by completing a "Request for Reimbursement" claim form and supplying the appropriate documentation to Corporate Health Systems.
4. Your claim is verified for eligibility by Corporate Health Systems staff according to the IRS regulations.
5. If your claim is denied for any reason, a copy of your claim form and directions as to what is needed or an explanation of denial (i.e. duplicate claim) is sent to you.
6. Corporate Health Systems reimburses you according to your employer's reimbursement schedule (see your employer's reimbursement schedule located in this section).

How do I submit a claim?

Complete a "Request for Reimbursement" claim form and submit **itemized receipts** for each line you have filled out. Receipts must include the following information:

- Nature of the expense – the specific service that was provided (not payment on accounts)
- Date of service – when the service happened (not when the service was paid for)
- Person receiving service (can be an eligible dependent)
- Amount of the service
- Name of the provider – clinic name and/or doctor's name and address

If any of these requirements are not met, the line missing the documentation cannot be paid until the corrected portion is received. All other lines with correct documentation will be paid. The IRS regulates the requirements for documentation.

NOTE: Eligible Over-the-Counter Drugs are reimbursable with a valid cash register receipt that includes the date of service, cost and name of the drug.

Claim forms and documentation must be mailed or faxed to:

Corporate Health Systems, Inc.
PO Box 46850
Eden Prairie, MN 55344-6850
Fax: (952) 939-0990

When is a Doctor's Statement Form required?

On occasion, a claim may require further information via a Doctor's Statement Form. Your CHS administrator will notify you if this is required. Some examples of expenses which require a Doctor's Statement Form are:

- Services that are not covered by insurance but are medically necessary for you.
- Over-the-counter supplements and vitamins.
- Items that are considered dual purpose.

The Doctor's Statement Form must indicate the specific medical condition, the specific treatment needed and how this treatment will alleviate the medical condition.

General Commonly Asked Questions continued

Is there an alternative way to be reimbursed?

Yes, the *mbi Flex Convenience* card is an alternative to traditional reimbursement methods.

The *mbi Flex Convenience* card is a debit card funded directly from your pre-tax Flexible Spending Account. While it does not completely eliminate reimbursement claim forms, it can significantly reduce them.

- *When used for expenses such as office visit and prescription co pays, which make up **55%** of all claims, a claim form will not be required. You may be asked to provide documentation of the expense, if the expense can not be auto-adjudicated.*

Simply swipe your card at an eligible location such as pharmacies, physician or dental offices and the funds are directly withdrawn from your pre-tax Flexible Spending Account and auto-adjudicated – eliminating all out of pocket expenses and reimbursement waiting periods.

Corporate Health Systems may request documentation for claims paid using the *mbi Flex Convenience* card that cannot be auto-adjudicated. Corporate Health Systems will request that you submit documentation to support your purchase via email. You then submit your receipt and a copy of the email to Corporate Health Systems and your claim will be processed without your completing a traditional reimbursement claim form.

If you do not submit the required documentation, your *mbi Flex Convenience* card will be deactivated and the expense paid using the *mbi Flex Convenience* card will be deducted from your paycheck. ***It is important that you retain documentation for ALL claims, regardless of the reimbursement method.***

When must a claim be incurred in order to be eligible?

All claims must be incurred during the plan year or during the subsequent Claims Grace Period if applicable as determined by your employer. Claims incurred outside of the plan year or outside of the Claims Grace Period, before your enrollment date, or after your participation terminates, will not be reimbursed.

What happens to money I do not use by the end of the plan year?

If you do not have claims that equal or exceed the amount of your annual election, you will forfeit your remaining account balance at the end of the plan year or subsequent Claims Grace Period (if applicable).

If I submit a claim during the Grace Period, does Corporate Health Systems determine which expenses are paid from the old plan year and which expenses are paid from the new plan year?

No. Corporate Health Systems will process claims as they are received. It is important for you to submit all expenses you wish to have reimbursed from your prior year's account balance **before** you submit new plan year expenses. Corporate Health Systems will NOT be able to reprocess claims. For example: You submit an expense incurred *during* the grace period and this claim reimburses all remaining prior year funds. At a later date you submit an expense incurred *prior* to the grace period. This claim will be denied because no funds remain in your prior year's account.

Plan Specific Commonly Asked Questions

PRE-TAX PREMIUMS
~Allows you to pay medical and dental premiums on a pre-tax basis.

How are my premiums taken out of my paycheck?

Your employer will automatically take your medical and dental premium contribution(s) out of your check on a pre-tax basis unless you notify them otherwise.

HEALTH FSA
~Allows you to fund your unreimbursed medical, dental & optical expenses on a pre-tax basis.

When is my Health FSA election available to me for reimbursement?

Your entire annual election is available to you on the first day of the plan year or on your first day of participation.

If I participate in Health FSA will those expenses still be eligible for credit on my personal tax return?

By participating in the Health FSA and Pre-Tax portion of the plan, you are already receiving the tax savings on these expenses and are unable to claim them again on your tax return. Participation in a Flexible Benefit Plan may affect your Earned Income Credit amount.

DEPENDENT CARE FSA
~Allows you to fund your unreimbursed dependent care expenses on a pre-tax basis.

When is my Dependent Care FSA election available to me for reimbursement?

You can only be reimbursed for money, which you have already contributed to your account. Since your annual election is divided and deducted evenly over the number of payrolls in a year (or remaining in the year) it is likely that you may not have contributed an amount equal to your Dependent Care claim. When this happens, Corporate Health Systems will reimburse you up to the amount contributed, pending the remaining amount until you have made further contributions. The remainder of the claim, up to the deposited amount, will be paid out automatically until the entire claimed amount has been reimbursed.

How does participating in Dependent Care FSA affect my ability to claim these expenses on my personal tax return?

You may use a combination of Dependent Care FSA and the Federal Child Care Tax Credit, but you are limited by the maximum as defined under the Federal Child Care Tax Credit. Participation in a Flexible Benefit Plan may affect your Earned Income Credit amount.

Eligible Health FSA Expenses

The Health FSA covers a variety of health care services that may not be included in certain medical and dental insurance plans. These expenses can be paid, with pre-tax dollars, through use of the Health FSA. All medical, dental and optical expenses that qualify as medical deductions under IRS rules will qualify for tax-free reimbursement under this plan. Below, is a short list of example expenses; both allowable and not allowable.

HEALTH FSA EXPENSES ALLOWED:

Dental and Orthodontic Care:

- Artificial teeth or dentures
- Braces, orthodontic devices

Therapy and Treatments:

- X-ray treatments
- Speech therapy
- Alcoholism treatment
- Drug therapy treatment
- Legal sterilization
- Acupuncture
- Physical therapy treatment
- Vaccinations
- Hair transplant (if medically necessary)
- Electrolysis (if medically necessary)
- The cost of a weight loss program (only to treat obesity as prescribed by a physician)

Fees and Services:

- Physicians' fees
- Hospital services fees
- Services of chiropractors
- Christian Science practitioner
- Services connected with donating an organ

Hearing Expenses:

- Hearing aids and batteries

Eye Care:

- Eyeglasses
- Contact lenses
- Contact Solution
- Lasik surgery

Medical Equipment:

- Wheelchair or autoette (cost of operating/maintaining)
- Excess cost of orthopedic shoes over cost of ordinary shoes
- Crutches (purchased or rented)
- Excess cost of special mattress prescribed to alleviate arthritis
- Prescribed oxygen equipment and oxygen used to relieve breathing problems
- Support hose (if medically necessary)
- Artificial limbs

Co-Payments (not premiums):

- Health insurance out-of-pocket
- Dental insurance out-of-pocket
- Prescription medication co-payments

Assistance for individuals with disabilities:

- Cost of guide for the visually impaired
- Special devices, such as tape recorder and typewriter, for the visually impaired
- Costs of equipping automobile
- Cost of Braille books and of regular editions
- Seeing Eye Dog

Psychiatric Care:

- Services of psychotherapists, psychiatrists and psychologists

Physical Exams:

Prescription & Over-the-counter medications:

- Prescription co-payments
- Over-the-counter medications used to treat a medical condition

HEALTH FSA EXPENSES NOT ALLOWED:

- Illegal medication
- Mechanical exercise device not prescribed
- Vacuum cleaner purchased by an individual with dust allergy
- Expenses of divorce when doctor or psychiatrist recommends divorce
- Contributions to State disability funds
- Maternity clothes
- Insurance against loss of income, life, limb or eyesight
- Distilled water purchased to avoid drinking fluoridated city water supply
- Mobile telephone used for personal calls as well as calls to physician
- Treatments unrelated to a specific problem (for example, massage for general well-being)
- Marriage counseling
- Nursemaids or practical nurses in charge of healthy infants
- Cosmetic procedures
- Over-the-counter supplements/vitamins or other substances related to general good health. *(See list on next page)*

THE IRS WILL CHANGE THIS LIST FROM TIME TO TIME.
FOR A COMPLETE AND CURRENT LISTING OF HEALTH EXPENSES SEE IRS PUBLICATION 502.

Eligible Over-the-Counter Medications

What documentation is required when I submit an Over-the-Counter medication expense?

- The nature of the expense – the name of the medication must be on the receipt OR a copy of the packaging (i.e. box) must be attached to the claim form
- Date of Service
- Amount of service
- Name of the provider

Why are certain items not reimbursable?

All reimbursable items must meet the definition of "Medical Care" – in particular, the medication must cure, mitigate, treat or prevent or affect the structure or function of the body. Certain items (as listed toward the bottom of this page) do not meet this definition of "Medical Care".

What if I wish to be reimbursed for items not on these lists?

Contact Corporate Health Systems for additional information regarding reimbursable Over-the-Counter medications.

OVER-THE-COUNTER EXPENSES ALLOWED:
(The items below do not represent a complete list)

- Allergy medicine
- Antacids
- Anti diarrhea medicine
- Aspirin
- Bactine
- Band-Aids, bandages, gauze First aid kits, nasal strips
- Bee Sting kits
- Ben Gay
- Pedialyte for dehydration
- Sleeping aids
- Visine
- Bug bite ointments
- Calamine lotion
- Cold medicine
- Cold pack
- Condoms
- Cough drops, lozenges
- Diaper rash ointments
- Laxatives
- Rubbing alcohol
- Sunburn ointment
- Wart remover
- First aid cream
- Hot pak
- Incontinence supplies
- Menstrual cycle products for pain
- Motion Sickness pills
- Muscle pain creams
- Nicotine gum and patches
- Pain reliever
- Sinus sprays
- Suppositories

OVER-THE-COUNTER EXPENSES <u>NOT</u> ALLOWED:
(The items below do not represent a complete list)

- Chapstick
- Face creams and moisturizers
- Vitamins
- Cosmetics
- Food, food replacements
- Toiletries
- Dietary supplements
- Medicated shampoos and soaps
- Toothbrush/toothpaste

OVER-THE-COUNTER EXPENSES ALLOWED ONLY WITH A DOCTORS NOTE:
(The items below do not represent a complete list)

- Acne Treatments
- Feminine hygiene products
- St. John's Wart for depression
- Weight loss medications
- Fiber supplements for constipation
- Glucosamine/Chondroitin for arthritis
- Hormone therapy for menopause
- Lactaid for lactose intolerance
- Orthopedic shoes
- Sunscreen for cancer
- Prenatal vitamins

THE IRS WILL CHANGE THIS LIST FROM TIME TO TIME.
FOR A COMPLETE AND CURRENT LISTING OF HEALTH EXPENSES SEE IRS PUBLICATION 502.

Eligible Dependent Care FSA Expenses

For which expenses can I use the Dependent Care FSA?

You may use the Dependent Care FSA to pay for childcare or other dependent care services if you meet the following criteria:

- You need to pay for childcare or other dependent care services in order to be gainfully employed.
- You need to pay for the care of a mentally or physically incapacitated dependent or spouse to be gainfully employed.

Are there any requirements pertaining to the Dependent Care FSA?

Yes. Childcare or dependent care services will qualify for reimbursement under the plan if they meet the following requirements:

1. If you are married, the services must be provided to enable both you and your spouse to be employed, unless one spouse is a full-time student at an educational institution and the other is employed full time.
2. The amount to be reimbursed must not be greater than either your or your spouse's income; whichever is lower.
3. The child must be under 13 years old, or, if older, mentally or physically incapable of caring for herself or himself.
4. The services may be provided inside or outside your home, but not by someone who is your dependent for income tax purposes, such as an older child, your spouse, or a grandparent who lives with you.
5. If childcare is at a daycare center, the center must comply with all state issued rules and regulations.
6. You may also use the Dependent Care FSA to pay for expenses for care of a mentally or physically incapacitated dependent or spouse if such care is necessary to enable you to work.

Sample Case of Benefits Taken Pre-Tax vs. After-Tax

The following is an example of how Flexible Spending Accounts affect your taxes and can boost your take-home pay.

The following example shows the effect of paying for eligible benefit expenses AFTER-TAX (salary deduction) compared to paying for benefits PRE-TAX (salary reduction). This example is based on monthly gross pay of $2,000 for a married person claiming two exemptions (2006 tax tables). They figure their monthly day care is $200, their annual medical and dental bills are around $120 or $10 per month and their monthly medical contribution is $50.

	Benefits Taken *WITH* FLEXIBLE BENEFITS (Pre-tax)	**Benefits Taken *WITHOUT* FLEXIBLE BENEFITS** (After-tax)
Gross Wages	$2000.00	$2000.00
Benefits Paid Before Taxed:		
Health Premiums	$50.00	$0.00
Dependent Care	$200.00	$0.00
Medical Spending Account	$10.00	$0.00
Taxable Wages	**$1740.00**	**$2000.00**
Taxes:		
Social Security Tax	$133.11	$153.00
Federal Tax	$52.00	$80.00
State Tax	$36.00	$51.00
Benefits Paid After Tax:		
Health Premiums	$0.00	$50.00
Dependent Care	$0.00	$200.00
Medical Spending Account	$0.00	$10.00
Take Home Wages	**$1,518.89**	**$1,456.00**

By paying these expenses *PRE-TAX*, take-home pay is $62.89 per month higher or $754.68 annually.

Health Care Expenses Worksheet

Use this worksheet to estimate the health care expenses you (and your eligible dependents) expect to incur during the plan year that will not be reimbursed from another source (that is, insurance). The total you get here is the total amount you may want to deposit in your Health Flexible Spending Account. Remember to be conservative in your estimates because any unused balances in your Health FSA are forfeited.

ESTIMATE YOUR UN-REIMBURSED COSTS FOR:

Medical:

Medical deductibles	$_____
Out-of-Pocket payments	$_____
Routine exams (OB-GYN, physicals, etc.)	$_____
Medical Office Co-payments ($10 per visit, for example)	$_____
Prescription Drugs (including birth control, allergy shots, insulin)	$_____
Hearing aids and exams	$_____
Vision Care (eye exams, contact lenses, prescription eyeglasses)	$_____
Medically required equipment (wheelchair, prosthetic devices)	$_____
Chiropractor	$_____
Emergency Room charges	$_____
Over-the-counter medications	$_____
Other medical expenses not covered by insurance	$_____

Dental:

Dental deductibles	$_____
Co-insurance payments	$_____
Orthodontia (braces, retainers)	$_____
Other Dental expenses not covered by insurance:	$_____
_____	$_____
_____	$_____

TOTAL HEALTH CARE EXPENSES $_____
(indicate this amount on your Enrollment Form)

Note: To determine the impact on each paycheck, divide your Total Health Care Expenses by the number of pay periods remaining in the plan year.

$_____ / _____=_____/paycheck

Dependent Care Expenses Worksheet

In determining whether to participate in the Dependent Care Flexible Spending Account, you should consider the dependent care Income Tax Credit. Whether the tax credit or the spending account is more advantageous is dependent upon each individual's tax situation.

The Dependent Care Income Tax Credit and the Dependent Care Flexible Spending Account interact with various other tax laws concerning items of income, losses, deductions and credits. Consult a tax advisor for more information regarding your individual tax situation.

Taking the Income Tax Credit on Form 1040:

1. Your Annual Eligible Expenses:
   ($3,000 maximum for 1 child;
   $6,000 maximum for 2 or more children) $_____/ Year

2. Your Tax Credit Percentage:
   (use chart below to determine percentage) x_____ %

Adjusted Gross Income	Credit %	Adjusted Gross Income	Credit %
$0 - $15,000	35%	$29,001 - $31,000	27%
$15,001 - $17,000	34%	$31,001 - $33,000	26%
$17,001 - $19,000	33%	$33,001 - $35,000	25%
$19,001 - $21,000	32%	$35,001 - $37,000	24%
$21,001 - $23,000	31%	$37,001 - $39,000	23%
$23,001 - $25,000	30%	$39,001 - $41,000	22%
$25,001 - $27,000	29%	$41,001 - $43,000	21%
$27,001 - $29,000	28%	$43,000 or higher	20%

3. Your **Estimated** Tax Credit Savings: $_____/ Year

Using the Dependent Care (Section 125) Flexible Spending Account Plan:

1. Your Annual Dependent Care Expenses ($5,000 maximum): $_____/ Year

2. Your Tax Savings Percentage:
(7.65% FICA + federal tax percentage from the chart below) x _____ %

Head of Household		Married, Filing Joint	
Adjusted Gross Income	**Tax %**	**Adjusted Gross Income**	**Tax %**
$0 - $9,800	10%	$0 - $22,600	10%
$9,800 - $31,500	15%	$22,600 - $66,200	15%
$31,500 - $69,750	25%	$66,200 - $120,750	25%
$69,750 - $151,950	28%	$120,750 - $189,600	28%
$151,950 - $328,250	33%	$189,600 - $333,250	33%
$328,250 and higher	35%	$333,250 and higher	35%

3. Your **Estimated** Section 125 Flexible Spending Account Savings: $_____

This worksheet is provided for informational purposes only. Corporate Health Systems, Inc. does not guarantee its accuracy nor do we provide legal or accounting advice. If you have questions about participating in this plan, consult your attorney or tax advisor.

Reimbursement of Orthodontic Expenses

With growing confusion concerning reimbursement for orthodontic expenses, it is necessary to specifically address these issues in an effort to clarify the subject.

The IRS guidelines for reimbursement affirm that an expense cannot be reimbursed until the service has been provided. What this means for reimbursement of orthodontic expenses is the full amount for orthodontic services cannot be reimbursed when the work commences, even if the total orthodontia expenses have been paid in full. The reason for this is, the person receiving orthodontic work will continue to have services provided, usually for the next 12 to 36 months.

Monthly reimbursements with Service Agreement or Payment Contract:

We can reimburse orthodontic expenses on a monthly basis in an amount established by a service agreement or payment contract between the orthodontist and the patient. Such an agreement should include:

1) Place of service (Name of Orthodontic facility)
2) Total cost of services less insurance payments or provider discounts
3) Initial payment made (if any)
4) Monthly payment amount agreed upon
5) Number of month's treatment and payments are expected to last
6) Date treatment began
7) Name of person receiving treatment

When no Service Agreement or Payment Contract is available:

If such an agreement or contract is not available, please refer to the following instructions for using the Orthodontic Service Agreement Form to determine the amount you are eligible for reimbursement each month. This form should be completed and signed by your orthodontic provider and submitted with your initial claim.

If the full amount is due upon installation of the braces or, the doctor offers a discount if the full amount is paid upon installation, the following process must take place:

1) The orthodontist should distribute the total cost of the braces to the number of office visits necessary over the estimated length of service, subtracting any payments from your insurance company or provider discounts received.
2) If the orthodontist determines that for example, one third of the service will be incurred in the first visit when the braces are applied, then that "one third" payment (initial or down payment) will be reimbursed at the time of the first visit.
3) The orthodontist should then determine the estimated number of months of service and divide the remaining balance by that number. This amount can be reimbursed on a monthly basis.

Submitting an orthodontic expense for reimbursement:

When submitting your *first* orthodontic claim, the orthodontic service agreement or payment contract must be included with a completed Request for Reimbursement Claim Form. Please make sure the claim form indicates the person receiving service, provider name, date of service, the monthly payment amount, and nature of expense being orthodontia.

Once the initial orthodontic agreement or contract is submitted, you may request future reimbursements by completing a Request for Reimbursement Claim Form, and one of the following options.

1) Attach a receipt or copy of the "coupon" (if you were provided a payment book) that *clearly indicates* the person receiving service, provider name, date of service, the monthly payment amount, and the nature of the expense being orthodontia.

OR

2) In the Nature of Expense column, write, ***"contract on file"***. No other information or receipt is required.

Orthodontic Service Agreement Form

(Should be used when orthodontic service agreement or payment contract is not available from your orthodontist)

Name of the person receiving the service _____

Date braces were placed: ___/___/___

Total amount for orthodontic services $_____

Insurance payments - $_____

Provider discount - $_____

Initial payment due upon application of braces - $_____
(this amount may be submitted for reimbursement)

Remaining balance = $_____

Remaining Balance
Divided by _____ treatment months,
Equals monthly reimbursements $_____
(Qualified monthly reimbursable amount)

_____
Provider Signature

_____
Name of Orthodontist/Clinic

CHS USE ONLY:

Date Received: ___/___/_____

Processed by: _____

Notes Entered: ___/___/_____

Date Contract ends: ___/___/_____

Osseo Area Schools – ISD 279
2007-2008 Reimbursement Schedule

Reimbursement Request Deadline Date	Reimbursements Distributed By
07/05/2007	07/12/2007
07/20/2007	07/27/2007
08/03/2007	08/10/2007
08/20/2007	08/27/2007
09/05/2007	09/12/2007
09/20/2007	09/27/2007
10/05/2007	10/12/2007
10/17/2007	10/26/2007
11/05/2007	11/09/2007
11/20/2007	11/27/2007
12/05/2007	12/12/2007
12/20/2007	12/27/2007
01/04/2008	01/11/2008
01/18/2008	01/25/2008
02/05/2008	02/12/2008
02/20/2008	02/27/2008
03/05/2008	03/12/2008
03/20/2008	03/27/2008
04/04/2008	04/11/2008
04/18/2008	04/25/2008
05/05/2008	05/12/2008
05/20/2008	05/27/2008
06/05/2008	06/12/2008
06/20/2008	06/27/2008
Flex Run Out Period ***(07/01/2007 – 06/30/08 Plan Year)***	
07/31/2008*	08/07/2008*
08/29/2008*	09/05/2008*
09/30/2008*	10/07/2008*

NOTE: Claims can be incurred up to 9/15/08 and applied to the 2007-08 year.

Claims must be received by the end of the day on the "Reimbursement Request Deadline Date" in order to be paid on the "Reimbursements Distributed By" Date.

- ✓ For employees electing to have Direct Deposit, your reimbursement is deposited on the "Reimbursements Distributed By" Date.
- ✓ If you choose to have a standard check mailed to you, the check is mailed on the "Reimbursements Distributed By" Date.

* If your employer renews their flex contract with CHS for the next plan year, that year's reimbursement schedule will be used for reimbursement distribution dates: if not, the dates listed above will be used.

** If the "Reimbursements Distributed by" date conflicts with a holiday, your reimbursement will be mailed the next working day.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

with

VOLUNTARY EMPLOYEE BENEFICIARY ASSOCIATION

(VEBA)

Plan Outline

Administrator:	Corporate Health Systems, Inc. Local Phone: (952) 939-0911 Toll Free Phone: (888) 939-0922 Website: www.corphealthsys.com
Plan Year:	July 1 through June 30
Employee Eligibility:	Must be enrolled in the Deductible Medical Plan
Waiting Period for Enrollment: *(Time employee must wait before being eligible to enroll)*	Once you are enrolled in the Deductible Medical Plan, enrollment is automatic
Initial Enrollment Period: *(Time frame after the waiting period during which employee must enroll)*	30 days
Coverage Termination Date upon loss of eligibility:	Employer contributions cease the day a participant loses eligibility. Expenses can be submitted against the participant's account balance until the participant's account balance reaches zero.
Percent of Unused Balance that rolls over into the next plan year:	100%
<u>Annual</u> Employer HRA/VEBA Contribution:	Single Deductible Medical Plan election: $ 504 Single+1 Deductible Medical Plan election: $1,020 Family Deductible Medical Plan election: $1,200
Employer HRA/VEBA Contribution Funding:	Monthly
HRA/VEBA Run-Out Period: (*This is the number of days after the end of a plan year you have to file a claim that was incurred within the plan year)*	90 days

Commonly Asked Questions

What is HRA?

HEALTH REIMBURSEMENT ARRANGEMENT
~ Allows reimbursement of your un-reimbursed medical, dental and optical expenses and is funded by your employer.

What is VEBA?

VOLUNTARY EMPLOYEE BENEFICIARY ASSOCIATION
~ The funds contributed for you by your employer are held in a VEBA 501(c) (a) trust account managed by North Central Trust and invested in an interest earning money market account.

How do I enroll?

You are automatically enrolled in the HRA /VEBA plan if you are enrolled in the group Deductible Medical Plan.

How are the HRA/VEBA rules determined?

The IRS determines the rules and regulations for the HRA/VEBA. All HRA's/VEBA's must meet IRS Revenue Rulings 2002-41 and IRS Notice 2002-45 and be in accordance with Sections 105 and 106 of the Internal Revenue Code of 1986 and with Revenue Ruling 2002-41 (June 26, 2002).

Are my HRA/VEBA expenses coordinated with my Flexible Spending Health Care account?

Yes. If you participate in the Flexible Spending Health Care account, expenses must first be submitted and processed under the Flexible Spending Health Care account and those monies exhausted prior to reimbursement under the HRA/VEBA account.

When are HRA/VEBA funds available to me for reimbursement?

Once your Flexible Spending Health Care account is exhausted (if applicable), you can be reimbursed from funds your employer has already contributed to your HRA/VEBA account. If your employer has not yet contributed an amount equal to your claim, Corporate Health Systems will reimburse you up to the amount contributed, pending the remaining amount until further contributions have been made. The remainder of the claim, up to the deposited amount, will be paid out automatically until the entire claimed amount has been reimbursed.

Commonly Asked Questions continued:

How do I submit a claim?

To be reimbursable, the Participant must have incurred an eligible expense after his/her entry date into the plan. An expense is "incurred" when the Participant is provided with the care giving rise to the expense, not when the service is billed or paid. Reimbursement shall not be made for future projected expenses.

Complete a" Request for Reimbursement" claim form and submit **itemized receipts** for each line you have filled out. Receipts must include the following information:

- Nature of the expense – the specific service that was provided (not payment on accounts)
- Date of service – when the service happened (not when the service was paid for)
- Person receiving service (can be an eligible dependent)
- Amount of the service
- Name of the provider – clinic name and/or doctor's name and address

If any of these requirements are not met, the line missing the documentation cannot be paid until the corrected portion is received. All other lines with correct documentation will be paid. The IRS regulates the requirements for documentation.

NOTE: Eligible Over-the-Counter Drugs are reimbursable with a valid cash register receipt that includes the date of service, cost and name of the drug.

All claims must be incurred during the plan year. Claims incurred outside of the plan year or before your enrollment date will not be reimbursed.

Claim forms and documentation must be mailed or faxed to:

Corporate Health Systems, Inc.
PO Box: 46850
Eden Prairie, MN 55344-6850
Fax: (952) 939-0990

How do I get information regarding my HRA/VEBA Account?

Go to www.corphealthsys.com to view your account's claim history, account balance and payment history. Claim forms can also be printed from the website. Your user ID and PIN number will be mailed to your home. Your account information can only be accessed with these codes. You can also contact your Corporate Health Systems Benefit Administrator.

What happens to money I do not use by the end of the plan year?

If you do not have claims that equal or exceed the amount of the annual contribution, your remaining funds will be moved to the next plan year and will be available to you for reimbursement after the plan run-out period has been exhausted.

This summary is only an outline of general information. It is not a contract for coverage. Please refer to your summary plan description or certificate for detailed information.

Eligible HRA/VEBA Expenses

The HRA/VEBA covers a variety of health care services that may not be included in certain medical and dental insurance plans. All medical, dental and optical expenses that qualify as medical deductions under IRS rules will qualify for reimbursement under this plan. Below is a short list of example expenses; both allowable and not allowable.

HRA/VEBA EXPENSES ALLOWED:

Dental and Orthodontic Care:

- Artificial teeth or dentures
- Braces, orthodontic devices

Therapy and Treatments:

- X-ray treatments
- Speech therapy
- Alcoholism treatment
- Drug therapy treatment
- Legal sterilization
- Acupuncture
- Physical therapy treatment
- Vaccinations
- Hair transplant (if medically necessary)
- Electrolysis (if medically necessary)
- The cost of a weight loss program (only to treat obesity as prescribed by a physician)

Fees and Services:

- Physicians' fees
- Hospital services fees
- Services of chiropractors
- Christian Science practitioner
- Services connected with donating an organ

Hearing Expenses:

- Hearing aids and batteries

Eye Care:

- Eyeglasses
- Contact lenses
- Saline Solution
- Lasik surgery

Medical Equipment:

- Wheelchair or autoette (cost of operating/maintaining)
- Excess cost of orthopedic shoes over cost of ordinary shoes
- Crutches (purchased or rented)
- Special mattress & plywood boards prescribed to alleviate arthritis
- Prescribed oxygen equipment and oxygen used to relieve breathing problems
- Support hose (if medically necessary)
- Artificial limbs

Insurance Premiums:

- Health Insurance (including individual and non-employer sponsored coverage and including continuation premiums
- Long Term Care Insurance

Co-Payments (not premiums):

- Health insurance out-of-pocket
- Dental insurance out-of-pocket
- Prescription medication co-payments

Assistance for individuals with disabilities:

- Cost of guide for the visually impaired
- Special devices, such as tape recorder and typewriter, for the visually impaired
- Costs of equipping automobile
- Cost of Braille books and of regular editions
- Seeing Eye Dog

Psychiatric Care:

- Services of psychotherapists, psychiatrists and psychologists

Physical Exams

Prescription & Over-the-counter medications:

- Prescription co-payments
- Over-the-counter medications used to treat a medical condition

HRA/VEBA EXPENSES NOT ALLOWED:

- Illegal medication
- Mechanical exercise device not prescribed
- Vacuum cleaner purchased by an individual with dust allergy
- Expenses of divorce when doctor or psychiatrist recommends divorce
- Contributions to State disability funds
- Maternity clothes
- Insurance against loss of income, life, limb or eyesight
- Distilled water purchased to avoid drinking fluoridated city water supply
- Mobile telephone used for personal calls as well as calls to physician
- Treatments unrelated to a specific problem (for example, massage for general well-being)
- Marriage counseling
- Nursemaids or practical nurses in charge of health infants
- Cosmetic procedures
- Over-the-counter supplements/vitamins or other substances related to general good health. *(See list on next page)*

THE IRS WILL CHANGE THIS LIST FROM TIME TO TIME.
FOR A COMPLETE AND CURRENT LISTING OF HEALTH EXPENSES SEE IRS PUBLICATION 502.

Eligible Over-the-Counter Medications

What documentation is required when I submit an Over-the-Counter medication expense?

- The nature of the expense – the name of the medication must be on the receipt OR a copy of the packaging (i.e. box) must be attached to the claim form
- Date of Service
- Amount of service
- Name of the provider

Why are certain items not reimbursable?

All reimbursable items must meet the definition of "Medical Care" – in particular, the medication must cure, mitigate, treat or prevent or affect the structure or function of the body. Certain items (as listed toward the bottom of this page) do not meet this definition of "Medical Care".

What if I wish to be reimbursed for items not on these lists?

Contact Corporate Health Systems for additional information regarding reimbursable Over-the-Counter medications.

OVER-THE-COUNTER EXPENSES ALLOWED:
(The items below do not represent a complete list)

- Allergy medicine
- Antacids
- Anti diarrhea medicine
- Aspirin
- Bactine
- Band-Aids, bandages, gauze First aid kits, nasal strips
- Bee Sting kits
- Ben Gay
- Pedialyte for dehydration
- Sleeping aids
- Visine
- Bug bite ointments
- Calamine lotion
- Cold medicine
- Cold pack
- Condoms
- Cough drops, lozenges
- Diaper rash ointments
- Laxatives
- Rubbing alcohol
- Sunburn ointment
- Artificial limbs
- Wart remover
- First aid cream
- Hot pak
- Incontinence supplies
- Menstrual cycle products for pain
- Motion Sickness pills
- Muscle pain creams
- Nicotine gum and patches
- Pain reliever
- Sinus sprays
- Suppositories

OVER-THE-COUNTER EXPENSES <u>NOT</u> ALLOWED:
(The items below do not represent a complete list)

- Chapstick
- Face creams and moisturizers
- Vitamins
- Cosmetics
- Food, food replacements
- Toiletries
- Dietary supplements
- Medicated shampoos and soaps
- Toothbrush/toothpaste

OVER-THE-COUNTER EXPENSES ALLOWED ONLY WITH A DOCTORS NOTE:
(The items below do not represent a complete list)

- Acne Treatments
- Feminine hygiene products
- St. John's Wort for depression
- Weight loss mediations
- Fiber supplements for constipation
- Glucosamine/Chondroitin for arthritis
- Hormone therapy for menopause
- Lactaid for lactose intolerance
- Orthopedic shoes
- Sunscreen for cancer
- Prenatal vitamins

THE IRS WILL CHANGE THIS LIST FROM TIME TO TIME.
FOR A COMPLETE AND CURRENT LISTING OF HEALTH EXPENSES SEE IRS PUBLICATION 502.

Osseo Area Schools – ISD 279
2007-2008 HRA/VEBA Reimbursement Schedule

Reimbursement Request Deadline Date	Reimbursements Distributed By
07/05/2007	07/12/2007
07/20/2007	07/27/2007
08/03/2007	08/10/2007
08/20/2007	08/27/2007
09/05/2007	09/12/2007
09/20/2007	09/27/2007
10/05/2007	10/12/2007
10/17/2007	10/26/2007
11/05/2007	11/09/2007
11/20/2007	11/27/2007
12/05/2007	12/12/2007
12/20/2007	12/27/2007
01/04/2008	01/11/2008
01/18/2008	01/25/2008
02/05/2008	02/12/2008
02/20/2008	02/27/2008
03/05/2008	03/12/2008
03/20/2008	03/27/2008
04/04/2008	04/11/2008
04/18/2008	04/25/2008
05/05/2008	05/12/2008
05/20/2008	05/27/2008
06/05/2008	06/12/2008
06/20/2008	06/27/2008
HRA/VEBA Run Out Period ***(07/01/2007 – 06/30/08 Plan Year)***	
07/31/2008*	08/07/2008*
08/29/2008*	09/05/2008*
09/30/2008*	10/07/2008*

Claims must be received by the end of the day on the "Reimbursement Request Deadline Date" in order to be paid on the "Reimbursements Distributed By" Date.

- ✓ For employees electing to have Direct Deposit, your reimbursement is deposited on the "Reimbursements Distributed By" Date.
- ✓ If you choose to have a standard check mailed to you, the check is mailed on the "Reimbursements Distributed By" Date.

* If your employer renews their flex contract with CHS for the next plan year, that year's reimbursement schedule will be used for reimbursement distribution dates: if not, the dates listed above will be used.

** If the "Reimbursements Distributed by" date conflicts with a holiday, your reimbursement will be mailed the next working day.

OSSEO AREA SCHOOL DISTRICT #279

FLEXIBLE BENEFITS ELECTION FORM

PLAN YEAR: July 1 – June 30

EMPLOYEE INFORMATION:

Name: Social Security #:

Address: City: State: Zip:

Home Phone: ( ) - Work Phone: ( ) -

Position: Building Location: Date of Hire:

Flexible Spending Account (FSA) – **Health Care**

Plan Year Election: $ _____ (Maximum $3,000 per Plan Year)

Group or individual insurance premiums are not an eligible expense under the Health Care Flexible Spending Account.

Flexible Spending Account (FSA) – **Dependent Care**

Plan Year Election: $ _____ (Maximum $5,000 per Plan Year or $2,500 if filing separately)

Premium Conversion Account – Health and dental premiums paid by payroll deduction for dependent coverage

Participation is automatic.

☐ Waive Participation (I do not have an insurance deduction or do not want insurance deductions pre-taxed.)

Flexible Spending (FSA) – **Debit Card**

☐ Elect (Annual cost $18.00, deducted from your FSA health care account)

***REQUIRED** Email Address: _____

If you would like a debit card generated for your spouse, please provide the following information, there is no additional cost.

Spouses Name: _____ Social Security #: _____ Date of Birth: _____

I understand that I may be required to provide documentation to substantiate the claim for an expense paid with the debit card and that I must do so within the timeframe stated in the request. In the event that I do not provide the required documentation and fail to repay the unauthorized charge; my employer will deactivate the card and consider the charge a debt to the organization and may deduct the charge from my paycheck. *I understand that I am required to supply Corporate Health Systems with my email address for purposes of communicating claims information and participation with the Flexible Spending Debit Card is NOT permitted if I fail to supply my email address.

ENROLLMENT AUTHORIZATION:

I understand the benefit options and requirements presented therein. I am enrolling for the eligible benefits I indicate above and I authorize reductions from my earnings. I understand and agree that if my eligible expenses do not reach the amount I have allocated to that benefit, I will forfeit any amounts remaining in my participant account at the end of the Plan Year. I assume this risk of forfeiture of moneys remaining in my flex accounts. I also understand that all expenses for which I seek reimbursement must be for services performed during the Plan Year and while I am a participant in the Flexible Benefits Plan. I understand payments for Reimbursement Accounts will be made directly to me. I understand that I cannot revise or revoke this Enrollment Authorization or in any way change the amounts deducted from my salary during the Plan Year, except where the change is consistent with a family status change as defined in the Flexible Benefits Plan. I agree to observe the terms and conditions of the Flexible Benefits Plan and all rules and regulations established by the Company to administer the Plan. I understand that the Employer cannot be held responsible for the tax consequences which may or may not result from the benefit(s) I have selected above. This plan is regulated by Internal Revenue Code Sections 105, 125, and 129, and is subject to discrimination regulations. In the event that the plan is found to be out of compliance with discrimination rules, I may be required to reduce or eliminate my pre-tax deduction election.

Corporate Health Systems, Inc.
PO Box 46850
Eden Prairie, MN 55344-6850
Phone: (952) 939-0911 Fax: (952) 939-0990 www.corphealthsys.com

_____ _____ _____

EMPLOYEE SIGNATURE **EMPLOYEE #** **DATE**

EFFECTIVE DATE: _____

Revised April 2007

Corporate Health Systems, Inc.
Flexible Spending Account Authorization Form
AUTOMATIC DIRECT DEPOSIT

EMPLOYEE NAME:	**(Last)**	**(First)**	**(MI)**
TELEPHONE NUMBER:	**( )**		
SOCIAL SECURITY NUMBER:			
EMPLOYER:			
DIVISION OR LOCATION:			

FINANCIAL INSTITUTION:			**BRANCH:**						
CITY:			**STATE:**		**ZIP:**				
☐ **CHECKING (Attach a Voided Check)**			☐ **SAVINGS (Attach a Voided Deposit Slip)**						
For Savings Only, indicate 9-digit Federal Routing/Transit Number:									

I hereby authorize my employer to deposit reimbursements from my Flexible Spending Account directly into my checking or savings account indicated below. I also authorize the financial institution named below to accept my deposits and to credit the amount to my account. This authority will remain in effect until my employer has received written cancellation notice from me in such time and such manner as to afford my employer a reasonable opportunity to act upon it.

Date:_____ Signature:_____

Please note: The first time a reimbursement is made on an Automatic Direct Deposit basis, your financial institution will process the reimbursement as a trial run. The funds will not actually be deposited to your account. Instead you will be issued a reimbursement check that you will have to cash and deposit yourself. After the trial run all subsequent reimbursements will be deposited directly into your account. Remember to attach a voided check if you want deposits made to your checking account. Attach a voided deposit slip if you want deposits made to your savings account.

AUTOMATIC DIRECT DEPOSIT

Another Convenient Feature Of Your Flexible Spending Account (FSA)

You have the option to have your FSA reimbursements automatically deposited into your checking or savings account. This added service is designed to save you time handling your reimbursements from the plan. Instead of receiving a check for your FSA reimbursement, which you need to take to your bank or credit union to deposit, you will receive a notification stating the amount that has been deposited directly into your checking or savings account. You will continue to receive the flexible spending account summary highlighting the activity of your FSA reimbursement account(s) from Corporate Health Systems, Inc..

To sign up for Automatic Direct Deposit:

- Fill out the form completely, including: your name, Social Security number, telephone number, name and location of your financial institution and the name of your employer, including your division or location.
- Mark the appropriate box to indicate whether your FSA reimbursements will be deposited to your checking or savings account. If Savings, please indicate the 9 digit Federal Routing/Transit Number of your account.
- Attach a voided check to the form if you want reimbursements deposited in your checking account. Attach a voided deposit slip to the form if you want your reimbursements deposited in your savings account.
- Sign the form and mail it along with the voided check or deposit slip to:

Corporate Health Systems, Inc.
P.O. Box 46850
Eden Prairie, MN 55344-6850

If you participated in this option with Corporate Health Systems, Inc. last plan year and your banking information has not changed, you do not need to complete this form again as your banking information is still on file.

REQUEST FOR REIMBURSEMENT

Instructions: **FAILURE TO COMPLETE ALL SECTIONS OF THE FORM MAY DELAY THE PROCESSING OF YOUR CLAIM**. Please print or type the requested information. For all types of claims, complete Part I of the form. Complete Part II for any medical/dental/optical/over the counter type of expenses. Complete Part III for any dependent daycare expense. You **MUST** document each expense by either attaching itemized receipts or have the provider complete the provider certification section (daycare only). Attach copies (do not send originals) of the receipts for each expense showing who the service is for, the provider or store name, the incurred date (not paid date), the amount, and the nature of the expense. If you are submitting more than one expense, number the receipt copy to correspond to the line number on which the expense is listed. **Sign and date the form.** Please make a copy of this form for your records and send the original with attached receipts to:

Corporate Health Systems, Inc. Attn: FSA Claims P.O. Box 46850 Eden Prairie, MN 55344-6850 or Fax to (952) 939-0990

PART I EMPLOYEE INFORMATION

EMPLOYEE NAME_____ EMPLOYER NAME_____

LAST 4 DIGITS OF SOCIAL SECURITY NUMBER_____

ADDRESS_____ CITY / STATE / ZIP_____ ☐ CHECK IF NEW ADDRESS

PART II MEDICAL / DENTAL / OPTICAL / OVER THE COUNTER EXPENSES

LINE	PERSON RECEIVING SERVICE	PROVIDER'S NAME (Doctor, Dentist, Etc.) OVER THE COUNTER PRODUCTS (Store Name)	SERVICE DATE (MO/DAY/YR)	REQUESTED AMOUNT	NATURE OF EXPENSE OR NAME OF PRODUCT	OFFICE USE
1						
2						
3						
4						
5						
6						
7						
8						
			TOTAL AMOUNT REQUESTED:			

PART III DEPENDENT DAYCARE EXPENSES

LINE	DEPENDENT'S NAME WHO IS RECEIVING THE SERVICE	DAYCARE PROVIDER'S NAME	SERVICE DATE RANGE (MO/DAY/YR - MO/DAY/YR)	REQUESTED AMOUNT	AGE OF DEPENDENT	PROVIDER'S CERTIFICATION SIGNATURE AND EXPENSE AMOUNT	OFFICE USE
1						/$	
2						/$	
3						/$	
4						/$	
5						/$	
			TOTAL AMOUNT REQUESTED:				

I certify the above information is correct and the expenses claimed were incurred by me or my eligible dependents after my effective date of coverage in my employer's flexible benefit plan but prior to the end of my employer's plan year. I certify these expenses are **not** eligible for reimbursement under any other plan, and comply with the requirements of this plan. I have not and will not claim these expenses on my personal income tax return. I certify, to the extent required by federal law, that I will file the designated form with the IRS by April 15 of the year after the expenses were incurred.

EMPLOYEE SIGNATURE _____ **DATE** _____

A REMINDER ABOUT REIMBURSABLE HEALTH CARE EXPENSES

See your Summary Plan Description for additional information.

1. You can use a Medical Reimbursement Account to get reimbursed for any eligible expenses not paid in full by another plan, or for any eligible expenses not covered by your health plan**. An eligible expense must meet the following requirements:**
   - Must be directed or prescribed by a physician, *except for* eligible over-the-counter products.
   - Must be directly related to a physical or mental condition.
   - Expenses must be incurred on or after the effective date of the plan and while you are a participating employee.
   - Expenses must be incurred for you, your spouse, or other person who qualifies as an eligible dependent for federal income tax purposes.

2. Examples of eligible expenses include:
   - Deductibles (the part of covered expenses you pay before your health plan pays any benefits).
   - Coinsurance amounts (the percent of covered expenses you must pay, if any, after the deductible requirement has been met).
   - Dental expenses, such as, exams or other accepted services.
   - Vision care expenses, such as, eye examinations and eyeglasses.
   - Hearing care expenses, including hearing examinations and hearing aids.
   - Routine physical examinations
   - Prescription medications
   - Over the counter medicines and products

3. You must furnish proof the expenses were incurred by attaching an itemized statement from the provider. If a statement is attached, please write the corresponding line number which the expense is listed (taken from column (1) on the front of the form).

4. HRA/VEBA Eligible Expenses (if applicable):

   Eligible expenses are subject to your employer's HRA/VEBA Plan Document. See the HRA/VEBA plan document for a list of eligible expenses as they may differ from those listed above.

A REMINDER ABOUT REIMBURSABLE DAY CARE EXPENSES

1. In order for your day care expenses to qualify for reimbursement from the Day Care Expense Account, the following requirements must be met:

   - If you are married, your spouse must be working for pay, attending school or seeking employment while you are at work.
   - The children receiving day care must be under the age of 13 at the time the day care services are provided, or the person receiving care must be physically or mentally incapable of self care.
   - The provider cannot be listed as a dependent on your federal income tax form, and, if the provider is your own child, must be at least 19 years of age.
   - Expenses must be incurred on or after the effective date of the plan and after the date you become a plan participant.
   - Under federal law, when you file your income tax return with the IRS you must also report the name, address, and taxpayer identification number of all providers of dependent day care services whose fees were reimbursed to you under this plan during the year. Failure to do so constitutes tax fraud **unless** the provider of these services is a 501(c) (3) tax-exempt organization. If you have questions on how this might affect your tax filing, refer them to your tax advisor.

1. If the amount of day care expense reimbursement you receive for a calendar year exceeds your earnings if you are single, or the earnings of the lower paid spouse if you are married, the difference must be reported as taxable income for the year. There are special rules if your spouse is a full time student or is physically or mentally incapable of self care. Again, see your tax or legal advisor.

2. You must furnish proof that the expenses were incurred **either** by having the provider complete the Certification of Provider Section of the form or by attaching an itemized statement from the provider. If a statement is attached, please write on that statement the line number (taken from column (1) from the front of the form) corresponding to that item of expense.

3. If there is not enough money in your Day Care Expense account to cover in full the eligible expenses listed on this form, you will be reimbursed up to the amount of your account balance. Additional reimbursements due you will be temporarily suspended. Suspended amounts will automatically be processed each time reimbursements are paid.