HEALTH CARE ACCOUNT- How to request reimbursement?

(Do not fax or mail this instruction page)

Options:

1. Use a Smartphone: Download the mobile Apps **"BofA Health"** on your iOS/ android smartphone. Take picture of your receipt and enter the claim detail and submit your reimbursement request.

2. Online Submission: Log in to your account at bankofamerica.com/benefitslogin. Submit your claim online and attach the picture or scanned copy of your receipt online.

Option 1 & 2 are the fastest and most convenient way to complete your claims and send your documents for processing . Your images will be uploaded on a real-time basis.Processing may take 4 - 5 business days from the receipt date of your submission. You can upload three image files at a time and each image file can use as many pages as you need (be sure to use the multi page TIFF or PDF files on your scanner). You can also take a picture of your document and upload it.

3. Fax/ Mail: Enter the claim online at bankofamerica.com/benefitslogin, then print the online fax cover sheet and submit the cover sheet with your supporting documents through Fax or Mail. Otherwise complete and sign this claim form and attach the copy of your supporting documents and submit through Fax or Mail.

Fax: 1.866.791.0252 **Mail: Bank of America Benefit Solutions, PO Box 25165, Lehigh Valley, PA 18002-5165**

Submitting your claims via fax or mail may take 7-10 business days from the date received to process. For quicker processing turnaround times and convenience, we highly recommend uploading your images electronically through option 1 or 2.

Instructions to fill out this form:

- Please print/ write in capital letters, with the letters centered in the boxes
- Complete all information of " Your Information"- Section 1
- Use your documentation to complete "Your Expenses"- Section 2 of the form, including the following:
  1. Service Provider Name
  2. Patient Name & Relationship with participant
  3. Write Expense Code using the List available in the right side
  4. Enter Service Start & End Date
  5. Your Out-of-Pocket expenses
- Read the Certification of Section 3 and then Sign and date the form

SECTION 1: YOUR INFORMATION (Use only CAPITAL LETTERS)

Participant ID or SSN (If SSN, NO Dashes)	Employer or Group Name
1 2 3 4 5 6 7 8 9	ABC GROUP

Participant Last Name	Participant First Name
D O E	J O H N

Participant Email	Daytime Phone # (Area Code First- NO Dashes)
JOHN_DOE@EMAIL.COM	1 1 1 2 2 2 3 3 3 3

SECTION 2: YOUR EXPENSES (Use only CAPITAL LETTERS)

Expenses 1

Provider Name (1)	Patient Name & Relationship (2)	Expense Code (3)
CITY HOSPITAL	MARY DOE- SPOUSE	1 0 6

Service Start Date (MMDDYY)	Service End Date (MMDDYY) (4)	Out-of-Pocket Expenses ($) (5)
0 2 0 5 1 4	0 2 1 0 1 4	2 0 0 . 0 0

List of Expense Codes:
Medical:
101 = Ambulance
102 = Coinsurance
103 = Deductible
104 = Doctor
105 = Equipment
106 = Hospital

SECTION 3: SELF CERTIFICATION

EMPLOYEE SIGNATURE:* [signature] DATE: 2/25/2014

*Your signature is required in order to process your claim for reimbursement

Acceptable Supporting Documentation:

- Copy of Explanation of Benefits(EOB) from your insurance company
- Copy of itemized receipts from your pharmacy or medical/dental/vision provider. Your receipts must show:
  - Date of service or purchase *(not just the payment date)*
  - Type of service or name of product *(please check bankofamerica.com/benefitslogin for eligible service or product list. There are some product or services which require a letter of medical necessity from your physician, e.g. Massage Therapy, Wellness service etc.)*
  - Amount Charged *(Receipt must clearly show the Patient responsibility)*
  - Name of Service Provider *(person or organization)*

Unacceptable Supporting Documentation:

- Credit/Debit Card receipt, Cancelled checks or other payment statements are not considered acceptable evidence
- Documentation showing a Previous balance/ Balance forward amount
- Prepayments are not allowable. Do not submit pre-treatment estimates or estimated insurance statements
- Do not send original copy of receipts or supporting documentation. Keep original copies with you for any future requirement

Notes:

- **While submitting any Orthodontia claims** for the first time, please submit the orthodontia contract from the orthodontist along with any proof of payment (such as Credit Card receipt, Cancelled Check etc.).
- **Receipts for over-the-counter (OTC) medications/items** must show the purchase date and the name of the medicine/item. Please circle the expense on your receipt. A valid prescription is required for most of the OTC medications (e.g. Cough & Cold drops, Pain relief drugs, allergy medicine etc.) to get approved. But for insulin, diabetic supplies, OTC medical devices (crutches, blood sugar monitors, blood pressure monitors, etc.), bandages, contact lens solutions, etc. don't need prescriptions.

Health Care Claim Form

Fax to: 1.866.791.0252

Mail to: Bank of America Benefit Solutions, PO Box 25165, Lehigh Valley, PA 18002-5165

Go Paperless! You won't need to Complete paper Forms anymore. Download our mobile Apps "BofA Health" on your iOS/ android smartphone or visit bankofamerica.com/benefitslogin to submit online and expedite reimbursement

SECTION 1: YOUR INFORMATION (Use only CAPITAL LETTERS)

Participant ID or SSN (If SSN, NO Dashes)

Employer or Group Name

Participant Last Name

Participant First Name

Participant Email

Daytime Phone # (Area Code First- NO Dashes)

SECTION 2: YOUR EXPENSES (Use only CAPITAL LETTERS)

Expenses 1

Provider Name

Patient Name & Relationship

Expense Code

Service Start Date (MMDDYY)

Service End Date (MMDDYY)

Out-of-Pocket Expenses ($)

Expenses 2

Provider Name

Patient Name & Relationship

Expense Code

Service Start Date (MMDDYY)

Service End Date (MMDDYY)

Out-of-Pocket Expenses ($)

Expenses 3

Provider Name

Patient Name & Relationship

Expense Code

Service Start Date (MMDDYY)

Service End Date (MMDDYY)

Out-of-Pocket Expenses ($)

Expenses 4

Provider Name

Patient Name & Relationship

Expense Code

Service Start Date (MMDDYY)

Service End Date (MMDDYY)

Out-of-Pocket Expenses ($)

More expenses? Please complete another Claim Form.

List of Expense Codes:

Medical:
101 = Ambulance
102 = Coinsurance
103 = Deductible
104 = Doctor
105 = Equipment
106 = Hospital
107 = Laboratory
108 = Pharmacy Prescription
109 = Related Travel
110 = Therapy
111 = Over The Counter (OTC)

Medical - Preventative:
201 = Immunization
202 = Physicals
203 = Screening
204 = Smoking Cessation
205 = Weight Loss

Dental:
301 = Equipment
302 = Examination
303 = Orthodontia
304 = Prescribed Medication
305 = Pharmacy Prescription
306 = Treatment

Vision:
401 = Equipment
402 = Examination
403 = Prescribed Medication
404 = Pharmacy Prescription
405 = Treatment

SECTION 3: SELF CERTIFICATION

I hereby certify that all items I requested to be reimbursed by the Flexible Spending Account (FSA) or Health Reimbursement Arrangement (HRA) comply with the Plan Documents. Such items have not and will not be covered by any other plan or pro-gram of any employer or other person, nor have these items been paid for by a debit card or stored valued card offered with the FSA or HRA. I further certify that such items will not be deducted or taken as tax credits on my personal federal and state income tax returns for any year.

If you have questions regarding the status of an individual as an eligible dependent, such as a qualifying child, qualifying relative or qualifying adult, you should consult a tax professional in conjunction with the provisions of your employer's plan.

EMPLOYEE SIGNATURE:* DATE:

*Your signature is required in order to process your claim for reimbursement