Welcome Packet

UNIVERSITY OF SAN FRANCISCO

CHANGE THE WORLD FROM HERE

Plan Year:
January 1, 2014 *through* December 31, 2014

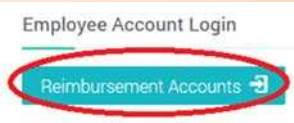
(CBA became the administrator of the plan on August 1, 2014)

WELCOME!

Upon enrollment in your Flexible Benefit Plan(s), the following information provides more details and helpful information on how to effectively use your benefit(s) as well as answers to frequently asked questions.

How do I login to access my personal online account?

Access your online account at http://www.cbadministrators.com/.
Click on 'Reimbursement Accounts' under 'Employee Account Login.'



If this is the first time using the web portal, your user name and default password is:

Default Username:

- The first two letters of your last name in CAPITALS, followed by
- "USF", followed by
- The last 4 digits of your social security number
  *(For example, if your last name is Smith, and your SSN is 123-45-6789, your username would be **SMUSF6789.**)*

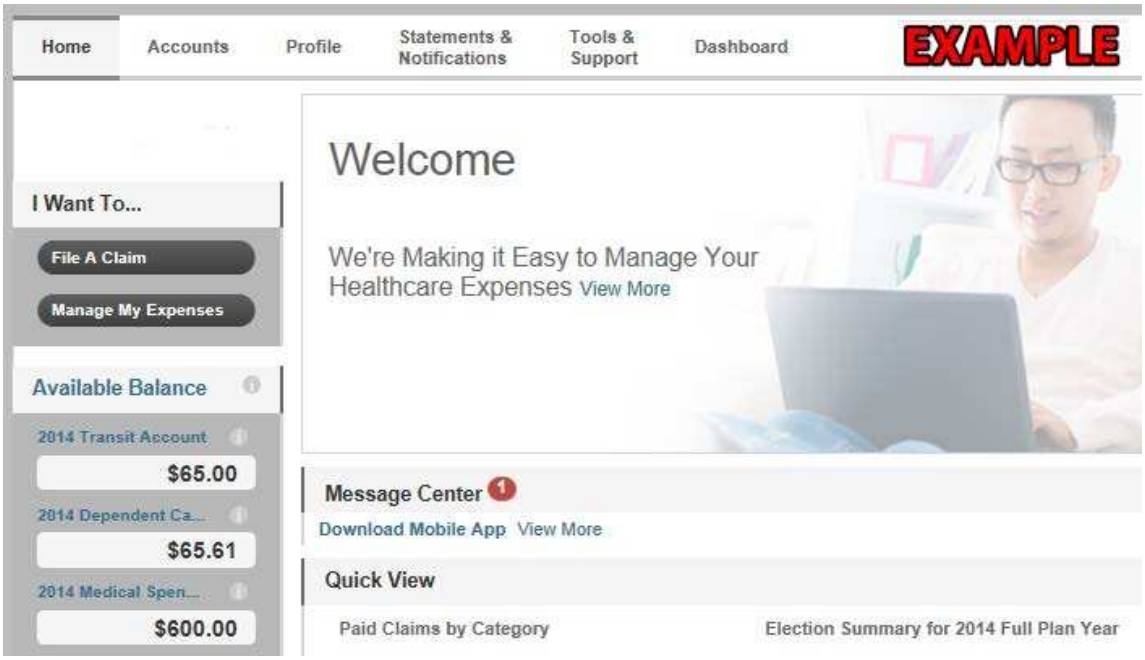
Default Password: PASSWORD (this is case sensitive)

CBA

Contact CBA Customer Service: (916) 303-7090 or (800) 574-5448 M-F 8:30a – 4:30p PST
Fax: (916) 303-7083 or (800) 584-4591 | Email: customerservice@cbadministrators.com
Mailing Address: P.O. Box 2170, Rocklin, CA 95677

Example of your Personal Home Page

- When you login to your personal online account, you may view up-to-date account information at any time, 24/7 with online access. You may check available balances or view claim history of any account via the HOME or ACCOUNTS tabs. Select PROFILE tab to review and update your personal and dependent information, direct deposit banking information, or to change your password or security questions. Select STATEMENTS & NOTIFICATIONS to view any history of account statements, denial letters, or receipt reminder history. Click the FORMS tab to view or download any materials, including the SPD.



Frequently Asked Questions:

How soon can I start using my Spending Account(s) after I enroll?

- You may submit claims for qualified expenses incurred after the plan year starts or, if later, the effective date you become a participant. The Medical FSA account is pre-funded by your employer, meaning your entire annual election amount is available for reimbursement at any time during the plan year, regardless of the amount you have contributed from your paycheck. However, this rule only applies to the Medical FSA. For all other accounts you will only be reimbursed up to the amount you have contributed as of the date CBA processes your claim. Still, in general you should always request the entire amount of your expense, regardless of the amount in your account at any given point in time.

Where can I find more details about my Plan?

- Your Summary Plan Description (SPD) is available online and provides the most detailed information about your plan. There is a lot of other helpful information online that can be found by logging into your personal online account and selecting the TOOLS & SUPPORT tab.

What happens if my employment terminates or I lose eligibility to participate in the plan(s)?

- **Medical FSA:** Benefits will not be payable for services rendered after **your last day of employment or change in benefit eligibility**. (Refer to your SPD for information about COBRA for the Medical FSA, if it is available).
- CBA must receive your **Medical FSA c**laims for reimbursement no later than **60 days after your last day of employment or change in benefit eligibility** for expenses that were incurred prior to the last day of employment or change in benefit eligibility.
- **Dependent Care FSA:** Benefits will not be payable for services rendered after **your last day of employment or change in benefits eligibility.**
- CBA must receive your **Dependent Care FSA** claims for reimbursement **no later than 60 days after your last day of employment or change in benefit eligibility** for expenses that were incurred prior to the last day of employment or change in benefit eligibility.

How your CBA debit card works:

- Two debit cards will be provided that can be used to access accounts you've enrolled in. You may provide the second debit card to your spouse or adult dependent, or keep the second card as an alternate card to use, just in case.
- The debit cards will be good for 3 years, so be sure to keep them through the expiration date. If CBA has to reissue your card before it expires, you may be charged a replacement card fee.
- If this is the first year that you have chosen to use a debit card as your primary reimbursement option, you will receive your cards at your address on record with CBA (usually your home). In addition, we (CBA) may issue replacement cards on a periodic basis. In most cases, your card will arrive within two weeks from the date you received this material.
- You do not have to activate your cards. They will automatically activate the first time you use them.
- Your CBA debit cards can be used to pay for qualified services at merchants that accept VISA or by using your PIN (Personal Identification Number).
    - To obtain a personal PIN for your CBA debit card, call **1-866-898-9795** and the automated system will walk you through the process. You may call the same number if you need to re-set your PIN.
    - To use your PIN, when you swipe your CBA debit card, select 'Debit' on the keypad and enter your PIN when prompted. PINs will only allow you to pay for eligible goods and services at the point-of-sale. Cash-back and ATM transactions are not permitted.
    - If you are prompted to enter a PIN and have not selected one yet or do not wish to use a PIN, let the merchant know that you wish to pay using the signature process (VISA). The merchant will be able to direct you accordingly.
    - If your purchase is declined after attempting to use the VISA signature process and/or PIN, you will need to use another form of payment and submit the claim for reimbursement.
- In order to use the debit card, you must agree to notify CBA in writing (email is fine) of any change to email or mailing address. If you do not maintain an email address, your card privileges will be suspended or terminated without further notice until you provide us with a new address.
- It is your responsibility to report a lost or stolen card to CBA immediately. If you fail to notify CBA immediately, you may be responsible for all amounts paid up to the date you report the loss.
- If you received documentation but are unable to provide it to CBA when requested, or purchased an ineligible expense with your card, you will have to repay the debit card expense. In most cases, you can write a check or request for CBA to draft the funds from your bank account. If you cannot repay a charge when required, your card privileges may be suspended and the amount due may be deducted from a future claim. In extreme cases, you could lose your eligibility to participate in the plan.
- **PLEASE NEVER SUBMIT A PAPER CLAIM FORM OR FILE A CLAIM ONLINE FOR AN EXPENSE YOU'VE PAID FOR WITH YOUR DEBIT CARD.**

Using your debit card for Medical FSA expenses:

- Whenever you use your card for medical expenses, you agree to retain complete records of your purchase. While over 70% of all Flexible Spending Account (FSA) swipes can be auto-approved (i.e. we will not require you to submit supporting documentation after your purchase), 30% of debit card FSA purchases DO REQUIRE supporting documentation.
- For medical expenses, debit cards are only allowed to be used at retailers and pharmacies that are IIAS Compliant. IIAS stands for Inventory Identification Approval System.
- If CBA requires supporting documentation, complete third-party documentation must be submitted that includes: (1) patient's name; (2) service provider's name; (3) full date of service (including year); (4) description of service; (5) charge or patient portion for your service. you will receive an email notification approximately 6 days after your purchase using your debit card. If you do not respond to our first request in a timely manner, you will receive a second courtesy request approximately 20 days after your original purchase. If you fail to respond to this second request, you will receive one last request approximately 40 days after your original purchase. This final request will include a warning that your claim will automatically be denied if you fail to provide the required documentation within 5 business days. If you fail to repay the

denied charge before 60 days from your original purchase date (or the date your plan year ends, if sooner), your card privileges may be suspended or terminated without further notice until such time as you clear your account. An extra fee may be charged to re-activate your card. If your claim is denied, you still have the ability to provide us with the required documentation instead of paying back the charge. In addition, whenever you have an outstanding denied claim that has not been repaid or cleared, you agree to allow CBA to automatically deduct the amount due from a future claim.

Using your debit card for Dependent Care FSA expenses:

- The debit card **cannot** be used to pay for child care expenses under the Dependent Care FSA.

Claim Filing Tips, Suggestions, and Instructions:

What does an expense "incurred" mean?

- An expense is considered incurred on the date services are rendered, without regard to when you pay. Reimbursements are approved based on the date the service is rendered. This is why a check copy, credit card payment receipt, statement with payment balance forward or cash register receipts are not acceptable forms of documentation under the law. The only exception to this rule is that you may use a cash-register receipt as your documentation when you purchase Over-the-Counter (OTC) medical supplies from a retailer or pharmacy.

Important information about emailing a claim to CBA:

- Emailed claims must be sent as a single file in PDF (Adobe) format. This means you need to scan your claim form and supporting documentation into a single PDF file before emailing. Claims that are not combined into a single PDF file may be delayed. In addition, claims that are not combined have a much higher incidence of errors in processing because your documentation can get separated. **Also, please be aware that sending personal and medical information via email is not secure.**

When is a claim form required?

- A claim form is always required when you submit a manual (paper) claim (via email, fax, or mail) for reimbursement. A properly completed claim form is critically important for two reasons. First, using a claim form ensures we can identify the participant. And second, claim forms include a certification that is required to be signed by the participant. The certification is a legal requirement of the plan. Without a signed certification, your employer may not pay out tax-free benefits.
- You do not have to submit a claim form when you file a claim electronically through the online system.

How does CBA reimburse me?

- Each participant has the option to be reimbursed by check or direct deposit (check is the default option). Direct deposit is highly recommended because it is efficient, convenient, and environmentally sensitive. If you are not already receiving reimbursement via direct deposit, you may sign-up at any time through your personal online account under the PROFILE tab, or by completing a direct deposit form.

How often does CBA pay claims?

- Reimbursements are paid each Wednesday and Friday (except holidays). The cut-off to receive claims for each reimbursement cycle is noon (PST) on the previous business day (i.e. noon on Tuesday for reimbursement on Wednesday.) Claims received after the cut-off will be included on the next reimbursement date.

What if I have to pay for a service before it is performed?

- In general, you may not request reimbursement for any expense until the service has been rendered. If you are required to pre-pay for a service, you will have to wait to be reimbursed until the service is provided.

What is the smallest claim amount that I can submit?

- CBA does not have a minimum claim or reimbursement amount. Having said this, most people don't want to receive a $3 check in the mail; therefore, we suggest accumulating expenses and submitting them in batches so you receive a sizable reimbursement.

Can a claim be denied?

- While we go to great efforts to reimburse claims, sometimes a claim must be denied (returned) because it is either incomplete, illegible or an ineligible expense. When we have to deny a claim, we will provide a written notification (via email or US mail). The notification will include an explanation of the denial and instructions for resubmitting the expense (if applicable).

What supporting documentation is required to be reimbursed?

- The supporting third-party documentation required differs for each reimbursement account. Third-party refers to documentation that is provided to you by your service provider (doctor, dentist, insurance carrier or day care provider). Your documentation must also be complete and legible.
- For medical-related reimbursement accounts (such as Medical FSA), documentation must include: (1) patient's name; (2) service provider's name; (3) full date of service (including year); (4) description of service; (5) charge or patient portion for your service.
- For Dependent Care FSA, you may obtain your provider's signature on the claim form in-lieu of providing separate documentation.

What is the deadline to submit claims?

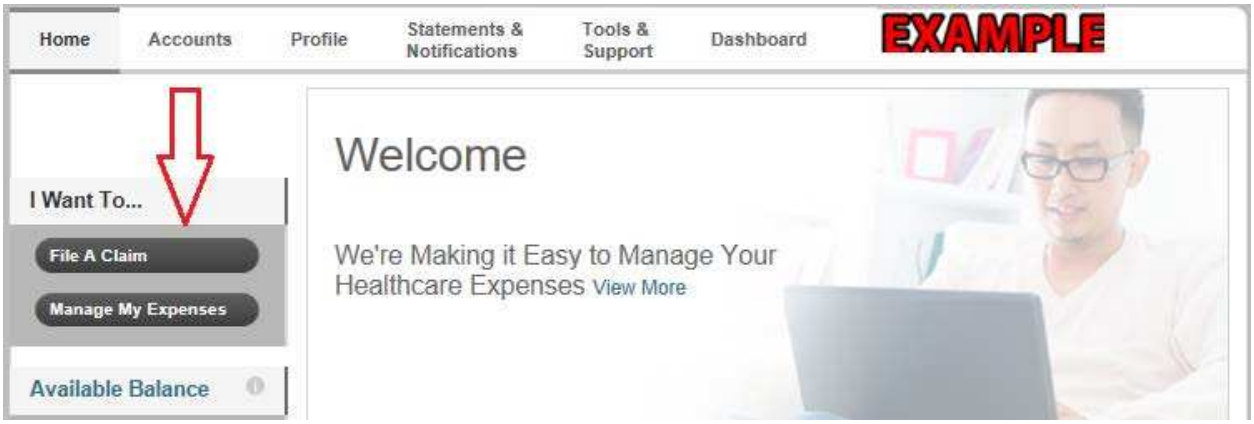
- Following the end of each plan year, active participants in the Medical FSA and Dependent Care (day care) FSA must submit all claims by the designated filing date. Claims ***received*** by CBA after this deadline will be denied (meaning you will not be reimbursed). If you terminate employment or otherwise lose your eligibility to participate in these accounts during the plan year, you may be required to submit claims shortly after you lose your eligibility. Review your enrollment materials or SPD to determine the filing deadline for your plan.
- **DO NOT ALTER YOUR DOCUMENTATION.** Third-party documentation must stand-alone. Review the documentation at the point-of-service to ensure that all necessary information is included. It is your responsibility to make sure that the provider gives you what you need to receive your pre-tax reimbursement. Please avoid highlighting your paperwork. Highlighted areas often become illegible in transmission. BE AWARE: Colored, carbon or thermal-paper receipts may transmit too light to be legible. They may also fade over time. Copies are acceptable and even recommended in these circumstances.
- **Expenses covered by insurance** must be processed by your carrier before you request reimbursement. If you have insurance coverage for an expense, your insurer must process the claim before you are permitted to request reimbursement from your FSA. Most insurance carriers issue Explanation of Benefits (EOBs) after they process a claim. EOBs are excellent third-party documentation to use for your FSA reimbursement request.
- When submitting a claim for **prescription drugs** only, the most common error we see is submitting the cash register receipt as documentation. Generally, the patient name will not be included on a cash register receipt. Without the patient name, your expense will be denied. Instead, use your pharmacy tag or tax receipt provided with your prescription. If you misplace your tax receipt, most pharmacies can provide you with a detailed printout of all your prescriptions. Please be advised that prescription drugs obtained outside of the U.S. are not reimbursable. The only exception is if you refill an existing prescription while you are visiting another country.
- You must obtain a prescription to be reimbursed for your **Over-The-Counter (OTC)** drug and medicine purchases. Remember though, there are still thousands of medical supplies and products available that do not require a prescription for you to be reimbursed. Review your employee materials from CBA for detailed information about OTC drugs, medicines and supplies.
- **Personal use items** such as soap, toothpaste, toothbrush, cosmetics, cream, shampoo, lotion, etc. are not reimbursable even if they contain a medicated component (i.e. dandruff shampoo).
- In order to establish **medical necessity** for a product or service that would normally be considered a personal use expense, you must submit a prescription (statement) from your treating physician on your physician's letterhead that: 1) identifies the medical condition being treated; 2) recommends the specific course of treatment (i.e. massage therapy, weight-loss, etc.); and, 3) states the duration of the treatment (i.e. 12 sessions; 3 months; lifetime.) In addition, for reimbursement purposes, you may not commence treatment or incur an expense until after you obtain your prescription.

- You may find it necessary to **obtain medical care while outside the U.S.** Expenses you incur abroad may be considered for reimbursement under the following circumstances: 1) The service must be considered legal in the U.S.; 2) The documentation must be in English or translated to English by the third-party provider of service; 3) The cost for the service must be expressed in US dollars on the date the service is rendered. If the provider cannot bill you in US dollars, you will need to have the cost of the expense(s) converted into US dollars by a banking institution within that country on the same day the expense was incurred. 4) All other documentation requirements must also be met.
- **Orthodontia** is one of the most popular expenses in a Medical FSA, and for good reason. You know exactly how much you owe and exactly when you owe it. However, obtaining complete documentation can be confusing. Commonly, orthodontia is either paid for in-full at the start of treatment or monthly payments are extended over the treatment period. IRS guidance allows for reimbursement in either of these circumstances based on the payment contract you and your provider agree upon. This will determine your allowable reimbursement for the current plan year. If full payment is made at the start of treatment, you can claim 100% of your cost once treatment begins (i.e. bands have been placed or in the case of Invisalign®, when the first trays are delivered). If you have a monthly payment contract with your provider, we can set-up an automatic reimbursement. Just include a copy of your orthodontia contract with a completed claim form and request the amount you will owe for the entire plan year. You will receive your reimbursement once a month throughout the plan year. If you do not have a contract, your provider can complete an Orthodontia Information Form located online under the TOOLS & SUPPORT tab.
- For **daycare expenses**, we recommend you request the amount you pay, regardless of the amount in your pre-tax account. If the amount of a claim exceeds the amount in your account, the excess portion will be reimbursed automatically as you continue to make payroll contributions.

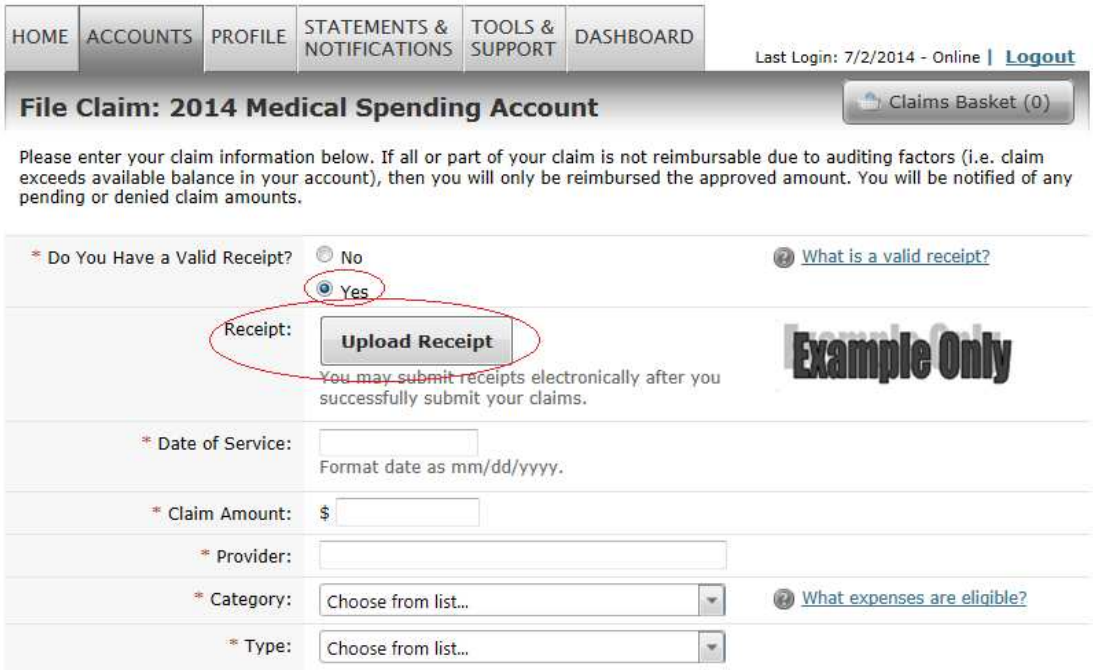
Instructions: How to file a claim using the online system

(This is the most secure method to file a claim.)

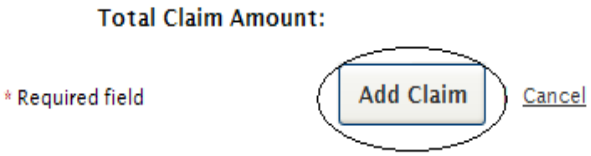
- Now that you have enrolled, you may begin to file claims after the start of the Plan Year (or the date you enrolled, if later). Follow the steps to prepare and file an online claim via our participant portal site:
- After you have logged into your account at http://www.cbadministrators.com/, click on 'File A Claim'. Then select the 'File Claim' button next to the appropriate account.



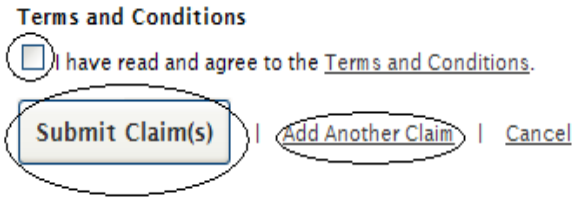
- You must select 'YES' next to 'Do You Have a Valid Receipt?' to continue online filing.
- A copy of your receipt may be uploaded (must be in PDF, JPG, GIF format and cannot exceed 2 MB) by clicking 'Upload Receipt'. Use 'Browse' to locate and attach the receipt and/or other supporting documentation to your claim and upload.



- Note: Under 'Category' and 'Type', if more than one selection from the drop-down list seems right, select the one that best fits the expense.
- Make sure to click 'Add Claim' on the bottom of the screen; this will take you to the next screen.



- If you have more than one expense/claim, click on 'Add Another Claim'. Repeat as needed.
- On the Claims Basket screen, when all expense(s) have been entered, check the box to agree to the Terms & Conditions and click 'Submit Claim(s)'. (If you need to leave the site for any reason, be sure to click 'Submit Claim(s)' first or you will lose everything you have entered.)



- If you uploaded all your receipts and/or supporting documentation, there is nothing more you need to do.
- If you cannot upload your receipts and/or supporting documentation, click 'Print the Claim Confirmation Form' and send the confirmation to CBA with your documentation via e-mail, fax or mail. This confirmation page serves as your claim form and verifies that all claims have been successfully submitted. Your claim is considered received by CBA only after CBA receives your supporting documentation.

Additional Receipt Submission Options

Email:	customerservice@cbadministrators.com
Fax:	Print the Claim Confirmation form and include as the cover letter **Fax receipts to:** (800) 584-4591
Mail:	Print the Claim Confirmation form and include in your mailing **Mail receipts to:** P.O. Box 2170 Rocklin, CA 95677

- **NEVER SUBMIT A PAPER CLAIM FOR A CLAIM YOU HAVE ALREADY FILED ONLINE OR FOR AN EXPENSE YOU'VE PAID FOR WITH YOUR CBA DEBIT CARD.**

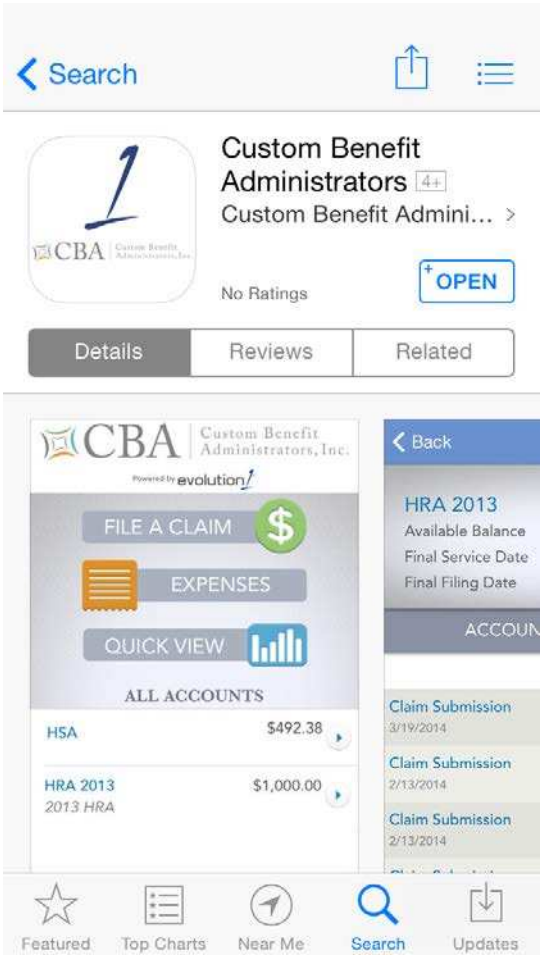
Instructions: How to file a paper (or manual) claim form

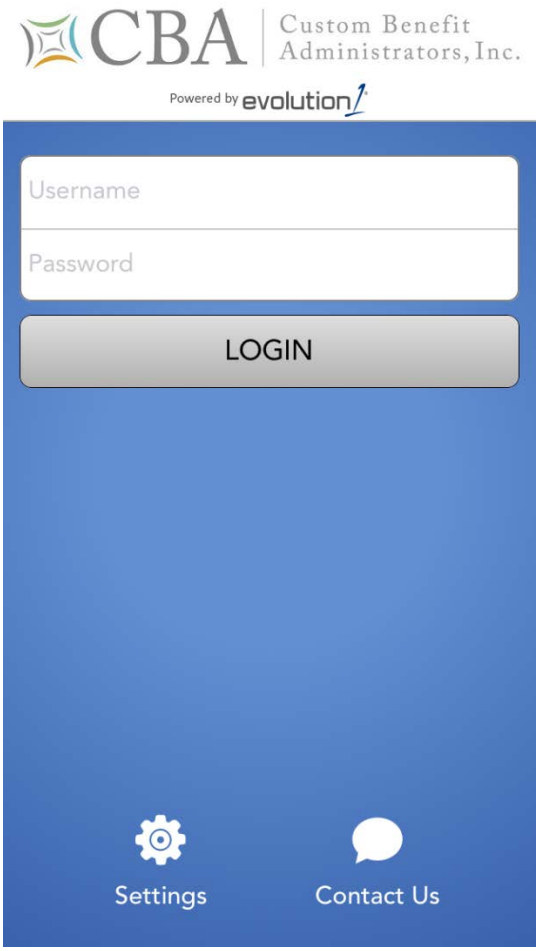
- You may opt to file claims using the claim form (available online under the TOOLS & SUPPORT tab.)

- Complete the claim form in full including your certification (signature).
- Do not highlight, alter or write on your documentation.
- Consider photocopying colored, carbon or thermal-paper receipts, as they may transmit too light to be legible. They may also fade over time, so photocopying may help to preserve the long-term integrity of the document.
- Retain a complete copy for your records.
- Submit your completed claim form and required documentation via email (PDF only), fax or mail. **Please be aware emailing may not be secure.**
- **NEVER SUBMIT A PAPER CLAIM FORM FILING FOR A CLAIM YOU HAVE ALREADY FILED ONLINE OR FOR AN EXPENSE YOU'VE PAID FOR WITH YOUR CBA DEBIT CARD.**

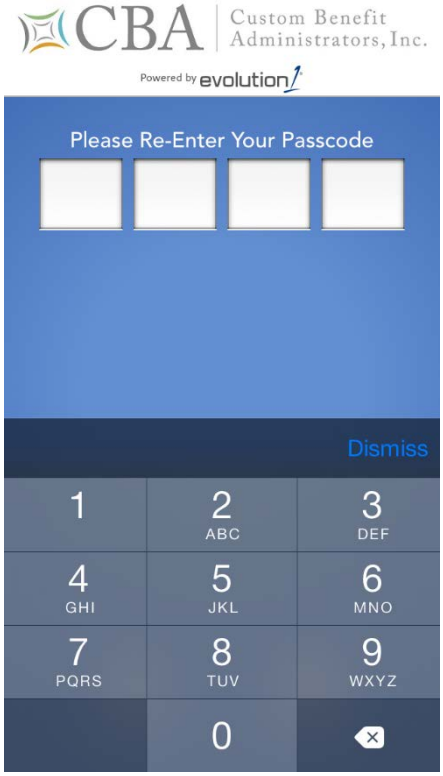
Instructions: How to use the CBA mobile app

- You may download the CBA mobile app (it's FREE!) for iOS (iPhone, iPod touch, iPad) version 3.0 and higher or Android version 1.6 and higher.
    - Use the mobile app to manage your accounts whenever and wherever you want.
    - You can access the balance information of your account(s), final service dates to incur claims, final filing date to submit claims, account activity including claim submissions, denied claims, and new election amounts.
    - For Medical FSA (and some HRA accounts) only, you may also submit a new claim, including taking a picture of the receipt or documentation and upload it.
- Go to your Mobile App Store on your phone and search Custom Benefit Administrators.
- Select and install application, then enter your username and password (same as used to access online personal CBA account.)

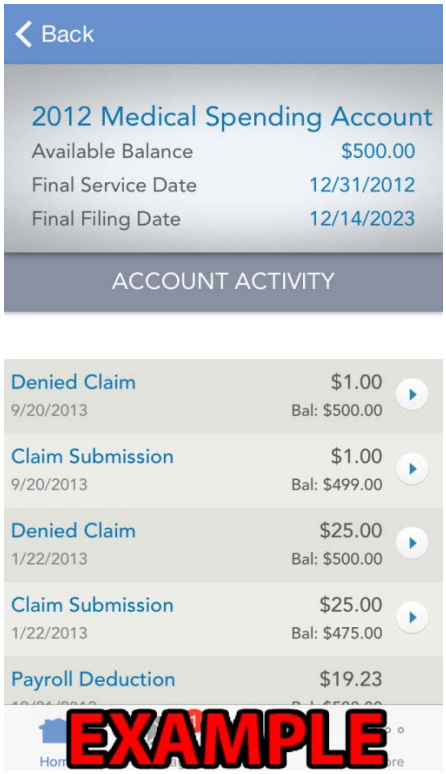




- Enter a 4-digit passcode to login (you'll be asked to re-enter it again to confirm it upon first login). Once you've logged in the first time, any time you login afterward you'll only be asked to enter your 4 digit passcode.

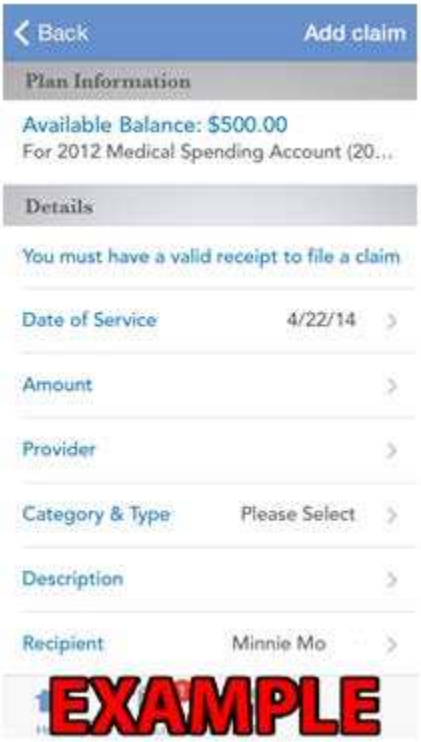


- Select the account you wish to review and then review your Account Details and Account Activity.



- **For Medical FSA <u>only</u>** – you may submit a claim via your mobile app. Select 'File A Claim'.

- Enter details regarding the claim. Select Upload Receipt to take a picture of the documentation or receipt. Once the documentation is uploaded, 'Mobile Receipt' appears under Receipts. You may select Mobile Receipt to view the picture of the uploaded receipt. Select 'Add Claim' to submit your claim. If you have enabled text alerts, you will receive a text (and email, if applicable) stating a claim has been filed for your account.



EMPLOYEE NOTICE
HIPAA PRIVACY RIGHTS & PRACTICES
FOR THE
UNIVERSITY OF SAN FRANCISCO Health Flexible Spending Account (FSA)

The University of San Francisco FSA ("Plan") has the duty to protect your medical information. The Plan further has the duty to provide you with a notice of its privacy practices, which follows. The Plan has the right to change or modify this notice, at any time, and any modifications will be communicated to you. This notice describes how your medical information may be used and disclosed, and how you can get access to it. Please review it carefully.

The Health Insurance Portability and Accountability Act limits how a covered entity can use and disclose protected health information (PHI). Generally, a covered entity, including your health plan, your health care provider, or, a health care clearinghouse, can share information without your authorization, for purposes of treatment of you, payment for your medical services, and for the health plan's operation. In all other instances, you must authorize any disclosure of your health information.

Permitted Disclosures
The Plan can use and disclose your PHI for the following purposes, without your authorization, for making or obtaining payment for your health care, and for conducting health plan operations.

Examples of when and how your PHI can be used and disclosed for payment purposes, without your authorization, are:

- For coordination of benefits among multiple plans that cover you
- For utilization review purposes
- For case management purposes
- For precertification purposes
- Any other purpose necessary to ensure coverage for you, and to obtain or make payment for services rendered to you.

Examples of when and how your PHI can be used and disclosed for health plan operations, without your authorization, are:

- To ensure coverage for you
- For quality assessment purposes
- For cost containment purposes
- To ensure compliance with the terms of the Plan, or with clinical or other relevant medical guidelines and protocols
- To provide you with treatment alternatives
- For health plan and provider accreditation verification, licensure, or any other credentialing purposes
- For underwriting, premium rating, and related functions
- To create, renew, or replace your health insurance or health benefits
- To conduct audits, including compliance, medical, legal, business planning, cost containment, or customer service audit functions.

The Plan can share your PHI with the plan sponsor for certain administrative activities, without your authorization. Examples of sharing PHI include, but are not limited to:

- Seeking premium bids for current or future coverage
- Obtaining reinsurance
- Amending, modifying, or terminating the plan
- Participant and enrollment information

Your PHI can be released in summary form, or, as a part of "de-identified" information, in accordance with the Code of Federal Regulations. Other instances, in which your PHI may be released, without your authorization, include:

- When legally required by federal, state, or local law. This instance would include the release of PHI upon the receipt of an order, subpoena, or other judicial or administrative process that would compel the disclosure of your PHI. However, your PHI would only be disclosed after a reasonable effort has been made to notify you of the request for such information.
- For law enforcement purposes, such as investigation of a crime.
- To respond to a threat to public health or safety.
- For workers compensation purposes, or other no fault law.
- To a government authority, such as a social service or other protected services organization, authorized to receive reports of abuse, neglect, or domestic violence.

Authorization for Use and Disclosure

Except as provided above, the Plan will not release any of your PHI without your authorization. If you authorize the release of some, or all of your PHI, you may revoke the authorization at any time. If you authorize release of your PHI, your authorization must include the following items:

1. A description of information used or disclosed
2. Identification of the parties releasing, and the parties requesting the information.
3. An expiration date of the authorization
4. Your signature
5. Information about how to revoke the authorization

Your Individual Rights

You have certain individual rights regarding your PHI; specifically:

1. If the Plan maintains your PHI, you have the right to inspect and request a copy it. The plan may charge a reasonable fee for copying this information. If the Plan does not maintain the PHI, which is the subject of your request, you will be directed to the appropriate party who can assist you with your inquiry.
2. You have the right to restrict the use and disclosure of your PHI, although the Plan is not required to agree with your request.
3. You have the right to receive confidential communications. You have the right to limit or restrict where, or how, the Plan may contact you regarding your PHI.
4. You have the right to request amendments or modifications to your PHI. If you believe your PHI is inaccurate or incomplete, you have the right to request an amendment to your records. In order to be entitled to amend the records, the Plan must maintain the relevant records, and you must make the request for amendment in writing. The Plan has the right to deny your request to amend or modify your PHI if:
   - You do not have a substantive reason for the request
   - The relevant records were not created by the Plan
   - The request falls within an exception to the amendment rights provided by the law
   - It is determined that the information is complete or accurate
5. You have the right to obtain an accounting of any disclosure that has been made of your PHI, other than those disclosures made for health care payment, treatment, or other health care plan operations. To exercise this right, or if you would like to pursue any of your individual rights regarding your PHI, contact:

Name & Title:	**Director of Employee Benefits**
Employer Name:	**University of San Francisco**
Address:	**2130 Fulton Street LMM 339**
City, State, Zip:	**San Francisco, CA 94117**

You have the right to contact U.S. Department of Health and Human Services' Office for Civil Rights (OCR) if you have any complaints about how the Plan has handled your PHI. You can submit your complaint on-line, or download a complaint form at this OCR website (http://cms.hhs.gov/hipaa). Or, you can send your complaint or question to this e-mail address: askhipaa@cms.hhs.gov. Or, you can call the CMS HIPAA Hotline: 1-866-282-0659.

Flexible Spending Account (FSA)

Page ___ of ___*(including this claim form)*

Reimbursement Claim Form

Custom Benefit Administrators

Employer: _____

FAX TO: (916) 303-7083 or (800) 584-4591
EMAIL TO: customerservice@cbadministrators.com

Employee Name: _____ Social Security Number: _____

Phone: _____ E-mail: _____

Dependent Care Expense Claims

Name & Date of Birth of Dependent(s)	Period Covered From	To	Name, Address, and Taxpayer Identification Number (or SSN) of Service Provider	Amount Incurred
☐ *Attach a receipt from your daycare provider, or include the daycare provider's signature.*			**Provider's Signature:**	
			Total Dependent Care Expense Claim*	**$**

*NOTE: The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the Plan Year or the earned income of your spouse. (If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earnings of $250 if there is one (1) child or dependent, or $500 if there are two (2) or more.) No payment may be made under the Plan if the service provider is your dependent for federal income tax purposes; or is your child or stepchild and is under age 19.

Medical Expense Claims

Date Expense Incurred (mm/dd/yyyy)	Name of Service Provider	Expense Description (Medical, Dental, Vision, Rx, OTC, etc.)	Person for Whom Expense was Incurred	Net Amount
☐ *Attach appropriate receipt(s) and submit with this claim form.*			**Total Medical Care Expense Claim**	**$**

REQUIRED DOCUMENTATION: All claims must include "complete" – "third-party" documentation. "Complete" documentation must include the: (1) patient's name; (2) service provider's name; (3) full date of service (including year); (4) description of service; (5) charge or patient portion for the service. If you have insurance, your carrier must process your claim prior to being reimbursed from your FSA. An Explanation of Benefits (EOB) from your insurance carrier is considered "complete" documentation. "Third-party" means provided to you by your service provider (e.g. doctor, pharmacy, day care, etc.) or insurance carrier.

CERTIFICATION: The undersigned participant in the Plan certifies that all services for which reimbursement is claimed by submission of this form were provided during a period while the undersigned was covered under the Plan with respect to such expenses and that the expenses have not been reimbursed and employee will not seek reimbursement from any other plan covering health benefits or from any other source. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim, which is provided by the undersigned, and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes, including federal and state income tax, on amounts paid from the Plan which relate to such expense.

***DO NOT USE THIS FORM IF YOU HAVE FILED YOUR CLAIM ONLINE (or used your CBA Debit Card)**

_____ _____

Employee's Signature Date

Flexible Spending Account (FSA)

Claim Form & Filing Instructions

When filing your claim, you must include copies of complete "third-party" documentation.

Your documentation must include:

(1) the service date (including the year);
(2) the name of the service provider;
(3) the patient's name;
(4) a description of the service provided; and,
(5) your total financial obligation for the service provided.

A statement from your service provider or an Explanation of Benefits (EOB) from your insurance carrier will usually include all of the required information.

The following documentation/receipts are NOT acceptable for reimbursement:

- Canceled Checks are never acceptable or needed. Please do not send them.
- Cash Register receipts for anything **other than over-the-counter** drugs and medicine UNLESS the patient name is indicated on the receipt.
- Credit Card receipts that do not contain the above (5) requirements.

NOTE: If your claim is returned because your documentation is incomplete or illegible, simply submit a new claim with complete and legible documentation.

You may send your claims to CBA using any of the following methods:

E-MAIL - E-mail claims to: **customerservice@cbadministrators.com**

You must send us a scanned copy of your signed claim form and documentation as a single file to the e-mail address above in "PDF" format exclusively. No other format can be accepted. Claims that do not meet these requirements may be returned or delayed. Please be aware that e-mailing information over the Internet may not be secure.

FAX - Local - **(916) 303-7083** / Long Distance - **(800) 584-4591**

Please refrain from calling us immediately to confirm receipt of your fax. Faxed claims are not instantly available to our customer service representatives. In most cases, you will be able to view the status of your claims online within 2-business days at www.cbadministrators.com.

MAIL - Mail to: **CBA Claims Processing, P.O. Box 2170, Rocklin, CA 95677**

Please DO NOT mail your claims "signature required" or it could delay your reimbursement up to a week or even more. We cannot be held responsible for mail that is lost or misrouted by the postal service. Mail received "postage due" will be returned.

If you register claims using the online portal, your claims are considered "received" only after CBA receives your supporting documentation.

Regardless of how you choose to send a claim, please send each claim ONCE ONLY. For example, please do not mail a claim that you have already faxed.

Keep a copy of your entire claim for your records.

You may make copies of this claim form for future use.

DIRECT DEPOSIT ENROLLMENT FORM

Authorization to Receive Reimbursements by Direct Deposit (ACH Credit)

Check one: Initial enrollment ☐ Change existing enrollment ☐

Company Name (your Employer)

Employee Name **Employee SSN**

Verify your mailing address (complete with street, city, state and zip) **Email Address**

Checking ☐ Savings ☐

Name of DEPOSITORY (Name of Financial Institution)

Branch Address **City / State / Zip**

YOUR 9-DIGIT BANK ROUTING NUMBER	YOUR ACCOUNT NUMBER

I (we) hereby authorize Custom Benefit Administrators (CBA) to initiate credit entries to the checking or savings account designated above at the financial institution named above, hereinafter referred to as DEPOSITORY, and to credit the same to such account. This authority will remain in full force and effect until CBA has received ***written*** notification from me of its termination in such time and in such manner as to afford CBA and DEPOSITORY a reasonable opportunity to act on it.

Signature **Date**

Attach "VOID" check here

Deposit slips are not acceptable

Send completed form to: **Custom Benefit Administrators (CBA)**
FAX (916) 303-7083 or P.O. Box 2170, Rocklin, CA 95677

Questions? (916) 303-7090 or (800) 574-5448 or
customerservice@cbadministrators.com

CBA Use ONLY

Entered into BOW	Pre-Note Hold – Release Date	Entered into LH1 & Activated

Direct Deposit

Enrollment Form & Instructions

- ⇨ Direct deposit is a convenient way to receive disbursements from your Flexible Spending Account(s).
- ⇨ Direct deposit reimbursements are processed on the same schedule as check reimbursements. The direct deposit will initiate on "check" day and normally post to your account on the following business day.
- ⇨ When you sign up for direct deposit, you will be notified each time we pay a reimbursement (to receive notifications, we must have your email address on file).
- ⇨ Complete and return this form to enroll for direct deposit.
- ⇨ Return the completed form to CBA or your employer (if permitted).
- ⇨ While not required, we strongly recommend that you attach a "void" check to ensure the accuracy of your account information.
- ⇨ Direct deposit takes approximately three weeks to set-up. During this set-up period, any claims that you submit will be paid by check and mailed to your address on record.
- ⇨ You must complete a new Direct Deposit Enrollment Form each time you change your bank account.
- ⇨ Once you sign up for direct deposit, it will remain in force until you cancel it in writing (or e-mail). Please allow two weeks to process your cancellation.
- ⇨ You may send your direct deposit enrollment directly to CBA using any of the following methods:

FAX - Local - (916) 303-7083 / Toll-free - (800) 584-4591

MAIL - Mail your form to: CBA, P.O. Box 2170, Rocklin, CA 95677

E-MAIL - E-mail your form to: customerservice@cbadministrators.com