Benefit Advantage

EMPLOYEE INFORMATION PACKET

MEDICAL CENTER

NAME _____ AGE _____

ADDRESS _____ DATE _____

Rx

What is an FSA?

An FSA is a Flexible Spending Account plan that allows you to use tax-free income to pay for your family's out of pocket medical and dependent care expenses.

You just set aside some of your gross salary to pay for current qualified medical and child care expenses and…

The money you put in the plan is exempt from tax…

FOREVER!

SIGNATURE _____

☐ LABEL

REFILL 0 1 2 3 4 5 PRN NR

It's EASIER than you think!

Health Care Flexible Spending

The Health Care FSA gives you the benefit of allocating money pre-tax to reimburse you for out- of-pocket medical expenses for you and your dependents during the plan year. Dependents include your spouse, children residing with you, or a parent for whom you claim on your taxes as a dependent. You do not need to participate in your Company's group insurance plan in order to participate in the Health Care Flexible Spending Account.

Prior to the beginning of each plan year, you may elect how much you want to contribute to the plan. Throughout the plan year equal payroll deductions will be taken from your pay before Federal, State, and Social Security taxes are assessed. The deduction will then be deposited into your Flexible Spending Account(s). You must complete, sign, and date your election form by the deadline set by your employer.

Election Limit
Your election limit is set by your employer, but cannot exceed $2500.00

Incurring Expenses
As you incur eligible expenses, you will complete and send to Benefit Advantage a reimbursement request form itemizing your expenses with supporting documentation. The expenses must be for services incurred during the current plan year. You will have a run off period after the close of the plan year to submit your requests for expenses incurred during the previous plan year. Please refer to your Summary Plan Description (SPD) for limits on your plan.

Documenting Your Expenses
All documentation included with your claim form must have the following listed; Date of Service, Description of Service, Patient Name, Provider Name and Patient Responsibility. Statements from your provider that list codes for a description are not valid documentation.

Over The Counter (OTC)
OTC items must be supported by a prescription or Letter of Medical Necessity.

Reimbursements
All qualified claim requests will be processed and issued to you within 5 business days. Payment will be issued directly to the participant. It is the responsibility of the participant to forward these funds on to their provider if necessary. Benefit Advantage will not send any funds to the provider.

Health Care Account
You may be reimbursed your entire annual Health Care FSA Election at any time during the plan year after you have incurred the expense. Any unspent dollars up to $500 at the end of the plan year will be carried over to the subsequent plan year. Unspent dollars over the allowable $500 carryover at the end of the plan year are forfeited.

Termination
If your employment terminates during the plan year, you may only submit claims incurred up to your termination date. You will have a submission period to submit claims; please refer to your SPD for time limit.

Dependent Care Account

The IRS states an eligible dependent is less than 13 years old and living with you. An eligible dependent may also include your mentally or physically impaired spouse/dependent/child that is living with you and incapable of caring for him or herself.

To be eligible to participate in this account all of the following must apply:

1. The expenses must be necessary to allow you and your spouse to work or to seek employment.

2. These providers **must** declare the funds you pay them as income.

Eligible providers include:

- Child care centers
- Family day care providers
- Babysitters
- Nursery schools (this does not include tuition for kindergarten)
- Caregivers for disabled dependent or spouse who lives with you.

The IRS states the annual maximum amount a family may withhold in a dependent care plan is the lesser of $5,000 per family, your income or your spouse's income. A single parent is eligible for this program with the above limitations.

If you and your working spouse have dependent care accounts with your employers, the maximum combined contribution allowed by the IRS is $5,000. Married individuals filing separate tax returns can each claim a maximum of $2,500 through a flexible spending account.

If you are married and your spouse is a full-time student or unable to care for him or herself, you may claim $2,400 if you have one (1) dependent or $4,800 if you have more than one dependent.

Dependent Care expenses are reimbursed up to the cash balance in your account.

Unpaid claims are reimbursed as more money is credited to your account.

Benefit Advantage
Mail: PO BOX 5546 DePere, WI 54115-5546
Phone: (800) 686-6829
Fax: (920) 339-0830

Know Your Health Care FSA Eligible and Ineligible Expenses

Maximize the Value of Your Reimbursement Account - Your Health Care Flexible Spending Account (FSA) dollars can be used for a variety of out-of-pocket health care expenses. The following is based on a list of eligible and ineligible expenses used by federal employees.

Eligible Expenses

BABY/CHILD TO AGE 13
- Lactation Consultant*
- Lead-Based Paint Removal
- Special Formula*
- Tuition: Special School/Teacher for Disability or Learning Disability*
- Well Baby /Well Child Care

DENTAL
- Dental X-Rays
- Dentures and Bridges
- Exams and Teeth Cleaning
- Extractions and Fillings
- Oral Surgery
- Orthodontia
- Periodontal Services

EYES
- Eye Exams
- Eyeglasses and Contact Lenses
- Laser Eye Surgeries
- Prescription Sunglasses
- Radial Keratotomy

HEARING
- Hearing Aids and Batteries
- Hearing Exams

LAB EXAMS/TESTS
- Blood Tests and Metabolism Tests
- Body Scans
- Cardiograms
- Laboratory Fees
- X-Rays

MEDICAL EQUIPMENT/SUPPLIES
- Air Purification Equipment*
- Arches and Orthotic Inserts
- Contraceptive Devices
- Crutches, Walkers, Wheel Chairs
- Exercise Equipment*
- Hospital Beds*
- Mattresses*
- Medic Alert Bracelet or Necklace
- Nebulizers
- Orthopedic Shoes*
- Oxygen*
- Post-Mastectomy Clothing
- Prosthetics
- Syringes
- Wigs*

MEDICAL PROCEDURES/SERVICES
- Acupuncture
- Alcohol and Drug/Substance Abuse (inpatient treatment and outpatient care)
- Ambulance
- Fertility Enhancement and Treatment
- Hair Loss Treatment*
- Hospital Services
- Immunization
- In Vitro Fertilization
- Physical Examination (not employment-related)
- Reconstructive Surgery (due to a congenital defect, accident, or medical treatment)
- Service Animals
- Sterilization/Sterilization Reversal
- Transplants (including organ donor)
- Transportation*

MEDICATIONS
- Insulin
- Prescription Drugs

OBSTETRICS
- Breast Pumps and Lactation Supplies
- Doulas*
- Lamaze Class
- OB/GYN Exams
- OB/GYN Prepaid Maternity Fees (reimbursable after date of birth)
- Pre- and Postnatal Treatments

PRACTITIONERS
- Allergist
- Chiropractor
- Christian Science Practitioner
- Dermatologist
- Homeopath
- Naturopath*
- Optometrist
- Osteopath
- Physician
- Psychiatrist or Psychologist

THERAPY
- Alcohol and Drug Addiction
- Counseling (not marital or career)
- Exercise Programs*
- Hypnosis
- Massage*
- Occupational
- Physical
- Smoking Cessation Programs*
- Speech
- Weight Loss Programs*

Note: This list is not meant to be all-inclusive, as other expenses not specifically mentioned may also qualify. Also, expenses marked with an asterisk (*) are "potentially eligible expenses" that require a Note of Medical Necessity from your health care provider to qualify for reimbursement. For additional information, check your Summary Plan Document or contact Benefit Advantage, Inc. at 800-686-6829.

The IRS does NOT allow the following expenses to be reimbursed under Health Care FSAs, as they are not prescribed by a physician for a specific ailment.

Ineligible Expenses

- Contact Lens or Eyeglass Insurance
- Cosmetic Surgery/Procedures
- Electrolysis
- Insurance Premiums and Interest (FSA Ineligible Only)
- Long Term Care Premiums (FSA Ineligible Only)
- Marriage or Career Counseling
- Personal Trainers
- Sunscreen (spf less than 30)
- Swimming Lessons

Note: This list is not meant to be all-inclusive.

Please Note: The IRS does not allow Over-the-Counter (OTC) medicines or drugs to be purchased with Health Care FSA funds unless accompanied by a prescription and the prescription is filled by a pharmacist. If you have an OTC prescription, you can use your benefits card for these purchases.

Ineligible Over-the-Counter Medicines and Drugs (unless prescribed in accordance with state laws)

- Acid controllers
- Acne medications
- Allergy & sinus
- Antibiotic products
- Antifungal (Foot)
- Antiparasitic treatments
- Antiseptics & wound cleansers
- Anti-diarrheals
- Anti-gas
- Anti-itch & insect bite
- Baby rash ointments & creams
- Baby teething pain
- Cold sore remedies
- Cough, cold & flu
- Denture pain relief
- Digestive aids
- Ear care
- Eye care
- Feminine antifungal & anti-itch
- Fiber laxatives (bulk forming)
- First aid burn remedies
- Foot care treatment
- Hemorrhoidal preps
- Homeopathic remedies
- Incontinence protection & treatment products
- Laxatives (non-fiber)
- Medicated nasal sprays, drops, & inhalers
- Medicated respiratory treatments & vapor products
- Motion sickness
- Oral remedies or treatments
- Pain relief (includes aspirin)
- Skin treatments
- Sleep aids & sedatives
- Smoking deterrents
- Stomach remedies
- Unmedicated nasal sprays, drops & inhalers
- Unmedicated vapor products

OTC items that are not medicines or drugs remain eligible for purchase with FSAs. You can use your benefits card for these items.

Eligible Over-the-Counter Items (Product categories are listed in bold face; common examples are listed in regular face.)

- **Baby Electrolytes and Dehydration**
  Pedialyte, Enfalyte
- **Contraceptives**
  Unmedicated condoms
- **Denture Adhesives, Repair, and Cleansers**
  PoliGrip, Benzodent, Plate Weld, Efferdent
- **Diabetes Testing and Aids**
  Ascencia, One Touch, Diabetic Tussin, insulin syringes; glucose products
- **Diagnostic Products**
  Thermometers, blood pressure monitors, cholesterol testing
- **Ear Care**
  Unmedicated ear drops, syringes, ear wax removal
- **Elastics/Athletic Treatments**
  ACE, Futuro, elastic bandages, braces, hot/cold therapy, orthopedic supports, rib belts
- **Eye Care**
  Contact lens care
- **Family Planning**
  Pregnancy and ovulation kits
- **First Aid Dressings and Supplies**
  Band Aid, 3M Nexcare, non-sport tapes
- **Foot Care Treatment**
  Unmedicated corn and callus treatments (e.g., callus cushions), devices, therapeutic insoles
- **Glucosamine &/or Chondroitin**
  Osteo-Bi-Flex, Cosamin D, Flex-a-min Nutritional Supplements
- **Hearing Aid/Medical Batteries**
- **Home Health Care (limited segments)**
  Ostomy, walking aids, decubitis/pressure relief, enteral/parenteral feeding supplies, patient lifting aids, orthopedic braces/supports, splints & casts, hydrocollators, nebulizers, electrotherapy products, catheters, unmedicated wound care, wheel chairs
- **Incontinence Products**
  Attends, Depend, GoodNites for juvenile incontinence, Prevail
- **Prenatal Vitamins**
  Stuart Prenatal, Nature's Bounty Prenatal Vitamins
- **Reading Glasses and Maintenance Accessories**

For additional information, please contact Benefit Advantage at 800-686-6829.

Benefit Advantage

EMPLOYEE TAX SAVINGS WORWORKSHEET

Estimate your tax bracket and/or check with your tax advisor for an accurate estimate.

ESTIMATED TAX BRACKET
15%
25%
28%
33%
35%

DO THE MATH:	Column A	Estimated Out Of Pocket	Column B
Federal Tax Bracket:	%	Medical Expenses:	
FICA:	7.65 %	Dependent Care Expenses:	
		Total Expenses:	
State Tax – if applicable:	%		
Total Tax Percentage (Sum)	%		

Calculate Your Personal Tax Savings

Enter Column **B** Total: _____

Multiply by Column **A** % Total: **X** _____

ESTIMATED ANNUAL TAX SAVINGS USING THE CAFETERIA PLAN: _____

Benefit Advantage

EMPLOYEE WORKSHEET

Category 1: Unreimbursed Medical Expenses (annual)

Consult your employer or Benefit Advantage for the max you may elect.

$_____ Acupuncture
_____ Ambulance Hire
_____ Artificial Limbs or Teeth/Dentures
_____ Birth Control Pills
_____ Birth Prevention Surgery/Sterilization
_____ Braces
_____ Braille-Books & Magazines
_____ Care for Handicapped/Mentally Disabled Dependent
_____ Childbirth Classes
_____ Chiropractors
_____ Coinsurance/Co pays
_____ Communication Equipment – Deaf
_____ Contact Lenses and Supplies
_____ Corrective Eye Surgeries (RK, etc.)
_____ Crutches
_____ Deductible
_____ Dental Fees/Treatment
_____ Dermatologist
_____ Diagnostic Fees
_____ Eyeglasses, including Exam Fee
_____ Guide Dog/and it's upkeep
_____ Hearing Devices & Batteries
_____ Hospital Bills
_____ Infertility Treatments
_____ Insulin/Diabetic Supplies
_____ Laboratory Fees
_____ Lodging for Medical Care (limit/night)
_____ Mileage for Medical Care (limit/mile)
_____ Obstetrical Expenses
_____ Orthodontia
_____ Orthopedic shoes
_____ Osteopaths
_____ Over the counter medicines (OTC)
_____ Oxygen
_____ Physical Therapy
_____ Physician/Surgical Fees
_____ Podiatrist Fees
_____ Practical Nurse
_____ Prescription Medicine
_____ Psychiatric/Psychologist Fees
_____ Routine Physicals
_____ Smoking Cessation (Prescription Only)
_____ Smoking Programs
_____ Therapeutic Care for Drug/Alcohol Addiction
_____ Vaccines
_____ Wheelchair
_____ X-rays

$_____ Total

Remember you can see IRS publication 502 or contact Benefit Advantage for a more comprehensive list of eligible expenses.

Category 2: Daycare Expenses (annual)

$ _____ per week x 52 weeks = _____

Transfer Category 1 and Category 2 to the appropriate areas on your enrollment form.

Your annual elections will be divided by the number of pay periods during the plan year to give you the amount to be deducted each pay period.

Can I change my election during the plan year?

You may be able to change your Medical FSA election during the plan year if you experience a "Change in Status" event and if the change is consistent with the event, such as:

- A change in your legal marital status.
- A change in the number of tax dependents
- Termination or commencement of employment by the employee, spouse or dependent.
- A change in employment status that results in gaining or losing eligibility for health coverage.
- Medicare or Medicaid entitlement for the employee, spouse or dependent.
- A change in cost or coverage (for Dependent Care account only).

Still have Questions?

Benefit Advantage can answer your questions about your personal situation and give you a better idea of how an FSA can benefit you.

Just call (800) 686-6829 and press 4 for the Flex Dept.

Also, you can log onto our website

www.benefitadvantage.com for more information.

Benefit Advantage

FREQUENTLY ASKED QUESTIONS

Q1 What are the advantages to a Health Flexible Spending, or LTD Health Flexible Spending Benefit Plans, and how will it affect me?

A1 The Health Flexible Spending, and LTD Health Flexible Spending Benefit Plans are another benefit we are pleased to offer our employees. These plans allows you to have certain expenses deducted from your paycheck before taxes, thus reducing the amount of taxes you pay, giving you more spendable income for the year. You have three choices. They are:

1. Pre-tax treatment of insurance premiums (Employer Sponsored Group Plans only)
2. Health Care Reimbursement Account (i.e.: medical, dental and vision expenses.)
3. Dependent Care Reimbursement Account (i.e.: daycare, babysitter)

Babysitter must report income.

Q2 Do I have to participate in all choices?

A2 No. Those who do not have children, a spouse or parents requiring daycare will not be interested in the Dependent Care Account. Most will probably want to participate in the Pre-tax premium coverage and the Health Care Reimbursement Account. Employees can enroll in any combination of the choices or in none at all. The decision is yours.

Q3 Is this an automatic election or do I need to sign a form?

A3 Every employee must complete a form(s) to enroll or to decline participation. Return your completed form(s) to the Human Resource Department on or before the last day of enrollment.

Q4 Can I change my election amount or get into the plan after the beginning of the plan year?

A4 You can change your election during the plan year, **only** if you have a change in family status, such as marriage, divorce, death, birth, or adoption. Otherwise, you will have to wait until the next enrollment period. The change you make **must be consistent** with the qualifying event. If you have any of the above qualifying events, you must contact your Human Resource Department within 30 days of the event.

Q5 Who determines what an eligible expense is that I can deduct on a pre-tax basis?

A5 The IRS formulates the guidelines for the Reimbursement Accounts and determines what is eligible.

Q6 How do I get reimbursed for Health Care expenses?

A6 To obtain reimbursement from Benefit Advantage you must send a copy of your Explanation of Benefit Form (EOB) from your insurance company or itemized receipt and complete a Health Care Reimbursement Request Form.
For your convenience, additional Reimbursement Request Forms are available in your Human Resource Department or on Benefit Advantage's website at: www.benefitadvantage.com.
If the expense is for a service that is not eligible for reimbursement under your Insurance plan (i.e.: eyeglasses), send a copy of the itemized statement for the services that were provided. Please note that we cannot accept credit card receipts or canceled checks as proof of service.

If you know your monthly health care expenses will remain at the same dollar amount for the calendar year, (i.e. orthodontics) you are encouraged to use a Recurring Health Care Reimbursement Request Form. This allows you to submit the reimbursement form only once to Benefit Advantage and we will see that you are reimbursed accordingly. **You must notify us if the provider or amount of your claim changes**. This form is also available in your Human Resource Department or on Benefit Advantage's website at: www.benefitadvantage.com. **The Recurring Claim Form does not carry over into the next plan year.** At re-enrollment time, you must fill out a new Recurring Form and submit it to Benefit Advantage.

Q7 I've been deducting medical and dental expenses on my income taxes. Can this continue if I enroll in the Health Care Flexible Spending Benefit Plan?

A7 You may not claim expenses reimbursed from your Health Care Flexible Spending or LTD Health Care Flexible Spending Plans on your tax return.

Q8 If I allocate $100 into my Health Care Expense Account or LTD Health Care Expense Account, and I incur only $80 of charges for the calendar year, what happens to the $20?

A8 The IRS states that if you do not have expenses that equal the money you have set aside on a pre-tax basis, you will be allowed to carryover up to $500 to the subsequent plan year. Any money over the $500 carryover limit will be forfeited. This is why we ask you to be cautious with your election. Your employer cannot return forfeited amounts directly to you.

Q9 What forms do I need to send to Benefit Advantage for reimbursement for dependent care expenses?

A9 You need to complete a day care Reimbursement Request Form or send the Reimbursement Request Form with receipts showing amount of payment, date of service provided, Tax I.D. or Social Security number of your dependent care provider. If your dependent care provider does not issue receipts, a signature line is provided on the reimbursement form for their signature and Tax I.D. or Social Security number.

If you know your monthly dependent care expense will remain at the same dollar amount for the calendar year, you are encouraged to use the Recurring Dependent Care Reimbursement Request Form. This form allows you to submit the reimbursement form only once to Benefit Advantage and we will see that you are reimbursed accordingly. **You must notify us if the provider or amount of your claim changes.** Additional forms are available in your Human Resource Department. **The Recurring Claim Form does not carry over into the next plan year.** At re-enrollment time, you must fill out a new Recurring Form and submit it to Benefit Advantage. Recurring claims are released at the end of the first full week of each month.

Q10 My mother-in-law baby-sits for my two children. She doesn't claim this income on her income taxes. Can I participate in the dependent care account?

A10 No. You may participate in the Dependent Care Reimbursement Account only if the daycare provider claims the amount you pay them on their income taxes.

Q11 I over-calculated my dependent care expenses. Can I get the leftover money in my account at the end of the year?

A11 No. Money left in your dependent care account will be forfeited.

Q12 I am currently using the Child Care Credit on my income tax return. Can I use the Dependent Care Spending Benefit Plan also? Which gives me greater savings?

A12 The Dependent Care Account allows immediate elimination of Federal, State (except PA and NJ) and FICA taxes on expenses up to $5,000 regardless of the number of children.

It is possible to use both; however, expenses in the Dependent Care Account reduce expenses allowed by the Child Care Credit dollar for dollar.

Please contact the individual who prepares your income tax return for assistance in determining which program provides the greatest savings for you.

Q13 How does participation in the Health Flexible Spending Benefit Plan affect information on my W-2 form?

A13 Your taxable income on the W-2 form will be reduced by contributions to any portion of the Flexible Benefit Plan. Funds contributed to the Dependent Care Account will be shown in a separate location on the W-2 form as a non-taxable item.

Q14 If I terminate employment, what happens to the money I have allocated to the Plan?

A14 You will have a run-out period following termination to submit claims for reimbursement of expenses that were **incurred before or on your termination date.** Any unused amount after the run-out period will be forfeited if you terminate with a positive balance. You may be eligible to elect to continue your participation in the Health Care Reimbursement Account with COBRA.

Q15 Once I file an eligible medical, dental, or dependent care expense, how long do I have to wait until Benefit Advantage reimburses me?

A15 Benefit Advantage sends out reimbursements on a daily basis. Benefit Advantage guarantees a 5 day turnaround on claims. You can review your claim status at www.benefitadvantage.com.

Q16 Will I receive a report showing me how much money I have used from the Plan?

A16 You may view your account status at anytime at www.benefitadvantage.com. On Benefit Advantage's website you can review your claim history, payment history and current balance.

Q17 Who do I contact with questions or concerns on the Health Flexible Spending Account Benefit Plan?

A17 Call Benefit Advantage at (920) 339-0351 or (800) 686-6829.

Benefit Advantage

CLAIMS INQUIRY & SUBMISSION

YOU CAN REVIEW YOUR ACCOUNT ONLINE

www.benefitadvantage.com

Select **Log In** from the top right corner.

Select your destination: Account Access - Employee

ONLINE ACCOUNT STATUS

To obtain your flexible spending account balance or claim status information:

- Username: Social Security Number with dashes
- Password: Social Security Number with dashes.

Upon initial login, you will be prompted to answer two security questions for verification if you forget your password and need to request it.

NEED HELP WITH YOUR ACCOUNT

Call Benefit Advantage at **1-800-686-6829** during business hours:

- Monday – Thursday 8:00 am - 4:30 pm CST
- Friday 8:00 am – 4:00 pm CST

REIMBURSEMENT CLAIM FORMS

To access the claim form on our website:

- Go to the Homepage
- Select Forms
- Select the appropriate form: Medical Claim form, Dependent Care Claim form or Orthodontia claim form
- Print the selected claim form, complete, then mail, fax or email to Benefit Advantage
- To submit a claim via our Website see right side of this information

SUBMITTING CLAIM VIA MAIL/FAX/EMAIL

Mailing Address:

Benefit Advantage
P.O. Box 5546
De Pere, WI 54115-5546

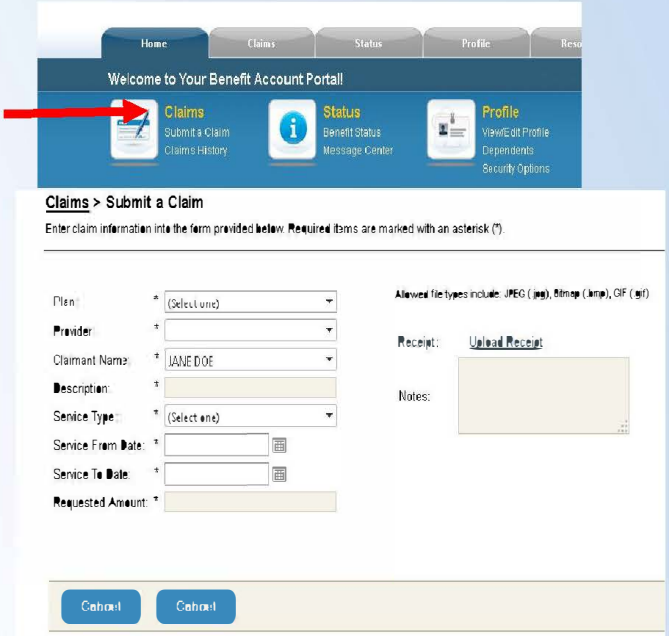
Fax Numbers:
(920) 339-0038 or (920) 339-5736

Email:
claims@benadvan.com

SUBMITTING CLAIMS VIA THE WEBSITE

Benefit Advantage offers you the opportunity to submit claims against your account through our website. Once you've logged on to the website, follow these steps:

1) Select "Submit a Claim" below the "Claims" icon. Review the disclaimer at the top to ensure that you are complying with Internal Revenue Service regulations.



2) Select the plan/year for the claim you are submitting

3) Select from drop down, or type name of the provider.

4) Indicate the Claimant Name. If a participant is submitting a claim for a spouse, child, or other eligible dependent, that person must be in the system before a claim can be made. If they are not in the system, go to the Profile Tab>Dependents to add him/her.

5) Provide a Description of the service provided, such as "office visit" or co-pay.

6) Select a Service Type, such as "dental".

7) Select or enter Service From Date & Service To Date.

8) Enter the Requested Amount that you wish to claim.

9) Click on the Upload Receipt link to point to the receipt that supports your claim, select Open. (Uploading a receipt is optional for dependent care, transit and parking. Receipts are required for the medical accounts.)

10) Click Submit.

11) You will receive a confirmation message if the claim has been successfully uploaded.

Benefit Advantage
PO Box 5546 De Pere, WI 54115-5546
Phone (800) 686-6829
Fax (920) 339-0038
E-mail: claims@benadvan.com

Company Name: _____

AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT

Print Your Name: _____

Print Your SS#: _____

Effective Date: _____

The information listed below is necessary to completely process the direct deposit funds into a specific bank account. (Please print all of the following information.)

For claims reimbursed through Direct Deposit, I realize if I fail to notify Benefit Advantage of any bank account changes, a service fee of $10.00 will be charged for each direct deposit item. Returned items will be reissued as a paper reimbursement less the $10.00 fee.

☐ New ☐ Change ☐ Cancel

☐ Checking (Must attach voided check) ☐ Savings (Please verify information with bank)

This information is for Benefit Advantage's use only and will not be disclosed to an outside party.

Transit ABA Routing #: _____

Account Number #: _____

Name of Bank: _____

I authorize my Section 125 Health Care FSA, Dependent Care FSA, Transit & Parking FSA, and/or Section 105 HRA reimbursements to be sent to the financial institution listed above and to be deposited in the designated account. I understand I may direct deposit to only one bank account.

In the event funds are deposited erroneously into my account, I authorize Benefit Advantage to debit my account not to exceed the original amount of the credit.

I also understand that all direct deposits are made though the Automated Clearing House (ACH), and that funds availability is subject to the limitations of the ACH as well as my financial institution. Benefit Advantage will not be held liable for any bank fees, overdrafts, etc… associated with these reimbursements.

Employee Signature: _____ **Date:** _____/_____/_____

Return this form to address or fax number at the top of the page.

You may review your account at www.benefitadvantage.com for balance details

Benefit Advantage
PO Box 5546 De Pere, WI 54115-5546
Phone (800) 686-6829
Fax (920) 339-0038
E-mail: claims@benadvan.com

Pages:_____

Company Name:_____

Health Care FSA CLAIM FORM

NAME:	Last	First	MI	SS#	
ADDRESS:	Street	City	State ZIP	PHONE:	( )

☐ **Please check if this is a new address**

MUST FILL OUT	MEDICAL EXPENSE CLAIMS				
Patient Name	**Relationship**	**Date of Service** MM/DD/YY	**Name of Provider**	**Claim Amount**	**Description of Service**
SAMPLE John Doe	SAMPLE Spouse	SAMPLE 01/01/03	SAMPLE Prevea Clinic	SAMPLE $10.00	SAMPLE Office Visit
			Total:		

There is a $25 minimum payment amount.

For claims reimbursed through Direct Deposit, I realize if I fail to notify Benefit Advantage of any bank account changes, a service fee of $10.00 will be charged for each direct deposit item. Returned items will be reissued as a paper reimbursement less the $10.00 fee.

You must attach documentation that includes the following information for your claim to be paid:

- Date(s) of Service Performed
- Description of Service Performed *(i.e. eye exam, co-pay)
- Amount of expense incurred
- Name of Patient, & Service Provider

*Undefined codes are not acceptable descriptions of your expense.

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

The Internal.Revenue Service regulates this Flexible Spending Account. Documentation guidelines utilized by Benefit Advantage are intended as a means to determine your expenses quality for reimbursement. It is the responsibility of each participant to comply with documentation requirements and avoid submitting duplicate or ineligible claims. Failure to comply with the above requirements may delay the payment of your claim.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: _____ **Date:**_____/_____/_____

Original receipts will not be returned, please keep a copy for your own records.

You may review your account at www.benefitadvantage.com for balance details.

Benefit Advantage
PO Box 5546 De Pere, WI 54115-5546
Phone (800) 686-6829
Fax (920) 339-0038
E-mail: claims@benadvan.com

HOW TO FILE YOUR REQUEST

DEFINITION OF MEDICAL CARE:

Must be "for diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body". Special rules may apply.

STEP I

Complete ALL personal information on the reimbursement request form. All items you are requesting reimbursement for should be itemized. Failure to complete your claim form could result in a delay or denial of your claim.

STEP II

HEALTH CARE FLEXIBLE SPENDING ACCOUNT:

Cancelled checks, balance due statements, cash register receipts or credit card statements are not acceptable per IRS Regulations. The only exception is that cash register receipts are allowed for contact lens supplies, eligible over the counter expenses and diabetic supplies. Photocopies and faxes of documents are acceptable. We will not return original receipts.

Attach proper documentation to the claim form:

- The insurance explanation of benefits (EOB) indicating the amount for which you are responsible (including deductibles). Any medical, dental, or vision expense covered by insurance (in part or in full) must first be submitted to your insurance carrier.

OR

- An itemized bill with the following (if you have no insurance coverage for your health care expense).

  - Name of provider and patient
  - Service cost, date, and description
  - Notation when there is NO insurance coverage

OR

- Co-pay receipts if you are covered under an HMO or a prescription drug plan.

If you have more claims than the spaces provided please attach additional claim forms.

STEP III

SIGN the request form.

The Internal Revenue Service regulates this Flexible Spending Account. Our documentation guidelines are intended as a means to qualify your expenses for approval and reimbursement. It is the responsibility of each participant to comply with these guidelines and to avoid submitting duplicate or ineligible claims. Failure to comply with the above requirements will delay the payment of your claim.

Our goal is to process payments within 24 hours of receipt with proper documentation. We guarantee a 5 working day turnaround maximum. There is a $20 stop payment fee for all checks that need to be reissued. Direct Deposit is available at no charge and is highly recommended.

This outline is intended for quick reference. If you have any additional questions, please call the Flexible Spending Account Department at (920) 339-0351 or (800) 686-6829, available 8-4:30pm, Monday through Thursday and 8-4 pm on Friday Central Standard Time.

Benefit Advantage
PO Box 5546 De Pere, WI 54115-5546
Phone (800) 686-6829
Fax (920) 339-0038
E-mail: claims@benadvan.com

Company Name:_____

Dependent Care CLAIM FORM

NAME:	Last MI First	SS#:	
ADDRESS:	Street City State ZIP	PHONE :	( )

☐ **Please check if this is a new address**

DAYCARE CLAIM FORM

DATE OF SERVICE FROM	TO	DEPENDENT NAME	DEPENDENT BIRTH DATE	CLAIM AMOUNT	PROVIDER TAX ID#/SS#	*PROVIDER NAME
				$		
				$		
				$		
			Total:	$		

Dependent Care expenses are reimbursed up to the cash balance in your account. Unpaid claims are reimbursed as more funds are received from your employer and credited to your account.
There is a $25 minimum payment amount.

For claims reimbursed through Direct Deposit, I realize if I fail to notify Benefit Advantage of any bank account changes, a service fee of $10.00 will be charged for each direct deposit item. Returned items will be reissued as a paper reimbursement less the $10.00 fee.

PROVIDER VERIFICATION

Signature of the Provider is mandatory if no Federal Tax ID is given above or documentation attached and the daycare provider must declare this as income on their tax return.

I verify that the above charges are accurate as described.

_____ _____ _____
Provider Signature **Federal Tax ID Number** **Date**

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

The Internal Revenue Service regulates this Dependent Care Spending Account. Documentation guidelines utilized by Benefit Advantage are intended as a means to determine your expenses quality for reimbursement. It is the responsibility of each participant to comply with documentation requirements and avoid submitting duplicate or ineligible claims. Failure to comply with the above requirements may delay the payment of your claim.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: _____ **Date:** _____/_____/_____

You may review your account at www.benefitadvantage.com for balance details.

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HOW TO FILE YOUR REQUEST

DEFINITION OF DEPENDENT CARE:

Must be "for care of an eligible dependent by IRS regulations enabling you or your spouse to work or to seek employment"

DEFINITION OF ELIGIBLE DEPENDENTS:

The IRS states an eligible dependent is less than 13 years old and living with you. An eligible dependent may also include your mentally or physically impaired spouse/dependent/child that is living with you and incapable of caring for him or her self.

The provider of the care **MUST** declare the funds you pay them as income

CHECKLIST

- ✓ Fill out only if you are manually submitting claims throughout the year
- ✓ Documentation must be attached
- ✓ Sign the bottom of the claim form

The provider **MUST** sign the claim form or include a tax id in order to process the claim.

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E-mail: claims@benadvan.com

RECURRING DAYCARE REIMBURSEMENT REQUEST FORM

A Recurring Claim allows Benefit Advantage to automatically enter and post a claim to your Dependent Care Account at the end of the first full week of every month. Reimbursements **to you** will occur as funds are received by Benefit Advantage from your employer. Deposit dates may vary month to month. Benefit Advantage will not be held responsible for any late charges or overdraft fees related to this payment.

Employer Name: _____

Employee Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____ Daytime Phone #: _____

I VERIFY THAT I MAKE REGULAR ONGOING PAYMENTS TO:

Name of Day Care Provider: _____ Provider Tax ID Number: _____

Name of Dependent: _____ Birth Date: / /

The charge for the care is $_____ per month, beginning on ___/___/___ & ending on ___/___/___.

Note: This recurring claim is only valid for the current plan year.

PROVIDER VERIFICATION

Signature of the Provider is mandatory if no Federal Tax ID or documentation is given. Also, the daycare provider must declare this as income on their tax return.

I verify that the above charges are accurate as described.

_____ _____ ____/____/____

Provider Signature **Federal Tax ID Number** **Date**

There is a $25 minimum payment amount.

For claims reimbursed through Direct Deposit, I realize if I fail to notify Benefit Advantage of any bank account changes, a service fee of $10.00 will be charged for each direct deposit item. Returned items will be reissued as a paper reimbursement less the $10.00 fee.

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

I agree that if the amount changes or if for any reason, such as illness or vacation, the expenses are not incurred as scheduled, I will **immediately** notify Benefit Advantage in writing.

The Internal Revenue Service regulates this Dependent Care Spending Account. Documentation guidelines utilized by Benefit Advantage are intended as a means to determine your expenses quality for reimbursement. It is the responsibility of each participant to comply with documentation requirements and avoid submitting duplicate or ineligible claims. Failure to comply with the above requirements may delay the payment of your claim.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: _____ **Date:** ____/____/____

You may review your account at www.benefitadvantage.com for balance details.

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Fax (920) 339-0038
E-mail: claims@benadvan.com

HOW TO FILE YOUR REQUEST

DEFINITION OF DEPENDENT CARE:

Must be "for care of an eligible dependent by IRS regulations enabling you or your spouse to work or to seek employment"

DEFINITION OF ELIGIBLE DEPENDENTS:

The IRS states an eligible dependent is less than 13 years old and living with you. An eligible dependent may also include your mentally or physically impaired spouse/dependent/child that is living with you and incapable of caring for him or her self.

The provider of the care **MUST** declare the funds you pay them as income

CHECKLIST

- ✓ Fill out only if you are manually submitting claims throughout the year
- ✓ Documentation must be attached
- ✓ Sign the bottom of the claim form

The provider **MUST** sign the claim form or include a tax id in order to process the claim.

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E-mail: claims@benadvan.com

RECURRING ORTHO CARE REIMBURSEMENT REQUEST FORM

Employer Name: _____

Employee Name: _____

Address: _____

_____

Social Security #: _____

Daytime Phone #: _____

ORTHO CONTRACT MUST BE ATTACHED

☐ I have attached a signed statement from the above stated Provider verifying the amount and frequency of charges. I agree that if the amount changes or if for any reason the expenses are not incurred as scheduled, I will notify Benefit Advantage immediately in writing.

Name of Provider: _____

Name of Patient: _____

Ortho charge:$_____ per month, beginning on:_____/_____/_____ & ends on :_____/_____/_____

Start Date of Treatment: _____/_____/_____ Term of Treatment: _____/_____/_____

This claim form is only valid for the current plan year and will be posted to your Flexible Spending Account at the end of the first full week of every month.

For claims reimbursed through Direct Deposit, I realize if I fail to notify Benefit Advantage of any bank account changes, a service fee of $10.00 will be charged for each direct deposit item. Returned items will be reissued as a paper reimbursement less the $10.00 fee.

EMPLOYEE'S CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan, and, to the best of my knowledge and belief, are eligible for reimbursement under my Reimbursement Plans. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual income tax return.

The Internal Revenue Service regulates this FSA Spending Account. Documentation guidelines utilized by Benefit Advantage are intended as a means to determine your expenses quality for reimbursement. It is the responsibility of each participant to comply with documentation requirements and avoid submitting duplicate or ineligible claims. Failure to comply with the above requirements may delay the payment of your claim.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Signature:_____ **Date:**_____/_____/_____
Plan Participant Name

You may review your account at www.benefitadvantage.com for balance details.

Online Account Access

Benefit Advantage offers access to your account via the Internet to obtain your account balance, claim information and/or payment status:

SET-UP AN ACCOUNT:

1) Visit our website at: **www.benefitadvantage.com**
2) Select **Log In** from the home page.
3) Select your destination: Account Access - Employee
4) **User Name** - your user name is your Social Security Number (with dashes).
5) **Password** – also your full Social Security Number (with dashes).
6) Once you have followed these steps, the system will prompt you to answer two security questions for verification if you forget your password and need to request it.
7) Go to the Security Options under the Profile Tab and enter your email address as your **User Name**. You will need to **update your password**, which must be between six and 20 characters in length. It must contain an upper case letter, a number and a special character.

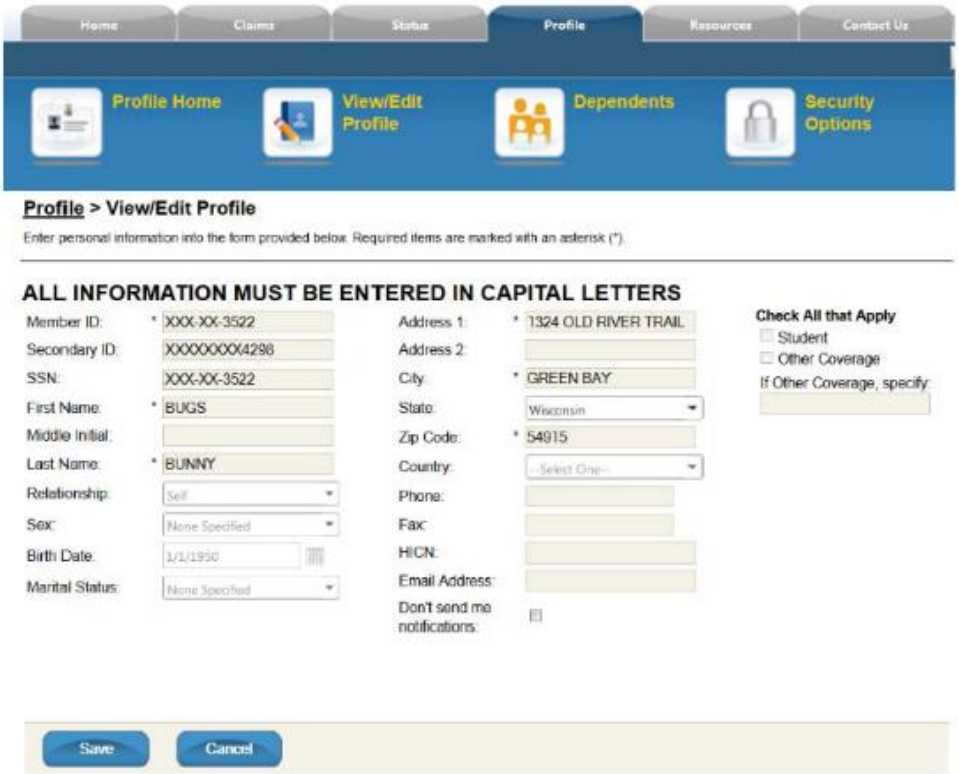
Need help with your account? Call customer service **1-800-686-6829** during business hours:

- Monday – Thursday 8:00 am - 4:30 pm CST
- Friday 8:00 am – 4:00 pm CST

Updating Personal Information

Here you can view and edit personal data, add dependents to your plan, and modify your personal security options.

You can view, add or edit your personal information as needed. Required fields are marked with an asterisk (*). Click Save when you are finished.



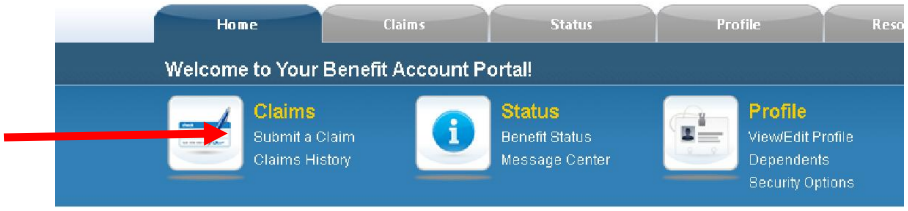
You can view, add or edit your dependents' information.

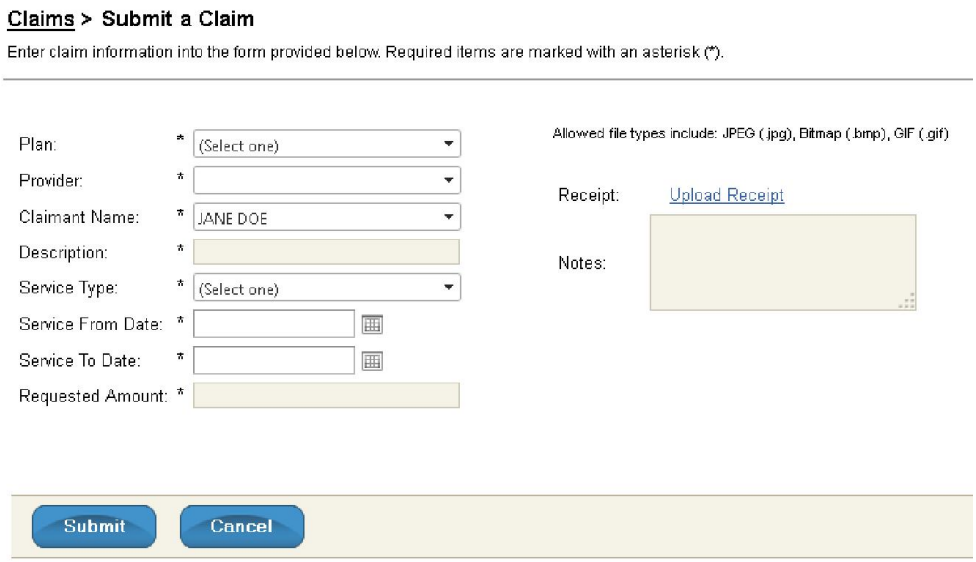
Profile Home
View/Edit Profile
Dependents
Security Options
Profile > Dependents
Name
Relationship
Date of Birth
Edit
BUGS BUNNY
Self
1/1/1950
Edit
JESSICA BUNNY
Spouse
3/5/1962
Add Dependent
Cancel

Submitting Claims via the Website

Benefit Advantage offers you the opportunity to submit claims against your account through our website. Once you've logged on to the website, follow these steps:

1) Select "Submit a Claim" below the "Claims" icon. Review the disclaimer at the top to ensure that you are complying with Internal Revenue Service regulations.

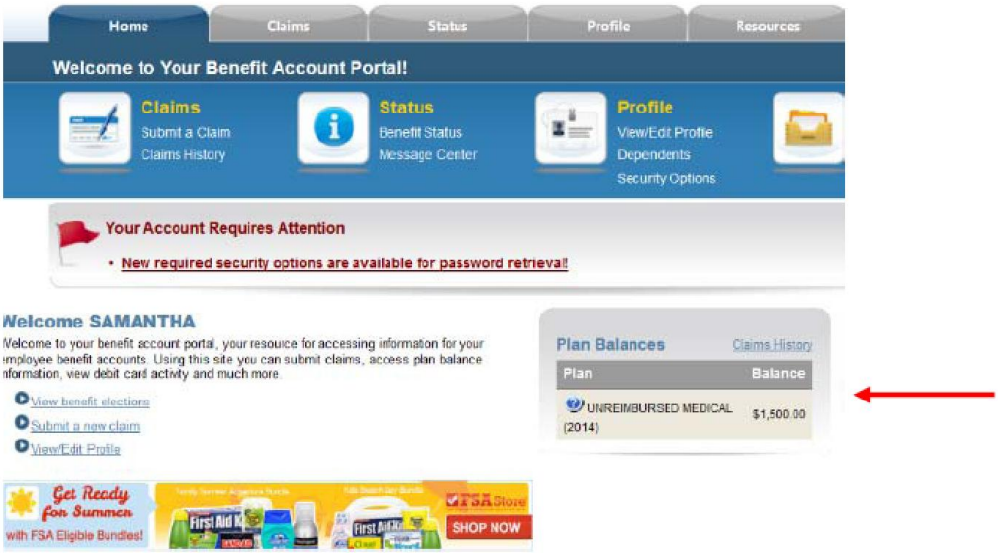




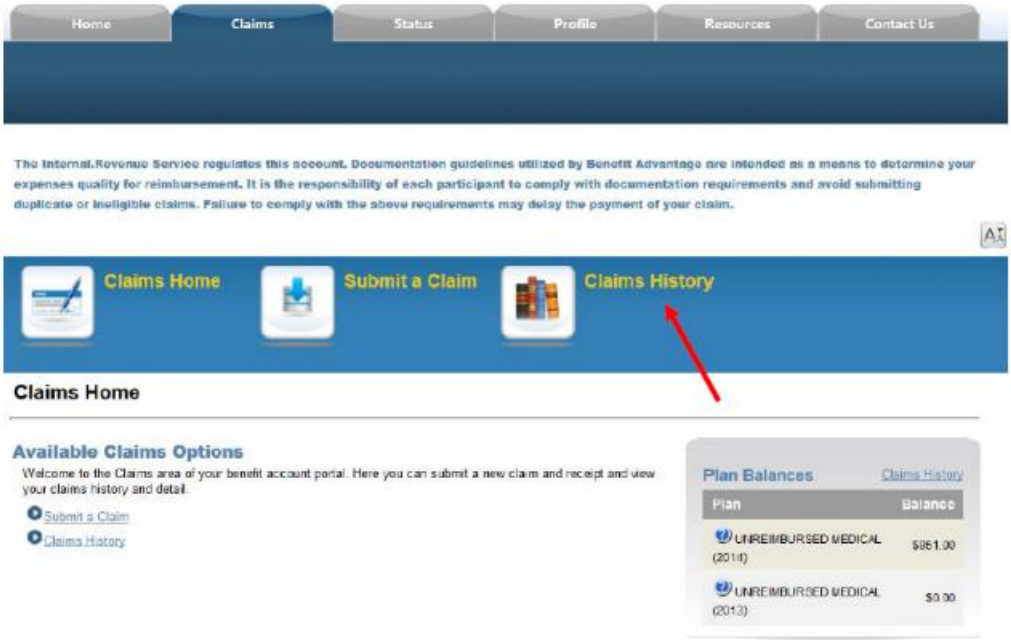
2) Select the plan/year that you wish to submit a claim against.
3) Select from the drop down, or type in the name of the provider.
4) Indicate the Claimant Name. If a participant is submitting a claim for a spouse, child, or other eligible dependent, that person must be in the system before a claim can be made. If they are not in the system, go to the Profile Tab>Dependents to add him/her.
5) Provide a Description (of the service provided), such as "office visit" or co-pay.
6) Select a Service Type, such as "dental".
7) Select or enter the Service From Date and Service To Date.
8) Enter the Requested Amount that you wish to claim.
9) Click on the Upload Receipt link to point to the receipt that supports your claim, select Open. (Uploading a receipt is optional for dependent care, transit and parking. Receipts are required for the medical accounts.)
10) Click Submit. You will receive a confirmation message if the claim has been successfully uploaded.

Viewing Balances and Claims History

You will see your plan balance information in several locations throughout the website. First is on the home page.



Second, you'll find your balance under the Claims Tab. This is also where you will find your Claims History.



If claims are tracked by specific family members, you will need to select the family member and plan year for the claims that you would like to see. Click on View. To get more details on a specific claim, you may click on the Claim Number link.

Claims Home | Submit a Claim | Claims History

Claims > Claims History

Select the family member and plan year for which you would like to view your claims. Click on the claim number to view claim detail.

Member: JANE DOE

Plan Year: 2014

View

Claim Number	Date of Service	Plan	Type	Claimant	Provider	Claimed	Paid	Excluded	Date Paid
		*** ALL ***							
00000869572	03/15/2014	UNREIMBURSED MEDICAL	FSA	DOE, JANE		$28.00	$13.00	$15.00	5/27/2014
00000869571	01/12/2014	UNREIMBURSED MEDICAL	FSA	DOE, JANE		$35.00	$35.00	$0.00	5/27/2014

Claims Home | Submit a Claim | Claims History

Claims > Claims History > Claim Details

Claim Number:	00000869572	Claim Type:	MED
Alt Claim Number:	0	Date of Service:	3/15/2014
Status:	VALID	Claim Amount:	$28.00
Claimant Name:	DOE, JANE	Excluded:	$15.00
Plan:	MED	Reason:	INELIGIBLE EXPENSE SUBMITTED
Pay To:	Member	Description:	
Process Date:	4/6/2014	Notes:	
Provider:			

View EOB

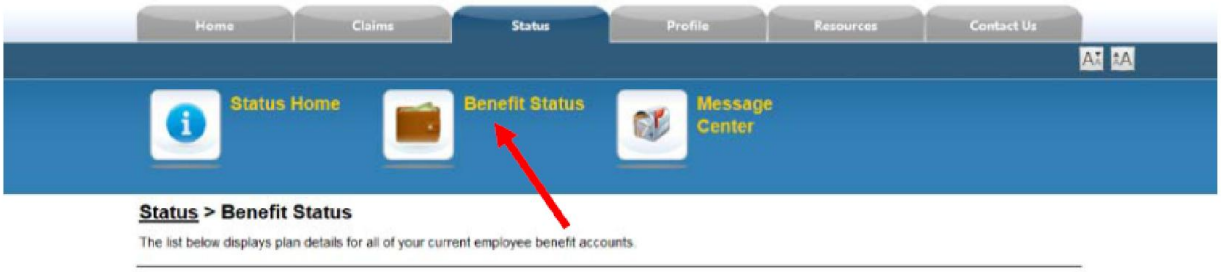
Check History

Date	Payee	ClaimantName	Check	Amount Paid	Total Check
05/27/2014	DOE, JANE	DOE, JANE	C00869572	$13.00	$13.00

< Previous | Next >

You will also find your balance under the Status Tab under Benefit Status. This will display information about your plan such as your annual election, Total Rollover (if applicable, claims paid, denied, deposits, etc.

You will also see the Plan Start Date, Plan End Date, the Last Date to Incur Claims and the Last Date to Submit Claims.

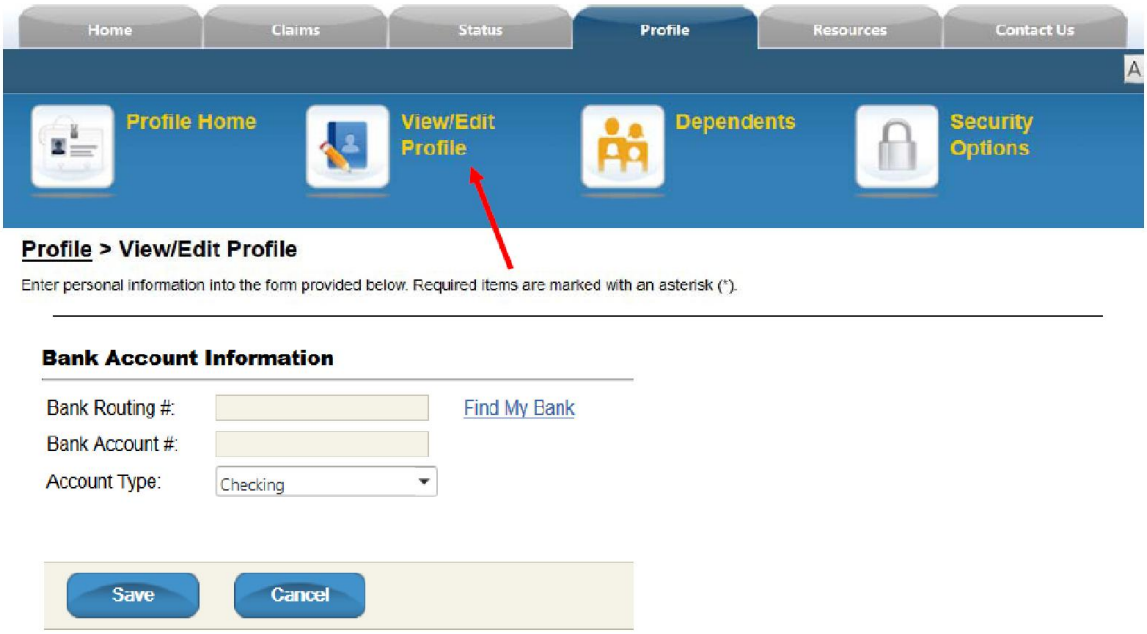


Plan Description: Medical Spending Account

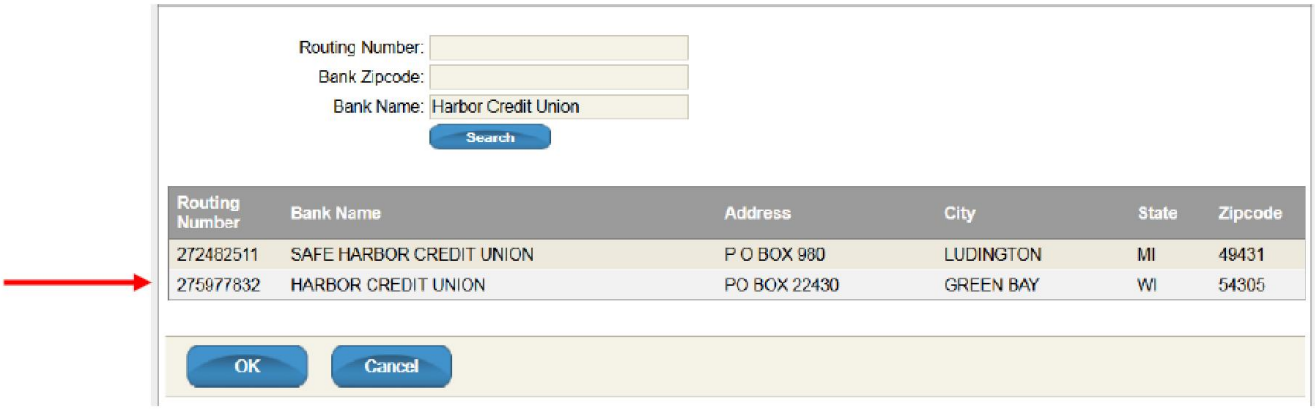
Plan Name	Plan Year	Election	Total Rollover	Total Benefit	Claims	Paid	Denied	Deposits	Pending Settlements	Available Balance	Plan Start Date	Plan End Date	Last Date to Incur Claims	Last Date To submit claims
UNREIMBURSED MEDICAL	2014	$1,500.00	$0.00	$1,500.00	$0.00	$0.00	$0.00	$0.00	N/A	$1,500.00	1/1/2014	12/31/2014	12/31/2014	3/31/2015

Direct Deposit Information

Benefit Advantage can send reimbursement of your claims to you by direct deposit. You can add/change/delete your bank information through the website. Go to Profile > View/Edit Profile. Change the Bank Routing #, Bank Account # and/or Account Type as needed. Click Save.



You can use the "Find My Bank" link to search for your bank routing number. Type the name of your bank in the field and click Search. When you've located your bank, click on it and then click on Ok. Complete the Bank Account # and Account Type. Click Save.



IMPORTANT: Make sure that your bank information is filled in correctly. If you provide incorrect information or fail to notify Benefit Advantage of any bank account changes, a service fee of $10.00 will be charged for each returned direct deposit item. Returned items will be reissued as paper reimbursement less the $10.00 service fee. Benefit Advantage will not be held liable for any bank fees, overdrafts, etc. associated with these reimbursements.