MERITAIN® HEALTH
An Aetna Company

Case Western Reserve University

A Guide to Your Flexible Spending Account

145.8272021

FSA Plan Provisions

A Health Flexible Spending Account, commonly known as an FSA, is an employer sponsored, pre-tax, IRS regulated benefit. All plans managed by Meritain Health® are administered in accordance with the IRS guidelines and substantiation requirements.

Group ID

15355

Plan year

1/1/2022–12/31/2022

FSA Reimbursement

Claims are processed daily. Payments are processed weekly, on Mondays.

Health care FSA minimum

$120

Health care FSA maximum

$2,850

Dependent care FSA minimum

$120

Dependent care FSA maximum

$5,000 per household or $2,500 per spouse if filing separate tax returns.

Election changes

The IRS does not allow changes in your annual election unless you have a qualified change in status. You need to notify your employer within **30** days of any qualified status change.

End of the year run-out

- FSA claims can be submitted up until 6.30.23. Your employer has opted for the grace period extension offered by the IRS, which allows an additional 2 months and 15 days (3/15/23) to incur expenses toward your FSA after the plan year has ended.
- DCA claims can be submitted up until 6.30.23. Your employer has opted for the grace period extension offered by the IRS, which allows an additional 2 months and 15 days (3/15/23) to incur expenses toward your DCA after the plan year has ended.

Terminated employee filing deadline

You will have up until 6.30.23 to submit Health care FSA claims incurred while employed at Case Western Reserve University, unless you qualify and elect continuation of your coverage under COBRA. You will have up until 6.30.23 to submit dependent care FSA claims incurred while employed at Case Western Reserve University.

For additional plan information

For additional plan information, refer to your Summary Plan Description (SPD), contact your employee benefits department, or contact our FSA team at **1.800.566.9305, option 5.**

Flexible Spending Accounts

Making the most of your money

What if you could make your earnings stretch further? A **Flexible Spending Account (FSA)** can help you do just that. Case Western Reserve University offers you an opportunity to participate in two FSA programs: A Health care FSA and a Dependent care FSA. An FSA is a tax-effective, money-saving option that will help you pay for qualified health care expenses that aren't covered by your medical plan, and for dependent care services necessary to enable you to work.

Here's how an FSA works:

- **Eligible medical expenses.** Use pre-tax dollars to pay for eligible health care expenses not reimbursed by an insurance plan. All IRS code 213(d) expenses are eligible, including your deductible, coinsurance and copays, and expenses above usual and customary limits. Out-of-pocket expenses on prescription drugs, dental, vision, hearing and orthodontic care are eligible as well. Certain over-the-counter items may qualify, too.
- **Dependent care costs.** Pre-tax dollars can be set aside for day care type expenses for eligible children or adults. Expenses are eligible if they're for the care of a person under age 13, or an older dependent who is unable to care for themselves. They must regularly spend at least eight hours a day in your home.

Maximize your savings potential

You will gain the most savings from your FSA if you plan carefully. When you enroll in an FSA, you designate in advance the amount of money you wish to have deducted from your salary and deposited into your FSA over the length of a year. To do this, you must estimate in advance the annual costs you want your FSA to cover.

Important note!

While it is not possible to precisely anticipate your eligible FSA costs, Meritain Health® provides a calculation worksheet to help you: FSA Worksheet and Eligible Expenses Guide. Located in this kit, this worksheet includes examples of eligible and ineligible expenses that can be applied towards your health care FSA.

Frequently Asked Questions About FSAs

If I have a question about my FSA, whom should I call?

You can contact your dedicated service team for help with claims questions, or for more information about your benefits. The phone number for customer service is **1.800.566.9305, option 5**.

How do I file a claim?

1. Access your online member portal account and upload your forms and supporting documentation.
2. Download the mobile application and follow the file a claim instructions, **OR**
3. Fill out a Reimbursement Request form, attach your health care and/or dependent care supporting documentation and submit your request. Request forms are available inside this packet or you can download a form online. Fax or mail in your request per the information found in the top right corner of the form.

What if I want to change my election mid-year?

IRS regulations do not allow you to stop, start or change your contributions at any time during the plan year UNLESS you experience a qualified change in status, such as a change in marital status, number of dependents or employment status. Keep in mind that the election change must be consistent with the event.

What if I have more expenses during the plan year than I have contributed at that time?

The annual amount you have elected for health care costs is available to you at the beginning of the plan year. The amount available for reimbursement for dependent care is limited to the balance in your account.

Your Meritain Health Prepaid Benefits Debit Card

What is a benefits debit card?

Your new Meritain Health Prepaid Benefits Debit Card is a special-purpose MasterCard® that gives you an easy, automatic way to pay for qualified health care expenses. You can electronically access the pre-tax dollars set aside in your FSA.

How does my debit card work?

It works like a MasterCard, with the value of your FSA contribution stored on it. When you have a qualified, eligible expense at a business that accepts MasterCard debit cards, you can simply use your benefits debit card. The amount of the qualified purchases will be deducted—automatically—from your account, and the pre-tax dollars will be electronically transferred to the provider/merchant for payment.

Is this just like other MasterCards?

No. Your benefits debit card is a special-purpose MasterCard that can be used only for qualified health care expenses. It can't be used, for example, at gas stations or restaurants. There are no monthly bills and no interest.

Do I need a new card each year?

No. As long as an FSA remains part of your benefits plan and you elect to participate each year, your card will be loaded with your new annual election amount at the beginning of each plan year. The debit card is valid for five years; but, if you skip a year, your original card will be reactivated.

If you didn't keep your original card, you'll need to request a new card for a nominal fee of $5.00. This fee will be deducted from your available balance. If you need a new debit card, please call Meritain Health at **1.800.566.9305, option 5**.

Where can I use my debit card?

Your card can be used to pay for eligible goods and services at providers/merchants that offer these goods or services and accept MasterCard. IRS regulations allow benefits debit card holders to use their cards in discount stores and supermarkets that are able to identify FSA-eligible items at checkout. If a card holder tries to use his or her card in a discount store or supermarket that doesn't offer this feature, the card may be declined. Your debit card can be used at daycare providers that accept payment cards.

When using your card, make sure to only use it for expenses that have been incurred during the active plan year. Once the new plan year begins, all card transactions will be paid from the new year's election. **It's important not to use the card to pay for a prior plan year expense.**

What can I expect after I use my card?

Save your itemized bills, Explanation of Benefits (EOB) and/or provider statements for services and purchases made with your benefits debit card. You may be asked to submit those documents to verify and validate a transaction as FSA eligible.

An FSA, is an IRS regulated benefit. It must be utilized to pay for qualified health related expenses you and your eligible dependents incur during the applicable period of coverage. All plans managed by Meritain Health are administered in accordance with the IRS guidelines and substantiation requirements. When and if requested, you must provide the health FSA administrator with the applicable supporting documentation to validate your charge(s).

What if I fail to submit eligible supporting documentation to verify a charge?

If eligible supporting documentation isn't submitted as requested to verify a charge made with your benefits debit card, the card may be suspended until eligible supporting documentation is received. You may be required to repay the amount charged. Submitting an eligible supporting document or repaying the amount in question will allow the card to become active again. It's important to confirm that your expenses are eligible.

Eligible supporting documentation must include:

- Date of service.
- Merchant or provider name.
- Patient name.
- Service(s) rendered or items purchased.
- Patient responsibility/total amount of purchase.
- Amount covered by insurance, if applicable.

Direct Deposit For FSA Reimbursements

How the program works

When you submit an eligible claim for reimbursement, the Meritain Health claims office will process it and, instead of sending you a check in the mail, Meritain Health will deposit the funds into your checking account. Later, you will receive an Explanation of Payment (EOP), giving you the full details of the reimbursement.

How to sign up for this program

As soon as possible, complete and return the setup form included to your human resources department. Along with the setup form, you will need to provide a copy of a voided check listing your account and bank routing (transit) numbers. There is no set up fee, and this is a one-time set up process. You will only need to repeat this process if your bank account information changes.

Tired of waiting to receive your FSA Explanation of Payment (EOP) in the mail?

Members with direct deposit can view FSA EOPs online. When your FSA claim is processed, you will receive an email notification that your FSA EOP is available to view when you log on to **http://account.meritain.com**. If you already have your email address loaded into the Meritain Health system, you will begin receiving FSA EOP notices automatically.

Want to receive your EOP via email?

Simply provide your email address to Meritain Health, and you're on your way!

- When you elect direct deposit, simply note your email address on the direct deposit form.
- You can also contact Meritain Health and provide your email address that way. Call Customer Service at **1.800.566.9305**, option 5.

FSA Reimbursement Made Easy!

The IRS requires proof that you received medical services before claims can be reimbursed by your Flexible Spending Account (FSA). Follow the guidelines below to receive prompt payment.

Guidelines for FSA reimbursement

Expenses if you don't have automatic reimbursement, and other medical expenses

Submit a completed and signed FSA claim form with the following attachments:

A copy of your Explanation of Benefits (EOB)

- All claims must be submitted to your insurance company or health care plan before you request FSA reimbursement.
- Estimates for services that haven't been received can't be accepted.

Or eligible supporting documentation for copays

- Your office visit copay documentation must show the patient name, amount paid, provider name and the date of service.
- Your prescription drug copay documentation must show the name of the drug, amount paid, the date of purchase and the name of the patient.
- Credit card receipts, cancelled checks or cash register receipts can't be accepted for copays.

Or for OTC items

- Itemized cash register receipts are acceptable for OTC items/supplies.

Or when you don't have coverage

- An itemized statement from your health care provider if you don't have insurance coverage (e.g., for dental or vision services).

Important notes

Claim submission

Submit your FSA claims online or mail claim forms and attachments to:

Meritain Health
P.O. Box 30111
Lansing, MI 48909

Or fax to: **1.888.837.3725**

Orthodontic care

With your first FSA claim, submit a copy of the following: the orthodontic contract or signed financial agreement, banding date, a signed FSA claim form, and proof of down payment. For future claims, you will only need to submit a signed FSA claim form along with proof of payment.

If you have any questions, please contact our FSA department at 1.800.566.9305, option 5.

Viewing claims with the Meritain Health Member Portal

For online claim status inquiry, log on to
https://account.meritain.com by following the steps below.

Returning users

- Go to **https://account.meritain.com**.
- Click on *log in.*
- Enter username (or click forgot my usename.)
- Enter password (or click forgot my password.)
- Once you have successfully logged in, click on the *Flex/CDHP* link to access your account information.

New users

- Go to **https://account.meritain.com.**
- Click on *Register*.
- Enter group ID (see page 1).
- Select *Next*.
- Enter member ID, first name, last name, date of birth and zip code.
- *Select Next*.
- Check *Yes, I am* and select *Next*.
- Create your own username and password.
- Once you have successfully logged in, click on the *Flex/CDHP* link to access your account information.

Get Reimbursed Quickly!

Want to manage your Flex/CDHP benefits from anywhere? There's an app for that!

Now you can easily and securely access your benefit accounts, submit claims and upload eligible supporting documentation at any time. Using your smart phone or mobile device, you have quick access to common Flex/CDHP account tasks. And with an easy-to-use design, our app gives you a quick view of your financial and account information.

Get reimbursed quickly

Using the member portal app, you can quickly file your claim with eligible supporting documentation and request distribution from your Flex/CDHP account. You'll be able to get the payment process started right from your phone, wherever you are—and get your money faster.

To get your temporary mobile app credentials:

1. Log in to **www.meritain.com.**
2. Click on the *Flex/CDHP Accounts* link to access the Flex/CDHP Portal.
3. Click the *Tools & Support* tab.
4. Click on *download mobile app*.
5. Use the temporary credentials to log into the mobile app, which can be downloaded for iOS from the App Store® or for Android devices from the Google Play Store™.

Never lose your documentation again

With the mobile application, you can snap a photo of your documentation the moment a service and/or purchase happens. You'll be able to use those images to submit with a new request, add to an existing request OR to substantiate a recent debit card transaction.

It's an easy and convenient way to store your documentation and have peace of mind with a touch of a button.

Check balances on the go

Wondering whether you can pay for an elective procedure or a mounting bill? You can quickly check your account to view your current balance—without waiting to get home to your computer. The app features summarized financial information and charts. Everything you need is right at your fingertips.

Stay up to speed

You have the ability to set your account up to send text notifications. For example, you will be alerted when a claim requires additional information. Plus, you'll be alerted of claims that require eligible supporting documentation. So you can rest easy that when you need to take action, you won't be left in the dark.

If you have any questions or need more information, we can help. Just call Meritain Health Customer Service at **1.800.566.9305, option 5**.

Access the app from your smart phone or mobile device

The member portal app is available for iOS and Android™ processing systems, as well as mobile devices. This includes iPhone®, iPad®, iPod touch® and Android smart phones and tablets.

The Right Balance: Look Over The Counter!

Guidelines for Over-The-Counter (OTC) medications and supplies for FSAs

The Internal Revenue Service (IRS) allows FSA reimbursement for certain OTC items. To confirm whether or not an item is allowable before it's purchased, you may contact Meritain Health toll-free at **1.800.566.9305, option 5** or visit **www.irs.gov**.

Allowable OTCs

- Allergy and sinus medications
- Antacids
- Anti-diarrheals
- Aspirin
- Bactine®
- Bandages
- Bengay
- Blood pressure monitors
- Cold sore remedies
- Contact lens solutions
- Cough drops
- Denture adhesives
- Diabetic monitors and supplies
- Diaper rash ointments
- Digestive aids
- First aid cream
- First aid kits
- Head lice treatments
- Hemorrhoid treatments
- Insulin
- Laxatives
- Menstrual care products such as tampons, pads, liners, cups, etc.
- Pain relievers
- Pregnancy test kits
- Rubbing alcohol
- Smoking cessation products
- Sunscreen SPF 30 and above
- Wart removal

Please note

This is a partial list of allowable over the counter items!

Allowable with a Letter of Medical Necessity (LOMN)

To qualify for reimbursement, expenses must be for a medical condition. Some health care services and products may be for both general health and specific medical conditions. Therefore, Meritain Health will require validation from a licensed medical practitioner that an expense is recommended for treatment and is a direct result of a specific medical condition. You may submit the Meritain Health letter of medical necessity form or a letter from your doctor/provider. If submitting a letter from your provider it should include the patient name, medical condition being treated, specific treatment needed, expected length of treatment, date, name and signature of a licensed medical practitioner.

The LOMN will be valid for expenses incurred for one year from the date on the letter or end of treatment date, whichever occurs first. This is a partial list of items that may be eligible for reimbursement with a valid LOMN.

- Acne treatment
- Airborne®
- Botox®
- Compression hose
- Glucosomine/chondroitin products
- Home drug test kits
- Propecia®/Rogaine® treatment (with a non-cosmetic diagnosis)
- Supplements
- Vaporizer/humidifier
- Vitamins

Ineligible OTCs

This is a partial list of OTC items that are not eligible for reimbursement under IRS regulations.

- Anti-aging products
- Cannibis/cannabinoid based products
- ChapStick®
- Cosmetics
- Deodorants
- Face creams
- Lotions
- Teeth whitening products
- Toothbrushes
- Toothpaste

FSA Worksheet and Eligible Expenses Guide

Estimating your health care expenses

The planning worksheet below can help you estimate your eligible health care expenses that may not be covered under your company's group insurance plan. Remember, all eligible health care expenses for you, your spouse and your eligible dependents are reimbursable from your Health care FSA.

Medical expenses	Estimated plan year expenses	Dental & Vision expenses	Estimated plan year expenses
Medical copays	$	Dental copays	$
Lab fees	$	Dental deductibles	$
Physical exams	$	Dentures	$
Physician fees	$	Dental examinations	$
Prescription drugs	$	Orthodontia	$
Acupuncture or chiropractic	$	Restorative work (crowns, caps, bridges)	$
Hearing aids	$	Teeth cleaning	$
Immunization fees	$	Other dental expenses	$
Psychiatrist, psychologies, counseling*	$	Contact lens supplies	$
Other medical expenses	$	Vision copays	$
		Vision deductibles	$
		Eye examinations	$
		Prescription contact lenses	$
		Prescription eyeglass or sunglasses	$
		Other vision expenses	$
Total column 1	**$**	**Total column 2**	**$**
Column 1 ($) + Column 2 ($) = Total estimated expense			**$**

* Allowed for treatment of physical or mental disorder (e.g., depression, alcohol or drug treatment). A diagnosis is necessary for reimbursement.

Examples of costs your Health care FSA may cover

- Copays, deductibles, and out-of-pocket costs
- Acupuncture as a treatment
- Certain alcoholism and drug addiction treatment costs
- Artificial teeth or dentures
- Braille books for visually impaired
- Hypnosis to treat illness
- Certain residential improvements to accommodate the disabled
- Eye examinations, contact lenses (including cleaning and maintenance supplies) and eyeglasses
- Guide dogs for sight or hearing impaired persons
- Car controls for disabled drivers
- Lead-based paint removal
- Learning disability tuition/therapy
- Psychological or psychiatric care
- Nursing home expenses
- Certain medical transportation

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Case Western Reserve University

FSA Enrollment Form

EMPLOYEE INFORMATION			BENEFIT ADMINISTRATOR SECTION	
LAST NAME	FIRST NAME	MI	PLAN YEAR **1/1/2022–12/31/2022**	GROUP # **15355**
EMPLOYEE ID NUMBER	GENDER ❑ M ❑ F	DATE OF BIRTH	EFFECTIVE DATE	DIVISION #
HOME ADDRESS	EMAIL ADDRESS		DATE OF HIRE	
CITY	STATE / ZIP CODE		PAY CYCLE ❑ WEEKLY ❑ MONTHLY ❑ BI-WEEKLY ❑ SEMI-MONTHLY ❑ OTHER: _____	
HOME TELEPHONE	WORK TELEPHONE	**I GIVE THE FSA TEAM PERMISSION TO RELEASE INFORMATION ABOUT MY FSA TO MY SPOUSE. ❑ YES ❑ NO**		

Please check all that apply:

❑ HEALTH CARE ACCOUNT

I would like to contribute $_____ per pay period ($_____ annually) to my Healthcare Flexible Spending Account for the upcoming calendar year or the remainder of the current year.

PLEASE NOTE: The minimum annual election allowed by your employer is $120. The maximum annual election allowed by the IRS is $2,850 per calendar year.

❑ DEPENDENT CARE ACCOUNT

I would like to contribute $_____ per pay period ($_____ annually) to my Dependent Care Flexible Spending Account for the upcoming calendar year or the remainder of the current year.

PLEASE NOTE: The minimum annual election allowed by your employer is $120. The maximum annual election allowed by the IRS is $5,000 per family or $2,500 per individual (or spouse when married and filing separate tax returns)

ELIGIBLE DEPENDENTS:

Dependent's Name (Last, First, MI)	Gender	Relationship	Birth Date	Social Security Number
	❑ M ❑ F	Spouse		
	❑ M ❑ F	Child		
	❑ M ❑ F	Child		
	❑ M ❑ F	Child		

EMPLOYEE SIGNATURE REQUIRED

I understand that the above elections will remain in effect until the last day of the calendar year indicated on this Form. I understand that I may change my elections during the calendar year only if (1) I experience a "status change," as defined under the Plan and my change in elections is consistent with that "status change," or (2) I exercise a Special Enrollment Right as described in the Notice of Special Enrollment Periods that accompanies this Election Form. I also understand that if I do not submit a new Election Form during the next annual election period, the above elections will terminate at the end of the calendar year for which they are effective. I understand that the Employer may modify my benefit elections if appropriate to insure that the Plan complies with the requirements of the Plan and applicable law and that, subject to the requirements of applicable law, the Employer has the right to amend or terminate the Plan. I understand that if I fail to request Plan enrollment within 30 days after my (and/or my dependent's) other coverage ends, I will not be eligible to enroll myself or my dependent(s), as applicable, during the special enrollment period.

EMPLOYEE SIGNATURE	DATE
	

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Mail completed form to:	**Meritain Health P.O. Box 30111 Lansing, MI 48909**
Fax to:	**1.888.837.3725**
Customer Service:	**1.800.566.9305, option 5**

FLEXIBLE SPENDING ACCOUNT REIMBURSEMENT REQUEST FORM

Employer Name: Case Western Reserve University

Employee Name:_____ **SS# or ID#:**_____

Address:_____ **Telephone #:**_____

City:_____ **State:**_____ **Zip:**_____ **Is this a change of address?** ❑ Y or ❑ N

Flexible Spending Account (FSA)

Date of Service	Name of Provider	Type of Service	Name of Patient	Amount of Expense	Was this service covered by any insurance plan?
				$	Y / N
				$	Y / N
				$	Y / N
				$	Y / N
				$	Y / N
				$	Y / N
				$	Y / N
				$	Y / N
				$	Y / N
				$	Y / N
Total amount requested from your **FSA:**				$	

Please fill out all requested information completely. For further instructions, see Guidelines for Reimbursement *on the back of this form. If more space is needed, list additional requests on a separate page. Please include all requests in the total. A minimum request amount (as established in your plan document) may need to be met before a claim can be paid.*

I certify that I have actually incurred these eligible expenses. I understand that *expense incurred* means that the service has been provided that gave rise to the expense, regardless of when I am billed or charged for, or pay for the service. The expenses have not been reimbursed or are not reimbursable from any other source. I understand that any amounts reimbursed may not be claimed on my or my spouse's income tax returns. I have received and read the printed material regarding the reimbursement accounts and understand all of the provisions.

Employee Signature:_____ **Date**:_____

Guidelines for Reimbursement

NOTE: Incomplete or illegible submission may result in processing delays. Be sure to include all necessary information, and sign and date the form. Please make copies for your records, as these documents will not be returned. If you fax your claim, keep the original.

Health Flexible Spending Account

- Attach a copy of the Explanation of Benefits (EOB) for each submission. All claims **MUST** be submitted to your insurance company prior to request for reimbursement. **Estimates for services that have not yet been incurred cannot be accepted.**

  OR

  Submit a paid receipt for your copays. **Credit card receipts, canceled checks, or cash register receipts cannot be accepted for copays. Itemized cash register receipts are acceptable for over-the-counter (OTC) items/supplies.**

  OR

  If you do not have insurance coverage, submit an itemized statement from the provider showing the provider's name and address, patient name, date of service and description of service and amount charged. Additionally, prescription expenses must include the drug name or number. **Balance forward or paid on account statements cannot be accepted.**

- Orthodontic reimbursement: For the first request, submit a copy of the Service Agreement or contract itemizing the treatment period, down payment, monthly payment, banding date and amount covered by insurance, if any. For subsequent claims, submit a copy of your monthly payment coupon and/or itemized receipt each time you request reimbursement.

Health Care Expenses Generally Eligible for Reimbursement

You *Should* Claim

- Fees for health services or supplies provided by physicians, surgeons, dentists, ophthalmologists, optometrists, chiropractors, podiatrists, psychiatrists, psychologists, or Christian Science practitioners.
- Acupuncture.
- Fees for hospital, ambulance, laboratory, surgical, obstetrical, diagnostic, dental and X-ray services.
- Costs incurred, including room and board, during treatment for alcohol or drug addiction at a hospital or treatment center.
- Special equipment, such as wheelchairs, special handicapped automotive controls, and special phone equipment for the deaf.
- Special items, such as dentures, contact lenses, eyeglasses, hearing aids, crutches, artificial limbs and guide dogs for the vision or hearing impaired.
- Transportation for needed medical therapy.
- Nursing services.
- Rehabilitation expenses.

You Should *NOT* Claim

- Any items which will be paid for by insurance or for which you are reimbursed by insurance or any other health plan.
- Bottled water.
- Health club dues.
- Any illegal operation or treatment.
- Programs to control weight (unless the program is undertaken at a physician's direction to treat an existing illness, including obesity).
- Elective cosmetic surgery.
- Medical insurance premiums paid outside of your company by you or your spouse at his or her place of employment.
- Nursing care for a normal, healthy baby.
- Maternity clothes.
- Burial expenses.

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Fax to:	**1.888.837.3725**
Customer Service:	**1.800.566.9305, option 5**

DEPENDENT CARE REIMBURSEMENT REQUEST FORM

Employer Name:_____

Employee Name:_____ **SS# or ID#:**_____

Address:_____ **Telephone #:**_____

City:_____ **State:**_____ **Zip:**_____ **Is this a change of address?** ❑ Y or ❑ N

Dependent Care Account (DCA)

Name of Day Care Provider	Dates of Service		Dependent's Name	Date of Birth	Is qualifying dependent under age 13 OR is mentally or physically incapable of self-care due to a diagnosed medical condition and is over age 12? (Check Yes)	Amount of Expense
	From	To				
					❑ Yes	$
					❑ Yes	$
					❑ Yes	$
					❑ Yes	$
					❑ Yes	$
					Total amount requested from your **DCA**:	$

Provider Information/Certification

My signature certifies that I have provided the services for these expenses for_____
(Qualifying dependent's first name)

Name:_____

Provider Signature:_____ **Provider SSN# or Tax ID:**_____

Signature not required if signed receipt or Day Care Center statement is attached. Altered receipts cannot be accepted.

Please fill out all information completely. If more space is needed, list additional requests on a separate page. Please include all requests in the total. A minimum request amount (as established in your plan document) may need to be met before a claim can be paid. For further instructions, see the **Guidelines for Reimbursement** *below.*

I certify that I have actually incurred these eligible expenses. I understand that *expense incurred* means that the service has been provided that gave rise to the expense, regardless of when I am billed or charged for, or pay for the service. The expenses have not been reimbursed or are not reimbursable from any other source. I understand that any amounts reimbursed may not be claimed on my or my spouse's income tax returns. I have received and read the printed material regarding the reimbursement accounts and understand all of the provision.

Employee Signature:_____ **Date:**_____

Guidelines for Reimbursement

NOTE: Incomplete or illegible submission may result in processing delays. Be sure to include all necessary information, and sign and date the form. Please make copies for your records, as these documents will not be returned. If you fax your claim, keep the original.

Dependent Care Reimbursement Account

- Expenses submitted must have been incurred for the care of a "qualifying individual" for the purpose to be gainfully employed.
- A qualifying individual is (i) a dependent of yours under age 13, (ii) a dependent of yours (or your spouse) who is incapable of caring for himself/herself.

Direct Deposit Authorization Form

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Send a completed form with voided check or deposit slip through one of the following options:

Fax: 1.716.541.6636

Add/update online: www.meritain.com
Select the *Flex/CDHP* link to access your account, then select the *Tools and Support* tab, under the *How do I?* section. Finally, select the *Change Payment Method* option and follow the instructions.

Questions: 1.800.566.9305, option 5.

To be reimbursed directly into your bank account, please complete this form and fax it to the number on the right.

Type of Request ☐ New ☐ Change ☐ Cancellation

Employee Information	Employer:	Meritain Health ID:
Name: (last, first, initial)		Home/Personal Phone:
Address:		Work Phone:
City:	State:	Zip Code:

Financial Information	Name(s) on the account:	
Bank or Financial Institution:		Routing/Transit Number:
Address:		Account Number:
City:	State: Zip code:	☐ Checking Account ☐ Savings Account*

Voided check (for checking account) or deposit slip (for savings account*) ~ *This is required* ~

Please place directly below

Place check or deposit slip here

Terms and Conditions

1. You must complete, sign, and date this authorization form to enroll in the direct deposit program. If you have a joint account, the form must be signed by both parties. Once your form is received by Meritain Health, there may be up to a 7- 10 business day time period before the direct deposit becomes effective. Any claims paid during this time will be mailed to you as a check.

2. In order to take advantage of the direct deposit program, your financial institution must be a member of an Automated Clearing House (ACH).

3. You will receive a direct deposit statement each time an electronic transfer is made to your account. The statement will indicate what claims are paid, as well as year-to-date information on your reimbursement account. It can take up to 72 hours for a payment to post into your account after Meritain Health transmits the funds**. Please verify that the deposit has been made into your account before attempting to withdraw funds**.

4. It is your responsibility to notify Meritain Health of any changes to your bank account, such as a closure, or a change in the account number. Complete this form with the new information, and check the change box. There may be up to a 7-10 business day processing period before the change becomes effective. During this time, you will receive checks for any reimbursement claims paid.

5. You may change or cancel direct deposit at any time by visiting your account online, change will take effect immediately **OR** by completing this form, checking the cancellation or change box and faxing to the number noted above. Once the form is received and processed by Meritain Health, it may take 7-10 business days before the update becomes effective.

6. If a direct deposit is returned to Meritain Health, or for any reason cannot be made to your account, Meritain Health will investigate the cause and if needed, issue a reimbursement check. Until the problem is corrected, you will continue to receive checks for any reimbursement claims paid.

7. Direct deposit services will remain in effect from one plan year to the next unless you cancel the direct deposit services.

8. Meritain Health reserves the right to automatically cancel your direct deposit services upon termination of employment or termination of your reimbursement account.

Questions? Please call Meritain Health at 1.800.566.9305, option 5.

** If the savings deposit slip does not contain a routing number maintained by your bank, you will need to submit a bank form, or statement on bank letterhead that verifies the account and routing numbers of your savings account.*

Employee / Account Holder Certification

I certify that I have read and understand the terms and conditions on this form. By signing here, I authorize my Health Reimbursement Arrangement or Flexible Spending Account reimbursements to be sent to the financial institution and account designated above. This authorization is to remain in effect until Meritain Health has been given a reasonable amount of time to act on written notification from me to terminate the deposits and continue reimbursements with mailed checks.

Employee Signature: _____ Date: _____

Joint Account Holder's Signature: _____ Date: _____

Note: Any joint account holder MUST sign this form in order to be reimbursed.

Not all services are covered. See plan documents for a complete description of benefits, exclusions and limitations of coverage. Providers are independent contractors and are not agents of Meritain Health. Provider participation may change without notice. Meritain Health and Aetna do not provide care or guarantee access to health services.

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