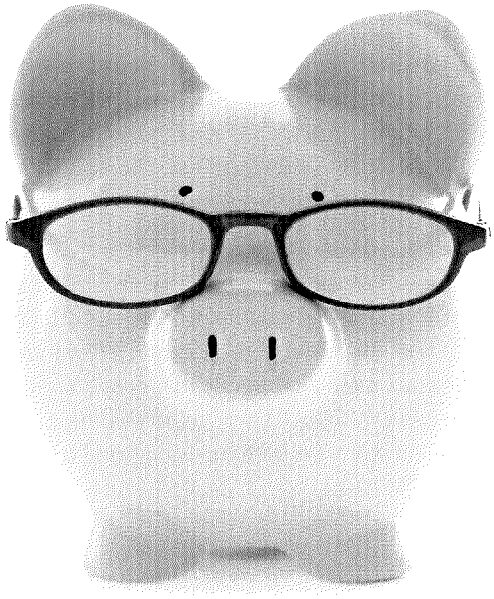
BENEFIThelp Solutions

YOUR PERSONAL GUIDE
TO MAXIMIZING BENEFITS

Looking for more spendable income?



..You found it.

FLEXIBLE SPENDING ACCOUNT

Sign-up for a flexible spending account and start saving

Today, everyone is faced with rising healthcare costs and complex employee benefits. At BenefitHelp Solutions, helping you means more to us than just paying claims and answering phones quickly. It's about helping you understand your benefits and saving you money.

Did you know that there's a simple way to get your hands on additional spendable income, month after month? If you, like most people, spend a few hundred dollars or more each year in out-of-pocket healthcare costs, you can get 25 to 40 percent of that money back in your pocket when you sign up for a Flexible Spending Account (FSA).

MANAGE YOUR FLEXIBLE SPENDING ACCOUNT ONLINE

Log on to ***www.benefithelpsolutions.com*** *24/7 to view your account activity, submit claims, and update your profile information.*

HOW AN FSA WORKS

With an FSA, you determine how much out-of-pocket child care and healthcare expenses you have each year, and then you have that amount (divided by the number of payroll periods) automatically set aside from your paycheck. The money is pulled out before taxes are deducted and held in a special account for you. When you start paying healthcare or dependent care expenses, you get reimbursed from your FSA account — and that money never gets taxed. The bottom line: you get more spendable income for paying off credit-card debt, planning a much-needed vacation or finally getting yourself an iPhone. What will you do with the money you'll save?

EXAMPLE OF PETER'S ANNUAL SAVINGS	WITH AN FSA	WITHOUT AN FSA
Peter's taxable income	$30,000	$30,000
Pre-tax amount deposited into an FSA	$1,200	$0
Peter's taxable income	$28,800	$30,000
Subtract estimated Federal, State & FICA taxes	$8,060	$8,400
Take home pay spent on FSA eligible expenses	$0	$1,200
Peter's actual spendable income	$20,740	$20,400
Annual savings	$340	$0

In this example, Peter is saving $340 by simply enrolling in an FSA. Enroll in a dependent care account as well and save even more. Your savings results may vary based on your income, tax bracket and amount contributed to the FSA account.

Determining your FSA contribution

To help you determine how much money you should set aside for your FSA, use this worksheet to calculate your out-of-pocket expenses for the year. For a full list of eligible FSA account expenses and eligibility requirements, visit us online at www.benefithelpsolutions.com/eligible.

FILL-IN THE FOLLOWING:

MEDICAL EXPENSES NOT COVERED BY INSURANCE	ANNUAL ESTIMATE
Deductibles, copays, coinsurance	_____
Prescription drugs	_____
Over-the-counter items	_____
DENTAL EXPENSES NOT COVERED BY INSURANCE	
Checkups and cleanings	_____
Fillings, X-rays, crowns, bridges	_____
Dentures, inlays	_____
Orthodontia	_____
VISION AND HEARING EXPENSES NOT COVERED BY INSURANCE	
Exams	_____
Prescription eyeglasses	_____
Contact lenses and cleaning solution	_____
Corrective eye surgery (LASIK, cataract, etc.)	_____
Hearing aids and batteries	_____
Total healthcare expenses	$_____
DEPENDENT CARE EXPENSES	
Licensed day care, nursery or pre-school	_____
Before and after school programs	_____
Summer day camps	_____
Total dependent care expenses	$_____

Two account types.

HEALTHCARE SPENDING ACCOUNT

A Healthcare Spending Account allows you to pay for eligible expenses not covered by your healthcare plan. Some eligible expenses include:

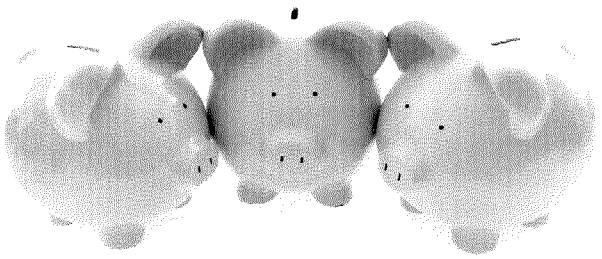
- Deductibles, copayments and coinsurance for medical and dental plans
- Prescription medications and approved over-the-counter healthcare products
- Eye exams, glasses, prescription sunglasses, contact lenses and solutions, and LASIK eye surgery

DEPENDENT CARE SPENDING ACCOUNT

A Dependent Care Spending Account reimburses you for care provided by eligible caregivers for dependents age 12 and younger, or for a disabled spouse or other dependents whom you claim for tax purposes. A few examples of eligible dependent care expenses:

- Care provided in your home by an eligible caregiver
- Care provided outside your home at a qualified day care provider
- Care provided at a licensed day care facility
- Summer day camps
- Before- and after-school programs

For more detailed dependent care information, click on FSA Accounts in the member section at www.benefithelpsolutions.com



Hassle-free

Payment

BENEFITS CARD

Not all employers offer the Benefits MasterCard (Benefits Card) option. To find out if you are eligible for a Benefits Card, please contact your group administrator.

The Benefits Card provides direct access to your Flexible Spending Account, allowing you to pay for eligible healthcare expenses at qualified locations wherever MasterCard™ is accepted. When you use your Benefits Card, you no longer have to wait for reimbursement because the money is deducted directly from your FSA account at the time of purchase. However, in most instances, you will still have to submit supporting documentation for your purchases.

Your Benefits Card can be used at participating grocery stores, pharmacies and wholesale clubs with vision and pharmacy services (most of these stores have elected to participate in the IRS Benefits Card program); or at hospitals, and medical, dental and vision provider offices.

When you're at the grocery store or pharmacy and it's time to pay, swipe your Benefits Card and select "Credit," if asked. The Benefits Card automatically approves your eligible items and debits the money from your FSA account. If you are also buying non-eligible items, the terminal or clerk will ask you for another form of payment. Then just pay the remainder with another card, cash, or check as you'd normally do.

When paying for services provided by a medical, dental or vision care provider, the Benefits Card can automatically approve services that match a set copay or a multiple of that copay (not coinsurance) from your group health plan(s). Supporting documentation for these services is not needed; however, if the provider's charge is an amount other than the copay, you can still use the Benefits Card to have the expense directly deducted from your account. You will just need to submit supporting documentation to BenefitHelp Solutions when you receive the letter requesting it.

Reimbursement

AUTOPAY

Not all employers offer the AutoPay option. To find out if you are eligible for AutoPay, please contact your group administrator.

AutoPay is an option that allows you to be reimbursed automatically for your eligible out-of-pocket medical, dental and prescription expenses processed by your medical administrator without having to submit claim forms or supporting documentation (currently, ODS is the only administrator eligible). When your medical administrator receives a claim from your provider, they will process and pay the claim according to your plan benefits. The administrator will send you an Explanation of Benefits (EOB) and, at the same time, send the information to BenefitHelp Solutions for automatic reimbursement of eligible out-of-pocket expenses. The amount shown on the EOB in the Patient Responsibility column is the amount you will automatically receive — up to your annual FSA election amount.

Orthodontia and IRS-ineligible expenses, such as cosmetic procedures, are excluded from AutoPay.

DIRECT DEPOSIT

By having your Flexible Spending Account reimbursement directly deposited into your bank account, you eliminate the hassle of having to go to the bank each time you receive a check. Instead of receiving a reimbursement check in the mail, you will receive a Direct Deposit Remittance Advice. The Remittance Advice will provide a full explanation of what was paid. All direct deposits will be initiated on the same day as the normal check reimbursement date.

CONTACT US:

WWW.BENEFITHELPSOLUTIONS.COM
PHONE: 503-219-3679
TOLL-FREE: 888-398-8057
FAX: 888-249-5058

Flexible spending accounts Enrollment or change form

BENEFITHelp Solutions

** This information is mandatory. Enrollment may be delayed if fields with an asterisk are not filled out.*

Section 1 Application reason

PLEASE PRINT CLEARLY

* Reason for application	* Change reason	* Effective date

Section 2 Account holder information

* First name	M.I.	* Last name	* Date of birth	* Membership identification or SSN

* Mailing address	* City	* State	* ZIP

* Email address	* Contact number

* Employer	* Group identification number (if known)
Norris & Stevens, Inc.	9210

Section 3 Benefit election (check all that apply)

☐ Waive participation — You will not be eligible to participate in the healthcare or dependent care account until the next open enrollment period unless an applicable change of status occurs. Please notify your employer of any change in status within 30 days of the applicable change.

	Date of first pay period deduction	Number of remaining pay periods	Pay period amount	* Annual election (up to $2,650)
☐ Enroll me in the healthcare flexible spending account (FSA)				

	Date of first pay period deduction	Number of remaining pay periods	Pay period amount	* Annual election (up to $5,000)
☐ Enroll me in the dependent care assistance program (DCAP) If married and filing seperately, DCAP election should not exceed $2,500				

Pay period amount x Pay periods in the plan year = Annual election

Section 4 Reimbursement (for explanations, please review page 2)

Benefits card

☐ I would like a Benefits MasterCard ☐ I already have a Benefits MasterCard ☐ I would like a Benefits MasterCard card for my dependent over age 18

Dependent's first name	Dependent's last name	Dependent's identification number or SSN	Dependent's date of birth

Direct deposit

☐ Enroll me in direct deposit ☐ Checking ☐ Savings Bank name

Rounting number	Account number

Section 5 Authorization

I have read and agree to the terms and conditions on pages 1 and 2 and authorize my employer to reduce my salary on a per-pay-period basis.

* Employee signature	* Signature date

Please return to your human resources or benefits department upon completion.

Questions? Contact BenefitHelp Solutions at 888-398-8057.

Benefits MasterCard

The Benefits MasterCard provides direct access to your flexible spending account (FSA), allowing you to pay for eligible health care expenses at qualified locations where MasterCard™ is accepted. When you use your Benefits MasterCard, you no longer have to pay for eligible expenses out of your pocket and wait for reimbursement. The money is deducted directly from your FSA account at the time of purchase. You may need to submit supporting documentation for certain purchases.

When using your Benefits MasterCard at pharmacies, simply swipe your card first and choose "Credit" if asked. The card is a smart card that will only pay for IRS-eligible FSA purchases. The store clerk will ask you for another form of payment to pay for your other purchases. You then pay for the non-FSA-eligible items with another card, cash or check. Your IRS-eligible purchases are automatically approved and paid directly from your FSA account. That's it — no claim forms to submit!

When paying for services provided by a medical, dental or vision provider, the Benefits MasterCard can automatically approve services that match a set copay or a multiple of that copay (not a percentage coinsurance) from your group health plan(s). Supporting documentation for these services is not needed. If the provider's charge is not a copay, you can still use the Benefits MasterCard and benefit from having the expense directly deducted from your account. For expenses that do not match the copay, you will need to submit supporting documentation. In some situations, your card will automatically be approved even if it is an ineligible expense. This most often happens when paying for services incurred in a prior plan year or for services where you coincidentally owe a multiple of the copayment. It is your responsibility to use your Benefits MasterCard only for eligible expenses.

Direct deposit

By having your flexible spending account reimbursement directly deposited into your bank account, you eliminate the hassle of having to go to the bank each time you receive a check. Instead of receiving a reimbursement check in the mail, you will receive a direct deposit remittance advice. The remittance advice will indicate the date your claim was paid, the amount that will be deposited to your bank account, and an explanation of benefits (EOB). All direct deposits will be initiated on the same day as the normal check reimbursement date. Deposits may take up to five (5) business days to appear in the designated account. Should you make any changes to your bank account, such as account closure or change in account number, please notify BenefitHelp Solutions immediately. If there is an interruption in the direct deposit service, you will receive checks for reimbursement claims paid during that time. You may cancel participation in the direct deposit program at any time.

Terms and Conditions

By signing this application:

1. Acceptable plan terms. You agree to abide by the terms, conditions and provisions of the plan contained in your employer's plan documents. These documents are available to you through your human resources or benefits department.
2. Responsibility. You acknowledge that the Internal Revenue Code (IRC) permits claim reimbursement only for eligible expenses incurred after the effective date and prior to the termination date of your healthcare flexible spending account, dependent care assistance program and/or commuter expense reimbursement program. You assume full responsibility for all taxes, penalties, interest or other consequences that may be assessed to you by any state, federal or other governmental taxing authority as a result of receiving reimbursement for a disallowed expense. You will only use your account to pay for eligible expenses incurred by yourself and/or your tax dependents. Expenses cannot be reimbursed by any other plan. If requested, you agree to provide appropriate supporting documentation within the requested time frame. You understand that you cannot change or revoke an election until open enrollment or during an applicable change in status.
3. Dependent care. You understand that the IRC prohibits you from claiming the Federal Child Care Tax Credit for dependent care assistance program expenses that have been reimbursement through your dependent care assistance program account.
4. Plan modification. You have been informed that the plan offered by your employer may be modified from time to time, and you agree that your employer may cancel or amend your plan according to the employer's independent judgment and discretion without your consent or prior notice.
5. Social security. You choose to participate in the plan knowing that your salary reduction elections may reduce your FICA withholdings (Society Security) and that this may reduce your Social Security benefits upon retirement.
6. Forfeiture. You understand that you must claim reimbursement for eligible expenses incurred during the plan year for which you were an active participant within the run-out period of the plan year (and grace period if applicable), as stated in your Summary Plan Document. If any unused amounts remain in your account(s) after any carryover (if applicable), these amounts will be forfeited.
7. Benefits MasterCard. If it is determined that the Benefits MasterCard paid for an ineligible expense, you will either refund your account the amount of the ineligible expense or offset the ineligible expense with an eligible expense. If you fail to do so, the ineligible amounts may be included as taxable income at the end of the year. You understand that if you do not provide supporting documentation as required, your Benefits MasterCard may be deactivated until your account is settled.
8. HSA contributions. You understand that if you, your spouse or your children participate in an HSA plan, HSA contributions may be disallowed if any HSA participants also participate in the healthcare flexible spending account.
9. Status change. Unless otherwise noted in your Plan Documents, Qualified Status Changes (QSCs) must be submitted within 30 days of the event. Please discuss with your human resources department to determine if your event is a QSC. If there's an election change, you understand that additional funds due to an increase in your election can only be used for claims incurred on or after the date of change.

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Health flexible spending account carryover

A general guide on the health flexible spending account and the carryover.

What is the health FSA carryover?

The health FSA carryover is a plan design feature that allows you to keep up to $500 in unused FSA funds each plan year. The unused funds are then rolled over into the following plan year health FSA.

How does it work?

You can carryover a balance up to $500 in unused funds from the previous plan year and make up to the full election allowed by the Internal Revenue Service and your employer.

Example:
Suzy participates in the health FSA and elects $2650 in the 2018 plan year.

- Suzy incurs $2000 of eligible expenses in the 2018 plan year and submits all claims for eligible medical care services by the end of her 90-day claims run out period.
- During open enrollment for the 2019 plan year, Suzy elects $2650.
- Suzy has $650 in unused 2017 funds remaining in her account.
- $150 is forfeited (lost) and $500 carries over to the 2019 plan year.
- This results in $3150 available in Suzy's health FSA for eligible medical care expenses in the 2019 plan year.

Do I still need to worry about the claims run out period?

Yes. All claims from the previous plan year must be submitted to the plan by the end of the run out period. Claims for expenses incurred during the prior plan year but submitted after the run out period ends will not be reimbursed.

When is the carryover effective?

The carryover amount will be added to your election after all claims have been processed for the prior plan year. If you did not make a new election, but you are still an eligible employee, the carryover amount will be available to you for the entire plan year.

What if I don't make a new election?

If you did not make a new election, but you are still an eligible employee, the carryover amount will be available to you for the entire plan year. You will not contribute to your FSA, but you will have the option to receive reimbursement for medical expenses in the new plan year.

Example:

Suzy participates in the health FSA and elects $2650 in the 2018 plan year.

- Suzy incurs $2000 of eligible expenses in the 2018 plan year and submits all claims for eligible medical care services by the end of her 90-day claims run out period.
- During open enrollment for the 2019 plan year, Suzy does not make a new election.
- Suzy has $650 in unused 2018 funds remaining in her account after the end of the run out period.
- $150 is forfeited (lost) and $500 carries over to the 2019 plan year.
- Suzy incurs $400 of eligible expenses in the 2019 plan year.
- Again, Suzy does not make an election for the 2020 plan year.
- At the end of the run out period in 2020. Suzy has $100 remaining in her account.
- $100 carries over to for Suzy to use for eligible expenses in the 2021 plan year.

How does the carryover affect my health savings account eligibility?

The IRS does not allow you to contribute to an HSA while you have funds in an FSA. If you are planning to contribute to an HSA next plan year, you must not carry over any funds.

You can avoid carrying over funds by using all your FSA dollars or by opting out of the carryover and forfeiting any excess funds to your employer at the end of the plan year.

Questions?

Contact a BenefitHelp Solutions customer service representative at 503-219-6379 or toll free at 888-398-8057 for more information.

BENEFITHelp Solutions

Eligible medical care expenses

Commonly asked questions about over the counter medications and items, adult children and the coordination of multiple accounts

Medical care expenses for you, your spouse and your dependents are all available for reimbursement or purchase with your healthcare flexible spending accounts (health FSAs), 213(d) healthcare reimbursement arrangements (HRAs) and health savings accounts (HSAs). Eligible medical care expenses include many over the counter items that you purchase without the involvement of your physician or insurance.

Over the counter medications

Over the counter items that contain an active ingredient are considered medication and require a prescription from your healthcare provider. This includes things like,

- Acid controllers
- Allergy and sinus relief
- Antibiotic products
- Anti-diarrheal
- Anti-gas
- Anti-itch and insect bite treatment
- Anti-parasitic treatments
- Baby rash ointments and creams
- Cold sore remedies
- Cough, cold and flu relief
- Digestive aids
- Feminine anti-fungal and itch
- Hemorrhoidal preps
- Laxatives
- Motion sickness relief
- Pain relief
- Respiratory treatments
- Sleep aids and sedatives
- Stomach remedies

Over the counter items

Over the counter items that have an established medical function, do or do not, contain an active ingredient are available for purchase using your account without involvement from your healthcare provider. This includes things like,

- Band aids
- Braces and supports
- Catheters
- Contact lens supplies and solutions
- Denture adhesive
- Diagnostic tests and monitors
- Elastic bandages and wraps
- Insulin and diabetic supplies
- Ostomy products
- Reading glasses
- Wheelchairs, walkers and canes

Stockpiling is not permitted. Only reasonable quantities to be used in the plan year of the same over the counter item can be reimbursed. BenefitHelp Solutions interprets reasonable to be no more than three of the same over the counter product purchased in a single month. If there is a medical condition requiring more than what BenefitHelp Solutions considers reasonable, you may submit a letter of medical necessity.

Adult dependents

The definition of dependents under federal guidance has been expanded to include adult children up to the age of 26. This means your health FSA may pay for eligible medical care expenses of your dependent through the age of 26.

Does my adult dependent have to be a tax dependent?

No. Your adult dependent does not have to be your tax dependent, living with you or attending school. However, any dependents of your dependent will not be eligible unless they are your tax dependent.

If my dependent will be 27 in June and my plan year ends in December, can I claim his or her expenses through May?

No. The IRS allows you to use your account for dependent claims only if that dependent will not be 27 during the tax year, January to December.

If my 24 year old child has insurance through his employer, does the employer plan have to pay or deny eligible medical care expenses before I can use my account to pay the medical expenses?

Yes.

Understanding the $2,650 limit for your health FSA

An employee of a specific (or related) employer can have just one health FSA and the election for that health FSA cannot exceed $2,650.

What if I have a second job and my second job offers a health FSA?

You may elect to participate in the second health FSA and make the full $2,650 election.

My spouse also has access to a health FSA. Are there any restrictions on their election?

Your spouse, regardless of whether he or she has the same employer, can make an independent election of up to $2,650

How do I submit claims for reimbursement from my health FSA when I have more than one insurance plan covering me?

When you have more than one insurance plan, the expense must be processed by all of your insurance carriers before you submit your claim for reimbursement or use your benefits card to pay for the final cost.

My spouse and I both have a health FSA, how do we submit claims using both accounts?

You may use both accounts as you normally would, just be careful to not submit the same expense to each account.

Questions?

Contact a BenefitHelp Solutions customer service representative at 503-219-6379 or toll free at 888-398-8057 for more information.

A guide to your Benefits MasterCard

With your Benefits MasterCard, you've chosen the easy way to save money and time. This guide will help you get the most out of your Benefits Card, and answer your questions

When you use your Benefits Card, money is automatically deducted from your benefits account; so your only out of pocket expense is when your account contributions are deducted from your paycheck. The Benefits Card is quick and easy, and saves you from having to submit forms and wait for a reimbursement check. Many types of purchases will still need supporting documentation.

Debit card or credit card? (Or maybe a little of both...)

Your Benefits Card is a debit card that is used to access the money you or your employer set aside for your pre-tax healthcare-related purchases. But it's important to note that the store registers may read it as a credit card.

Just remember these differences and you'll have no troubles:

1. The card will only work at healthcare providers and qualified merchants for eligible expenses. The merchants and providers may be restricted depending on the plan in which you are enrolled. But don't worry the card is smart enough to deny purchases of milk (an ineligible expense), but approve the purchase of band-aids (an eligible expense) at the same store.
2. There is no PIN (personal identification number) for this card, and it's important to remember to choose "Credit" when given the option at the check-out terminal.
3. You can't use the Benefits Card at an ATM machine, or to get cash back when making a purchase at a store.

Benefits MasterCards work for IRS tax-saving programs

- Flexible Savings Account (FSA)
- Health Reimbursement Arrangement (HRA)
- Health Savings Account (HSA)

Online access

Log on to your account to view eligible expenses, review your account balance and transaction history or submit a manual claim.

www.benefithelpsolutions.com

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Your personal guide to maximizing benefits

WHO ACCEPTS MY BENEFITS CARD?

Grocery stores, pharmacies and wholesale clubs with vision and pharmacy services

Most of these stores have elected to participate in the IRS Benefits Card program. When you're ready to check out, their system can tell which items are eligible expenses and which are not.

When it's time to pay, swipe your Benefits Card and select "Credit," if asked and it automatically approves your eligible items and deducts the money from your benefits account. If you are also buying non-eligible items, the terminal or clerk will ask you for another form of payment. Then just pay with another card, cash or check as you'd normally do. That's it, no claim forms to submit. Your IRS eligible purchases are approved and have been deducted from your account. You may notice an "F" on the receipt, which shows it as an eligible IRS expense.

Hospitals, medical, dental and vision care providers

Most services provided in these locations are eligible IRS expenses; however some are not, such as cosmetic procedures. Unlike grocery or pharmacy stores, providers do not typically use bar codes, so their systems can't tell which services are eligible.

When paying for your healthcare services, you can hand your Benefits Card to the front desk and the system will automatically approve services that match your copay, or multiples of your copay (not coinsurance) from your benefit plan. You will not have to submit supporting documentation for these services.

If the provider's charge is for something other than a copay, it's just a three-step process:

1. Wait until you receive the bill showing your insurance carrier has processed payment. Once you've received that bill, use your Benefits Card to pay it, just like you would use a credit card.
2. Once the provider has processed your Benefits Card payment, you'll get a letter from BenefitHelp Solutions asking for supporting documentation.
3. Send the letter back to BenefitHelp Solutions with a copy of the provider bill or your insurance company's Explanation of Benefits (EOB) to complete the transaction.

That's it three simple steps, and no additional money out of your pocket!

TIPS FOR MAXIMIZING YOUR BENEFITS

What if there's not enough money in my account?

If you are buying an eligible expense that costs more than what you have available in your account, the store might allow a partial payment from the amount that is left in your account, and then ask for the balance with another form of payment. (You may have done this before with a gift card.) For those merchants or providers that won't allow a partial payment, your purchase will come up "denied." Then, you just pay for the service and submit a claim form for reimbursement, and you'll be reimbursed the amount left in your benefits account.

What if my purchase was for an ineligible expense?

If you mistakenly use your Benefits Card at a provider's office for an ineligible expense, such as teeth whitening or paying for a service from a prior plan year, you can either refund the money into your benefits account or replace the ineligible expense with an eligible expense by submitting a paper claim. You'll receive a letter asking for supporting documentation for an ineligible purchase, and it will give you the details and timeframe by which you need to respond. If you don't respond within that timeframe, your card will be temporarily deactivated until we receive the information.

Avoiding claim denials

When submitting supporting documentation for Benefits Card transactions or paper submissions, it is important to remember a few things:

- The IRS requires documentation that includes the type of service, who provided the service, the date of service and the amount not paid by insurance. As a result, balance forward statements from a provider, cancelled checks or credit card receipts do not meet the IRS criteria.
- For services or products that are considered over the counter medications or that have both a medical and personal use (vitamins, supplements, gym memberships, massage therapy), the IRS requires documentation from a licensed provider stating that these services and/or products are prescribed or medically necessary. The statement must indicate the medical condition, the specific treatment needed, how the treatment will alleviate the condition and the length of the treatment.
- The best form of documentation is your insurance company's Explanation of Benefits (EOB). If you no longer have the EOB for the service, you can often print a copy from your insurance company's website.

Saving receipts

Although the Benefits Card makes the process much simpler, it is still smart to hang on to all your receipts in case the IRS asks for supporting documentation down the road.

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Understanding your benefits card

What is a benefits MasterCard™?

The benefits MasterCard™ (benefits card) provides direct access to your healthcare flexible spending account (health FSA) or health reimbursement arrangement (HRA), allowing you to pay for eligible health care expenses at qualified locations where MasterCard™ is accepted.

How does the benefits card work?

The benefits card is preloaded with eligible merchant category codes (MCCs) and healthcare items identified by the Inventory Information Approval System (IIAS). For a comprehensive list, please visit *sig-is.org*. When prompted, you will select credit to access the card, just as you would a regular MasterCard™.

When you use your benefits card at an eligible merchant or for an eligible item (purchased at a retailer that uses the IIAS), the amount of the transaction will be automatically deducted from your account to pay the merchant or retailer at the point of sale.

In many cases, the approved transaction will be insufficient to fully comply with all documentation requirements and you will need to provide additional documentation. Your third-party documentation should address the following questions:

- Who was treated?
- What services were provided?
- What did the services cost and was there any contribution from your health insurance?
- When was the service provided?
- Who provided the service?

An explanation of benefits (EOB) provided by your insurance carrier is often the best form of substantiation.

Are there any expenses that can be approved without additional documentation?

There are a few types of expenses that will be approved at the point of sale and will not require additional documentation. These include:

- A prescription purchased at a pharmacy that uses IIAS
- An amount that matches the copayment of your group health plan at a retailer or merchant with an eligible MCC
- Recurring fees that match a previously substantiated amount and provider
- Eligible over-the-counter products purchased at a retailer that uses IIAS

What is a recurring expense?

A recurring expense is one that is paid to the same service provider for the same amount on a regular basis. Your orthodontic installment payments, is a good example of the recurring expense. You would be required to submit documentation, like the contract between you and the provider, initially. The subsequent card swipes matching the amounts listed on the contract would be approved without further documentation from you.

What are common transactions that will be approved by my benefits card but will require additional documentation?

- Deductible payments
- Vision expenses (except copays)
- Coinsurance payments
- Naturopath visits
- Chiropractor visits
- Acupuncture visits
- Dental expenses (except copays)

Common misconceptions about the benefits card

1. If I use the card, I do not need to send any documentation.

   This is false. Except for the four circumstances mentioned earlier, all transactions will require additional documentation.

2. I can use the card for day care services.

   This is false. Dependent care expenses must first be incurred to be eligible. Payment on the first of the month for that month's services is not allowed. Most employers do not yet offer the benefits card for the dependent care account due to the timing concerns.

3. I can use the card to pay last year's balance at my doctor's office, and it will be covered as a current year expense.

   This is false. The benefits card uses the transaction date for the date of service and pulls funds from the current year account. A prior year's expenses are not eligible under the current year's account.

4. I can use the card for future services, such as chiropractic services that I get a discount on if I pay in advance.

   This is false. For an expense to be eligible, the cost giving rise to the expense must be realized. This means your chiropractic care is not eligible for reimbursement until you've received the care. As the expense is not yet eligible, you cannot use your card to pay for it.

5. I can use my benefits card to pay for over the counter medicines and products.

   This is false. Over the counter items with an active ingredient, like aspirin and Neosporin, require a prescription to be eligible for reimbursement from your health FSA and HRA. You would not be able to purchase these items with your benefits card unless you did so with a prescription. Over the counter items, such as band aids, would be available for purchase with your benefits card if you are buying them at a retailer using the IIAS.

6. I can use the card during the run-out period – the claims submission period following the end of the plan year – for services incurred during the prior plan year.

   This is false. The benefits card pulls funds from the current year's account. If you are taking advantage of the run out period, you are providing claims for the prior year's account. Due to this, you are unable to use your card for prior year's expenses during the run out period.

How soon do I need to send documentation once I've used my card?

BenefitHelp Solutions will send a letter requesting documentation once you've used your card. You must respond to this letter provided within 45 days before you card is temporarily suspended. Once you document or otherwise resolve your transaction, your card will be reactivated.

What is the advantage of the benefits card?

The benefits card is a way to have immediate access to the funds you set aside for the reimbursement of eligible medical care expenses.

When and how do I request a benefits card?

A benefits card can be requested at any time through an enrollment form.

What happens to my benefits card if my name changes?

You will need to notify your employer of your name change and submit a written request to BenefitHelp Solutions. Your card will be deactivated and a new one provided to you.

What do I do with my card once I have used all of my available funds?

Your benefits card is valid until the expiration date on the front of the card, or you terminate your account. You will be able to use the card when you re-enroll.

What happens if I cannot substantiate a card swipe?

If a card swipe is not substantiated, it becomes an ineligible expenses. You can do one of two things:

- You can offset the ineligible card swipe by submitting manual claims for eligible expenses until the amount that was ineligible is resolved.
- You can refund your plan for the cost of the ineligible expenses.

Can I get a benefits card for my spouse or dependent?

Included on the enrollment form is the option to request a benefits card for your eligible dependent (s) and spouse. A dependent must be a qualified tax dependent and at least 18 years old to receive a benefits card.

I've been asked for a letter of medical necessity, what is that and why am I being asked for it?

A letter of medical necessity is a letter from your practitioner explaining why a particular item or service is necessary for the treatment, cure, diagnosis or mitigation of your medical condition. It is required when expenses may or may not be eligible under regulatory guidance. Vitamins and supplements usually fall into this category. You can find a form for your provider to fill out at *benefithelpsolutions.com/pdfs/med_necessity_ltr.pdf*. You may also want to review our list of eligible and ineligible expenses *benefithelpsolutions.com/pdfs/fsa_expenses.pdf* for assistance on what kinds of things typically require a letter of medical necessity.

My doctor gave a prescription for the item, but I'm still being asked for the letter of medical necessity. Is it necessary that both be provided?

Both are not usually required, but a prescription does not take the place of a letter of medical necessity. A prescription is written specifically for a pharmacist, and will not explain how a specific treatment is medically related. We must receive the letter addressing how something is treating a medical condition before it is eligible.

Can I check my account and transactions online?

Absolutely! Please visit *mywealthcareonline.com/benefithelpsolutions/resources*. If it is your first visit, you will need to set up a user name and password. Our customer service team is happy to help if needed.

What if my card is lost or stolen?

The cardholder should notify BenefitHelp Solutions immediately upon learning of a lost or stolen card or a fraudulent transaction. BenefitHelp Solutions will inactivate the card immediately. You, the cardholder, must file a claim within 110 days of the fraudulent transaction. If notification is received timely your liability will be zero. Late notification will result in your liability for funds used fraudulently.

Questions?

Contact BenefitHelp Solutions customer service representative at 503-219-6379 or toll free at 888-398-8057 for more information.

Flexible spending account reimbursement form

BENEFITHelp Solutions

To help us process your reimbursement request quickly, please print clearly and return this form as instructed. Please complete all sections of this form. If this form is incomplete or requires additional information, your reimbursement may be delayed. Please do not use a fax cover sheet.

☐ Check box if this claim is to offset a previously submitted ineligible expense.

Section 1 Account holder information

* First name	M.I.	* Last name	* Membership identification or SSN
* Mailing address		* City	* State / * ZIP
* Contact number	* Email address		☐ New address
* Employer			* Group identification (if known) #

Section 2 Reimbursement request

1	* Name of dependent or self		* Service start date (MM/DD/YY)	* Service end date (MM/DD/YY)
	* Name of provider or merchant	Product description		* Out-of-pocket cost
2	* Name of dependent or self		* Service start date (MM/DD/YY)	* Service end date (MM/DD/YY)
	* Name of provider or merchant	Product description		* Out-of-pocket cost
3	* Name of dependent or self		* Service start date (MM/DD/YY)	* Service end date (MM/DD/YY)
	* Name of provider or merchant	Product description		* Out-of-pocket cost
If you need more space, please use page two. Each page will contain its own total.			* Total on this form	

Please review the timelines and substantiation requirements documented in your Summary Plan Document for eligibility criteria. For a list of common eligible and ineligible expenses and additional information on substantiation please visit benefithelpsolutions.com/pdfs/fsa_expenses.pdf. An explanation of benefits provided by your insurance company is acceptable substantiation. You may need to submit a letter of medical necessity at benefithelpsolutions.com/pdfs/med_necessity_ltr.pdf to establish the medical necessity of your medical expenses. For orthodontia expenses, BenefitHelp Solutions must have a copy of your orthodontia contract on file.

Section 3 Authorization (please read and sign below)

I acknowledge and certify that:

- The information submitted with this reimbursement request is accurate and complete to the best of my knowledge.
- I am requesting reimbursement for my own personal expenses.
- These services have already been provided or paid for.
- I have not and will not seek reimbursement for this expense from any other plan or party.
- I understand BenefitHelp Solutions reserves the right to deny a claim if I have not provided substantiation or if there is reason to believe the expense is not qualified as defined under the conditions in my Summary Plan Document or regulatory guidance.

* Employee signature	* Signature date
X	

** Reimbursement may be delayed if fields with an asterisk are not filled out.*

Ready to submit? Mail, fax or submit this form online to BenefitHelp Solutions.

Mail: BenefitHelp Solutions, P.O. Box 67230, Portland OR 97268 Fax: 888-249-5058 Online: benefithelpsolutions.com

Questions? Contact BenefitHelp Solutions at 888-398-8057.

Additional reimbursement requests

Account holder information

*First name	M.I.	*Last name	*Membership identification
* Employer			*Group identification (if known)

Reimbursement request

4	* Name of dependent or self		* Service start date (MM/DD/YY)	* Service end date (MM/DD/YY)
	* Name of provider or merchant	Product description		* Out-of-pocket cost
5	* Name of dependent or self		* Service start date (MM/DD/YY)	* Service end date (MM/DD/YY)
	* Name of provider or merchant	Product description		* Out-of-pocket cost
6	* Name of dependent or self		* Service start date (MM/DD/YY)	* Service end date (MM/DD/YY)
	* Name of provider or merchant	Product description		* Out-of-pocket cost
7	* Name of dependent or self		* Service start date (MM/DD/YY)	* Service end date (MM/DD/YY)
	* Name of provider or merchant	Product description		* Out-of-pocket cost
8	* Name of dependent or self		* Service start date (MM/DD/YY)	* Service end date (MM/DD/YY)
	* Name of provider or merchant	Product description		* Out-of-pocket cost
9	* Name of dependent or self		* Service start date (MM/DD/YY)	* Service end date (MM/DD/YY)
	* Name of provider or merchant	Product description		* Out-of-pocket cost
10	* Name of dependent or self		* Service start date (MM/DD/YY)	* Service end date (MM/DD/YY)
	* Name of provider or merchant	Product description		* Out-of-pocket cost
11	* Name of dependent or self		* Service start date (MM/DD/YY)	* Service end date (MM/DD/YY)
	* Name of provider or merchant	Product description		* Out-of-pocket cost
12	* Name of dependent or self		* Service start date (MM/DD/YY)	* Service end date (MM/DD/YY)
	* Name of provider or merchant	Product description		* Out-of-pocket cost
Each page will contain its own total.				* Total on this form

Please review the timelines and substantiation requirements documented in your Summary Plan Document for eligibility criteria. For a list of common eligible and ineligible expenses and additional information on substantiation please visit benefithelpsolutions.com/pdfs/fsa_expenses.pdf. An explanation of benefits provided by your insurance company is acceptable substantiation. You may need to submit a letter of medical necessity at benefithelpsolutions.com/pdfs/med_necessity_ltr.pdf to establish the medical necessity of your medical expenses. For orthodontia expenses, BenefitHelp Solutions must have a copy of your orthodontia contract on file.

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BENEFITHelp Solutions

Dependent care assistance program

Definition

The dependent care assistance program (DCAP) helps you save money on eligible dependent care expenses by offering to pay for the expenses with pretax dollars. The pretax funds are withheld from your employer and made available to you through reimbursements by BenefitHelp Solutions.

What are eligible dependent care expenses?

Eligible dependent care expenses are dependent care costs that *enable* an employee (and his or her spouse) to work or look for work. The expense must satisfy the following conditions:

1. You and your spouse must be gainfully employed.

   An eligible dependent care expense must be incurred to *enable* you (and your spouse, if married) to work or look for work.

   Your spouse must be: (a) working, (b) a full-time student for at least five calendar months in the year, or (c) mentally or physically incapable of self-care.

2. The expense must be considered care.

   The primary function of the expense must be for the well-being and protection of the qualifying individual for whom the expense was paid. Such expenses typically include babysitters, family day care, child and dependent care centers and home care. Expenses for education, including kindergarten, are excluded.

3. The expense must be for a qualifying individual.

   The individual for whom the care is provided must be a qualifying individual. This includes a dependent who is:

   A. Under age 13 and:
      a. Has the same principal home address as you
      b. Is your child, stepchild, foster child, sibling, stepsibling or a descendant of one of the preceding
      c. Is not be able to provide more than half of his or her own support for the plan year
   B. A spouse who is physically or mentally incapable of caring for himself or herself and who has the same principle home address as you for more than half of the year
   C. A person who is physically or mentally incapable of caring for himself or herself, who has the same principle home address as you for more than half of the plan year and is your tax dependent

What are some examples of eligible dependent care expenses?

- Before- and after-school care or extended day programs that are not educational in nature
- Au pairs, babysitters and nannies for work-related care of a dependent
- Day camp, including summer day camp
- Nursery school, preschool and prekindergarten even if they are educational in nature, provided that the dependent has not yet entered kindergarten

My day care provider picks my children up from school and charges me a transportation fee. Is this fee a covered expense?

Yes, the cost of transportation furnished by day care providers in order to allow you to be gainfully employed is an eligible dependent care expense.

I do not always work a full week or the full month, but I pay my day care provider in advance for the full month. Are the entire month's expenses eligible for reimbursement?

Yes, if costs for child care are paid on a weekly, monthly or longer period — regardless of whether the period ends up including days you did not work due to part-time employment or temporary illness — the cost of the week, month or longer is eligible for reimbursement.

What happens to my dependent care account when I am on FMLA leave?

If your leave is paid, you will be able to continue contributing to your dependent care account. If your leave is not paid, you will not contribute to your dependent care account. While you are on leave, you are not working and none of the dependent care expenses you incur during the period for which you are on leave will be eligible for reimbursement. Under the conditions of your plan, you may be able to modify or revoke your dependent care election while on leave and modify it again upon your return from leave.

What are some examples of ineligible dependent care expenses?

- Overnight camp
- Lessons including music, dance, swimming, etc.
- Expenses that are primarily educational in nature including tuition, summer school and tutoring programs for children who have started kindergarten

How much can I contribute to my DCAP?

During open enrollment, or if you are a new employee as described by your employer, you will be able to make an election up to the maximum federal limit, or in some cases, the maximum allowed by your employer. Under federal guidelines, you may elect up to $5,000 if you are single or married and filing your income tax jointly with your spouse, or up to $2,500 if you are married but filing your income tax separately from your spouse. This maximum applies to the household. Be aware if your spouse has an opportunity to elect a DCAP as well. The amount of your election is withheld from your paycheck in equal contributions throughout the plan year.

Example: Employer X offers a cafeteria plan that:

- Operates from January through December each year, with an open enrollment period in November;
- Includes a DCAP with election amounts up to $5,000; and
- Has 24 pay periods each plan year.

Suzy is an employee of Employer X and decides to participate for the plan year beginning Jan. 1, 2018 and ending Dec. 31, 2018.

- In November 2017, Suzy is single and decides to make a $5,000 election.
- Beginning Jan. 1, 2018, Employer X will withhold $208.33 from Suzy's paycheck. The amounts withheld will be available to Suzy to use for eligible dependent care expenses.

Can I change my election?

Under the conditions of a cafeteria plan, elections made to any of the benefits provided under the plan are irrevocable. In order to change your election after the start of the plan year, a qualifying change of status must occur. This includes:

- A change in marital status, such as marriage, divorce or death of your spouse
- A change in the number of your dependents by an event such as birth, adoption or death
- A change in your or your spouse's employment status
- An event that causes your dependent to satisfy or cease to satisfy an eligibility requirement, such as your eligible dependent child turning 13
- A change in your residence, your spouse's residence or your dependent's residence
- A change in the cost of your dependent care coverage

If I participate in the DCAP, will I still be able to claim the household and dependent care credit on my federal income tax return?

You may not claim any other benefit for the tax-free amounts you receive under the DCAP, although the balance of your eligible employment-related expenses may be eligible for the dependent care credit. Please consult your tax advisor to determine whether the tax credit may be more favorable to you than participating in the DCAP.

What happens to amounts in my DCAP that I do not use?

Unused DCAP balances are forfeited to your employer. The funds are used as described in the Summary Plan Description provided by your employer.

When do I have to submit my requests for reimbursement of eligible dependent care expenses?

You may submit eligible dependent care expenses any time after the first of the plan year, but reimbursement requests and the necessary substantiation must be received prior to the end of the plan year's run-out period. For details on your plan year and any run-out periods, please review the Summary Plan Description provided by your employer.

Example: Employer X offers a cafeteria plan that:

- Operates from January through December each year, and
- Includes a 90-day run-out period ending March 31 of the following year.

For the plan year beginning Jan. 1, 2018, and ending Dec. 31, 2018, Suzy must submit all dependent care expenses incurred between Jan. 1, 2018, and Dec. 31, 2018, with the necessary substantiation by March 31, 2019.

How do I request reimbursement for an eligible dependent care expense?

To receive reimbursement for an eligible dependent care expense, funds must be available, the expense must be paid for, and the services giving rise to the cost must have been provided. Once services have been completed and paid for, you may submit a claim online at *mywealthcareonline.com/benefithelpsolutions/resources* or by completing a form at *benefithelpsolutions.com/pdfs/fsa_cf_dep_only_fillable.pdf*.

Submit your form by email:	*bhsclaims@benefithelpsolutions.com*
Submit your form by mail:	P.O. Box 67230 Portland, OR 97268
Submit your form by fax:	888-249-5058

What do I need to include with my reimbursement request?

You must include substantiating documents with your claim. You may provide third-party documentation that includes the name of the dependent, the name of the caretaker or facility, the cost of services and the dates of services. If you prefer, you may provide a claim form outlining the dates of services, the name of the caretaker or facility, the cost of services, the dates of services, the tax identification number of the caretaker or facility, and the signature of the caretaker or a representative of the facility.

Example: Suzy's dependent, Annie, attends Churchill Elementary for kindergarten. After kindergarten, Annie attends an after-school program run by Birdee, which costs $300 each month. Birdee requests payment by the first of each month.

- Suzy pays $300 on Jan. 1 for Annie's after-school care.
- At that time, Suzy asks Birdee to sign a claim form and provide her tax identification number confirming the cost of care is $300 for dates of service beginning Jan. 1 and ending Jan. 31.
- Suzy submits the completed claim form to BenefitHelp Solutions on Jan. 15.
- As the expense had not been fully incurred as of Jan. 15, BenefitHelp Solutions does not reimburse Suzy.
- On Jan. 31, when the expense is fully incurred, Suzy has the same $208.33 in her DCAP that was in her account on Jan 15. BenefitHelp Solutions sends Suzy a check for $208.33.
- The next payroll contribution by Employer X is Feb. 15. At that time, BenefitHelp Solutions sends a check to Suzy for the remaining $91.67.

Is there a way to expedite my reimbursement for eligible dependent care expenses?

The example above includes dates of service beginning the first of the month and ending the last day of the month. If you wish to receive reimbursement more often, you may want to submit your request weekly or even twice weekly. You cannot be reimbursed until all dates of service have been rendered. By submitting weekly claims that include dates of service for only the week, you will receive your reimbursements at the end of each week for the services that have been provided. You may also submit a monthly claim that includes the cost for each week independently.

Example: Suzy's dependent, Annie, attends Churchill Elementary for kindergarten. After kindergarten, Annie attends an after-school program called Growing Sprout Day Care, which costs $300 each month. Growing Sprout Day Care requests payment by the first of each month.

- Suzy pays $300 on Jan. 1 for Annie's after-school care.
- Growing Sprout Day Care provides receipts showing the facility's name, the dates of service and the cost for those dates. To help Suzy, Growing Sprout Day Care breaks down the cost of January's care as follows:

Jan. 6 to Jan. 10	$75
Jan. 13 to Jan. 17	$75
Jan. 20 to Jan. 24	$75
Jan. 27 to Jan. 31	$75

- Suzy submits her claim form to BenefitHelp Solutions with the receipt provided by Growing Sprout Day Care on Jan. 15.
- As of Jan. 15, there is $208.33 in Suzy's DCAP. BenefitHelp Solutions processes Suzy's claim on Jan. 20. At that time, the first two weeks of services have been incurred. BenefitHelp Solutions sends Suzy a check for $150.
- On Jan. 27, when the third week is fully incurred, BenefitHelp Solutions sends Suzy another check for the remainder of her account, $58.33.
- The next payroll contribution by Employer X is Feb. 15. At that time, BenefitHelp Solutions sends a check to Suzy for the remaining $91.67.

What if I terminate my employment or otherwise lose eligibility during the plan year?

When you no longer satisfy the conditions necessary to contribute to your DCAP, contributions will cease as of your termination or loss of eligibility date (for some employers this means the date of the event, for others it means the end of the month following the date of the event). No additional funds will be added to your DCAP. Please review the Summary Plan Description provided by your employer for details on the conditions of your termination.

The amount that remains in your DCAP can be used for reasonable work-related dependent care expenses through the date of termination or loss of eligibility. You will have a run-out period to submit eligible dependent care expenses incurred before your termination or loss of eligibility.

Example: Employer X offers a cafeteria plan that:

- Operates from January through December each year;
- Includes a 90-day run-out period following the end of month after termination or loss of eligibility; and
- Terminates contributions to the cafeteria plan on the last day of the month following a terminating event or loss of eligibility.

On July 15, 2018, Suzy takes a position with Employer Z.

- The last contribution to Suzy's DCAP is on July 30 out of Suzy's final paycheck from Employer X.
- At that time, Suzy has a remaining balance of $908.29.
- Suzy sends her eligible dependent, Annie, to an archery day camp through United Archers beginning Aug. 1 and ending Aug. 30. The cost for camp is $900.
- On Sept. 1, Suzy submits a request for reimbursement for the archery day camp to BenefitHelp Solutions. Included with her request is a receipt showing the dates of service, the cost for camp and the service provider.
- BenefitHelp Solutions denies the claim because the expense was for dates when Suzy was not participating.
- At the end of the run out period, Oct. 31, Suzy did not submit any additional dependent care expenses that were eligible for reimbursement. Her account balance, $908.29, is forfeited to Employer X.

What if my employer offers a spend-down allowance?

Your contributions will cease like they did in the previous question, but the amount that remains in your DCAP can be used for reasonable work-related dependent care expenses through the end of the plan year. Following the conclusion of the plan year, you will have the run-out period provided by your employer to submit requests for reimbursement.

If you are unsure whether your DCAP has a spend-down allowance, please review the Summary Plan Description provided by your employer, or contact BenefitHelp Solutions for assistance.

Example: Employer X offers a cafeteria plan that:

- Operates from January through December each year;
- Includes a 90-day run-out period ending March 31; and
- Terminates contributions to the cafeteria plan on the last day of the month following a terminating event or loss of eligibility.

On July 15, 2018, Suzy takes a position with Employer Z.

- The last contribution to Suzy's DCAP is on July 30 out of Suzy's final paycheck from Employer X.
- At that time, Suzy has a remaining balance of $908.29
- Suzy sends her eligible dependent, Annie, to an archery day camp through United Archers beginning Aug. 1, 2018, and ending Aug. 30, 2018. The cost for camp is $900.
- On Feb. 1, 2019, Suzy submits a request for reimbursement for the archery day camp to BenefitHelp Solutions. Included with her request is a receipt showing the dates of service, the cost for camp and the service provider.
- BenefitHelp Solutions sends Suzy a check for $900.
- Suzy does not submit any additional dependent care expenses prior to March 31, 2019. The remaining $8.29 is forfeited back to Employer X.

Questions?

Contact a BenefitHelp Solutions customer service representative at 503-219-6379 or toll free at 888-398-8057 for more information.

Dependent care reimbursement form

BENEFITHelp Solutions

To help us process your reimbursement request quickly, please print clearly and return this form as instructed. Please complete all sections of this form. If your request is incomplete, has not ended or requires additional information, your reimbursement may be delayed. Please do not use a fax cover sheet.

☐ Check box if this claim is to offset a previously submitted ineligible expense.

Section 1 Account holder information

* First name	M.I.	* Last name	* Membership identification or SSN
* Mailing address		* City	* State / * ZIP
* Contact number	* Email address		☐ New address
* Employer		* * Group identification (if known)	

Section 2 Reimbursement request

1	* Name of dependent	* Date of birth (MM/DD/YY)	* Dependent's age	* Out-of-pocket cost
	* Name of provider	* Service start date (MM/DD/YY)		* Service end date (MM/DD/YY)
	** Provider's SSN or tax ID	** Provider's signature		** Signature date (MM/DD/YY)
2	* Name of dependent	* Date of birth (MM/DD/YY)	* Dependent's age	* Out-of-pocket cost
	* Name of provider	* Service start date (MM/DD/YY)		* Service end date (MM/DD/YY)
	** Provider's SSN or tax ID	** Provider's signature		** Signature date (MM/DD/YY)
If you need more space, please use page two. Each page will contain its own total.				* Total on this form

A child care provider's signature and tax identification number will take the place of any additional substantiation. Expenses for dependents over the age of 13 are not eligible for reimbursement from your DCAP account. Please review the timelines and substantiation requirements documented in your Summary Plan Document for eligibility criteria. An expense will not be reimbursed until after the service end date.

Section 3 Authorization (please read and sign below)

I acknowledge and certify that:

- The information submitted with this request is accurate and complete to the best of my knowledge.
- I am requesting reimbursement for eligible expenses incurred by myself or an eligible dependent while I was a participant in the plan.
- I have already received these services and confirm that by requesting reimbursement here I have not and will not seek reimbursement for this expense from any other plan or party.
- I understand BenefitHelp Solutions reserves the right to deny a claim if I have not provided substantiation or if there is reason to believe the expense is not qualified as defined under the conditions in my Summary Plan Document.

* Employee signature	* Signature date
X	

** Reimbursement may be delayed if fields with an asterisk are not filled out.*
*** All expenses must be substantiated by third party documentation or completion of these boxes.*

Ready to submit? Mail, fax or submit this form online to BenefitHelp Solutions.
Mail: BenefitHelp Solutions, P.O. Box 67230, Portland OR 97268 Fax: 888-249-5058 Online: benefithelpsolutions.com
Questions? Contact BenefitHelp Solutions at 888-398-8057.

Additional reimbursement requests

Account holder information

* First name	M.I.	* Last name	* Membership identification or SSN
* Employer			* Group identification (if known)

Reimbursement request

3	* Name of dependent	* Date of birth (MM/DD/YY)	* Dependent's age	* Out-of-pocket cost
	* Name of provider	* Service start date (MM/DD/YY)		* Service end date (MM/DD/YY)
	** Provider's SSN or tax ID	** Provider's signature		** Signature date (MM/DD/YY)
4	* Name of dependent	* Date of birth (MM/DD/YY)	* Dependent's age	* Out-of-pocket cost
	* Name of provider	* Service start date (MM/DD/YY)		* Service end date (MM/DD/YY)
	** Provider's SSN or tax ID	** Provider's signature		** Signature date (MM/DD/YY)
5	* Name of dependent	* Date of birth (MM/DD/YY)	* Dependent's age	* Out-of-pocket cost
	* Name of provider	* Service start date (MM/DD/YY)		* Service end date (MM/DD/YY)
	** Provider's SSN or tax ID	** Provider's signature		** Signature date (MM/DD/YY)
6	* Name of dependent	* Date of birth (MM/DD/YY)	* Dependent's age	* Out-of-pocket cost
	* Name of provider	* Service start date (MM/DD/YY)		* Service end date (MM/DD/YY)
	** Provider's SSN or tax ID	** Provider's signature		** Signature date (MM/DD/YY)
7	* Name of dependent	* Date of birth (MM/DD/YY)	* Dependent's age	* Out-of-pocket cost
	* Name of provider	* Service start date (MM/DD/YY)		* Service end date (MM/DD/YY)
	** Provider's SSN or tax ID	** Provider's signature		** Signature date (MM/DD/YY)
8	* Name of dependent	* Date of birth (MM/DD/YY)	* Dependent's age	* Out-of-pocket cost
	* Name of provider	* Service start date (MM/DD/YY)		* Service end date (MM/DD/YY)
	** Provider's SSN or tax ID	** Provider's signature		** Signature date (MM/DD/YY)

Each page will contain its own total.	* Total on this form $ 0.00

A child care provider's signature and tax identification number will take the place of any additional substantiation. Expenses for dependents over the age of 13 are not eligible for reimbursement from your DCAP account. Please review the timelines and substantiation requirements documented in your Summary Plan Document for eligibility criteria. An expense will not be reimbursed until after the service end date.

** Reimbursement may be delayed if fields with an asterisk are not filled out.*
*** All expenses must be substantiated by third party documentation or completion of these boxes.*