

HEALTH CARE REIMBURSEMENT ACCOUNT

The Health Care Reimbursement Account provides a unique opportunity to pay certain IRS approved health care expenses with pre-tax dollars.

Eligibility

Employee

Faculty and staff are eligible to participate in the Health Care Reimbursement Account if they are employed in a "Regular" position with an FTE of .5 or greater or employed in a "Temporary" position for more than six months with an FTE of .5 or greater.

Dependents

Dependents eligible for reimbursement of Health Care Reimbursement Account claims as defined by the University of Nebraska include the following:

Spouse

- Husband or wife, as recognized under the laws of the state of Nebraska
- Common-law spouse if the common-law marriage was contracted in a jurisdiction recognizing a common-law marriage

Child

The following dependent children may be eligible for coverage:

- Natural-born or legally adopted child who has not reached the limiting age of 26
- Stepchild who has not reached the limiting age of 26
- Child for whom the employee has legal guardianship and who has not reached the limiting age of 26
- Child with a mental or physical disability who has attained the limiting age of 26 may continue coverage beyond age 26 if proof of disability is provided within 31 days of attaining age 26

Coverage ends when the dependent child turns age 26.

Initial Enrollment

Employees must enroll for coverage within 31 days of the date of hire or benefits eligibility date (date the employee satisfies the criteria to be benefits-eligible). The 31 day period is not based on the employee's effective date of coverage.

Enrollment after the initial 31-day period is limited to the annual NUFlex enrollment or when a Permitted Election Change Event occurs.

Effective Date of Participation

Participation is effective on the first day of the month following the employee's date of hire or eligibility. Participation for employees hired on the first day of the month will be effective on the first day of the month. Participation for employees hired on the first working day of the month will be effective on the actual date of hire (if first working day is Jan. 5, coverage will be effective Jan. 5).

Change in Status Guidelines

Employees may enroll or increase their Health Care Reimbursement Account contribution during the calendar year when a Permitted Election Change Event occurs. An annual Health Care Reimbursement Account election may not be reduced before the end of the calendar year when a Permitted Election Change Event occurs.

Employees must enroll or make a change in contribution within 31 days of the Permitted Election Change Event.

Listed below are several Permitted Election Change Events that may allow an employee to initiate a midyear Health Care Reimbursement Account change.

- Change in legal marital status
- Change in number of dependent children
- Change in employment status or work schedule that results in a gain or loss of coverage eligibility
- Change in coverage under spouse's employer's benefits plan, if substantial

Coverage Effective Date as a Result of a Permitted Election Change Event

Coverage changes due to a Permitted Election Change Event will be effective on the first day of the month following the date of the change. However, changes that occur on the first day of the month will be effective immediately. The employee must provide appropriate documentation to verify the Permitted Election Change Event. Only those expenses incurred after the effective date of the change will be covered or reimbursable.

Birth of a Dependent Child

Coverage changes due to a birth of a child will be effective on the dependent's date of birth. The applicable premium will begin on the first day of the month following the date of birth. The employee must provide appropriate documentation to verify the Permitted Election Change Event.

Adoption or Legal Guardianship

Coverage changes due to a dependent child who is added as a result of adoption or legal guardianship will coincide with the earlier of: 1) the date of placement for adoption, or 2) the date of entry of an order granting legal guardianship or custody of the child. Placement generally means when the adoptive parents have taken legal responsibility for the child. Premiums will begin on the first day of the month following the event. The employee must provide appropriate documentation to verify the Permitted

Election Change Event.

Marriage

Coverage changes due to marriage will be effective on the first day of the month following the date of marriage. Changes in coverage for a marriage occurring on the first day of the month will be effective immediately. The employee must provide appropriate documentation to verify the Permitted Election Change Event.

Divorce, Legal Separation or Annulment

Coverage changes due to a divorce, legal separation or annulment will be effective on the first day of the month following issuance of a court decree, the actual date of divorce (six-month period following the court decree), or, in cases of legal separation, date of the court order or separation agreement. There is no waiting period in Iowa so the change in status will be effective on the first day of the month following the date of the final court decree. The employee must provide appropriate documentation to verify the Permitted Election Change Event.

Termination of Coverage

Participation terminates on the last day of the month following the date of termination or date the employee is no longer eligible for coverage. If the date of termination or employee's coverage ineligibility is the last day of the month, coverage will terminate immediately.

Leave of Absence

Health Care Reimbursement Account participation may be continued while the employee is on an approved leave of absence through the end of the calendar year.

Active Military Duty Leave of Absence

An employee who commences a leave of absence for active duty in the military may cancel Health Care Reimbursement Account participation during the leave. Upon return from active duty, the employee may re-enroll for coverage. The employee must provide appropriate documentation to support the date military service ended.

Annual NUFlex Enrollment

Participation in the Health Care Reimbursement Account does not automatically renew each year. Employees may enroll in the Health Care Reimbursement Account during the annual NUFlex enrollment.

COBRA Continuation of Coverage

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a

life event known as a "qualifying event." COBRA continuation coverage is offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plans because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plans, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose coverage under the Plans because of either one of the following qualifying events:

- (1) Your hours of employment are reduced; or
- (2) Your employment ends for any reason other than gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose coverage under the Plans because of any of the following qualifying events:

- (1) Your spouse dies;
- (2) Your spouse's hours of employment are reduced;
- (3) Your spouse's employment ends for any reason other than gross misconduct;
- (4) Your spouse becomes enrolled in Medicare (Part A, Part B or both); or
- (5) You become divorced [or legally separated] from your spouse. If an employee cancels coverage for his or her spouse in anticipation of a divorce [or legal separation] and a divorce [or legal separation] later occurs, then the divorce [or legal separation] will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the COBRA Plan Administrator within 60 days of the decree of dissolution of marriage date and can establish that the employee canceled the coverage earlier in anticipation of the divorce [or legal separation], then COBRA coverage may be available for the period after the divorce [or legal separation].

Your dependent children will become qualified beneficiaries if they lose coverage under the Plans because of any of the following qualifying events happens:

- (1) The parent-employee dies;
- (2) The parent-employee's hours of employment are reduced;
- (3) The parent-employee's employment ends for any reason other than gross misconduct;
- (4) The parent-employee becomes enrolled in Medicare (Part A, Part B or both);
- (5) The parents become divorced [or legally separated]; or
- (6) The child stops being eligible for coverage under the plan as a "dependent child."

The Plans offer COBRA continuation coverage to qualified beneficiaries only after the COBRA Plan Administrator has received timely notice that a qualifying event has occurred, including the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B or both).

[Additional COBRA Information](#)

Reimbursement Account Contacts

- UNL: (402) 472-2600
- UNMC: (402) 559-5911
- UNO: (402) 554-3660
- UNK: (308) 865-8522
- UNCA: (402) 472-2600

Benefits Summary

The Health Care Reimbursement Account can be used to pay for eligible medical, dental, vision, and prescription drug expenses which are not reimbursed by the health insurance plan (excludes most cosmetic services). Employees determine how much they want to set aside for health care expenses during the year. As health care expenses are incurred, reimbursement from the Health Care Account is made by filing claims.

Contributions

Employees may contribute up to \$5,000 annually to the Health Care Reimbursement Account.

Contributions are withheld on a pre-tax basis and are exempt from both state and federal income taxes and Social Security.

Participating employees are required to make contributions through Dec. 31 of each year.

An annual Health Care Reimbursement Account election may not be reduced before the end of the calendar year when a qualified change in status occurs.

Claim Guidelines

Only expenses for services received during the calendar year and after the effective date of coverage may be reimbursed, provided such services were incurred in a benefits-eligible status. Expenses are "incurred when the participant is provided with the medical care that gives rise to the medical expenses, and not when the participant is formally billed or charged for, or pays for the medical care."

Contributions not used by the end of the calendar year will be forfeited.

Employees who participate in both the Health Care and Dependent Day Care Accounts may not use money from one account to cover expenses in the other account.

Qualifying Health Care Expenses

For an expense to be reimbursable under the Health Care Reimbursement Account, it must meet two types of requirements: (1) it must be for medical care, as defined in Internal Revenue Code Section 213, and (2) it must meet additional health Flexible Spending Account restrictions under Internal Revenue regulations. Generally, expenses which are eligible for reimbursement are those which would be deductible on a federal income tax return. Below are examples of some eligible expenses. **Employees**

should contact the Campus Benefits Office to verify qualifying expenses which can be reimbursed through the Health Care Reimbursement Account.

Eligible Medical Expenses		
<p>Baby/Child to Age 13</p> <ul style="list-style-type: none"> Lactation Consultant* Lead-Based Paint Removal Special Formula* Tuition: Special School/Teacher for Disability or Learning Disability* Well Baby Care 	<p>Medical Procedures/Services</p> <ul style="list-style-type: none"> Acupuncture Alcoholism (inpatient and outpatient treatment) Ambulance Drug Addiction Hospital Services Infertility Treatment In Vitro Fertilization Norplant Insertion or Removal Physical Exam (non employment related) Reconstructive Surgery (if medically necessary due to congenital defect or accident) Service Animals* Sterilization/Sterilization Reversal Transplants (including organ donor) Transportation* Vaccinations/Immunizations Vasectomy and Vasectomy Reversal 	<p>Medication</p> <ul style="list-style-type: none"> Birth Control Homeopathic Medications* Insulin Prescription Drugs
<p>Dental Services</p> <ul style="list-style-type: none"> Dental X-Rays Dentures and Bridges Exams/Teeth Cleaning Extractions and Fillings Gum Treatment Oral Surgery Orthodontia/Braces 	<p>Medical Equipment/Supplies</p> <ul style="list-style-type: none"> Abdominal/Back Supports Air Purification Equipment* Arches/Orthopedic Shoes Band-aids Braces and Supports Contraceptive Devices Crutches and Wheel Chairs Elastic Bandages and Wraps Exercise Equipment* First Aid Supplies Hospital Bed Mattresses* Medic Alert Bracelet or Necklace 	<p>Obstetric Services</p> <ul style="list-style-type: none"> Lamaze Class Midwife Expenses OB/GYN Exams OB/GYN Prepaid Maternity Fees (reimbursable after date of birth) Pre and Postnatal Treatments
<p>Hearing</p> <ul style="list-style-type: none"> Hearing Devices and Batteries Hearing Exams 		<p>Practitioners</p> <ul style="list-style-type: none"> Allergist Chiropractor Christian Science Practitioner Dermatologist Homeopath or Naturopath* Osteopath Physician Psychiatrist or Psychologist
<p>Lab Exams/Tests</p> <ul style="list-style-type: none"> Blood Tests and Metabolism Tests Body Scans X-Rays Cardiographs Laboratory Fees Spinal Fluid Tests Urine/Stool Analysis 		<p>Therapy</p> <ul style="list-style-type: none"> Alcohol and Drug Addiction Counseling (not marital or career) Exercise* Hypnosis
<p>Vision Services</p> <ul style="list-style-type: none"> Eye Examinations 		

- Eyeglasses
- Contact Lenses and Contact Lens Supplies
- Laser Eye Surgeries
- Artificial Eyes
- Prescription Sunglasses
- Radial Keratotomy/LASIK
- Reading Glasses
- Oxygen*
- Pregnancy Test Kits
- Post Mastectomy Clothing
- Prosthesis
- Splints/Casts
- Support Hose*
- Syringes
- Wigs*
- Massage
- Occupational Physical
- Speech
- Weight Loss Programs*

Ineligible Expenses

- Cosmetic Surgery/Procedures
- Dancing/Exercise/Fitness Programs
- Diaper Service
- Electrolysis
- Personal Trainers
- Hair Loss Medication
- Hair Transplant
- Health Club Dues
- Long Term Care Premiums
- Marriage Counseling
- Maternity Clothes
- Sunscreen
- Swimming Lessons
- Teeth Whitening/Bleaching
- Vitamins or Nutritional Supplements

*Dual purpose item that requires a medical practitioner's diagnosis and recommendation indicating the OTC drug is to treat a medical condition (see section below on Dual Purpose OTC Drugs).

Over-the Counter (OTC) Drug Reimbursement

Certain over-the-counter drugs (OTC) items will require a prescription to be considered for reimbursement under the Health Care Reimbursement Account. This means that an OTC must be **accompanied by a doctor's prescription to be eligible for reimbursement**. A prescription for an OTC drug or medicine should be exactly the same as one for a drug or medicine that can only be obtained with a doctor's prescription. When the employee goes to the doctor, the employee should ask him or her to write a prescription for the item for which they want to be reimbursed. The prescription must comply with state prescription laws and be written on a physician's prescription pad.

Below is a list of OTC drugs and medical items that **NOW REQUIRE** a doctor's prescription

Acne treatments

Cough, cold & flu medicines

Acid controllers	Digestive aids
Allergy & sinus medicines and products	Feminine anti-fungal/anti-itch
Antibiotic products	Hemorrhoid preps
Antidiarrheals	Laxatives
Anti-gas	Motion sickness
Anti-itch & insect bite	Aspirin & pain relief
Anti-parasitic treatments	Respiratory treatments
Baby rash ointments/creams	Sleep aids & sedatives
Cold sore remedies	Stomach remedies
Eye drops & eye ointment	

Some OTC drugs and supplies will continue to be eligible for reimbursement without a doctor's prescription. Below is a list of OTC drugs and medical items that do not require a doctor's prescription.

Insulin & diabetic supplies	Diagnostic tests & monitors
Band aids	Elastic bandages & wraps
Braces & supports	Fertility monitors
Catheters	First aid supplies
Birth control	Hearing aids and batteries
Contact lens supplies & solutions	Ostomy products
Denture adhesives	Reading glasses
Diabetic monitors, test kits, strips & supplies	Wheelchairs, walkers, canes, etc.

Dual Purpose OTC Drugs

Some OTC drugs have dual purposes, those purchased to alleviate or treat sickness, pain, and injury while at the same time used for personal/cosmetic or general health reasons. To receive reimbursement for a dual purpose OTC drug, **employees must submit a medical practitioner's diagnosis and recommendation that the OTC drug is to treat the medical condition along with the cash register receipt. The medical practitioner's diagnosis and recommendation documentation must be renewed annually.**

Below is a list of OTC drugs that are considered Dual Purpose drugs (have both a medical purpose and a personal/cosmetic or general health purpose) **that requires a medical practitioner's diagnosis and recommendation to purchase OTC for treatment)**

- Hormone therapy and treatment for menopause
- Dietary supplements or herbal medicine to treat a specific medical condition
- Prenatal vitamins
- Fiber supplements to treat a specific medical condition
- Weight-loss drugs to treat a specific disease including obesity
- Lactose intolerant pills and supplements
- Nasal spray for snoring
- Orthopedic shoes and inserts
- Glucosamine/Chondroitin for arthritis

OTC Drugs that are Excluded from Reimbursement

- Any item that is merely beneficial to the general health of an individual or improving one's appearance
- Cosmetics or sundry items
- Chapstick, skin moisturizers, face cream, perfume, lipstick, fingernail polish, eye and facial makeup
- Toiletries such as toothpaste, toothbrush, deodorant, shaving lotion, mouthwash
- Medicated shampoo and soap
- Feminine hygiene products
- Vitamins
- Dietary supplements and vitamins to improve and maintain general health
- Special diet drinks or food supplements
- Acne and skin care treatment products
- Suntan and sunscreen lotion
- Hair loss treatments
- Breath-right strips
- Feet care products like corn pads

With the addition of OTC drugs as an eligible Health Care Reimbursement Account expense, an aggregate claim dollar submission minimum has been established. Claims for **both health care and OTC drugs** must equal at least \$25 per submission in order to be processed. Any claim submitted that is less than the \$25 minimum will be returned to you for future submission. Claims for any dollar amount will be processed for reimbursement in January, February, and March following the end of the plan year.

To receive reimbursement for OTC drugs, you must submit a legible cash register receipt that clearly identifies (circled): a) the OTC drug name, b) date of purchase, and c) amount paid. You must also indicate on the receipt the covered person's name for which the OTC drug was purchased, (i.e. employee, spouse, or dependent child.)

The IRS only allows a "reasonable limit" of OTC drugs to be reimbursed through the Health Care Reimbursement Account. The university has defined "reasonable limit" as: a) two packages or bottles, etc. or b) a reasonable supply corresponding to a 90-day supply. A claim submission of three (3) or more OTC drugs for the same or similar general category may be returned to you for clarification or documentation.

Weight Loss Expenses

Listed below are several weight loss related expenses that may potentially qualify for reimbursement through the Health Care Reimbursement Account. In all cases, the expense must be recommended by a physician to treat a specific medical condition (such as obesity, heart disease, or diabetes, etc.).

Exercise Programs and Health Club Memberships

An expenditure which is merely beneficial to the general health of an individual is not a medical care expense. Thus, exercise programs are clearly not medical care when unrelated to a treatment plan for a specific illness or injury. Health club membership fees that are incurred primarily for the purpose of alleviating obesity may be deductible as a medical expense. In addition, payments for a per treatment

basis at a health club (e.g., fees for a specific treatment and even in some cases, personal trainer fees) may be an eligible expense if the treatment is primarily for a specific medical condition.

Health club dues incurred primarily for medical care may be reimbursed through the Health Care Reimbursement Account if certain substantiation requirements are met. Adequate substantiation includes a physician's recommendation that the individual join a health club in order to treat a particular disease such as obesity. If the participant belonged to the health club before being diagnosed, then the dues would not be reimbursable. In addition, once an individual no longer is in need of treatment, the health club dues would cease being reimbursable.

Summary: Exercise programs qualify only if required to treat an illness (such as obesity) when diagnosed by a physician. The purpose of the expense must be to treat the disease rather than to promote general health. To show that the expense is primarily for medical care, a note from a physician recommending it to treat a specific medical condition is required. Health club fees may qualify for reimbursement in limited circumstances. One instance might be where fees are incurred upon the advice of a physician to treat a specific medical condition (e.g. rehabilitation after back surgery or treatment for obesity). If the participant belonged to the health club before being diagnosed, then the fees would not qualify. When treatment is no longer needed, the fees would no longer qualify for reimbursement.

Weigh-Loss Programs

A weight-loss program undertaken at a physician's direction to treat an existing disease (such as obesity or heart disease) is considered medical care and therefore, the cost of such a program may be reimbursable by the Health Care Reimbursement Account. However, a weight-loss program intended to improve a participant's appearance, general health, and sense of well-being are not medical care, and therefore, not deductible or reimbursable through the Health Care Reimbursement Account.

Adequate substantiation must be provided since some weight-loss programs charge a single combined price for diet consultations, exercise, and special foods while other programs are part of a more lavish spa experience with extras that are not considered medical care.

A physician must provide adequate written documentation which 1) recommends the individual for the weigh-loss program and 2) evidences the special medical condition (e.g. obesity) and the fact that the weight-loss program is needed to treat the condition.

Amounts spent on special food that is a substitute for the food an individual normally consumes and that satisfies nutritional needs are not considered to be for medical care thus, not reimbursable (See Special Food section).

Summary: Weight-loss program expenses may qualify if the weight-loss program is recommended by a physician to treat a specific medical condition (such as obesity, heart disease, or diabetes) and is not simply to improve general health. However, the cost of food associated with a weight-loss program (such as special pre-packaged meals) would not qualify since it just meets normal nutritional needs. To show that the expense is primarily for medical care, a note from a physician recommending it to treat a specific medical condition is required.

Vitamins, Natural Medicines, Nutritional and Herbal Supplements

Dietary supplements may be reimbursable if they treat a specific medical condition. A physician's diagnosis and recommendation would be required for reimbursement.

Dietary supplements however, taken for general health, whether or not recommended by a physician, will not qualify as medical care. In contrast, if a physician recommends supplements to cure, mitigate, or prevent a particular disease, then the expense may be reimbursable (e.g., calcium pills to treat osteoporosis, iron pills to treat anemia, vitamins containing folic acid to prevent birth defects, etc.).

Summary: Vitamins and herbal supplements might qualify if recommended by a physician for a specific medical condition. They will not qualify if used to maintain general health (e.g. one-a-day vitamins). Non traditional natural medicines (alternative healers) treatments provided by professionals may be eligible if provided to treat a specific medical condition. Expenses do not qualify if the remedy is a food or substitute for food that the person would normally consume in order to meet nutritional requirements. To show that the expense is primarily for medical care, a note from a physician recommending it to treat a specific medical condition is required.

Special Foods

Amounts spent on special food that is a substitute for the food an individual normally consumes and that satisfies nutritional needs are not considered to be for medical care thus, not reimbursable.

Summary: Expenses do not qualify if the remedy is a food or substitute for food that the individual would normally consume in order to meet nutritional requirements. For example, the cost of food associated with a weight-loss program (such as special pre-packaged meals) would not qualify since it just meets normal nutritional needs.

Filing Claims for Reimbursement

Employees may file health care claims at any time during the year by completing a Reimbursement Account Claim Form. Reimbursement Account Claim Forms may be downloaded from this website.

Health Care Reimbursement Account claims will be paid each pay period based on the claims submission deadline. The monthly claims filing deadline includes the following:

- Monthly paid employees: All Health Care Reimbursement Account claims must be received in the Campus Benefits Office by the 12th of each month.
- Biweekly paid employees: All Health Care Reimbursement Account claims must be received in the Campus Benefits Office by the pay date prior to the reimbursement payment.

All health care expenses must be submitted for reimbursement by Mar. 31, following the year in which the expense was incurred. After Mar. 31, any remaining unreimbursed amounts will be forfeited.

Amounts payable from the Health Care Reimbursement Account will be included in the employee's pay and shown on the payroll advice.

Reimbursement Account Claim Filing Instructions

A Reimbursement Account Claim Form should be completed based on the following instructions.

- **Employee Information: Complete Part A.**
- **Health Care Claim Information:** Complete Part B by listing the date of service, patient name, patient relationship to you, provider name, condition for which the over-the-counter item was purchased (if applicable), and the amount not paid by the insurance company for each health care expense. Dependent and claim eligibility requirements are located on the University of Nebraska benefits webpage at www.nebraska.edu/benefits. Note: expenses related to cosmetic services including dental bleaching or cosmetic surgery are excluded.

The following documentation should be attached to the completed claim form:

If you have medical or dental insurance, all expenses must be submitted to your insurance company before being submitted for reimbursement. When you receive the Explanation of Benefits (EOB) statement from your insurance company, submit a copy along with the completed claim form. (Do not attach bills.) If you or a covered dependent are covered by two insurance plans, attach EOBs from both insurance plans to claim the amount not paid by either plan. ***If you have vision insurance,*** reimbursement of vision care services requires an EOB or detailed/itemized statement noting the amount insurance paid, if any, and your out-of-pocket expense.

If you do not have insurance coverage, submit an itemized statement from the provider showing the date of service, patient name, patient relationship to you, provider name and address, description of service, and the amount charged along with the completed claim form. In addition, you must note on the itemized statement that you do not have insurance coverage. Canceled checks, credit card receipts, billing statements showing "previous balance" or "received on account" are not acceptable.

Prescription drug reimbursement requires, in addition to the Reimbursement Account Claim Form, pharmacy-provided documentation of proof of expense must include the 1) name of the drug or prescription Rx number, 2) date of service, 3) amount paid, and 4) for whom the prescription was dispensed.

Over-the-counter (OTC) medicines and drugs. Certain Over-the-counter (OTC) medicines and drugs require a prescription to be considered for reimbursement under the Health Care Reimbursement Account. This means that an OTC must be **accompanied by a doctor's prescription to be eligible for reimbursement**. A prescription for an OTC drug or medicine should be exactly the same as one for a drug or medicine that can only be obtained with a doctor's prescription. When the employee goes to the doctor, the employee should ask him or her to write a prescription for the item for which they want to be reimbursed. The receipt or documentation from the store must be legible and include the name of the drug printed on the receipt, date of purchase, and amount paid. In addition, the covered person's name for which the OTC drug was purchased must be noted on the receipt and/or claim form. The claim form must also indicate the existing or imminent medical condition for each OTC medicine or drug. Purchases for general good health will not be accepted.

Some OTC drugs have dual purposes, those purchased to alleviate or treat sickness, pain, and injury while at the same time used for personal/cosmetic or general health reasons. To receive

reimbursement, **you must submit the “Letter of Medical Necessity for Dual Purpose OTC Drugs” form** which has been completed by your attending physician. To expedite payment, this form should be attached to your submitted claim form. You must renew this notice at the beginning of each calendar year (Jan. 1) and submit to your Campus Benefits Office.

Dependent Day Care Claim Information: Complete Part C by listing the date of service, dependent name, dependent age, care provider’s name, provider’s Tax ID or Social Security Number, and amount of the dependent care expense. Dependent and claim eligibility requirements are located on the University of Nebraska benefits webpage at www.nebraska.edu/benefits.

Reimbursement Guidelines: Claims for both health care and OTC drugs must equal at least \$25 per submission in order to be processed. Any claim submitted that is less than the \$25 minimum will be returned to you for future submission. Claims for any dollar amount will be processed for reimbursement in January, February, and March following the end of the plan year.

The IRS only allows a “reasonable limit” of OTC drugs to be reimbursed. The university has defined “reasonable limit” as: a) two packages or bottles, etc. or b) a reasonable supply corresponding to a 90-day supply. A claim submission of three (3) or more OTC drugs for the same or similar general category may be returned to you for clarification or documentation.

All dependent day care expenses must be submitted to your Campus Benefits Office for reimbursement by March 31st, following the year in which the expense was incurred. **After Mar. 31, any remaining unreimbursed amounts will be forfeited.**

All health care expenses must be submitted to your Campus Benefits Office for reimbursement by Mar. 31, following the year in which the expense was incurred. **After Mar. 31, any remaining unreimbursed amounts will be forfeited.**

If you are unsure of an expense, please refer to the list of eligible expenses on our website. Health care expenses must meet requirements of Section 125 and Publication 502 and not all expenses listed Publication 502 are eligible for reimbursement. Dependent day care expenses must meet requirements of Section 125 and Publication 503.

Read the certification statement and the dependent and claim eligibility requirements (located on the University of Nebraska benefits Web page at www.nebraska.edu/benefits) carefully. Please sign and date the claim form and forward with supporting documentation to your Campus Benefits Office. A copy of this claim form and supporting documentation should be kept for your records.

Submission of an Orthodontic Claim

Employees are encouraged to contact their Campus Benefits Office prior to any orthodontic payment or service to obtain billing and reimbursement guidance for the Health Care Reimbursement Account. **Reimbursement of an orthodontic claim is based on when the claim was incurred, not when the expense was paid to the provider.** The fact the participant has “been billed for” or “has paid the expense” does not qualify the claim for reimbursement. The orthodontic claim must be incurred, a bill submitted to the insurance company, and an EOB generated before the claim can be considered for reimbursement. The only date that is relevant to establishing that an expense has been incurred is

“when the participant is provided with the orthodontic care that gives rise to the dental expense”.

Requests for reimbursement that involve a prepayment component will not be processed. Although an orthodontic provider may require prepayment (prior to the completion of services), the claim will only be adjudicated once a service or procedure is incurred. Because orthodontia typically spans a period of several years, individuals are often charged an initial, up-front payment and then required to make periodic payments over the rest of the treatment period.

If an EOB is provided from an insurance company that indicates the orthodontia lifetime maximum orthodontia limit had been reached (and no further claims will be paid), the orthodontia claim may be processed based on the provider’s itemized billing/statement or payment coupons from that date forward. The EOB must be however, submitted with each claim.

If an employee does not have insurance coverage, an itemized statement from the provider showing the date of service, patient name, patient relationship, provider name and address, description of service, and the amount charged along with the completed claim form should be submitted. In addition, the itemized statement should indicate that the employee is “not enrolled for insurance coverage”. Canceled checks, credit card receipts, billing statements showing “previous balance” or “received on account” are not acceptable. Requests for reimbursement that involve a prepayment component will not be processed. Although an orthodontic provider may require prepayment (prior to the completion of services), the claim will only be adjudicated once a service or procedure is incurred. Because orthodontia typically spans a period of several years, individuals are often charged an initial, up-front payment and then required to make periodic payments over the rest of the treatment period. If no insurance coverage is available however, the employee should submit a memo from the provider which includes the monthly services dates and cost.

Reimbursement Account Claim Forms

- [Reimbursement Account Claim Form](#)
- [Supplemental Reimbursement Account Claim Form](#)
- [Letter of Medical Necessity for Dual Purpose OTC Drugs](#)