

# 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 6 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 unmarried dependent children may be eligible for coverage:

- Natural-born or legally adopted child who has not reached the limiting age of 19
- Stepchild who is living in the employee's home and is chiefly dependent on the employee for financial support (must be claimed as an IRS dependent), and who has not reached the limiting age of 19
- Child for whom the employee has legal guardianship and who has not reached the limiting age of 19
- Mentally or physically handicapped child who has attained the limiting age of 19. Coverage may be continued beyond age 19 if proof of disability is provided within 31 days of attaining age 19. If a student (ages 19 through 23), proof of disability must be provided within 31 days of the disability.

#### Student (ages 19 through 23)

The following unmarried dependent children may be eligible for coverage:

- Dependent child who has not reached the limiting age of 24 and is a full-time student
- Dependent children who are students (ages 19 through 23) must receive over half of his or her financial support from the employee.
- Full-time student status generally requires a dependent to enroll (and attend) for 12 or more undergraduate (9 or more graduate) credit hours each semester. The number of credit hours required for full-time student status is based on the school's definition of a full-time student.

**In addition to** the dependent eligibility requirements noted in the Dependent's eligibility section, employees must certify that a spouse and/or dependent child satisfies **all of the following** for participation in the Health Care Reimbursement Account.

- Employee provided over half of the dependent child's total financial support for the calendar year\*
- Dependent resided with the employee for the entire calendar year unless eligible as a student ages 19 through 23\*

- Dependent is a U.S. citizen or resident, or a resident of Canada or Mexico for some part of the calendar year in which the employee's tax year began
- Employee's relationship with the dependent does not violate local law

\*Dependent child of divorced parents is considered to be a dependent of both parents for participation purposes and thus, employee is not required to provide over half of dependent's total financial support. In addition, a dependent child of a divorced parent is not required to reside with the employee.

## 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 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 January 5<sup>th</sup>, coverage will be effective January 5<sup>th</sup>).

## 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 which results in a gain or loss of coverage eligibility
- Change in coverage under spouse's employers' 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. Changes however, that occur on the first day of the month will be effective immediately. The employee may be required to furnish 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.

## 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

Employees may continue Health Care Reimbursement Account participation while 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 reenroll for coverage. The employee may be required to provide 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 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 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 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 his or her 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: 472-2600
- UNMC: 559-5911
- UNO: 554-3660
- UNK: 865-8522
- UNCA: 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 December 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. Some examples of eligible expenses include the unreimbursed portion of:

Acupuncture	Nursing services (including nurses' board and social security tax where paid by payer)
Alcoholism or drug dependence treatment	Obstetrical expenses
Ambulance service	Optometrist
Artificial limbs	Orthodontia
Birth control pills	Orthopedic shoes
Braces	Osteopath fees
Braille books and magazines	Over-the counter drugs
Car adaptations and controls for the handicapped	Oxygen
Chiropractors	Prescription drugs and medicine
Christian Science practitioner's fees	Psychiatric care
Coinsurance amounts you pay	Psychologist fees
Contact lenses (and solutions & cleansers)	Vision correction services including RK (Radial Keratotomy), LASIK, and PRK
Cosmetic surgery (as necessary to correct Congenital abnormality or repair required by accident)	Routine physicals and other non-diagnostic services or treatments
Cost of operations and related treatments	Smoking Cessation Program
Crutches	Special education for the blind
Deductibles you pay for health care	Special plumbing for handicapped
Dental fees	Sterilization fees
Dentures	Surgical fees
Diagnostic fees	Syringes, needles and injections
Doctor's fees	Telephone, special for the deaf
Eye Examinations	Television audio display equipment for the deaf
Eyeglasses, including prescribed sunglasses	Therapy treatments
Hearing devices and batteries	Transplants, organ
Home improvements due to medical conditions	Transportation expenses, primarily in the rendering of medical services, i.e., railroad fare to hospital or to recuperation home, cab fare in obstetrical cases
Hospital bills	Tuition at special school or tutoring for learning disabled or handicapped
Insulin	Vitamins by prescription
Laboratory fees	Wheelchair
Laetrile by prescription	Wigs prescribed by a doctor
LASIK Surgery	X-rays
Mentally handicapped or retarded care – includes treatment, training and special homes	
Nursing home care for medical treatment	

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

## Over-the Counter (OTC) Drug Reimbursement

Below are examples of Over-the-Counter (OTC) drugs that may be reimbursed through the Health Care Reimbursement Account. Over-the-counter medicines and drugs that are taken orally or applied to the body to **alleviate or treat sickness, pain, injuries, or a medical condition are eligible for reimbursement**. OTC medicines may be in the form of a liquid, pill, or ointment if they contain a drug.

In addition, 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, **you 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**.

### Covered Medical-Only List

*(to alleviate or treat personal injury or sickness)*

Antacids  
Allergy medications  
Pain reliever including aspirin  
Cold remedies including cough syrup, drops, throat lozenges, nasal sprays  
Incontinence supplies  
Take-home screening kits for detecting colon cancer, Hepatitis C, HIV  
Anti-diarrhea medicine, laxatives, gas relief  
Menstrual cycle products for pain and cramp relief  
Yeast infection products  
Sinus medications, nasal sinus sprays, nasal strips  
Nicotine gum or patches for smoking cessation  
Special ointment or cream for sunburn  
BenGay, Tiger Balm and similar products for muscle or joint pain  
Pedialyte for ill child's dehydration  
First aid cream, Bactine, special diaper rash ointment, calamine lotion, bug bite medication,

### Excluded Items List

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

### Dual Purpose List

*(have both a medical purpose and a personal/cosmetic or general health purpose; requires 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

wart remover treatments  
Visine, eye drops and other  
such eye products  
Hemorrhoid suppositories and  
creams  
Sleeping aids  
Motion-sickness pills  
Band aids, bandages, gauze  
pads, first aid kits, cold/hot  
packs for injuries, rubbing  
alcohol, liquid adhesive for  
small cuts  
Reading glasses, contact lens  
cleaning solution  
Pregnancy test kits, condoms,  
spermicidal foam  
Wrist, knee, ankle supports  
Thermometers (ear or mouth)  
Anti-fungal ointments and  
creams  
Antiseptic ointments and  
creams  
Vapor rubs  
Lice treatments

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 March 31st, following the year in which the expense was incurred. After March 31st, 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 Web page at [www.nebraska.edu/benefits](http://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*** require additional documentation for reimbursement. 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 (January 1<sup>st</sup>) 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 Web page at [www.nebraska.edu/benefits](http://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 March 31st, any remaining unreimbursed amounts will be forfeited.**

All health 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 March 31st, 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](http://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](#)