Flexible Spending Account

with the EBS Flex Card

The Benefit That Benefits Everyone!

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EBS Benefit Solutions, Inc.

Flexible Spending Account (FSA)

What is an FSA?

A Flexible Spending Account (FSA) is an employee benefit plan established under Section 125 of the Internal Revenue Code. An FSA allows you to pay for everyday health care expenses with pre-tax dollars. As a participant, you will save money by reducing your taxable income. The funds you elect are set aside from your paycheck pre-tax to reimburse you for qualified expenses for yourself, your spouse and any dependents claimed on your federal tax return.

How can an FSA help you save?

You save federal, state and FICA taxes on the money that you set aside. Take a look at the example below to see how an FSA account can benefit you.

Health Care Account

A Health Care Account can reimburse you for eligible out of pocket medical or dental expenses for you and your dependents.

Examples: Medical co-payments and deductibles, over the counter drugs, vision expenses, hearing aids, etc.
Exclusions: Expenses not medically necessary or cosmetic in nature.

Dependent Care Account

A Dependent Care Account can reimburse you for the financial burden of paying for day care expenses for your dependents (children and adults) so you can work.

Examples: Preschools, before and after school care, day camps, etc.
Exclusions: Overnight camps, activities or lunch fees.

	Participating in an FSA	Not Participating in an FSA
Annual Salary Before Taxes	$24,000	$24,000
Less		
• Health Care Acct Contribution	($1,500)	$0
• Dependent Care Acct Contributions	($4,000)	$0
Taxable Income	$18,500	$24,000
Estimated Taxes (based at 25% for Federal)	($4,625)	($6,000)
Less		
• Health Care Expenses	$0	($1,500)
• Dependent Care Expenses	$0	($4,000)
Available Income	$13,875	$12,500
Estimated Savings $1,375		

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Important Information

Enrollment:
You must enroll each Plan year. Elections do not "roll" from year to year. Your election is valid for the current Plan year only.

Status Changes:
Changes to your annual election are permitted only upon a qualifying "life change" event (ie, marriage, death, divorce, birth or adoption, and/or change in employment status). Contact your Human Resources department to request an "Adjustment to Participant Elections" change form.

Termination/COBRA:
Typically, claim reimbursement for expenses incurred while you were employed must be submitted within 90 days from your termination date. You should check your Summary Plan Description (SPD) for your Plan's exact provisions (request from your Plan Sponsor). You may, however, continue your participation in the health care account through the election of COBRA. COBRA is not available for the dependent care account.

Use it or Lose it:
Claim deadlines apply. If funds remain in your account at the end of the claim deadline, they will be forfeited to the Plan Sponsor. Be sure to plan ahead by completing the "FSA Estimated Annual Expense Worksheet" to determine your out-of-pocket costs and knowing your Plan's exact provisions.

Separate Accounts:
Budget for health care expenses and dependent care expenses separately. You may enroll in either the health care account, the dependent care account or both (depending on the benefits offered by your employer). Deposits to, and payments from, the two accounts cannot be blended.

Maximum Reimbursement:
The IRS maximum for the dependent care FSA is $5,000 annually, per family. The maximum for the health care account is set by your employer. After your first contribution to the health care account, you have access to the total amount you elected for the Plan year.

Qualified Dependents:
Regardless of who is covered on your medical insurance, you can submit claims for medical expenses for your spouse and dependents, as long as they are claimed on your federal tax return. Qualifying dependents for the dependent care account are children under the age of 13, a disabled spouse, or other dependents that reside with you who are physically or mentally disabled.

Eligible / Ineligible Expenses:
Eligible expenses include health care expenses that are not covered by your health insurance Plan, as well as certain dependent care expenses. Some ineligible expenses are cosmetic expenses, teeth whitening, vitamins, health club dues and insurance premiums. Check your Plan's SPD for any potential Plan specific restriction. EBS provides a listing of qualifying and non-qualifying expenses on our www.myebsaccount.com website. A Certification of Medical Necessity may be completed by your physician to cover non-standard expenses.

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Administering Your Account

On-Line Access

Monitoring your account is easy! Simply login to www.myebsaccount.com.

From the site, you will be able to:

- Submit claims for reimbursement.
- Review your claims history.
- View account summaries, including your annual election and current account balance.
- Print a statement on demand.
- Print forms and documents, such as an FSA/HRA eligible expense listing, reimbursement forms, direct deposit forms, certificate of medical necessity applications and more.
- Use our on-line calculator to assist you in estimating your out of pocket expenses.
- Change your username and password.
- Enter/update your email address.

Requesting Reimbursement

Reimbursement for out-of-pocket expenses can be done either on-line or by submitting a paper reimbursement request form. Reimbursement request forms are found on-line in the Document Library section of the website.

Claim deadlines apply. Terminated participants typically have 90 days following the date of termination to request reimbursement for services incurred or products purchased prior to termination. Active participants typically have a Plan specified number of "run out" days following the Plan year in which to submit claims. Grace period days may also apply to some Plans. Check your Summary Plan Description for your Plan's exact provisions regarding termination policies, run out days and grace period days.

If you are an EBS Flex Card holder, you do not need to submit paper or on-line claims for transactions made with your Flex Card, although you may be required to submit documentation for your claims.

How to Submit a Claim

For eligible expenses, a copy of the receipt and/or Explanation of Benefits from your insurance carrier must accompany either your paper reimbursement request form or your on-line request (by attaching a scanned copy).

The receipts attached to your reimbursement request form must include the following information:

- Patient Name
- Provider Name
- Date of Service
- Description of Service
- Out of Pocket Cost

- For Dependent Care, provider's tax identification number or Social Security number.

Reimbursement checks are paid weekly, and can be reimbursed to you by check or through direct deposit (you must complete a Direct Deposit form). There is a $30 minimum check amount, except for the final check.

Note: ACT (Automatic Claims Transfer) is a feature offered by several insurance carriers to expedite processing of medical or dental claims. If your Plan utilizes ACT, and you have elected to have claims automatically reimbursed through ACT, you do not need to submit manual claims for insurance related copayments and expenses. You may change your ACT election on-line at any time. Please note that ACT is not available if 1) you or any of your dependents have Coordination of Benefits with another medical or dental Plan or 2) you are an EBS Flex Card holder. Some insurance carriers discontinue this feature for dependents when they reach a certain age, ie age 19. You should check with your employer to understand how/if ACT affects your account.

Customer Service Center

If you need assistance with your account, please call our Customer Service team, Mondays, Tuesdays, Thursdays and Fridays from 8am to 5pm EST and Wednesdays from 9am to 5pm EST at (800) 327-7130 or email us at FSA.Pilot@excellus.com. Please keep in mind that many of your questions can be answered by visiting your account on-line.

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FSA Estimated Annual Expense Worksheet

Use this worksheet to help estimate your out-of pocket health and/or dependent care expenses for the Plan year. You may include expenses for anyone who will be included on your Federal Tax Return (i.e. spouse, children, etc). An expense listing is attached and is also available on the www.myebsaccount.com website.

Remember: You can not change your election during the Plan year unless you experience a qualifying change in status.

Health Care Account	**Annual Expense**
Deductibles	$
Co-payments	$
Routine Well Visits	$
Dental Expenses not covered by insurance	$
Orthodontia	$
Vision Expenses *(Exams, Glasses, Contact Lenses)*	$
Hearing Expenses *(Exams, Hearing Aids)*	$
Prescription Drugs	$
Over the Counter Drugs	$
Diabetic Supplies	$
Therapy/Treatments *(Physical Therapy, Speech, Chiropractic)*	$
Mileage for medical care related transportation	$
Other Medically Necessary Un-reimbursed Expenses	$
Total Estimated Health Care Expenses (A)	$

Dependent Care Account	**Annual Expense**
Payment to a Dependent Care Facility	$
Payment to a Dependent Care Individual	$
Payment to Adult Care Provider	$
Total Estimated Dependent Care Expenses (B)	$

Health Care + Dependent Care Total	**Total Expense**
Total Estimated Annual Expenses (A)+(B) = (C)	**$**

Summary				
$_____ Total Annual Expenses (C)	÷ Divided by	_____ Number of Pay Periods *	= Equals	$_____ Total Per Pay Period Deduction

**If enrolling mid year, account for the number of pay periods remaining in current Plan year.*

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Qualifying and Non-Qualifying Expenses

EBS Benefit Solutions, Inc. partners with Employee Benefits Institute of America (EBIA) to provide a Health Care Expenses Table, which is available on our www.myebsaccount.com website. The following lists of qualifying and non-qualifying expenses is not intended to be a complete, comprehensive list and is subject to change at any time without notice. Visit the table on-line frequently to find the most recently published information. Caution: Some items in the list may not be reimbursable under your Plan. Consult your Plan's Summary Plan Description for guidance.

The following health care expenses qualify for reimbursement:

- Abortion, Legal
- Acupuncture
- Adoption, pre-adoption medical expenses
- Alcoholism treatment
- Ambulance
- Artificial limbs/teeth
- Asthma treatments
- Birth control pills
- Body scans
- Braille books and magazines
- Breast reconstruction surgery following mastectomy
- Chelation therapy
- Chiropractors
- Circumcision
- Co-insurance amounts
- Co-payments
- Deductibles
- Dental sealants
- Dental treatment
- Diagnostic items/services
- Drug addiction treatment
- Drug overdose treatment
- Egg donor fees
- Eye exams, eyeglasses
- Fertility treatments, GIFT
- Flu shots
- Guide dog, other animal aide
- Hospital services
- Immunizations
- In vitro fertilization
- Infertility treatments
- Laboratory fees
- Laser eye surgery; lasik
- Learning disability instructional fees
- Lodging at a hospital or similar institution
- Meals at a hospital or similar institution
- Medical alert bracelet or necklace
- Medical information plan charges
- Medical records charges
- Norplant insertion or removal
- Obstetrical expenses
- Occlusal guards to prevent teeth grinding
- Operations
- Optometrist
- Organ donors
- Orthodontia
- Osteopath fees
- Oxygen
- Patterning exercises
- Physical exams
- Physical therapy
- Preventive care screenings
- Prosthesis
- Psychiatric care
- Radial keratotomy
- Screening tests
- Seeing-eye dog
- Shipping and handling fees
- Sleep deprivation treatment
- Smoking cessation programs
- Sterilization procedures
- Supplies to treat medical condition
- Surgery
- Taxes on medical services and products
- Telephone for hearing impaired
- Television for hearing impaired
- Therapy
- Transplants
- Transportation expenses for person to receive medical care
- Tuition evidencing separate breakdown for medical expenses
- Vaccines
- Vasectomy/Vasectomy reversal
- Viagra
- Vision correction procedures
- Wheelchair
- X-ray fees

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Qualifying and Non-Qualifying Expenses

The following health care expenses *may* qualify for reimbursement:

Note: For these expenses to be considered, you must have your physician complete a Certificate of Medical Necessity, which can be found on-line at www.myebsaccount.com.

- Alternative healer services
- Automobile modification
- Behavioral modification programs
- Birthing classes
- Capital expenses
- Club dues and fees
- Counseling
- Crowns, dental
- Dancing lessons
- DNA collection and storage
- Dyslexia
- Eggs and embryos storage fees
- Elevator
- Fiber supplements
- Fitness programs
- Gambling problem treatment
- Genetic testing
- Health club/institute fees
- Home improvements
- Hormone replacement therapy
- Inclinator
- Lactation consultant
- Lamaze classes
- Language training
- Lead based paint removal
- Legal fees
- Lodging not at a hospital or similar institution
- Lodging of a companion
- Massage therapy
- Mastectomy related special bras
- Medical conference admission, transportation, meals, etc
- Mentally handicapped special home
- Mineral supplements
- Nasal strips or sprays
- Nursing services
- Nutritionist's professional expenses
- Personal trainer
- Propecia
- Psychoanalysis
- Psychologist
- Rubdowns
- Schools and special education
- Sperm storage fees
- Stem cell harvesting and/or storage
- Student health fee
- Swimming lessons
- Swimming pool maintenance
- Transportation of someone other than the person receiving medical care
- Transportation to and from a medical conference
- Tuition for special needs program
- Ultrasound, prenatal
- Umbilical cord freezing and storage
- Varicose veins, treatment
- Veterinary fees
- Weight loss programs

The following health care expenses DO NOT qualify for reimbursement:

- Appearance improvements
- Controlled substances in violation of federal law
- Cosmetic procedures
- Ear piercing
- Electrolysis or hair removal
- Face lifts
- Founder's fee
- Funeral expenses
- Hair removal and transplants
- Household help
- Illegal operations and treatments
- Late fees for medical payments
- Lodging while attending a medical conference
- Maternity clothes
- Mattresses
- Meals not at a hospital or similar institution
- Meals of a companion
- Meals while attending a medical conference
- Medical newsletter
- Missed appointment fees
- Recliner chairs
- Surrogate expenses
- Tanning salons and equipment
- Teeth whitening
- Transportation costs of disabled individual commuting to and from work
- Veneers

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Qualifying and Non-Qualifying Expenses

The following over the counter (OTC) items qualify for reimbursement:

- Allergy medicine
- Analgesics
- Antacids
- Antibiotic ointments
- Antihistamines
- Anti-itch creams
- Arthritis gloves
- Aspirin
- Bactine
- Bandages
- Band-Aids
- Blood pressure monitoring devices
- Blood sugar test kits/strips
- Calamine lotion
- Carpal tunnel wrist supports
- Claritin
- Cold medicine
- Cold/hot packs
- Condoms
- Contact lenses, materials and equipment
- Contraceptives
- Cough suppressants
- Crutches
- Decongestants
- Dentures and denture adhesives
- Diabetic supplies
- Diaper rash ointments and creams
- Diarrhea medicine
- Ear wax removal products
- Expectorants
- Eye drops
- Fever reducing medications
- First aid cream
- First aid kits
- Fluoridation device or services
- Gauze pads
- Glucose monitoring equipment
- Headache medications
- Hearing aids
- Hemorrhoid treatments
- Insect bite creams and ointments
- Insulin
- Laxatives
- Liquid adhesive for small cuts
- Medical monitoring and testing devices
- Menstrual pain relievers
- Morning after contraceptive pills
- Motion sickness pills
- Nicotine gum or patches
- Ovulation monitor
- Pain relievers
- Pregnancy test kits
- Reading glasses
- Rubbing alcohol
- Sinus medication
- Smoking cessation medications
- Spermicidal form
- Sunburn creams and ointments
- Sunscreen with high SPF
- Thermometers
- Throat lozenges
- Toothache and teething pain relievers
- Walkers
- Wart removal treatments
- Yeast infection medications

The following OTC expenses *may* qualify for reimbursement:

Note: For these expenses to be considered, you must have your physician complete a Certification of Medical Necessity, which can be found on-line at www.myebsaccount.com.

- Acne Treatment
- Air Conditioner/Purifier
- Breast pumps
- Cayenne pepper
- Chondroitin
- Christian Science practitioners
- Dietary supplements
- Ear plugs
- Exercise equipment or programs
- Glucosamine
- Herbs
- Holistic or natural healers
- Incontinence supplies
- Nutritional supplements
- Orthopedic shoes and inserts
- Prenatal vitamins
- Retin-A
- Rogaine
- Special foods
- St. John's Wort
- Sunglasses
- Treadmill
- Vitamins
- Wigs

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Qualifying and Non-Qualifying Expenses

The following OTC expenses DO NOT qualify for reimbursement:

- Cologne/Perfume
- Cosmetics/Makeup
- Dental floss
- Deodorant
- Diapers or diaper service
- Diet foods
- Face creams
- Feminine hygiene products
- Hair colorants
- Hand lotion
- Lipstick
- Moisturizers
- Mouthwash
- Nail polish
- One-a-day vitamins
- Permanent waves
- Safety glasses
- Shampoos
- Shaving cream and lotion
- Skin moisturizers
- Soaps
- Toothbrushes

The following dependent care expenses qualify for reimbursement:

Note: Dependent care expenses are those that are necessary for you and your spouse (if married) to be gainfully employed.

- Care provided in your home, someone else's home or in a daycare center for child care and/or eldercare. Licensing requirements may apply.
- Registration fees to a daycare.
- Before and after school care for children under age 13.
- Education expenses for a child not yet in kindergarten, such as nursery school expenses.
- Expenses paid to a relative (e.g. child, parent, or grandparent of participant) are eligible. However, the relative cannot be under age 19 or a tax dependent of the participant.
- Day camp (not overnight) expenses if the camp qualifies as a day care center.
- FICA and FUTA payroll taxes of the daycare provider are eligible..

The reimbursement may not exceed the smaller of the following limits:

1. The maximum allowed under the plan.
2. $5,000 if you are filing a joint tax return, and $2500 if separate returns are filed.
3. Your taxable compensation (after all compensation reduction elections).
4. If you are married, your spouse's actual or deemed earned income.

The following dependent care expenses do not qualify for reimbursement:

- Care provided when you are not working.
- Kindergarten or school fees.
- Overnight camp or educational camp expenses.
- Food, clothing or entertainment expenses.
- Child support payments.
- Expenses paid to a housekeeper, maid, cook, etc. , unless incidental to child or dependent adult care.
- Transportation costs.

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EBS Flex Card

As part of your EBS Flexible Spending Account or Health Reimbursement Account program, you will receive the convenient, and easy to use, EBS Flex Card. The EBS Flex Card allows you to pay for FSA/HRA eligible services and items (and parking and transit expenses, if permitted by your employer) without incurring an out of pocket expense.

The Card works like a debit card, reducing the amount of your available account balance with each purchase. Since you pay for your allowable expenses at the point of service, you avoid the "traditional" payment method of paying out of pocket, completing and submitting a Claim Form (or submitting the claim on-line) and waiting for reimbursement.

However, it is important to remember that the IRS requires that *every* Flex Card transaction be substantiated to certify that the expense was actually for FSA eligible services or items. Substantiation can occur in one of two ways:

1. **Auto-substantiation:** This means that the purchase is pre-coded with a bar code or SKU# as an approved item or service. Non-health care related merchants, such as grocery stores, drug stores, pharmacies, discount stores, warehouse clubs and convenience stores are required to have this type of inventory information approval system (IIAS) in order to accept Flex Cards. When services and items are approved at the point of sale using an auto-substantiation method, the IRS requirements have been met. However, you should always retain copies of all your receipts. *Note: Without an IIAS system, the Flex Card will not be accepted and the service or item will need to be paid for out of pocket, and you will need to submit a claim for reimbursement.*
2. **Manual substantiation:** This means that the purchase was not able to be substantiated at the point of sale. While you were able to pay for your services and items with the Flex Card, to verify that the purchase is eligible under the terms of your FSA/HRA Plan, and within the IRS guidelines, EBS will request a copy of your receipt. It is important that you immediately comply with this request. Failure to comply can result in deactivation of the EBS Flex Card, repayment of the transaction amount or reclassification of the amount to taxable income.

Here are some important tips to remember:

- Keep all receipts. This is the most important item to remember! When EBS requests a copy of your receipt, comply immediately. *Remember: The EBS Flex Card makes transactions cashless but not always paperless!*
- Two EBS Flex Cards will be mailed directly to your home address. Included with the Card is important and helpful information about how the card operates. Please be sure to fully read these materials and sign the Card as soon as it is received.
- The Flex Card works like a debit card, but when prompted at payout, select "Credit". No PIN is required. Do not use the Card prior to your participation effective date.
- To activate the Flex Card, you must call the number printed on the card. Retain the Flex Card from Plan year to Plan year as it is valid for three years. You will receive a new Card at the appropriate time.
- If you inadvertently pay for a non-allowable expense with the Card, you will be required to re-pay the amount. The amount will then be returned to your account.
- At merchants with an IIAS system, your eligible items and non-eligible items will total separately. You can pay for your eligible items with the Flex Card, and you will be asked for another form of payment for the non-eligible items.
- The IRS states that services are eligible for reimbursement *after* the services have been rendered. This means that you cannot use your Flex Card to pre-pay for services such as weight loss, fitness memberships or massage therapy (remember: you may first need a Certification of Medical Necessity from your physician for these types of services to be allowable).
- If you forget your EBS Flex Card, or it is not accepted at the time of payment, simply use another form of payment and submit a claim for reimbursement with either a paper claim form or on-line at www.myebsaccount.com.
- Replacement cards, or additional cards for your dependents, can be requested by completing the "Additional EBS Flex Card Request Form".
- Monitor your account frequently on-line. Report any potential fraudulent activity immediately to EBS.
- If you lose your Card, call the EBS Customer Service Center at 1-800-327-7130 as soon as possible.

Flexible Spending Account Enrollment Form

For: ❑ Open Enrollment; Effective Date: _____ or ❑ New Hire; Hire Date: _____

Employer Name

Participant First Name | MI | Last Name

Address

City | State | Zip Code

Email Address

Social Security Number / Member ID | Phone Number

FSA Benefit Type	Per Pay Period Amount	Total Annual Amount
Health Care Contribution	$.	$.
Dependent Care Contribution	$.	$.

# of Pay Periods per Year: _____ First Payroll Deduction Date: ____/____/_____

Automatic Claims Transfer (ACT): If you are eligible for ACT, certain out of pocket expenses may automatically be reimbursed to you (those that have been submitted through your insurance provider), unless you or any of your dependents have Coordination of Benefits (COB) with other Plans. If you are eligible, but do not want ACT, check the box, and you must submit your claims manually for reimbursement. *Note: ACT may be deactivated when your dependents attain a specified age (ie, age 19). Contact EBS Customer Service to verify the terms of your eligibility for ACT.* **This feature is not applicable to Flex Card Holders.**

❑ **I do not want ACT—or—I have COB and am not eligible for ACT.**

By submitting this form, I elect to participate in my Employer's Flexible Spending Account (FSA) Plan and agree to have my compensation reduced by the contributions indicated above for the Plan year. Any previous FSA election relating to the same benefits is hereby revoked. As a participant, I understand that:

- My Health Care and Dependent Care FSA contributions (indicated above) will be credited to my Health Care and Dependent Care FSA accounts. These contributions will reduce the amount of my compensation and are in addition to any premiums I pay on a pre-tax basis for Employer sponsored Health Insurance.
- I may file claims for reimbursement from my FSA accounts for qualified expenses incurred during the Plan year and after I have become a participant. I will forfeit amounts remaining in my FSA accounts after I am reimbursed for all expenses claimed through the period allowed under the Plan to file claims for expenses for the Plan year.
- I will pay the Employer for any tax liability or penalties it incurs if I am reimbursed for an expense that is not a qualified expense.
- I cannot change the amount of my FSA contributions or pre-tax health insurance premiums, unless I have a qualifying "life change" event as defined in the Plan and satisfy any other conditions for changes contained in the Plan and tax law.
- My FSA contributions will terminate when my employment terminates, unless I elect to continue my Health Care contributions on an after-tax basis, as allowed under COBRA.
- My Employer may change the amount of my FSA elections if necessary to satisfy tax law requirements.
- I understand that I must provide acceptable documentation for every claim I submit, including Flex Card purchases upon request.
- EBS Benefit Solutions, Inc. is not responsible for retaining copies of my receipts, beyond the current Plan year.

Participant Signature _____ Date _____

Return signed form to your Employer.

To Be Completed by the Plan Sponsor

- Notify Payroll of deduction amount and date
- Keep copy of Enrollment Form for your records
- Forward copy of Enrollment Form to EBS
- During Open Enrollment, consider reporting Employer funded money in a file to EBS

This Plan has employer funded money: ❑ Yes; ❑ No. If Yes, please complete:

ER Money:	Payroll Based?	Annual Amount
❑ Health Care	❑ Yes ❑ No	$
❑ Dependent Care	❑ Yes ❑ No	$

Direct Deposit Authorization Form

Employer Name

Participant First Name | MI | Last Name

Address

City | State | Zip Code

Email Address

Social Security Number / Member ID | Phone Number

Please check one:		
❑ Set up new Direct Deposit	❑ Change Direct Deposit	❑ Cancel Direct Deposit

Authorization Agreement for Direct Deposit Reimbursement

Bank Account Information:

Type of account: (*Please check one*)

❑ Checking — You must attach a ***voided check*** with pre-printed MICR account information, or a ***letter or form*** from the Bank certifying the ABA number, Account number and MICR information.

❑ Savings — You must attach a ***letter or form*** from the Bank certifying the ABA number, Account number and MICR information.

Name of Bank: _____

Transit ABA Routing #: _____ Account #: _____

(Please allow 10 business days after receipt by EBS Benefit Solutions, Inc. for bank pre-notification to be completed.)

- Direct Deposit is available only if your employer uses Electronic Funds Transfer.
- Please be sure to provide your SSN or Member ID.
- Mail to EBS Benefit Solutions, FSA Dept. 30 Perinton Hills Mall, Fairport NY 14450 or fax to 877-256-7228.
- Call Customer Service with questions at 800-327-7130.

By submitting this form, I hereby authorize EBS Benefit Solutions, Inc. to deposit my reimbursements directly into the back account indicated above and, if necessary, to withdraw amounts from the account in order to adjust for any amounts erroneously deposited. This authorization will remain in effect until EBS Benefit Solutions, Inc. receives written notice from me of its termination.

_____ _____

Participant Signature Date

EBS Benefit Solutions
An Excellus Company

Flexible Spending Account (FSA)
Reimbursement Request Form

Employer Name

Participant First Name | MI | Last Name

Address

City | State | Zip Code

Email Address

Social Security Number / Member ID | Phone Number

Claimant Name	Date of Service	Amount	Type of Service	Claim Ref #	EBS Use Only
			❑ Medical ❑ Vision ❑ Dep Care ❑ Dental ❑ OTC ❑ Rx	01	
			❑ Medical ❑ Vision ❑ Dep Care ❑ Dental ❑ OTC ❑ Rx	02	
			❑ Medical ❑ Vision ❑ Dep Care ❑ Dental ❑ OTC ❑ Rx	03	
			❑ Medical ❑ Vision ❑ Dep Care ❑ Dental ❑ OTC ❑ Rx	04	
			❑ Medical ❑ Vision ❑ Dep Care ❑ Dental ❑ OTC ❑ Rx	05	
			❑ Medical ❑ Vision ❑ Dep Care ❑ Dental ❑ OTC ❑ Rx	06	
			❑ Medical ❑ Vision ❑ Dep Care ❑ Dental ❑ OTC ❑ Rx	07	
			❑ Medical ❑ Vision ❑ Dep Care ❑ Dental ❑ OTC ❑ Rx	08	

- For each claim, attach Explanation of Benefits (EOB), and/or itemized bill showing: date of service, provider name, patient name, charged amount and description. For Dependent Care, include the provider's tax id or SSN. **Do not send credit card receipts or cancelled checks**.
- Please be sure to provide your SSN or Member ID.
- Mail to EBS Benefit Solutions, FSA Dept, PO Box 22999 Rochester, NY 14692.
- For faster reimbursement processing, submit your claims online at www.myebsaccount.com.
- If covered by insurance, submit EOB or bill showing insurance payment.
- Submit one expense (either product or service) per row, even if items are contained on the same receipt. Each item must be itemized and must have a corresponding receipt. Label receipts to correspond to "Claim Ref #". If you have more than 8 items to submit, use additional Reimbursement Request Forms. *Note: Please do not "lump" or group items together or write "see attached". EBS can only process claims that are properly submitted. Claims will be returned to you unless they are properly submitted.*
- Call Customer Service with questions at 800-327-7130.

By submitting this form to EBS, I certify that the information here is true and correct, that the expenses incurred were for myself, spouse or qualified dependents and that these expenses are not reimbursable under any other plan coverage.

Medical Mileage Reimbursement Request Form

Employer Name

Participant First Name | MI | Last Name

Address

City | State | Zip Code

Email Address

Social Security Number / Member ID: ___ - ___ - ___

Phone Number: ___ - ___ - ___

Patient Name	Date of Service	Destination	Type of Service	Total Miles	Mileage Rate	Amount to Reimburse *
			❑ Medical ❑ Vision ❑ Dental ❑ OTC ❑ Rx		$	$
			❑ Medical ❑ Vision ❑ Dental ❑ OTC ❑ Rx		$	$
			❑ Medical ❑ Vision ❑ Dental ❑ OTC ❑ Rx		$	$
			❑ Medical ❑ Vision ❑ Dental ❑ OTC ❑ Rx		$	$
			❑ Medical ❑ Vision ❑ Dental ❑ OTC ❑ Rx		$	$
			❑ Medical ❑ Vision ❑ Dental ❑ OTC ❑ Rx		$	$
			❑ Medical ❑ Vision ❑ Dental ❑ OTC ❑ Rx		$	$
			❑ Medical ❑ Vision ❑ Dental ❑ OTC ❑ Rx		$	$
** Multiply the "Total Miles" by the "Mileage Rate" to get the "Amount to Reimburse"*					Total Amount Requested:	$

To Receive reimbursement for medical mileage:

- Medical mileage rates are set annually by the IRS. The current rate is found on your www.myebsaccount.com home page.
- Use this form to track mileage, calculate the mileage reimbursement amount and file a claim for expense reimbursement for transportation primarily for and essentially to medical care.
- Use one row for each round trip.
- Upon request, be able to produce documentation related to the mileage expense you are claiming. For example, if you are claiming round-trip mileage to a doctor's appointment, you must have copies of receipts or statements pertaining to that visit and be able to supply these copies to EBS if requested.
- Please be sure to provide your SSN or Member ID.
- Mail Claims to EBS Benefit Solutions, FSA Dept PO Box 22999, Rochester, NY 14692 .
- Call Customer Service with questions at 800-327-7130.

By submitting this form to EBS, I certify that the information here is true and correct, that the expenses incurred were for myself, spouse or qualified dependents and that these expenses are not reimbursable under any other plan coverage.

EBS Benefit Solutions
An Excellus Company

Certification of Medical Necessity

Employer Name

Participant First Name | MI | Last Name

Address

City | State | Zip Code

Email Address

Social Security Number / Member ID | Phone Number

Under Internal Revenue Service (IRS) rules, some health care services and products are only eligible for reimbursement from your FSA/ HRA Account when your doctor or other licensed health care provider certifies that they are medically necessary. Your provider must fully complete this Certification to render the services eligible.

You must submit a copy of this Certification prior to submitting your first Reimbursement Request Form for this specific service or product. If treatment extends beyond the time period listed, you will need to submit a new Certification detailing the new time period.

Medical Information

Patient's Name:	Relationship to Participant:
Medical Condition:	
Recommended treatment/services/products:	
Describe how the treatment/service/product will alleviate the diagnosis or symptoms:	
What other treatments have been attempted?	
For how long will the treatment/services/products be required:	Is this expense medically necessary? ❑ Yes ❑ No

Provider Information

Provider Name:	Phone # (with area code):
Provider Signature:	Date:

- Mail to EBS Benefit Solutions, FSA Dept. 30 Perinton Hills Mall, Fairport NY 14450.
- Please be sure to provide your SSN or Member ID.
- Call Customer Service with questions at 800-327-7130.

By submitting this form to EBS, I certify that this information is true and correct.

Participant Signature: _____ Date: _____

Authorization to Release Protected Health Information

Employer Name

Participant First Name | MI | Last Name

Address

City | State | Zip Code

Email Address

Social Security Number / Member ID | Phone Number

EBS Benefit Solutions, Inc. maintains a strict policy of adhering to state and federal regulations with regard to Protected Health Information (PHI). Generally, except as permitted by law, we cannot disclose your personal information to another person without your consent. By executing this form, you are authorizing EBS to release your PHI to the persons or entities below (PHI includes information regarding your account and your claims).

Authorization

I hereby authorize the use or disclosure of my PHI to the following *(please print clearly)*:

1.

2.

3.

- Mail to EBS Benefit Solutions, FSA Dept. 30 Perinton Hills Mall, Fairport NY 14450 or fax to 877-256-7228.
- Call Customer Service with questions at 800-327-7130.
- Please be sure to provide your SSN or Member ID.

I understand that I have the right to revoke this authorization at any time, but that the following two exceptions apply to my right to revoke: (i) if EBS has acted in reliance upon the authorization; and (ii) if the authorization was obtained as a condition of obtaining insurance and the insurer has the right to content a claim under the policy.

I also understand that (1) this authorization is voluntary and EBS will not refuse payment, enrollment or eligibility for benefits based on my refusal to sign it; (ii) the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by privacy rules and regulations; and (iii) unless revoked earlier, this authorization is effective for release of information for the duration of my enrollment in the Plan.

To revoke, I must notify EBS in writing.

Participant Signature

Date

Additional EBS Flex Card(s) Request Form

Employer Name

Participant First Name | MI | Last Name

Address

City | State | Zip Code

Email Address

Social Security Number / Member ID | Phone Number

Flex Cards are valid for up to three years. Only existing participants in the EBS Flex Card program can request replacement or additional cards. ***There is a $5.00 charge for each additional Flex Card requested which will be automatically debited from your FSA/HRA account.***

❑ I am the primary card holder and need to **replace** my EBS Flex Card.

❑ I am the primary card holder and am requesting **additional** EBS Flex Card(s) for my dependent(s).

Information for 1st Additional Card Requested	
Dependent Name:	
Dependent SS#: *Required*	Dependent Date of Birth: *Must be at least 18 years old*
Relationship to Participant: ❑ Spouse ❑ Child ❑ Other _____	

Information for 2nd Additional Card Requested	
Dependent Name:	
Dependent SS#: *Required*	Dependent Date of Birth: *Must be at least 18 years old*
Relationship to Participant: ❑ Spouse ❑ Child ❑ Other _____	

- Delivery of the EBS Flex Card(s) will take approximately 10 business days following the receipt and processing of your request..
- Please be sure to provide your SSN or Member ID.
- Mail to EBS Benefit Solutions, FSA Dept. 30 Perinton Hills Mall, Fairport NY 14450 or fax to 877-256-7228.
- Call Customer Service with questions at 800-327-7130.

By submitting this form to EBS, I certify that the dependents names on this Form are valid dependents as claimed on my federal tax return.

Participant Signature: _____ Date: _____