HEALTH CARE SPENDING ACCOUNT

Form Filing Instructions for Reimbursement

Important Information

- ✓ Only eligible expenses incurred during your spending account plan year, and while you are an active participant, are eligible for reimbursement.
- ✓ An expense is incurred when the service is provided — not when you are billed or pay for the service.
- ✓ Due to the nature of orthodontist and prenatal billing, prepaid expenses for the plan year can be reimbursed before the service is completed.
- ✓ You will receive an account summary with each reimbursement in addition to quarterly account statements.
- ✓ You will have until June 30, 2018, to submit your claims and documentation for expenses incurred while you are a participant during 2017. Any claims submitted via fax or postmarked after June 30, 2018, will not be reimbursed.
- ✓ For more information and important rules, read the "Spending Accounts" section of the Summary Plan Description (SPD). The SPD is available online at **mylacountybenefits.com**. Select "View the Summary Plan Description" in the "my resources" menu.

How to Submit Your Claims Online

When you use **mylacountybenefits.com** to submit your claims, you'll do less paperwork and typically receive your reimbursements more quickly.

1. Go to mylacountybenefits.com and select "Spending Accounts" in the "my resources" menu.
2. Fill out the claim information online.
3. Attach scans of your proof of expenses or follow the on-screen instructions to fax or mail them.

The online system also allows you to check the status of your claims, see your account balance and more. Give it a try. It's fast and easy.

Reimbursement Instructions

1. After you have incurred an eligible expense during the plan year, submit a claim, either online (see instructions above) or by using this form. Please note: Health care expenses must be processed first by your primary and secondary (if applicable) health plans. You will be reimbursed for eligible expenses up to the amount you elected for the year minus any previous reimbursements.

2. As you complete the form, make an entry for each proof of expense, such as a receipt. For example, if you have 10 prescription receipts, you must enter them as 10 separate claims. Claim forms that have expenses combined together from different receipts will be returned to you. If more than one eligible expense incurred on the same day is listed on one receipt, you may enter those expenses as one claim.

- Include photocopies of your proof of expense (e.g., receipts, explanation of benefits) with this claim form. DO NOT staple receipts to the form and **DO NOT send original receipts**.
- All proof of expense documentation must be received in an 8 ½" x 11" format. **Your claim form and documentation will be returned to you if it is not in this format.**
- Proof of expense must contain the following pieces of information:
  - Date of Service
  - Provider Name
  - Expense Type
  - Relationship
  - Miles to provider and back
  - Amount Requested

  In lieu of submitting the information above, you may submit an Explanation of Benefits (EOB) from the insurance carrier.
- Cancelled checks and credit card statements/receipts are not considered to be valid proof of expense.
- If you are claiming expenses for over-the-counter medications or drugs, you must provide a doctor's prescription and attach proof of the expense, such as itemized receipts.
- Receipts for over-the-counter expenses that do not clearly identify the product being purchased must be accompanied by a copy of the box or container for each product for which you are requesting reimbursement.
- To receive reimbursement for mileage related to transportation expenses to and from medical care, enter the number of miles on the form and Benefit Concepts will calculate the reimbursement amount based on current per mile rates.

3. Fax or mail this claim form, completed and signed, along with the appropriate documentation to 866-629-6390, or to the address found at the top of the page on the other side of this claim form.

4. If you have questions about completing a claim form, eligible expenses or about your spending accounts in general, call Benefit Concepts at 866-629-6436, Monday through Friday, 5:30 a.m. to 6:30 p.m. Pacific time.

FSA-HLTH
Spending Account Administrator
P.O. Box 67128
Los Angeles, CA 90067
Fax: 866-629-6390
mylacountybenefits.com

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HEALTH CARE SPENDING ACCOUNT CLAIM FORM

Employer Information

County of Los Angeles

Employee Information

First Name	Last Name		Last Four Digits of Social Security Number
Address			
City	**State**	**Zip**	**Work Phone**

Health Care Expenses

Date of Service	Provider Name	Expense Type	Relationship (Expense For)	Amount Requested
/ /		☐ Medical ☐ Drugs ☐ Dental ☐ Other ☐ Vision Miles ______	☐ Self ☐ Spouse ______________ ☐ Dependent child ______________ ☐ Other ______________	$
/ /		☐ Medical ☐ Drugs ☐ Dental ☐ Other ☐ Vision Miles ______	☐ Self ☐ Spouse ______________ ☐ Dependent child ______________ ☐ Other ______________	$
/ /		☐ Medical ☐ Drugs ☐ Dental ☐ Other ☐ Vision Miles ______	☐ Self ☐ Spouse ______________ ☐ Dependent child ______________ ☐ Other ______________	$
/ /		☐ Medical ☐ Drugs ☐ Dental ☐ Other ☐ Vision Miles ______	☐ Self ☐ Spouse ______________ ☐ Dependent child ______________ ☐ Other ______________	$
/ /		☐ Medical ☐ Drugs ☐ Dental ☐ Other ☐ Vision Miles ______	☐ Self ☐ Spouse ______________ ☐ Dependent child ______________ ☐ Other ______________	$
/ /		☐ Medical ☐ Drugs ☐ Dental ☐ Other ☐ Vision Miles ______	☐ Self ☐ Spouse ______________ ☐ Dependent child ______________ ☐ Other ______________	$
/ /		☐ Medical ☐ Drugs ☐ Dental ☐ Other ☐ Vision Miles ______	☐ Self ☐ Spouse ______________ ☐ Dependent child ______________ ☐ Other ______________	$
/ /		☐ Medical ☐ Drugs ☐ Dental ☐ Other ☐ Vision Miles ______	☐ Self ☐ Spouse ______________ ☐ Dependent child ______________ ☐ Other ______________	$
			Total Reimbursement Requested	**$**

Health Care Expense Certification

I certify that all services for which reimbursement is requested under the County of Los Angeles Health Care Spending Account were incurred by myself or my eligible dependents within the Plan Year of my election, and that in the case of qualifying health care expenses, they have not been reimbursed and I will not seek reimbursement under any other health care coverage. I will not use qualifying health care expenses reimbursed through my health care reimbursement account as deductions when filing my Federal Income Tax return.

Signature ____ **Date** ______________________