

Cafeteria Plan Account Rules and Claim Filing Instructions

Rules for Both Dependent and Medical Accounts

1. You cannot submit a claim unless you are participating in the Cafeteria Plan.
2. You can be reimbursed only for eligible expenses occurring during the coverage period in which you contribute.
3. You can submit a claim at any time during the plan year and up to thirty days after the plan year has ended.
4. If you terminate employment, you can submit a claim for a 30 days after the date of termination as long as the service occurred before your date of termination.
5. IRS rules stipulate that any money left in your account(s) after all reimbursements for the plan year have been processed **cannot be carried forward or returned**. Money in one account cannot be used for expenses incurred in another account, ie; unused amounts left in the medical account cannot be used to reimburse dependent care expenses.
6. You cannot receive payment from any other source for expenses reimbursed by claim, and you certify that you are not eligible to bill any other source for the reimbursed expense.
7. If you have received reimbursement for expenses, you cannot claim the expenses for income tax purposes.
8. You cannot bill for a service period that begins in one plan year and ends in the next plan year. File two reimbursement claims, one for each plan year covering the period during that plan year.
9. Complete ALL the information on the claim form for each amount claimed for reimbursement.
10. Attach copies of receipts from service providers or the Explanation of benefits Form from Insurance Carriers to the claim. Sign and date the claim, and make a photocopy of the claim for your records.
11. Submit the Claim with attached receipts by the 10th of the month and the 25th of the month for reimbursement on the following payday.

Dependent Care Expenses

1. You can use a Dependent Care Spending Account only if you pay dependent day care expenses to be able to work.
2. Your day care services can take place either inside or outside of your home. If you are married, your spouse must also work, go to school full time, or be incapable or self-care for you to be eligible.
3. Contributions are limited by the plan to \$5,000 annually and are also limited to the least of (a) the earned income of the spouse if the employee is married; (b) \$5,000 if unmarried or married filing jointly or (c) \$2,500 if married not filing jointly.
4. Only (a) dependents under the age of thirteen or (b) dependent adult or children thirteen years or older who are mentally or physically incapable of self-care are covered.
5. You cannot claim expenses if the service provider is your child or stepchild and are under age 19 of if you claim the service provider as a dependent for Federal income tax purposes.
6. To be reimbursed, you must include the facility's name, address, and tax identification number of the Social Security number of the individual providing the dependent day care service.
7. The maximum amount you can be reimbursed during the time you are covered in the Plan Year can not exceed the salary reduction amount allowed by the plan and that you have elected and made under the Dependent Care Assistance plan less any previous reimbursements paid. **Dependent Care expenses are only available after those amounts are deducted from pay earned.**

Unreimbursed Medical Expenses

1. The total annual election for eligible medical expenses (less any previous reimbursements paid) is available when requested for covered expenses.
2. To be reimbursed, you must include the dependent's name, date expenditure incurred, name of Service Provider, description of the expense, and the amount of the claim less any amounts that have been or will be paid by insurance or other sources.
3. **Internal Revenue Service publications 502 lists the eligible tax-free expenses.** An Eligible expense means any item for which you could have claimed a medical deduction on an itemized Federal Income tax return (except insurance premiums, long-term care and other similar charges) and is not eligible under you medical or any other source. **You are responsible for understanding what expenses are eligible and claiming only those items.** You or your dependents while participating in the plan must incur the expenses.

Cafeteria Plan
Request for Reimbursement
CLAIM FORM

Office Use Only ____/____

NAME:		SS#	
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Please read the Reimbursement Account Rules and Claim Filing Instructions on the other side before completing this claim.

Medical Expense Claims

Date of Service	Patient Name	Patient Soc Sec #	Relationship to Employee	Name of Provider	Describe Service	Claim Amount
						\$
						\$
						\$
						\$
						\$
						\$
						\$
						\$
						\$

TOTAL \$ _____

Dependent Care Expense Claims

Date of Service From	To	Dependent's Name	Age	Care Provider Name	Care Provider Address	Provider Tax ID/SS#	Claim Amount
							\$
							\$
							\$
							\$

TOTAL: \$ _____

EMPLOYEE CERTIFICATION FOR REIMBURSEMENT

I certify that the expenses for reimbursement requested from my accounts were incurred by me (and/or my spouse and/or eligible dependents), were not reimbursed by any other plan and are eligible for reimbursement under my Reimbursement Plan. I (or we) will not use the expense reimbursed through this account as deductions or credits when filing my (our) individual tax return.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, administrator, or plan service provider, files a statement of claim containing false, incomplete or misleading information may be guilty of a criminal act punishable under law.

Employee Signature: _____ Date: _____