

Santa Barbara County Employees' Retirement System
Retiree Health Reimbursement Arrangement Claim Form

SECTION A - EMPLOYEE INFORMATION

Name _____
(Print or type: Last, First, Middle Initial)

Mailing Address _____

City, State, Zip _____

Daytime Phone # (_____) _____

Email Address _____

Number of pages faxed _____

Fax, scan and email or mail signed, completed claim form and supporting documentation by 2:00 p.m. Pacific Time:

Creative Benefits, a division of WageWorks, Inc.
 PO Box 1928, Vista, CA 92085-1928
FAX: Toll free (888) 295-5757 or (760) 758-4610
EMAIL: claims@creativebenefits.com
PHONE: Toll free (888) 295-5656

If you have an address change, be sure to update your records with SBCERS.

Is this a new address? (check one) YES NO

Social Security # _____
 or your Participant ID # _____
as assigned by Creative Benefits

Client #3575 SBCERS

Please send photocopies of forms and documents. Keep originals for your records, as claim and supporting documentation become part of this claim and cannot be returned to you.

- The IRS has determined that canceled checks, check carbons, balance forward, previous balance statements, charge card receipts or statements are not acceptable documentation of expenses.
- Receipt of faxed claims cannot be verified due to our large volume. Please call the automated system at (888) 295-5656 after 5p.m. Pacific Time or go online to www.creativebenefits.com to determine if your claim has been received and entered.
- To obtain additional claim forms, please call CB and identify yourself using the client number or contact SBCERS.

SECTION B - EXPENSES TO BE SUBMITTED FOR THE HEALTH REIMBURSEMENT ARRANGEMENT. Attach copies of your Explanation of Benefits (EOBs) from your insurance company; or supporting documentation from a third party provider describing the services and for whom were rendered, date(s) of services and amount charged, or attach a copy of the insurance bill or Social Security Benefit Statement (SSA-1099) supporting the listed premium item.

| expense description <small>(e.g. co-pay, lab, etc.)</small> | person for whom expenses were incurred <small>(one name per line)</small> | relationship <small>(spouse, child, tax dependent, or domestic partner)</small> | date of birth <small>(format date: mm/dd/yy)</small> | dates of service <small>(from-to)</small> | amount of expense |
|--|--|--|---|--|-------------------|
| | | | | | \$ |
| | | | | | \$ |

TOTAL amount to be reimbursed \$ _____

| type of health premiums <small>(e.g. Medical, Medicare, Dental, etc.)</small> | name of insurance company | dates of coverage <small>(from-to)</small> | amount of premium |
|--|---------------------------|---|-------------------|
| | | | \$ |
| | | | \$ |

TOTAL amount to be reimbursed \$ _____

SECTION C - PARTICIPANT AFFIDAVIT - FOR USE WHEN NO INSURANCE BILL IS AVAILABLE

My signature on this form certifies that I have incurred and paid these premiums and that these expenses have not been reimbursed prior to this submission. Upon request, I will submit evidence that this claim was incurred and paid by me.

SIGN AND DATE FORM EACH TIME

I certify this claim in accordance with Section D - Participant Certification. Unsigned claims will automatically be denied.

RETIREE SIGNATURE _____ DATE _____

SECTION D - PARTICIPANT CERTIFICATION. I understand that:

- I have not been reimbursed and will not seek reimbursement for these same expenses under any other plan and cannot claim these same expenses for an income tax deduction. All of these incurred expenses qualify as eligible expenses for myself, spouse or registered domestic partner, and/or other eligible tax dependents in accordance with the Plan and IRS regulations.
- If I have included an over-the-counter medicine, drug or supply, I certify that it is being used "to diagnose, treat or prevent a specific medical condition or for the purpose of affecting any function or structure of the body." If the over-the-counter item is a supplement, herbal remedy or vitamin, I certify that it is being used for medical care as defined above with the advice of a licensed health care practitioner and not simply to promote general health and have attached the physician's statement. I understand that certain over-the-counter remedies may require additional certification from my health care practitioner.
- By providing my email address, I am requesting all possible communications be sent to me via email.
- The Health Reimbursement Arrangement will not reimburse you for individual Life Insurance premiums.

HEALTH REIMBURSEMENT ARRANGEMENT - ELIGIBLE EXPENSES (Check your Summary Plan Document for details or limitations.)

Services by an M.D. or Licensed Practitioner when medically necessary, including:

- Acupressurist
- Acupuncturist
- Anesthesiologist
- Chiropractor
- Christian Science Practitioner
- Dermatologist
- Ophthalmologist
- Optometrist
- Osteopath
- Podiatrist
- Psychiatrist/Psychologist
- Psychotherapist
- Surgeon

Medical/Hospital services or other fees:

- Diagnostic services by or under direction of M.D.
- Surgical services by or under direction of M.D.
- X-rays and radiological services for diagnosis or treatment
- Expenses for donating or receiving an organ transplant
- Nursing services for specific medical ailments by an RN or LPN who is not related to employees
- Services of a physical, speech or an occupational therapist
- Ambulance
- Laboratory fees
- Prescription drugs: including insulin, laetrile and birth control pills
- Over-the-counter drugs, medications and supplies.* Only a quantity of six may be purchased at a time.
- Vitamins and dietary supplements.** Only a quantity of six may be purchased at a time.
- Vaccinations and immunizations
- Orthotics
- Transportation and lodging expenses incurred for medical reasons
- Legal fees paid to authorize treatment for mental illness
- Deductibles and copayments

Other health-related expenses

- Treatment of alcoholism or drug dependency, including expenses for meals and lodging at a treatment center
- Lead-based paint removal in the home
- Smoking cessation programs and related drugs
- Employee plus dependent Medical, Dental, Vision, Rx, Medicare, COBRA or other healthcare insurance premiums.

Dental, vision & hearing

- Dental checkups and care (by a DDS or dental hygienist), including dentists' fees, X-rays, fillings, braces, extractions and dentures
- Orthodontics (usually the pro-rated cost attributable to this plan year)
- Cost of guide dog for blind or deaf
- Braille books and magazines (in excess of regular book cost)
- LASIK, Laser, RK surgery or PRK surgery, prescription eyeglasses and contact lenses (including solutions)
- Special devices for the blind (tape recorder, typewriter)
- Hearing aids and care (including batteries)
- Cost of note-taker for a deaf person in school
- Household visual alert & expenses for special phone equipment for a deaf person
- Adapting a television for the deaf

Maintenance & support devices (these require a letter of medical necessity from a licensed physician)

- Support hose and orthopedic shoes (in excess of regular shoe cost)
- Wheelchairs, crutches and wigs for hair loss due to medical treatment
- Oxygen and oxygen equipment
- Cost of equipping an auto for the disabled (in excess of regular auto cost)
- Prostheses and prosthetic supplies
- Colostomy supplies
- Capital expenses - the amounts between the cost of improvements or special equipment installed and the increase in the value of the home
- Psychiatric care - may include costs of supporting mentally ill dependents at a specially equipped center where a dependent receives medical care
- Massage therapy

* If used for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body

** If specifically directed by a licensed practitioner of the healing arts, a written directive is needed

INELIGIBLE EXPENSES (Health Care)

- Athletic or health club membership
- Cosmetic procedures and/or surgeries
- Household help
- Any illegal treatment
- Prepayment for services
- Cost of remedial reading classes for a non-handicapped child
- Dancing or ballet, even when recommended by a doctor
- Weight reduction programs for general well-being
- Teeth bleaching or whitening
- Marriage counseling
- Toiletries and sundry items (such as toothpaste, shaving cream, deodorant, shampoo, makeup)
- Electric toothbrushes
- Sunscreen under SPF 30
- Insect repellent

This list is not intended to be a guarantee of reimbursement or eligibility. All claims are reviewed when they are received and the determination of eligibility or reimbursement is made based upon the information received from the plan participant.