



**JAEGER & FLYNN
ASSOCIATES, INC.**

BENEFITS | HUMAN RESOURCES | RISK MANAGEMENT | INSURANCE

ALBANY BUSINESS REVIEW



2015 BEST PLACES TO WORK

December 8, 2015

Welcome members and families of Sheet Metal Workers Local Union No. 83 to Jaeger & Flynn Associates, Your Exclusive Benefits Partner for all participants of SMW Local 83 Health and Benefits Fund!

We would like to take a moment to introduce ourselves to you and welcome you to our JFA family! We are Jaeger & Flynn Associates, Inc. and we are working with SMW Local Union No. 83 as their Broker/Consultant to assist in the administration of your member health and welfare benefits.

In this capacity, we are also here for you and are available to you on an ongoing basis for any benefit-related questions or concerns that should arise. We are available to guide you to the appropriate plans that meet you and your family's needs and will mediate on your behalf with your insurance carrier.

We look forward to working with all the members at SMW Local Union No. 83 and we encourage you to use our services. Our service staff can be reached during normal business hours, 8:30am-5:00pm Monday through Friday at 1-800-388-8538 extension 280.

To: All Participants

In this letter we will address the following items;

- BlueShield of Northeastern New York Health Insurance Plan (no plan changes for 2016!)
- ESI Prescription Drug Plan (no plan changes for 2016 but old ESI cards are no longer valid!)
- Vision Reimbursement (no plan changes for 2016!)
- Delta Dental Plan (no plan changes for 2016!)
- Be sure to review your State and Federal Notices packet available on your JFA HRA and Benefits website, Evolution1 in January 2016
- Your New HRA and Benefits website through JFA, Evolution1 with Welcome Kit which includes;
 - ✓ A notice regarding the "HRA Black-out Period" for claims processing
 - ✓ Instructions on how to login to the new online HRA system, filing a claim and downloading the JFA mobile app
 - ✓ A form to fill out and return to us if you would like to sign up for Direct Deposit (our fastest reimbursement method and can also be done online)
 - ✓ A Reimbursement Request form to use or the online claim filing feature
 - ✓ A HIPAA Authorization form to fill out and return to us if you would like any of your dependents to be able to contact JFA Flex about your account

If you have any benefit questions, please do not hesitate to contact the JFA Member Services Team at 518-373-0069, extension 280 or by email at groupservice@jaegerflynn.com. If you have any HRA benefit question, please do not hesitate to contact the JFA Flex Team at 518-792-0042, option 1 or by email at jfaflex@jaegerflynn.com.

BlueShield of Northeastern New York Health Insurance Plan: There are no changes to your BlueShield of Northeastern New York (BSNENY) medical plan benefits for 2016. All currently enrolled BSNENY members will receive new ID cards the last week of December 2015 for use starting January, 1 2016. If you do not have your new ID card by January 1st you can continue to use your current 2015 ID card as your BSNENY ID number is not changing for 2016.

ESI Prescription Drug Plan: There are no changes to your Prescription benefits plan for 2016, copays are remaining at \$10 for Generic/Tier1, \$30 for Brand/Tier 2 and \$60 for Non-Formulary/Tier 3 after your individual deductible requirement of \$50.

IMPORTANT! – Although your Prescription Drug plan benefits are not changing for 2016 we are moving from a direct contract with ESI to a contract through BSNENY for 2016. What does this mean to you?

- **Active members – Starting January 1, 2016 you should discard your current separate ESI Prescription drug card as it will no longer work.** Your BSNENY ID card should be used for your prescription benefits starting January 1, 2016. If you have not received your new 2016 BSNENY ID card you can continue to use your 2015 BSNENY ID card for your medical and prescriptions benefits as your BSNENY ID number is not changing for 2016 and your 2015 ID card includes all of the necessary information that your pharmacy needs to process your prescriptions. Also, if you are currently using the mail-order pharmacy benefit you do not need to do anything, all mail-order prescriptions will continue to process with no interruption.
- **Retired members – Starting January 1, 2016 you should discard your current separate ESI Prescription drug card as it will no longer work.** You will receive a new Prescription Drug card in the mail late December 2015 for you to use starting January 1, 2016. Also, if you are currently using the mail-order pharmacy benefit you do not need to do anything, all mail-order prescriptions will continue to process with no interruption.

Your New HRA and Benefits website starting January 2016: For 2016 we are excited to announce that SMW Local No. 83 will be providing members with up-to-date information about their own personal benefits and electronic access to HRA plan balances 24 hours a day, 7 days a week starting early January 2016. Your unique user name and temporary password has been provided on the next page for you to use and log on to Evolution1** and view your 2016 benefit plan enrollments including your HRA plan.

BLACK-OUT Period for all HRA Claims and Reimbursements:

Please note that all HRA claims through 12/21/2015 dates of service may be submitted to R&K for processing, R&K will reimburse you for submitted expenses through 12/21/2015 on 12/28/2015.

All claims after with dates of service after 12/21/2015 need to be submitted to JFA and will be processed after January 10th. JFA processes claims daily (after January 10th) so you will see your reimbursement quickly! A reimbursement Request form is included in this packet for your convenience.

Vision Reimbursement: There are no benefit changes to your Vision Reimbursement benefit plan, you will continue to submit your covered vision expenses to your Union Hall for reimbursement.

Delta Dental Plan: There are no benefit changes to your Delta Dental benefit plan.

Be sure to review the State and Federal Notice packet available on Evolution1 starting January 2016: This notice packet contains important information regarding your benefits. We are required to provide these to you on an annual basis and include your Federal & State COBRA Rights, HIPAA Special Enrollment Rights, Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP) information, Notice of Medical Loss Ratio (MLR) Status, The Women's Health and Cancer Rights Act of 1998, Medicare Part D Notification of Creditable Coverage, JFA Notice of HIPAA Privacy Practices and Notice of Availability of Coverage in the Health Insurance Marketplace, and any required Summary of Benefits and Coverage's (SBC's).

HRA Eligible Expenses

Maximize the Value of Your Reimbursement Account - Your Integrated Health Reimbursement Account (HRA) can be used for a variety of out-of-pocket health care expenses. The following is based on a list of eligible and ineligible expenses used by federal employees.

Eligible Expenses

BABY/CHILD TO AGE 13

- Lactation Consultant*
- Lead-Based Paint Removal
- Special Formula*
- Tuition: Special School/Teacher for Disability or Learning Disability*
- Well Baby /Well Child Care

DENTAL

- Dental X-Rays
- Dentures and Bridges
- Exams and Teeth Cleaning
- Extractions and Fillings
- Oral Surgery
- Orthodontia
- Periodontal Services

EYES

- Eye Exams
- Eyeglasses and Contact Lenses
- Laser Eye Surgeries
- Prescription Sunglasses
- Radial Keratotomy

HEARING

- Hearing AIDs and Batteries
- Hearing Exams

LAB EXAMS/TESTS

- Blood Tests and Metabolism Tests
- Body Scans
- Cardiograms
- Laboratory Fees
- X-Rays

MEDICAL EQUIPMENT/SUPPLIES

- Air Purification Equipment*
- Arches and Orthotic Inserts
- Contraceptive Devices
- Crutches, Walkers, Wheel Chairs
- Exercise Equipment*
- Hospital Beds*
- Mattresses*
- Medic Alert Bracelet or Necklace
- Nebulizers
- Orthopedic Shoes*
- Oxygen*
- Post-Mastectomy Clothing
- Prosthetics
- Syringes
- Wigs*

MEDICAL PROCEDURES/SERVICES

- Acupuncture
- Alcohol and Drug/Substance Abuse (inpatient treatment and outpatient care)
- Ambulance
- Fertility Enhancement and Treatment
- Hair Loss Treatment*
- Hospital Services
- Immunization
- In Vitro Fertilization
- Physical Examination (not employment-related)
- Reconstructive Surgery (due to a congenital defect, accident, or medical treatment)
- Service Animals
- Sterilization/Sterilization Reversal
- Transplants (including organ donor)
- Transportation*

MEDICATIONS

- Insulin
- Prescription Drugs

OBSTETRICS

- Breast Pumps and Lactation Supplies
- Doulas*
- Lamaze Class
- OB/GYN Exams
- OB/GYN Prepaid Maternity Fees (reimbursable after date of birth)
- Pre- and Postnatal Treatments

PRACTITIONERS

- Allergist
- Chiropractor
- Christian Science Practitioner
- Dermatologist
- Homeopath
- Naturopath*
- Optometrist
- Osteopath
- Physician
- Psychiatrist or Psychologist

THERAPY

- Alcohol and Drug Addiction
- Counseling (not marital or career)
- Exercise Programs*
- Hypnosis
- Massage*
- Occupational
- Physical
- Smoking Cessation Programs*
- Speech
- Weight Loss Programs*

HRA ELIGIBLE

- Post-tax Insurance Premiums
- Long Term Care Premiums

Note: This list is not meant to be all-inclusive, as other expenses not specifically mentioned may also qualify. Also, expenses marked with an asterisk (*) are "potentially eligible expenses" that require a Note of Medical Necessity from your health care provider to qualify for reimbursement. For additional information, check your Summary Plan Document or contact your Plan Administrator.

The IRS does NOT allow the following expenses to be reimbursed under Health Care HRAs, as they are not prescribed by a physician for a specific ailment.

Ineligible Expenses

- | | | |
|--------------------------------------|-----------------------------------|--------------------------------|
| ■ Contact Lens or Eyeglass Insurance | ■ Insurance Premiums and Interest | ■ Personal Trainers |
| ■ Cosmetic Surgery/Procedures | ■ Marriage or Career Counseling | ■ Sunscreen (spf less than 30) |
| ■ Electrolysis | | ■ Swimming Lessons |

Note: This list is not meant to be all-inclusive.

Please Note: The IRS does not allow Over-the-Counter (OTC) medicines or drugs to be purchased with Health Care HRA funds unless accompanied by a prescription and the prescription is filled by a pharmacist.

Ineligible Over-the-Counter Medicines and Drugs (unless prescribed in accordance with state laws)

- | | | |
|---------------------------------|--|---|
| ■ Acid controllers | ■ Cough, cold & flu | ■ Medicated nasal sprays, drops, & inhalers |
| ■ Acne medications | ■ Denture pain relief | ■ Medicated respiratory treatments & vapor products |
| ■ Allergy & sinus | ■ Digestive aids | ■ Motion sickness |
| ■ Antibiotic products | ■ Ear care | ■ Oral remedies or treatments |
| ■ Antifungal (Foot) | ■ Eye care | ■ Pain relief (includes aspirin) |
| ■ Anti-parasitic treatments | ■ Feminine antifungal & anti-itch | ■ Skin treatments |
| ■ Antiseptics & wound cleansers | ■ Fiber laxatives (bulk forming) | ■ Sleep aids & sedatives |
| ■ Anti-diarrheals | ■ First aid burn remedies | ■ Smoking deterrents |
| ■ Anti-gas | ■ Foot care treatment | ■ Stomach remedies |
| ■ Anti-itch & insect bite | ■ Hemorrhoidal preps | ■ Un-medicated nasal sprays, drops & inhalers |
| ■ Baby rash ointments & creams | ■ Homeopathic remedies | ■ Un-medicated vapor products |
| ■ Baby teething pain | ■ Incontinence protection & treatment products | |
| ■ Cold sore remedies | ■ Laxatives (non-fiber) | |
| ■ Contraceptives | | |

OTC items that are not medicines or drugs remain eligible for purchase with an HRA.

Eligible Over-the-Counter Items (Product categories are listed in bold face; common examples are listed in regular face.)

- | | | |
|--|--|--|
| ■ Baby Electrolytes and Dehydration
Pedialyte, Enfalyte | ■ Elastics/Athletic Treatments
ACE, Futuro, elastic bandages, braces, hot/cold therapy, orthopedic supports, rib belts | ■ Hearing AID/Medical Batteries |
| ■ Contraceptives
Un-medicated condoms | ■ Eye Care
Contact lens care | ■ Home Health Care (limited segments)
Ostomy, walking aids, decubitis/pressure relief, enteral/parenteral feeding supplies, patient lifting aids, orthopedic braces/supports, splints & casts, hydrocollators, nebulizers, electrotherapy products, catheters, un-medicated wound care, wheel chairs |
| ■ Denture Adhesives, Repair, and Cleansers
PoliGrip, Benzodent, Plate Weld, Effident | ■ Family Planning
Pregnancy and ovulation kits | ■ Incontinence Products
Attends, Depend, GoodNites for juvenile incontinence, Prevail |
| ■ Diabetes Testing and AIDs
Ascencia, One Touch, Diabetic Tussin, insulin syringes; glucose products | ■ First AID Dressings and Supplies
Band AID, 3M Nexcare, non-sport tapes | ■ Prenatal Vitamins
Stuart Prenatal, Nature's Bounty Prenatal Vitamins |
| ■ Diagnostic Products
Thermometers, blood pressure monitors, cholesterol testing | ■ Foot Care Treatment
Un-medicated corn and callus treatments (e.g., callus cushions), devices, therapeutic insoles | ■ Reading Glasses and Maintenance Accessories |
| ■ Ear Care
Un-medicated ear drops, syringes, ear wax removal | ■ Glucosamine &/or Chondroitin
Osteo-Bi-Flex, Cosamin D, Flex-a-min Nutritional Supplements | |

Managing your benefits as easy as 1-2-3!

1. An easy-to-use **Consumer Portal** will allow secure, 24/7 access to your accounts to:



to-the-minute plan balances

claims and payment details

submit receipts online

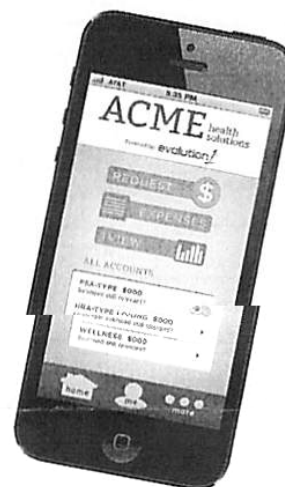
reimbursements

update your direct deposit information

- Check your up-
- View all plans,
- File claims and
- View upcoming
- Sign up for or

2. We have an App for that!

- File claims!
- Access available account balances on your iPhone®, iPod Touch®, iPad®, or Android®-powered device
- Submit receipts using your device's camera
- Receive account balances, claim confirmations and other selected alerts via text message on any mobile device



3. Need help logging on? Go to <https://jfaflex.LH1ondemand.com>

Your **USER ID** is your first initial, followed by your last name and the last four digits of the social security number provided on your Enrollment Form. **Example: jsmith1234**

Your **PASSWORD** when you log in for the **first** time is **password**. You will be prompted to change this password immediately. Once changed, you will have access to YOUR OWN ONLINE ACCOUNT!

****IMPORTANT:** You will not be able to view your HRA account balance and health plan election online until January 1st.



**JAEGER & FLYNN
ASSOCIATES, INC.**
ENTERED • FLEX PLAN SERVICES • FLEX MANAGEMENT • COMPLIANCE

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (HIPAA FORM)

Fax Completed Form to: 518.792.0226; Questions/Assistance: 518.792.0042, Option 1

Use this form if you wish to permit Jaeger & Flynn Associates, Inc. to discuss the details of your Reimbursement Account with someone other than you. This may include information on your reimbursement request status, payments, denials, and account balances. The Notice of Privacy Practices can be found at <http://ifaflex.ih1ondemand.com> or www.jaegerflynn.com. If you would like a paper copy of the Notice of Privacy Practices, please email ifaflex@jaegerflynn.com.

This form must also be completed by any individual age 18 (spouse or child) and over who is covered by your Plan, if that individual permits JFA to discuss his or her protected health information with you, even though you are the Reimbursement Plan accountholder, and may be requesting reimbursement for expenses incurred by that individual.

INSTRUCTIONS

This form is to document the designation of one or more Authorized Representative(s) for a participant. This form authorizes the release of medical information to the name representative(s). This authorization does not provide your Authorized Representative with any authority, either implied or direct, over any direct care decisions or account management. If you wish to set up a power of attorney or living will, please discuss this with your attorney. We will not condition benefit payments, enrollment, or eligibility for benefits on the execution of this form.

This form does NOT authorize the release of psychotherapy notes. This form does not constitute legal advice and is provided "as is". This form is based upon current federal law and is subject to change based upon changes in federal law or subsequent interpretive guidance. This form must be modified to reflect state law where the state law is more stringent.

You may refuse to sign this form.

AUTHORIZATION & DISCLOSURE

- I hereby authorize the use and disclosure of my individually identifiable health information as described below.
- I understand that signing this Authorization is voluntary and that if I refuse to sign this form it will not prevent receipt of health care or eligibility for benefits under a health plan.
- I understand that I am entitled to receive a copy of this form upon signing it.
- I understand that if the organization or individual authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.
- I understand that I have a right to revoke this Authorization, but that I must send a written revocation to the address below. I also understand that the revocation applies to uses and disclosures made after the revocation is made.

PATIENT & AUTHORIZED REPRESENTATIVE INFORMATION

Your Name:	
ID Number (health plan, if applies):	
Your Date of Birth (MM/DD/YYYY)	

Person or organization authorized to receive my health information (name, address, telephone number):

Specific description of information to be disclosed:	<input type="checkbox"/> All of my health information <input type="checkbox"/> Changes to call or profile including resetting password <input type="checkbox"/> HIV/AIDS-related information and/or records <input type="checkbox"/> Mental health information and/or records <input type="checkbox"/> Drug/alcohol diagnosis and treatment information <input type="checkbox"/> Other:
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What is the purpose of the disclosure?	
Authorization will expire on (date or event)	

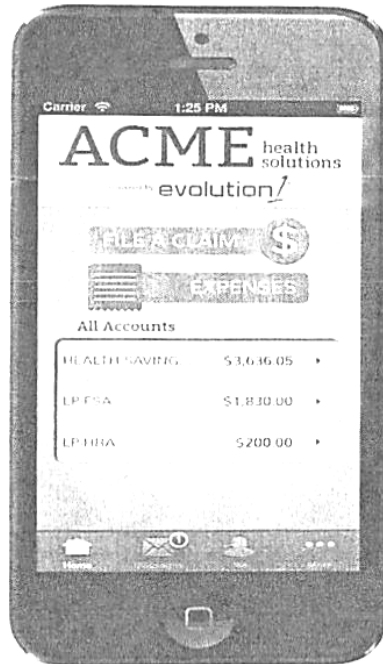
DATE (MM/DD/YYYY):	
NAME OF EMPLOYER: SMW Local No. 83	
PATIENT REPRESENTATIVE, PRINTED REPRESENTATIVE NAME:	RELATIONSHIP TO PATIENT, INCLUDING AUTHORITY FOR STATUS AS REPRESENTATIVE:

Yes, we have an App for that!

1Mobile offers real-time access to account information via iPhone, iPod touch, iPad and Android-powered devices.

Go to your App Store, search for ifaflex and install the app. You are ready to use the mobile app to access your account, file claims, and use your device's camera to upload receipts!

Larger action buttons make it easier to complete tasks on your phone. Easy access to the website messages from the navigation bar.

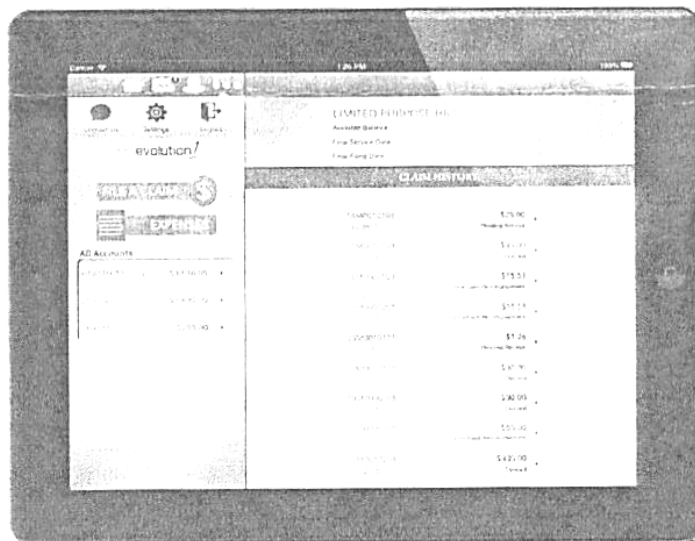


JAEGER & FLYNN ASSOCIATES, INC.
 BENEFITS HUMAN RESOURCES RISK MANAGEMENT INSURANCE

We've put the most commonly used tasks where they should be: front and center.

tablets too!

The 1Mobile experience on a tablet is intuitive and now functions natively with speed on both iOS and Android



Easy access to Consumer Portal messages from the navigation bar.

Once you've downloaded our mobile app, log in for the first time using your username and password. You will be prompted to create a 4 digit passcode to use in the future for your mobile device. Once in, you will be able to file a claim, check your balances and even take a picture of a required receipt.



DIRECT DEPOSIT FORM

Fax Completed Form to: 518.792.0226 | Questions/Assistance: 866.311.7110

For fastest reimbursements, complete this form for Direct Deposit to your personal checking or savings account.

STEP 1: PARTICIPANT INFORMATION	
Employer Name	SMW Local No. 83
Participant Name	
Participant Social Security Number	
Email Address (required)	
STEP 2: FINANCIAL INSTITUTION INFORMATION	
Important Note: If you remit this form with incorrect information, JFA will not be held responsible for any misdirected direct deposits as a result of incorrect information that is simply written below.	
Please CHECK ONE	I am <input type="checkbox"/> beginning <input type="checkbox"/> changing a Direct Deposit account.
Account Type	<input type="checkbox"/> Checking <input type="checkbox"/> Savings
Routing Number (must be 9 digits)	
Account Number	
Bank Name	
Bank Address, City, ST Zip	

JON SMITH		1200
1234 8th ST S		
FARGO, ND 58102		
PAY TO THE ORDER OF		\$
MEMO		
⑆ 0123456789⑆ 68590134⑆ 1200		
Routing Number		Account Number

STEP 3: PARTICIPANT AUTHORIZATION	
I hereby certify that the information provided on this form is accurate. Further, I understand my completion and submission of this form authorizes Jaeger & Flynn Associates, Inc. to issue payment directly to the specified account unless I notify them otherwise. I understand that I will be provided with notification of the amount and date of each direct deposit made. If I have provided an email address to JFA, I understand that such notification will be made to me via email, and that neither the Plan, Employer, nor any agent of the Plan or Employer, shall be held liable for my not having received any communication by virtue of the inability to receive the communication at the email address provided. In the event funds are deposited erroneously into my account, I authorize Jaeger & Flynn Associates, Inc. to debit my account(s), not to exceed the original amount of the credit. I also understand that all direct deposits are made through the automated clearing house (ACH), and that funds availability is subject to the terms and limitations of the ACH as well as my financial institution.	
Participant Signature	
Date	



JAEGER & FLYNN
ASSOCIATES, INC.

RECRUITING | HUMAN RESOURCES | RISK MANAGEMENT | INSURANCE

REIMBURSEMENT REQUEST FORM

Fax Completed Form to: 518.792.0226 | Questions/Assistance: 866.311.7110

For faster service, file your claim online at: <https://jfaflex.lh1ondemand.com>.

Use this form for reimbursement of any out-of-pocket expenses. Missing or incomplete information may result in the denial or delay of your request.

STEP 1: PARTICIPANT INFORMATION						
Employer Name		SMW Local No. 83				
Participant Name						
Participant Social Security Number						
Mailing Address						
Email Address						
STEP 2: REIMBURSEMENT INFORMATION						
PLAN TYPE*	DATE EXPENSE INCURRED	Merchant or Provider Name	TYPE OF EXPENSE	NAME OF PERSON RECEIVING PRODUCT OR SERVICE	Relationship	AMOUNT
HRA						\$
HRA						\$
HRA						\$
HRA						\$
HRA						\$
HRA						\$
HRA						\$
HRA						\$
Any person who knowingly and with the intent to defraud, injure or deceive; submits a reimbursement request containing any materially false, deceptive incomplete or misleading information pertaining to such request, may be committing a fraudulent act which is a crime and may subject such person to criminal and/or civil penalties or denial of benefits.						
TOTAL REIMBURSEMENT AMOUNT REQUESTED						\$

*PLAN TYPE: **HRA** - Integrated Health Reimbursement Arrangement

STEP 3: PARTICIPANT CERTIFICATION	
<p><i>To the best of my knowledge, the provided information is complete and accurate. I certify that the requests I am submitting are eligible expenses, incurred by myself or eligible dependents, as defined by the IRS and by my employer-sponsored Plan, and that I have not been previously reimbursed for these expenses, nor am I seeking reimbursement from any other source. I understand that Jaeger & Flynn Associates, Inc., including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement and if any expenses are found to be ineligible I will be responsible for reimbursing the plan. If submitting expenses for my Dependent Care Assistance Program account, I have obtained or made reasonable efforts to obtain the provider's Tax ID (TIN) and I will include the TIN on IRS Form 2441, which I must attach to my federal income tax return. If there are any changes in the provided information, I understand it is my responsibility to notify Jaeger & Flynn Associates, Inc. By submitting the form, I certify the above. I understand that I should retain a copy of all submitted documentation in the event of an IRS audit.</i></p>	
PARTICIPANT SIGNATURE: _____	DATE: _____

COMPLETION GUIDE

- Please complete the Reimbursement Request Form fully and clearly. Missing, incomplete, or illegible information may result in the denial or delay of your request.
- Please do not highlight any of your documentation, as highlighted sections may be unreadable when reviewed.
- Please keep a copy of all documentation that you submit.

For Section 2: Reimbursement Information

- **Plan Type:** Enter the code located in the key to identify the Plan account from which you are requesting reimbursement. Note: In the event you are enrolled in/eligible for more than one Plan, and the expense you are submitting is eligible for reimbursement under more than one Plan, your employer's Plan reimbursement sequencing rules may apply.
- **Did You File Online?:** If you entered your reimbursement request information at <https://ifaflex.lh1ondemand.com>, please mark "Y" for "Yes".
- **Date Expense Incurred:** This is the date when you actually received the product or service, not necessarily when you paid for the expense. For instance, you may have visited the doctor on September 1st, but not been billed or paid for the office visit until October 1st. The "date incurred" is September 1st.
- **Merchant/Provider Name:** Provide the details on where the expense was incurred.
- **Name of Person Receiving Product/Service:** Provide your name or the name of the eligible dependent for whom the service was provided or product purchased. If you are claiming reimbursement for someone other than yourself, the individual must meet the definition of "dependent" under your Plan.
- **Amount:** Provide the total amount requested for each expense. This amount should be your "total responsibility" to the merchant/provider, minus any other insurance coverage that may be providing a partial benefit.
- **Total Reimbursement Requested:** Please total the amounts for each of your requested expenses. Please use additional forms as needed.

Documentation Requirements

Documentation for medical expenses required by the IRS includes a third-party receipt containing the following information:

- Date service was received or purchase was made;
- Description of service or item purchased;
- Dollar amount (after insurance, if applicable).

If you are enrolled in a Deductible Reimbursement plan, you are required to obtain and provide an Explanation of Benefits (EOB) statement from the health insurance carrier, instead of a merchant/provider receipt. The EOB clearly indicates what portion of your medical services are subject to deductible, and therefore eligible for reimbursement under your specific Plan.

Documentation for dependent care expenses required by the IRS includes a third-party receipt containing the following information (please be advised that if a receipt is unavailable, a signature from the provider is sufficient):

- Incurred dates of service;
- Dollar amount;
- Name of day care provider.
- Tax id or Social Security Number of Provider

Unacceptable forms of documentation include:

- Provider statements that only indicate the amount paid, balance forward, or previous balance;
- Credit card receipts that only reflect a payment;
- Bills for prepaid dependent care/medical expenses where services have not yet been rendered.

When submitting a receipt for a co-payment amount, please be sure the co-payment description is on the receipt. In some cases, you will need to ask for a receipt at the point of service. If "co-payment" is not clearly identified, please have the provider write "co-payment" on the receipt and sign it.

Send your Reimbursement Request & Documentation to:

JAEGER & FLYNN ASSOCIATES, INC. FLEX PLAN SERVICES
MAIL: 42 SOUTH STREET, GLENS FALLS NY 12801 FAX:
518.792.0226
EMAIL: JFAFLEX@JAEGERFLYNN.COM