Special Rule Regarding Orthodontic Expenses

Pre-tax reimbursements must relate to medical care that is actually incurred during the plan year. An expense is treated as "incurred" when the care is actually provided, not when you are billed or when you pay for the care. This timing requirement presents difficulties regarding orthodontic services since they usually span more than one calendar year and/or FSA plan year. Reimbursement of the entire orthodontic expense "up-front" violates the expense incurred requirement.

ORTHODONTIC EXPENSES PAID WITH DEBIT CARD: Per IRS regulations, orthodontic reimbursements must be made in accordance with a reasonable payment plan. A down payment can be reimbursed (or paid for via the debit card) when the services begin or the braces are applied. The IRS deems 20-30% of the treatment fee (less any insurance payments) as a reasonable down payment amount. The remaining balance, divided by the number of anticipated treatment months is the amount that can be reimbursed each month, either via debit card or paper claim.

A contract or financial agreement showing the treatment start date, the entire fee, any insurance payments and the expected treatment time frame will be requested from you to substantiate the debit card swipe(s). Once a debit card has been substantiated, further debit card swipes in the same amount will be automatically substantiated through the later of the contract year or the Plan Year.

ORTHODONTIC EXPENSES PAID VIA CHECK OR CREDIT CARD:
Reimbursement of orthodontic expenses that have been paid via manual check or credit card require you to submit a signed and completed claim form along with either a copy of the contract or financial agreement. To set up automatic reimbursement of orthodontic expenses on a monthly basis, you may have your orthodontist complete the attached claim form. Reimbursement of orthodontic expenses set up to automatically reimburse are processed on the first day of each month. A new orthodontic claim form must be submitted each Plan Year.

TO AVOID VIOLATING THE "UP-FRONT" REQUIREMENT, DO NOT USE YOUR DEBIT CARD OR ANY OTHER METHOD OF PAYMENT TO PAY THE FULL COST OF ORTHODONTIC EXPENSES.

Please refer to your Plan or contact our office prior to receiving orthodontic treatment if you have any questions about the reimbursement process.

Mail or Fax Claim To:

Benefit Extras, Inc.
P.O. Box 1815
Burnsville, MN 55337
Phone: (952) 435-6858

ORTHODONTICS ONLY
Flex Spending Claim Form
flex@benefitextras.com
Fax: (952) 435-8435

1. Employer/Employee Information

Employer
Employee Name

Complete address below ONLY if it has changed

Street		
City	State	Zip
Soc. Sec. #	Date of Birth	

2. Instructions for Completion

- Section 125 of the IRC states participants cannot be reimbursed in advance of the date of service. However by submitting this form, you will eliminate the need to submit paper claims with each recurring monthly **ORTHODONTIC** visit. Benefit Extras will automatically send you a reimbursement check the first day of each month.
- Complete applicable portions of Section 1 of the **Orthodontic Claim Form**.
- Have your dental/orthodontic office complete and sign Section 3.
- **Sign the Employee Certification in Section 4.**
- Fax or mail completed **Orthodontic Claim Form** to Benefit Extras.

3. Orthodontic Expenses (to be completed by the Orthodontic Provider)

Patient Name: _____

Relationship to Employee: _____

Treatment Start Date: _____

Total Treatment Fee: _____

Down Payment Amount & Date: _____

Treatment Time in Months: _____

Treatment End Date: _____

Monthly Charge: _____

Insurance Coverage Amount: _____

Orthodontic Provider: _____

I certify that our office will provide orthodontic care as described above and further certify that this orthodontic services are for treatment and not strictly for cosmetic purposes.

_____ _____
Orthodontic Provider Signature **Date**

4. Employee Certification

I, the undersigned, certify that the above expenses were incurred by me (and/or my spouse/or eligible dependents), have been paid by me (or them), were not reimbursed by any other plan, and to the best of my knowledge and belief are eligible for reimbursement under my account. I (or we) will not use the expenses reimbursed through this account as deductions or credits when filing my (our) individual income tax return. If audited, I understand that it is my responsibility (not my employer's) to provide written proof that these expenses were actually incurred and eligible for reimbursement. In the event that any reimbursement that I may claim and receive under this plan is later determined by the IRS to be unsubstantiated, I hereby acknowledge and accept responsibility for any adverse tax consequences that may result to me. I understand the employer does not accept responsibility for direct payment to any individuals other than the employee.

X_____ _____
Employee Signature (Required) **Date**

PLEASE RETAIN A COPY FOR YOUR RECORDS!