HEALTH FSA

This plan is designed to let employees pay medical expenses not covered by your health insurance (dental, vision, orthodontic, co-pays, etc) with pre-tax dollars. The maximum dollar amount that an employee may contribute to his or her medical FSA for a plan year is the statutory limit allowed by the IRS.

Qualifying Dependent:

►Yourself
►Spouse
►Dependents

Requirements:

Basic Rules for reimbursement of eligible expenses:

1. An individual may only be reimbursed for expenses incurred while the participant is in the plan.
2. An expense is incurred when the service is performed (not when billed or paid).
3. The expense must be reimbursed from funds allocated for the plan year in which the expense was incurred.
4. The participate must submit proper documentation showing that the service has been provided.

Documentation must be submitted showing the following:

1. Provider's name
2. Dates of service
3. Amount charge to participate
4. Description of service or prescription
5. Dependent's Name

Example of what is covered:

1. Office Visits
2. Deductibles
3. Eyewear
4. Dental
5. Orthodontia
6. Prescriptions
7. Co-Pays

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Examples of what is not covered:

1. Expenses already reimbursed by your insurance
2. Expenses meant for one's general health (i.e. vitamins, first aid supplies, toiletries)
3. Expenses solely for cosmetic reasons.
4. Expenses that incurred prior to enrollment or after termination of employment.

Support needed when filing a claim:

You must supply the following provider's information

1. Copy of invoice or statement showing date of service
2. Name of Provider
3. Amount charged to member or applied to deductible
4. Name of dependent
5. Description of services provided

Please note that a receipt or copy of check showing amount paid will not be accepted.

Reimbursement:

Medical FSA claims reimbursements must have been incurred during the period of coverage year only. The uniform coverage rule applies meaning that per the IRS guidance permits reimbursement up to the annual amount deducted from their payroll.

Use-it-or-lose-it requirements:

The Use-it-or-lose-it rules, means any amount left at the end of the year that is not used, cannot be paid in cash or any other benefits and it has been forfeited by the employee. There may be a 30, 60 or 90 day filing period at the end of the year to submit claims.

Section 125 Medical Qualified Expenses (partial list):

Below is a partial list of expenses that can be reimbursed through your Cafeteria plan. These include services incurred by yourself or eligible dependents for the diagnosis, treatment or prevention of disease. It is possible that changes in the IRS rules can affect qualified expenses.

- abdominal supports
- abortion
- acupuncture
- ambulance
- anesthetist
- arch supports
- artificial limbs
- blood transfusions
- cardiographs
- chiropractor
- Christian Science Practitioner
- contact lenses
- contraceptives
- convalescent home (for medical treatment)
- crutches
- dental services
- dentures
- dermatologist
- diagnostic fees and services
- drug/alcohol treatment
- elastic hosiery
- eye care
- eyeglasses
- fertility monitors
- guide dog
- hearing aids and batteries
- hydrotherapy
- insulin treatments
- laser eye surgery
- oral surgeon
- organ transplant (including donor's expenses)
- orthodontist services
- orthopedist
- orthopedic shoes
- oxygen and oxygen equipment
- physician services
- podiatrist
- pregnancy tests
- pre/postnatal care
- prescription medication
- preventive care screening
- psychological services
- registered nurse
- sleep and snoring aids
- special school costs for the handicapped
- spinal fluid test
- splints
- sterilization procedures
- stop-smoking aids
- surgeon
- transportation expenses (relative to health care)
- vitamins (with prescription from physician)
- wheelchair

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Section 125 Non-Qualified Expenses (partial list):

Below is a partial list of expenses that cannot be reimbursed through your Cafeteria plan. It is possible that changes in the IRS rules can affect non-qualified expenses.

- athletic club membership
- cosmetic surgery and procedures
- cosmetics, hygiene products and similar items
- diaper service
- electrolysis or hair removal/hair transplants
- expenses paid by an insurance company
- funeral expenses
- health club membership
- household help
- illegal operations and treatments
- illegally procured drugs
- maternity clothes
- premiums for life insurance, income protection, disability, loss of limbs, sight or similar Benefits
- prepayment for services that have not yet been rendered or received
- Scientology counseling
- Specifically designed car for the handicapped other than an autoette or special equipment
- special foods or beverages
- surrogate expenses
- weight loss programs

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DEPENDENT CARE

This plan is designed to let employees pay dependent care expenses with pre-tax dollars to qualified caretakers.

AMOUNT ALLOWED FOR PAYROLL DEDUCTION:

The IRS has allowed for a limited amount to be withheld from payroll pretax dollars.
$2500.00 for a married person filing separate
$5000.00 for a married person filing jointly
$5000.00 for a single person

Note: If an employee and their spouse both work for a company that has a 125 plan and both parties are participating they are only allowed $2500.00 each to be at their max of $5000.00 or only 1 may participate and take the whole amount from their paycheck.

Qualifying Dependent:

1. A dependent under the age of 13 whom you are claiming on your federal income tax return.
2. Your spouse, parent, or other that you claim as a federal tax dependent, who is physically or mentally incapable of caring for themselves and spend at least 8 hours in your household.

Requirements:

The provider must comply with all state and local regulations.

Note: Day camps, nursery schools, day care centers and after-school programs are eligible. The cost of over-night camp is not considered a work-related expense. For details on specific provider requirements contact Envision Healthcare.

Examples of a Qualified Care Provider:

1. The Child Care, Day Care, or Custodial Care Center (must provide care for more than six individuals other than those who reside at the facility).
2. A Babysitter who reports their income as taxable income.
3. A Paid Governess, Au Pair or Nanny.

Support needed when filing a Claim:

You must supply the following provider's information

1. Name of Provider
2. Address
3. Tax Identification Number or Social Security Number
4. Date of services rendered
5. Amount of charge
6. Name of Dependent
7. Description of services provided

Reimbursement:

Dependent Care Reimbursements are not subject to the uniform reimbursement requirements as a Medical FSA. Dependent care expenses can only be paid up to the amount that has been deducted from their payroll. There is no advance payment, only after it has incurred.

Use-it-or-lose-it requirements:

The same rule applies as with Medical FSAs, meaning any amount left at the end of the year that is not used, cannot be paid in cash or for any other benefits, and it has been forfeited by the employee. There is a 60 day filing period at the end of the year to submit claims.

Envision Healthcare
Debit Card Frequently Asked Questions

Q. **How do I activate my Envision debit card?**

A. Your Envision debit card will be activated upon first usage. You do not need to call to activate your card.

Q. **Where can I use my Envision debit card?**

A. You can use your Envision debit card at both healthcare and non-healthcare merchants. A healthcare merchant includes medical providers, such as doctors, dentists, vision care facilities, and other locations that sell only medical services / products. A non-healthcare merchant is any retailer who may carry healthcare products along with other product lines. Examples of non-healthcare merchants include: grocery stores, mass merchandisers and pharmacy stores.

Q. **Do I need to keep my receipt after using my Envision debit card?**

A. Yes, you should retain all itemized receipts and documentation from your purchases with the Envision debit card. If requested by Envision you are obligated to submit your receipts to prove expense are eligible under your Benefit Plan and applicable IRS regulations.

Q. **Do I choose debit or credit at the credit card terminal when using my Envision debit card?**

A. The Envision debit card has the capability to do either. If you choose "credit" you will be required to sign for the transaction. If you choose "debit", you will be required to input the card's PIN. To retrieve the PIN, log on to your Envision benefits debit card account at www.mywealthcareonline.com/envisionhealthcare.

Q. **How can I check the balance on my Envision debit card?**

A. To obtain balance information and transaction history you can access your Envision debit card account online at www.mywealthcareonline.com/envisionhealthcare 24 hours a day 7 days a week. You may also contact our Customer Service Department to obtain balance information at (866) 672-7526 Monday thru Friday between 8am – 5pm CST.

Q. **What if my Envision debit card is lost or stolen?**

A. Login to your account at www.mywealthcareonline.com/envisionhealthcare or Contact our Customer Service Department at (866) 672-7526.

Q. **How do I file for reimbursement for claims paid without using my Envision debit card?**

A. Complete an Envision Reimbursement Request form, attach the required documentation for reimbursement and fax it to (800) 596-3464 or email it to info@envisionhealthcare.com for processing. You will be reimbursed via check for any eligible claims paid without using your Envision debit card.

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How much should I contribute to the Flexible Spending Account?

This guide will help you to determine the amount to contribute to your Flexible Spending Account. Please take time to review and answer the applicable questions. You may want to review your checkbook register and medical/dental records to help determine your out of pocket expenses.

Un-reimbursed Medical

A. *Medical Expenses-estimate your medical expenses*

1. Medical Coverage Deductibles $_____per year
2. Co-insurance $_____per year
3. Routine Exams (OB-Gyn, school physicals) $_____per year
4. Prescriptions $_____per year
5. Vision Care (eye exams, glass, contacts) $_____per year
6. Other: _____ $_____per year

Total Medical Expenses: **$_____per year**

B. *Dental Expenses-estimate your dental expenses*

1. Examinations and Cleanings $_____per year
2. Braces, Retainers, or other Orthodontia $_____per year
3. Fillings, Crowns and Bridges $_____per year
4. Dentures, including Replacements $_____per year
5. Implants, Inlays and X-rays $_____per year
6. Fluoride Treatments $_____per year
7. Other:_____ $_____per year

Total Dental Expenses: **$_____per year**

C. Other:_____ $_____per year

TOTAL OUT OF POCKET HEALTH CARE EXPENSES **$_____per year**

Dependent Care

A. 1. If you are a single parent or your spouse works, what are your expenses for care of dependent children under age 13? $_____per year

Individuals filing as Single or Married filing joint have a $5,000.00 max per year.
Married individuals filing separate have a $2,500.00 max per year.

TOTAL OUT OF POCKET DEPENDENT CARE EXPENSES **$_____per year**

This form is intended to assist you in enrolling in a Flexible Benefits Plan. This guide is not intended to provide any legal or tax advice. You may wish to contact your tax advisor prior to enrolling in the plan.

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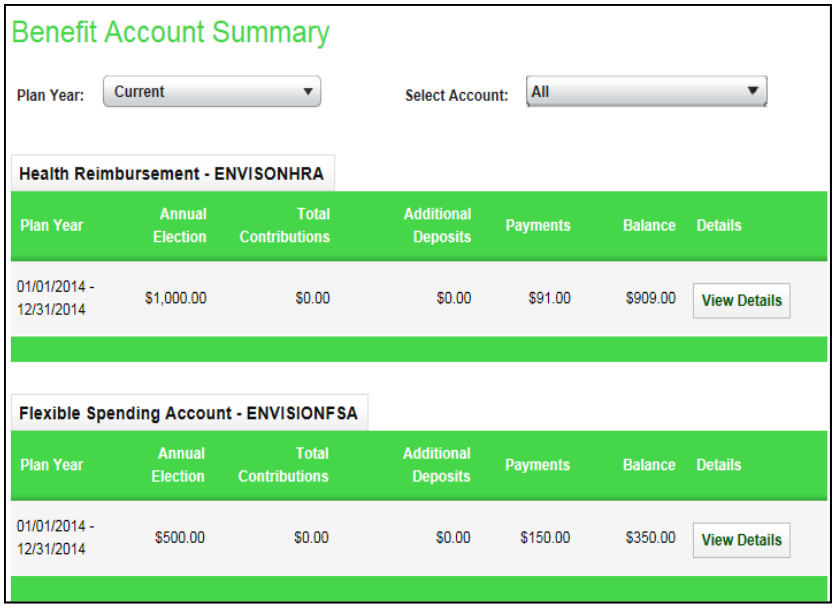
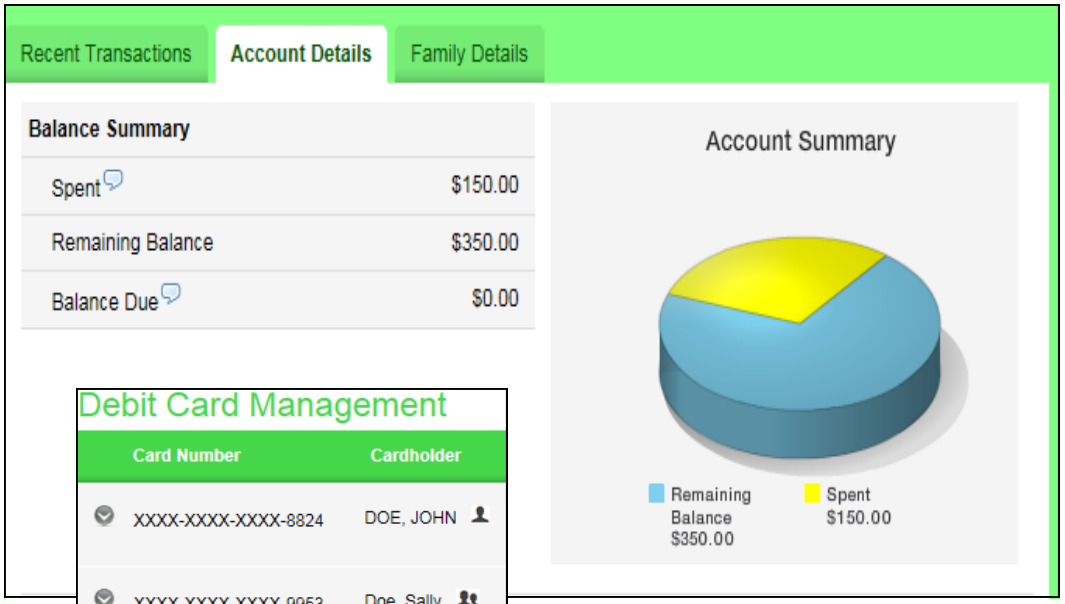
ENVISION HEALTHCARE, INC. PORTAL

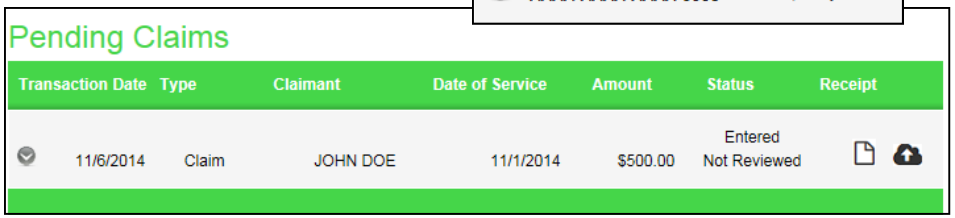
Our secure online portal gives you 24 hour access to your Envision benefit plans. Go to **www.mywealthcareonline.com/envisionhealthcare** and click “register” to set-up your login. During this process you will be prompted to enter both your Envision debit card number and your Employee ID. Once registered, you can sign-in to access your account. If you have any questions feel free to contact Customer Service at (866) 672-7526.

Online Account Access

- Access Account Activity
- Track Healthcare Expenses
- View Benefit Account Balances
- Submit a Reimbursement Request
- Maintain Account Information
- Establish Account Alerts







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Phone (866) 672-7526 Fax (800) 596-3464

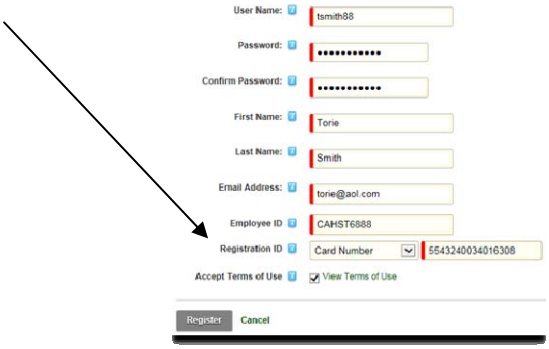
ENVISION HEALTHCARE, INC. PORTAL REGISTRATION INSTRUCTIONS

STEP #1 **REGISTER TO CREATE YOUR LOGIN AT** www.mywealthcareonline.com/envisionhealthcare

- On the home page, click “register” to create your username and password.

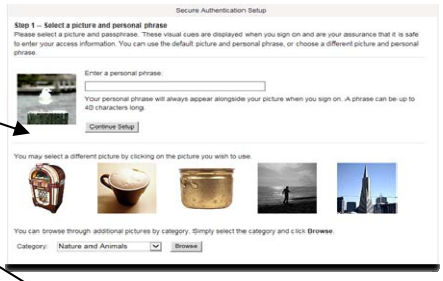
STEP #2 **ENTER YOUR IDENTIFICATION INFORMATION AND CHOOSE YOUR USERNAME /PASSWORD.**

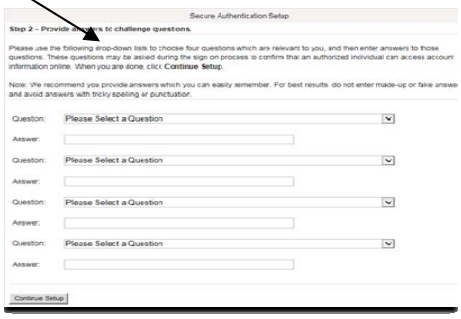
- Enter your desired username
- Enter a password meeting the minimum security requirements
- Enter your first and last name as it appears on your Envision benefits debit card
- Provide an email address
- Enter your Employee ID (if one was not assigned, use your social security #)
- For Registration ID select “card number” and enter in your Envision benefits debit card number.
- View the terms of use, check the accept the terms of service check box
- Click Register



STEP# 3 **SECURE AUTHENTICATION SETUP** To protect your privacy, Envision Healthcare implements Secure Authentication. click **“Begin Setup”**

- Select a picture and personal phrase
- Provide answers to challenge questions
- Verify your secure authentication information and click **“Submit Setup Information”**.





You have successfully completed the set-up process. You will receive an email confirming your registration on the Envision Healthcare, Inc. Portal. Click “Proceed to Account” to access to your account.

If you have any questions or need assistance please contact us at (866) 672-7526 or info@envisionhealthcare.com

Handling Your Customer Service Needs

The Customer Service Department at Envision Healthcare is available Monday through Friday, 8am to 5pm C.S.T. You may contact us toll free at (866) 672-7526 or by email at info@envisionhealthcare.com Our friendly Customer Service Representatives are happy to assist you with any questions you may have regarding your Envision plan benefits, claim status or payment history.

If you have forms to submit to our office such as reimbursement forms, address changes, etc., they can be mailed, faxed securely to our toll free fax number (800) 596-3464, or emailed to us at info@envisionhealthcare.com. If you submit your form via email, we will reply back with a confirmation of receipt.

Forms can be mailed to:
Envision Healthcare, Inc.
P.O. BOX 5047
Oak Brook, IL 60522-5047

You can download necessary forms and access your secure claim information on our website at www.envisonhealthcare.com.

Call Us Today at (866) 672-7526

Debit Card Cafeteria Plan Election Form

COMPANY NAME: _____

HEALTH INSURANCE COVERAGE TYPE: ☐ PPO ☐ HMO ☐ Spouse's plan

EMPLOYEE CURRENTLY ENROLLED AN: ☐ HRA ☐ HSA

Note: Enrollment in an HRA or HSA may limit Healthcare FSA

EMPLOYEE INFORMATION:

Name:	Soc. Sec#:		Date of Hire:
Address:	Date of Birth:	Marital Status:	Gender M or F
City:	Number of Dependants:		Salary:
State: / Zip Code:	Phone Number:	Email Address:	

Add-On Dependent(s)	Dependent(s) Needing Cards (Circle One)*	Date of Birth	Social Security#
Spouse:	Y / N		
Child:	Y / N		
Child:	Y / N		
Child:	Y / N		
Child:	Y / N		

*If not indicated, no card will be issued.

ANNUAL ELECTIONS:

	Annual Election	Per Pay Period Deduction	First Payroll Deduction
Healthcare Flexible Spending Account			/ /
Dependent Care Spending Account			/ /
Transportation/Vanpooling			/ /
Parking			/ /

AUTHORIZATION: **By signing this form I acknowledge that I am authorizing the company to deduct equal amounts from my paychecks to collect the designated pre-tax amount indicated above. I recognize that these selections constitute a deliberate binding decision on my part that shall not be changed until the enrollment period for the next plan year or if I experience a change in status.**

_____ _____

Employee Signature **Date**

If you elect not to participate in the FSA plan, please sign and date the form below.
I elect *NOT* to participate in the FSA program at this time.

_____ _____

Employee Signature **Date**

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INTERNAL USE ONLY

Date Entered: _____

Initials: _____

HRA ☐ FSA ☐

CRA ☐ NON CRA ☐

DIRECT DEPOSIT FORM

Authorization Agreement for Claim Payments

I (we) hereby authorize Envision Healthcare, Inc. to instruct my financial institution to accept claims deposits or charge backs on the dates due to the account listed below. The authority remains in effect until Envision Healthcare, Inc. has received written notification from me of termination in time to allow reasonable opportunity to act on it, or until Envision Healthcare, Inc. has sent me written notice of termination of this agreement.

Contact Information

Company Name: _____

Employee Name: _____

Employee Phone #: (_____) - _____

Employee Address: _____

City: _____ State: _____ Zip Code: _____

_____ _____

Employee Signature Date

☐ New Enrollment ☐ Update Existing Account

Required Financial Institution Information

Name of Financial Institution: _____

Account Type: (check one) ☐ Checking ☐ Savings

Account Number: _____

Transit Routing Number: _____

ATTACH A VOIDED CHECK FOR THIS ACCOUNT
DO NOT ATTACH DEPOSIT SLIP

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Section 125 *Medical* Reimbursement Request Form

Section 1 This section must be completed fully for all claims. **(PLEASE PRINT)**

EMPLOYER NAME: _____

EMPLOYEE NAME: _____

ADDRESS: _____

☐ **Check if this is a NEW address** EMPLOYEE DAY TIME PHONE NUMBER: _____

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

Section 2 This section must be completed for all claims incurred by you, your spouse, or other eligible dependents. Supporting documentation **MUST** be attached. We want to promptly process your claims. Please complete all appropriate sections as the claim form will be returned to you if incomplete. Use an additional form if you need more space. Please keep a copy of this form for your records.

EXPENSES

Item	Service Dates	Provider Of Service	Description Of Service	Amount Requested
1				$
2				$
3				$
4				$
5				$
6				$
7				$
8				$
9				$
10				$
11				$
12				$
13				$
14				$
15				$
			TOTAL AMOUNT REQUESTED	$

Section 3 Employee's Signature is required to process this claim.

AUTHORIZATION: I authorize any medical professional, hospital, other medical facility or provider to disclose to Envision Healthcare, Inc. information concerning care, treatment or billing for any treatment I obtained at that facility. This authorization shall expire on the date in which my employer terminates coverage with Envision Healthcare, Inc. I also understand that I may revoke this authorization at any time, but that such revocation will have no effect on any actions taken by Envision Healthcare, Inc. prior to receipt of revocation. I understand that information disclosed pursuant to the authorization may re-disclosed and no longer protected by federal privacy laws. I authorize Envision Healthcare, Inc. to transmit the information contained electronically.

To the best of my knowledge, my statements in the request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the application plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed under this or any other benefit plans and will not be claimed as an income tax deduction. I authorize my FlexPay medical accounts to be reduced by the amount requested.

SIGNATURE: _____ **DATE**: _____

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Section 125 *Dependent Care* Reimbursement Request Form
Section 125 *Insurance Premium* Reimbursement Request Form

Section 1 This section must be completed fully for all claims. **(PLEASE PRINT)**

EMPLOYER NAME: _____

EMPLOYEE NAME: _____

ADDRESS: _____

☐ **Check if this is a NEW address** EMPLOYEE DAY TIME PHONE NUMBER: _____

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

Section 2 This section is for **DEPENDENT CARE** claims only. This section must be completed for all claims incurred by you, your spouse, or other eligible dependents. Supporting documentation **MUST** be attached. We want to promptly process your claims. Please complete all appropriate sections as the claim form will be returned to you if incomplete. Use an additional form if you need more space. Please keep a copy of this form for your records.

DAY CARE/DEPENDENT CARE INFORMATION:

Period Covered	Provider's Full Name	Provider's Tax ID	Amount Requested
			$
			$
			$
			$
			$
			$
			$
		TOTAL AMOUNT REQUESTED	$

Section 3 This section is for **INSURANCE PREMIUM** claims only. This section must be completed for all claims incurred by you, your spouse, or other eligible dependents. Supporting documentation **MUST** be attached. We want to promptly process your claims. Please complete all appropriate sections as the claim form will be returned to you if incomplete. Use an additional form if you need more space. Please keep a copy of this form for your records.

INSURANCE INFORMATION:

Date Paid	Period Covered	Insurance Carrier's Full Name	Amount Requested
			$
			$
			$
		TOTAL AMOUNT REQUESTED	$

Section 4 Employee's Signature is required to process this claim.

To the best of my knowledge, my statements in the request for reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the application plan year and for eligible plan participants. I certify that these expenses have not been previously reimbursed under this or any other benefit plans and will not be claimed as an income tax deduction. I authorize my FlexPay medical accounts to be reduced by the amount requested.

SIGNATURE: _____ **DATE**: _____

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FLEXIBLE SPENDING ACCOUNT (FSA)

Q. What is a Flexible Spending Account (FSA)?

A. A Flexible Spending Account (FSA) is part of the benefit plan offered to you by your employer and allows you to use tax-free dollars to pay for certain medical and/or dependent care expenses. There are two types of FSAs: a Medical FSA (for eligible medical expenses incurred by you, your spouse or your dependent) and a Dependent Care FSA (for eligible dependent care expenses). We also offer Debit cards which are compatible with these plans, please inquire for further information.

Q. What is the advantage of enrolling in an FSA?

A. Enrolling in an FSA allows you to make tax-free salary contributions to pay for eligible medical and dependent care expenses that are not covered or reimbursed by any other source. FSAs increase your take-home pay by reducing taxable income, making these out-of-pocket expenses more affordable. FSAs also help employees budget for health expenses that they can forecast in the coming year. You are unable to deduct these types of expenses unless they exceed 10.5% of your adjusted gross income, which you may do at the end of a tax year.

Q. What are some examples of qualified medical expenses?

A. A qualified medical expense is any medical expense that helps to treat or mitigate a specific medical condition or ailment; it can be out of pocket medical expenses as related to a major medical insurance policy (co-payments, deductibles, co-insurance, prescription expenses), dental expenses, vision expenses, over the counter drugs, as well as many other expenses. Please inquire to see a more detailed list of examples of permissible expenses.

Q. Who is eligible to elect an FSA?

A. Eligibility requirements for a Medical FSA and a Dependent Care FSA are determined by the employer and outlined in the plan documents.

Q. Is there a maximum or minimum annual amount that I can elect for an FSA?

A. Any applicable maximum/minimum amounts for your annual FSA elections are determined by the employer and outlined in the plan documents.

Q. Can I elect a Medical FSA and a Dependent Care FSA?

A. Yes. Participation in each FSA is completely voluntary - you can enroll in one, both or neither. To participate, you must make your election(s) prior to the beginning of each new Plan Year and use the elections in the corresponding year.

Q. What employee taxes are eliminated by contributing to a Medical or Dependent Care FSA?

A. You will not pay federal income tax, Social Security tax and most state taxes (except for Pennsylvania and New Jersey) on contributions to a Medical and/or Dependent Care or Transit FSA.

Q. How can I check my Account balance?

A. There are several ways you can determine your Account balance:

- Your Account balance will be displayed on the Explanation of Benefits (EOB) issued with each reimbursement check (as of the day the check was created).
- You can access Account information 24/7 online by using Envision Healthcare's secure web-site interface.
- You may call Envision Healthcare at 866-672-7526 (8 am-5pm Central Time, Monday - Friday).

Q. Who is responsible for determining if an expense is eligible?

A. Eligibility of expenses is dictated by the IRS and those guidelines are used by Envision Healthcare. We will use these guidelines to authorize payments for any claim request. If a unique claim request is called into question we will contact the IRS or an attorney to determine the eligibility of the expense.

Q. Can I change my FSA election during the Plan Year?

A. Generally, your election cannot be changed during a Plan Year unless you experience a Qualified Status Change (QSC) as defined by the Internal Revenue Service. A change in election must be preceded by a qualifying event, including but not limited to: change in marital status, number of dependents, a child's eligibility due to age, employment status of employee or spouses. For more information please inquire.

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