

Instructions

1. Employee must complete **Employee Information** – Be sure to indicate if this is a new address.
2. Complete **Claim Information** in its entirety. Please ensure that your supporting documentation clearly indicates the requested amount.

Eligible expenses include but are not limited to: Acupuncture, Alcohol & Drug Rehabilitation (inpatient treatment only), Ambulance, Artificial Limbs, Artificial Insemination/In vitro Fertilization/Fertility Enhancement, Blood Pressure Monitoring Devices, Body Scan, Birth Control Pills/Condoms/Spermicide, Chiropractor, Co-Insurance and Deductible, Contact Lenses & Cleaning Solutions, Crutches, Dental Treatment, Dentures, Diagnostic Tests, Eye Exam, Eye Glasses/Prescription Glasses, Flu Shots, Hearing Devices, Hospital Services, Immunizations (e.g. well baby shots), Insulin, Laboratory Fees, Lamaze Classes relating to childbirth, Laser Eye Surgery/Lasik, Learning Disability Treatment, Medical Alert Bracelet/Necklace, Obstetric Treatment Orthodontia, Over-the-counter pregnancy test, Over-the-counter medications to treat a specific medical condition, Oxygen, Physical Exams, Physical Therapy, Podiatry Treatment, Prescription Drugs, Psychiatric Treatment, Psychological Treatment, Radial Keratotomy, Smoking Cessation – prescription only, Surgery & Related Expenses, Tubal Ligation or Vasectomy, X-rays.

Ineligible Expenses include but are not limited to: Cosmetic Surgery and Procedures, Expenses for services rendered outside the coverage period, Expenses reimbursed by an insurance provider or another health plan, Hair Loss Items, Herbs/Vitamins/Supplements that do not require a prescription for use, Insurance Premiums, Long Term Care Services, Marriage Counseling, Personal Use Items, Teeth Whitening.

3. Check the appropriate box in **Supporting Documentation** section and attach Acceptable Supporting Documentation as described below:
 - a) Itemized Statement or bill from your provider including:
 - Provider name
 - Patient name
 - Description of service
 - Original date of service (the date of service, not the date of payment, must fall within the plan year for which you are enrolled)
 - Patient portion of charge
 - b) Explanation of Benefits (EOB) from your insurance carrier
 - c) Pharmacy Statement including:
 - Patient name
 - Prescribing physician
 - RX number
 - Name of the drug
 - Date the RX was filled
 - Co-payment amount
 - * Unacceptable Documentation includes the following:
 - Cancelled Checks
 - Credit/cash receipts (An itemized cash register receipt is acceptable for eligible over-the-counter expenses)
 - Balance forward statements
- When attaching small receipts, we suggest you tape them to a standard size sheet of paper
4. Sign and date **Employee Certification**
 5. **Submit Claims To:**
CONEXIS Cafeteria Plan Services
P.O. Box 227197
Dallas, Texas 75222
Fax: (888) 866-3312 Phone: (866) 279-8385

Medical expenses which have been reimbursed under this plan are not deductible for income tax purposes
