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# Instructions for Reimbursement from Your Spending Account

- Use this form to request reimbursements of expenses incurred during the plan year.
- If you are submitting expenses for more than one plan year, you must submit a separate form for each year that you are an eligible participant.
- Failure to follow these instructions may delay your reimbursement.

## 1 Complete all information requested on the Claim Form

- Print in capital letters, with your letters centered in the boxes provided.

Example:

A	B	C	D		1	2	3	4
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- Use the Claim and Relation Codes listed below to complete the boxes.
- Sign and date the form then provide a phone number where we can reach you should we have questions regarding your claim.

### Please Do Not:

- Staple documents
- Use a Highlighter
- Use red ink
- Use a photocopy of the form
- Write outside the boxes provided
- Submit expenses for multiple plan years on the same form
- **Mail this Instruction Sheet**

## 2 Attach supporting documentation for each expense

- Copy your receipts and other supporting documentation onto a white, letter-sized sheet of paper
- Place all receipts facing the same direction.
- Write your Social Security Number or your employee Alternate ID at the top of each page.
- **Retain original documentation and a copy of the form for your records.**

## 3 Submit your request

- **By Mail** – Put the original claim form on top of copied documentation and mail to:  
**Account Service Center, PO Box 22130, Pittsburgh, PA 15222-0158** (*Make sure your envelope has the correct postage.*)
- **By Fax:** 412-586-3422 – Please include a copy of this claim form with your documentation copies.

If you would like an email confirmation when we receive your documents, log on to your account & click the Update Email Address link.

**Remember:** Sign up for Direct Deposit and receive your reimbursement faster! To sign up, log in to your account and select “Direct Deposit Sign-Up” from the left side menu.

### Claim Codes Table

Copayments & Deductibles		Expenses OTHER THAN Copayments or Deductibles				
<b>02</b>	Copay-Medical	<b>20</b>	Prescription Drug – Not COPAY		<b>Vision</b>	
<b>03</b>	Copay-Dental	<b>22</b>	Emergency Room		<b>50</b>	Contact Solution
<b>04</b>	Copay-Vision	<b>23</b>	Ambulance Fee		<b>52</b>	Prescribed Glasses & Contacts
<b>05</b>	Copay-Prescription	<b>24</b>	Diabetic Supply		<b>53</b>	Non-prescription Frames, Lens
<b>07</b>	Deductible-Medical	<b>25</b>	Over-the-Counter		<b>54</b>	Vision (Unspecified)
<b>08</b>	Deductible-Dental	<b>27</b>	Medical Supply			
<b>09</b>	Deductible-Vision	<b>28</b>	Medical Mileage & Transportation			
<b>Dependent Care</b>		<b>29</b>	Medical (Unspecified)			
<b>70</b>	Dependent Care	<b>30</b>	Medical Claim – FSA Only			
<b>Qualified Transportation</b>		<b>31</b>	Co Insurance			
<b>90</b>	Mass Transit	<b>32</b>	Premium			
<b>92</b>	Parking	<b>33</b>	Prescription Claim – FSA Only			
		<b>Dental</b>				
		<b>40</b>	Orthodontia			
		<b>42</b>	Dental (Unspecified)			

  

Relation Codes Table	
Relation	
<b>CH</b>	Child
<b>EE</b>	Employee / Participant
<b>OT</b>	Other
<b>SP</b>	Spouse

*Some of these expenses may not be eligible for reimbursement under your plan. Refer to your company's plan documents for a listing of eligible expenses.*

### ELIGIBLE DOCUMENTATION

#### Medical Expenses

- Explanation of Benefits from your insurance company.
- Itemized bill from the provider that includes: name of patient, date of service, description of service and the amount of your responsibility

#### Prescription Expenses

- Prescription receipt or Pharmacy Print-out that includes: name of patient, date of service, name of medication and the amount of your responsibility.
- Cash register receipts are acceptable for over-the-counter drugs and medicines **ONLY** and must include the merchant name, date of purchase, and the identification and amount of the expense. If the product identification is not on the receipt or is not clearly identified on the receipt, a portion of the actual merchandise package (box top/label) that includes the identification of medication may be submitted with the receipt of purchase.

#### Dependent Care Expenses

- Dependent Care provider bills that include the name of the dependent, name of the provider, date of service, provider's EIN or SSN, provider's address, description of service, and amount charged for the service.

*This sheet is for **Reference Only**. **PLEASE DO NOT SUBMIT THIS SHEET WITH YOUR CLAIM FORM***