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Fund Reimbursement Request
Reimburse Expenses Not Covered by the Medical and/or Dental Plan
Claim Instructions

NOTE: This form should be used to submit expenses that are only covered by the fund portion of your Aetna HealthFund® and/or Aetna DentalFund® plan and are not covered by your underlying medical or dental plan or any other medical or dental plan.

- See your employer's Summary Plan Description to determine which, if any, expenses are eligible.
- To submit expenses covered by your underlying medical plan and fund, please use the "Medical Benefits Request" form. This is labeled as "Claim-Medical" on Aetna Navigator's Forms Library.
- To submit expenses covered by your underlying dental plan and fund, please use the "Dental Benefits Request" form. This is labeled as "Claim-Dental" on Aetna Navigator's Forms Library.

You may submit a claim at any time during the year, but it is recommended that you accumulate a minimum of $50.00 in eligible expenses prior to submitting for reimbursement.

TO THE EMPLOYEE

1. Complete Sections 1 through 4. Be sure to sign the Employee Certification in Section 5.

2. Please attach the appropriate documentation. Keep in mind, a canceled check is not considered appropriate documentation. See below for details on the appropriate documentation:

   a) When submitting for Long Term Care premium reimbursement, if allowed under your Employer's plan OR when submitting for premium reimbursement for other than Long Term Care, if allowed under your Employer's plan, please submit the following documentation:
   - A statement from your insurance carrier that includes:
     - Member's name and birth date
     - Name and address of insurance carrier
     - Months in which premium expenses were incurred
     - Premium paid per month as well as total amount of paid premium

   b) When submitting for an expense for an Over-the-Counter item, if allowed under your Employer's plan, please submit the appropriate documentation which may include but is not limited to:
   - If submitting for Over the Counter non-medication products only, an itemized receipt from a merchant that shows the name of the product, the date purchased and the amount paid. If the receipt does not show the name of the product, please submit some other proof of purchase such as a box-top or label that shows the name.
   - If submitting for Over-the-Counter medications, in addition to an itemized receipt from the store, a prescription is required with each request for reimbursement. The prescription must include the patient's name and be written, signed and dated by the licensed health care professional. Please see the second page of these instructions for further information regarding Over the Counter expense reimbursements.

   c) If submitting an expense for other items, if allowed under your Employer's plan, either
   - An itemized bill or statement from the provider for expenses are covered by your medical and/or dental plan, which shows:
     - Name and address of provider
     - Date(s) of service and dollar amount charged
     - Patient's name
     - Type of service; or
   - Explanation of Benefits (EOB) detailing expenses that were not covered by your medical and/or dental plan.

3. Retain a copy of this form and accompanying documentation for your files.

4. **Please send the completed form and appropriate documentation to the address on the back of your Aetna HealthFund® and/or Aetna DentalFund® ID card**.

Over-the-Counter (OTC) Medical Expense Reimbursements

The list below is not intended to be all-inclusive, but is rather to answer frequently asked questions regarding OTC expenses.
This list is subject to change per IRS rulings or interpretation changes. OTC medicines indicated in Section II when purchased on or after 1/1/2011 must be prescribed by a physician in order to be reimbursed by an HRA. For more details on the Over the Counter expense list please visit: www.aetnafsa.com.

I. Eligible Medical Expenses for Reimbursement reimbursable without prescription.
Band Aids
Eye Care (contact lens solution, lubricant drops, patches)
Family planning (condoms, contraceptive creams, pregnancy test, ovulation predictor kits, etc.)
Home diagnostic tests or kits (blood pressure, cholesterol, diabetes, colorectal cancer, HIV, urine test, thermometers, etc.)
Incontinence products (Adult pads, Serenity pads, etc.)
Joint-support bandages and hosiery, e.g., knee or elbow supports
Vaporizers and humidifiers

II. Eligible Medical Expenses for Reimbursement when prescribed by a licensed health care professional. *A Prescription is required with each request for reimbursement. The prescription must include the patient's name and be written, signed and dated by the licensed health care professional.*
Acid Controllers
Allergy and Sinus
Antibiotic Products
Anti-Diarrheals
Anti-Gas
Anti-Itch and Insect Bite
Antiparasitic Treatments
Baby Rash Ointments/Creams
Cold Sore Remedies
Cough, Cold and Flu
Digestive Aids
Feminine Anti-Fungal/Anti-Itch
Hemorrhoidal Preps
Laxatives
Motion Sickness
Pain Relief
Respiratory Treatments
Sleep Aids and Sedatives
Smoking Cessation Products
Stomach Remedies

III. Not Reimbursable (merely beneficial to good health)
Cosmetics (makeup, lipstick, cotton swabs, cotton balls, baby oil, etc.)
Denture care (e.g., cleansers)
Hair care (color, shampoo, conditioner, brushes, hair-loss products)
Nail care and personal grooming items (scissors, nail files, etc.)
Personal hygiene products (deodorant, soap, body powder, shaving cream, razors, feminine care, etc.)
Routine dental care (toothpaste, toothbrush, electric toothbrush, floss, mouthwash including antibacterial mouthwash and fluoride rinse, breath strips, teeth-whitening, etc.)
Vitamins and Supplements or other homeopathic medicines (may be eligible with evidence of medical necessity)
Skin care (facial cleanser, skin and body moisturizing lotion, etc.)

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1. Employee Information

Name (Last, First, MI)	Daytime Telephone Number ( )
Address (include ZIP Code) ☐ Check if address is new	Home Telephone Number ( )
Social Security Number	Plan you are submitting for reimbursement from ☐ Aetna HealthFund ☐ Aetna DentalFund

2. Employer Information

Employer Name	Group Number (on ID card)

3. Expense Information – Please fill out for each member with claim activity.

Member #1 Name of Member (Last, First, MI)	Relationship to Employee ☐ Self ☐ Spouse ☐ Child ☐ Other	Birth Date (MM/DD/YYYY)
Social Security Number	Identification Number (on ID card) **W**	

Date(s) of Service (MM/DD/YYYY)
From _____ Thru _____ Total Amount Submitted $ _____

Or, if submitting for Premium Reimbursement for plans where premium reimbursement is allowed:
Request Premium Reimbursement for the following periods of coverage (MM/DD/YYYY)
From _____ Thru _____ Total Amount Submitted $ _____

Over the Counter Product (OTC) Information (where coverage is allowed). A prescription is required with each request for reimbursement for OTC medicines. The prescription must include the patient's name and be written, signed and dated by the license health care professional. Please see the instructions that accompany this form for OTC items which do not require a prescription.

OTC Product Name	Date of Purchase	Amount
		$
		$
		$
	Sales Tax (where applicable)	$
	Total	$

Member #2 Name of Member (Last, First, MI)	Relationship to Employee ☐ Self ☐ Spouse ☐ Child ☐ Other	Birth Date (MM/DD/YYYY)
Social Security Number	Identification Number (on ID card) **W**	

Date(s) of Service (MM/DD/YYYY)
From _____ Thru _____ Total Amount Submitted $ _____

Or, if submitting for Premium Reimbursement for plans where premium reimbursement is allowed:
Request Premium Reimbursement for the following periods of coverage (MM/DD/YYYY)
From _____ Thru _____ Total Amount Submitted $ _____

Over the Counter Product Information (where coverage is allowed). A prescription is required with each request for reimbursement for OTC medicines. The prescription must include the patient's name and be written, signed and dated by the license health care professional. Please see the instructions that accompany this form for OTC items which do not require a prescription.

OTC Product Name	Date of Purchase	Amount
		$
		$
		$
	Sales Tax (where applicable)	$
	Total	$

4. Expenses Reimbursed From Any Other Health Plan

Have you been reimbursed for these expense(s) from any other health plan? ☐ Yes* ☐ No
*If Yes, please attach to this form a copy of your member statement that outlines what the other carrier paid.

5. Employee Certification

I certify that the above information is correct and that all expenses for which reimbursement is claimed from Aetna HealthFund and/or Aetna DentalFund have been incurred by me or by an individual who is enrolled in the plan who qualifies as my spouse or my dependent under IRS guidelines, and that these expenses have not been reimbursed under any other health plan coverage (unless stated otherwise in Section 4), nor shall reimbursement be sought from any other health plan coverage, including a Health Savings Account. I declare that I have not and will not deduct these expenses on my federal, state or local income tax returns.

Employee Signature _____ **Date** _____

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.