City of Chico Flexible Benefit Plan

CBA Contact Information:

Website:
www.cbadministrators.com
(24/7 information via Internet)

E-mail:
customerservice@cbadministrators.com
(For Customer Service questions & Claim Submission)

Phone:
(916) 303-7090 or
(800) 574-5448

Fax:
(916) 303-7083 or
(800) 584-4591

Mail:
P.O. Box 2170, Rocklin, CA 95677

Access to Your Account:

www.cbadministrators.com

If you have previously accessed your account, use your current username and password.

1st Time Users….

Default Username:

- The first two letters of your last name (in CAPITAL LETTERS), plus
- Your 4-digit year of birth, plus
- The last four digits of your social security number
- *Example: If your last name is Smith, you were born in 1962 & your SSN is 123-45-6789, your user name would be SM19626789.*

Default Password:

- **PASSWORD** (in CAPITAL LETTERS)

Things You Should Know

How often are claims processed? Claims are processed daily. Reimbursements are generated each Wednesday and Friday (except holidays). In order for your claim to be included in the reimbursement, it must be **received** by noon Pacific Standard Time on the previous business day (e.g. noon on Tuesday and Thursday). "Received" means that CBA has received all the information required to process your claim. For example, if you file a claim using the online portal, your claim is "received" only after CBA receives your supporting documentation (if required).

We make every effort to reimburse you as quickly as possible. However, sometimes a claim must be denied (returned) because additional information is needed. Whenever we have to deny a claim, we will send you a notification by e-mail or mail. Your notification will include an explanation as to why the claim was denied. In addition, we'll explain what information is needed to approve your expense (if applicable).

What methods of reimbursement are available? CBA pays reimbursements by direct deposit or check (mailed via 1st class U.S. mail). If you have not already signed-up for direct deposit, you may enroll at any time. A direct deposit form is attached. They are also available on our website or from your employer.

How soon can I access my funds? Reimbursements from the Medical FSA are not limited to the amount you have contributed. You may be reimbursed up to your annual election at any time during the plan year provided your expense is otherwise eligible. The Dependent Care FSA works differently. Funds are available only as they are contributed each pay period. Still, you should always request what you PAY for day care. By doing this we will automatically reimburse the difference as you continue to make contributions.

Does my Plan have a Grace Period to incur expenses? No.

When is the deadline for filing claims? Active Participants have until March 31, 2012 days following the end of the plan year to submit claims. If you become ineligible prior to the end of the plan year, you will have 90 days following your loss of eligibility to submit claims for services rendered prior to the date you lost your eligibility. Refer to your SPD for more details.

Where can I find more details about my Plan? Your Summary Plan Description (SPD) is available online & provides the most detailed information about your Plan. There is a lot of other helpful information online.

Claim Filing Tips and Suggestions

1. YOUR CLAIM MUST BE COMPLETE A completed and signed claim form AND adequate "third-party" documentation is required for all submissions.

2. "THIRD-PARTY" DOCUMENTATION EXPLAINED "Third-party" refers to documentation that is provided to you by your service provider (doctor, dentist, insurance carrier or day care provider). Your documentation must also be complete and legible.

For the Medical Expense FSA, documentation must include: 1) complete date of service, including the year; 2) patient name; 3) name or description of the service; 4) name of the service provider; and, 5) total charge or a clear indication of your portion of the charge.

For the Dependent Care FSA, you may obtain your provider's signature on the claim form in-lieu of providing separate documentation.

3. DO NOT ALTER YOUR DOCUMENTATION "Third-party" documentation must stand-alone. Review the documentation at the point-of-service to ensure that all necessary information is included. It is your responsibility to make sure that the provider gives you what you need to receive your pre-tax reimbursement. Please avoid "highlighting" your paperwork. Highlighted areas often become illegible in transmission. BE AWARE: Colored, carbon or thermal-paper receipts may transmit too light to be legible. They may also fade over time. Copies are acceptable and even recommended in these circumstances.

4. KEEP YOUR ORIGINAL DOCUMENTATION Good, clean copies are fine! You should always retain your original documentation. The IRS requires you to retain all tax records for at least three (3) years!

5. DATE OF "SERVICE" IS WHAT WE NEED Reimbursements are based on the date of service. The date you pay for a service is not important. This is why check copies, credit card receipts and cash register receipts are not acceptable (PLEASE NOTE: For qualified OTC expenses, the IRS permits the use of "complete" cash register receipts. Keep in mind however, that this is a special exception that only applies to OTC expenses.)

Although, in some cases, a provider may require pre-payment of services, reimbursement cannot be considered until the service has actually been performed. Documentation that only shows "pre-payment", "payment on account" or "balance forward" is not adequate.

6. E-MAILED CLAIMS You may e-mail your claims to our Customer Service e-mail address as a single file in .pdf format. Claims submitted piece-meal, in multiple files or in different formats may be returned. *Please* send each claim only once (e.g., do not e-mail AND fax the same claim).

7. DON'T PANIC IF AN EXPENSE IS DENIED If we have to deny a claim, we will e-mail or mail you a notice explaining why the expense(s) could not be reimbursed. In many cases, we have to deny expenses simply because documentation is illegible or incomplete. When this occurs, all you need to do is send a NEW CLAIM with complete, clear documentation and your expense will be reconsidered. Remember, your documentation must be clear and complete. If you can't read your documentation, chances are, we can't either.

8. EXPENSES COVERED BY INSURANCE MUST BE PROCESSED BY YOUR CARRIER BEFORE YOU REQUEST REIMBURSEMENT If you have insurance coverage for an expense, your insurer must process the claim before you are permitted to request reimbursement from your FSA. Most insurance carriers issue "Explanation of Benefits" (EOBs) after they process a claim. EOB's are excellent "third-party" documentation to use for your FSA reimbursement request.

9. PRESCRIPTION DRUGS The most common error we see is submitting a cash register receipt as documentation for prescription drugs. Generally, the patient name will not be included on a cash register receipt. Without the patient name, your expense will be denied. Instead, use your pharmacy tag or tax receipt provided with your prescription. If you misplace your tax receipt, most pharmacies can provide you with a printout of all your prescriptions.

10. OVER-THE-COUNTER (OTC) DRUGS, MEDICINES & SUPPLIES Commencing January 1, 2011, you must obtain a prescription to be reimbursed for your OTC drug and medicine purchases. Remember though, there are still thousands of supplies and products available

OTC that do not require a prescription for you to be reimbursed. Review your enrollment packet from CBA for detailed information about OTC drugs, medicines and supplies.

11. NO PERSONAL USE ITEMS Only OTC drugs, medicines & medical supplies are eligible for reimbursement under your Medical FSA. Personal use items, such as soap, toothpaste, toothbrush, cosmetics, cream, shampoo, lotion, etc. are not reimbursable, even if they contain a medicated component (e.g. dandruff shampoo).

12. ORTHODONTIA CLAIMS EXPLAINED Orthodontia is one of the most popular expenses in a Medical FSA, and for good reason. You know exactly how much you owe and exactly when you owe it. However, obtaining complete documentation can be confusing.

Commonly, orthodontia is either paid for in-full at the start of treatment or monthly payments are extended over time. IRS guidance allows for reimbursement in either of these circumstances based on the payment contract you and your provider agree upon. This will determine your allowable reimbursement for the current plan year.

If full payment is made at the start of treatment, you can claim 100% of your cost once treatment begins (treatment is usually considered "started" once bands have been placed or in the case of Invisalign®, when the first trays are delivered).

If you have a monthly payment contract with your provider, we can set-up an automatic reimbursement. Just include a copy of your orthodontia contract with a completed claim form and request the amount you will owe for the entire plan year. You will receive your reimbursement once a month through-out the plan year. If you do not have a contract, your provider can complete an Orthodontia Information Form located online under the "Forms" tab.

13. MASSAGE THERAPY, WEIGHT-LOSS PROGRAMS, & VITAMINS & SUPPLEMENTS REQUIRE MEDICAL NECESSITY Some general health services and items may be used to treat a specific medical condition and, therefore, may be reimbursable through your Medical FSA. However, you are responsible to establish the medical necessity of such an expense (refer to "MEDICAL NECESSITY" below).

Examples include: massage therapy to treat sciatica; weight-loss programs (no food) to treat diabetes; or Vitamin C to treat scurvy.

14. PRESCRIPTION DRUGS OBTAINED OUTSIDE THE U.S. ARE NOT REIMBURSABLE Only medications and remedies that are legally procured in the United States are eligible for reimbursement. Currently, the Federal government deems drugs that are mail-ordered from a source outside the United States to be obtained illegally. We will deny claims for drugs purchased from a source outside the U.S. The only exception is if you refill an existing prescription while you are visiting another country.

15. MEDICAL NECESSITY In order to establish "medical necessity" for a product or service that would normally be considered a personal use expense, you must submit a "prescription" (statement) from your treating physician on your physicians letterhead that: 1) identifies the medical condition being treated; 2) recommends the specific course of treatment (e.g., massage therapy, weight-loss, etc.); and, 3) states the duration of the treatment (e.g. "12 sessions", "3 months", "lifetime"). In addition, for expenses such as classes, massages, and memberships, the expense may not commence until you obtain your "prescription". In other words, you can only be reimbursed for this type of expense if you incur this type of expense solely to treat your medical condition.

For example, lets say you get a weekly massage. Then one day you injure you lower back. Even though your doctor may recommend you continue with your weekly massage, you MAY NOT be reimbursed for this expense. Why? Because you did not "incur" the expense solely to treat your medical condition. Rather the medical benefits were simply a by-product of a non-medical expense that you choose to incur regardless of a medical condition.

16. MEDICAL EXPENSES OBTAINED OUTSIDE THE U.S. REQUIRE SPECIAL CONSIDERATION You may find it necessary to obtain medical care while outside the U.S. Expenses you incur abroad may be considered for reimbursement under the following circumstances: 1) The service must be considered "legal" in the U.S.; 2) The documentation must be in English or translated to English by the "third-party" provider of service; 3) The cost for the service must be expressed in US dollars on the date the service is rendered. If the provider cannot bill you in US dollars, you will need to have the cost of the expense(s) converted into US dollars by a banking institution on the date the expense was incurred; 4) All other documentation requirements must also be met (refer to Tip #2).

17. CLAIMING EXPENSES FOR YOUR DEPENDENTS Under Federal law, only expenses for you, your spouse or your IRS tax dependents are eligible for reimbursement. You may NOT be reimbursed for expenses incurred by a **domestic partner** unless your domestic partner qualifies as your federal tax dependent. Contact your tax professional for assistance in determining eligibility of your dependent(s).

18. DAY CARE EXPENSES MAY ONLY BE REIMBURSED IF YOU ARE THE "CUSTODIAL" PARENT You must be the "custodial" parent to qualify for pre-tax reimbursement of day care expenses. If your situation changes during the plan year, contact your tax professional for assistance in determining if you remain the "custodial" parent.

19. FOR DAY CARES EXPENSES, ALWAYS REQUEST THE AMOUNT YOU PAY, REGARDLESS OF THE AMOUNT IN YOUR PRE-TAX ACCOUNT We encourage participants to submit claims for their entire day care expense regardless of your payroll deduction. If the amount of a claim exceeds the amount in your account, the excess portion will be automatically reimbursed to you as you continue to make payroll contributions.

FILING CLAIMS

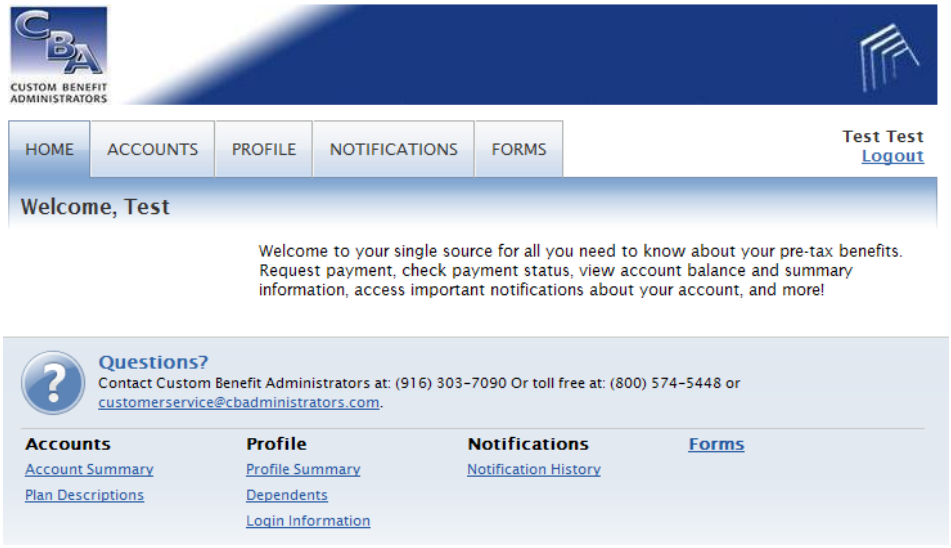
Now that you have enrolled in one or more of your employer's flexible spending accounts, you may begin to file claims against your account(s) upon the start date of the Plan Year (or the date you enrolled, if later).

You may access your plan dollars by the following methods:

1. **Online Claim Filing**: File your claims online via our participant portal website. Login to your account at www.cbadministrators.com. Your user name and password is shown on the first page of this document.
   - Click on **FILE CLAIMS**.
   - Select **File Claim** next to the appropriate account.
   - You must mark "YES" that you have a valid receipt to continue online filing.
   - Note: Under "Type of Product/Service", if more than one Product/Service seems right, select the one that best fits the expense.
   - Make sure to click **Submit** on the bottom of the screen.
   - If you have more than one expense/claim, choose **Add New Claim**. Repeat as needed.
   - Once all claims are entered, check the box to agree to the Terms & Conditions and click **Submit**.
   - **Final Step -** Click **Print Confirmation** and send the confirmation to CBA with your documentation via e-mail, fax or mail. This confirmation page serves as your claim form and verifies that all claims have been successfully submitted. Your claim is considered "received" by CBA only after CBA receives your supporting documentation.
   - **NEVER SUBMIT A PAPER CLAIM FORM FILING FOR A CLAIM YOU HAVE ALREADY FILED ONLINE.**

2. **Paper Claim Form Filing**: You may opt to file claims using a paper claim form available on the website under the "Forms" tab.
   - Complete the claim form in full including your "certification" (signature).
   - Do not highlight, alter or write on your documentation.
   - Consider photocopying colored, carbon or thermal-paper receipts, as they may transmit too light to be legible. They may also fade over time, so photocopying may help to preserve the long-term integrity of the document.
   - Retain a complete copy for your records (IRS recommendation is three years).
   - Submit via e-mail, fax or mail along with your required documentation.
   - **NEVER SUBMIT A PAPER CLAIM FORM FILING FOR A CLAIM YOU HAVE ALREADY FILED ONLINE.**

YOUR PERSONAL HOME PAGE



Accounts: You can view up-to-date account information at any time.

- Choose **Account** Summary to check the balances of any account. You can also check the claims history of any account by clicking the History link.

- Select Profile to review and update your personal and dependent information that's on file in the system.
- Select Payment History to see a detail of the claims that have been paid. You can click **View Detail** for more information about any claim.

Plan Descriptions: Your Pre-tax plan information is available at any time. To view this information, log on and click on the **Accounts** tab.

Forms: There are many forms available on the website, including your Notice of Privacy Practices and Summary Plan Description (SPD). Log on and click on the **Forms** tab, and select the form you would like to download.

The forms are in .pdf format, requiring Adobe Acrobat Reader. You may download a free version of acrobat reader from the Adobe website: http://www.adobe.com/products/acrobat/readermain.html.

EMPLOYEE NOTICE
HIPAA PRIVACY RIGHTS & PRACTICES

FOR THE

CITY OF CHICO Health Flexible Spending Account (FSA)

The City of Chico FSA ("Plan") has the duty to protect your medical information. The Plan further has the duty to provide you with a notice of its privacy practices, which follows. The Plan has the right to change or modify this notice, at any time, and any modifications will be communicated to you. This notice describes how your medical information may be used and disclosed, and how you can get access to it. Please review it carefully.

The Health Insurance Portability and Accountability Act limits how a covered entity can use and disclose protected health information (PHI). Generally, a covered entity, including your health plan, your health care provider, or, a health care clearinghouse, can share information without your authorization, for purposes of treatment of you, payment for your medical services, and for the health plan's operation. In all other instances, you must authorize any disclosure of your health information.

Permitted Disclosures
The Plan can use and disclose your PHI for the following purposes, without your authorization, for making or obtaining payment for your health care, and for conducting health plan operations.

Examples of when and how your PHI can be used and disclosed for payment purposes, without your authorization, are:

- For coordination of benefits among multiple plans that cover you
- For utilization review purposes
- For case management purposes
- For precertification purposes
- Any other purpose necessary to ensure coverage for you, and to obtain or make payment for services rendered to you.

Examples of when and how your PHI can be used and disclosed for health plan operations, without your authorization, are:

- To ensure coverage for you
- For quality assessment purposes
- For cost containment purposes
- To ensure compliance with the terms of the Plan, or with clinical or other relevant medical guidelines and protocols
- To provide you with treatment alternatives
- For health plan and provider accreditation verification, licensure, or any other credentialing purposes
- For underwriting, premium rating, and related functions
- To create, renew, or replace your health insurance or health benefits
- To conduct audits, including compliance, medical, legal, business planning, cost containment, or customer service audit functions.

The Plan can share your PHI with the plan sponsor for certain administrative activities, without your authorization. Examples of sharing PHI include, but are not limited to:

- Seeking premium bids for current or future coverage
- Obtaining reinsurance
- Amending, modifying, or terminating the plan
- Participant and enrollment information

Your PHI can be released in summary form, or, as a part of "de-identified" information, in accordance with the Code of Federal Regulations. Other instances, in which your PHI may be released, without your authorization, include:

- When legally required by federal, state, or local law. This instance would include the release of PHI upon the receipt of an order, subpoena, or other judicial or administrative process that would compel the disclosure of your PHI. However, your PHI would only be disclosed after a reasonable effort has been made to notify you of the request for such information.
- For law enforcement purposes, such as investigation of a crime.
- To respond to a threat to public health or safety.
- For workers compensation purposes, or other no fault law.
- To a government authority, such as a social service or other protected services organization, authorized to receive reports of abuse, neglect, or domestic violence.

Authorization for Use and Disclosure

Except as provided above, the Plan will not release any of your PHI without your authorization. If you authorize the release of some, or all of your PHI, you may revoke the authorization at any time. If you authorize release of your PHI, your authorization must include the following items:

1. A description of information used or disclosed
2. Identification of the parties releasing, and the parties requesting the information.
3. An expiration date of the authorization
4. Your signature
5. Information about how to revoke the authorization

Your Individual Rights

You have certain individual rights regarding your PHI; specifically:

1. If the Plan maintains your PHI, you have the right to inspect and request a copy it. The plan may charge a reasonable fee for copying this information. If the Plan does not maintain the PHI, which is the subject of your request, you will be directed to the appropriate party who can assist you with your inquiry.
2. You have the right to restrict the use and disclosure of your PHI, although the Plan is not required to agree with your request.
3. You have the right to receive confidential communications. You have the right to limit or restrict where, or how, the Plan may contact you regarding your PHI.
4. You have the right to request amendments or modifications to your PHI. If you believe your PHI is inaccurate or incomplete, you have the right to request an amendment to your records. In order to be entitled to amend the records, the Plan must maintain the relevant records, and you must make the request for amendment in writing. The Plan has the right to deny your request to amend or modify your PHI if:
   - You do not have a substantive reason for the request
   - The relevant records were not created by the Plan
   - The request falls within an exception to the amendment rights provided by the law
   - It is determined that the information is complete or accurate
5. You have the right to obtain an accounting of any disclosure that has been made of your PHI, other than those disclosures made for health care payment, treatment, or other health care plan operations. To exercise this right, or if you would like to pursue any of your individual rights regarding your PHI, contact:

   Privacy Officer
   City of Chico
   411 Main Street
   Chico, CA 95927
   Phone: 530.879.7900 / Fax: 530.895.7906

You have the right to contact U.S. Department of Health and Human Services' Office for Civil Rights (OCR) if you have any complaints about how the Plan has handled your PHI. You can submit your complaint on-line, or download a complaint form at this OCR website (http://cms.hhs.gov/hipaa). Or, you can send your complaint or question to this e-mail address: askhipaa@cms.hhs.gov. Or, you can call the CMS HIPAA Hotline: 1-866-282-0659.

Reset/Clear Form

DIRECT DEPOSIT ENROLLMENT FORM

Authorization to Receive Reimbursements by Direct Deposit (ACH Credit)

Check one: Initial enrollment ☐ Change existing enrollment ☐

Company Name (your Employer)

Employee Name **Employee SSN**

Verify your mailing address (complete with street, city, state and zip) **Email Address**

Checking ☐ Savings ☐

Name of DEPOSITORY (Name of Financial Institution)

Branch Address **City / State / Zip**

YOUR 9-DIGIT BANK ROUTING NUMBER	YOUR ACCOUNT NUMBER

I (we) hereby authorize Custom Benefit Administrators (CBA) to initiate credit entries to the checking or savings account designated above at the financial institution named above, hereinafter referred to as DEPOSITORY, and to credit the same to such account. This authority will remain in full force and effect until CBA has received ***written*** notification from me of its termination in such time and in such manner as to afford CBA and DEPOSITORY a reasonable opportunity to act on it.

Signature **Date**

Attach "VOID" check here

Deposit slips are not acceptable

Send completed form to: **Custom Benefit Administrators (CBA)**
FAX (916) 303-7083 or P.O. Box 2170, Rocklin, CA 95677

Questions? (916) 303-7090 or (800) 574-5448 or
customerservice@cbadministrators.com

CBA Use ONLY

Entered into BOW	Pre-Note Hold – Release Date	Entered into LH1 & Activated

Direct Deposit

Enrollment Form & Instructions

- ⇨ Direct deposit is a convenient way to receive disbursements from your Flexible Spending Account(s).
- ⇨ Direct deposit reimbursements are processed on the same schedule as check reimbursements. The direct deposit will initiate on "check" day and normally post to your account on the following business day.
- ⇨ When you sign up for direct deposit, you will be notified each time we pay a reimbursement (to receive notifications, we must have your email address on file).
- ⇨ Complete and return this form to enroll for direct deposit.
- ⇨ Return the completed form to CBA or your employer (if permitted).
- ⇨ While not required, we strongly recommend that you attach a "void" check to ensure the accuracy of your account information.
- ⇨ Direct deposit takes approximately three weeks to set-up. During this set-up period, any claims that you submit will be paid by check and mailed to your address on record.
- ⇨ You must complete a new Direct Deposit Enrollment Form each time you change your bank account.
- ⇨ Once you sign up for direct deposit, it will remain in force until you cancel it in writing (or e-mail). Please allow two weeks to process your cancellation.
- ⇨ You may send your direct deposit enrollment directly to CBA using any of the following methods:

FAX - Local - (916) 303-7083 / Toll-free - (800) 584-4591

MAIL - Mail your form to: CBA, P.O. Box 2170, Rocklin, CA 95677

E-MAIL - E-mail your form to: customerservice@cbadministrators.com

Reset/Clear Form

Flexible Spending Account (FSA) Reimbursement Claim Form

Custom Benefit Administrators

Employer: _____

FAX TO: (916) 303-7083 or (800) 584-4591
EMAIL TO: customerservice@cbadministrators.com

Employee Name: _____ Social Security Number: _____

Phone: _____ E-mail: _____

Dependent Care Expense Claims

Name & Date of Birth of Dependent(s)	Period Covered From	To	Name, Address, and Taxpayer Identification Number (or SSN) of Service Provider	Amount Incurred
➔ *Attach a receipt from your daycare provider, or include the daycare provider's signature.*			**Provider's Signature:**	
			Total Dependent Care Expense Claim*	**$**

*NOTE: The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the Plan Year or the earned income of your spouse. (If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earnings of $250 if there is one (1) child or dependent, or $500 if there are two (2) or more.) No payment may be made under the Plan if the service provider is your dependent for federal income tax purposes; or is your child or stepchild and is under age 19.

Medical Expense Claims

Date Expense Incurred (mm/dd/yy)	Name of Service Provider	Expense Description (Medical, Dental, Vision, Rx, OTC, etc.)	Person for Whom Expense was Incurred	Net Amount
➔ *Attach appropriate receipt(s) and submit with this claim form.*			**Total Medical Care Expense Claim**	**$**

REQUIRED DOCUMENTATION: All claims must include "complete" – "third-party" documentation. "Complete" documentation must include the: (1) patient's name; (2) service provider's name; (3) full date of service (including year); (4) description of service; (5) charge or patient portion for the service. If you have insurance, your carrier must process your claim prior to being reimbursed from your FSA. An Explanation of Benefits (EOB) from your insurance carrier is considered "complete" documentation. "Third-party" means provided to you by your service provider (e.g. doctor, pharmacy, day care, etc.) or insurance carrier.

CERTIFICATION: The undersigned participant in the Plan certifies that all services for which reimbursement is claimed by submission of this form were provided during a period while the undersigned was covered under the Plan with respect to such expenses and that the expenses have not been reimbursed and employee will not seek reimbursement from any other plan covering health benefits or from any other source. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim, which is provided by the undersigned, and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes, including federal and state income tax, on amounts paid from the Plan which relate to such expense.

***DO NOT USE THIS FORM IF YOU HAVE FILED YOUR CLAIM ONLINE (or used your CBA Debit Card)**

_____ _____

Employee's Signature Date

Flexible Spending Account (FSA)

Claim Form & Filing Instructions

When filing your claim, you must include copies of complete "third-party" documentation.

Your documentation must include:

(1) the service date (including the year);
(2) the name of the service provider;
(3) the patient's name;
(4) a description of the service provided; and,
(5) your total financial obligation for the service provided.

A statement from your service provider or an Explanation of Benefits (EOB) from your insurance carrier will usually include all of the required information.

The following documentation/receipts are NOT acceptable for reimbursement:

- Canceled Checks are never acceptable or needed. Please do not send them.
- Cash Register receipts for anything **other than over-the-counter** drugs and medicine UNLESS the patient name is indicated on the receipt.
- Credit Card receipts that do not contain the above (5) requirements.

NOTE: If your claim is returned because your documentation is incomplete or illegible, simply submit a new claim with complete and legible documentation.

You may send your claims to CBA using any of the following methods:

E-MAIL - E-mail claims to: **customerservice@cbadministrators.com**

You must send us a scanned copy of your signed claim form and documentation as a single file to the e-mail address above in "PDF" format exclusively. No other format can be accepted. Claims that do not meet these requirements may be returned or delayed. Please be aware that e-mailing information over the Internet may not be secure.

FAX - Local - **(916) 303-7083** / Long Distance - **(800) 584-4591**

Please refrain from calling us immediately to confirm receipt of your fax. Faxed claims are not instantly available to our customer service representatives. In most cases, you will be able to view the status of your claims online within 2-business days at www.cbadministrators.com.

MAIL - Mail to: **CBA Claims Processing, P.O. Box 2170, Rocklin, CA 95677**

Please DO NOT mail your claims "signature required" or it could delay your reimbursement up to a week or even more. We cannot be held responsible for mail that is lost or misrouted by the postal service. Mail received "postage due" will be returned.

If you register claims using the online portal, your claims are considered "received" only after CBA receives your supporting documentation.

Regardless of how you choose to send a claim, please send each claim ONCE ONLY. For example, please do not mail a claim that you have already faxed.

Keep a copy of your entire claim for your records.

You may make copies of this claim form for future use.
