FSA Enrollment Kit

WELCOME

Welcome! Your employer has chosen Nova Healthcare Administrators, Inc., an Independent Health company, to administer your reimbursement account(s). Here at Nova, we love what we do, and we strive to create an exceptional experience for members. That's why we put together this enrollment packet. It contains essential information regarding your reimbursement account(s) and will help make sure you get the most out of your health care dollars.

Questions about your benefits?
Our Customer Service department is available Monday through Friday from 8 a.m. to 8 p.m., EST.
Call us toll-free at 1-877-268-3799.

Enclosed you will find:

- **Product Overview(s) and Support Materials** – A look at how your reimbursement account(s) work, including annual limits, approved expenses, Frequently Asked Questions (FAQs) and additional plan-specific information designed to make using your account(s) as easy as possible.
- **Reimbursement Account Information Center** – Information on our one-stop-shop for a variety of tools and information designed to simplify your reimbursement account experience. Check account balances, view statements, access reports, submit claims, download forms, and more.
- **NovaFlex App Overview** – Learn how to conveniently manage your health care account, including checking balances, making payments, scanning expenses and more, all from your phone.
- **Forms** – In addition to your reimbursement account enrollment form, we've included a collection of forms that will allow you to make the most of your account(s).

Completing your enrollment

Please read the information in this kit carefully. Whether you're enrolling using our standard member enrollment form or utilizing another enrollment platform, please make sure you fill out all necessary fields. It's important to note that even if you choose to decline coverage at this time, we still ask that you go through the enrollment process.

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Health Care Flexible Spending Account

Want a convenient way to manage your out-of-pocket health care expenses? Enroll in a **Flexible Spending Account (FSA)**.

FSAs are IRS-regulated accounts offered through your employer. You set aside pre-tax dollars to cover qualified medical expenses, while decreasing your taxable income and possibly increasing your take home pay.

The amount of money you save in taxes depends, in part, on the elections you make. You should carefully estimate the total amount you elect to set aside in your account.

If you overestimate the amount you think you will spend on a certain reimbursement benefit in a given year, you cannot keep the unused money as cash. You are also unable to use unspent money for any expense other than the type of expense designated for it.

Once enrolled, you may not change your annual election amount. According to IRS regulations, you may only change your elections at the beginning of each plan year unless you experience a change in your family status. A change of family status may include marriage, divorce, birth, adoption, death or a loss of spouse's employment. Changes in the contribution amount must be consistent with the change in your family status.

For example, if you gain a dependent, you increase your contribution; if you lose a dependent, you decrease your contribution. Contact your Human Resources department if you experience a change in status.

Through our partnership with FSA Store, you have access to a variety of planning tools, including a calculator that can help you determine the right contribution amount. Visit **FSA Store Learning Center** to get started.

With Nova you have access to your account information 24/7 at **https://myflexspend.com**, so you can check your account balance and claims information.

FSA OPTIONS

You can set aside pre-tax dollars to pay for eligible out-of-pocket medical, dental and vision expenses not covered under your health plan. FSA annual elections are available on the first day of the plan year.

CONTRIBUTION LIMITS

Your employer sets the annual minimum and maximum contribution amount (not to exceed the IRS maximum of $3,050 per plan year). For help estimating the right amount to set aside, visit **FSA Store Learning Center**.

ELIGIBLE EXPENSES

Medical expenses are the costs of diagnosis, cure, mitigation, treatment, or prevention of disease, and the costs for treatments affecting any part or function of the body. These expenses include payments for legal medical services rendered by physicians, surgeons, dentists, and other medical practitioners. They include the costs of equipment, supplies, and diagnostic devices needed for these purposes. Medical care expenses must be primarily to alleviate or prevent a physical or mental defect or illness. They don't include expenses that are merely beneficial to general health, such as vitamins or a vacation.

Qualified medical expenses are defined by the IRS and do not include long-term care expenses and insurance premiums. You can view a listing of eligible expenses at **novahealthcare.com/member/fsa-and-hsa-eligibility-list** or refer to **IRS Publication 502** for a comprehensive overview of includible expenses.

UNIQUE TO YOUR PLAN

The following items will be unique to your employer. Please confirm the following with your Human Resources department or call Nova's Customer Service department at **1-877-268-3799.**

- The Nova Innovations Prepaid Visa® may be available.
- You may enroll regardless of your health insurance benefit selections.
- This plan is only available as long as you are employed with your current employer.
- Plan dollars may need to be used within your plan year, grace period or may roll over. This varies by plan.

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Healthcare Claim Form

How to file a claim

File a Claim

- Return completed Healthcare Claim Form with documentation
  Mail: Nova Healthcare Administrators, PO Box 1534, Buffalo, NY 14231
  If you elect to mail your information it is advised that you keep a copy for your records.
  Please do not staple receipts to your claim form.
  Fax: (716) 774-8092
  Online: myflexspend.com

- Please pick only one delivery method - do not fax and mail.

- Claims must be received by Nova five full business days prior to your scheduled reimbursement date.

Complete the Healthcare Claim Form

Complete **ALL** employee information. Using approved documentation please complete patient name, provider name, date(s) of service, type of service and amount of claim.

Eligible FSA Expenses

An FSA can help offset out-of-pocket expenses on healthcare products and services for you and your dependents. This encompasses a large variety of eligible items including some dental expenses, as defined in Section 213(d) of the IRS tax code. You can view a listing of eligible expenses in IRS Publication 502. We advise that you keep a copy of all receipts submitted for reimbursement. Generally, credit card statements and cancelled checks will not provide enough detail to serve as qualified documentation for reimbursement.

Eligible HRA Expenses

Eligible HRA expenses include those that are primarily for diagnosis, cure, mitigation or prevention of disease as outlined in IRS Publication 502. Expenses must be for a qualifying account holder or dependent, fall within the HRA plan year, and must not have otherwise been reimbursed. For questions on specific expenses which may or may not be reimbursable, please refer to your benefit plan documents.

Qualified Documentation

- Itemized receipts include all of the necessary information required for reimbursement (provider name and address, patient name, itemized charges, date(s) of service, and type of service, as well as member and insurance liability amounts, when applicable.)

- An Explanation of Benefits (EOB) is the preferred form of documentation to submit for reimbursement, especially if a portion of your expense is covered by medical, dental or vision coverage.

- You may submit a maximum of 4 expenses on a single claim form.

Healthcare Claim Form

Please clearly **PRINT** all information

File a Claim by Mail:
Nova Healthcare Administrators
PO Box 1534
Buffalo, NY 14231
Fax: (716) 774-8092
Online: myflexspend.com

Your Information

Name: ______________________________ Employer Name: ______________________________

Address: ______________________________ Phone: ______________________________

City, State: ______________________________ Zip Code: ______________________________

Last 4 digits of your Social Security Number: __________ ☐ Please check here if this is a new address

Please indicate if you have the following types of coverage*: Medical coverage? ☐ Yes ☐ No
Dental coverage? ☐ Yes ☐ No Vision coverage? ☐ Yes ☐ No
*To prevent claim denial, please be sure to provide an explanation of benefits (EOB) or itemized receipt.

Healthcare Expenses

Patient Name	Provider Name (Doctor/Dentist/Pharmacy)	Dates of Service (MMDDYY – MMDDYY)	Total Charges
Type of Service (check one)	☐Chiropractic ☐Co-Pay ☐Dental ☐Ortho ☐Prescription ☐Psych/Therapist ☐Vision ☐Other: ________		

Patient Name	Provider Name (Doctor/Dentist/Pharmacy)	Dates of Service (MMDDYY – MMDDYY)	Total Charges
Type of Service (check one)	☐Chiropractic ☐Co-Pay ☐Dental ☐Ortho ☐Prescription ☐Psych/Therapist ☐Vision ☐Other: ________		

Patient Name	Provider Name (Doctor/Dentist/Pharmacy)	Dates of Service (MMDDYY – MMDDYY)	Total Charges
Type of Service (check one)	☐Chiropractic ☐Co-Pay ☐Dental ☐Ortho ☐Prescription ☐Psych/Therapist ☐Vision ☐Other: ________		

Patient Name	Provider Name (Doctor/Dentist/Pharmacy)	Dates of Service (MMDDYY – MMDDYY)	Total Charges
Type of Service (check one)	☐Chiropractic ☐Co-Pay ☐Dental ☐Ortho ☐Prescription ☐Psych/Therapist ☐Vision ☐Other: ________		

Total Request	

Certification

I certify that the expenses for which I am requesting reimbursement were incurred for service or supplies by my eligible dependents or me under the plan. These services were furnished on or after the effective date of my employee spending account. I understand the reimbursement of these expenses should be requested and made only after I have collected all benefit payments available from all plans under which my eligible dependents and I are covered. I further certify that I have not deducted or will not deduct on my individual income tax return any of the expenses reimbursed through my Healthcare Account. I understand reimbursement will be made in accordance with the guidelines set by the Internal Revenue Service and the provisions of the plan. I accept all responsibility for the proper treatment of benefits under this plan with respect to eligibility, income tax reporting and liability.

Employee Signature (required): ______________________________ Date: ____________________

Dependent Care Flexible Spending Account

A Dependent Care FSA is a cafeteria plan governed by Sections 125 and 129 of the Internal Revenue Code. Establishing a Dependent Care FSA is a convenient way to manage out-of-pocket qualified dependent care expenses. Contributions are made as a reduction in your gross salary, pre-tax, and are not considered wages for federal income tax purposes.

The amount of money you save in taxes depends, in part, on the elections you make. You should carefully estimate the total amount you elect to set aside in your account. Employees can only be reimbursed for allowable, documented expenses incurred during the plan year.

Check with your tax advisor to determine whether you should select a Dependent Care FSA, use the federal and state Child and Dependent Care tax credits or a combination of both to maximize your savings.

Reimbursement forms are available through your secure web portal or under *Reimbursement Account Resources* at novahealthcare.com/knowledge-center/member-resources. To substantiate reimbursements, the IRS requires receipts include information identifying dates of service, dependent name, type of service, amount paid, provider name and address, and Social Security Number or Tax ID. Credit card receipts and canceled checks do not include enough information to serve as substantiation for reimbursement. Please keep or request a detailed receipt from your provider when seeking reimbursement.

Claims will be reimbursed for the amount of your claim up to the total amount in your account at the time the claim is submitted. If the claim cannot be reimbursed in full, you will receive payments as money accumulates in your account. There is no need to resubmit your claim.

With Nova you have access to your account information 24/7 at https://myflexspend.com, so you can check your account balance and claims information.

FSA OPTIONS

You allocate pre-tax dollars to pay for dependent care expenses incurred to allow you and your spouse to work, look for work, or attend school full-time (at least five months a year).

CONTRIBUTION LIMITS

The maximum contribution is $2,500 if you are filing single, or $5,000 if you are married and file a joint tax return. Dependent care funds reimburse only up to the amount of funds available in your account.

ELIGIBLE EXPENSES

Care may be provided by a relative or non-relative but cannot be provided by your child under the age of 19, the child's parent or another tax dependent. Your care provider must conform to state and local laws (including being licensed if required) and is able to provide you with a Social Security or Tax ID number. This information is required for reimbursement. Eligible expenses include:

- Au Pair
- Before- and After-School Care
- Senior Day Care
- Nanny
- Summer Day Camp
- Pre-K or Nursery School

UNIQUE TO YOUR PLAN

The following items will be unique to your employer. Please confirm the following with your Human Resources department or call Nova's Customer Service department at 1-877-268-3799.

- The Nova Innovations Prepaid Visa® may be available.
- You may enroll regardless of your health insurance benefit selections.
- This plan is only available as long as you are employed with your current employer.
- Plan dollars may need to be used within your plan year, grace period or may roll over. This varies by plan.

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Dependent Care Claim Form

How to file a claim

File a Claim

- Return completed Dependent Care Claim Form with documentation
  Mail: Nova Healthcare Administrators, PO Box 1534, Buffalo, NY 14231
  If you elect to mail your information it is advised that you keep a copy for your records.
  Please do not staple receipts to your claim form.
  Fax: (716) 774-8092
  Online: myflexspend.com
- Please pick only one delivery method - do not fax and mail.
- Claims must be received by Nova five full business days prior to your scheduled reimbursement date.

Complete the Dependent Care Claim Form

Complete **ALL** employee information. Using approved documentation please complete provider name, dependent name, dates of service, type of service and amount of claim. A provider signature is **not required** however it can be added in lieu of a receipt as proof of service.

Eligible Expenses

Eligible dependent care expenses are those expenses you must pay for the care of a dependent so that you (and your spouse) can work. The care may be provided in your home or at a licensed center outside of your home. If the care is in your home, services cannot be provided by another child of yours under the age of 19, your spouse, or other dependents.

Qualified Documentation

- Itemized receipts include all of the necessary information required for reimbursement (provider name, provider contact information, dependent name, service dates (begin and end), a description of services and amount paid).
- If your dependent care provider does not provide authorized receipts you must ask the provider to sign the reimbursement form. Dependent care claims cannot be reimbursed without proper documentation or provider certification.
- You may submit a maximum of 4 expenses on a single claim form.

Why is Documentation Important

- The IRS has provided strict requirements stating that expenses reimbursed through a FSA must be substantiated using itemized receipt or provider certification. All supporting documentation must include provider name, provider contact information, dependent name, service dates (begin and end), a description of services and amount paid.
- Per IRS regulations, dependent care claims submitted without required proof of expense cannot be approved for reimbursement. Please note that claims submitted for future dates of service may be denied and will need to be resubmitted after the end date of services provided.
- Additionally, claims not authorized for reimbursement through a dependent care account by the IRS will also be denied.

Ineligible Expenses

Only dependent care expenses that enable you and your spouse to work are eligible. Dependent care expenses not eligible for reimbursement under current IRS regulations include: educational costs, weekends/evening-out babysitting, transportation, books, clothing, food, activities, and entertainment if these expenses are shown separately on your bill.

Dependent Care Claim Form

Please clearly PRINT all information

File a Claim by Mail:
Nova Healthcare Administrators
PO Box 1534
Buffalo, NY 14231
Fax: (716) 774-8092
Online: myflexspend.com

Your Information

Name: ______________________ Employer Name: ______________________

Address: ______________________ Phone: ______________________

City, State: ______________________ Zip Code: ______________________

Last 4 digits of your Social Security Number: __________ ☐ Please check here if this is a new address

Dependent Care Expenses

Dependent Name	Provider Name	Type of Service (fill in circle)	Total Charges
		○ Child Care ○ Summer Day Camp ○ Before/After School ○ Au Pair ○ Senior Day Care ○ Preschool	
Dates of Service (MMDDYY – MMDDYY)	Provider Tax ID or SSN	Signature of provider in lieu of itemized receipt:	

Dependent Name	Provider Name	Type of Service (fill in circle)	Total Charges
		○ Child Care ○ Summer Day Camp ○ Before/After School ○ Au Pair ○ Senior Day Care ○ Preschool	
Dates of Service (MMDDYY – MMDDYY)	Provider Tax ID or SSN	Signature of provider in lieu of itemized receipt:	

Dependent Name	Provider Name	Type of Service (fill in circle)	Total Charges
		○ Child Care ○ Summer Day Camp ○ Before/After School ○ Au Pair ○ Senior Day Care ○ Preschool	
Dates of Service (MMDDYY – MMDDYY)	Provider Tax ID or SSN	Signature of provider in lieu of itemized receipt:	

Dependent Name	Provider Name	Type of Service (fill in circle)	Total Charges
		○ Child Care ○ Summer Day Camp ○ Before/After School ○ Au Pair ○ Senior Day Care ○ Preschool	
Dates of Service (MMDDYY – MMDDYY)	Provider Tax ID or SSN	Signature of provider in lieu of itemized receipt:	

Total Request	

Certification

I certify that the expenses for which I am requesting reimbursement were incurred for service or supplies by my eligible dependents or me under the plan. These services were furnished on or after the effective date of my employee spending account. I understand the reimbursement of these expenses should be requested and made only after I have collected all benefit payments available from all plans under which my eligible dependents and I are covered. I further certify that I have not deducted or will not deduct on my individual income tax return any of the expenses reimbursed through my Dependent Care Account. I understand reimbursement will be made in accordance with the guidelines set by the Internal Revenue Service and the provisions of the plan. I accept all responsibility for the proper treatment of benefits under this plan with respect to eligibility, income tax reporting and liability.

Employee Signature (required): ______________________ Date: ______________

How is my plan regulated?

FSA plans are sanctioned and regulated by the IRS. Nova follows all procedures in accordance with IRS regulations, including determining qualified expenses.

Do health insurance premiums paid by me or my spouse qualify as an eligible expense?

Premium payments are only eligible for reimbursement if your employer offers an Individual Premium Plan.

Do I have to enroll in my employer's medical or dental plan in order to enroll in this plan?

Although enrollment in other group plans is typically not required in order to participate in an FSA, there may be other participation rules set forth by your employer.

Does enrollment in an FSA affect any other benefits?

Typically, no. Other employer-sponsored benefit plans, such as life insurance or disability income, are based on your gross salary prior to any salary reduction. However, you are saving on Social Security taxes, so your Social Security benefits may be minimally impacted.

When can I enroll in the plan?

You can only enroll in the plan during your employer's annual open enrollment or when you become newly eligible due to a qualifying event during the plan year. Your employer will notify you each year when it is time to re-enroll.

What if I terminate employment, can I still file claims?

Yes. You can file claims for qualified expenses on services received prior to the date of your termination through the run-out period of the plan or as allowed by your employer. Check with your HR/Benefits department.

What is a grace period?

Please check with your employer to determine whether a grace period is offered through your plan. A grace period is when the plan sponsor provides a period of up to 2 1/2 months after the end of the plan year so any qualified medical expenses incurred in that period can be paid from any funds left in the account at the end of the previous year. Your employer is not permitted to refund any part of the balance to you.

What is a run-out period?

A run-out period is a pre-determined timeframe after the plan year ends when you may file claims for expenses incurred during the previous plan year.

How do I file for reimbursement?

Claims can be submitted through your online web portal at https://myflexspend.com. If you wish to submit a paper claim, forms are available online through the web portal or novahealthcare.com/knowledge-center/member-resources. Forms can be returned with qualified documentation (an original invoice or Explanation of Benefits) by mail or fax.

Mail: Nova Healthcare Administrators
P. O. Box 1534
Buffalo, NY 14231

Fax: 716-774-8092

Online: https://myflexspend.com or using the NovaFlex App

Is direct deposit for claim reimbursement available?

Please check with your employer to determine whether direct deposit is offered through your plan. If so, participants can elect to have reimbursements deposited directly into their savings or checking account. Participants must complete a direct deposit authorization agreement and submit it to Nova.

Forms are available online at https://myflexspend.com or can be requested through Nova's Customer Service department at 1-877-268-3799.

How will I know the status of my account?

Each reimbursement check you receive will include an account summary. You will receive an annual statement on your account. You can also access your account information and other valuable information any time by logging in to Nova's secure web portal at https://myflexspend.com.

Who should I call with additional questions?

Contact your HR/Benefits department or Nova's Customer Service department at 1-877-268-3799, Monday through Friday between 8 a.m. and 8 p.m. ET.

Are over-the-counter expenses eligible for reimbursement?

The Coronavirus Aid, Relief, and Economic Security (CARES) Act has changed the way over-the-counter (OTC) medications and other non-prescription items will be reimbursed through Flexible Spending Accounts (FSAs), Health Savings Accounts (HSAs) and Health Reimbursement Arrangements (HRAs) if your health care plan benefits allow for OTC reimbursements. For a comprehensive list of eligible expenses, please visit www.irs.gov or www.fsastore.com/novaoe to view an Eligibility List.

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Eligible Health Care Reimbursement Expenses

Eligible expenses* typically include medical, dental and vision expenses for services incurred during the plan year for the diagnosis, treatment or prevention of disease. Also included are out-of-pocket costs beyond what your health plan has paid for a service, such as copays. Eligible expenses are determined by the IRS. Services performed solely for cosmetic reasons generally are not eligible.

To access a full list of eligible items, visit novahealthcare.com and click on *Member Resources* under the *Knowledge Center* tab. Then select the *FSA/HSA Eligibility List* in *Reimbursement Account Resources*.

Examples of Eligible Health Care Expenses

- Acupuncture
- Alcoholism treatment
- Ambulance
- Anesthesiologist
- Artificial limbs
- Birthing classes
- Braille books
- Braces
- Cancer screenings
- Chiropractor
- Clinics
- Coinsurance
- Contact lenses
- Contact solution
- Crutches
- Deductibles
- Dental procedures
- Dentures
- Ear thermometer
- Feminine care products
- Prescription sunglasses
- Fertility treatment
- Gynecologist
- Guide dog
- Hearing aid
- Hospital care
- Insulin
- Laboratory fees
- Lasik surgery
- Neurologist
- Nursing services
- Ophthalmologist
- Orthodontia
- Osteopath
- Over-the-counter medication
- Oxygen equipment
- Physical exam
- Physical therapy
- Preexisting conditions
- Prenatal vitamins
- Psychiatric care
- Psychoanalysis
- Psychologist
- Radial keratotomy
- Reasonable and customary charges (amounts in excess of)
- Smoking cessation program
- Speech therapy
- Steam inhaler
- Sterilization
- Support braces
- Surgery
- Telehealth
- Transplant
- Transportation to medical care
- Vaccinations
- Vasectomy
- Wheelchair
- Wound care
- X-rays

Health Care Expenses Not Eligible for Reimbursement

- Cosmetic procedures**
- CBD
- Essential oils
- Funeral expenses
- Health club dues and fees
- Health insurance premiums
- Insect repellent
- Joint supplements
- Laser hair removal
- Medical marijuana
- Medicated toothpaste
- Nitrile gloves
- Protein bars/powders/shakes
- Teeth whitening

* Benefits vary by plan. Please see your benefit summary for details.
** Not deemed medically necessary.

Important Information: Over-the-Counter Medications

Are over-the-counter expenses eligible for reimbursement?
The Coronavirus Aid, Relief, and Economic Security (CARES) Act has changed the way over-the-counter (OTC) medications and other non-prescription items will be reimbursed through Flexible Spending Accounts (FSAs), Health Savings Accounts (HSAs) and Health Reimbursement Arrangements (HRAs) if your health care plan benefits allow for OTC reimbursements. For a comprehensive list of eligible expenses, please visit www.irs.gov or www.fsastore.com/novaoe to view an Eligibility List.

While OTC items do not require a prescription, some eligible items will require a prescription.

Examples of items that DO require a doctor's prescription for reimbursement:	Examples of items that DO NOT require a prescription for reimbursement:	
• Antibiotics	• Athletic tape	• Eye mask for pain relief
• Antidepressants	• Bandages	• Hearing aid batteries
• Asthma medicine	• Baby breathing monitor	• Heating pads
• Anti-Parasitic	• Blood-sugar test kits and test strips	• Incontinence supplies
• Birth control	• Blood pressure monitor or unit	• Orthopedic and surgical supports
• Contact lenses	• Breast pump	• Pregnancy and fertility kits
• Eye treatment medications	• Cholesterol test kit	• Reading glasses
• Eyeglasses	• Defibrillator	• Sanitary pads
• Face cream with medication	• Dental sealants	• Tampons
• Prescription drugs and medicines		
• Sedatives		

If you have a Nova Innovations Prepaid Visa®, it may be used to purchase select OTC items with a valid prescription. Reimbursement requests for the purchase of a qualified OTC medication not paid for with a medical expense debit card may be submitted directly to Nova with the appropriate documentation. This includes a completed claim form, detailed purchase receipt and copy of prescription.

Eligible Expenses Made Easy

Nova partners with FSA Store, an e-commerce site exclusively stocked with FSA-eligible products, to help you spend and manage your reimbursement account(s). FSA Store identifies, very specifically, every item eligible per IRS guidelines. This includes items like sunscreen and lip balm, which are only eligible when they feature broad spectrum protection. For more information on eligible products, reimbursement account calculator and other tools, visit fsastore.com/novaoe.

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Why This ... Not That?

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The IRS has a very specific definition for items eligible for reimbursement through a reimbursement account. These expenses typically include medical, dental, and vision expenses for services incurred during the plan year for the diagnosis, treatment or prevention of disease. It is often difficult to differentiate between eligible and ineligible items because items in the same category can be both eligible and ineligible.

There are many items with unique qualities that cause one version to qualify as an expense and another to remain unqualified. To help you better understand an item's eligibility, we've included several examples below along with the requirement that each item be used to diagnose, treat or prevent disease.

	Eligible	Ineligible
Sunscreen	Primary use must be for protection against skin cancer and premature skin aging with indication of UVA and UVB protection (broad spectrum) and 15 and above (15+).	Products with an SPF less than 15, even if it is broad spectrum, have not been shown to protect against skin cancer and early skin aging. They have been shown only to help prevent sunburn.
Compression Hosiery	Medical compression 30-40 and above; any compression of anti-embolism stockings, ulcer care compression or Lymphedema. Treats condition-specific medical conditions such as anti-embolism, ulcer care or lymphedema.	Hosiery with a medical compression less than 30.
Eyeglasses and Maintenance Accessories	You can include any medical expenses you incur for eyeglasses and contact lenses needed for medical reasons. This includes accessories used to maintain corrective lenses and frames.	Fashion eyeglasses and sunglasses, chains, cases, etc.
Lip Balm	Eligible lip balms are part of a sun care line, have an SPF 15+ and provide UVA/UVB protection.	Any lip balm without an SPF or with an SPF less than 15, as well as lip balm with an SPF 15+ that does not provide broad spectrum coverage.

To access a full list of eligible items, please visit novahealthcare.com/knowledge-center/member-resources. The member resources page includes an FSA/HSA Eligibility List which is regularly updated. Through Nova's FSA Store, you will have access to a store full of products pre-qualified as eligible per IRS regulations. And, since the store is updated regularly, you can be confident your purchases qualify for reimbursement.

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5 Eligible Expenses You May Be Overlooking For Your HSA and FSA Funds

When you participate in a Health Savings Account (HSA) and/or Flexible Spending Account (FSA), you're able to contribute pre-tax funds for use on hundreds of eligible expenses. Since the CARES Act was signed into law, you gained even more flexibility in your ability to save.

This legislation expanded the list of expenses that are considered eligible by including popular over-the-counter products, which consumers can purchase with their HSA or FSA without a prescription. This change resulted in over 20,000 expenses becoming eligible. That's great news for consumers, since the average American shops for over-the-counter medications 26 times each year.

Here are five of the most overlooked expenses that are eligible to use HSA and FSA funds without a prescription.

1

Pain Relief Medications

Headaches. Muscle soreness. Sprains. There are so many reasons to need pain relievers. There are two common types of over-the-counter pain medications: acetaminophen and nonsteroidal anti-inflammatory drugs (NSAIDs), both of which are among the eligible expenses available from an HSA and FSA.

2

Cold and Flu Products

Winter may be behind us, but cold and flu season never really goes away. As much as 20 percent of the U.S. population gets the flu, on average each season. Fortunately, the over-the-counter medicines taken to cope with a severe cough or congestion are eligible expenses.

3

Allergy Products

Thirty percent of American adults and 40 percent of children suffer from allergies. And the cost of allergies to the health care system is estimated at $18 billion. Those who do have allergies can find relief with their HSA and FSA funds in the form of over-the-counter antihistamines and decongestants.

4

Heartburn Medications

Heartburn is among the more common afflictions in this country. That's why Americans spend billions of dollars each year on medicines that treat heartburn. The CARES Act means that these over-the-counter drugs are HSA- and FSA-eligible without a prescription.

5

Menstrual Products

The CARES Act also includes menstrual care products as eligible expenses for HSAs and FSAs. Eligible products include tampons, pads, and menstrual sponges.

How Do I Know What Qualifies?

- Download the NovaFlex App and scan a product barcode to help determine eligibility as a qualified medical expense. **That's peace of mind with a touch of a button.**
- Online shopping for eligible expenses can be done on sites like FSA Store and HSA Store. These sites are dedicated to items that are eligible under pre-tax accounts like FSAs and HSAs.

How it Works

Nova Innovations Prepaid Visa®: Whether you're paying with a standard card swipe or you've added your card to your digital wallet for mobile payment, we make it easier than ever to pay for these eligible items. Remember to save your receipts in case a purchase needs to be verified later.

Submit a Claim: You can submit claims for reimbursement through the online Consumer Information Center or using the NovaFlex App.

Questions?

We can help. **Just call Nova's knowledgeable Customer Service department at 1-877-268-3799.**

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Account Information At Your Fingertips

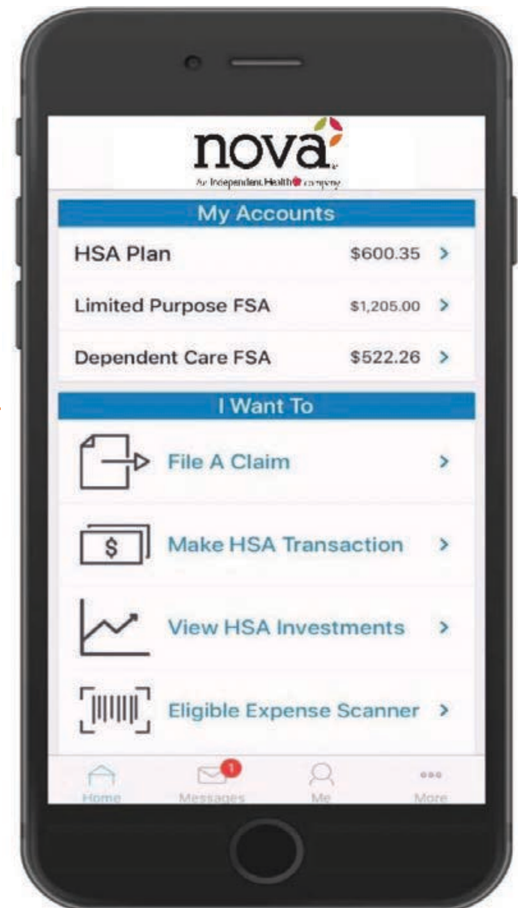
NovaFlex App

Want to Check Your Health Care Account Balances and Submit Claims Anywhere, Anytime? There's an App for That!

The NovaFlex App lets you securely access your health benefit account with a touch of a finger. Conveniently manage your reimbursement accounts on any iPhone, Android or tablet device.

View balance information for your account(s) right away.

Use the "I Want To" section to quickly take any number of actions from making payments to viewing HSA investments to scanning items for eligibility and more.



Stay Up to Speed

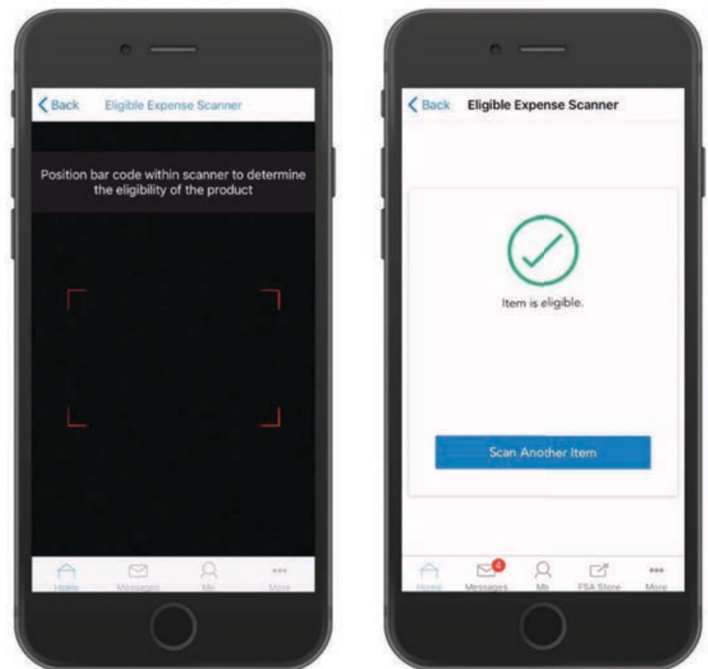
With the NovaFlex App you can get to the health care account information you need easily and on-the-go. Wondering whether you have enough money to pay a bill or make a purchase? NovaFlex puts the answers at your fingertips:

- Enjoy real-time access
- Log in to your account(s) with ease using your fingerprint
- Quickly check available balances and account details for medical and dependent care FSA, HSA, HRA, transportation and premium reimbursement plans
- View in-app messages and text alerts that provide instant notifications about your account(s)
- Submit claims – snap a photo of a receipt and submit with a new or existing claim
- Make an HSA distribution or contribution and view investment details
- Use the Eligible Expense Scanner to scan items to determine if they're qualified medical expenses
- Report a debit card as lost or stolen
- Retrieve a lost username or password
- Use your device of choice – including Apple® and Android™-powered smartphones

Scan Expenses

How can you easily determine which products can be paid for using your account funds? With NovaFlex, you can simply scan a product bar code to help determine eligibility as a qualified medical expense. That's peace of mind with a touch of a button.

With a quick barcode scan, you'll know in an instant whether an item qualifies as an eligible expense.



Get Started with NovaFlex in Minutes

Download the NovaFlex App for your Android or iPhone (also compatible with iPad® and iPod touch®) and log in using the same password you use to access the https://myflexspend.com consumer portal.

To ensure your health care information is protected, when you begin using the NovaFlex App, you will be prompted to set up five security questions that will allow you to reset or recover your username and password from your device, without having to call Nova's Customer Service department.

After your initial login and set-up, you can opt to use "Touch ID" fingerprint access in the future.

Questions?

Nova's Customer Service team is here to help.
Contact us at 1-877-268-3799.

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Healthcare already costs so much, why pay tax on it?

Outsmart rising inflation during Open Enrollment — flexible spending accounts (FSAs) give you the ability to spend pre-tax dollars on everything from out-of-pocket medical costs to guaranteed eligible health products.

A simple way to save

30% or more in tax savings on eligible healthcare items and services

Spend beyond the doctor: There are literally thousands of FSA eligible products

Spend on day 1. FSAs are funded in full on the first day of your plan year

Shop exclusively eligible products with your FSA card or any major credit card at FSA Store

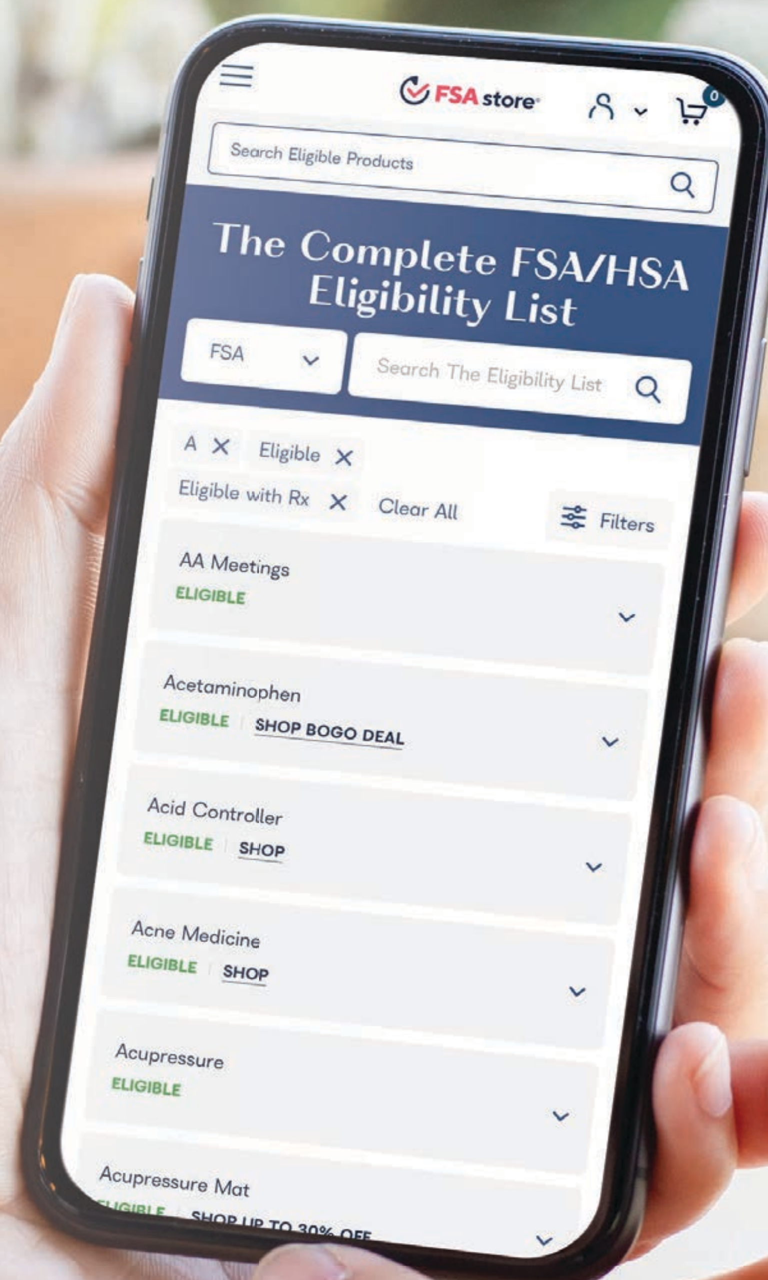
Shop Worry-Free

Guesswork stops here

With the **Eligibility List** — the web's most comprehensive list of products and services eligible for **tax-free spending.**

Start Searching

*No receipts needed when you shop with your FSA card.



Learn more about FSA Store:

CERTIFICATION OF MEDICAL NECESSITY

INSTRUCTIONS

Under Internal Revenue Service rules, certain health care services and products are eligible for reimbursement from your health flexible spending account (FSA) or health reimbursement arrangement (HRA) only when your physician or other licensed health care provider certifies that such services and/or products are medically necessary.

In order to process your claim, your physician/provider must complete this form (or provide a statement on his/her letterhead that includes the same information) and attach a prescription. Your physician/provider must (1) specifically identify the medical condition, (2) describe the recommended treatment for your medical condition, and (3) state a specific treatment period (with clear start and end dates).

You will need to submit a copy of this form (or of your physician's/provider's letter), and the corresponding prescription, each time you request reimbursement for a service/product. However, the physician/provider's certification will be valid for one year from the date on the form or letter. If you have any questions, please contact our Customer Service team at 1-877-268-3799 or (716) 505-8566, Monday-Friday 8 a.m. to 5 p.m. EST.

EMPLOYEE INFORMATION

Employee Name ____ Employer Name ____

MEDICAL CONDITION INFORMATION (to be completed by the physician/provider)

Patient's Name: ____

Medical Condition:____

Prescribed Treatment or Service/Product:____

Start Date of Treatment/Service/Use of Product:____

End Date of Treatment/Service/Use of Product: ____

Please describe how the prescribed treatment/service/product will treat, prevent and/or alleviate the medical condition*:

____

____

____

* For <u>specialty food products</u> – (1) the food must alleviate or treat an illness, (2) the food must not be part of normal nutritional needs, and (3) the need for food must be substantiated by the physician/provider. A substitute for food normally consumed and that satisfies nutritional needs **<u>is not</u>** medical care.

PROVIDER CERTIFICATION

This service/product is medically necessary to treat, prevent, and/or alleviate the medical condition as described above. The treatment is not for general health or cosmetic purposes.

Provider Name (please print) ____ Date ______________________

Provider Signature ____

EMPLOYEE CERTIFICATION

I certify that the service/product indicated above is medically necessary (that is, required for the prevention or alleviation of a physical or mental defect or illness). I understand that I must submit a completed copy of this Certification of Medical Necessity form or a provider letter containing the same information with each request for reimbursement of this expense. I understand that submitting this form does not guarantee that the expense will be reimbursed.

Employee Signature ____ Date ______________________

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Authorization to Disclose Protected Health Information (PHI)

Under Federal and State privacy laws, Nova Healthcare Administrators, Inc., Independent Health and/or Pharmacy Benefit Dimensions, LLC (individually or collectively herein "Company") is authorized to use or disclose your health information for payment, treatment and health care operations and as required by law. For uses and disclosures other than these purposes, your written authorization is required before sharing your health information. This includes sharing your health informationwith your spouse, relatives, employer, etc. This form allows you to authorize the Company to use or disclose your health information including HIV-related information to those individuals or entities you specify.

Please read before completing this form

- Incomplete authorizations will be considered invalid and will not be accepted. Incomplete authorizations will be returned. **An asterisk (*) is used to denote the required fields in this form.**
- Completion of this authorization form is voluntary. You may refuse to sign this form, but then Company will not be able to release your information.
- A copy of this authorization will be available to you, but you should retain a copy for your records.
- Signing or not signing this form will not affect any payment, enrollment or eligibility for benefit decisions made by Company.
- If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described in this authorization may be disclosed to other individuals or institutions and no longer protected by these regulations.
- You may revoke this authorization in writing at any time by sending a letter to the address listed below. Your revocation notice will not apply to actions taken by the requesting person/entity prior to the date we received your written request to revoke this authorization.

Send completed and signed authorization to:
Nova Healthcare Administrators
P.O. Box 408
Buffalo, NY 14231
Fax: (716) 250-7193
memberservice@novahealthcare.com

If you need assistance completing this form, please contact Nova using the number listed on your ID card or email memberservice@novahealthcare.com.

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Authorization to Disclose Protected Health Information (PHI)

Section A: Member Information*		
Name*:	Date of Birth*: / /	Member ID*: ______________________- _____

Section B: Authorized Individuals* (at least one individual is required) Please list the individuals and/or entities that you are authorizing to view or receive your health information. If more space is required to list individuals or entities, please attach an additional page.			
1.	Name*:	Relationship*:	Telephone Number*: ( )
2.	Name:	Relationship:	Telephone Number: ( )
3.	Name:	Relationship:	Telephone Number: ( )

Section C: Information That Can Be Released (Select C-1 or C-2 and if applicable, C-3)*
If more space is needed to describe the information that can be released, please attach an additional page.

☐ **C-1: I would like you to disclose any of my health information requested by the individuals and/or entities named in Section B. This does not include information in Part C-3 (below) unless I have placed my initials nextto the condition. If I do not place my initials in C-3, information related to those conditions will not be disclosed.**

- OR –

☐ **C-2: Only the following specific health information** (such as claims submitted by a specific provider or information related to one of the protected diagnoses listed below):

____

____

____

- AND, IF APPLICABLE -

C-3: Unless specifically initialed below, I understand my health information will not be disclosed related to the following conditions. By placing my initials next to one or more of these conditions, I am authorizing Company to disclose information related to the condition(s) (see page 4 for additional information):

________Alcohol and/or Substance Abuse ________HIV-Related

________Pregnancy/Reproductive ________Mental Health

________Sexually Transmitted Diseases ________Genetic Testing

Section D: Purpose and Time Period
Unless noted below, the authorized parties in Section B can obtain your health information upon their request and from the start date of your plan coverage.

☐ Purpose: ____

☐ Time Period: Only release health information concerning dates of service from (*insert date*)_____________to (*insert date*)_____________.

Section E: Expiration
This authorization will automatically expire one (1) year after termination of your enrollment, upon your death, in the case of a minor, when the named minor reaches the age of eighteen (18) years, or if Company receives a letter from you revoking this authorization.

For dates or events not described in the preceding paragraph, you may specify an expiration date or event for this authorization below:

This authorization will expire:

☐ On the following date (*insert date*): _____________

☐ On the following event: *(please specify)* ____

Section F: Personal Representative Information
Complete this section if you are a personal representative that is acting on behalf of a member. You must include a copy of one of the following documents as proof of your legal representation and authority:

□ Valid health care proxy
□ Certificate of guardianship issued by a Court of appropriate jurisdiction
□ Surrogate decision maker appointed pursuant to Family Health Care Decisions Act (FHCDA)

If the member is deceased, please submit a copy of one of the following:
□ Letters of Administration or Letters Testamentary

Name:	**Relationship:**	**Telephone Number:** ( )

Section G: Signature/Date*
Please read the following carefully before you sign, and refer to page 4 for additional information.

By signing this form, I understand the following: (1) if the entity authorized to receive my health information is not a health plan, health care provider or other covered entity as described by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, the released information may no longer be protected by federal privacy laws, rules and regulations; (2) the information disclosed will only include mental health, alcohol and substance abuse, HIV-related information, sexually transmitted disease, pregnancy and reproductive and/or genetic testing information if I specifically direct Company to release that information; (3) I am not required to sign this form, but if I do not sign this form, it will not be considered valid, it will be returned to me and no information will be released by Company; (4) I may revoke this authorization at any time by notifying Company in writing; (5) if I do revoke this authorization, my revocation will have no effect on any actions Company took according to this authorization before Company received my revocation; and (6) it is my choice whether I sign this form and signing or not signing this authorization will not affect any payment, enrollment, or eligibility for benefit decisions made by Company.

☐ By checking this box, this form replaces any HIPAA authorization forms previously sent to Company.

I sign this authorization under penalty of perjury and attest that the information contained in this authorization is true and correct and may be relied upon by Company.

____ Date: _________________________
Signature of Member or Personal Representative

Sensitive Information

- **Alcohol and Substance Abuse Information**
  By initialing the appropriate box on this form, alcohol and substance abuse information can be provided to the individuals listed by you on this form. If information is disclosed from alcohol or substance abuse records protected by federal confidentiality rules (42 CFR Part 2), these rules prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by these rules.

- **HIV-Related Information**
  By initialing the appropriate box on this form, HIV-related information can be provided to the individuals listed by you on this form. HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

  For example, under New York state law, HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; authorized agencies involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed toyour blood; special court order; attorney assigned to represent a minor or by an executor or administrator of an estate (Public Health Law §2782). Under state law, anyone who illegally discloses HIV-related information may be punished by a fine of up to $5,000 and a jail term of up to one year. However, some re-disclosures of medical and/or HIV-related information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019.

- **Pregnancy and Reproductive Information**
  By initialing the appropriate box on this form, information relating to pregnancy and reproductive health can be provided to the individuals listed by you on this form. Information regarding pregnancy and reproductive health cannot be disclosed, even to a parent or guardian of a minor patient, without the specific authorization of the patient (Public Health Law §17).

- **Mental Health Information**
  By initialing the appropriate box on this form, mental health information can be provided to the individuals listed by you on this form. Mental health information, including a patient's clinical records and information can be released, with your consent or the consent of someone authorized to act on your behalf, to those authorized agencies listed by you on this form who have a demonstrable need for such information provided such disclosure will not reasonably be expected to be detrimental to you or others (Mental Hygiene §33.13).

- **Sexually Transmitted Diseases**
  By initialing the appropriate box on this form, information regarding sexually transmitted disease can be provided to the individuals listed by you on this form. Parents may access most of their child's medical records until the child turns 18, with the exception of information relating to the diagnosis and treatment of sexually transmitted disease (Public Health Law §17). Such information cannot be released to any party, including the child's parent or guardian, without the child's specific authorization.

- **Genetic Testing**
  By initialing the appropriate box on this form, genetic testing information can be provided to the individuals listed by you on this form. Genetic testing information includes any information relating to laboratory tests of human DNA, chromosomes, genes or gene products to diagnose a predisposition to a genetic disease of disability in the individual or offspring (Civil Rights Law §79-l). Genetic testing information shall not be released without your specific consent with the exception of information released to a health insurer or health maintenance organization for the purpose of claims administration.

<u>Instructions for Completion of Authorization to Disclose Protected Health Information (PHI)</u>

Section A: Enter your name, date of birth, and your member ID number including your suffix

Section B: List the name, relationship, and telephone number for the individuals and/or entities that you are authorizing to view or receive your health information.

Section C: Choose either Box C-1 <u>**OR**</u> box C-2 <u>**AND**</u> initial C-3 if applicable.

- **Box C-1:** Select this box to permit all of your health information to be disclosed. Please note, checking this box alone does NOT include the sensitive conditions listed in C-3, which you must separately initial in C-3.

- **Box C-2:** Select this box to limit the health information that you wish to be disclosed. You should write in the specific information you are authorizing to be disclosed and be as detailed as possible. Please note, checking this box alone does NOT include the sensitive conditions listed in C-3, which you must separately initial in C-3 or manually write in here.

- **Box C-3:** If you wish for any of these sensitive conditions to be disclosed, you must initial them individually here.

Section D: You may leave this section blank to default to the purpose and time period rules as indicated on the form, or you may specify a different purpose and/or time period.

- **Purpose:** The circumstances in which you are authorizing the information to be disclosed. For instance, you may choose to list a narrow purpose such as litigation or claim payment resolution. If left blank, your representatives may obtain your information upon their request.

- **Time Period:** The scope of the information to be released. For instance, you may choose to list a specific time frame such as 1/01/2021-12/31/2021. If left blank, your representatives may obtain your information from the start date of your plan coverage.

Section E: This form will expire automatically upon the events noted on the form, but you may specify additional dates or events that would trigger the form to expire, such as upon your death or listing a specific date.

Section F: If you are a personal representative that is acting on behalf of a member in signing this authorization, please check which authority you hold and include a copy of the relevant document(s) as proof of your legal representation and authority. Please list your name and telephone number as well as relationship to the member.

Section G: Please sign and date the form in this section, whether you are filling it out for yourself or on behalf of the member. As a reminder, if you are signing on behalf of the member, please include a copy of the relevant document(s) as proof of your legal representation and authority. If you wish this form to replace previous HIPAA Authorization forms on file with Company, please check the box in this section.

REIMBURSEMENT ACCOUNT ENROLLMENT FORM

Employer Information (employer use only)	
Group Name:	Effective Date:
Date of Hire:	First Payroll Deduction Date:
Location/Department (if applicable):	
Payroll Deduction Frequency (e.g., weekly, monthly, etc.):	
Employer Initials:	Date:

FOR NEW ENROLLMENTS/Please check one:	FOR CHANGES*/Please check all that apply:	
❑ OPEN ENROLLMENT	❑ PLAN CHANGE	❑ NAME CHANGE
❑ NEWLY ELIGIBLE/REASON ______________________	❑ ADD DEPENDENT	❑ REMOVE DEPENDENT
❑ NEW HIRE/DATE OF HIRE____/____/____	❑ ADDRESS CHANGE	❑ TERMINATION (effective date) ____________________

PLEASE PRINT AND RETURN TO YOUR EMPLOYER UPON COMPLETION. For changes, complete first & last name only.

APPLICANT'S LAST NAME	FIRST NAME	MI	❑ MALE ❑ FEMALE	SOCIAL SECURITY NUMBER
ADDRESS (NUMBER, STREET, APARTMENT)				DATE OF BIRTH
CITY	STATE	ZIP + 4	HOME: ( ) CELL: ( ) WORK: ( ) E-MAIL:	

ANNUAL ELECTIONS

	CONTRIBUTION PER PAY PERIOD		# PAY PERIODS REMAINING IN PLAN YEAR		ANNUAL ELECTION AMOUNT
HEALTH CARE FLEXIBLE SPENDING ACCOUNT - GENERAL PURPOSE	$	x		=	$
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (DCA)	$	x		=	$

DEPENDENT INFORMATION

LAST NAME	FIRST NAME	M.I.	SSN	DATE OF BIRTH	RELATIONSHIP	GENDER
DEPENDENT						❑Male ❑Female
DEPENDENT						❑Male ❑Female
DEPENDENT						❑Male ❑Female
DEPENDENT						❑Male ❑Female
DEPENDENT						❑Male ❑Female

CERTIFICATION & CONSENT

I certify I will have the above total amount deducted from each of my paychecks. I understand this will lower my gross pay, and consequently, my tax base and my Social Security base. I also understand that I cannot make any changes during the plan unless I experience a change in family status. In addition, I certify that if I am issued a debit card with this benefit, I will only use it for eligible medical and/or dependent care expenses as defined by the IRS under Section 213 and/or section 21 for my spouse, dependents, and myself. I also certify any expense paid using such debit card has not been reimbursed by any other plan covering health benefits, nor will I seek reimbursement under any other plan or deduct such expenses on my income tax return. I understand this certification is reaffirmed each time the card is used, and I agree to acquire and retain sufficient documentation for any expense paid with the card and submit such documentation as substantiation when requested.

AUTHORIZATION: I have read and agree to the authorization above.

Subscriber's Signature	Date

According to IRS regulations, you may only change your elections at the beginning of each plan year unless you experience a change in your family status. A change of family status may include marriage, divorce, birth, adoption, death or loss of spouse's employment. Changes in the contribution amount must be consistent with the change in your family status.

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