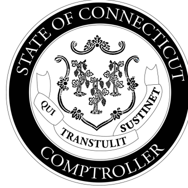


ORTHODONTIA EXPENSES INSTRUCTIONS & WORKSHEET
State of Connecticut

The treatment of orthodontic expenses under a Healthcare Flexible Spending Account (FSA) is different than other medical expenses because services generally span more than one plan year. Under IRS regulations, the service must be reimbursed from the same FSA plan year in which the services were provided, and the service must have been incurred. Nevertheless, IRS officials have informally commented that a pre-payment of orthodontia expenses is permissible in certain instances. Below are the various options for reimbursement of orthodontic services, instructions on how to submit a reimbursement request for orthodontic expenses, and instructions on completing the Orthodontia Worksheet.

If a service agreement or contract has been drawn between the orthodontic provider and participant agreeing on services provided and payments due over the course of the treatment, the participant is reimbursed on a monthly basis according to the agreement. Reimbursements for these payments may span over one or more FSA plan years, as per the agreement. For example, if the agreement indicates a one-time payment of $500 upon placement of the braces and a monthly fee of $50 thereafter for two years, the amounts eligible for reimbursement are those incurred within each plan year (up to your current remaining balance). Pre-payments of monthly fees are not reimbursable as the service must be provided and payment must have a due date within your plan year coverage period. (Payments due in one plan year cannot be reimbursed from the next plan year.)

If full payment is required by the orthodontic provider before services can begin, the total cost for the treatment is eligible for reimbursement when the work is started, and the payment is made. A one-time reimbursement for the total cost of the treatment up to your current available balance may be made from your current plan year Healthcare FSA. For example, if a full payment of $3,000 is required at time of placement and your current Healthcare FSA balance is $2,500, you are eligible to be reimbursed for $2,500.

If the orthodontic provider does not offer the options above, complete the Orthodontia Worksheet to determine the monthly amount that may be eligible for reimbursement from your Healthcare FSA.

Loan payments and interest on a loan are not eligible expenses. Thus, the TASC Card cannot be used to make payments to a loan company. Complete the Orthodontia Worksheet if no other receipt or contract is available from the orthodontic provider.

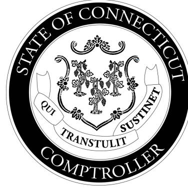
Submitting orthodontia expenses for reimbursement:

1. A *Reimbursement Request Form* must be completed each time you want to be reimbursed.

2. With each reimbursement request, include a copy of the Orthodontic Contract, coupon (if provided a payment book), or itemized receipt. All documentation must clearly indicate the month and year of the service provided (or payment due date), the monthly payment amount, the name of the provider, and a description of the service (orthodontia, braces, placement, or banding fee).

3. In the absence of a contract or service agreement:
    a. Complete the Orthodontia Worksheet;
    b. Have it signed by your orthodontist; and
    c. Submit with each reimbursement request.

The information contained in this communication is confidential and to be used by TASC employees and representatives for only its intended purpose.
©TASC



ORTHODONTIA EXPENSES INSTRUCTIONS & WORKSHEET
State of Connecticut

4. Initial payments, banding, or placement fees are eligible for reimbursement upon placement. An itemized receipt must accompany the Request for Reimbursement Form that indicates the service is a banding or placement fee instead of a monthly fee.

5. A request for reimbursement of payment in full for orthodontic treatment at the start of the orthodontic services requires an itemized receipt from the orthodontic provider to accompany the reimbursement request.

In the absence of a contract or service agreement, the orthodontic provider must apportion the total cost of the treatment, less the initial payment due and any payments expected from your insurance company or provider discounts, to the remaining number of months required for treatment. This will determine the monthly payment amount eligible for reimbursement from the Healthcare FSA. Include a **copy** of this completed form with each reimbursement request submitted to TASC.

1. Enter the total cost for the duration of the treatment in the *Total Cost* section in below.

2. Enter in any insurance payments and provider discounts.

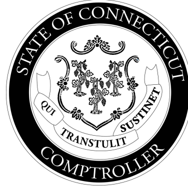
3. Enter the estimated portion of the total cost that is apportioned to the services provided in the first visit (when the braces are applied) in the *Initial Payment Due* section (generally, one-third or less of the total cost).

4. Subtract the insurance payments, provider discounts, and initial payment due from the total cost and enter this amount in the *Total Remaining Balance* section.

5. Enter the number of months the treatment is expected to continue after placement of the braces.

6. Divide the Total Remaining Balance by the number of months and enter this amount in the *Monthly Payment* section. This is the amount eligible for reimbursement from the FSA on a monthly basis.

The information contained in this communication is confidential and to be used by TASC employees and representatives for only its intended purpose.
©TASC



ORTHODONTIA EXPENSES INSTRUCTIONS & WORKSHEET

State of Connecticut

CLIENT/CONTACT INFORMATION

Client/Company Name:	**State Of Connecticut**	TASC ID #:	**4721-0392-1958**
Employer Class:	**NA**	Employer Division:	**NA**

PARTICIPANT AND PATIENT INFORMATION

First Name:		MI:		Last Name:	
TASC ID# (if known):		Email Address:			
Primary Phone #:		Mobile Phone #:			
Patient First Name:		MI:		Last Name:	
Date Treatment Begins:					

CALCULATION

Total Cost for Orthodontia Services:		$
Subtractions:	Insurance Payments:	$
	Provider Discount:	$
	Initial Payment Due (upon placement of braces):	$
	Total Remaining Balance:	**$**
	Number of Months:	
Monthly Payment and Eligible Monthly Reimbursable Amount: *(Total Remaining Balance divided by the Number of Months)*		**$**

AUTHORIZATION

____ ________________________________

Signature of Orthodontic Service Provider Date

____

Print Name of Orthodontic Service Provider

For enrollment assistance: call toll-free 888-698-1429
Have your enrollment form, employer name, and the Client ID# ready.

Find all IRS limits on our resource web page: www.tasconline.com/benefits-limits/

The information contained in this communication is confidential and to be used by TASC employees and representatives for only its intended purpose.
©TASC