Avera Health Plans

NOTE: All reimbursement payments are now processed electronically. Please provide accurate bank information below.

Flexible Spending Account Member Enrollment Form

Complete this form to enroll in a flexible spending account. Your employer will deduct funds from your paycheck before taxes for certain medical and dependent care expenses.

Plan year ______________________

First name ______________________ Last name ______________________

Address ______________________ City ______________________ State ________

Social Security Number ______________________ Date of hire ______________ (MM/DD/YY) ZIP ____________

Date of birth ______________________ Email ______________________

Waiver of Participation. I choose not to participate in the Flexible Spending Account at this time. I understand that I will not have another opportunity to enroll during the plan year unless I have a qualifying event.

Employee Signature ______________________ Date ____________

NOTE: The attached worksheet will help you determine how much of your salary you may want to place into your Flexible Spending Account(s).

1. **Medical Expense Reimbursement Account (Maximum $2* 50)** $ ______ /year which is $ ______ /paycheck
2. **Dependent Care (Daycare) Expense Reimbursement Account (Maximum $5000)** $ ______ /year which is $ ______ /paycheck

Employee Signature ______________________ Date ____________

Direct Deposit: All reimbursements payments are deposited directly into your bank account and, if necessary, adjustments for any deposits made in error. I authorize Avera health Plans to deposit my reimbursements to the following account:

❑ Savings **(Attach a deposit slip)** ❑ Checking **(Attach a voided check)**

Account number ______________________ Transit ABA routing number ______________________

Bank name ______________ Bank location ______________ Phone ______________

After you have completed the form, attach copy of a voided check or savings deposit slip and give this to your employer. All reimbursements are made by direct deposit.

Employee Signature ______________________ Date ____________

FOR EMPLOYER USE ONLY

Employer name ______________________ Payroll frequency ______________________

Effective date ______________ Signature ______________________ Date ____________

Qualifying event ______________________ Effective date of qualifying event ______________

Fax or mail to Avera Health Plans, Flex Member Services, 3816 S. Elmwood Ave., Sioux Falls, SD 57105-6538

Flexible Spending Calculation Worksheet

Please print this and use this as a tool to help calculate.

Medical Expense Reimbursement Account

Complete this worksheet to determine how much of your salary you should place into your Medical Expense Savings Account.

Be as accurate as possible when recording last year's expenses and be conservative when estimating next year's expenses.

Any money you put into the program must be used exclusively for eligible unreimbursed medical expenses and you forfeit any money remaining in this program at the end of the year.

If you are covered by a dental plan, be sure to include only additional uninsured amounts beyond deductibles and coinsurance in Section 3.

If you don't have dental insurance, most medically necessary expenses are eligible for reimbursement.

Dependent Care Reimbursement Account

IRS regulations limit the amount you can contribute to a Dependent Care Reimbursement Account to $5,000 for a married parent filing jointly or a head of household filer, and $2,500 for a married parent filing separately.

The cost of a kindergarten program does not qualify if the program's propose is primarily educational. Overnight camp expenses are not qualified expenses.

Only expenses necessary to provide care for a dependent while you are working are eligible for reimbursement.

Estimate expenses as accurately as possible. Any money left in your account can not be returned to you.

	Actual expenses last year	Expected expenses for coming year
SECTION 1: Deductibles and Coinsurance		
How much do you and your spouse pay each year to fulfill medical and dental insurance deductibles?	______	______
How much do you and your spouse pay each year to fulfill medical and dental insurance coinsurance requirements?	______	______
Total annual cost for Section 1	______	______
SECTION 2: Other unreimbursed medical expenses		
Routine exams	______	______
Prescription drugs	______	______
Vision care	______	______
Equipment/other expenses for the disabled	______	______
Treatment of mental/nervous conditions	______	______
Treatment of alcoholism or drug dependency	______	______
X-rays	______	______
Other uninsured medical expenses	______	______
Total annual cost for Section 2	______	______
SECTION 3: Other unreimbursed dental expenses		
Exams and cleaning	______	______
Braces and retainers (only if medically necessary)	______	______
Fillings, crowns, bridges	______	______
X-rays	______	______
Dentures	______	______
Other uninsured dental expenses	______	______
Total annual cost for Section 3	______	______
Grand totals (last year and upcoming year) Section 1 + Section 2 + Section 3	______	______
SECTION 4: Dependent care expenses		
Day care center	______	______
Nursery/preschool	______	______
Before/after school expenses	______	______
Dependent care expenses	______	______
Other dependent care expenses	______	______
Total annual cost for Section 4	______	______

Discrimination is Against the Law

Avera Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Avera Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Avera Health Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact the Avera Health Plans Service Center at 1-888-322-2115, (TTY 711), 8 a.m. to 5 p.m. CST, Monday through Friday.

If you believe that Avera Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Complaint and Appeals Coordinator
Avera Health Plans
3816 S. Elmwood, Suite 100,
Sioux Falls, SD 57105-6538

Fax 1-800-269-8561
Email ComplaintAppeals@AveraHealthPlans.com

You can file a grievance in person or by mail, fax, or email. You may also contact the Complaint and Appeals Coordinator if you need assistance with filing a complaint.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or call 1-800-368-1019 or 1-800-537-7697 (TDD). Or mail:

US Department of Health and Human Services,
200 Independence Avenue SW Room 509F, HHH Building,
Washington, D.C. 20201

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Getting Help in Other Languages

Language assistance services are available free of charge. Our Service Center is available 8 a.m. to 5 p.m. CST, Monday – Friday, toll-free at 1-888-322-2115 (TTY: 1-800-877-1113).

- ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-322-2115 (TTY: 1-800-877-1113).
- LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-322-2115 (TTY: 1-800-877-1113).
- CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-322-2115 (TTY: 1-800-877-1113).
- XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-322-2115 (TTY: 1-800-877-1113).
- 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-888-322-2115 (TTY: 1-800-877-1113) 。
- ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-322-2115 (TTY: 1-800-877-1113).
- ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-322-2115 (телетайп: 1-800-877-1113).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-322-2115 (رقم هاتف الصم والبكم: 1-800-877-1113).

- ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-322-2115 (TTY: 1-800-877-1113).
- ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အယိ, နမၤန့ၢ် ကျိာ်အတၢ်မၤစၢၤလၢ တလၢာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘၣ်သ့န့ၣ်လီၤ. ကိး 1-888-322-2115 (TTY: 1-800-877-1113).
- ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-322-2115 (ATS: 1-800-877-1113).
- 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-322-2115 (TTY: 1-800-877-1113) 번으로 전화해 주십시오.
- ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-322-2115 (መስማት ለተሳናቸው: 1-800-877-1113).
- OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-322-2115 (TTY - Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-877-1113).
- ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-322-2115 (TTY: 1-800-877-1113)។