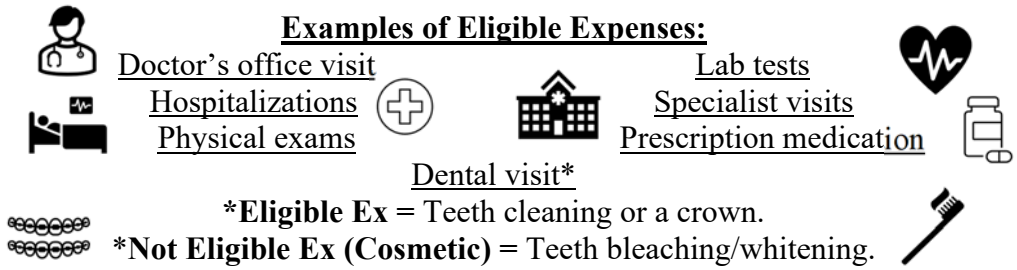
How Does My Health Insurance Expense Reimbursement Account Work?

The IAFF Local 587, has established a plan to reimburse you for **any eligible IRS permitted medical, dental or vision expense.** Here is how it works:

Once you become a Participant, a reimbursement trust account will be maintained in your name, to keep a record of the amounts available to you for certain eligible expenses. The maximum dollar amount that may be credited to the account in any plan year is **$500.00** for those with **employee only coverage**, **$1,000 for those with employee plus 1 coverage** and **$1,500.00** for those with **employee plus family coverage.**



Examples of Eligible Expenses:

Doctor's office visit
Hospitalizations
Physical exams
Lab tests
Specialist visits
Prescription medication
Dental visit*

***Eligible Ex** = Teeth cleaning or a crown.
***Not Eligible Ex (Cosmetic)** = Teeth bleaching/whitening.

As you incur eligible expenses, you may be required to provide supporting documentation. Cash register receipts, canceled checks, credit card slips or credit card bills will not be accepted. If the expense is eligible, you will receive a reimbursement and the amount will be recorded in your account. If the reimbursement request is rejected as not eligible, you will be notified why.

Examples of Supporting Documentation:

1- Invoice from your third-party service provider, that must show:

-Who received the service
-When the expense was incurred
-The type of expense
-The amount of the expense and who was paid.

2- EOB (Explanation of Benefits) from your insurance carrier, that shows:

-Your out-of-pocket expense for that service.

3- Rx receipt from providers like:

-Walgreens/CVS - Publix Pharmacy - Target Pharmacy - Walmart Pharmacy

4- In-Store vision receipt from providers like:

VisionWorks - LensCrafters

You can access your account balance and MySourceCard activity at any time by signing into our website. **If you have never created a login ID for our website, please follow the following instructions:**

- Go to www.div125.com
- Login ID field – type in your SSN# without spaces or dashes
- Skip the password field and click login
- Enter employer code: **48898691**
- You can then personalize your ID and password

Ways to Use Your HRA Funds

Option 1- MySourceCard:

Important - If you do not follow this step you will not receive a MySourceCard.
You must submit the attached MySourceCard Enrollment Agreement form as directed.

Employee only - $500 / Employee plus 1 - $1,000 / Employee plus family - $1,500

How To Use the MySourceCard:

1- The card will only work at eligible medical, dental, vision & Rx providers.

2- Simply swipe your card at your provider's office.

3- Payment is automatically deducted from your available balance.

4- No need to pay cash up front and wait to be reimbursed.

5- Always remember to **SAVE YOUR DETAILED RECEIPTS.

**Canceled checks, credit card slips or credit card bills will not be accepted.

6- No need to submit every claim!

a. Many card swipes will automatically be approved without additional documentation.

b. If we need to see any detailed receipts, we'll let you know by email.

c. Make sure to submit your documentation within 60 days of the swipe, to avoid an interruption on your card!

or

Option 2- Claim Submission:

Are you required to substantiate your swipe? Your provider doesn't take credit cards?

Forgot to use your card?

Simply submit a claim with your supporting documentation using one of the below methods.

A. Submitting a Claim online:
After you sign in to www.div125.com, all online claims can be accessed from your user home page by clicking this icon located on the right side of the screen. Simply follow the prompts to submit your claim

B. Mobile App Submission
Note: You must create your login ID using the website, before you can log into the mobile app.
- For **the iPhone** you can download the app here:
Scan this QR code with your smart phone's camera.
https://itunes.apple.com/us/app/myrsc/id561492867?mt=8

- For **Android Phones** you can download the app here:
Scan this QR code with your smart phone's camera.
https://play.google.com/store/apps/details?id=com.dpath.myrsc&hl=en

C. Submit a claim form with your supporting documentation Via email, sent to Claims@div125.com.

D. Submit a claim via fax: (954) 983-9695.

E. Submit your claim via USPS mail:
Please allow additional time for processing.

Diversified Administration, Inc.
6600 Taft Street, Suite 304
Hollywood FL. 33024

Once your claim has been approved, you will be reimbursed via direct deposit into the account of your choosing.

Note: Please make sure you have submitted a direct deposit form when sending in your claim information.

Important Notes:

1- When using the claim form, please make sure to put **"IAFF Local 587 Health Insurance Trust Fund"** in the line that says "employer".

2- When submitting a claim for reimbursement, and it is your first time doing so, please make sure to include the direct deposit form.

3- Attached to this document, you will find both the claim and direct deposit forms.

4- If you have any additional questions or any concerns, please feel free to call:

(954) 983-9970
Option 3

Diversified Administration, Inc.
Tax Savings For Employers & Employees

E-mail: Claims@Div125.com
Fax: 954-983-9695
Mail: 6600 Taft Street, Suite 304
Hollywood, FL 33024
Phone: 954-983-9970

Reset the Form

Submit via E-Mail

Secure Upload

MySourceCard® Enrollment Agreement

As a participant in one or more of your Employer Plans or as an account holder under the HSAtoday™ program, you will receive a mySourceCard® MasterCard® Debit Card issued by Benefit Bank, and agree to use it according to this Agreement and the Cardholder Agreement that will be provided to you with the Card.

You understand that the Card is restricted to certain merchant categories and is not accepted at all MasterCard® acceptance locations. You understand that you may not obtain a cash advance with the Card at any merchant, bank or ATM. You understand that the Card is to be used exclusively for Qualified Expenses as defined by the plan(s) in which you participate. If the Card is issued pursuant to Employer Plans and you use the Card for an expense that is not a Qualified Expense, you are indebted to your employer and must repay the full amount of the non-qualified expense.

You agree to save all invoices and receipts related to any expense paid with the Card; upon request you must submit these documents for review by the Plan Service Provider. Failure to submit the receipt(s) will cause the expense to be treated as a non-qualified expense and you will be required to remit payment to your employer. Payment may be in the form of an offsetting claim, a personal check, electronic draft from your personal checking or savings account, a post-tax deduction from your paycheck, or other options established by your employer.

Please Note: Additional terms and conditions would apply if you use the Card to access your funds in your HSA under the HSAtoday™ program. In such event, these additional terms and conditions would be set forth in an HSA Addendum to your HSA custodial account agreement.

Participant Information

For proper Cardholder Identification, please complete the following information.
Your Card will not be issued until this form is received by Diversified Administration, Inc.

☐ This is the first time I am ordering a MySource Card
☐ This is to order a replacement card
☐ This is to obtain original cards for my family members
☐ This is to update my information

Employer name: IAFF Local 587 Health Insurance Trust Fund

Name on Primary Card (21 chars max, including spaces)_____

Address Line 1_____

Unit/Apartment Number:_____ City:_____ State: ZIP:_____

E-mail Address:_____

Social Security Number:_____-_____-_____ Mother's Mainden Name:_____

Name on 2nd Card (21 chars max, including spaces)_____

Card Holder's Signature:_____

Secure Upload

Submit via E-Mail

Diversified Administration, Inc.
Tax Savings For Employers & Employees

3 Ways To Submit Your Claim Form and Receipts
E-mail: **Claims@Div125.com**
Fax 954-983-9695 or 954-983-0574
6600 Taft Street Suite 304, Hollywood, FL 33024

Reset the Form
Submit via E-Mail
Secure Upload

Want us to confirm receipt of your claim? Just put your @ or # ____________

Employer Name Iaff Local 587 Health Insurance Trust Fund **Today's Date** ____/____/____

Employee Name ____________ **Last 4 Digits of your SSN** ________

To view tips which will help ensure the quick and accurate processing of your claim, click here.
To view a short video showing this claim form's many high-tech features, click here.

Please select the correct benefit for your reimbursement.
If you have any questions not addressed in the links above, please contact us at 954-983-9970.

Benefit Is Being Claimed	Dates the Service or Expense Occured	Recipient of Service or Expense	Name of Service and Provider	Reimbursement Total Claimed
Health Reimbursement Arrangement	From: ___/___/___ To: ___/___/___	○Self ○Spouse ○Child Name:______		$
Health Reimbursement Arrangement	From: ___/___/___ To: ___/___/___	○Self ○Spouse ○Child Name:______		$
Health Reimbursement Arrangement	From: ___/___/___ To: ___/___/___	○Self ○Spouse ○Child Name:______		$
Health Reimbursement Arrangement	From: ___/___/___ To: ___/___/___	○Self ○Spouse ○Child Name:______		$
Health Reimbursement Arrangement	From: ___/___/___ To: ___/___/___	○Self ○Spouse ○Child Name:______		$
Health Reimbursement Arrangement	From: ___/___/___ To: ___/___/___	○Self ○Spouse ○Child Name:______		$
Health Reimbursement Arrangement	From: ___/___/___ To: ___/___/___	○Self ○Spouse ○Child Name:______		$
Health Reimbursement Arrangement	From: ___/___/___ To: ___/___/___	○Self ○Spouse ○Child Name:______		$
Health Reimbursement Arrangement	From: ___/___/___ To: ___/___/___	○Self ○Spouse ○Child Name:______		$
Health Reimbursement Arrangement	From: ___/___/___ To: ___/___/___	○Self ○Spouse ○Child Name:______		$
Health Reimbursement Arrangement	From: ___/___/___ To: ___/___/___	○Self ○Spouse ○Child Name:______		$

☐ **I understand I must provide substantiating documentation along with a completed claim form in order to get the reimbursements totaled below .**

HRA TOTAL

$

The undersigned participant in the Plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form were incurred during a period while the undersigned was covered under the Company's Cafeteria Plan or HRA with respect to such expenses and that the medical expenses have not been reimbursed or will not be reimbursed under any other health insurance plan coverage. 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 payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

X ______________________________
Employee's Signature

Secure Upload
Submit via E-Mail

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Tax Savings For Employers & Employees

E-mail: Claims@Div125.com
Mail: 6600 Taft Street, Suite 304
Hollywood, FL 33024
Phone: 954-983-9970
Fax: 954-983-9695

Reset the Form

Submit via E-Mail

Secure Upload

Employee Direct Deposit Authorization Form

Participant Information

Employer Name: IAFF Local 587 Health Insurance Trust Fund

First Name:_____ Last Name:_____ SSN:_____-____-_____

Attach VOID Check Below

Please attach a copy of your void check in the space below, or on a separate page. You may also enter your account and routing numbers on the line below. DO NOT attach a Deposit Slip because deposit slips do not show the necessary information.

Joan Doe
Anywhere, USA

PAY TO THE ORDER OF $ _____ $_____

_____DOLLARS

YOUR TOWN BANK
YOUR TOWN, AR 123456

FOR _____ _____
⑆25550005⑆ 1234556789022⑈ Signature

Routing Number:_____ Account Number:_____

Account Type: ◯ Checking Account ◯ Savings Account

Bank Name:_____

Account Holder's Signature

By signing this agreement, I authorize the Plan Service Provider to initiate credit entries to the Account(s) indicated above for the purpose of reimbursements from my Account(s) and to initiate, if necessary, debit entries and adjustments for any credit entries made in error.

Primary Account Holder's Signature:

If the account is a joint account or in someone else's name, that individual must also sign to indicate agreement with the statement above.

Secondary Account Holder's Signature:

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