

Instructions

1. Employee must complete **Employee Information** – be sure to indicate if this is a new address
2. Complete **Claim Information** in its entirety. Please ensure that your supporting documentation clearly indicates the requested amount.

Eligible expenses include but are not limited to: Acupuncture, Alcohol & Drug Rehabilitation (inpatient treatment only), Ambulance, Artificial Limbs, Artificial Insemination/Invitro Fertilization/Fertility Enhancement, Blood Pressure Monitoring Devices, Body Scan, Birth Control Pills/Condoms/Spermicide, Chiropractor, Co-Insurance and Deductible, Contact Lenses & Cleaning Solutions, Crutches, Dental Treatment, Dentures, Diagnostic Tests, Eye Exam, Eye Glasses/Prescription Glasses, Flu Shots, Hearing Devices, Hospital Services, Immunizations (e.g., well-baby shots), Insulin, Laboratory fees, Lamaze classes relating to childbirth, Laser Eye Surgery / Lasik, Learning Disability Treatment, Medical Alert Bracelet/Necklace, Obstetric Treatment, Orthodontia, Over-the-counter pregnancy tests, Over-the-counter medications to treat a specific medical condition, Oxygen, Physical Exams, Physical Therapy, Podiatry Treatment, Prescription Drugs, Psychiatric Treatment, Psychological Treatment, Radial Keratotomy, Smoking Cessation non-prescription only, Surgery & Related Expenses, Tubal Ligation or Vasectomy, X-rays

Ineligible expenses include but are not limited to: Cosmetic surgery and procedures, Expenses for services rendered outside the coverage period, Expenses reimbursed by an insurance provider or another health plan, Hair loss items, Herbs/Vitamins/Supplements that do not require a prescription for use, Insurance Premiums, Long term care services, Marriage Counseling, Personal Use Items, Teeth Whitening

3. Check the appropriate box in Supporting Documentation section and attach Acceptable Supporting Documentation as described below:

a) Itemized Statement or bill from your provider including:

- Provider name
- Patient name
- Description of service
- Original date of service (the date of service, not the date of payment must fall within the plan year for which you are enrolled)
- Patient portion of charge(s)

b) Explanation of Benefits (EOB) from your insurance carrier

c) Pharmacy Statement including:

- Patient name
- Prescribing physician
- RX number
- Name of the drug
- Date the RX was filled
- Co-payment amount

*Unacceptable Documentation includes the following:

- Cancelled Checks
- Credit / cash receipts (An itemized cash register receipt is acceptable for eligible over-the-counter expenses)
- Balance forward statements

--When attaching small receipts, we suggest you tape them to a standard size sheet of paper

4. Sign and date **Employee Certification**

5. **Submit Claims To:**

CONEXIS CXO Claims

P.O. Box 6049

Orange, CA 92863-6049

Fax: (877) 864-9555 Phone: (877) 864-9549

Medical expenses which have been reimbursed under this plan are not deductible for income tax purposes.

