

Internal Services Agency  
Department of Personnel Services  
Employee Benefits Office



Terry Schutten, County Executive  
Mark Norris, Agency Administrator  
David Devine, Department Director

## County of Sacramento

### ORTHODONTIA CONTRACT

**A new contract is required at the beginning of each plan (calendar) year**

_____ EMPLOYEE NAME	_____ SSN
_____ PATIENT NAME	_____ PATIENT DOB
_____ PROVIDER NAME	
_____ PROVIDER ADDRESS	
\$ _____ TOTAL PLAN YEAR COST	\$ _____ AMOUNT PAID PER MONTH
DATES OF SERVICE WITHIN PLAN YEAR ____/____/____ - ____/____/____	

**The above information is true and correct.**

\_\_\_\_\_  
**Signed by Orthodontist**

\_\_\_\_\_  
**Date**

This contract, when signed, will cover your orthodontia payment receipts for the contract amount for the current plan year **only**, or until you are no longer incurring expenses, whichever comes first.

**SELECT ONE OPTION FOR REIMBURSEMENT FROM THE LIST BELOW. I WOULD TO BE REIMBURSED:**

- Each Reimbursement Date       2<sup>ND</sup> Reimbursement Date       Last Reimbursement Date

### AUTHORIZATION

I understand that by endorsing any reimbursement check and/or accepting a deposit of a reimbursement into my bank account that I am confirming that the orthodontia expenses for which the amount is issued have been properly incurred according to the IRS regulations and the rules of the plan.

\_\_\_\_\_  
**EMPLOYEE SIGNATURE**

\_\_\_\_\_  
**DATE**

**Fax to Flex-Plan Services at 1(866) 535-9227 or the Employee Benefits Office at (916) 874-4621**

According to the IRS guidelines, orthodontia treatment may be reimbursed from a Medical Reimbursement Account in one of two ways, depending upon the type of financial agreement between the orthodontist and the responsible party.

**FINANCIAL AGREEMENTS WITH THE PROVIDER:**

**FULL REIMBURSEMENT:** In this case the orthodontist must specify that the full cost of the orthodontic services must be prepaid, or paid in full, at the beginning of the treatment. If the orthodontist does not provide other financial payment options, the full amount of the charge incurred (up to the participant's full annual election) can be reimbursed upon payment to the provider.

**PERIODIC REIMBURSEMENT:** In this case, the orthodontist may offer financial payment options. Regardless of the option chosen by the responsible party, reimbursement must be issued in accordance with the length of the orthodontic treatment. For example, if the patient has treatment for 24 months, and the total cost of the treatment is \$2,400 (regardless of the payment option chosen), the maximum reimbursement amount per month is \$100.

**REIMBURSEMENT OPTIONS:**

**VOUCHER SUBMISSION REIMBURSEMENT:** The participant can submit proof of expenses along with a Request for Reimbursement form to the plan administrator at any time. Reimbursement checks will be issued based upon the County's preset reimbursement schedule.

**ORTHODONTIA CONTRACT REIMBURSEMENTS:** The participant and their orthodontist may complete and submit an Orthodontia Contract to the plan administrator. Reimbursement checks will be issued based on the County's preset reimbursement schedule. The employee may select the frequency of payment based upon this preset schedule. The contract is submitted once each year, unless any of the information on the contract changes.