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# HEALTH CARE REIMBURSEMENT ACCOUNT

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The Health Care Reimbursement Account allows you to pay for your uninsured medical expenses with pre-tax dollars. With this account, you can pay for your out of pocket medical expenses for yourself, your spouse and all of your dependents for medical services that are incurred during your Plan Year. The maximum you may place in this account for the Plan Year is \$2,500.

## EXAMPLES OF ELIGIBLE HEALTH CARE EXPENSES

### FEES/CO-PAYS/DEDUCTIBLES:

Acupuncture	Prescription Eye glasses/Contact lenses	Physician
Ambulance hire	Psychiatrist	Psychologist
Anesthetist	Hospital	Erectile dysfunction medication
Chiropractor	Laboratory	Sterilization Fee
Dental Fees	Nursing	Surgery
Diagnostic	Obstetrician	X-Rays
Eye Exams	Laser Eye Surgery	Wheel Chair

### OTHER ELIGIBLE EXPENSES:

- Prescription drugs
- Artificial limbs & breasts (only if reconstructive)
- Birth control pills, patches (e.g. Norplant)
- Orthopedic shoes/inserts
- Carpal tunnel wrist supports
- Incontinence supplies
- Vaccinations & Immunizations
- Elastic hose (medically prescribed)
- Contact lens supplies
- Therapeutic care for drug and alcohol addiction
- Take-home screening kits (HIV, colon cancer)
- At home pregnancy test kits
- Mileage, parking and tolls ( you may be reimbursed \$.235\* a mile plus parking and tolls when medical reasons make it necessary to travel)
- Tuition fees for medical care (if the college furnishes a breakdown of medical charges)
- Orthodontic expenses (not for cosmetic purposes)
- Diabetic supplies
- Routine Physicals
- Condoms
- Dentures
- Oxygen
- Physical Therapy
- Fertility Treatments
- Hearing aids and batteries
- Reading glasses
- Medical equipment
- Pedialyte for dehydration

**NOTE: ORTHODONTIC TREATMENT IS REIMBURSED ACCORDING TO YOUR PAYMENT PLAN WITH THE ORTHODONTIST.** FOR EXAMPLE: If your payment plan is set up to pay \$100 a month for the orthodontic treatment, you can be reimbursed \$100 a month for the payments that become due during the Plan Year.

This above list is compiled from IRS publication 502. If you are unsure that your expected medical expense will be eligible under tax code regulations, please call Flexible Benefit Administrators at (757) 340-4567 or (800) 437-FLEX before making your election for the Plan Year. IRS publication 502 can be ordered by calling the IRS at (800) 829-3676.

\* Mileage reimbursement rate is based on IRS regulation and subject to change.

**FLEX NOTE:**

**You can save between 28% and 38% in taxes on every \$100 you place in the Plan.**

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## Health Care Reimbursement Account (continued)

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### OVER-THE-COUNTER DRUGS

Please be advised that Senate legislation has stated that effective January 1, 2011, participants are required to have a prescription for Over-the-Counter (“OTC”) products to be eligible under their FSA plan. Therefore a prescription or letter of medical necessity would be required after January 1, 2011 for OTC items.

### OVER-THE-COUNTER EXPENSES

- Examples of medications and drugs that may be purchased in reasonable quantities **with a prescription or letter of medical necessity:**

Antacids	Allergy & sinus medication
Pain relievers/aspirin	Cough & cold medications
Ointments & creams for joint pain	Laxatives
Anti-diarrhea medicine	Bug-bite medication
First aid creams (Bactine, diaper rash)	

### OVER-THE-COUNTER EXPENSES THAT ARE NOT ELIGIBLE

- The following examples are OTC items that are **not eligible** and will not be reimbursed under any circumstances because the items are considered dietary supplements, toiletries, cosmetic or personal use items:

Multi/Daily Vitamins	Herbal/natural supplements
Weight loss products/foods	Acne creams/face cleanser
Face cream/moisteners	Medicated shampoo/soaps
Mouthwash/toothpaste	Toothbrushes (even if dentist recommends a special one)
Feminine hygiene products	Deodorant
Eye/facial makeup/preparations	Chapstick
Suntan lotion	Rogaine

### DUAL PURPOSE DRUGS & ITEMS

#### EXPENSES THAT NEED DOCUMENTATION FROM YOUR PHYSICIAN TO BE ELIGIBLE THROUGH THE HEALTH CARE ACCOUNT

- The following items are examples of products that are considered as having both a medical purpose and a general health, personal/cosmetic purpose and require a medical practitioner’s note stating the name of the patient, the specific medical condition for which the OTC is recommended, the time frame of the treatment and that the treatment is not cosmetic:

Weight-loss drugs (to treat obesity)	Nasal sprays for snoring
Pills for lactose intolerance	
Fiber supplements (to treat a medical condition for a limited time)	
OTC Hormone therapy (to treat menopausal symptoms)	
St. John’s Wort (for depression)	

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## Health Care Reimbursement Account (continued)

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**EXPENSES FOR IMPROVEMENT OF GENERAL HEALTH** are not eligible for reimbursement even if a doctor prescribes the program. However, if the program is prescribed for a specific medical condition (e.g. Obesity, Emphysema), then the expense would be eligible. We must have a letter from your doctor on file for each Plan Year stating specifically what illness or disease is being treated or prevented and the length of time you will be required to use this treatment in order to reimburse for any of these types of expenses.

Health Club Dues  
Weight Loss Programs  
Exercise equipment

Exercise classes  
Wigs

**NOTE:** For Weight Loss Programs, only the cost of the program is an eligible expense. Any cost for food or food supplements is not an eligible expense.

**COSMETIC** expenses, prescriptions and treatments are not eligible. This applies to any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat an illness or disease. If cosmetic treatment is necessary to correct a deformity or abnormality, a personal injury or a disfiguring disease, it must meet IRS eligibility guidelines outlined in IRS publication 502 and will require a physician's letter of medical necessity.

### **OTHER EXPENSES THAT ARE NOT ELIGIBLE FOR REIMBURSEMENT THROUGH THE HEALTH CARE ACCOUNT**

- ⊖ **ESTIMATES** for medical expenses that have not been rendered cannot be reimbursed. Medical services do not have to be paid for, however, the services must have been rendered during the Plan Year, to be eligible for reimbursement.
- ⊖ **PREMIUM EXPENSES** for any insurance policies are not eligible for reimbursement through the Health Care Account. This includes contact lens insurance.
- ⊖ **EXPENSES PAID BY AN INSURANCE COMPANY** are not eligible for reimbursement through the Health Care Account. Only the portion you have to pay out of your pocket for your medical expenses is eligible for reimbursement.

***FLEX NOTE:***

***The maximum you can place in your Health Care Account is \$2,500.***

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## Health Care Reimbursement Account (continued)

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### CLAIMS SUBMISSION

#### OBTAINING A REIMBURSEMENT FROM YOUR HEALTH CARE ACCOUNT

To obtain a reimbursement from your Health Care Account, you must complete a Claim Form. This form is available from your employer (See sample Claim Form in back of handbook). You must attach a receipt or bill **from the service provider** which includes all the pertinent information regarding the expense:

- Date of service
- Patient's name
- Amount charged
- Provider's name
- Nature of the expense
- Amount covered by insurance (if applicable)

**Cash register receipts, credit card receipts and canceled checks** alone are not eligible forms of documentation for medical expenses. These items are not considered third party receipts because they only reflect that payment has been made and do not provide the required information listed above. Prescription documentation must include the **name** of the prescribed medication.

#### OBTAINING A REIMBURSEMENT FOR OVER-THE-COUNTER ITEMS

**For the purchase of over-the-counter medications, with a prescription or a letter of medical necessity**, cash register receipts will be accepted as documentation **if the receipt is detailed and indicates the name of the service provider, the date of the purchase, the amount of the purchase and the name of the product purchased.** **You must also send in a copy of the prescription or letter of medical necessity signed by a physician, along with your claim form.**

If the receipt does not specifically reflect the name of the product we cannot accept the claim for reimbursement of that item. The name of the patient does not have to be on the receipt, however, the name of the patient must be listed on the claim form.

**NOTE:** In order to be eligible for reimbursement through the Health Care Account, the medical expense must be incurred during the Plan Year. IRS defines "incurred" as when the medical care is provided (or date of service), not when you are formally billed, charged for, or pay for the care. **FOR EXAMPLE:** If you go to the doctor on December 26<sup>th</sup> and your Plan Year begins on January 1<sup>st</sup>, this expense is not eligible in the new Plan Year. Even if you pay for this expense after January 1<sup>st</sup>, the "date of service" was before the Plan Year began and therefore is not eligible.

#### THE HEALTH CARE ACCOUNT IS A PRE-FUNDED ACCOUNT

This means that you can submit a claim for medical expenses in excess of your account balance. You will be reimbursed your total eligible expense up to your annual election. The funds that you are pre-funded will be recovered as deductions continue to be deposited into your account throughout the Plan Year.



Ph: 800-437-FLEX or 757-340-4567  
P.O.Box 8188 • Virginia Beach, VA 23450  
www.flex-admin.com

## Estimating Your Expenses

### ESTIMATING YOUR QUALIFYING HEALTH CARE EXPENSES

This worksheet will help you determine your annual expenses for each reimbursement account. Good planning and careful estimating is the best way to take full advantage of your Flexible Benefit Plan.

Medical deductibles

Medical co-payments

Prescription drugs

Vision Exams, Glasses, Contacts

Dental/Orthodontia

Routine exams and physicals

Over-the-counter expenses

TOTAL ESTIMATED MEDICAL

EXPENSES FOR THE PLAN YEAR (Max. \$2,500)

### ESTIMATING YOUR DEPENDENT CARE EXPENSES

Child day care expenses

Pre-School expenses

Summer Day Camp expenses

Adult day care expenses

Other eligible expenses

TOTAL ESTIMATED DEPENDENT CARE

EXPENSES FOR THE PLAN YEAR (Max. \$5,000)



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# FSA Medical Reimbursement Claim Form

## How to File

Check box if this is to offset previously submitted ineligible expense(s).

Form can be submitted by (1) e-mail, (2) fax or (3) mail.

To submit by e-mail, Print Form and sign. E-mail form along with documentation to flexdivision@flex-admin.com

To submit by fax, Print Form and fax to: 757-431-1155

To submit by mail, Print Form and mail to: Flexible Benefit Administrators, Inc.  
P.O.Box. 8188, Virginia Beach, VA 23450

## Account Holder Information

Employee Name (Print name)

Social Security Number or Employee ID #

E-Mail address

(For Notification of Processed Claims, Reimbursement & Account Status)

Employer

## Claims For Out-Of-Pocket Expense

### INCOMPLETE FIELDS MAY RESULT IN YOUR CLAIM BEING DENIED

-Please indicate your qualifying expenses below. DO NOT include expenses reimbursed by any other source.

-Attach copies of bills, receipts, Explanation of Benefits (EOBs) or other claim documentation. Documentation below must include dates of service, description of service and the expense amount. Cancelled checks and/or credit card statements/receipts are NOT sufficient proof of your claim.

-Be sure to keep your original receipts, bills, etc. for your records.

1	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$	<input type="text"/>
	Person treated and Relationship	Type of Eligible Expense	Date of Treatment		Amount of Expense
2	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$	<input type="text"/>
	Person treated and Relationship	Type of Eligible Expense	Date of Treatment		Amount of Expense
3	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$	<input type="text"/>
	Person treated and Relationship	Type of Eligible Expense	Date of Treatment		Amount of Expense
4	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$	<input type="text"/>
	Person treated and Relationship	Type of Eligible Expense	Date of Treatment		Amount of Expense
5	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$	<input type="text"/>
	Person treated and Relationship	Type of Eligible Expense	Date of Treatment		Amount of Expense
6	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$	<input type="text"/>
	Person treated and Relationship	Type of Eligible Expense	Date of Treatment		Amount of Expense

Note: Orthodontia expenses are reimbursed as designated by the provider. We must have a copy of your orthodontic contract on file.

**Total \$**

### YOU MUST ATTACH APPROPRIATE PROOF OF SERVICE FOR EACH AMOUNT ABOVE.

I request reimbursement from my Health Flexible Spending Account (Health FSA) for the amounts listed above. To the best of my knowledge, my statements are complete and true. I certify these expenses are not covered or reimbursable from any other source, nor will I seek reimbursement for these expenses from any other source and that the expense is not for cosmetic purposes. I understand that I cannot use expenses reimbursed through the Health FSA account as tax deductions when filing income tax returns. I further certify that the expenses submitted on this claim are for myself and/or my qualified tax dependents for health coverage purposes as defined under the Internal Revenue Code 125.

I, the participant, further certify that the expense(s) noted above have not been previously paid for by use of my Benefits Card.

Employee's Signature:

Date

ADMINISTERED BY

**FLEXIBLE BENEFIT ADMINISTRATORS, INC.**  
**509 VIKING DRIVE, SUITE F**  
**P.O. BOX 8188**  
**VIRGINIA BEACH, VA 23450**  
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