Section 125 FSA Presentation

Presented by: J. Joseph Brogger II. CBC

Presented: 10.27.2017

Kalamazoo College
A flexible spending account (FSA) is an employer-sponsored benefit account that allows you to set aside pre-tax funds to help pay for eligible healthcare expenses. The tax-advantaged nature of an FSA allows your contributions to help you reduce your taxable income while giving yourself a spending vehicle that can save you up to 30% on out-of-pocket healthcare expenses.

**There’s a Compelling New Reason to Consider Enrolling in an FSA**

In late 2013, the US Department of Treasury made some monumental changes to a long-standing ‘use it or lose it’ policy. Traditionally, any unused FSA funds have been forfeited by the employee (you) at year’s end. Under the new ruling, you can rollover up to $500 into the future plan year.

**What Does this Mean to You?**

The ruling introduces a new, relatively risk-free reason to enroll in an FSA. Industry research has long indicated the fear of losing funds as the #1 reason consumers do not enroll in FSAs. However, with this fear a thing of the past, there’s very little reason not to enroll. Consider your healthcare consumption:

How much money do you spend annually on co-pays, prescription drugs, over-the-counter medicine, sunscreen, acne treatment, or even eye glasses?

If the answer is somewhere between $0 and $500, there is quite literally no reason not to have an FSA.

You can use your FSA to pay for these healthcare-related products – and because your FSA funds are pre-tax dollars, you can essentially get a savings of up to 30% on these items. Best of all, if you don’t need the money that year, you can roll $500 into next year – so the risk is minimal.

**There’s very little reason not to enroll**

To enroll in K College’s FSA plan, you must go to the on-line enrollment portal “Hornet Hive”.
Your Benefits Debit MasterCard® is provided to you by your Employer under a Benefit Plan as allowed by the IRS under applicable Sections of the U.S. Tax Code and in conjunction with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA). Your Debit Card is also usable under your Flex Spending Account (FSA) or Health Care Account (HCA).

HOW TO USE YOUR BENEFITS CARD
1. Read the front and back of this form carefully, record your Card number on this form, and retain it for your records.
2. Sign the back of your Card before using it.
3. Your Benefits Card will be activated upon first usage. You do not need to call to activate your Card. All the point of sale terminals are programmed to accept your Card.
4. If you are offered a choice, select the "CREDIT" option to sign your purchase receipt.
5. You may be prompted to enter a PIN. If you do not have it, ask the merchant to process the transaction so that you may sign the receipt instead.
6. Retain all itemized receipts and documentation. If requested by your Plan Administrator, Employer, or in the case of an HSA, the IRS, you are obligated to submit your receipts to prove expenses are eligible under your Benefit Plan and applicable IRS regulations.

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# Enrollment Worksheet

**Flexible Spending Account Enrollment Worksheet**

The following worksheet is provided to help you determine pre-tax amounts that you should set aside for the coming Plan Year. The worksheet will assist you in determining your annual expenditures for unreimbursed medical expenses and dependent care expenses.

**FSA 2018 Limit $2,650**

**Dependent Care Limit $5,000**

<table>
<thead>
<tr>
<th>Medical Flexible Spending Account Expenses:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular Monthly Costs Not Covered by Insurance</td>
<td></td>
</tr>
<tr>
<td>Monthly Prescription Co-pays:</td>
<td>$__________</td>
</tr>
<tr>
<td>Physician/ Chiro Office Visit Co-pays:</td>
<td>$__________</td>
</tr>
<tr>
<td>Contact Lens Supplies:</td>
<td>$__________</td>
</tr>
<tr>
<td>Other (_______________):</td>
<td>$__________</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td>$__________</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Expected One-Time Costs Not-Covered by Insurance</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentist Cleanings:</td>
<td>$__________</td>
</tr>
<tr>
<td>Braces and other Orthodontia:</td>
<td>$__________</td>
</tr>
<tr>
<td>Regular Eye Exams:</td>
<td>$__________</td>
</tr>
<tr>
<td>Prescription Eyewear:</td>
<td>$__________</td>
</tr>
<tr>
<td>Family Deductible:</td>
<td>$__________</td>
</tr>
<tr>
<td>Other:</td>
<td>$__________</td>
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<tr>
<td><strong>Total:</strong></td>
<td>$__________</td>
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</table>

<table>
<thead>
<tr>
<th>Dependent Care Assistance Plan Expenses</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>After School Care:</td>
<td>$__________</td>
</tr>
<tr>
<td>Regular Day Care:</td>
<td>$__________</td>
</tr>
<tr>
<td>Other (_______________):</td>
<td>$__________</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td>$__________</td>
</tr>
</tbody>
</table>

**Grand Total:** $__________
**FLEX SPENDING ACCOUNT (FSA) CLAIM FORM**

**Employer:** Kalamazoo College  
**ER ID:** 13425  

**Employee Name:**  
**Address:**  
**City:**  
**Zip:**  
**Day Phone #:**  
**Email:**

- **Method of payment:**  
  - [ ] Check  
  - [ ] Direct Deposit  
  - [ ] Form Attached  
  - [ ] Instructions on File

**Description of Expenses and Claim Amounts Requested.**  
**NOTE:** Enter each item on a separate line, and send copies of EOBs or an itemized statement with this form.

### HEALTH CARE EXPENSES

<table>
<thead>
<tr>
<th>Receipt Attached</th>
<th>Name of Person receiving service</th>
<th>Relationship (if applicable)</th>
<th>Type of Service</th>
<th>Date Service Began</th>
<th>Date Service Ended</th>
<th>Amount</th>
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</tbody>
</table>

**Total Health Care Claim Submitted** $___

**EMPLOYEE’S CERTIFICATION OF CLAIM REQUEST**

I certify that the reimbursement I am requesting from my Flex Spending Account Plan is for expenses incurred under the Plan. The expense(s) are not eligible for reimbursement by any other insurance or company plan, and I will not seek reimbursement from any other source. To the best of my knowledge and belief, they are eligible for reimbursement under IRS Section 213. I further certify that I will not use the expenses reimbursed through the Plan as a deduction on my personal income tax return.

By signing below I acknowledge that I understand that any person who knowingly files a statement of claim containing false or incomplete information, or with intent to injure, defraud or deceive any qualified plan, may be guilty of a criminal act punishable under federal and/or state law.

**Health Insurance Portability and Accountability Act (HIPAA)**

Under HIPAA regulations you are assured that certain health information, referred to as Protected Health Information (PHI), will be kept confidential. Disclosure of your PHI for any purpose other than for "Plan Administration" such as quality assurance, claims processing, auditing and monitoring or for the purpose of obtaining payment will be limited and subject to state and federal regulations. To learn more about these Privacy Rules contact your HRA Coordinator to receive a complete Notice of Privacy Practices.

**Claim Denial Appeal Procedures**

A claim is a request for a Plan benefit by a participant or beneficiary. Except as otherwise described in applicable summaries or booklets describing the benefits provided through this Plan (such as insurance carrier booklets or employer summaries describing your benefits), if you submit a claim for benefits and it is denied, in whole or in part, you or your beneficiary will receive a written explanation from the Administrator within 30 days after filing the claim. If special circumstances require, the Administrator may take up to an additional 15 days to contact you. The Administrator must notify you of this extension before the end of the initial 30-day period.

The Administrator's explanation will state the specific reasons for the denial, references to pertinent sections in the Plan document, additional information you must provide to improve your claim, and the procedure available for further review of your claim. If you do not agree with the reasons for denial of your claim, you may request an appeal within 180 days of receiving the denial. You should attach any documents or records that will support your appeal. As part of the review procedure, you are allowed to request and receive copies of pertinent documents, although in some cases, approval may be needed for the release of confidential information, such as medical records. You must submit issues and comments in writing. You may have someone act as your representative in the review procedure if you wish.

A decision will be made in writing within 60 days following the receipt of your request for review or the date that all information required of you is furnished, whichever date is later. If special circumstances require an extension of time, a written notice of the extension will be sent to you. Notification of the decision on review will be clearly described and will specify the reason for the decision.

**FLEX SPENDING ACCOUNT Reimbursement Instructions**

**Claiming Your Medical Expenses, Office visit co-pays and Prescription Reimbursements**

You may claim your eligible expenses (see packet information for eligible and excluded expenses) by submitting a reimbursement claim form along with copies of your expense receipts (see section "To Reclaim Money from your Flex Spending Account" below).

You may only claim expenses that can be proven with receipts and are eligible under IRS regulations for 213 expenses. You may claim any eligible expenses incurred while you were an active participant in the Plan. If the IRS audits your tax return, you must be able to provide the original receipts in order to validate the tax-free medical dollars you received. Medical dollars paid to you do not show as earnings on a W-2 form. Dollars paid to you through the Plan cannot be used as a medical deduction on your tax return.

Your employer has elected to allow you to roll over up to $500 of unused FSA funds at the end of the plan year. This will allow you to use any remaining balances. You will then have a 90-day grace period after each plan year to submit your claims. Rollover dollars can be used by consumers who are not participating in the next plan year. Rollover dollars can roll from year to year; there is no date limitation on rollover dollars. If you terminate your employment, you will have the 90 day grace period to submit claims but they must have been incurred while you were still active in the Plan.

**To Reclaim Money from Your Flexible Spending Account**

Complete the Claim Form and include a copy of your expense receipt(s) and any required documentation for your claim (make sure the Claim Form is signed and dated). The receipt must include the provider’s name, type of service, date of service, and patient’s name. Select the method for repayment (either check or direct deposit). If you wish to elect direct deposit, you must complete a separate Direct Deposit Form.

Submit the Claim Form and a copy of your claim documentation via fax, e-mail, or mail as follows:

**US Mail:**  
Group Benefits TPA Dept, Burnham & Flower Agency, Inc.,  
315 S. Kalamazoo Mall, Kalamazoo, Michigan, 49007.

**Fax:**  
(269) 276-0479  
**Email:** TPALH1Support@bfgroup.com

Questions: (269) 381-1173, ext 3181  
Toll Free: (888) 748-7966, ext. 3181

You will then receive your tax-free reimbursement as explained under your Plan rules.

**Health Insurance Portability and Accountability Act (HIPAA)**

Under HIPAA regulations you are assured that certain health information, referred to as Protected Health Information (PHI), will be kept confidential. Disclosure of your PHI for any purpose other than for "Plan Administration" such as quality assurance, claims processing, auditing and monitoring or for the purpose of obtaining payment will be limited and subject to state and federal regulations. To learn more about these Privacy Rules contact your HRA Coordinator to receive a complete Notice of Privacy Practices.

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FLEX SPENDING ACCOUNT (FSA) – DEPENDENT CARE
CLAIM FORM

Employer: Kalamazoo College

Employee Name: ________________________________

Address: ________________________________________

Day Phone #: (       )___________ DOB ___________ Email: ___________________________

City:____________ Zip: ______

FLEXIBLE SPENDING ACCOUNT

Day Care Expenses and Claim Amounts Requested. NOTE: Enter each item on a separate line, and send copies of Daycare Receipts with this form.

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Claim Submitted $ __________

EMPLOYEE'S CERTIFICATION OF CLAIM REQUEST

I certify that the reimbursement I am requesting from my FSA Dependent Care account is for expenses incurred under the Plan. I further certify that I will not use the expenses reimbursed through the Plan as a deduction on my personal income tax return.

By signing below I acknowledge that I understand that any person who knowingly files a statement of claim containing false or incomplete information, or with intent to injure, defraud or deceive any qualified plan, may be guilty of a criminal act punishable under federal and/or state law.

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To Request your Reimbursement

Complete the Claim Form and include a copy of your expense receipt(s) and any required documentation for your claim. Make sure the Claim Form is signed and dated. Select the method for repayment (either check or direct deposit). If you wish to elect direct deposit, you must complete a separate Direct Deposit Form. You can obtain a direct deposit form from your employer or by contacting us at the number below.

Submit the Claim Form and a copy of your claim documentation via fax, e-mail, or mail as follows:


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E-mail: TPASupport@bfgroup.com

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You will then receive your tax-free reimbursement as explained under your Plan rules. If the IRS audits your tax return, you must be able to provide original receipts in order to validate the tax-free medical dollars you received. Medical dollars paid to you do not show as earnings on your Form W-2. Dollars paid to you through the Plan cannot be used as a medical deduction on your tax return.

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The Administrator's explanation will state the specific reasons for the denial, references to pertinent sections in the Plan document, additional information you must provide to improve your claim, and the procedure available for further review of your claim. If you do not agree with the reasons for denial of your claim, you may request an appeal within 180 days of receiving the denial. You should attach any documents or records that will support your appeal. As part of the review procedure, you are allowed to request and receive copies of pertinent documents, although in some cases, approval may be needed for the release of confidential information, such as medical records. You must submit issues and comments in writing. You may have someone act as your representative in the review procedure if you wish.

A decision will be made in writing within 60 days following the receipt of your request for review or the date that all information required of you is furnished, whichever date is later. If special circumstances require an extension of time, a written notice of the extension will be sent to you. Notification of the decision on review will be clearly described and will specify the reason for the decision.
FSA FAQ’s

Flex Spending Account
Frequently Asked Questions

I am new to Flexible Spending Accounts and Health Reimbursement Accounts. How do these plans work?
When you enroll in a Flexible Spending Account (FSA), you will determine the total amount you want to set aside in a pre-tax account to pay for your eligible out-of-pocket healthcare and dependent care expenses. This amount will be deducted from your paycheck throughout the year on a pre-tax basis. In the case of a Healthcare FSA, the full amount you’ve elected for the plan year is available to you as of your effective date. As you incur expenses, you can request reimbursement at any time throughout the plan year by submitting a claim to Burnham & Flower Insurance Group on an FSA Reimbursement Claim Form with itemized supporting documentation. Upon approval of that request, we will disburse funds from your FSA directly to you.

What is eligible for reimbursement under my Flexible Spending Account?
A Flexible Spending Account (FSA) is designed to reimburse you for out-of-pocket medical expenses and dependent care expenses incurred within your plan year by you, your spouse and tax dependents. An eligible expense list is attached. Some expenses may not be listed but are still covered and may be limited to physician approval or medical necessity.

How do I complete the Reimbursement Claim Form?
Please include your full name and last four digits of your social security number to ensure proper identification. Enter the appropriate services you are requesting reimbursement for. Similar products and services may be combined on the same line of the Reimbursement Request Form. Enter a service start date and if the service provided spans more than one day, also enter the service end date. These dates are the date(s) which you actually received the service, not when the charge was billed or paid. For instance, a reimbursement request for dependent care expenses should include the first date and last date the dependent care services were received to account for the total amount requested.

For many medical expenses, the patient is charged after the reimbursement request has been processed by insurance however, the date(s) that the actual service took place is what should be listed on the form. If it is the service dates that determine eligibility, not billing or payment dates. If the request cannot be validated by itemized, third-party documentation, a service provider may sign his/her name in the appropriate field on the form (credentials must be included for all healthcare services) along with the provider’s Tax ID Number.

Under the “Amount” column, please enter only the amount you wish to be reimbursed. If your insurance coverage will be responsible for a portion of the total charges, you would only include the portion of that charge that is your responsibility to pay. The participant (not a spouse or dependent) must sign at the bottom of the form.

What does my documentation need to have to be considered “itemized?”
IRS guidelines regarding these types of benefits plans require the following information for any reimbursement request:
- The Service Provider’s Name - This could be the name of the doctor, dentist, clinic, retailer etc.
- The Date of Service - This refers to the date on which the charge was incurred/received (except in the instance of on-going services), not a billing or payment date.
- Detailed Description of Service – This should be the specific name of an eligible medical procedure or product. You may use Physician Procedure (CPT) Codes if you have them. Over-the-Counter products must be listed clearly on the register receipt. In the case of an abbreviated description, a representative of the retail provider may indicate the full product name, and print and sign his or her name on the receipt.
- Dollar Amount – This means the amount charged for each specific product or service. Some providers may offer ineligible products or services that they combine with charges for eligible services on an invoice. Without being able to separate the charges for each individual product or service, Burnham & Flower Insurance Group will be unable to reimburse the entire amount.
- Patient Name – required on all copay and deductible reimbursements.

In lieu of itemized documentation, service providers may indicate the date, detailed description and charge amount for any medical or dependent care service and put their signatures (credentials included – M.D., D.D.S., etc.), contact information and Tax ID Numbers in the indicated spaces on the Reimbursement Request Forms.

Prescriptions and Over-the-Counter products require third-party documentation – a provider’s signature will not suffice for these types of reimbursement requests.

What do I do if I lost or threw away a prescription bottle? No, but your pharmacy should be able to provide you with a detailed print out of all prescriptions filled within a requested time period. A prescription bottle does not include the necessary information needed to process the claim. You will not be able to request reimbursement with just a copy of your cash register receipt. A cash register receipt does not give the name of the patient, the quantity filled, or other necessary information.

What are the hours during which I can fax my reimbursement request?
You may send your fax at any time as our fax line can accept faxes 24 hours a day. Please use the Burnham & Flower Insurance Group Reimbursement Request Form as the cover page for your fax to ensure proper and timely processing. If you are resubmitting a previously denied request, please use the Denial Letter as your fax cover page.

All claims will be processed same-day as long as they are received by 3:00 pm. Any claims received after that time will be processed on the next business day.

What will be processed sooner, faxing or mailing my reimbursement request form?
Sending a request by fax will arrive in our offices sooner than by mail. Once received, however, no special priority is given to requests based on the mode they were sent. All reimbursement requests are processed within 24-hours of receipt (excluding weekends and Burnham & Flower Insurance Group scheduled holidays). If you have signed up for e-mail notification you should receive the notification within that same 24-hour period.

May I e-mail my reimbursement request form in?
Yes, if you wish to e-mail your reimbursement request, you may send it to TPASupport@bfgroup.com.

When will I receive payment?
Burnham & Flower Insurance Group will process your reimbursement request within 24 hours of receipt of the request (excluding weekends and Burnham & Flower Insurance Group scheduled holidays). We advise our clients to allow for 2-3 business days for electronic payments to post to their accounts and 5-10 business days for check mailing.

Why is my request not showing up online?
It may take up to 24-hours from the time we receive your reimbursement request before you can view it online. Burnham & Flower Insurance Group prides itself on quick turnaround on processing requests. To ensure that your reimbursement is likely to appear online without any delays, please make sure you are using the most current Reimbursement Request Form by downloading it from our website each time you submit a new request. Fill out the form clearly and completely and make sure to attach all necessary substantiation when submitting your claim.
I highlighted all the pertinent information on all the receipts that I faxed along with the Reimbursement Request Form. Why was Burnham & Flower Insurance Group unable to fulfill my request?

Your claim may have been denied due to an ineligible expense or lack of documentation. You will be notified by email or mail of any denied claims. You will have the opportunity to resubmit this claim. If you choose to do so, please provide us with the necessary substantiation.

May I send Explanations of Benefits to substantiate reimbursement requests?

You may submit an Explanation of Benefits (EOB) from your insurance company as your itemized documentation. You may request reimbursement for any amount that your insurance company has applied to your deductible or copayments as long as it is an eligible reimbursable expense.

Does Burnham & Flower Insurance Group receive information from my healthcare provider or my insurance company?

No, we do not receive any information from your healthcare provider or your medical plan carrier directly. You will be required to submit the proper documentation as your medical information is protected by HIPPA regulations and secure information.

How long do I have to submit a reimbursement request after the end of the year?

The amount of time that you have to submit your reimbursement requests after your loss of coverage for that plan year will vary by plan. If you have a balance in your account you will receive a letter in the fourth quarter of the plan year notifying you of your remaining balance and the deadline for reimbursement request submission. You may contact Burnham & Flower Insurance Group if you have any questions on this.

How do I appeal a request that Burnham & Flower Insurance Group was not able to reimburse?

You may appeal your claims denial any time within one year of the date the claim was denied. Your claim may have been denied due to an ineligible expense or lack of documentation. You will be notified by email or mail of any denied claims. You will have the opportunity to resubmit this claim. If you choose to do so, please provide us with the necessary substantiation.

What is a Letter of Medical Necessity? Why do I need one?

A Letter of Medical Necessity (LMN) is required for any item or service that is not typically eligible for reimbursement. The LMN must be provided by a medical practitioner who is qualified to diagnose and treat the stated medical condition, and it must state that the treatment and/or item in question is not eligible for reimbursement. The LMN must be signed by the physician and submitted along with a copy of the medical service receipt. You will receive notification of any expense for which Burnham & Flower Insurance Group has notified by email or mail of any denied claims. You will have the opportunity to resubmit this claim. If you choose to do so, please provide us with the necessary substantiation.

What information do Burnham & Flower Insurance Group require in a Letter of Medical Necessity?

To reimburse an expense that is usually considered ineligible under IRS guidelines, we must be notified of the following:

- The specific medical condition being treated – the physician writing the Medical Necessity Letter may also include Diagnosis and (ICD-9) codes
- The specific product or treatment prescribed for this medical condition
- The proposed start and end date of treatment (most letters will require an annual update)
- The signature and legible, printed name of the physician, including credentials

Any Medical Necessity Letter should be written by a physician qualified to diagnose and treat the listed condition.

What information do I need for a dependent care reimbursement?

The form must be completed in its entirety (See How Do I complete the Reimbursement Request Form?) in lieu of an itemized statement from your dependent care provider, he/she (or a representative of the daycare center) may indicate the service dates and charge amount in the appropriate fields on the Reimbursement Request Form, and provide a signature and Tax ID number on the line below.

Note: The reimbursement request should not be submitted until the service has been provided.

I submitted a dependent care reimbursement request and I received reimbursement for a lesser amount. Why did I not receive the full amount I requested?

The regulations allow for ongoing reimbursement throughout the term of the treatment. To calculate your monthly reimbursement amount, and how much should be allocated for each plan year, the following information is needed:

- Treatment start and end date (or the start date and length of treatment in months)
- Total treatment cost
- Down payment required by provider
- Amount covered by Insurance and/or provider discount, if applicable
- Monthly payment amount

If the provider offers a discount for full payment up front, you may choose that option, but be aware that reimbursement must still occur on a monthly basis according to a payment plan. To ensure that we have all the information needed to process and approve orthodontia reimbursement, please have the provider complete the Burnham & Flower Insurance Group Orthodontic Service Form. Once this form is received, you will be set-up on monthly automatic reimbursements until your balance has been used. Please contact Burnham & Flower Insurance Group for additional information regarding submitting Orthodontia claims.

Due to delays in processing my health insurance claim, I received the bill after the final deadline for reimbursement requests had expired. Can I submit the expense for reimbursement in the current plan year?

No, you cannot submit an expense incurred in the prior plan year for reimbursement of the current plan year’s funds unless your plan allows for a grace period. To be eligible for reimbursement, a service must be incurred during the Plan year and submitted by the final reimbursement deadline. If a claim is submitted by a participant after the deadline, the Employer will be notified and it will be their decision on how to processed.

I have left or will be leaving the company through which I have my FSA reimbursement account. How long may I continue to incur and submit expenses for reimbursement?

The amount of time you have to incur expenses and submit them for reimbursement after your employment has ended will vary according to your plan specifications as determined by your Employer.
Important Information for Your Flexible Spending Account (FSA) Enrollment

Contributions are limited to a maximum of $2,650 each year. Following is a list of FSA eligible and ineligible expenses.

List of FSA eligible expenses:

- Acupuncture (excluding remedies and treatments prescribed by acupuncturist)
- Alcoholism treatment
- Ambulance
- Artificial limbs/teeth
- Chiropractors
- Christian Science practitioner's fees
- Contact lenses and solutions
- Co-payments
- Costs for physical or mental illness confinement
- Diagnostic fees
- Dietary supplements with doctor's letter of medical necessity
- Drug and medical supplies (i.e. syringes, needles, etc.)
- Eyeglasses prescribed by your doctor
- Eye examination fees
- Eye surgery (cataracts, LASIK, etc.)
- Hearing devices and batteries
- Hospital bills
- Insulin
- Laboratory fees
- Laser eye surgery
- Obstetrical expenses
- Oral surgery
- Orthodontic fees
- Orthopedic devices
- Oxygen
- Physician fees
- Prescribed medicines
- Psychiatric care
- Psychologist's fees
- Routine physicals and other non-diagnostic services or treatments
- Smoking-cessation programs
- Surgical fees
- Vitamins with doctor's letter of medical necessity
- Weight-loss programs with doctor's letter of medical necessity
- Wheelchair
- X-Rays

List of FSA ineligible expenses:

- Cosmetic surgery and procedures
- Dental bleaching
- Marriage and family counseling
- Over-the-counter items, drugs, or medications that are not medically necessary or are not prescribed by your physician.
- Weight loss programs for general health or appearance
- Premiums you or your spouse pay for insurance coverage (Payroll-deducted premiums sponsored by your employer are eligible under the Premium Only Plan)

Long-Term Care Insurance does not qualify for reimbursement from a Health FSA. In addition, Long-Term Care Insurance can not be offered through a Cafeteria Plan.
Direct Deposit Form

If you chose to receive your reimbursements by direct deposit to your bank account, please complete this form and return it with your Enrollment form to your company’s benefits administrator.

You must attach a copy of a voided check for a checking account deposit, or a deposit slip for a savings account deposit in the designated space below. If you choose a savings account deposit, please verify the bank’s routing number - the number on your deposit slip may not be the correct number for direct deposit transactions.

Company Name: 
Client ID: 

Employee Information

Employee Name: Social Security #: 

Account Information

Bank Name: Type of Account (circle): Checking Savings

Bank Routing Number: 
(see diagram below)

Bank Account Number: 
(see diagram below)

Authorization

I authorize the direct deposit of funds reimbursed from my Pre-tax Accounts into the bank account specified above. My administrator will continue to use this as my “Account of Record” until notified, in writing, to discontinue use of the account. I understand that direct deposit will continue automatically into each new Plan Year unless I notify my administrator, in writing, of a change. I authorize my bank account to be debited for any reimbursements sent in error or claims denied after reimbursement. I certify that I have read, and understand, the information on this Authorization form.

Signature: __________________________________________ Date: ______________________

RETURN THIS FORM TO YOUR BENEFITS ADMINISTRATOR

Suzy Public
123 Main Street
Bloomington, MN 55439

Date

Pay to the Order of

_____________

Dollars

For

Routing Number: 091000019  Bank Account Number: 3564895891

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- Free application available for any Apple or Android smartphone or tablet
- Gain instant access by entering the same username and password from WealthCare Portal
- View account balances and transaction history
- Attach receipts by taking a photo
- Safely fund your HSA and FSA Accounts
- Add or edit text message alerts
- Contact the administrator for assistance
Mobile App Screen Shots
### Mobile App Screen Shots

#### Accounts
- **FSA**
  - **Account:** FSA
  - **Date:** 05/04/2015 - 12/31/2016
  - **Balance:** $345.00

- **HRA**
  - **Account:** HRA
  - **Date:** 06/01/2014 - 06/31/2017
  - **Balance:** $299.32

#### Flexible Spending Account
- **Remaining Balance:** $523.99
- **Spent:** $125.99

#### Details
- **Paid YTD:** $1,500.00
- **Additional Deposits:** $823.78
- **Balance:** $123.99

#### Payroll Info
- **Payroll Cycle:** No Auto Deposit
  - **Employer Per Pay Period Contribution Election:** $0.00
  - **Employee Per Pay Period Contribution Election:** $0.00
  - **Contributions YTD:** $0.00