

**Flexible Spending Account (FSA)  
Employee Health Care Reimbursement Claim Form**  
(Must be completed to request reimbursement from FSA Account)

**EMPLOYEE INFORMATION**

Employee Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

\_\_\_ Check here if this is a change in address

Today's date: \_\_\_\_\_

Day Phone Number: ( ) \_\_\_\_\_ Evening Phone Number: ( ) \_\_\_\_\_

Member ID Number: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Department: \_\_\_\_\_

Your Health FSA may be used to reimburse eligible expenses (as defined by the plan) incurred by a covered employee, his/her spouse or tax dependents (as defined by the plan), but only to the extent such expenses are not reimbursed or reimbursable through insurance or under any health plan. *For information regarding the types of eligible expenses that can and cannot be reimbursed from your Health FSA account, refer to your Plan's Summary Plan Description.*

**EXPENSE DESCRIPTION**

**Note: please attach all supporting documentation (EOB or itemized statement). Claims submitted must total at least \$25. Cancelled checks do not qualify as third-party documentation and are not accepted by the IRS.**

<b>Date(s) of Service From - To</b>	<b>Amount of Expense</b>	<b>Brief Description of Expense</b>	<b>Qualified Individual for whom services were provided</b>
<b>GRAND TOTAL</b> (including any additional sheets)			

I request reimbursement from my Health FSA for the expense(s) listed above. I certify that these expenses were incurred by myself, my spouse and/or my tax dependent and are eligible for reimbursement from my Account and have not been previously reimbursed and are not reimbursable through insurance or any health plan. I understand that any balance in my FSA that remains after the claim filing cutoff date as stated in my Summary Plan Description for the plan year or any applicable grace period will be forfeited.

\_\_\_\_\_

\_\_\_\_\_

**Signature**

**Date**

**Mail this form along with supporting documentation to:**

PreferredOne Flex Administration  
P.O. Box 583439  
Minneapolis, MN 55458-3439  
or  
Fax: 763.847.4004

## Flexible Spending Account (FSA) Medical Expense Coverage and Exclusions

*For information regarding the types of eligible expenses that can and cannot be reimbursed from your Health FSA account, refer to your Plan's Summary Plan Description.*

### Eligible Medical Care Expenses

A covered employee may receive reimbursement from his/her Health FSA only for medical care expenses incurred during the period of coverage for which an election is in force.

1. **Incurred.** A medical care expense is incurred at the time the medical care or service is furnished, and not when the person is billed, charged, or pays for the medical care.
2. **Medical Care Expenses.** "Medical care expenses" means eligible expenses incurred by a covered employee or his/her spouse or dependents for medical care as defined in Code Section 213 (d) and your employer's health FSA plan. In addition, this is only to the extent that the covered employee or other person incurring the expense is not reimbursed (nor is the expense reimbursable) through any insurance plan, other insurance, or any other accident or health plan. If only a portion of a medical care expense is reimbursed or reimbursable elsewhere (e.g., because the medical insurance plan imposes co-payment or deductible limitations), the health FSA can reimburse the remaining portion if eligible under the plan.

### General Purpose FSA – Examples of Eligible Expenses:

- Medical and dental expenses (including for example, amounts for certain hospital bills, doctor and dental bills and prescription drugs) that are covered but not paid by insurance (deductibles, co-pays, co-insurance) excluding most cosmetic procedures.
- Vision and hearing expenses including examinations, eyeglasses, contact lenses, laser eye surgery, hearing aids and seeing-eye dogs.
- Fees paid to medical doctors, chiropractors, and hospitals for services rendered.
- Dental care including orthodontia.
- Routine physical examinations, X-rays, and lab fees.
- Prescription drugs including insulin and birth control pills.
- Special equipment (wheelchairs, crutches, etc.) bought or rented (requires letter of medical necessity).
- Over-the-counter drugs (**unless** excluded as eligible expense under your employer's health FSA plan).
- Expenses for weight-loss programs or treatments, but only if the programs, treatment, or drugs are prescribed by a physician as necessary to alleviate a specific medical condition (reimbursement request must be accompanied by a written statement from a physician verifying that such expenses are medically necessary).

### Limited Purpose FSA – Examples of Eligible Expenses:

- Eligible dental and vision care expenses that are covered but not paid by insurance (deductibles, co-pays, co-insurance) excluding most cosmetic procedures.
- Vision expenses including examinations, eyeglasses, contact lenses, laser eye surgery, and seeing-eye dogs.
- Dental care including orthodontia.
- Prescription drugs related to dental and vision care.
- Over-the-counter drugs for dental and vision care (**unless** excluded as eligible expense under your employer's health FSA plan).

### Exclusions—Examples of expenses not reimbursable under either the General Purpose or Limited Purpose Health FSA

The following expenses are not reimbursable, even if they meet the definition of "medical care" under Code § 213 and may otherwise be reimbursable under regulations governing health FSAs:

1. Health insurance premiums that you, or your spouse, pay for coverage under another health plan.
2. Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease.
3. Long-term care services, custodial care, household and domestic help (even though recommended by a qualified physician due to a covered employee's or dependent's inability to perform physical housework).
4. Costs for sending a child of special needs to a special school for benefits that the child may receive from the course of study and disciplinary methods.
5. Bottled water.
6. Maternity clothes, diaper service, or diapers.
7. Cosmetics, toiletries, tooth brushes, toothpaste, sundries, etc.
8. Uniforms or special clothing.
9. Automobile insurance premiums.
10. Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
11. Any item that does not constitute "medical care" as defined under Code § 213.
12. Any item that is not reimbursable under Code § 213 due to the rules in Prop. Treas. Reg. § 1.125-2, Q-7(b)(4) or other applicable regulations.
13. Vitamins and herbal or dietary food supplements, unless prescribed by a physician for the treatment of a specific medical condition.
14. Services that are determined not medically necessary by the FSA Plan Administrator or its designee.