

Health Expenses Eligible for Reimbursement under a Flexible Spending Account

EXPENSES NOT REIMBURSED THROUGH HEALTH INSURANCE, *including*:

- Medical, dental, vision, prescription: Deductibles, copayments, coinsurance, laboratory fees
- Alcoholism and drug treatment
- Chiropractor fees regardless of number of visits or maximums
- Contact lenses, supplies
- Dental treatment, exams, X-rays, etc.; braces and other orthodontic appliances
- Dermatologist, Gynecologist fees
- Hearing aids and batteries
- Insulin, test strips, and syringes
- Mental & nervous, psychiatrist, psychologist, psychotherapist
- Over-the-counter medications – pain reliever, antacids, allergy medication, cold medicine
- Physical, speech, and occupational therapy
- Physical exams, annual check ups, school exams, Vaccinations
- Lasik vision correction
- Vision expenses, eyeglasses, exams, lenses, etc.

Over-the-counter Health Expenses Eligible for Reimbursement Under a Flexible Spending Account

MEDICINES AND DRUGS

Allergy treatment
 Analgesic
 Antacids
 Antihistamines
 Anti-diarrhea
 Aspirin
 Cold treatments
 Cough drops
 Hemorrhoid medication
 Laxatives
 Nasal spray
 Pedialyte

REPRODUCTIVE

Birth control pills
 Condoms
 Infertility treatments
 In-vitro-fertilization
 Pregnancy test kits
 Prenatal vitamins
 Spermicidal foam
 Vasectomy and reversal

SMOKING

Nicotine gum
 Nicotine patch
 Smoking cessation products

FIRST AID

Bactine
 Band-aids
 Bug bite meds
 Calamine lotion
 Carpal tunnel wrist support
 Cold/hot packs for injuries
 Diaper rash ointments
 First aid creams
 First aid kits
 Motion sickness pills
 Muscle/joint relief such as
 (Ben-Gay, Tiger balm)
 Rubbing alcohol
 Sun burn treatment
 Thermometer

EYE

Contact lens
 Contact lens solutions
 Eyeglasses
 Reading glasses
 Visine

OTHER

Back supports
 Bio-feedback therapy
 Hearing aids and batteries
 Immunization
 Medic alert bracelet
 Orthotics
 Physical, speech, and
 occupational therapy
 Sales tax
 Shipping cost

WITH MEDICAL NECESSITY FROM PHYSICIAN

Dietary supplements
 Fiber supplements
 Glucosamine/chondroitin
 Herbal medication
 Hormone over the
 counter treatment
 Lactose intolerant treatment
 Nasal sprays for snoring
 St. John's Wort
 Sunscreen
 Weight loss drugs

Health Expenses NOT Eligible for Reimbursement Under a Flexible Spending Account

- Air purifiers
 - Cosmetic surgery and related expenses
 - Diaper service
 - Dietary supplements unless authorized by a physician for a medical condition
 - Non durable medical equipment
 - Non-FDA regulated medications, unless prescribed by a physician
 - Insurance premiums
 - Marriage counseling
 - Massage -- for general well being
 - Maternity clothes
 - Retin-A and Rogaine unless for non-cosmetic purposes
 - Weight loss for general well being
 - Wigs, where not medically necessary
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Dependent Day Care Expenses Eligible Under a Flexible Spending Account

- Must provide Tax ID number or social security number of care provider
 - Child care centers, Family day care providers, Baby-sitters
 - Nursery school
 - Caregiver for disabled dependent or spouse living with the employee
 - Summer day camp
 - Preschool and after-school programs
 - Specialty day camps – computer camp, soccer camp
 - Indirect expenses – application fees, deposits, agency fees if child ultimately attends the day care provider
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Dependent Day Care Expenses NOT Eligible Under a Flexible Spending Account

- Expenses provided by a dependent of the employee (unless the person is 19 or older and not claimed as a dependent)
 - Food and clothing
 - Education expenses from kindergarten and above
 - Health care expenses for a dependent
 - Overnight camps
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Over the counter medicines and drugs

Under the Internal Revenue Code, BAI can reimburse FSA plan participants for many over the counter medicine and drugs. Following is a description of what is eligible and what you must do to receive reimbursement.

Dual-purpose items and dietary supplements – these are items that might have both a medical purpose and a personal, cosmetic, or general health purpose. To receive reimbursement, both a medical practitioner’s diagnosis of a medical condition and a statement from the medical practitioner that the item will treat the diagnosed condition/disease **are required** to be submitted with the claim.

Over the counter medicine and drugs – these include: antacids, allergy medicine, pain reliever, and cold medication. To submit claims for reimbursement, the IRS **requires** employees to provide the following with their claims:

- Name of the item
- Date of purchase
- Amount of item
- Proof of purchase – if the receipt does not indicate the name of the medicine or drug, in addition to the receipt, we need the box top or label indicating the name as well as the price.

An eligible expense includes amounts paid for the diagnosis, cure, relief, or treatment of a disease or function of the body and must primarily be to cure or improve the physical or mental defect or illness. For additional information, please see IRS Publication 502, and/or Section 213 of the Internal Revenue Code, available at www.irs.gov. Publication 502 is a guide only since not all expenses listed in Publication 502 are eligible expenses under a flexible spending account.

HOW TO PLAN FOR FSA ACCOUNT NEEDS

HEALTH CARE ACCOUNT

Estimate for yourself and your eligible dependents how much you expect to spend on each of the following eligible health care expenses:

- Medical and dental deductibles
\$ _____
- Medical and dental coinsurance

- Health copayments

- Eye exams, eyeglasses, and/or contact lenses

- Orthodontia

- Other health expenses not covered by your insurance such as:

- Routine physical examinations

- Health expenses (crutches, hearing aid batteries, wheelchair, etc.)

- Prescription drugs & qualified over-the-counter medications

- Other IRS tax deductible health expenses

- TOTAL**

Your total may be the amount that you want to deposit into your Health Care FSA for the current plan year. Divide the TOTAL by the number of plan year pay periods to determine your Health Care FSA deduction per pay period.

DEPENDENT DAY CARE ACCOUNT

$$\frac{\text{_____}}{\text{Weekly amount for dependent care}} \times \frac{\text{_____}}{\text{Number of weeks of care}} = \frac{\text{_____}}{\text{TOTAL}}$$

Your total may be the amount that you want to deposit into your Dependent Care FSA for the current plan year. Divide the TOTAL by the number of plan year pay periods to determine your Dependent Care FSA deduction per pay period.

2010 -- FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM
Jewish Theological Seminary of America

↑ FULL NAME (PRINT) ↑	↑ SOCIAL SECURITY NUMBER ↑	↑ WORK PHONE ↑
↑ HOME ADDRESS, CITY, STATE, ZIP ↑		
↑ Email address, indicate work or home (REQUIRED for direct deposit and year end reminder notifications) ↑		

FLEXIBLE SPENDING ACCOUNTS: I authorize the following payroll deductions each pay period, pretax, for the reimbursement of eligible health and/or dependent care expenses.

Health Care FSA Maximum health FSA \$10,000/yr. Minimum health FSA \$240/yr.	\$ _____ annually
Dependent Care FSA Maximum dependent care FSA \$5,000/yr. Minimum dependent care FSA \$240/yr.	\$ _____ annually

I understand that my Social Security benefits may be somewhat lower since Social Security taxes are not payable on my pretax deductions and/or contributions.

BANK INFORMATION -- DIRECT DEPOSIT <i>If you are electing direct deposit, please attach a copy of a voided check. Your email address is required for BAI to notify you of the deposit.</i>	Check one: <input type="checkbox"/> Savings <input type="checkbox"/> Checking	
↑ COMPLETE ACCOUNT NAME ↑ ↑ ABA ROUTING NUMBER ↑ ↑ ACCOUNT NUMBER ↑ (Sample: John E. and Mary Jones)		
NAME AND ADDRESS OF THE RECEIVING BANK:		
PRINT: BANK NAME	ADDRESS	CITY, STATE, ZIP

This authorization replaces any previous authorization. I certify that I will comply with all the provisions of the flexible spending account's summary plan description and plan document.

_____	_____
SIGNATURE	DATE

✓ PLEASE PRINT ALL INFORMATION; remember to keep a copy for your records and return the signed copy to Human Resources ✓ Indicate the dollar amount you wish deducted annually. ✓ Complete the Bank Information section if you would like your reimbursement electronically transferred. ✓ Complete the email section to receive 1) verification of direct deposit and/or 2) year end reminder statements of account balances
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