THE FOLLOWING HEALTHCARE EXPENSES QUALIFY FOR REIMBURSEMENT UNDER A FLEXIBLE SPENDING ACCOUNT (FSA) PLAN.
(Only healthcare expenses not reimbursed by insurance can be claimed)

- Annual Deductible for your health care plan
- Office Visit and Prescription Drug co-payments
- Over the counter drugs and medicines
- Medical doctors, dentists, eye doctors, optometrists, chiropractors, osteopaths, podiatrists, psychiatrists, psychologists, physical therapists, acupuncturists, Christian Science practitioners and naturopaths
- Medical examination, x-ray and laboratory service
- Hospital care (including meals and lodging), clinic costs and lab fees
- Medical treatment at a center for drug and alcohol addiction
- Expenses for weight loss programs as treatment for specific ailment, not to include food items, replacements or supplements
- Medical aids such as hearing aids (including batteries), dentures, eyeglasses, contact lenses and solutions, braces, artificial limbs, orthopedic shoes, elastic hose as medically prescribed, crutches, wheelchairs, guide dogs and the cost of maintaining them
- Stop smoking programs (but not non prescription drugs to aid in smoking cessation)
- Automobile modifications (hand controls, special equipment, mechanical lifts)
- Orthodontic treatment
- Dental co-pays and coinsurance
- Eye surgery to correct vision
- Any expenses listed as eligible under Section 213(d)

HEALTHCARE EXPENSES THAT REQUIRE A PHYSICIAN’S LETTER OF MEDICAL NECESSITY FOR REIMBURSEMENT

- Bedpans and ring cushions
- Boost © and/or Pediasure ©
- Foot spa
- Herbs
- Massagers
- Massages
- Special school for a disabled child
- Reconstructive surgery in conjunction with birth defect, disease or accident
- Special teeth cleaning system (such as a Water Pik)
- Therapeutic support gloves
- Wigs for hair loss caused by disease
- Vitamins, multivitamins, minerals and supplements

HEALTHCARE EXPENSES THAT DO NOT QUALIFY FOR REIMBURSEMENT UNDER THE FSA PLAN.

- Anything NOT medically necessary
- Health insurance premiums that you or your spouse pay for coverage under another health plan;
- Basic cost of Medicare Insurance, life insurance or income protection policies
- Long-term care services or premiums
- 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 disfiguring disease)
- The salary expense of a nurse to care for a healthy newborn at home
- Household and domestic help (even though recommended by a qualified physician due to an employee’s or dependent’s inability to perform physical housework)
- Custodial care
- Marital or other relationship therapy
- Health club dues, or fitness programs
- Social activities, such as dance lessons (even though recommended by a qualified physician for general health improvement)
- Bottled water
- Maternity clothes
- Diaper service or diapers
- Cosmetics, toiletries, toothpaste, etc.
- Vitamins, supplements or minerals
- Special foods even if prescribed
- Marijuana and other controlled substances, even if prescribed
- Travel your doctor tells you to take for rest or change
- SoniCare or related battery powered toothbrushes
OVER-THE-COUNTER (OTC) ITEMS
(THIS LIST IS NOT ALL INCLUSIVE)

REIMBURSABLE ITEMS INCLUDE:

- Antacids
- Anti-diarrhea medicine (laxatives)
- Menstrual cycle products for pain and cramp relief
- Cough drops, throat lozenges, sinus medications, nasal sinus sprays
- Nicotine gum or patches for stop smoking purposes
- Special ointment or cream for sunburn (not just regular skin moisturizers)
- BenGay, Tiger Balm, and similar products for muscle pain or joint pain
- Pedialyte for ill child's dehydration
- First aid cream, Bactine, special diaper rash ointments, calamine lotion, bug bite medication, wart remover treatment
- Visine and other such eye products
- Suppositories and creams for hemorrhoids
- Motion sickness pills

THE FOLLOWING ITEMS ARE NOT OTC DRUGS, SO THE OTC DRUG RULING TECHNICALLY DOES NOT APPLY TO THEM; HOWEVER, THEY ARE REIMBURSABLE THROUGH A HEALTH FSA:

- Bandaids, bandages, gauze pads, first aid kits, cold/hot packs for injuries, rubbing alcohol, liquid adhesive for small cuts
- Reading glasses, contact lens cleaning solutions
- Carpal tunnel wrist supports
- Pregnancy test kits, condoms, spermicidal foam
- Thermometers (ear or mouth)
- Nasal strips, etc.

NON REIMBURSABLE ITEMS INCLUDE:

- Toothpaste or toothbrushes (electric or otherwise) even with recommendation or prescription from a Licensed Dentist
- Chapstick or similar products
- Face cream, moisturizers, and suntan lotion
- Medicated shampoos and soaps
- One-a-day vitamins

MAY BE REIMBURSABLE WITH A LETTER OF MEDICAL NECESSITY FROM PHYSICIAN:

- Weight-loss drugs to treat a specific disease (including obesity)
- Pills for persons who are lactose intolerant
- Nasal sprays for snoring
- Orthopedic shoes and inserts (for orthopedic shoes, you can only be reimbursed for the difference between the cost of a normal pair of shoes and the orthopedic shoes)
- Sunscreen
- Acne treatments (most acne treatment is not reimbursable because it constitutes a cosmetic procedure directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent illness or disease. The exception to this rule if the 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 disfiguring disease)
- Glucosamine/Chondroitin for arthritis or other medical condition
- St. John's Wort for depression
- OTC hormone therapy and treatment for menopause to treat symptoms such as hot flashes, night sweats, etc.
- Dietary supplements or herbal medicines to treat a specific medical condition
- Pre-natal vitamins
- Fiber supplements
The following dependent care expenses qualify for reimbursement under a FSA Plan.

Dependent care expenses are those that are necessary for you and your spouse (if married) to be gainfully employed.

- Nanny expenses, for services provided inside your home, are eligible to the extent they are attributable to dependent care expenses and expenses of incidental household services.
- Dependent care expenses incurred for services outside your home, providing they are incurred for the care of a qualifying dependent that regularly spends at least 8 hours per day in your home.
- Registration fees to a daycare facility are eligible as long as the fees are allocable to actual care and not described as materials or other fees.
- Nursery school expenses are eligible, even if the school also furnishes lunch and educational services.
- Expenses paid to a relative (e.g. child, parent, or grandparent of participant) are eligible. However, the relative cannot be under age 19 or a tax dependent of the participant.
- FICA and FUTA payroll taxes of the daycare provider are eligible.
- Dependent care expenses incurred to enable the employee to find work are eligible.
- The reimbursement may not exceed the smaller of the following limits:
  - The maximum allowed under the plan.
  - $5,000 (if you are filing a joint tax return) and $2,500 if separate returns are filed.
  - Your taxable compensation (after all compensation reduction elections).
  - If you are married, your spouse's actual or deemed earned income.

Excluded Items from Dependent Care Reimbursement

- The maximum allowed under the plan.
- $5,000 (if you are married and filing a joint tax return or are filing as single, head of household) and $2,500 if you are married and separate returns are filed.
- Your taxable compensation (after all compensation reduction elections).
- If you are married, your spouse's actual or deemed earned income.
FSA
Reimbursement Claim Form

Employer: ____________________________________________

Employee Name: _____________________________________
SSN or Employee ID: ________-________-_________

Phone: (_________) _____________-_______________________
E-mail: _______________________________________________

### DEPENDENT CARE EXPENSE CLAIMS (DAYCARE EXPENSES)

<table>
<thead>
<tr>
<th>Name of Dependents</th>
<th>Period Covered</th>
<th>Name, Address, and Taxpayer Identification Number of Service Provider</th>
<th>Amount Incurred</th>
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*NOTE: Attach a receipt from your daycare provider, or include the daycare provider’s signature.*

Provider’s Signature:

TOTAL DEPENDENT CARE EXPENSE CLAIM* $  

### UNREIMBURSED MEDICAL EXPENSE CLAIMS

<table>
<thead>
<tr>
<th>Date Expense Incurred (mm/dd/yy)</th>
<th>Name of Service Provider</th>
<th>Expense Description</th>
<th>Person for Whom Expense Incurred</th>
<th>Net Amount</th>
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*NOTE: Attach appropriate receipt(s) and submit with this claim form.*

TOTAL MEDICAL CARE EXPENSE CLAIM $  

**Read Carefully:** The undersigned participant in the Plan certifies that all services for which reimbursement or payment is claimed by submission of this form were provided during a period while the undersigned was covered under the Company’s Cafeteria Plan with respect to such expenses and that the medical expenses have not been reimbursed or are not reimbursable under any other health plan coverage. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, or city income tax on amounts paid from the Plan which relate to such expense.

Employee’s Signature ___________________________ Date ________________
AUTHORIZATION FOR AUTOMATIC REIMBURSEMENT DEPOSIT

Employee Name __________________________
Employee SSN __________________________
Employer __________________________

I hereby authorize Rehn & Associates to initiate credit entries to my:

☐ Checking account
☐ Savings account

As indicated below and the depository named below to credit the same to such account.

ACCOUNT NUMBER _________________________________________________________

DEPOSITORY _________________________________________________________
(Financial Institution)

BANK ACH TRANSIT ROUTING NUMBER _____________________________________________

**AN ACTUAL VOIED CHECK MUST BE ATTACHED **

If an actual check is not available to attach (i.e. some savings accounts), you are responsible for obtaining the correct ACH transit routing number from your financial institution.

This authority will remain in full force and effect until Rehn & Associates has received written notification from me of its termination in such time and in such manner as to afford Rehn & Associates a reasonable opportunity to act.

___________________________
Signature
___________________________
Date

****IF YOU HAVE SIGNED UP FOR DIRECT DEPOSIT IN A PREVIOUS PLAN YEAR, THERE IS NO NEED TO SEND THIS FORM AGAIN****

Fax to:
1-(509)-535-7883

Or Mail to:
Rehn & Associates
Attn: FSA Department
PO Box 5433
Spokane, WA  99205