Plan Year 7/1/2025 to 6/30/2026

Flexible Spending Account

Cherokee County School District

Group #2376

What is a Flexible Spending Account?

The IRS allows employees to pay for eligible Medical and Dependent Care expenses with pre-tax dollars. These valuable benefits that your employer has chosen to offer as part of your benefit package allow you to increase your take home pay. We encourage you to please take a moment to review the attached material.

Enrollment/Waive *(See attached information that will help you with determining your election)*

The attached Enrollment Form must be completed, even if you are "waiving" coverage.

2025 FSA Maximum Amount

FSA Medical maximum annual election - **$3,300**

Dependent Care maximum annual election - **$5,000**

Run-out Period

Claims must be submitted no later than **September 31, 2026** for the **2025** plan year.

FSA Medical Carry-Over $660

The carry-over funds will be held in a separate "Rollover" bucket during the run out period, the funds are available for both plan years. Remaining funds after the run out period up to **$660.00** will be carried over for claims incurred in **2026.**

Termination of Employment

If employment terminates (regardless of the reason), you have **90 days** from your termination date to submit claims. Claims incurred after your termination date are not eligible.

FSA Participation

If you elect to participate in the FSA, the HRA reimburses your medical health plan expenses first. The FSA can be used once the HRA as been exhausted.

Point C Flex

Important Contact Information

Hours of Operation: **Monday to Thursday** 8:30 AM to 6:00 PM EST **Friday** 8:30 AM to 4:30 PM EST

Contact your Point C Claim Team: 1-855-408-6507

Claim Submission:

Email: flex@pointchealth.com

Fax: 856-888-2855

Mail: 1934 Olney Ave. Cherry Hill, NJ 08003

Refer to the web portal instructions for 24/7 account access to your Account Balance, Electronic Claim Submission, and more!

Flexible Spending Account (FSA)

What is a Flexible Spending Account (FSA)?

An FSA is an account designed to let you set aside before tax-dollars to cover qualified expenses that you would normally pay out of your pocket with after tax-dollars. You pay no Federal or Social Security taxes on the money you deposit into these accounts. This means that you lower your taxable income and may subsequently lower your overall tax liability.

In this packet you will find a worksheet to help you estimate your FSA election.

You may elect to participate in a Health Care Flexible Spending Account (FSA)

* FSA funds can be used for eligible expenses for you and anyone whom you claim as a dependent on your income tax.

How to Set Up an FSA

* During your FSA Open Enrollment Period you may want to review your current year health care expenses, then estimate the amount you think you will spend out-of-pocket next year.
* Through your employer, the amount you elect is available to you on your FSA plan effective date.
* The amount you elect is deducted tax-free from your paycheck throughout the year in equal installments.
* If you decide to participate, your taxable income will be reduced by the amount you elect to defer into your FSA.

Health Care FSA Eligible Expenses

* Medical, Prescription, Dental, and Vision expenses, including expense not covered by your Health Plan
* Deductible, Coinsurance, Copayments
* Over the Counter Drugs and Feminine Hygiene Care Products (effective 1/1/2020)
* Hearing Exams and Hearing Aids

Expenses are incurred when the service is provided, not when the participant is formally billed or pays for the service.

IRS Rules

In exchange for tax advantages of FSAs, the IRS imposes the following restrictions:

* **Use it or lose it** - amounts left in your account at the end of the year are forfeited. They cannot be returned to you or carried over to the next year unless your plan has adopted the 2 and a 1/2 month grace period OR the $660 carry over option. See page 1 to find out which option applies.
* **No transfers** - you cannot use money from your health care FSA for other accounts, i.e. dependent care, transit, or vice versa.
* **No changes** - once you enroll you may not stop or change your contributions during the year unless you have a change in status.

It is important to plan carefully when deciding how much to contribute.

Please follow the instructions enclosed to register on our website and track your FSA expenses.

If you have any questions please contact the Point C Flex Department at flex@pointchealth.com.

1934 Olney Avenue * Suite 200 * Cherry Hill, NJ 08003

For a more complete list of health care and dependent care expenses that can be reimbursed through your FSA, you may contact the IRS at https://www.irs.gov/forms-instructions-and-publications for publications 502 and 503.

Note: Reimbursement under a health care FSA must be for medical care as defined in Code 213(d). Most, but not all, of the Code 213(d) rules are incorporated by reference into the rules governing health FSAs. There are two important differences. First, under a health care FSA, expenses can only be reimbursed in the year in which they are incurred, while an expense is deductible by a taxpayer for the year in which the expense was paid. Second, insurance premiums are not reimbursable under a health care FSA.

FSA Eligible Expenses

Qualified Health Care Expense Worksheet	
Medical/RX Insurance Out of Pocket Expenses (Deductible, Copayments, Coinsurance)	$
Dental Expenses	$
Vision Expenses	$
Hearing Expenses	$
Over The Counter Drugs	$
Other Medically Necessary Out of Pocket Expenses	$
Total Anticipated Health Care Expenses for the Plan Year	$
Divided By The Number of Pay Periods	$
Deduction Amount Per Pay Period	$

Income Tax Filing: Married Filing Jointly with 4 Exemptions

FSA Savings Example Married Employee with Children

David and his wife, Vicki, both work outside the home and have a combined annual income of $65,000 and two small children who are both in day care.

They decided to deposit $1,200 in their Health Care Account to pay deductibles and copayments.

They also decide to deposit $4,800 in their Dependent Care Account to help pay the children's day care expenses.

Expenses	With FSA	Without FSA
Gross Annual Pay	$65,000	$65,000
FSA Election for Health Care Expenses	$1,200	$0
DCA Election for Day Care Expenses	$4,800	$0
Adjusted Gross Taxable Income	**$59,000**	**$65,000**
Federal Income Tax	$6,124	$7,515
Social Security Tax	$4,514	$4,973
After Tax Health Care Expenses	$0	$1,200
After Tax Day Care Expenses	$0	$4,800
Net Annual Income	**$48,362**	**$46,512**
FSA Saved David & Vicki	***$1,850***	

Expenses	With FSA	Without FSA
Gross Annual Pay	$25,000	$25,000
FSA Election for Health Care Expenses	$500	$0
Adjusted Gross Taxable Income	**$24,500**	**$25,000**
Federal Income Tax	$2,621	$2.696
Social Security Tax	$1,875	$1,913
After Tax Health Care Expenses	$0	$500
Net Annual Income	**$20,004**	**$18,891**
FSA Saved Tony	***$113***	

Income Tax Filing: Single with Standard Deductions

FSA Savings Example Single Employee

Tony, recently out of college, is healthy earns $25,000 a year. He decided to deposit $500 into a Health Care FSA to pay for a new pair of eyeglasses.

FREQUENTLY ASKED QUESTIONS REGARDING FLEXIBLE SPENDING ACCOUNTS

- **What is an FSA plan?**
  A flexible spending account is an employer-sponsored benefit that allows you to set aside pre-tax dollars to pay for eligible out of pocket medical, dental, vision & RX expenses and/or dependent daycare expenses.

- **Who owns the FSA?**
  The money is the account holders to use during the plan year. Ultimately your employer owns the account and any unused balance, after the end of the plan year or any run-out period, is forfeited back to your employer.

- **Does the money in my FSA earn interest?**
  No. The money is simply set aside tax-free to be used for qualified expenses.

- **How does the FSA work?**
  You estimate your eligible expenses for health care and/or dependent care based on your needs for the upcoming year. You may take under consideration any regular maintenance medications you are on, any planned procedures (non-cosmetic), co-pays for office visits, co-insurance for medical equipment or dental work, prescription eyewear etc. Try the on-line FSA estimation calculator tool inlcuded in your member packet.

  NOTE: This is a “use it or lose it” benefit so make your election wisely! Err on the side of conservative! Once you determine how much you want to have set aside from your pay you will be required complete an election form. The money you elect for your FSA will be automatically deducted from your paycheck over the course of a year on a pre-tax basis. When you have an eligible expense, you can either swipe your card at the point of service, or manually submit a claim form along with supporting documentation to be reimbursed from your FSA. For health care FSA claims, you have access to your full election DAY 1. For dependent care claims, you may only be reimbursed your accrued balance.

- **What does pre-tax dollars mean and why is this important?**
  With an FSA, the money you set aside to pay for health care and/or dependent care expenses come out of your salary before taxes are withheld. This reduces your taxable income, and consequently, your tax liability. You pay for your eligible expenses with tax-free money from your FSA.

- **What is the difference between the health care FSA and the dependent care FSA?**
  These are two completely separate accounts with separate purposes. Health care and dependent care elections and balances cannot be co-mingled. Health care elections are used for expenses such as doctor office co-pays, RX co-pays, prescription eyeglasses, and dental co-insurance. Dependent care elections are used for child day care and after school program fees.

- **Can I change my annual election amount?**
  You can change your elected amount during the plan year only if you have a “Qualified Life Event”. Such as a change in employment status or family status (e.g., marriage, divorce, or the birth of a child). Contact your employer if any employment or family status changes occur to determine if your status change would allow you to modify your election amount. Election changes must be made within 30 days of the event.

- **Are there contribution limits?**
  For health care FSAs, your employer determines the minimum and maximum amounts you can set aside in your FSA. However as a result of Health Care Reform beginning January 1, 2025 the maximum contribution amount for the health care FSA will be $3,300. For dependent care FSAs, the annual maximum you can contribute is $5,000, including any amount set aside by a spouse into their dependent care FSA.

- **What happens to the money in the FSA if I don't use it all in one year?**
  The IRS has a "use or lose" rule for FSAs. This rule states that you'll lose any unused money still in your account at the end of the plan year. Your employer, however, may have a "run-out" period after the plan year's ends that allows you to submit claims for eligible expenses that were incurred during the plan year. This run-out period may or may not include a grace period that allows you to incur claims for up to 2.5 months after the end of the plan year, and submit them against the prior year's balance for reimbursement. Your employer may have a rollover option that allows a maximum dollar amount to roll over into the next year. Check with your employer or plan document to determine if your plan has a run-out period, rollover, or a grace period.

- **What are eligible medical expenses?**
  Your health care FSA can be used to pay for a variety of health care expenses incurred by you, your spouse and your dependents. Doctor visits, chiropractor fees, prescription drug copayments, dental care and vision care not otherwise covered by a health plan are all eligible health care expenses. You may also use your FSA funds to reimburse eligible expenses under a spouse's health plan. For a complete list of eligible expenses, see your administrator.

- **What are eligible dependent care expenses?**
  Eligible dependent care expenses include in-home childcare, payments to licensed day care facilities, before or after school programs, and elder care. You may be reimbursed for dependent care expenses incurred for any individual in your family who's under age 13 and can be claimed as a dependent on your federal income tax return, or for a spouse or dependent who's not able to care for him or herself. These expenses must be incurred, regardless of when billed or paid, while you're working or looking for work. Unlike a health care FSA, you're only able to receive a reimbursement from a dependent care FSA if sufficient funds have accumulated in your account from payroll deductions.

- **If my child turns 13 this year, can I use the dependent care account for the whole year?**
  No. You may only submit claims for reimbursement for expenses incurred before your child reaches the age of 13.

- **I'm enrolled in a Health Savings Account (HSA). Can I still enroll in an FSA?**
  If you contribute to an HSA, you may only participate in a limited-use FSA and dependent care FSA. A limited-use FSA allows reimbursement of dental, vision and preventive care services only.

- **How am I reimbursed from my FSA?**
  You may use your Point C debit card at the point of service. This transaction will automatically be withdrawn from your election amount. You may also use your card to pay balance due for any eligible expenses. Please NOTE: in some cases, substantiation may be required. If you have an eligible expense you can complete an FSA claim form and send it along with required supporting documentation by online portal, mobile app, mail, email or fax. Claims forms can be found in your member packet, or contacting the Flex Team at Point C.

- **Where can I use my prepaid Point C card?**
  IRS regulations allow you to use your Prepaid Benefits Cards in participating pharmacies, mail-order pharmacies, discount stores, department stores, and supermarkets that can identify FSA/HRA-eligible items at checkout and accept Mastercard® prepaid FSA cards. Eligible expenses are deducted from the account balance at the point of sale. Transactions are fully substantiated, and in most cases, no paper follow-up is needed. You may also use the Card to pay a hospital, doctor, dentist, or vision provider that accepts Mastercard®. In this case, there is auto-substantiation technology that electronically verifies the transaction's

eligibility according to IRS rules. If the transaction cannot be auto substantiated, paper follow-up will be required.

- **How will I receive the FSA reimbursement for paper claims I submit?** After your claim is approved, you will receive a check in the mail or direct deposit if you are allowed and opt in.

- **How often are claims for reimbursement paid?**
  Claims are processed and paid on a weekly basis. After claims are approved, members are typically reimbursed from their FSA right away.

- **What is acceptable documentation for FSA claims?**
  When you send a manual FSA claim, please include documentation, such as:
  - An explanation of benefits (EOB) that you received for the medical service for which you are filing a claim.
  - Receipts containing the type of service or product provided, date the expense was incurred, name of employee of dependent for whom the service or product was provided, person or organization providing the service or product, and the amount of the expense.
  - Payment plan for regular expenses such as orthodontia payment plans.
  - For dependent care expenses, a copy of the bill or signed receipt is acceptable. Also, haveyour provider complete the Dependent Care section of the claim form.
  - **IMPORTANT: WE MUST BE ABLE TO AUTHENTICATE WHOM IS SUBMITTING A CLAIM.**You may include any of the following 3 points to be identified OR the last 4 Digits of your card number is acceptable by itself.
    Member full name, member email address, member full address, employer name, phone number, date of birth, last 4 of social.

- **What about recurring claims, such as orthodontia payments?**
  You can submit a health care FSA claim form with supporting payment plan documentation from the service provider. This eliminates the need to send in a claim form for each payment. You'll automatically receive monthly allocation reimbursements up to your annual elected amount. You will need to submit a new orthodontia claim each year.

- **How do I keep track of my FSA balance?**
  You should always know your account balance before you make a purchase with your Card. You

can visit your Account Summary page at www.pointc.wealthcareportal.com thru the member portal and view your account activity and current balance. You will need to register to view your account – simply follow the online instructions. Access your account with the mobile app! It's free, secure and easy!

*** Can I elect the FSA plan even if I am not enrolled in my company's health plan?** Yes, provided you meet the FSA plan's eligibility requirements.

- **What happens to the money in the FSA if I leave my employer?**
  If you leave your place of employment during the plan year, you may have a period after termination to submit claims for reimbursement. Services and health care expenses must be incurred before your termination date unless you continue to contribute to your health care FSA account through COBRA. Check with your employer for more information.

- **My spouse and I are each offered an FSA through our employers, can we both elect?**
  Yes. But you can't use both FSAs to pay for the same expense. As a bonus, if you both have a health care FSA, you may each be eligible to elect up to the maximum contribution of $3,300, for a combined household contribution of $6,600.

- **How does participation in my employer's dependent care FSA affect my ability to claim the dependent care tax credit on my federal income tax returns?**

You cannot claim a dependent care tax credit for amounts received under an employer's FSA plan. You may wish to consult with a tax advisor to determine whether the FSA plan or the dependent care tax credit is more beneficial in your individual case. Generally, the higher your income, the more beneficial it is to participate in the dependent care FSA.

- **Can I continue to use an FSA after I retire?**
  No. Only active employees are eligible to participate in an FSA. Retirees are not eligible to have FSAs.

- **My domestic partner is covered on my insurance plan. Can I use my FSA for my domestic partner's medical expenses?**
  If your domestic partner meets the IRS qualifications of a tax dependent, you can legally use your FSA funds for his or her medical expenses. If your partner doesn't meet the qualifications, you cannot use your FSA for any of their expenses.
- **Can I use my FSA to pay for voluntary cosmetic surgery?**
  No. The FSA can be used for cosmetic surgery *only* if prescribed by a physician and deemed medically necessary

Dependent Care Account (DCA)

You may elect to participate in a Dependent Care Flexible Spending Account (FSA)

- Funds can be used for the care of an eligible dependent while you are working.
- The IRS limit is $5,000 if filing Married Jointly or Head of Household
- The IRS limit is $2,500 if filing Married Separately

How to Set Up a Dependent Care FSA

- Review your current dependent care expenses, then estimate the amount you think you will spend next year.
- The amount you elect is deducted tax-free from your paycheck.
- Funds are not available in advance.
- If you decide to participate, your taxable income will be reduced by the amount you elect to defer into your FSA.

Dependent Care Account Eligible Expenses

Eligible expenses are those you pay for the care of an eligible dependent that are necessary so that you and, if married, your spouse can work. Some examples of eligible expenses include:

- Babysitters, Day Care Centers , Pre-school or Nursery School, Summer Day Camp, Adult Day Care and Eldercare

Eligible Dependents

- A child under age 13 and any dependent, including your spouse or parent, regardless of age who lives with you and is physically or mentally incapable of self-care.

How to Claim Reimbursement from Your FSAs

You must submit a Reimbursement Claim Request form and a receipt for your dependent care expense for reimbursement.

The receipt must include:

- Name of person receiving care.
- Name of the Care Provider with their Tax Identification Number or Social Security Number.
- Date(s) care was rendered with the corresponding cost.

Reimbursement

- You will receive the full amount of your claim provided you have enough funds in your account.
- If you do not have enough money in your account, you will receive partial payment and the balance will be sent once you have the funds in your account.

IRS Rules

In exchange for tax advantages of FSAs, the IRS imposes the following restrictions:

No Grace Period, No Carry Over Provision

You cannot transfer money from your Dependent Care to your Medical FSA and vice versa.

You can only make changes during open enrollment or if you have a life event.

Qualified Dependent Care Worksheet	
Childcare Service	$
Pre-School	$
After School Care	$
Other Dependent Care Expense	$
Total Anticipated Health Care Expenses for the Plan Year	$
Divided By The Number of Pay Periods	$
Deduction Amount Per Pay Period	$

WealthCare Portal Online Enrollment

It's time to enroll in your employer offered Tax Advantage accounts! Online enrollment for these benefits is available at **https://pointc.wealthcareportal.com.**

If you currently have an account.

You will receive an email with a link and instructions on how to enroll in the new plan year.

If you are new or have never enrolled.

You will need to register before making your elections. You can do this by selecting "Register" at the bottom of the home page, then fill out the appropriate information.

Your employee ID is your SSN with no dashes, and the registration ID is the name of your employer.

Enrollment Steps.

1. Visit the "My Accounts" tab and select "Online Enrollment".
2. On this screen, you will see all the plans that are available for enrollment.
3. You must select either "Enroll" or "Waive" for each plan offered.
4. Read the instructions at the top of the enrollment form, and fill out all of the required fields. If you do not have time to complete all of the information, you can click the "Save for Later" button and come back to it any time during the Open Enrollment Period.
5. On the next page, you will choose your annual election. The system will calculate the annual amount based on your per pay election. Check the box to agree to the terms of enrollment and hit "next".
6. The last page will confirm all of the options for the plan chosen. You can make changes by hitting the "Edit Info" button. If there are no changes, hit "next".
7. You are now enrolled in this plan. You have until midnight May 19th to make any changes.
8. Please continue this process for all of the available plans, even if you are choosing to waive enrollment.

If you have any concerns or questions during the online enrollment process, please contact Point C directly at 1-855-408-6507 option 1 for Flex department or flex@pointchealth.com.

Thank you for using our online enrollment system!

Flexible Spending Department

Mobile Convenience

For ultimate convenience, get 24/7 access, direct from your tablet or mobile device.

Getting started

* Install "Point C Benefits Mobile" from the App Store or Google Play .
* If you previously registered online, enter your User Name and Password to access your account.

To Register:

* Enter your first and last name, and zip code.
* If prompted, enter Employer Name and Employee ID (SSN without dashes)
* The portal will then prompt you to send a one-time passcode to verify your identity. Enter the code to continue.
* Create a username and set up your security questions.
* If no e-mail or mobile phone is in our records, please contact us to update and set up account 855-408-6507.
* Once completed, you'll be able to access your account!

Check out these convenient mobile features, which help make managing your healthcare easier than ever.

Access accounts: Check balances, view transaction

Manage claims: Submit new claims, upload receipts and check claims status.

Track and pay expenses: Track medical claims and other expenses.

Access cards: Manage card details, access your PIN, and more.

Receive alerts: View important account messages.

Update your profile: Update personal information, including your email and mobile phone.

Calculate your tax savings:
https://pointc.wealthcareportal.com/Page/TaxSavings

Online Control

The member website provides powerful self-service account access, plus education and decision-support resources to help put you in the driver's seat.

Getting started

* Register at **https://pointc.wealthcareportal.com.**
* Enter your first and last name, and zip code.
* If prompted, enter Employer Name and Employee ID (SSN without dashes)
* The portal will then prompt you to send a one-time passcode to verify your identity. Enter the code to continue.
* Create a username and set up your security questions.
* If no e-mail or mobile phone is in our records, please contact us to update and set up account 855-408-6507.
* Once completed, you'll be able to access your account!

Enjoy a full suite of capabilities that help you maximize your healthcare experience.

Full account details: View plan details and account history.

Multimedia education: Learn more about account features, benefits, and how to optimize your experience.

Interactive tools: Access tools and calculators to help you plan and make critical spend/save decisions.

Communications: View a complete history of account communications and manage your personal preferences.

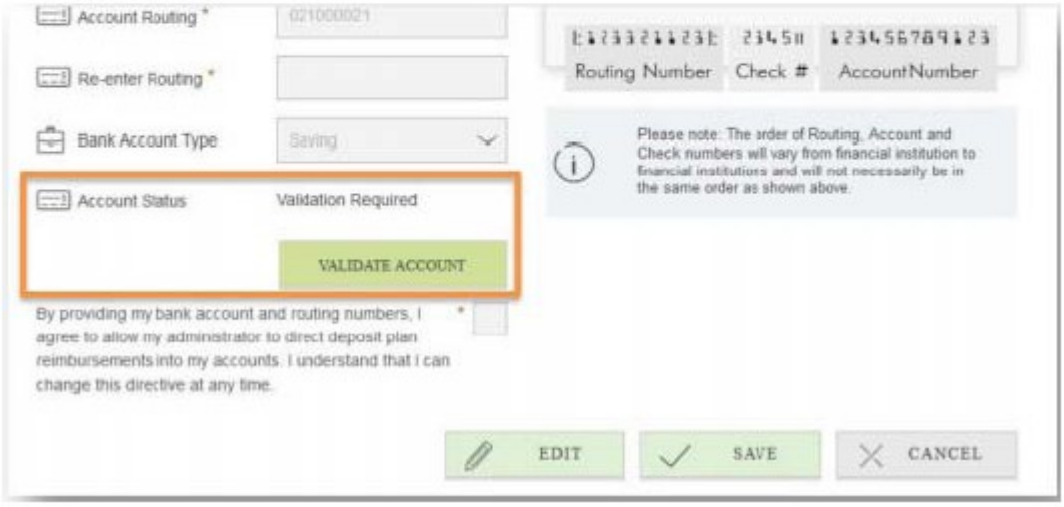
Self-service: Take advantage of expanded account servicing options to manage your account and answers to your questions.

Questions or Concerns? Please call Point C at 855-408-6507 or e-mail flex@pointchealth.com

1934 Olney Avenue, Cherry Hill, NJ 08003

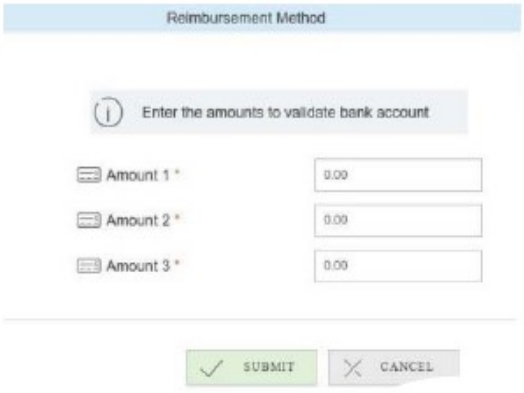
Direct Deposit—Micro Validation

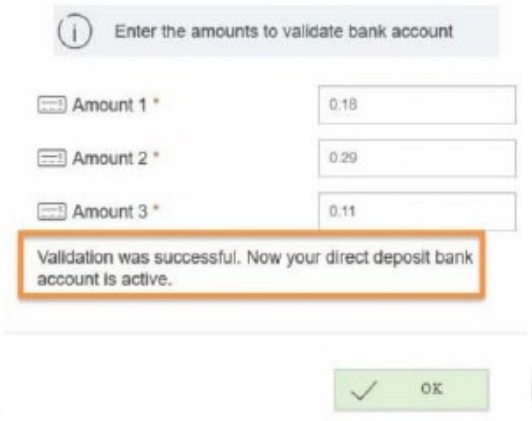
Once you have filled out your direct deposit information, two small credits and one offsetting debit will be processed against the bank account entered. These credits are random amounts between $0.05 and $0.25.



When the credits have been processed, an e-mail will be generated to the e-mail on file (be sure your information is up to date!) letting you know to validate your account. You will need to check your bank account to obtain the credit and debit amounts.

Then you will log back into the Wealthcare Portal or Mobile app and enter the transaction amounts on the reimbursement settings page. If the amounts are correct, you will have successfully validated your account and are ready to receive direct deposits!





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Questions or Concerns? Please call Point C at 855-408-6507 or e-mail flex@pointchealth.com

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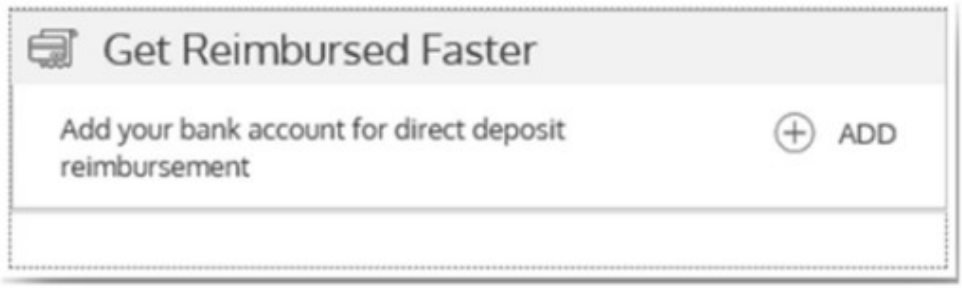
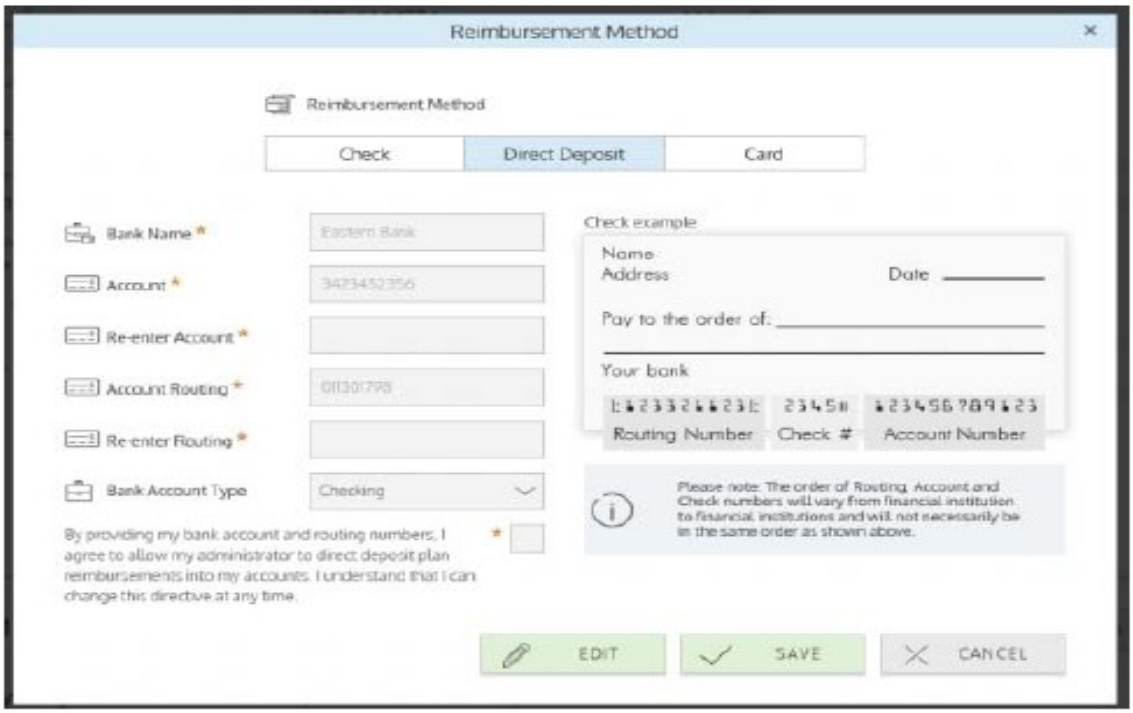
Direct Deposit—Micro Validation

To eliminate hassles and delays caused by invalid participant direct deposit accounts, Point C has implemented a bank account validation process for new direct deposit accounts. As a participant, you will obtain *micro-transaction* amounts from your bank account and enter them into the WealthCare Portal or Mobile application.

Once you are logged into the portal, you will see the below widget on your home page:



Click the "Add" button and fill in the account information as shown below:



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Questions or Concerns? Please call Point C at 855-408-6507 or e-mail flex@pointchealth.com

1934 Olney Avenue, Cherry Hill, NJ 08003

Contact Information:
Point C
855-408-6507
856-888-2855 (Fax)
flex@pointchealth.com
https://pointc.wealthcareportal.com

Employee Election/Salary Reduction Form
Flexible Spending Account

1. EMPLOYEE INFORMATION					
Last Name:	First Name:	M.I.:	Employer:		
Address:		Date of Hire:		Hours/wk:	
City:	State:	Zip:	SSN:		
Home Phone:	Business Phone #	Ext.	Date of Birth		
Email Address:	Marital Status: ☐ Married ☐ Single		Gender: ☐ Male ☐ Female		
Plan Year:	Effective Date:	☐ **Waive Coverage**			
Election Effective Date:	**Date Payroll Deduction Begins:**				
Payroll Period: ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Semi-Monthly					

2. FLEXIBLE SPENDING ACCOUNT (FSA) PRE-TAX BENEFIT ELECTIONS		
FSA Plan Maximum Contribution $3,300 **Rollover Amount $660** ***(Your Plan may not offer this option)***		
Please Select One: ☐ **Flexible Spending Account – Health** ☐ **Limited Flexible Spending Account***	**FSA Payroll Contribution:** **Per Pay Contribution $** **Annual Contribution** $	**FSA Employer Contribution:** Per Pay Contribution $ ***(Your Plan may not offer this option)***
***NOTE:** If you or your spouse have a Health Savings Account (HSA), FSA benefits are limited to Dental and Vision Expenses ONLY or Post Deductible expenses. Do you have an HSA?		☐ Yes ☐ No

3. DEPENDENT CARE ACCOUNT (DCA) PRE-TAX BENEFIT ELECTIONS	
Dependent Care Maximum Contribution $5,000 **If Married Filing Separately $2,500**	
☐ **Flexible Spending Account – Dependent Care** Per Pay Contribution $ Annual Contribution $	**FSA Dependent Care Employer Contribution:** Per Pay Contribution $ ***(Your Plan may not offer this option)***

3. DEPENDENT INFORMATION

Last Name	First Name	M.I.	Social Security	Date of Birth	Gender	F/T Student
Spouse:					☐ M ☐ F	☐ Y ☐ N
Child:					☐ M ☐ F	☐ Y ☐ N
Child:					☐ M ☐ F	☐ Y ☐ N
Child:					☐ M ☐ F	☐ Y ☐ N
Child:					☐ M ☐ F	☐ Y ☐ N

4. CERTIFICATION

I am electing the benefit(s) as indicated above. I understand that:

1. FSA contributions will be deducted from my paycheck on a pre-tax basis.
2. The Plan Sponsor may reduce my election to prevent the plan from becoming discriminatory.
3. The election(s) I make will remain in effect until the end of the plan year. Changes will only be permitted if there is a relevant change in family status (e.g. marriage, divorce, death of spouse, birth or adoption of child, or if you or your spouse experience a change in employment).
4. I understand that FSA salary reductions must be reimbursed for qualified expenses incurred during the plan year (or applicable grace period) and may not be carried over (unless your employer has elected the carry over option). If at the end of the plan year, the total reduction in compensation exceeds the substantiated expenses, the difference in amount reverts to the plan sponsor.

I authorize my employer to make the required pre-tax payroll deduction(s) for the FSA benefit(s) elected and acknowledge that my Social Security Benefits may be reduced due to my election.

Signature	Date	Employer Approval	Date

Contact Information:
Point C
855-408-6507
856-888-2855 (Fax)
flex@pointchealth.com
https://pointc.wealthcareportal.com/

Qualified Expense Worksheet

HEALTH CARE EXPENSE WORKSHEET (Includes Medical, Dental and Vision Expenses Not Covered by Insurance)	
Co-Payments/Co-Insurance/Deductibles	$
Dental Expenses (braces, exams, preventative, crowns, etc.)	$
Vision Expenses (eye exams, glasses, contacts & supplies)	$
Hearing Expenses (exams, hearing aids, batteries)	$
Prescription and Over-The-Counter Drugs (OTC drugs must be prescribed as of 01/01/2011 to be eligible)	$
Other Medically Necessary Un-Reimbursed Expenses (IRS Publication 502 section 213)	$
Total anticipated health-related expenses for the Plan Year	$
Divide total anticipated expenses by # of pay periods	$
Deduction Amount Per Pay Period	**$**

DEPENDENT CARE EXPENSE WORKSHEET	
Total Day Care Expenses for:	
First Quarter (January – March)	$
Second Quarter (April – June)	$
Third Quarter (July – September)	$
Fourth Quarter (October – December)	$
Total Expenses for Dependent Care Services (IRS Pub. 503)	$
Total planned dependent care expenses for the Plan Year	$
Divide total planned expenses by # of pay periods	$
Deduction Amount Per Pay Period	**$**

Contact Information:
Point-C
855-408-6507 (P)
856-888-2855 (F)
flex@pointchealth.com
https://pointc.wealthcareportal.com

Point-C Benefits Card Enrollment Agreement

As a participant in one or more of your Employer Plans or as an account holder under one of the programs (FSA/HRA/HSA/TMA), you will receive a Point-C Benefits Card MasterCard® Debit Card issued by Bancorp Bank, and agree to use it according to this Agreement and the Cardholder Agreement that will be provided to you with the Card.

You understand that the Card is restricted to certain merchant categories and is not accepted at all MasterCard® acceptance locations. You understand that you may not obtain a cash advance with the Card at any merchant, bank or ATM. You understand that the Card is to be used exclusively for Qualified Expenses as defined by the plan(s) in which you participate. If the Card is issued pursuant to Employer Plans and you use the Card for an expense that is not a Qualified Expense, you are indebted to your employer and must repay the full amount of the non-qualified expense.

You agree to save all invoices and receipts related to any expense paid with the Card; upon request you must submit these documents for review by the Plan Service Provider. Failure to submit the receipt(s) will cause the expense to be treated as a non-qualified expense and you will be required to remit payment to your employer. Payment may be in the form of an offsetting claim, a personal check, electronic draft from your personal checking or savings account, a post-tax deduction from your paycheck, or other options established by your employer.

Please Note: Additional terms and conditions would apply if you use the Card to access your funds in your HSA under the HSA program. In such event, these additional terms and conditions would be set forth in an HSA Addendum to your HSA custodial account agreement.

For proper Cardholder Identification, please complete the following information.
Your Card will not be issued until this form is received by your Plan Service Provider. If you currently have a debit card for the year there is no need to complete a new application.
The card will be loaded with the new year election.

Name on 1st Card: (21 characters maximum including spaces) ***Please Print***		
Address		
City	State	Zip
Social Security Number	Date of Birth	Home Phone
E-mail Address		
Name on 2nd Card: (21 characters maximum including spaces) ***Please Print***		
Mother's Maiden Name (Security purposes only):		
Signature:		Date:
Group Name	Group Number	***ALL FIELDS ARE REQUIRED***

For Official Use Only		
Plan Services Provider Initials:	Received Date:	Process Date:

Contact Information & Claims Submission:
855-408-6507
856-888-2855 (Fax)
1934 Olney Ave, Suite 200 Cherry Hill, NJ 08003
flex@pointchealth.com
https://pointc.wealthcareportal.com

##13T01272##########

FSA Claim Form

NOTE:	**Claims must be submitted to your insurance, and you must have an EOB showing your cost share before you submit to Point C for reimbursement.**

Employer Name		
Last name	**First name**	**Social #**
Address ☐ Check box if this is a new address		
City	**State**	**Zip**
Email	**Phone**	☐ Check if Point C Benefits Card was Used

All requested information on this form must be provided along with a copy of your EOB for medical and receipt for prescriptions. Incomplete forms will not be processed.

	Expense # 1	Expense # 2	Expense # 3	Expense # 4	Expense # 5
Date of Service					
Name and Relationship of Person Receiving Medical Service	**Name:** ☐ **Self** ☐ **Spouse** ☐ **Dependent**	**Name:** ☐ **Self** ☐ **Spouse** ☐ **Dependent**	**Name:** ☐ **Self** ☐ **Spouse** ☐ **Dependent**	**Name:** ☐ **Self** ☐ **Spouse** ☐ **Dependent**	**Name:** ☐ **Self** ☐ **Spouse** ☐ **Dependent**
Type of Service Provided					
In-Network Provider	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
EOB/RX Proof Attached	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
Amount Paid					
Reimbursement Requested Amount					
				Total Reimbursement Requested	

I authorize the above expenses to be reimbursed from my Flexible Spending Account. To the best of my knowledge, my statements on this Form are true and complete. I certify all the following: Either I, my Spouse or my Dependent has received the services described above on the dates indicated, or the expenses qualify as valid Medical Care Expenses under Code Section 213(d), as further defined in the Plan document (the "Plan"). I certify that all drugs were obtained legally in the United States. These expenses have not previously been submitted for reimbursement under the Plan. They have not been reimbursed under this Plan or any other plan, and I will not seek reimbursement for them under the major medical plan or any other health plan. These expenses are for medical care excluding cosmetic purposes, are not incurred for general health purposes, and do not constitute toiletries. I understand that the expenses reimbursed may not be used to claim any federal income tax deduction or credit. I also understand that I may be asked to provide further details about some expenses (*e.g. a statement from a medical practitioner that the expense is to treat a specific medical condition or a more detailed certification from me*).

Employee Signature: _____ **Date:** _____
*(Employee Signature **must** be provided in order to process this form)*

This plan is governed by IRS guidelines. To satisfy IRS requirements documentation is needed to process your claim(s). When submitting for reimbursement, please complete and provide necessary documentation. This will quicken the processing time of your claim(s). Please visit our website https://pointc.wealthcareportal.com/Page/Home*for additional forms.*

Contact Information & Claims Submission:
855-408-6507
856-888-2855 (Fax)
1934 Olney Ave, Suite 200 Cherry Hill, NJ 08003
flex@pointchealth.com
https://pointc.wealthcareportal.com

FSA Claim Form Documentation

Important Claim Submission Information

FSA's do not allow advance reimbursement.

All services must have been provided before you submitted for reimbursement.

Expenses that are reimbursable by other insurance or programs are not eligible for reimbursement.

All documentation should show date of service, procedure performed and prove the claim was initially processed by your health care carrier.

IMPORTANT: WE MUST BE ABLE TO AUTHENTICATE WHOM IS SUBMITTING A CLAIM.
You may include any of the following 3 points to be identified OR the last 4 Digits of your card number is acceptable itself.
Member full name, member email address, member full address, employer name, phone number, date of birth, last 4 of social.

Acceptable Documentation for Reimbursement

Medical
A copy of the Explanation of Benefits (EOB).

Prescription
A copy of the pharmacy Prescription Medication detail sheet.

Dental and Vision
A copy of the statement or itemized bill showing the date of service, procedure/items purchased and name of the person receiving the service/items.

Over-the-Counter Purchases (OTC)
A copy of the itemized register receipt. If the receipt abbreviates product names provide the name of the product to ensure a timely reimbursement.

Claims will not be processed if the claim form is not completed or if the proper documentation is not received.

If you have questions regarding an expense, please feel free to contact us.

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##13T01272##########

Dependent Care Account Claim Form

Employer Name		
Last name	**First name**	**Social #**
Address ☐ Check box if this is a new address		
City	**State**	**Zip**
Email	**Phone**	☐ Check if Point C Benefits Card was Used

All requested information on this form must be provided along with a copy of your statement/receipt from your dependent care provider. Incomplete forms will not be processed.

Provider Name			**Provider Tax ID**
Provider Address			
Name of Child(ren)	**Date of Birth**	**Dates of Service**	**Total**

I hereby certify that the above information is correct and authorize payment through my Dependent Care Flexible Spending Account. 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. Unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the Plan which relate to such expense.

I further certify that these expenses did in fact occur within the current plan year and have not been reimbursed under this or any other plan and I will not seek reimbursement for them under any other plan. I understand that reimbursed expenses are not eligible for any federal income tax deduction or credit (such as Dependent Care Tax Credit). I agree to file IRS Form 2441 with my tax return and provide any day care provider taxpayer identification number required thereon. Misrepresentation may lead to adverse employment action and taxable W-2 income.

****Note: Date and Provider signature is required AFTER services hav been rendered, not at time of payment.**

Employee Signature: _____ **Date:** _____

Provider Signature: _____ **Date:** _____

(Required if separate receipt not submitted)

Contact Information & Claims Submission:
855-408-6507
856-888-2855 (Fax)
1934 Olney Ave, Suite 200 Cherry Hill, NJ 08003
flex@pointchealth.com
https://pointc.wealthcareportal.com

Dependent Care Reimbursement Instructions

Important Claim Submission Information

The following information MUST be included on your statement in order to receive payment:

Provider's name
Provider's address
Provider's Tax ID #
Child's name
Child's date of birth

You MUST provide receipts, statements or bills from your dependent care provider proving that expenses have been incurred.

Cost of the services provided on those dates.

Please Note

Canceled checks and credit card receipts will not be accepted.

Signature of dependent care provider is only needed if separate receipts are NOT submitted.

Employee signature must be provided.

If you have questions regarding an expense, please feel free to contact us.

This plan is governed by IRS guidelines. To satisfy IRS requirements documentation is needed to process your claim(s). When submitting for reimbursement, please complete and provide necessary documentation. This will quicken the processing time of your claim(s). Please visit our website https://pointc.wealthcareportal.com/Page/Home for additional forms.