



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 \$640 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.

| 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 | \$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 |
| <i>FSA Saved Tony</i> | <i>\$113</i> | |

| 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 |
| <i>FSA Saved David & Vicki</i> | <i>\$1,850</i> | |

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.



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, and Summer Day Camp

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 | \$ |

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@pointhealth.com

1934 Olney Avenue, Cherry Hill, NJ 08003

10 Tips to optimize your account experience.



Use your debit card whenever possible to avoid the hassle of filing claims.



Submit claims via mobile app or our member website for quicker reimbursement.



Check your balance 24/7 via mobile app, text, or our member website.



Upload and store your receipts for quick reference and safekeeping.



Register to receive mobile alerts to stay engaged with your account.



Register your bank account to enable direct deposit and avoid reimbursement delays.



Use our convenient eligibility checker to verify that an expense is eligible.



Use online bill pay to pay providers for qualified expenses.



Snap a picture and upload receipts instantly - right from your mobile device.



Track all of your healthcare spending with our online expense tracker.

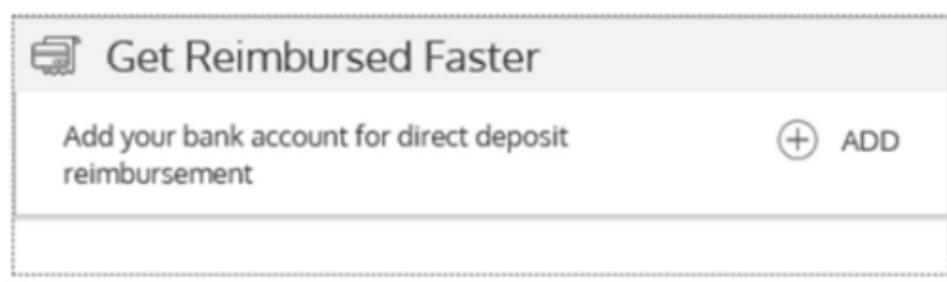
Questions or Concerns? Please call Point-C at 855-408-6507 or e-mail flex@pointhealth.com


1934 Olney Avenue, Cherry Hill, NJ 08003


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.

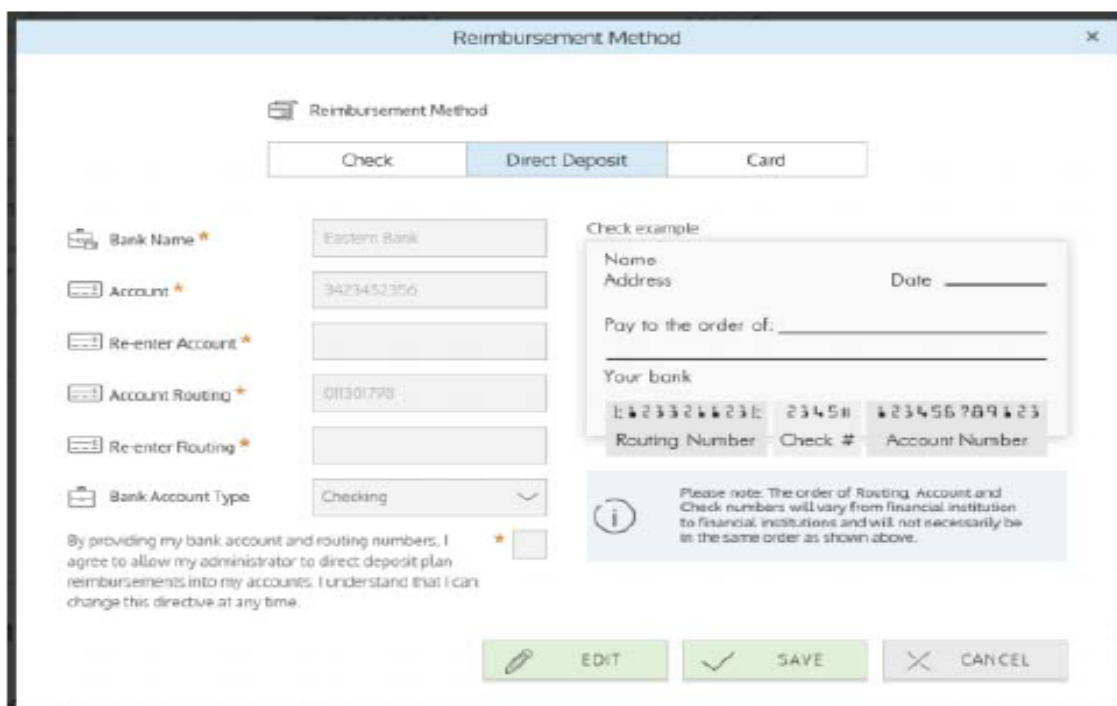
Once you are logged into the portal, you will see the below widget on your home page:



 **Get Reimbursed Faster**

Add your bank account for direct deposit reimbursement  **ADD**

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



Reimbursement Method

Reimbursement Method

Check Direct Deposit Card

Bank Name * Eastern Bank

Account * 3423452356

Re-enter Account *

Account Routing * 011301798

Re-enter Routing *

Bank Account Type Checking

By providing my bank account and routing numbers, I agree to allow my administrator to direct deposit plan reimbursements into my accounts. I understand that I can change this directive at any time. *

Check example

Name _____ Date _____

Address _____

Pay to the order of: _____

Your bank

1 2 3 3 2 6 2 3 1 2 3 4 5 6 7 8 9 1 2 3

Routing Number Check # Account Number

Please note: The order of Routing, Account and Check numbers will vary from financial institution to financial institutions and will not necessarily be in the same order as shown above.

EDIT SAVE CANCEL



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.

The screenshot shows a web form for direct deposit micro-validation. It includes fields for 'Account Routing' (021000021), 'Re-enter Routing', 'Bank Account Type' (Saving), and 'Account Status' (Validation Required). A green 'VALIDATE ACCOUNT' button is highlighted with an orange box. To the right, there are fields for 'Routing Number', 'Check #', and 'Account Number' with sample data. A note states: 'Please note: The order of Routing, Account and Check numbers will vary from financial institution to financial institutions and will not necessarily be in the same order as shown above.' At the bottom, there is a checkbox for agreement and buttons for 'EDIT', 'SAVE', and 'CANCEL'.

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!

The screenshot shows the 'Reimbursement Method' form. It has a section titled 'Enter the amounts to validate bank account' with three input fields for 'Amount 1', 'Amount 2', and 'Amount 3', each containing the value 0.09. Below this is a 'SUBMIT' button. To the right, there is a confirmation message: 'Validation was successful. Now your direct deposit bank account is active.' with an 'OK' button. The 'Amount 3' field and the confirmation message are highlighted with an orange box.



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

1934 Olney Avenue, Cherry Hill, NJ 08003



Enroll in an FSA — and keep more of your money



Stretch your dollars and save more

Who wouldn't like to keep more of their income? Enrolling in a **Flexible Spending Account (FSA)** can help you do just that. An FSA lets you pay for many of your health expenses with income you won't be taxed on. That's right, **with an estimated 30% in tax savings,*** it's a great way to reduce your taxes and effectively **increase your take-home pay.**

Use an FSA to pay for:

- ✓ Doctor visits
- ✓ Prescription eyeglasses & contacts
- ✓ Prescription & over-the-counter meds
- ✓ Dental care
- ✓ Health trackers & diagnostics
- ✓ Menstrual products
- ✓ SPF & skincare products
- ✓ First aid & pain relief, and much more!

Benefits you can see immediately

You can contribute up to **\$3,200** to your FSA†

Bonus: FSA benefits extend to your spouse and dependents as well.

*Assumes average tax rates, including state, federal and FICA taxes.
For illustrative purposes only. Individual earnings may vary.
†Check with your HR representative for details on your plan.

Explore what an FSA
can do for you at
FSAstore.com

Enjoy extra savings on us



**100% ELIGIBILITY
GUARANTEED**



**ALL FSA CARDS
ACCEPTED**



**2,500+ FSA ELIGIBLE
PRODUCTS**

\$5 OFF†


USE CODE TAKE24EN

Visit **FSAstore.com**
to redeem your offer.

†One use per customer.
Exp. 6/30/2025. See Terms for details.



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 <input type="checkbox"/> Check box if this is a new address | | | |
| City | | State | Zip |
| Email | Phone | <input type="checkbox"/> 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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent | Name: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent | Name: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent | Name: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent | Name: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent |
| Type of Service Provided | | | | | |
| In-Network Provider | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| EOB/RX Proof Attached | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> 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: _____
(Employee Signature **must** be provided in order to process this form)

Date: _____

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.

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.

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.



Dependent Care Account Claim Form

| | | | |
|---|--------------|--|-----------------|
| Employer Name | | | |
| Last name | | First name | Social # |
| Address <input type="checkbox"/> Check box if this is a new address | | | |
| City | | State | Zip |
| Email | Phone | <input type="checkbox"/> 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 have been rendered, not at time of payment.**

Employee Signature: _____

Date: _____

Provider Signature: _____

Date: _____

(Required if separate receipt not submitted)

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.