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Plan Year 1/1/2024 to 12/31/2024

Flexible Spending Account

County of Dakota County

Group # 24194

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.

2024 FSA Maximum Amount

FSA Medical maximum annual election - **$3,200**

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

Run-out Period

Claims must be submitted no later than **April 30, 2025** for the **2024** plan year.

FSA Medical & DCA Grace Period

Unused funds as of **December 31, 2024** may be used for eligible expenses incurred during the first **2 months 15 days** of the **2025** plan year. **(March 15, 2025)**

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.

Point-C Flex

Important Contact Information

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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

Donna Foody	Ext. 8231
Theresa Shover	Ext. 8228
Julie Hacker	Ext. 8251

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 $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 www.irs.gov/forms_pubs/index.html 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.

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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.

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	$

Make Your Account Work Harder For You!

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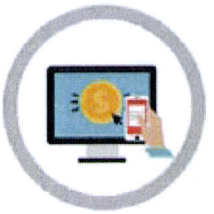
10 Tips to optimize your account experience.

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

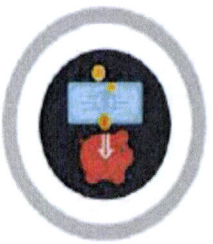


Submit claims via mobile app or our member website for quicker reimbursement.

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

Upload and store your receipts for quick reference and safekeeping.

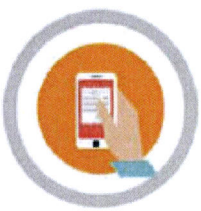
Register to receive mobile alerts to stay engaged with your account.



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@pointchealth.com

1934 Olney Avenue, Cherry Hill, NJ 08003

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

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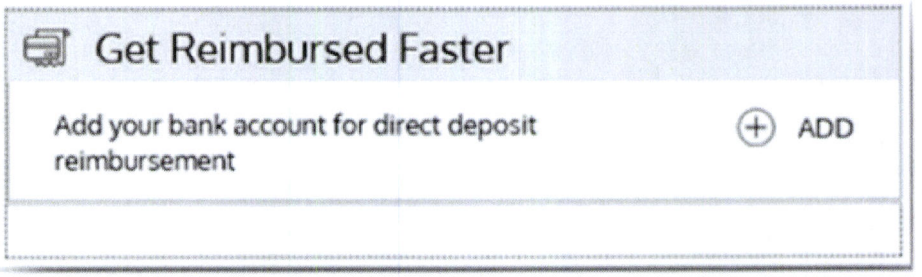
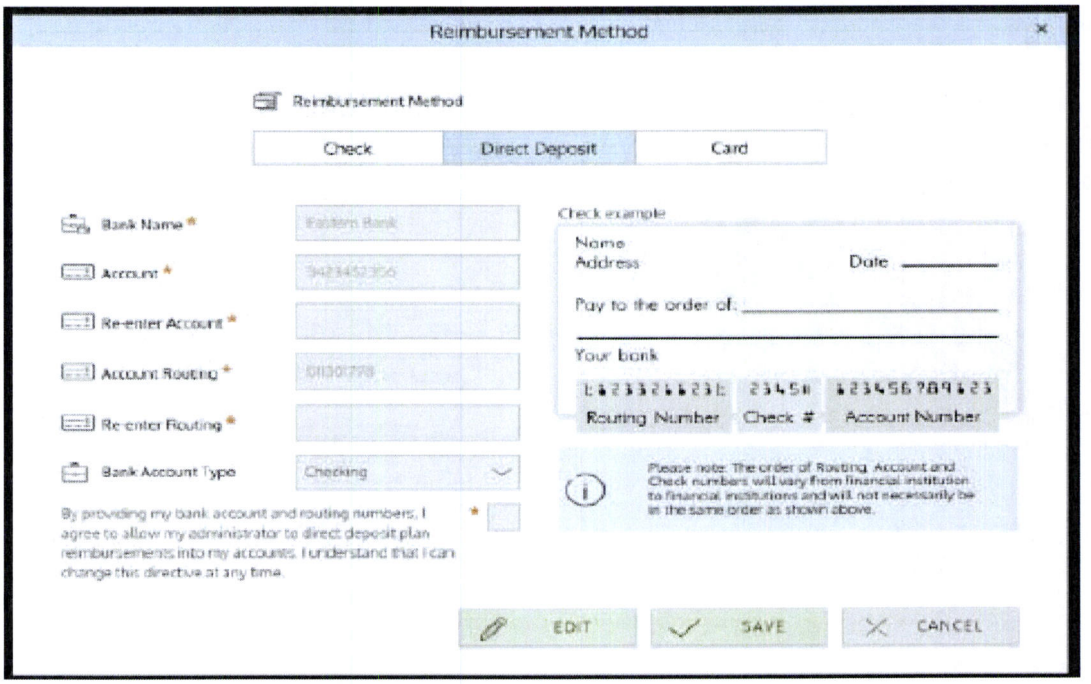
Direct Deposit—Micro Validation

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

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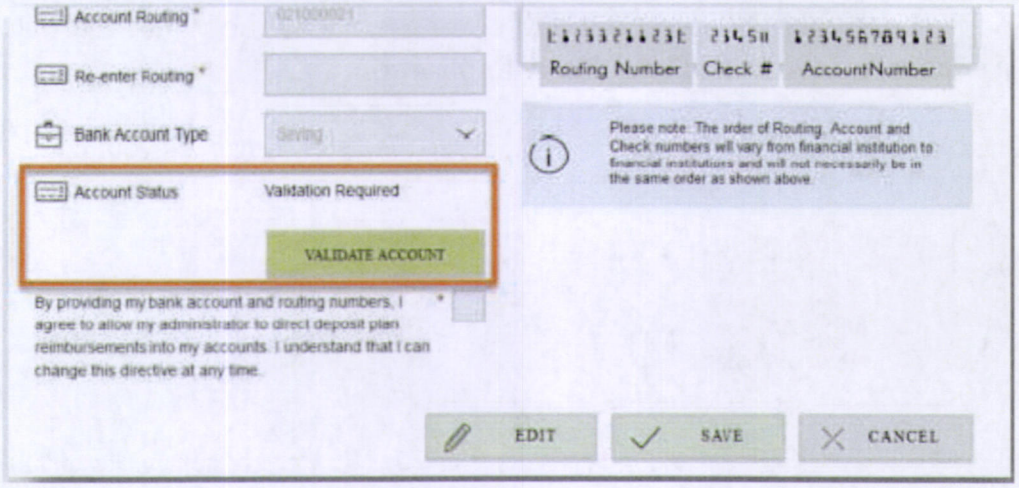
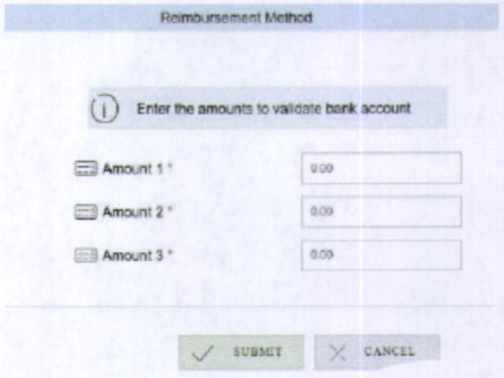
Direct Deposit—Micro Validation

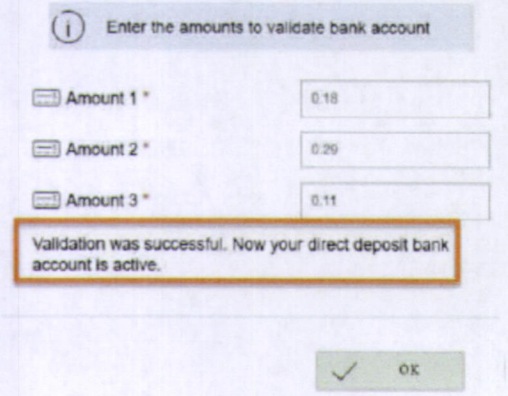
Once you have filled out your direct deposit information, two small credits and one offsetting debit will be processed against the bank account entered. These credits are random amounts between $0.05 and $0.25.



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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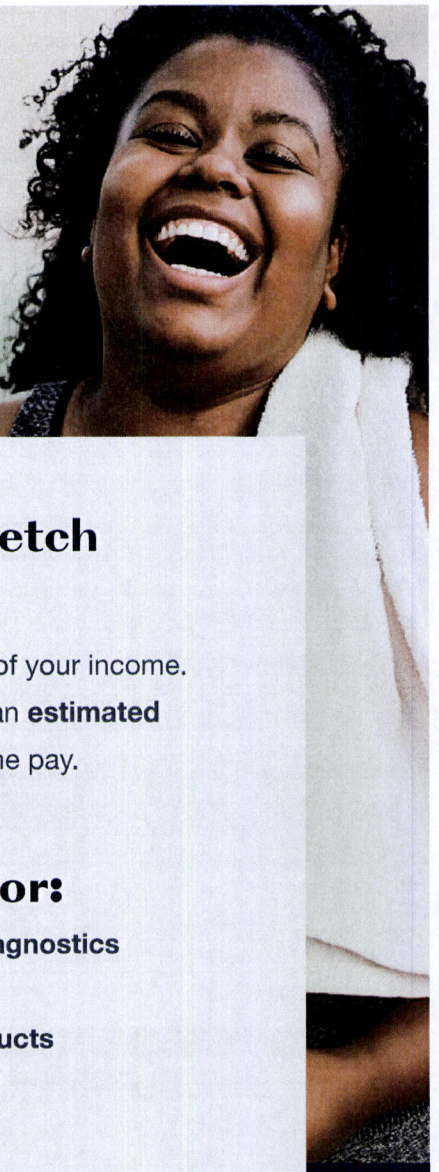
FSA store®

Enroll in an FSA, keep more of your money



As prices rise, you'd probably like to stretch your dollars further.

Enrolling in a **Flexible Spending Account (FSA)** can help you keep more of your income. How? By paying for many of your health needs with pre-tax dollars. With an **estimated 30% in tax savings**,* it's a great way to effectively increase your take-home pay.

Just a few things your FSA can be used for:

- ✓ **Doctor visits**
- ✓ **Prescription eyeglasses or contacts**
- ✓ **Prescription & over-the-counter meds**
- ✓ **Dental care**
- ✓ **Health trackers & diagnostics**
- ✓ **Menstrual products**
- ✓ **SPF & skincare products**
- ✓ **First aid & pain relief**

Benefits you can see immediately

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

Bonus: FSA benefits extend to your spouse and dependent children 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.

Enjoy extra savings on us

100% ELIGIBILITY GUARANTEED

ALL FSA CARDS ACCEPTED

2,500+ FSA ELIGIBLE PRODUCTS

$5 Off‡

USE CODE

TAKE5EN

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

‡One use per customer. EXP. 6/30/2024
See Terms for details

point
Consumer Driven Products

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 $3,200	**Rollover Amount $640** ***(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.

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.

point
Consumer Driven Products

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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)

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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.