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# Flexible Spending Account (FSA)

## Employee Guide

**Employer Name:** Deptford Township Board of Education

**Plan Dates**: 9/1/2023-8/31/2024

### Healthcare

| | | |
|---|---|---|
| **Healthcare FSA eligible expenses:** | | Prescriptions, copays, coinsurance, deductibles, vision care, dental expenses incurred by you or your eligible dependents. Over-the-Counter (OTC) medications are only eligible with a valid prescription.<br>A complete list of expenses eligible under the medical FSA is available at https://www.flexfacts.com/shopfsa.php |
| **Healthcare FSA ineligible items:** | | Cosmetic procedures, vitamins/supplements and food under a weight-loss program (may be reimbursable with a doctor's letter of medical necessity or prescription). |
| **Plan year dates:** | 9/1/2023-8/31/2024<br>Grace period until 11/15/2024 | The plan year is the time period during which you may incur your expenses. You have 2.5 month grace period to use the funds once the plan has ended. |
| **Maximum annual election:** | $3,050 | The maximum amount you can deduct from your paycheck over the course of the plan year. Your full annual election is available as of the first day of the plan year. |
| **Claim run-out date:** | 11/30/2024 | The day which all of your manual claims must be submitted. All claims must have incurred during the plan year including the grace period. |

### Dependent Day Care

| | | |
|---|---|---|
| **Dependent Day Care FSA eligible expenses:** | | Expenses incurred for the care of a child age 12 and under; or a disabled dependent incapable of self-care that allow the employee (and spouse, if applicable) to work. Additional restrictions may apply. |
| **Dependent Day Care FSA ineligible expenses:** | | Overnight camp, care provided by your dependent under the age of 18, babysitting when you are not working, care of your dependent who does not spend at least 8 hours per day in your home. |
| **Plan year dates:** | 9/1/2023-8/31/2024<br>Grace period until 11/15/2024 | The plan year is the time period during which you may incur your expenses and include the grace period. |
| **Maximum annual election:** | $5,000 | The maximum amount you can deduct from your paycheck over the course of the plan year. Your funds will be available as they are deducted from your paycheck. Additional restrictions may apply. |
| **Claim run-out date:** | 11/30/2024 | The day which all of your manual claims must be submitted. All claims must have incurred during the plan year including the plan year. |

## When can I use my Flex Facts debit card?

The easiest way to use your funds is by using your Flex Facts debit card at the point of service. The card can be used at any medical or eligible dependent care facility that accepts MasterCard. You can also use your card at most pharmacies. When you use your card funds are automatically deducted from your account to pay for eligible expenses.

Please note that you should retain all of your receipts. The IRS requires that we request copies of receipts for certain claims. If you are required to send in receipts an e-mail or letter will be sent to you the business day after you use your card.

If you are not able to use your card at the point of service you can file a claim online, by fax or by mail.

## How do I file a claim?

You can file a claim via the following methods:

- **Online** - Log into your Flex Facts account. (See page 3 for instructions on how to register for your Online Flex Facts account)
  - Go to Main Menu > Claims > Submit Claims
  - Follow the prompts to enter the claim details
  - Be sure to click Add Claim Documents to upload a copy of your detailed receipt.
- **Email** - Email your completed Claim Form and detailed receipt(s) to claims@flexfacts.com.
- **Mail** – Mail your completed Claim Form, along with a copy of the detailed receipt(s), to:

  Flex Facts Claims Department
  1200 River Ave, Suite 10E
  Lakewood, NJ 08701

- **Fax:** 877-747-8564

You can download the Claim Forms at www.flexfacts.com or request a copy from your human resources representative.

## When will I receive the claim reimbursement?

Manual claims are reimbursed via manual check or direct deposit. It generally takes 7-10 business days from the date the claim is processed, for the check to be received.

To speed up the reimbursement process, you can sign up for direct deposit. Funds are generally deposited into your bank account within 3-5 business days, from the date the claim is processed.

## How long do I have to submit claims?

Most plans allow 90 days after plan year end, to submit claims for expenses incurred during the plan year.

Accounts/cards will be deactivated upon termination of any kind. Employees generally have 90 days from date of termination to submit claims for expenses incurred during active participation in the plan.

Refer to your Plan Documents for specific plan details.

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# REGISTER FOR AN ONLINE ACCOUNT

View your account balances and card transactions, submit a claim, and much more, right from your computer or smartphone.

Visit www.flexfacts.com > Participant Login > Register or download the mobile app*.

Enter your first name, last name and home zip code. If you received a debit card, check the box and enter your debit card number. Otherwise, click Next.

Choose to receive the verification code via email or text, enter the code, and click Next.

If you cannot receive the code via email or text, click 'I cannot receive a verification code'. If you didn't receive the code, click 'I did not receive my code'. You will be asked to enter:

- Employer ID: enter **GBSDTPBOE**
- Employee ID: enter your Social Security Number (no dashes or spaces)

Create your username and password, set up your security questions, and confirm your email address. Review and confirm your info to complete your registration.

Sign up for direct deposit to receive your payments sooner.

- On the top right corner of the page, click on Your Name > Profile
- Click Edit under Reimbursement Method
- Select Direct Deposit, enter your bank account information, and click Save

*Download our Mobile App on the App Store or Google Play Store to access your account on the go. Use the same Flex Facts User ID and Password when logging into your Flex Facts account via a desktop computer or the mobile app.

## CONTACT US:

- Phone: 732-640-5951
- Email: info@flexfacts.com
- Fax: 877-747-8564

## HOURS OF OPERATION:

Excluding Holidays:
Monday – Thursday: 8:30 AM - 8:30 PM
EST Friday: 8:30 AM - 5:00 PM EST

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**Please send the completed claim form and detailed bills/ EOBs to:**

**Email:** claims@flexfacts.com **Fax:** 877-747-8564

Mail: 1200 River Avenue, Suite 10E, Lakewood, NJ 08701

# Medical & Dependent Care Claim Form

## STEP 1 Employee Information

Full Name: _____ (Last Name) _____ (First Name) _____ (Middle Initial)

Employer: _____ Last 4 digits of Social Security #: _____

Phone: _____ Email: _____

Address: _____ (Address) _____ (City) _____ (State) _____ (Zip)

☐ Check here if submitting a Change of Address

## STEP 2 Medical Claim

| FSA | HRA | Date of Service | Patient Name | Name of Provider | Description of Service | Amount Requested | Pay Me | Pay Provider* |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | | | | | | ☐ | ☐ |
| ☐ | ☐ | | | | | | ☐ | ☐ |
| ☐ | ☐ | | | | | | ☐ | ☐ |

*if pay provider is selected, please be sure to include bill with provider's mailing address

## STEP 3 Dependent Care Claim

| Service Period (From) | (To) | Dependent Name | Dependent Date of Birth | Name of Provider | Description of Service (Day Care, Pre-K, Day Camp, etc.) | Provider Tax ID/ SSN | Amount Requested |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |

**Dependent Care Provider Signature** (if bill is not available): _____

## STEP 4 Direct Deposit (Skip this step if you are already enrolled in direct deposit)

| Bank Name | Account # | Routing # | Account Type (Checking/ Savings) |
|---|---|---|---|
| | | | |

By signing this form, I authorize Flex Facts to initiate debits and/or credits to or from my bank account indicated above. Debits will only be initiated in order to correct a reimbursement error. My authorization will remain in effect until I provide written notification of termination of this authorization or change my direct deposit information online. A reasonable amount of time will be provided for Flex Facts to apply any requested changes.

## STEP 5 Employee Certification

By signing this form, I agree to have my benefit account(s) reduced by the amount(s) requested. I certify that the expenses above were incurred by me (and/ or my spouse and/or eligible dependents) during the applicable plan year and are eligible for reimbursement under my Plans. (Please refer to your SPD/ Plan Document for information on eligible expenses). I certify that these expenses have not previously been reimbursed by this or any other benefit plan, will not be reimbursed from any other source and will not be claimed as an income tax deduction. I understand that I may be asked to provide further details or documentation. I understand and agree that I am obligated to inform Flex Facts in writing if the amount charged for the dependent care services change, the service is terminated, or if there is any reason the expenses are not incurred.

Employee Signature: X_____ Date: _____

## STEP 6 Submit this signed form and copy of required bill(s)/ EOB(s).

- ✓ **HRA:** Explanation of Benefits (EOB)
- ✓ **FSA/ Non-HRA Medical:** Medical bill (must include Provider Name, Patient Name, Date of Service, Description of Service, Amount)
- ✓ **DCA:** Dependent care bill (must include Provider Name, Amount)