



Plan Year 1/1/2025 to 12/31/2025

Flexible Spending and Transportation Management Accounts

County of Monmouth

Group # 9992

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** ****Both employee and spouse must be working in order to elect Dependent Care****



Run-out Period

Claims must be submitted no later than **March 31, 2026** for the **2025** plan year, any unused funds will be forfeited.

FSA Medical & DCA Grace Period

Unused funds as of **December 31, 2025** may be used for eligible expenses incurred during the first **2 months 15 days** of the **2026** plan year. (January 1st, 2026 to March 15th, 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.

Transportation Management Accounts (TMA)

TMA's allow employees to contribute **\$325** for Transit and **\$325** for Parking of pre-tax dollars each month. *Funds can be carried over into the next year.

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@pointhealth.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@pointhealth.com.

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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.



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	\$

What is a Transportation Management Account?

A Transportation Management Account, also called a "TMA," allows employees to contribute pre-tax dollars for commuting expenses. Within a TMA, there are two "sub" categories: a Mass Transit Account and a Parking Account. Allowing you to save money on expenses you already incur.

- * **Mass Transit** - Qualified transit or bus expenses to and from work
- * **Parking** - Qualified parking at or near a transit stop or station, paid parking at your work location

How is a TMA funded?

You contribute to a TMA through payroll deductions. Your deductions can be made on a pre-tax basis, which means before taxes, FICA, and Medicare are taken out of your paycheck.

How much money can I set aside in my account on a pre-tax basis?

Effective 1/1/2025, if you have qualified expenses, you may contribute on a pretax basis up to \$325 a month into the **Mass Transit Account** if you have qualified mass transit expenses, and \$325 a month into the **Parking Account** if you have qualified parking expenses.

These limits are set by the IRS, our benefit packet will be updated as the limits change. Should your monthly expenses for transit or parking be higher than these amounts, your employer may allow you to contribute additional funds on a post-tax basis – be sure to check your employer's benefit plan design.

IRS Requirements

- * The IRS requires the use of your Point-C Benefit Debit Card for all **transit** expenses.
- * Pre-tax **transit & parking** funds can only be used at authorized vendors.
- * You can make changes to your **transit & parking** contribution throughout the year as long as you do not exceed the annual limit, check with your employer regarding change restrictions
- * Retroactive changes are not allowed
- * Funds for **transit & parking** rollover month to month, ONLY **parking** has a run-out period, unused **transit** funds are forfeited when employment ends
- * Pre-tax **transit & parking** expenses are not tax deductible, however Post-tax **transit & parking** expenses are tax deductible
- * Your Point-C Benefit Debit Card is optional for **parking** expenses, If another form of payment is used for **parking**, you will need to submit your receipt and claim form for reimbursement
- * Money from the **parking** account cannot be used for mass **transit** expenses, and vice versa.

Examples of qualified Transportation and Parking expenses

- * Transit Passes, Tokens, Fare Cards, and Vouchers
- * Parking in order to use mass transit and Parking at your work location
- * Commuter highway vehicles seating at least 6 adults, not including the driver, at least 80% of the vehicle's mileage must be for transportation between home and work and employees must occupy at least half of the seating space

Examples of Non-qualified expenses

- * Carpooling, Tolls, Mileage, Gas
- * Transportation and/or Parking expenses to attend work meetings or leisure events
- * Expenses incurred by your spouse and/or dependents in connection with their commutes

Please go to the IRS web site for more information regarding Internal Revenue Code Section 132, and be sure to check your employer's benefit plan material, too.

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

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Transit Benefits – Terminal Restrictions

The IRS requires debit card use for the pre-tax transportation benefit, manual claim reimbursement is not allowed. Your Point C Debit Card will work at the transit vendor terminals that sell only transit media fares. If the cost of your pass exceeds your current Transit Account balance, you will need to split the payment at the ticket counter and use another form of payment for the difference.

Please note: The separate Parking Benefit does allow the option of manual claim reimbursement or the use of your Point C Debit Card.

It is recommended that you purchase your transit passes at terminals similar to the ones shown or on the transit vendors web site.

If a ticket counter sells other items such as newspapers, food items, etc, your card will be declined.

If you are unsure of whether or not the transit vendor that you use will be compliant with the terminal restrictions, please contact Point C at 855-408-6507, and we will be happy to assist you.

Introducing uberPOOL, Lyft, and Via!

Point C is excited to announce a new feature that enables your Point C Benefits Debit Card to pay for eligible uberPool, Lyft, and Via rides using your Transit Benefits.

Within select cities, these companies offer van pool-compliant vehicles for you to commute to/from your workplace. These compliant vehicles hold a minimum of 6 passengers, as you will be sharing this ride with other commuters (in the true spirit of commuter programs).

Using your Point C Benefits Debit Card to pay for these services is easy!

1. Sign up for the eligible provider in your area using their mobile app.
2. Add your Point C Benefits Debit Card to the wallet to your provider's account.
3. When you request a ride, choose your IAA Benefits Debit Card as the payment method.
4. When the ride is requested, the service provider will automatically send you a compliant vehicle.

These ridesharing companies are available for use in the following cities:

UberPool

Miami, FL
Atlanta, GA
Boston, MA
Chicago, IL
Denver, CO
Las Vegas, NV
Los Angeles, CA
New York, NY
Philadelphia, PA
San Diego, CA
San Francisco, CA
Seattle, WA
New Jersey
Washington DC

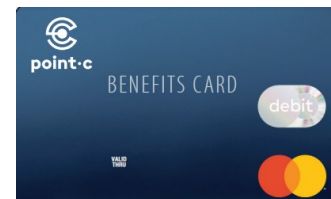
Lyft Line

Miami, FL
Atlanta, GA
Austin, TX
Boston, MA
Chicago, IL
Denver, CO
Las Vegas, NV
Los Angeles, CA
Nashville, TN
New Jersey
New York, NY
Philadelphia, PA
Portland, OR
San Diego, CA
Seattle, WA

Silicon Valley
Washington DC

Via

Chicago, IL
New York, NY
Washington DC



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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. Open Enrollment starts October 21st. You have until November 1st 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@pointhealth.com

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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.

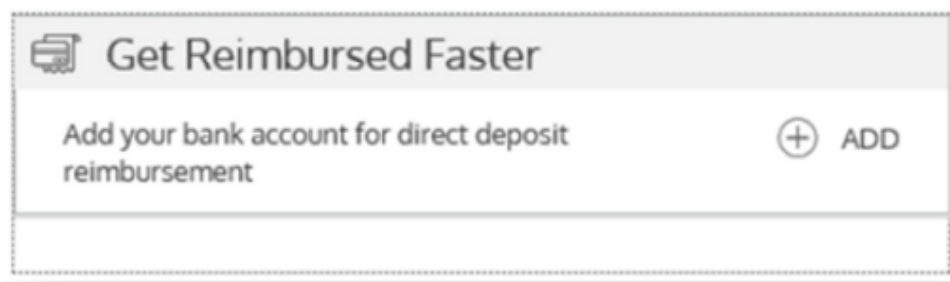
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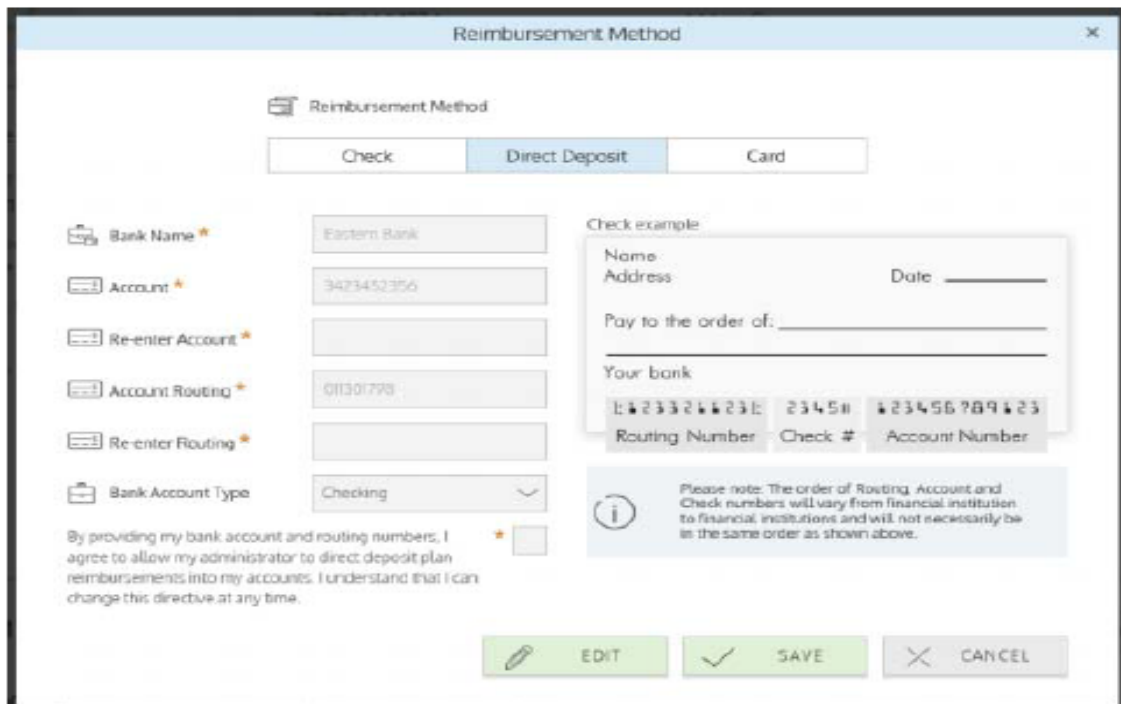
Direct Deposit—Micro Validation

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:

A screenshot of a web form titled "Reimbursement Method" with a close button (X) in the top right corner. The form has three tabs: "Check", "Direct Deposit" (which is selected), and "Card". Below the tabs are several input fields: "Bank Name" (Eastern Bank), "Account" (3473452356), "Re-enter Account", "Account Routing" (011301790), "Re-enter Routing", and "Bank Account Type" (Checking). To the right of these fields is a "Check example" section with fields for Name, Address, Date, and Pay to the order of. Below that is a section for "Your bank" with fields for Routing Number, Check #, and Account Number. At the bottom left is a checkbox with a small asterisk and a text block: "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." At the bottom right is a blue information box with a note: "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 very bottom are three buttons: "EDIT", "SAVE", and "CANCEL".

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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.

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. 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.' Below the form is a consent statement: '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.' At the bottom are 'EDIT', 'SAVE', and 'CANCEL' buttons.

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: 'Amount 1 *' (0.00), 'Amount 2 *' (0.00), and 'Amount 3 *' (0.00). Below this is a 'SUBMIT' button. To the right, another section titled 'Enter the amounts to validate bank account' shows three input fields: 'Amount 1 *' (0.18), 'Amount 2 *' (0.29), and 'Amount 3 *' (0.11). A green 'OK' button is at the bottom right. A message box with an orange border says: 'Validation was successful. Now your direct deposit bank account is active.'

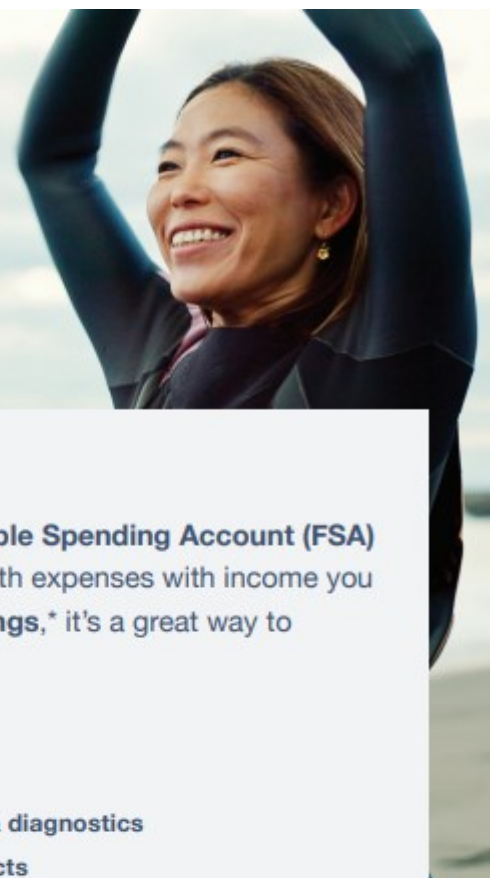


Questions or Concerns? Please call Point-C at 855-408-6507 or e-mail flex@pointhealth.com

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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 **\$3,300** 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.

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: <input type="checkbox"/> Married <input type="checkbox"/> Single		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Plan Year:		Effective Date:		<input type="checkbox"/> Waive Coverage		
Election Effective Date:			Date Payroll Deduction Begins:			
Payroll Period: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> 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:		FSA Payroll Contribution:		FSA Employer Contribution:		
<input type="checkbox"/> Flexible Spending Account – Health		Per Pay Contribution \$		Per Pay Contribution \$		
<input type="checkbox"/> Limited Flexible Spending Account*		Annual 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?					<input type="checkbox"/> Yes <input type="checkbox"/> No
3. DEPENDENT CARE ACCOUNT (DCA) PRE-TAX BENEFIT ELECTIONS						
Dependent Care Maximum Contribution \$5,000		If Married Filing Separately \$2,500				
<input type="checkbox"/> Flexible Spending Account – Dependent Care			FSA Dependent Care Employer Contribution:			
Per Pay Contribution \$			Per Pay Contribution \$			
Annual 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:					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N
Child:					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N
Child:					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N
Child:					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N
Child:					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> 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@pointhealth.com
<https://pointc.healthcareportal.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:

Transportation & Parking Account Enrollment Form

Transportation Management Account allows employees to elect to contribute pre-tax dollars for commuting expenses. This form is to be completed to enroll, stop or make changes to your elected salary deductions for your Transportation Management Account. Please print all information completely, sign and date and return to your employer as soon as possible.

Employee First Name	M.I.	Last Name	Date of Birth	
Email			Effective Date	
Home Street Address		City	State	Zip
Name of Employer				
Worksite Street Address		City	State	Zip
Social Security Number		Telephone Number		

I. ELECTION OF QUALIFIED TRANSPORTATION BENEFIT

Please elect one or more of the following qualified transportation benefits. Mass transit includes any public transit including subway and buses, suburban buses, van pools and ferry services. Private car pools, mileage, tolls, etc. are **not** covered in transit expenses. **The limits are subject to change based on IRS regulations.**

<input type="checkbox"/> Mass Transit: I authorize my Employer to deduct \$ _____ per month (up to \$325.00 a month maximum) on a pre-tax basis from my paycheck.	
<input type="checkbox"/> Mass Transit: I authorize my Employer to deduct \$ _____ per month on a post-tax basis from my paycheck.	
<input type="checkbox"/> Commuter Highway Vehicle/Van Pooling: A commuter highway vehicle must have seating capacity for at least six adults (not including the driver) and at least 80% of the mileage must be expected to be used for the purpose of commuting with three adults (not including the driver) actually riding in the vehicle.	
I authorize my Employer to deduct \$ _____ per month (up to \$325.00 a month maximum) on a pre-tax basis from my paycheck.	
Name of Organization or Person providing the Commuter Highway Vehicle:	
Note: The combinations of Mass Transit and Van Pooling have a combined maximum election amount of \$325.00 per month.	
<input type="checkbox"/> Qualified Parking: I authorize my Employer to deduct \$ _____ per month (up to \$325.00 a month maximum) on a pre-tax basis from my paycheck for parking.	
Total monthly deduction amount for transportation and parking amount (cannot exceed \$325/month for Mass Transit and/or Vanpooling combined + \$325/month parking)	(maximum)

Transportation & Parking Account Enrollment Form

II. CHANGE IN QUALIFIED TRANSPORTATION BENEFIT

Complete the **CHANGE** section only if you want to change or cease the dollar amount of your payroll deduction. It **is not** necessary to complete this section if you are only changing your **method** of transportation or parking location.

<input type="checkbox"/> Change of Deduction - I elect to change my deduction in the program: <input type="checkbox"/> from \$ _____ for Mass Transit to \$ _____ per month. <input type="checkbox"/> from \$ _____ for Commuter Highway Vehicle to \$ _____ per month. <input type="checkbox"/> from \$ _____ for Qualified Parking to \$ _____ per month.
<input type="checkbox"/> Change in Name and/or Address _____ _____
<input type="checkbox"/> I elect to cease participation in the program: I understand that my Employer will cease my payroll deduction for the program as soon as possible. _____
CERTIFICATION & SIGNATURE Date

I agree that any unclaimed amount deducted from my paychecks under the Transportation Management Account will be forfeited. I hereby certify that I have elected the above Qualified Transportation Benefit, and will use that Benefit only for the purposes of commuting to and from work at the Employer.


Signature of the Employee Date

EMPLOYER USE ONLY	
THIS FORM WILL NOT BE PROCESSED UNLESS COMPLETED BY EMPLOYER REPRESENTATIVE	
<input type="checkbox"/> Election for Qualified Transportation Benefit Employee effective date: _____ Salary reduction amount will begin on: _____	
<input type="checkbox"/> Change in Deductions Effective payroll date: _____ Change amount from \$ _____ to \$ _____ for Mass Transit. Change amount from \$ _____ to \$ _____ for Commuter Highway Vehicle. Change amount from \$ _____ to \$ _____ for Qualified Parking Account.	
<input type="checkbox"/> Termination of employment: Date of Termination: _____ Last Payroll Date: _____ Year to date contribution \$ _____	

Signature of Employer Representative Date



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.



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 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 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@pointhealth.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.



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



Parking 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 here if Point C Benefits Card USED	

*Instructions: Complete the information below for Parking Expenses incurred or paid by you. You must provide bills, invoices, statements from an independent third party, parking receipts, or other evidence showing that the Expenses were incurred or paid (canceled checks will not be accepted). **All expenses must be submitted within 180 days of the date of purchase to be eligible for reimbursement under Code Section 132.** Be sure to provide all information requested by this Form. If the Form is incomplete, it will be returned to you. Please date and sign the Form, then send it along with your supporting documentation to the address at the top of this form.*

	Expense # 1		Expense # 2		Expense # 3		Expense # 4	
Date Parking Expenses Provided or Paid								
Qualified Parking Proof of Expense Attached? IF not, explain why proof is not available in ordinary course of business.	Name: <input type="checkbox"/> Qualified Parking <input type="checkbox"/> Yes <input type="checkbox"/> No		Name: <input type="checkbox"/> Qualified Parking <input type="checkbox"/> Yes <input type="checkbox"/> No		Name: <input type="checkbox"/> Qualified Parking <input type="checkbox"/> Yes <input type="checkbox"/> No		Name: <input type="checkbox"/> Qualified Parking <input type="checkbox"/> Yes <input type="checkbox"/> No	
Reimbursement Requested								
Total Reimbursement Requested								

I authorize the above expenses to be reimbursed from my Parking Fringe Benefit Account. To the best of my knowledge and belief, my statements in this Form are complete and true. I certify all of the following. I used the Parking Benefit for which I am requesting reimbursement above only for purposes of commuting to and from work at the Employer. I have received the services described above on the dates indicated, and the expenses are my out-of-pocket expenses that qualify as valid Parking Expenses under the Plan. I have not been reimbursed under any other plan. I understand that the expenses reimbursed may not be used to claim any federal income tax deduction or credit, or to claim reimbursement under another plan. I authorize a deduction in my Parking Account in the amount of the reimbursement.

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

Date: _____