



Flexible Spending Account (FSA) Dependent Day Care (DCA)

Employee Guide

Employer Name: Charlottesville City Schools
Plan Dates: 7/1/2020-6/30/2021

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 NOW eligible without a valid prescription. 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:	7/1/2020-6/30/2021 Grace period until 9/15/2021	The plan year is the time period during which you may incur your expenses.
Maximum annual election: \$2,750		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:	9/30/2021	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:	7/1/2020-6/30/2021 Grace period until 09/15/2021	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:	9/30/2021	The day which all of your manual claims must be submitted. All claims must have incurred during the plan year including the plan year.

How do I set up an account on FlexFacts.com?

To register for your Flex Facts online account:

- 1 **Click here** or go to www.flexfacts.com > Participant Login > Register
 - 2 Set up your username and password
 - 3 Registration ID: choose 'Employer ID' and enter **GBSCHARLO**
 - 4 Employee ID: enter your Social Security Number (no dashes)
 - 5 Click "View Terms of Use" and after reviewing, accept the terms and click Next
 - 6 Create your Security Questions and Answers to complete your registration
- + **Receive your reimbursements sooner** by enrolling in Direct Deposit (recommended)-
- ✓ Click on your name near the profile icon (top right corner of the page)
 - ✓ Click Edit near Reimbursement Method
 - ✓ Select Direct Deposit > Edit > enter your bank account information > Save



Once registered, you can submit claims online, access your account information including balances and claims history.

You can download our Mobile App to your Smartphone at the Apple iTunes store (iPhone) or the Google Play Store (Android) by searching for Flex Facts or scanning the QR codes.

To log in, use the same Flex Facts User ID and Password you created during registration.

The app can be used to view account balances, view transaction history and to upload claims by taking a picture from your smartphone.



Google



iPhone

CONTACT US

Toll Free: 877-94-FACTS (32287)

Local: 732-640-5951

Hours of Operation (excluding Holidays)

Monday – Thursday: 8:30 AM - 8:30 PM EST

Friday: 8:30 AM - 5:00 PM EST

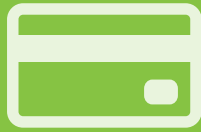
Email: Info@flexfacts.com

Fax: 877-747-8564

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



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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 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?

Filing Online:

Log into your Flex Facts account, click on the "My Account" tab and click "Submit Claim" and follow the Online instructions.

Email:

Email your completed Claim Form and receipts to claims@flexfacts.com

Mail/ Fax:

Complete a Claim Form and send it along with a copy of the receipt/invoice to:

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

Fax: 877-747-8564



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.



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*
<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>

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

STEP 3

Dependent Care Claim

Service Period (From)	Service Period (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)