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Flexible Spending Account (FSA)

Employee Guide

Employer Name: Township of Winslow
Plan Dates: 1/1/2025-12/31/2025

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. 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:	1/1/2025 – 12/31/2025 grace period until 3/15/2026	The plan year is the time period during which you may incur your expenses and includes the grace period.
Maximum annual election:	$3,300	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:	3/31/2026	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:	1/1/2025 – 12/31/2025 grace period until 3/15/2026	The plan year is the time period during which you may incur your expenses and includes 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:	3/31/2026	The day which all of your manual claims must be submitted. All claims must have incurred during the plan year including the grace period.

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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 **GBSTWPOW**
- 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

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 "Claims" tab and choose "My Claim Activity", then 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.

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Please send this form along with all applicable receipts to:

1200 River Avenue, Suite 10E, Lakewood, NJ 08701
Fax: 877-747-8564
E-Mail: Claims@flexfacts.com

Flexible Spending Account Claim Form

Personal Information

Employer: _____

Full Name: _____ _____ _____
Last *First* *M.I.*

Phone: _____ Social Security Number: _____

Birth Date: _____ E-mail Address: _____

☐ Please update my address on file to the new address listed below:

_____ _____
Street Address *Apartment/Unit #*

_____ _____ _____
City *State* *ZIP Code*

Claim Information

Please enter the claim information and amount you are seeking reimbursement for:

Provider Name: _____ Date of Service: _____ Amount: $_____

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Provider Name: _____ Date of Service: _____ Amount: $_____

IMPORTANT: Please be sure to submit an itemized receipt for each service listed above.

Direct Deposit Information

Enroll in Direct Deposit to receive your claim reimbursement within 3-5 business days from date the claim is processed.

Bank Name:_____ Account Type: _____

Account Number: _____ Routing Number: _____

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 prior reimbursement error. My authorization will remain in effect until I provide a written notification of the termination of this authorization or change my direct deposit information on-line. A reasonable amount of time will be provided for Flex Facts to apply any changes requested.

Employee Authorization

- If additional information is required you will receive a denial letter letting you know what additional information is needed.
- Claims incurred during a grace period will be paid out of the prior year first.
- Orthodontia expenses are paid based on the employer's interpretation of the regulations. Please contact your employer to see if advance payments for orthodontia expenses are allowed.
- By signing this form, I consent to/ confirm:
  - ✓ My account being reduced by the amount requested above.
  - ✓ This claim for reimbursement is only for expenses incurred by eligible plan participants during the plan year.
  - ✓ These expenses have not been reimbursed nor will I seek reimbursement for these expenses from any other source.

Signature: _____ Date: _____

Please send this form along with all applicable receipts to:

1200 River Avenue, Suite 10E, Lakewood, NJ 08701
Fax: 877-747-8564
E-Mail: Claims@flexfacts.com

Dependent Care Account Claim Form

Personal Information

Full Name: _____ _____ _____
Last *First* *M.I.*

Employer: _____

Social Security Number: _____

Phone: _____ E-mail: _____

If your address has changed please list the new address below.

New Address: _____

City, State, Zip _____

Please note: All fields below must be filled out in order for claim to be approved.

Claim Information

Name of Dependent: _____ Dependent Date of Birth: _____

Provider Name: _____ Provider Tax ID: _____

Service Start Date*: _____ Service End Date*: _____

Claim Amount: $_____

Provider Signature (if you are unable to obtain a receipt): _____

Name of Dependent: _____ Dependent Date of Birth: _____

Provider Name: _____ Provider Tax ID: _____

Service Start Date: _____ Service End Date: _____

Claim Amount: $_____

Provider Signature (if you are unable to obtain a receipt): _____

Employee Certification

- By signing this form, I agree to have my DCA account reduced by the amount requested.
- This claim for reimbursement is only for eligible expenses incurred by eligible plan participants during the plan year. Please refer to your SPD and Plan Document for information on eligible expenses.
- These expenses have not been reimbursed nor will I seek reimbursement for these expenses from any other source.
- *I understand and agree that I am obligated to inform Flexfacts 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: _____ Date: _____