Wage Works FAQ

1. ***Who is the new Flexible Spending Account administrator for our group?***
   WageWorks is a leading on-demand provider of Consumer-Directed Benefits (CDBs) in the United States
   www.wageworks.com
   877-WageWorks (877-924-3967)
   24/7 excluding some holidays
   Chat service is available 24/7 by logging into your WageWorks account

2. ***Why did the administrator change?***
   In order to provide you with the best customer experience in servicing your Flexible Spending Account, we have partnered with WageWorks. As always, Customer Satisfaction is our #1 goal.

3. ***When will this change be effective?***
   Wage Works will administer Flex benefits for the plan year beginning: January 1, 2021.

4. ***Will I be able to access my account online?***
   Yes, you can register online to access your account to view balances, transaction history, receipt requests, file claims and much more on www.wageworks.com. Simply go to www.wageworks.com and click on the **Employee Registration** link under the **Employee Log In/Register** section (upper right hand corner). Provide your first and last name, DOB, home zip code and the last four digits of your SSN. Once you have been identified as an active employee, you will be able to create a username and password.

5. ***Will I still be able to access to my prior year's plan on PayFlex.com?***
   Yes, you will be able to access your prior year's plan on your PayFlex.com Portal until 12/31/2020.

6. ***Will I receive a new FSA debit card?***
   Yes, WageWorks will be sending out one new debit card to each employee who is actively enrolled in the Healthcare FSA for the new plan year.

7. ***When will I receive my new FSA debit card?***
   You should receive your cards a few days prior to the plan start date.

8. ***When will my current PayFlex card be invalid?***
   Your current PayFlex FSA card will be invalid after 12/31/2020.

9. ***Can I have additional cards for my dependents?***
   Yes, you can obtain additional debit cards by contacting WageWorks via phone at 877-924-3967 or through your logging onto your online account at www.wageworks.com (please note that new users will need to setup their online account – see Question 4 for more info).

10. ***How much do additional/replacement cards cost?***
    With Wage Works, there is no charge for additional or replacement cards.

11. ***Can a card be mailed to my dependent if they live at a different address?***
    Unfortunately, no. The card will be mailed to the address on file for the employee. You will be responsible for forwarding the card to your dependent.

12. ***How many debit cards may I have on my FSA account?***
    There is no limit to the number of cards you may have for your account.

13. ***Will my dependent card have their name or the primary insured's name?***
    The card will have the dependent's name and will be linked to the account holder's annual election and available balance.

14. ***When is the last day to file a claim for the 2020 plan year?***
    All claims must have a DOS (Date of Service) on or prior to 12/31/2020 and be received by 03/01/2021.

15. ***I had funds remaining from the 2020 plan year, when will the money be added to my account at WageWorks?***
    Because you have a ROLLOVER plan, you have until 3/1/2021 to submit claims for the 2020 plan year for services incurred between 1/1/2020 and 12/31/2020. Up to $500 can be carried over to your 2021 plan year, any remaining funds over $500 will be forfeited.

16. ***I had remaining funds from the 2020 plan year, how long do I have to use it?***
    You have until 3/1/2021 to submit a request for reimbursement of services incurred between 1/1/2020 and 12/31/2020.

17. ***I have a question on a Claim/Debit Card Transaction/Receipt Request/Etc., who should I call?***
    If the DOS is between 1/1/2020 and 12/31/2020, call PayFlex at 877-533-0220. If the DOS is 1/1/2021 moving forward, please contact WageWorks at 877-924-3967.

PAYFLEX®

Reimbursement Account Claim Form

Mail or Fax completed form and documentation to:
PayFlex Systems USA, Inc.
PO Box 981158
El Paso, TX 79998-1158
Fax: 1-855-703-5305

To help avoid claim processing delays, you must sign, date and complete this form. You must also include supporting documentation.
WAIT! Did you know that you can file a claim online or by using the PayFlex Mobile® app?
Log in to your member website or mobile app to get started. You can also find instructions online for completing this form.

Member Identification Number *(Employer assigned number or W ID)*	**Member Full Name** *(Last Name, First, MI)*
Member Address *(Street, City, State, ZIP Code)*	

Note: If you have an address change, please notify your employer. For security purposes, we can only accept an address change from your employer.

Employer Name

Health Care Expenses (For you, your spouse and your eligible dependents)

☐ **Automatic Monthly Reimbursement for Orthodontia expenses:** To set up automatic reimbursements, check this box. Include a copy of your orthodontia contract with this form. **Note**: For automatic monthly reimbursements, you only need to send this form and the contract once.

Patient Name	Type of Service (deductible, dental, medical, orthodontia, over the counter, pharmacy, vision)	From Date of Service (not payment date) MM/DD/YYYY	To/Thru Date of Service (not payment date) MM/DD/YYYY	Amount Requested
				$
				$
				$
				$
			Total	**$ 0**

****If more lines are needed, please complete another form.**

Dependent Care Expenses (Child or Adult)

If your caregiver completes and signs below, you do not need to include an itemized statement. **If requesting for multiple dependents, each dependent must be listed on a separate line.**

Exact Dates of Service					
From MM/DD/YYYY	To MM/DD/YYYY	Amount Requested	Qualifying Person's (Dependent's) First and Last Name (Please Print)	Age On Service Date	Qualifying person (Dependent) is under age 13 OR is mentally or physically incapable of self-care due to a diagnosed medical condition and is over age 12. ***Please check, if Yes.**
		$			☐ Yes
		$			☐ Yes
		$			☐ Yes
		$			☐ Yes
	Total	**$ 0**	***You do not need to submit evidence of diagnosed medical condition.**		

Caregiver Information/Certification
My signature certifies that I have provided the services for these expenses for
_____
(Qualifying Person's (Dependent's) First Name)
Name *(Must be printed)* _____
Relative: ☐ Yes ☐ No
Provider Signature _____

Caregiver Information/Certification
(**Note:** This is for a second caregiver, if you have more than one.)
My signature certifies that I have provided the services for these expenses for
_____
(Qualifying Person's (Dependent's) First Name)
Name *(Must be printed)* _____
Relative: ☐ Yes ☐ No
Provider Signature _____

For Health Care Flexible Spending Account: I certify that I, my spouse or eligible dependent have incurred each expense on this form. These expenses are for eligible medical care. They are not for cosmetic reasons. I understand that "incurred" means the service has been provided.

For Health Reimbursement Arrangement (HRA) members: I understand that an Internal Revenue Service (IRS) rule only lets me use my HRA for eligible individuals if they're covered by a compliant group health plan*. I certify that the patient noted on my claim (myself, spouse, or eligible dependent) is covered under my Employer's group health plan or another compliant group health plan*. I have received and read the printed material regarding the reimbursement accounts and understand all of the provisions. *The group health plan must be compliant with the Affordable Care Act (ACA). It can't have annual or lifetime dollar limits on essential health benefits. And it can't exclude coverage because of pre-existing conditions.

For Dependent Care Flexible Spending Account: I certify that I have incurred the Dependent Care expenses for me and, if married, my spouse to work or attend school. These expenses are for my Qualifying Person (dependent). These qualify as eligible expenses under my plan and are not for educational expenses to attend kindergarten or higher. I understand that "incurred" means the service has been provided. This is regardless of when I am billed or charged for, or pay for the service. I acknowledge that I will have to report the caregiver's name, address and Tax Identification Number on Internal Revenue Service Form 2441.

I have not received reimbursement for any of these expenses. I will not seek reimbursement elsewhere, including from a Health Savings Account (HSA). If I receive reimbursement, I and (if married) my spouse will not claim these same expenses on our income tax return. I have received and read the printed material for the plan. I agree to all of the terms and conditions of the plan. Any person who, knowingly and with intent to defraud, files a statement of claim containing any material false, incomplete or misleading information is guilty of a crime.

Member Signature	**Date**

If you are mailing your claim, please keep a copy of this claim form and supporting documentation. We will not return these documents.

HealthEquity | WageWorks

Dependent Care
How to File a Claim for Approval

Claim Filing Options:

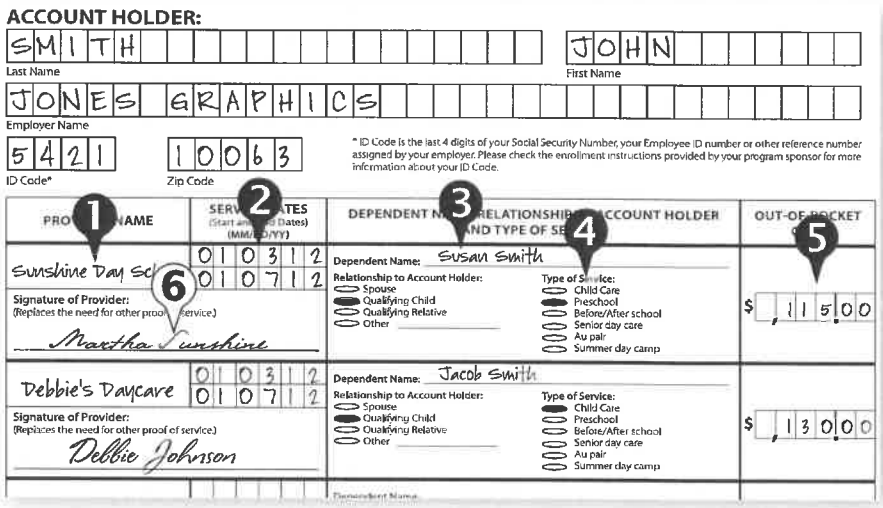
- **File claim online** - Log in to your account at **www.HealthEquity.com/WageWorks** to submit your claim electronically.
- **File claim via fax or mail** - Claim details may be entered online and a completed form may be printed and faxed or mailed with documentation. **Fax:** 877-353-9236, **US Mail:** CLAIMS ADMINISTRATOR, P.O. Box 14053, Lexington, KY, 40512

Instructions to fill out this form:

Complete ALL account holder information. Please give your employer name without abbreviation.

Use your documentation to complete each section of the form, including the following items:

① Provider Name
② Service Date(s)
③ Dependent Name and Relationship to Account Holder
④ Type of Service
⑤ Amount Billed
⑥ Provider Signature is ***not required***, but can replace need for other proof of service.



Tips For Claim Submission

- Dependent care expenses cannot be paid to anyone who is your child or stepchild under the age of 19 and claimed as a dependent on your tax returns.
- A dependent is defined as someone who spends at least 8 hours a day in your home and is one of the following:
  - A tax dependent child under the age of 13 for whom you have custody more than half of the year.
  - A dependent that is physically or mentally incapable of self care regardless of age.
- Only submit claims for eligible expenses. Extended overnight camps, kindergarten or higher-grade tuition, non work related day care or long term care services are not eligible expenses. The only expenses considered eligible are those that are incurred while you or your spouse are working, looking for work or attending school full time.

Tips For Documentation

- Ensure that the documentation is legible.
- Cancelled or copies of checks and credit card receipts do not contain all 5 required pieces of information needed to approve your expense, and are not acceptable for submission.
- If multiple pieces of documentation are attached, please circle the dollar amount that is being claimed on each piece of documentation.
- The use of a highlighter causes items to not be legible on the documentation; highlighter use is not recommended.
- At the end of the tax year, you are required to provide the IRS with the provider name, address and Tax ID # on Tax Form 2441 in order to obtain the tax advantage for these expenses.

Tips For Faxing

- Do not use a cover page when faxing the claim form and documentation.
- Please allow 2 business days from receipt of your claim for processing.
- You will be notified via email of the status of your claim if we have a valid email address on file (to update your email address, please log in to your account at **www.HealthEquity.com/WageWorks** and select "Profile" in the upper right corner of the screen.
- Send only photocopies of your claim form and documentation – keep the originals for your records if submitting via postal mail.
- Submit only claims for your own account.

HealthEquity | WageWorks

Dependent Care
Pay Me Back Claim Form

- **File claim online** - Join the growing majority of participants who submit their claim online for faster service. **Log in to your account at www.HealthEquity.com/WageWorks to file your claim electronically and upload your documentation.**
- **File claim via fax or mail** - Claim forms may also be filed either via fax or US Mail and sent to the following locations:
  Fax: 877-353-9236, **US Mail:** CLAIMS ADMINISTRATOR, P.O. Box 14053, Lexington, KY, 40512
- **Claim processing time** - Claims will be processed within 2 business days after the form is received. You may check the status of your claim by logging into your account at www.HealthEquity.com/WageWorks.

ACCOUNT HOLDER:

Last Name

First Name

Employer Name

ID Code*

Zip Code

* ID Code is the last 4 digits of your Social Security Number, your Employee ID number or other reference number assigned by your employer. Please check the enrollment instructions provided by your program sponsor for more information about your ID Code.

PROVIDER NAME	SERVICE DATES (Start and End Dates) (MM/DD/YY)	DEPENDENT NAME, RELATIONSHIP TO ACCOUNT HOLDER AND TYPE OF SERVICE	OUT-OF-POCKET COST
Signature of Provider: (Replaces the need for other proof of service.)		Dependent Name: ______ Relationship to Account Holder: Spouse / Qualifying Child / Qualifying Relative / Other ______ Type of Service: Child Care / Preschool / Before/After school / Senior day care / Au pair / Summer day camp	$
Signature of Provider: (Replaces the need for other proof of service.)		Dependent Name: ______ Relationship to Account Holder: Spouse / Qualifying Child / Qualifying Relative / Other ______ Type of Service: Child Care / Preschool / Before/After school / Senior day care / Au pair / Summer day camp	$
Signature of Provider: (Replaces the need for other proof of service.)		Dependent Name: ______ Relationship to Account Holder: Spouse / Qualifying Child / Qualifying Relative / Other ______ Type of Service: Child Care / Preschool / Before/After school / Senior day care / Au pair / Summer day camp	$
Signature of Provider: (Replaces the need for other proof of service.)		Dependent Name: ______ Relationship to Account Holder: Spouse / Qualifying Child / Qualifying Relative / Other ______ Type of Service: Child Care / Preschool / Before/After school / Senior day care / Au pair / Summer day camp	$

More expenses? Please complete another form.

CLAIM FORM TOTAL: $

CERTIFICATION AND AUTHORIZATION: I certify that the information on this page is accurate and complete. I am requesting reimbursement for work-related dependent care expenses incurred by an eligible dependent (for a child under the age of 13 or other dependents that are physically and mentally incapable of taking care of themselves) while I was a participant in the plan. These services have already been provided and confirm that by requesting reimbursement here that I have not and will not seek reimbursement of this expense from any other plan or party. Use of this service indicates my acceptance of the User Agreement at **www.HealthEquity.com/WageWorks** (available upon registration; enter username and password or click on First Time User? link).