ACCESSING YOUR FLEX ACCOUNT ONLINE

Our secure Online Inquiry System allows you to have 24/7 access to your account information, payment information and your available balance.

Completing your online account set-up is just a few clicks away!

Step 1. Log-on to our website at www.flex-admin.com

Step 2. Select **Participants**

Step 3. Select **ACCOUNT LOG IN** under the appropriate account type that you participate in. Please note that if you participate in more than one type of account, you do not have to set up a separate account for each one. You will be able to see all your account information under the one User ID and Password you create.

Step 4. Select **Participant Login**

Step 5. Select **Create Account**

Step 6. You will be prompted to enter your Name and Employee ID number (Social Security Number)

Step 7. You must then enter your Benefits Card Number or, if you do not have a Benefits Card, you may enter your Employer ID, which is: **FBAROW**

Step 8. Create your User ID, Password, Security Word and Birth City and your email address. Please note that your User ID will need to be between 4-10 characters. Your password needs to be between 7-10 characters and must include at least one letter and number.

Step 9. You are now ready to access your individual account!

Once you have completed these steps, you will have 24/7 access to current information regarding your Flexible Spending Account. It's that easy!

FlexibleBenefit ADMINISTRATORS

Problems Logging into Your Account?

E-mail to: flexdivision@flex-admin.com Include your Full Name, SS# or Employee ID#, Company Name, & Contact phone number

Telephone:
Local **757-340-4567** or Toll Free **800-437-3539** (Monday-Friday 8:30a-5:00p EST)

ROWAN COUNTY
FLEXIBLE BENEFIT PLAN
JULY 1, 2011 – JUNE 30, 2012

NAME:_____ **SSN:**_____

Benefits Card

Benefits Card Certification
I acknowledge that I will agree to the terms and conditions of the Cardholder Agreement received with my Benefits Card and certify that I will only use the card for qualified health care and/or dependent care expenses. I further certify that I will not seek reimbursement under any other health plan coverage for claims that have been paid for by the card, nor will I use the card for expenses that have been paid by any other health plan benefit. I acknowledge that I will, upon request of the plan administrator, provide required documentation of expenses.

☐ I would like to have a second card issued to my dependent, whose name and social security number are indicated below.

Dependent Name **Dependent Social Security Number**

Signature Date

AUTHORIZATION FOR CLAIMS COMMUNICATION TO BE SENT VIA EMAIL

I authorize Flexible Benefit Administrators, Inc. to send me information regarding my claims via email. I understand that I will no longer receive claims communication via U.S. mail to my home address.

It is also my responsibility to notify Flexible Benefit Administrators, Inc. if this information should change or if I elect to stop correspondence via email.

EMPLOYEE NAME EMAIL ADDRESS

HOME TELEPHONE NUMBER SIGNATURE

*****THIS IS A 2-PAGE FORM*****

AUTHORIZATION AGREEMENT FOR AUTOMATIC DEPOSITS (CREDITS)

I hereby authorize **ROWAN COUNTY**, hereinafter called **EMPLOYER,** to initiate credit entries to my

_____ ☐ checking ☐ savings account
(name of bank)

indicated below and the depository named below, hereinafter called **DEPOSITORY**, to credit the same to such account. I also authorize the **EMPLOYER** to draw drafts on my account or to initiate debit entries to my account, for the purpose of withdrawing money from my account, but solely in order to adjust an error resulting from a deposit or credit entry that has been made under this Authorization in an amount that is not correct. The **DEPOSITORY** shall not be liable for honoring any draft, debit entry or withdrawal initiated by the **EMPLOYER.**

Depository Name:	Office:
Bank Transit/ABA Number:	Account Number:

This authority is to remain in full force and effect until termination from the plan or notification in writing by the participant.

☐ My account information will remain the **SAME AS LAST YEAR** (Complete section below ONLY and do NOT attach check.)

Date:_____ Signature:_____

NOTE: New accounts, please attach a voided check to this authorization agreement.

SEND COMPLETED FORMS TO: Flexible Benefit Administrators, Inc.
(MAIL) 509 Viking Drive, Suite F, Virginia Beach, VA 23450
(FAX) (757) 431-1155
(EMAIL) flexdivision@flex-admin.com

TO: PARTICIPANTS IN THE FLEXIBLE BENEFIT PLAN –
FLEXIBLE SPENDING ACCOUNTS

FROM: FLEXIBLE BENEFIT ADMINISTRATORS, INC.
P.O. BOX 8188
VIRGINIA BEACH, VA 23450

Congratulations on your decision to participate in **ROWAN COUNTY'S** Flexible Benefit Plan. It is truly an outstanding benefit and provides great advantages for you and your family. In order for you to get the most benefit from your Plan, we want to remind you of a few things concerning your reimbursement claim forms.

The claim forms are separated into two expense areas:

1) **HEALTH CARE – For reimbursement of qualified medical expenses**

2) **DEPENDENT CARE – For reimbursement of qualified child care/dependent care expenses**

To be reimbursed, you must fill in the requested information and amount of the expense on the claim form in the appropriate expense area and attach a receipt or bill from the provider **(canceled checks are not considered receipts; the receipt must come from a third party)**. If you do not complete a claim form and turn in an appropriate receipt or bill, you will not be reimbursed. Remember to sign your claim form. Then, mail or fax the claim form and bill or receipts to:

Mail Your Claim To:	**Fax Your Claim To:**
Flexible Benefit Administrators, Inc. P.O. Box 8188, Virginia Beach, VA, 23450	Flexible Benefit Administrators, Inc. Fax Number: 757-431-1155

Scan and Email This Claim Form To:
Flexible Benefit Administrators, Inc.
FlexDivision@flex-admin.com

A SPECIAL REMINDER:

All claims received in the office of Flexible Benefit Administrators, Inc. will be processed within one week via direct deposit.

DO NOT HESITATE TO CALL!!

We are ready to help you get the greatest benefits possible from your Plan. Please call us at (757) 340-4567 or 1 (800) 437-FLEX if you have any questions or contact us through our website at www.flex-admin.com.

Participant forms may be downloaded from our website at www.flex-admin.com. Click on "Participants" and then "Forms" under the tab that applies to you. To view or print the forms you will need Adobe Reader (version 4.0 or higher). It is available free for download from the Adobe website.

ROWAN COUNTY
FLEXIBLE BENEFIT PLAN – CLAIM FORM

Employee's name_____ SS#_____

HEALTH CARE EXPENSES I, the participant, hereby file claim for the medical expense(s) noted below and certify that each expense was incurred on the date and for the person and reason noted. The expense(s) listed below was incurred for medical care not general health purposes and exclude cosmetic and/or toiletries expense(s). I, the participant, certify that I have not been reimbursed for the expense(s) noted below and that I will not seek reimbursement under any other plan covering health benefits. I, the participant, further certify that the expense(s) noted below have not been previously paid for by use of my Benefits Card. **Attached are receipts or bills as evidence of my expenses incurred during the Plan Year.**
** Please note: A doctor's note must be attached if considered a "dual purpose" drug

Date of Treatment	Person treated and Relationship	Type of eligible Expense	Amount of Expense
			$
			$
			$
			$
			$
			$
			$
		TOTAL	$

DEPENDENT CARE EXPENSES I, the participant, hereby file claim for the child or dependent care expense(s) noted below and certify that each expense was incurred on the dates and for the persons noted. I, the participant, certify that I have not been reimbursed for the expense(s) noted below and that I will not seek reimbursement under any other plan. I, the participant, further certify that the expense(s) noted below have not been previously paid for by use of my Benefits Card. **Attached are receipts or bills as evidence of my expenses incurred during the Plan Year**. Please note that receipts must come from the day care provider and have the dates of service, a description of the expense, the amount charged and the provider's SS# or Tax ID#.

Care Provided By:	Date Care Provided	Person cared for and relationship	Amount of Expense
			$
NAME			$
			$
ADDRESS			$
			$
			$
			$
TAX ID # OR SS#			$
		TOTAL	$

I authorize the service provider to release any information requested by the Plan Administrator in connection with this request for reimbursement.

_____ _____
EMPLOYEE'S SIGNATURE DATE

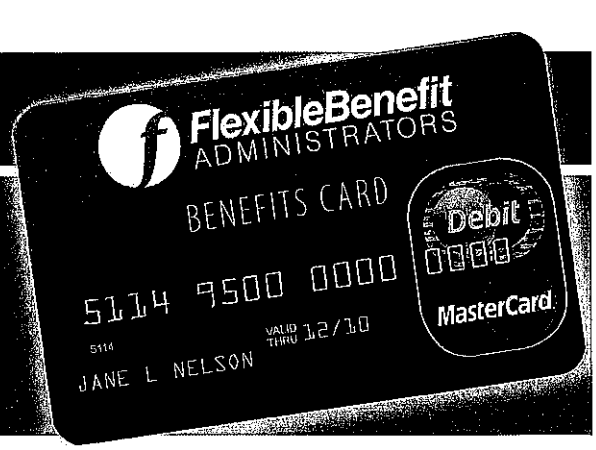
Mail This Claim Form To:	**Fax Claim Form To: (Please include cover sheet)**
Flexible Benefit Administrators, Inc. P.O. Box 8188, Virginia Beach, VA, 23450	Flexible Benefit Administrators, Inc. Fax Number: 757-431-1155

Scan and Email This Claim Form To:
Flexible Benefit Administrators, Inc.
FlexDivision@flex-admin.com

PLEASE:
- **DO NOT mail your claim form if you fax it.**
- **KEEP a copy of all claim forms and receipts for your records**
- **NOTIFY Flexible Benefits Administrators, Inc. if you have a change in address**

FlexibleBenefit ADMINISTRATORS

Using Your Benefits Card



How does the Benefits Card work?

The Benefits Card enables you to use the card at eligible locations wherever Mastercard® is accepted, such as physician and dental offices, pharmacies, and vision service locations. Approved expenses are automatically deducted from your pre-tax flexible spending account saving you out of pocket expenses!

The Benefits Card is intended only for, and restricted to, use for eligible services and/or purchases associated with your pre-tax account and incurred during the proper plan year, as governed by the Internal Revenue Service and all Federal and State laws.

The Benefits Card is NOT PAPERLESS, just less paper. The real benefit of the card is that you are not paying for expenses out of pocket and then waiting for reimbursement.

Will I have to submit any documentation after I use my card?

IRS regulations require substantiation for any card swipe that does not equal a "standard" co-payment amount (i.e., $10, $20, $35) or is not a recurring expense that has previously been audited. Co-insurance will generally not match "standard" co-payment amounts.

Documentation must include:

- Date of Service
- Patient/Dependent's Name
- Amount Charged
- Provider/Merchant's Name
- Prescription Number or Name
- Nature of Expense

Cash register receipts and credit card receipts are acceptable only for Over-The-Counter items and Prescription Numbers.

Save Your Detailed Receipts

How will I know when I need to submit documentation?

If a transaction you made using your Benefits Card requires documentation per IRS regulations, you will receive notice from Flexible Benefit Administrators, Inc. Notices can be sent regular U.S. mail or via email.

- **1st Letter:** Generated within 1-2 days of the transaction
- **2nd Letter:** Reminder letter sent after 20 days if documentation not yet received
- **3rd Letter:** Letter sent after 40 days stating card has been temporarily deactivated until proper documentation is received.
- 1st and 2nd notifications can be sent via email

To receive these notifications via email, please visit the website at www.flex-admin.com, selecting FLEX participants, Print Flex Participant Forms, and then select Email Authorization Form. You can then submit this form to Flexible Benefit Administrators, Inc.

Requested documentation needs to be submitted along with a Benefits Card Transaction Substantiation Form which can also be found on our website.

What is a Transaction Substantiation Form?

If you use your Benefits Card to pay for an expense, we may need to request further documentation of that purchase or transaction. In this case, you would receive a letter from our office, asking you to submit further documentation for the expense paid with your Benefits Card. If you are requested to submit further documentation to our office, you would simply complete a Transaction Substantiation Form and mail it into our office along with documentation of your expense.

You do not need to submit a Transaction Substantiation Form until we request one from you.

IIAS

Eligible FSA items purchased at participating Inventory Information Approval System (IIAS) merchants will be automatically approved! When purchasing prescriptions and/or Over-The-Counter FSA-eligible items, the merchant's IIAS will verify the items and automatically approve the transaction with no follow-up request. The Benefits Card will not be accepted at merchants who have not implemented IIAS. Please visit www.sig-is.org and select IIAS Merchants List for the most recent list of IIAS merchants.

Recurring expenses.

Once initial request for documentation is sent out and proper documentation is submitted, the transaction will be marked recurring.

Proper documentation includes participant/dependent's name, date, name of prescription or prescription number, amount and merchant's name.

Recurring expenses only apply to those transactions that match the exact dollar amount at the same merchant as a previous transaction. Recurring expense can be carried over into a new Plan Year.

Mail order prescriptions.

All prescriptions purchased through a mail order pharmacy will be automatically approved if you use your Benefits Card.

Such pharmacies include:

- Anthem Precision Management
- Caremark
- MEDCO
- AETNA Rx Home Delivery
- Tel-Drug
- Pharmacare
- National Diabetic Pharmacy

Debit or credit?

Choose credit. Even though this is not a credit card, it works like one. Your card does not have a pin number.

Lost or stolen card.

Contact Flexible Benefit Administrators immediately at (800) 437-3539.

Orthodontic contracts.

Orthodontic expenses (not for cosmetic purposes)

ORTHODONTIC TREATMENT IS PAYABLE ACCORDING TO YOUR PAYMENT PLAN WITH THE ORTHODONTIST. CARD SWIPES MUST COINCIDE WITH YOUR PAYMENT PLAN.

Once your contract is submitted, no additional documentation will be required unless your payment does not correspond exactly with your payment plan.

Ineligible expenses.

If the card is swiped for an ineligible expense, the participant is responsible for reimbursing their FLEX account.

Some examples of ineligible expenses are:

- Ineligible Services, prescriptions or OTC items
- Services outside of the Plan Year.
  The IRS prohibits you from using your card to pay for expenses incurred prior to your current plan or for those you plan to incur in the future.
- Lost receipt(s)

How do I request an additional card for my dependent?

Please contact Flexible Benefit Administrators, Inc. to find out how you can order an additional card for your dependent.

How do I activate my card?

Simply swipe your card at any eligible merchant and your card is activated.

Save all detailed receipts.

We may require you to submit your detailed receipts to substantiate you used your card for eligible expenses.

Can my spouse or dependent obtain information about my account?

Yes, your spouse and dependent (over the age of 18) can obtain your account information if they have an additional Benefits Card issued to them or an Authorization-to-Disclose Form is completed. This form is available on the website at www.flex-admin.com

TRANSACTION SUBSTANTIATION FORM

BENEFITS CARD - FLEXIBLE BENEFIT PLAN

Employer's Name _____

Employee's Name _____ SS# _____

Date of Transaction	Name of Merchant	Type of Eligible Expense (If OTC product, please write explanation of what product is)	Amount of Expense

I, the participant, hereby certify that each expense was incurred on the date and for the reason noted. The expense(s) listed was incurred for medical care, not general health purposes, and excludes cosmetic and/or toiletry expenses. I, the participant, certify that I have not been reimbursed for the expense(s) noted above and that I will not seek reimbursement under any other plan covering health benefits. I, the participant, further certify that the expense(s) noted above has been paid for by use of my Benefits Card.

Attached are itemized receipts or bills to substantiate my Benefits Card transaction. I understand that I may NOT use this form to seek reimbursement for items paid out-of-pocket; I may do so by filing a Claim Form, found at www.flex-admin.com.

Please Be Aware: A letter of medical necessity must be attached if the drug is considered a "dual purpose" item.

I authorize the service provider to release any information requested by the Plan Administrator in connection with this transaction.

Employee's Signature _____ Date _____

Mail This Form To:
Flexible Benefit Administrators, Inc.
Attn: Benefits Card Department
P.O. Box 8188, Virginia Beach, VA, 23450

Or

Fax This Form To: (Please include cover sheet)
Flexible Benefit Administrators, Inc.
Attn: Benefits Card Department
Fax Number: 757-431-1155

This form can also be scanned and emailed to benefitscard@flex-admin.com

PLEASE DO NOT mail your completed form if you fax it.
PLEASE KEEP a copy of all completed forms and receipts for your records
PLEASE NOTIFY Flexible Benefits Administrators, Inc. if you have a change in address

FlexibleBenefit ADMINISTRATORS

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