



**Community College Systems of NH  
Flexible Spending Account  
Plan Year 01/01/2017 – 12/31/2017**

**Flexible Spending Account (FSA)** - An FSA allows you to set aside a pre-determined amount of money to pay for health care and/or dependent care expenses on a pre-tax basis.

**Health FSA & Dependent Care FSA**

**Health FSA Maximum**..... up to **\$2,600**  
**Health FSA Minimum** ..... **\$200**  
**Dependent Care FSA Maximum**.....up to **\$5,000 per household**  
**Debit Cards**.....**Automatically Issued**

**Use it or Lose it No More** ..... **Up to \$500**  
 You can roll up to \$500 of your FSA Health funds into the next plan year. Any funds below \$5.00 and beyond \$500 will be forfeited.

**Run-Off Period** ..... **45 days**  
 You have 45 days after the plan year to submit claims for services rendered or items purchased in the prior plan year. Termed employees have 45 days from date of the qualifying event to submit claims. Only services rendered prior to the last coverage date will be eligible.

**Two ways to access your FSA Funds**

**Request Reimbursement**

**Submit an FSA claim to access funds**

Claim requests can be submitted many ways for your convenience:

1. Log into the Consumer Portal, enter the claim details, and upload scanned supporting documentation to us.
2. Log into the mobile app on your smartphone, enter the claim details and snap photos of supporting documentation to submit them to us.
3. Complete a claim form, attach copies of supporting documentation and send them by mail, fax or email to us.



*You can track all your claims through the Consumer Portal on our website or the mobile app.*

**Note:** You do not need to show proof of payment to receive reimbursement, only that the service(s) were rendered. Complete the claim form and submit the detailed documentation for the eligible product or service. If the product or services is eligible, payment will be sent directly to you.

**Flex Benefits Debit Card**

**Use your Flexible Benefits Debit Card at point-of-service to**

- Pay for eligible services at health provider.
- Purchase prescriptions at your pharmacy.
- Purchase eligible over-the-counter items at major pharmacies and supermarkets.
- Pay for over-the-counter items online at FSA Store (visit our Flex Benefit participant page for details).
- Pay for dependent care services at day care providers.



When Requested, submit debit card documentation one of three ways:

1. Log into the Consumer Portal, select the request and upload the scanned supporting documentation to us.
2. Log into the mobile app on your smartphone, snap photo of supporting documentation and submit to us.
3. Print the documentation request, attach copies of supporting documentation and send them by mail, fax or email to us.

**Note:** Keep your receipts and documentation for transactions. Some purchases will auto-adjudicate at time of purchase, but others will need proof of eligibility. csONE Benefit Solutions will send you a request for documentation if proof of eligibility is necessary. However, the IRS requires that you keep documentation for all transactions paid for with FSA funds.

**Need Help Deciding How Much to Put Into Your Health FSA?**

**Try this worksheet:**

**1. Estimate your uninsured health care costs per year**

- |  |          |
|--|----------|
| a. Health insurance deductibles                  | \$ _____ |
| b. Office visit copays/co-insurance              | \$ _____ |
| c. Prescription copays/co-insurance              | \$ _____ |
| d. Vision care (eye exams, contacts, eyeglasses) | \$ _____ |
| e. Routine exams (School physicals, etc.)        | \$ _____ |
| f. Chiropractic Services                         | \$ _____ |
| g. Other   | \$ _____ |
| Subtotal   | \$ _____ |

**2. Estimate your uninsured dental costs per year**

- |                                     |          |
|-------------------------------------|----------|
| a. Examinations and cleanings       | \$ _____ |
| b. Braces and retainers             | \$ _____ |
| c. Fillings, crowns and bridges     | \$ _____ |
| d. Dentures, including replacements | \$ _____ |
| e. Implants, inlays, X-rays         | \$ _____ |
| f. Other                            | \$ _____ |
| Subtotal                            | \$ _____ |

**3. Add the subtotals of the uninsured health and dental costs for total expenses \$ \_\_\_\_\_**

This amount is an estimate of the amount of dollars you should put into a Health Flexible Spending Account in order to get the most out of your pre-tax dollars.

**Secure Consumer Portal available to access your account 24/7/365 at [www.csONE.com](http://www.csONE.com).**

Customer Service Number: **1-888-227-9745 ext. 2040**      Fax: **603-224-0230**      PO Box 1320, Concord, NH 03302-1320