PayFlex Systems USA, Inc.
FLEX DEPARTMENT
PO BOX 8396
OMAHA, NE 68103-8396

RON DELLICOMPAGNI
609 MARSHALL DR
BROOMALL, PA 19008

*** THIS IS NOT A CHECK ***

NO. 505127926

PAYFLEX®

PayFlex Systems USA, Inc.
FLEX DEPARTMENT
PO BOX 8396
OMAHA, NE 68103-8396

DATE	AMOUNT
04/14/2021	***$1346.17

PAY *** ONE THOUSAND THREE HUNDRED FORTY-SIX DOLLARS AND SEVENTEEN CENTS ***

TO THE ORDER OF
RON DELLICOMPAGNI
609 MARSHALL DR
BROOMALL, PA 19008

** Deposit Advisement **
The above amount has been deposited into your account.

NON-NEGOTIABLE

DELLICOMPAGNI, RON
Cotiviti Inc.

Explanation of Payment

(Reimbursement)

Thank you for submitting your claim(s) to PayFlex. We approved your claim(s) and deposited your reimbursement amount into the bank account on file. Keep in mind; it may take up to 3 business days for the amount to appear in your account. You're responsible for verifying receipt of funds with your bank before executing any transactions.

Some of your other claims may need action. If action is required, please provide the requested documents or payment to PayFlex as soon as possible but no later than the claim filing deadline listed below. You can upload your documents online at www.payflex.com, through the PayFlex Mobile® app, or send them by fax or mail. The fax number and mailing address are below.

Account Name	Claim filing deadline
(2021) Dependent Care	03/31/2022

Draft #: 505127926 Date: 04/14/2021 Total Amount: ***$1346.17

Claim Summary

Account Name	Expense Type	Service Dates Begin	End	Amt Requested	Amt Paid	Amt Not Paid	Claim #	Amt This Payment
(2021) Dependent Care	Dependent Care	01/01/2021	03/15/2021	$11,902.55	$1,346.17	$9,903.60	873777470	$1,346.17
Remark: $5597.10 This expense is not eligible for reimbursement and has been denied. The service must have been provided before you submit for reimbursement. You may submit the claim for the expense after the service has been provided., $4306.50 Additional information required. The itemized statement shows an amount less than you requested on the claim form. Please submit the itemized statement for the difference of your requested amount.								
	Dependent Care	10/12/2020	12/31/2020	$1,998.95	$0.00	$1,998.95	873777470	$0.00
Remark: This expense is not eligible for reimbursement and has been denied because it may have been considered for payment on a previous claim.								

Total: $1,346.17

Your Account Summary After This Payment

Account Name	Annual Election	Deposits	Total Paid	Election Remaining	Amt This Payment
(2021) Dependent Care	$5,000.00	$1,346.17	$1,346.17	$0.00	$1,346.17

Do you get your claim notices by mail? Make the switch to paperless today! Log in to your account and click on Account Settings. Then click on Account notifications. Under Paperless settings, select the "Go paperless" box for Reimbursement Account - Explanation of Payment. When you go paperless, you'll get an email when you have a new document online.

Do you get your claim reimbursements by check? There's a faster way to get your money! Log in to your account and click on Account Settings. Then click on Bank accounts to get started.

Appeals: If this notice contains an adverse determination and is not just a request for additional information, you are entitled to a review (appeal) of the determination if you have questions or do not agree. To obtain a review, you or your authorized representative should submit a request in writing to the address shown on the explanation of payment notice. Your request should include the group name (e.g., your employer), your name, your member identification number and other identifying information shown on this notice, and any comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial claim. You may also review documents relevant to your claim. Upon request and free of charge, you may receive reasonable access to and copies of all documents, records, and other information including any internal procedures or any specific rules, guidelines or protocols relied upon or used during the processing of your claim. If you are appealing an adverse determination for your Health Care Flexible Spending Account, Health Reimbursement Account, Limited Flexible Spending Account or Retiree Reimbursement Account, then your written request for review must be filed within 180 days following receipt of this notice. A review will be conducted and you will be notified of the decision within 60 days (or 30 days if your plan has 2 levels of appeal). If you are appealing an adverse determination with respect to your Dependent Care Account, then your written request for review must be mailed within 60 days following receipt of this notice. A review will be conducted and you will be notified of the decision within 60 days. Please review your plan documents or contact your plan administrator to confirm the specific appeals process available to you. If you do not agree with the final determination on review, and if your plan is governed by ERISA, you have the right to bring a civil action under Section 502(a). Please refer to your Summary Plan Description, or contact your employer, to confirm the applicability of ERISA to your plan.

This material does not contain legal or tax advice. You should contact your legal counsel or tax advisor if you have any questions or need additional information. For more information about PayFlex, go to **payflex.com.**

Standard text messaging and other rates from your wireless carrier still apply.
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