

City of Newton Flexible Benefits ENROLLMENT FORM

Once completed, please return
this form to Human Resources.

PLEASE PRINT CLEARLY:

Employee Information

Employee Name _____
Last Name
First Name
MI

Soc. Sec. No. _____ - _____ - _____ Date of Birth ____/____/____

Home Address _____

_____ City _____ State _____ Zip _____

Home Telephone No. (____) _____ Work Telephone No. (____) _____
area code
area code

I am a Municipal Employee: I am a School Department Employee:

I Get Paid: Weekly Semi-monthly 24 Pay Checks Monthly
 20 Pay Checks

Medical Care Reimbursement Account

I elect to participate in the Medical Care Reimbursement Account program sponsored by the City of Newton.
 Further, I elect to contribute \$ _____ Annually. Maximum allowed is \$2,500.

Dependent Care Reimbursement Account

I elect to participate in the Dependent Care Reimbursement Account program sponsored by the City of Newton.
 Further, I elect to contribute \$ _____ Annually. Maximum allowed is \$5,000.

Beneficiary Designation

In the event of my death, the person named below is my designated beneficiary:
 Name _____ Relationship _____

Spouse and Dependent Information (Optional)

If expenses for reimbursement are for your spouse or dependent children, please complete the following.

Name	Relationship to Employee	Date of Birth
_____	_____	_____
_____	_____	_____
_____	_____	_____

Employee Certification

I understand that my annual FSA election may require adjustment to comply with IRS Section 125, 129 and 105 nondiscrimination guidelines. I also understand that I may not change or stop deposits to the account(s) indicated above until the end of the plan year unless I have a change in status, as defined by IRS regulations and my employer's plan. **If I do not use all the money in my account(s) by the end of the Plan Year, I understand that any balance will be forfeited.** I understand that there will be no interest build-up in the account(s). I have read and understand the rules and regulations on the reverse side of this form.

My signature authorizes reductions from my pay checks for the purpose of funding my tax-free reimbursement account(s).

X Employee Signature _____ Date _____

For Human Resources Only Plan Year: _____ Effective Date: _____

Annual Salary: _____

IMPORTANT INFORMATION REGARDING REIMBURSEMENTS

MEDICAL	DEPENDENT**
<p>ELIGIBLE EXPENSES:</p> <p>In general, an employee may be reimbursed for a health care expense which is deductible for federal income tax purposes, but which has not and/or will not be reimbursed by any other source, and which has not been or will not be deducted on the employee's income tax return. Some examples of eligible expenses include co-insurance and deductible amounts; vision, hearing, dental, over-the-counter medications; and prescription drug expenses not covered by your health insurance.</p> <p>INELIGIBLE EXPENSES:</p> <p>Examples of ineligible expenses include insurance premiums; vitamins/supplements for general good health; cosmetic procedures, products and prescriptions; and counseling not related to a medical condition.</p> <p>SUPPORTING DOCUMENTATION:</p> <p>The following forms of supporting documentation may be attached to the reimbursement request form:</p> <p>Expenses covered by your health care plan:</p> <p style="padding-left: 40px;">Medical and dental expenses covered by your health care plan must be submitted to that plan. You may attach the Explanation of Benefits Statement to the reimbursement request form for the portion of your claim not paid by your health care plan.</p> <p>For all expenses, you must attach bills or evidence of payment that clearly state all of the following:</p> <ol style="list-style-type: none">1. Name of person receiving the service2. Nature of service or supplies (includes medication name)3. Name and address of provider of services4. Amount reimbursable under the plan5. Date(s) service was rendered	<p>ELIGIBLE EXPENSES:</p> <p>The annual amount reimbursed cannot exceed the earned income of the lower-paid spouse or \$5,000, whichever is less. If you are married, filing separately, your annual reimbursement cannot exceed \$2,500.</p> <p>The expenses must be employment-related and incurred for the care of a dependent of the employee who is under age 13 and for whom the taxpayer is entitled to a dependent deduction under Internal Revenue Code Section 151(c), or is a dependent of the employee who is physically or mentally incapable of caring for himself or herself.</p> <p>The payments cannot be made to a person who is claimed as a dependent by the employee.</p> <p>Expenses for DAY camp programs are allowable; however, if camp hours exceed the employee's working hours, submit ONLY that portion of expenses incurred for work-related hours. OVERNIGHT CAMP is NOT an allowable expense, even on a prorated basis.</p> <p>SUPPORTING DOCUMENTATION:</p> <p>The following supporting documentation should be attached to the reimbursement request form:</p> <ol style="list-style-type: none">1. Name of person receiving the service2. Name and address of service provider3. Nature of Service4. Amount reimbursable under the plan5. Date service was rendered6. Provider's Tax ID Number

**QUALIFICATION GUIDELINES FOR A DEPENDENT CARE ACCOUNT

To qualify, both the employee and spouse must be working, or one working and the other enrolled as a full-time student, or actively looking for work. If the employee is single, divorced or legally separated, the employee's need for dependent care assistance must be work related.

PLEASE NOTE

Service dates for reimbursable expenses must fall within the plan year. Reimbursement requests not submitted during the plan year must be submitted prior to the end of the run-out period. Please contact the Human Resources Department at (617) 796-1260 or Cafeteria Plan Advisors (CPA, Inc.) for more information.

CPA, INC.
420 Washington Street, Suite 100
Braintree, MA 02184
(781) 848-9848 (Direct)
(781) 848-8477 (Fax)
www.CPA125.com

*City of Newton
Flexible Spending
Direct Deposit*

Deposit your reimbursements directly to your checking or savings account.
Claim payments are processed WEEKLY for all Direct Deposit accounts.

Complete and sign below.

Attach a voided check to this Authorization form. (If you fax the Authorization form, be sure to fax this page and a copy of the voided check.)

I hereby authorize Cafeteria Plan Advisors, Inc. to deposit my claim reimbursements directly to my bank.

Name: _____

Employer: _____

E-Mail Address: _____

Name of Bank: _____

Checking:

Savings:

Routing Number (9 digits): _____

Account Number: _____

Signature: _____

Date: _____

Note: You must notify us immediately of any change to your bank account.

Place voided check here:

Flexible Spending Accounts

It's not what you earn, it's what you keep that counts!

Flexible Spending Accounts let you set aside a portion of your paycheck **tax free** to pay for certain health and dependent care expenses. Contributions are deducted from your paycheck prior to federal, state and social security taxes. **No tax on your contribution saves you money** (see chart below).

<i>Medical FSA:</i>	Yes	No
Are you and your family currently spending money on out-of-pocket expenses such as: <ul style="list-style-type: none"> ▪ prescription copays and medicine ▪ doctor visit copays ▪ dental work - orthodontia ▪ eyeglasses/contacts/laser eye surgery ▪ chiropractic or acupuncture ▪ over the counter medicines 	<input type="checkbox"/>	<input type="checkbox"/>
Is it impossible to reach the 7 ½ % of your adjusted gross income as a medical tax deduction?	<input type="checkbox"/>	<input type="checkbox"/>
<i>Dependent Care FSA:</i>		
Do you have children in day care, after school care or summer camp so that you (your spouse) can work?	<input type="checkbox"/>	<input type="checkbox"/>
Do you spend money each year for childcare?	<input type="checkbox"/>	<input type="checkbox"/>

If you answered 'yes' to **any** of these questions you should be participating in a Flexible Spending Account as shown in the example below:

Flexible Spending Account	Annual Employee Contribution	Tax Savings Single	Tax Savings Married
Medical FSA	\$1000.00	\$280.00	\$410.00
Dependent Care FSA	\$5,000.00	\$1,400.00	\$2,050.00
	*Tax Rates:	Single	Married
	Federal	15%	28%
	State	5.30%	5.30%
	FICA (non municipal)	6.20%	6.20%
	Medicare	1.45%	1.45%
	Total	28%	41%

See reverse side for more details.

CAFETERIA PLAN ADVISORS, INC
420 WASHINGTON STREET - SUITE 100
BRAINTREE, MA 02184
800-544-2340
www.cpa125.com

Frequently Asked Questions

Why does the government allow a plan such as this?

The plan is governed by the IRS code. Studies have shown that when employees become aware of how much they spend on benefit items, they tend to practice cost containment. The government wants to help employers and employees control escalation of healthcare costs.

How much can I allocate?

The IRS limits dependent care contributions to \$5000 per tax year (joint return). Limits for medical reimbursement plans are set by the employer.

How long does the plan last?

An employee agrees to set aside an amount on an annual basis (the plan year). This amount can be increased or decreased each year. If you do not re-enroll, contributions cease.

What if I want to make a change during the year or I terminate

employment?

The IRS allows changes to be made in the event of a 'change in status' qualifying event such as birth, death, marriage or divorce or a change to your or your spouse's employment. If you terminate, your contributions cease when you stop getting paid. Please contact CPA, Inc. for further information.

How do I know if an expense is eligible?

If you would be able to deduct the expense as a medical expense on your taxes, it is eligible. If in doubt, contact CPA, Inc. for verification.

How will I get reimbursed for expenses?

You may submit claims as frequently as you like. Claims are paid twice a month by check or weekly for direct deposit accounts, which are deposited directly into your bank account. Checks are payable to the participant and mailed to participant's

home address. A Dependent care account is usually paid on an automatic basis after completion of a Dependent Care Certification Form. Medical accounts require a copy of the bill or receipt for the service attached to a Claim Voucher.

Can my medical expenses go towards dependent care and vice versa?

No. The IRS requires separate funds for each and they are treated as two separate accounts.

Can I get money back if it is not used?

It is important to calculate your expenses as precisely as possible – the IRS does not allow unused funds to be returned. You will receive statements and warning notices from CPA, Inc. prior to the plan year-end reminding you of your account balances and how you may use them.


Examples of Some Common Eligible Expenses:

Acupuncture
Alcohol/Drug Therapy
Braces (Orthodontics)
Chiropractors
Co-pays - Office Visits
Contact Lenses and Solution
Dental Fees – no bleaching
Dentures
Eye Exams and Glasses
Eye Surgery (Laser)
Handicapped/Hearing Impaired
/Sight Impaired/Learning Disabled - call for details


Health Club 
Medically necessary

Hearing Aids and Batteries

Hospital Care/Services
Insulin and Testing Supplies

Muscular Therapy 
Mileage – call for current allowance
Nursing Services
Orthopedic Shoes
Osteopath

Over the counter medicine (no vitamins)
Prescriptions and co-pays
Psychologist Fees
Psychiatric Care
Surgical Fees
Therapy (Physical and Occupational)
Viagra

Weight Loss Programs 
medically necessary



Requires a physician prescription each plan year stating a specific medical condition. (no exceptions).

SAMPLE OVER THE COUNTER MEDICINES

<i>These are typically reimbursable with proper claim substantiation. No recommendation from a health care provider is needed.</i>	
Type of Drug	Examples*
Allergy Prevention & Treatment	Benadryl, Sudafed, Actifed, Chloro Trimeton, and Nasalcrom
Antacids and Acid Reducer	Gas-X, Maalox, Mylanta, Tums, AXID AR, Pepcid AC, Prilosec OTC, Tagamet HB, and Zantac 75 AXID AR
Anticandial	Femstat 3, Gyne-Lotrimin, Mycelrx-7, Monistat 3, 7 and Vagistat-1
Antihistamines	Actidil Syrup and Capsules, Actifed, Allerest, Benadryl, Claritin, Chlor-Trimeton, Contac, Dimetane, Drixoral, Nyquil, Sudafed, Tavist-1, and Triaminic
Antidiarrheal and Laxatives	Ex-Lax, Pepto-Bismol, Immodium A.D. and Kaopectate
Anti-fungal/Anti-itch Lotions and Creams (e.g., athletes foot, jock itch, bug bites, poison ivy)	Bactine, Calceort, Cortaid, Hydrocortisone, and Lanacort, Calamine Lotion, Benadryl Cream, Caladryl, Cortaid, Lamisil AT, Lotramin AF, and Micatin
Cold Sore/Fever Blister	Abreva Cream
Cough Suppressants/Decongestant/Nasal Decongestant and Cold Remedies	Robitussin, Vicks 44, Chloraseptic, Advil Cold and Sinus, Afrin, Afrinol, Aleve Cold and Sinus, Children's Advil Cold, Duration, Dristan Long Lasting, Neo-Synephrine-12 Hour, Orrivin, Sudafed, Tavist-D, Tylenol Cold and Flu, Thera-flu, Alka Seltzer Cold and Flu, Nyquil, Actidil Syrup and Capsules, Actifed, Allerest, Benadryl, Claritin, Chlor-Trimeton, Contac, Dimetane, Drixoral, Sudafed, Tavist -1, and Triaminic
Diaper Rash Ointments	Balmax and Desitin
Eye Drops for Allergy/Cold Relief	Ocu Hist
Hemorrhoid Treatments	Preparation H, Hemorid, and Tronolane
Internal Analgesic/antipyretic	Advil, Aleve, Children's Motrin, Nuprin, Excedrin, Tylenol, Bayer
Menstrual Cycle Medications	Midol, Pamprin and Premysyn PMS
Motion Sickness Medications	Dramamine and Marizine
Pediculicide (head lice)	Nix
Poison Ivy Protection	Ivy Block
Smoking Cessation Aids	Commit, Nicoderm CQ, Nicorette, Nicotrol
Toothache and teething pain relievers	Orajel

DUAL PURPOSE MEDICINES

<i>Permissible only with Doctors verification listing diagnosis of a specific -medical condition and recommendation for medication.</i>
Anti-baldness/hair loss/hair replacement/such as Rogaine, but only if to replace hair loss due to a medical condition and not for balding due to age.
Medicated shampoo to treat a specific medical condition like psoriasis and only the amount in excess of the cost of normal shampoo. Many plan sponsors may exclude completely to avoid having to determine whether the cost of a medicated shampoo exceeds the cost of regular shampoo.
Dental fluoride treatments, special mouthwashes, or treatments for Gingivitis.
Glucosamine/chondroitin for arthritis and other medical conditions (not reimbursable if taken for overall joint health).
Herbal supplements used to treat a specific disease such as St. John's Wort for depression.
Nose strips for proper breathing or other medical conditions.
Retin-A and other acne medicines (not reimbursable if used for cosmetic purposes such as wrinkle reduction).

Snoring cessation aids and medications such as *Breathe Right Spray, Norezz.*

Weight loss/dietary supplements must be for a specific medical condition such as obesity.

OVER THE COUNTER

MEDICAL PRODUCTS AND DEVICES

Permissible products for medical care with proper claim substantiation.

Product or Device	Medical Care, Dual Purpose or General Well Being	Comments
1. Crutches, Walkers	Medical Care	Crutches are primarily used when there is a leg or foot injury. Walkers for medical purposes.
2. Bandages such as Band-aids, gauze, ace bandages	Likely Medical Care	Band-aids and gauze are arguably used to prevent infection where there is an imminent probability of infection. Ace bandages and other similar products are typically used to support bone and/or joint injuries.
3. Condoms and other contraceptive devices	Likely Medical Care	These prevent disease and pregnancy where there is imminent probability of either. IRS has informally indicated that these should be reimbursable.

OVER THE COUNTER ITEMS

NOT REIMBURSABLE

Products that are not for medical care.

Deodorants.
Face creams, moisturizers, eye creams, and wrinkle reducers.
Hair removal treatments and waxes.
Mouthwashes, antiseptics and oral anesthetics.
Teeth Whitening kits, and powders.
Toothpaste/toothbrushes (even if recommended for Gingivitis).
Vitamins taken to improve overall-health.

*This is not an exhaustive list and is intended to give examples of some of the most common brand names of OTC drugs.

Excerpts taken from The Employers Council on Flexible Compensation list of example OTC Drugs

Visit our web site, www.cpa125.com for more information.

City of Newton
Flexible Spending Account (FSA)
CLAIM REIMBURSEMENT REQUEST

Address Change

NAME: _____ SS#: _____ - _____ - _____
 HOME ADDRESS: _____ CITY: _____
 STATE: _____ ZIP: _____ PHONE: () _____
 E-MAIL ADDRESS: *(Optional)* _____

OUT-OF-POCKET MEDICAL EXPENSE not covered by other medical benefit plans.
 (For Participants & Eligible Dependents -as defined by the IRS guidelines)

ITEMS (group similar items)	DATES INCURRED (start/end dates)	AMOUNT
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
		TOTAL:\$ _____

DEPENDENT/CHILD CARE EXPENSES (Daycare)

_____	_____	\$ _____
_____	_____	\$ _____

All medical claims submitted require copies of bills/statements/receipts showing date and type of service. (No cancelled checks/credit card receipts). All claims must be received two days prior to claim payment day. Direct deposit payments are processed weekly on Wednesday, usually available in your bank on Thursday. Checks are issued twice a month (every other Wednesday). Please allow 3 business days to receive your check. Minimum payment for Medical Expenses is \$20.00.

This is to certify that I have incurred the expenses listed above that qualify for reimbursement under my employer's FSA. I have not been reimbursed from any other source including insurance programs or other programs offered by my employer. None of these expenses has previously been submitted. I understand and agree that since these expenses are to be reimbursed they may not be claimed as deductions for income tax purposes. Additionally, I am aware that unused funds may be forfeited or otherwise handled in accordance with the plan document and the current IRS law. I hereby request reimbursement for these claims.

PARTICIPANT'S SIGNATURE: _____ DATE: _____

**CITY OF NEWTON
CLAIM PROCESSING & PROCEDURES**


- **PAYMENTS:** Checks are issues twice a month (every other Wednesday).

Direct Deposit payments are processed weekly (Wednesday). Please allow up to two business days for funds to be in your account. All claims must be received by Monday to be included.
- All medical claims submitted require copies of bills/statements/receipts showing date and type of service. (No cancelled checks/credit card receipts).
- All claims must be received two days prior to the claim payment day.
- You may fax a claim and your receipts to CPA, Inc. Please limit fax to 10 pages.
- All expenses must be incurred (service date) during the Plan Year, not when you were billed or paid the expense.
- You may group expenses together on one line (see example below).

<u>ITEMS</u>	<u>DATE INCURRED</u>	<u>AMOUNT</u>
Co-pays (Medical)	1/6/09 - 5/31/09	200.00
Co-pays (Prescriptions)	2/1/09 - 3/31/09	150.00
Dental Expenses	2/28/09 - 3/15/09	750.00

IRS Reimbursable Expenses (examples). Please call CPA, Inc. if any questions.

- | | |
|---|---|
| <ul style="list-style-type: none"> Acupuncture Alcohol/Drug Therapy Birth Control Pills Braces (Orthodontics) Chiropractors Co-payments for Doctor, Dental Contact Lenses and Solution Dental Fees – <u>No bleaching</u> Dentures Eye Exams and Glasses Eye Surgery (Laser) Handicapped/Hearing Impaired/Sight Impaired/Learning Disabled Hearing Aids and Batteries Hospital Care/Services | <ul style="list-style-type: none"> Insulin and Testing Supplies Medications Mileage – (.24 -2009, call for current rate) Nursing Services Orthopedic Shoes Osteopath Over-the-counter <u>Medicines</u> Prescriptions/Co-Pays Psychologist Fees Psychiatric Care Physical Therapy Surgical Fees Therapy (Physical and Occupational) Viagra |
|---|---|

 The following items require a physician prescription each plan year stating the expense is necessary to treat a particular medical condition/disease. Wellness procedures and programs are NOT covered.

- | | |
|---|--|
| <ul style="list-style-type: none"> Health Club memberships Muscular Therapy | <ul style="list-style-type: none"> Weight Loss Programs Vitamins |
|---|--|

City of Newton
Flexible Spending Account (FSA)
DEPENDENT CARE CERTIFICATION FORM

Automatic Payment

EMPLOYER: CITY OF NEWTON PLAN YEAR: _____

EMPLOYEE: _____ SS#: _____ - _____ - _____

PLEASE PRINT

DEPENDENTS ELIGIBLE FOR FSA REIMBURSEMENT (Must be under age 13 or physically or mentally incapacitated-as defined by the IRS guidelines).

Name	Relationship	Date of Birth		Name	Relationship	Date of Birth

**Names(s) of Day
Care Facility or
Individual who**

provides care:

Name:	Name:
Address:	Address:
Corporate or Individual Tax ID:	Corporate or Individual Tax ID:

Are you married (as defined by IRS)? Yes No

If married: Is your spouse employed? Yes No

If your spouse is NOT employed, is he/she:
Full-time student during the period of this claim? Yes No
(Note: Full-time student = 5 months)

If your spouse is NOT employed, is he/she
Disabled and unable to care for dependents? Yes No

PARTICIPANT'S SIGNATURE: _____ DATE: _____