420 WASHINGTON STREET ♦ SUITE LL8 BRAINTREE MA 02184 ♦ (781) 848-9848

Town of Marshfield
Flexible Spending Account – Open Enrollment until 12/21/12
Plan year 1/1/2013 – 12/31/2013

"It's not what you earn, It's what you keep that counts"

The Flexible Spending Account is a tremendous opportunity for you to enhance your benefits package. Your employer knows that this is a highly beneficial program and wants you to have the opportunity to participate in a Flexible Spending Account.

Most employees pay for expenses such as dependent care expenses, out-of-pocket medical/dental expenses, prescription drug co-payments etc, on an after tax-basis. The Flexible Spending Account allows you to set aside a portion of your paycheck tax free to pay for those expenses. The result is a reduction in Federal, State and FICA taxes, which will give you an increase in your take home pay. ***Don't miss out on this opportunity to save approximately 30% in payroll taxes on dollars put through an FSA plan*.**

MEDICAL FLEXIBLE SPENDING ACCOUNT (FSA)

The Medical FSA allows you to set aside up to **$2,500** pre-tax from your paycheck to pay for expenses not covered by insurance. Some examples of these out-of-pocket expenses are:

Dental: Orthodontia/Crowns/Fillings/Dentures/Cleanings/X-rays
Co-pays: Doctor Visits/Prescriptions/Deductibles
Medical: Chiropractor/Psychologist Fees/Orthopedic Expenses/Hearing Aides
Vision Care: Contact Lenses/Contact Solution/Eye Glasses/Laser Eye Surgery/Eye Exam
Over-the-Counter Medications: No longer an eligible expense without an RX prescription

A **MasterCard debit card (**known as the "benny" card**)** will be provided for all FSA-medical account holders. The card can be used at medical, vision, dental and pharmacies locations and can provide auto substantiation for most items.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)

The Dependent Care FSA is a great tax savings for people who have children in daycare or parents who require elder care. The IRS allows you to set aside up to **$5,000** per calendar year pre-tax from your paycheck to pay for these expenses. In most instances participation in the Dependent Care FSA results in a greater tax savings than the Dependent Care Tax Credit. Examples of eligible Dependent Care Expenses are:

Daycare *Before/After School Care* *Summer Day Camp* *Pre-School* *Elder Care*

A representative from Cafeteria Plan Advisors, Inc. will be available on:

December 12th 2:00-4:00pm Town Hall & December 13th 3:30pm at High School Library

Cafeteria Plan Advisors, Inc. of Braintree, MA, is a leader in the administration and implementation of Cafeteria Plans and currently services over 120 municipalities along with many corporations, and public and private schools. To learn more about this exciting benefit please attend the informational meeting(s). For additional information please call Cafeteria Plan Advisors, Inc. at 781-848-9848 or visit our website: www.cpa125.com

Cafeteria Plan Advisors, Inc.
420 Washington St. Suite 100
Braintree, MA 02184
Phone 781.848.9848
www.CPA125.com
Fax 781.848.8477

AUTHORIZATION FOR PRE-TAX PAYROLL REDUCTION

Form must be returned to Cafeteria Plan Advisors by: 12/21/2012

Personal Information

Name: ***Employer:*** TOWN OF MARSHFIELD

Street: ***Plan Year:*** 01/01/2013- 12/31/2013

City, ST, Zip: ***SSN:***

E-Mail: ***Phone:***

Payroll Information

I am paid: Weekly: ☐ Bi-Weekly: ☐ Semi-Monthly: ☐ Monthly: ☐ Other: _____

IF APPLICABLE: I am a: Municipal Employee ☐ School Employee ☐ Department/Location: _____

Benefits Selected

☐ **FSA Dependent/ Day Care Account***	☐ **FSA Medical/Dental Care Account**
I elect to contribute $ _____ for the Plan Year. **($5,000 maximum)**	I elect to contribute $ _____ for the Plan Year. **($2,500 maximum)**
Confirm eligibility criteria prior to enrolling.	***FSA Debit Card included.*** *Do not include insurance premiums.*
FSA Administrative Fee: $5.50 per month. *****If enrolling in **only** the Dependent Care Account, Administrative Fee will be $4.50 per month**.**	

Direct Deposit Information (Required if not on file with Cafeteria Plan Advisors, Inc.)

I hereby authorize Cafeteria Plan Advisors, Inc. to deposit my claim reimbursements directly to my bank. I also authorize drafts to adjust any over deposits that were credited to my account in error. I will contact Cafeteria Plan Advisors, Inc. immediately with any bank information changes.

Name of Bank: ☐ **Checking** ☐ **Savings**

Check Routing Number (9 digits): **Account Number:**

Certification

I hereby authorize a salary reduction agreement for the amount(s) shown above. I understand that:

- Cafeteria Plan Advisors, Inc. will hold these funds until eligible expenses are incurred and a claim is submitted. Funds may be forfeited in accordance with IRS Publication 969 if eligible expenses are not submitted for reimbursement by plan year deadline or purchased utilizing the provided debit card (if applicable). If terminated, expenses may be incurred through termination date.
- Dependents must qualify under regulations set forth in IRC sections 152 and 129.
- Expenses generally must be consistent with allowable medical deductions under IRS Publication 969.
- This election cannot be revoked or changed during the plan year without a qualifying event as defined by the IRS.
- **Current participants must re-enroll each plan year.**
- **Dependent Care Plan Participants only**: I, the undersigned, certify that I have read the Dependent Care Reimbursement Plan Guidelines (www.cpa125.com) and meet all requirements necessary to participate in the FSA Dependent Care plan. The undersigned agrees to notify the plan administrator in writing within 30 days should the undersigned no longer meet eligibility as mandated by the IRS. Dependents must qualify under IRC section 152.

Signature: **Date:**

Medical Expense Claim Form Flexible Spending Account

Cafeteria Plan Advisors, Inc.
420 Washington Street, Suite 100
Braintree, MA 02184
www.cpa125.com

Email: info@cpa125.com
Phone: 781-848-9848
FAX: 781-848-8477

Address Change ___

Plan Year: _____

Name: _____ ***Employer:*** _____

Street: _____ ***SSN (Last four)*** ***XXX-XX-*** _____

City, State, Zip: _____ ***Participant Phone:*** _____

Email: _____

List Unreimbursed Medical Expenses by Classification *(Participants and IRS Eligible Dependents)*	**Dates of Service** MM/DD/YYYY START - END	**Amount** ($)
Medications	-	
Doctor/ Hospital Co-Pays and Deductibles	-	
Dental/ Eyes/ Hearing	-	
Medical Procedures/ Services and Therapy / Labs and Tests	-	
Over the Counter Medicine (attach copy of prescription for each)	-	
Other	-	
	Total	

- All claims require copies of bills/statements/receipts showing date and service. (IRS regulation)
- Cancelled checks/bank statement/credit card receipts are not adequate substantiation.
- Direct deposit payments are processed weekly on Wednesday and checks are mailed bi-weekly.
- Please allow 3 business days after processing date to receive your reimbursement.
- Expenses must be incurred during the plan year or before the termination date of employment to be reimbursed.
- All claims must be received by Monday to be included in that week's processing.

Certification

I, the undersigned, have incurred the expenses listed above that qualify for reimbursement under my employer's cafeteria plan. I have not been and will not be reimbursed for these expenses from any source including, but not limited to, insurance, this plan, or other programs offered by my, or my spouses, employer. I understand these expenses may no longer be claimed as deductions for income tax purposes since I am requesting reimbursement with funds deducted from my compensation on a pre-tax basis. I acknowledge I am solely liable for any taxes or penalties on ineligible expenses submitted through the medical flexible spending account. I, and only I, am responsible for the accuracy and validity of the submitted expenses and will retain substantiation. I hereby request reimbursement for these expenses, and, if applicable, reaffirm the authorization provided to Cafeteria Plan Advisors, Inc. to directly deposit the reimbursement into my bank.

Participant's Signature: _____ **Date:** _____

Attach copies of receipts and mail, fax, or scan as a PDF and email to info@cpa125.com

Retain originals for your records

Rev. 10-2012

Health Care FSA Eligible Expenses

BABY/CHILD TO AGE 13

- Lactation Consultant*
- Lead-Based Paint Removal
- Special Formula*
- Tuition: Special School/Teacher for Disability or Learning Disability*
- Well Baby /Well Child Care

DENTAL

- Dental X-Rays
- Dentures and Bridges
- Exams and Teeth Cleaning
- Extractions and Fillings
- Oral Surgery
- Orthodontia
- Periodontal Services

EYES

- Eye Exams
- Eyeglasses and Contact Lenses
- Laser Eye Surgeries
- Prescription Sunglasses
- Radial Keratotomy

HEARING

- Hearing Aids and Batteries
- Hearing Exams

LAB EXAMS/TESTS

- Blood Tests and Metabolism Tests
- Body Scans
- Cardiograms
- Laboratory Fees
- X-Rays

MEDICAL EQUIPMENT/SUPPLIES

- Air Purification Equipment*
- Arches and Orthotic Inserts
- Contraceptive Devices
- Crutches, Walkers, Wheel Chairs
- Exercise Equipment*
- Hospital Beds*
- Mattresses*
- Medic Alert Bracelet or Necklace
- Nebulizers
- Orthopedic Shoes*
- Oxygen*
- Post-Mastectomy Clothing
- Prosthetics
- Syringes
- Wigs*

MEDICAL PROCEDURES/SERVICES

- Acupuncture
- Alcohol and Drug/Substance Abuse (inpatient treatment and outpatient care)
- Ambulance
- Fertility Enhancement and Treatment
- Hair Loss Treatment*
- Hospital Services
- Immunization
- In Vitro Fertilization
- Physical Examination (not employment-related)
- Reconstructive Surgery (due to a congenital defect, accident, or medical treatment)
- Service Animals
- Sterilization/Sterilization Reversal
- Transplants (including organ donor)
- Transportation to Medical Facility

MEDICATIONS

- Insulin
- Prescription Drugs

OBSTETRICS

- Doulas*
- Lamaze Class
- OB/GYN Exams
- OB/GYN Prepaid Maternity Fees (reimbursable after date of birth)
- Pre- and Postnatal Treatments

PRACTITIONERS

- Allergist
- Chiropractor
- Christian Science Practitioner
- Dermatologist
- Homeopath
- Naturopath*
- Optometrist
- Osteopath
- Physician
- Psychiatrist or Psychologist

THERAPY

- Alcohol and Drug Addiction
- Counseling (not marital or career)
- Exercise Programs*
- Hypnosis
- Massage*
- Occupational
- Physical
- Smoking Cessation Programs*
- Speech
- Weight Loss Programs*

Note: This list is not meant to be all-inclusive, as other expenses not specifically mentioned may also qualify. Also, expenses marked with an asterisk (*) are “potentially eligible expenses” that require a Note of Medical Necessity from your health care provider to qualify for reimbursement.

Important Information About Your "Benny™" Card

- ✓ If you are a current participant, your Benny™ cards will be re-loaded with your election on the first day of the plan year. If you are a new participant, watch for your "Benny™" Cards in the mail.

- ✓ You will receive two "Benny™" Cards. Both cards will be issued in the Employee's name. If a card will be given to a spouse or dependent, they should endorse their own name on the back of the card.

- ✓ **Your card is valid for multiple years**. Do not throw it away or shred it when you have exhausted your funds. New election values are loaded each plan year.

- ✓ Additional cards/Replacement cards are $10.00. The fee is deducted directly from your account and two additional cards will be issued.

- ✓ Your card does not have a PIN. Select "Credit" when asked, "Credit or Debit?" and sign for your purchase.

- ✓ Check your balance frequently (www.cpa125.com). Make sure you have sufficient funds in your account to cover your expense. If the expense is more than your FSA balance, you may be able to use "Benny™" for the exact amount left in your account, and use another form of payment for the difference. Check with the merchant.

- ✓ Keep your receipts. You could be asked to provide information to verify the expenses comply with the IRS guidelines. Valid receipts should include the following information: merchant or provider name, service rendered or item purchased, date of service and amount of expense. Cancelled checks/credit card statements are not sufficient proof.