

# *Pre-Tax Benefit Plan*



City of Milpitas  
CALIFORNIA

**Plan Year:**

***January 1, 2016 through December 31, 2016***

*This packet includes:*

- *Flex Plan Summary*
- *Summary of Material Modification (SMM)*
- *Flex Enrollment Form*
- *Your Flex Summary Plan Description (SPD) is available online*



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## PRE-TAX BENEFIT PLAN

Your employer offers tax-free benefit plan(s) that provide you with ways to save up to thousands of dollars per year by offering the option to pay for certain types of expenses with pre-tax payroll deductions. If you choose to participate, you will reduce your taxable income which ultimately results in you having more money to spend!

This packet contains important information about your pre-tax benefit plan(s). For more details about the plan, please refer to your Summary Plan Description (SPD).

### Medical Flexible Spending Accounts (FSA):

#### What is the maximum I can elect?

- Medical Expense Flexible Spending Account: **\$2,550**

#### How do I use the Medical FSA?

- The Medical Expense FSA allows you to set aside tax-free dollars that will reimburse you for “qualified” medical, dental and vision expenses “incurred” during the plan year. “Incurred” means the service must be performed during the plan year. “Qualified” expenses include most medically necessary (meaning not cosmetic) out-of-pocket medical, dental, and vision related expenses. Insurance premiums of any kind, including Medicare, individual health insurance, long-term care, warranties, or membership fees that are not directly related to care are not eligible for reimbursement through the Medical FSA.
- IRS Publication 502 <http://www.irs.gov/pub/irs-pdf/p502.pdf> offers helpful information as a guide to what qualifies as a medical expense. Please be advised Publication 502 addresses all expenses that can be deducted on your individual tax return, not just the expenses that are eligible for reimbursement through a Medical FSA.
- IRS Publication 969 <http://www.irs.gov/pub/irs-pdf/p969.pdf> is another good source of information for medical FSAs.

The following is a sample of permitted expenses:

- |                                   |  |
|-----------------------------------|--|
| ✓ Acupuncture                     | ✓ Laboratory fees  |
| ✓ Allergy treatments              | ✓ Laser eye surgery  |
| ✓ Chiropractic                    | ✓ Medical mileage  |
| ✓ Contact lenses & supplies       | ✓ Orthodontia (child & adult)  |
| ✓ Dental (NO teeth whitening)     | ✓ Over-The-Counter medical items & supplies (restrictions may apply) |
| ✓ Doctor office visits & exams    | ✓ Prescriptions (medically necessary)                                |
| ✓ Glasses (prescription)          | ✓ Psychiatric care   |
| ✓ Hearing aids                    | ✓ Sterilization  |
| ✓ Hospital services & surgery     | ✓ Therapy (no marriage/family counseling)                            |
| ✓ Insulin & insulin supplies      | ✓ Vaccines (including Flu Shots)                                     |
| ✓ Insurance co-pays & deductibles | ✓ Vision exams   |

### **Can I be reimbursed through FSA for medical expenses incurred by my family members?**

- Yes! You may save taxes on all qualified medical expenses incurred by you, your spouse, and your dependent children. You may NOT be reimbursed for expenses incurred by a domestic partner unless your domestic partner is your federal tax dependent.
- Your plan **allows** reimbursement for qualified expenses that you incur for an eligible adult child up to age 26.

### **What is the last date I can submit FSA claims for the plan year?**

- If you are an active participant on the last day of the plan year, your designated final filing date is **March 31, 2017**. Please keep in mind that any unused amount left in your account is forfeited at the end of the plan year. This rule is called “use it or lose it.”

### **How do I enroll in the FSA plan?**

- You will make your Spending Account election using **the CBA Enrollment Form**. The appropriate enrollment instructions and/or forms are included or may be provided to you separately by your employer, if applicable.

### **Can I participate in a FSA and HSA (Health Savings Account) at the same time?**

- If you participate in the Medical FSA, neither you nor your spouse (if applicable) is permitted to make contributions to a HSA at any time during the plan year.

### **Can I be reimbursed more than I've had deducted from my paycheck?**

- The Medical FSA account is pre-funded, meaning your entire annual election amount is available for reimbursement at any time during the plan year, regardless of the amount you have contributed from your paycheck.

### **What happens if my employment terminates or I lose eligibility to participate in the plan(s)?**

- **Medical FSA:** Benefits will not be payable for services rendered after **the day on which** you lost your eligibility to participate. (Refer to your SPD for information about COBRA for the Medical FSA, if it is available).
- CBA must receive your Medical FSA claims for reimbursement no later than **March 31, 2017** for expenses that were incurred prior to the date you lost your eligibility to participate.

## How do I determine how much my family will spend on Medical Services?

- The following worksheet will help you calculate how much your entire family will spend on medical services during the course of the plan year.
- Only include services or expenses you will incur during the plan year based on the date of service (not the date you pay for a service).
- While determining the amount you would like to contribute on an annual basis, please keep in mind that any unused amount is forfeited at the end of the plan year. This rule is called “use it or lose it.”

### Office Visits & Co-Payments

- Medical office visits \$ \_\_\_\_\_
- Acupuncture office visits \$ \_\_\_\_\_
- Chiropractic office visits \$ \_\_\_\_\_
- Therapy (**no marriage or family counseling**) \$ \_\_\_\_\_
- Homeopathic office visits \$ \_\_\_\_\_

### Prescription Drugs (Legal)

- Allergy treatments \$ \_\_\_\_\_
- Birth control pills \$ \_\_\_\_\_
- Other prescription drugs \$ \_\_\_\_\_

### Vision Expenses

- Eye exams \$ \_\_\_\_\_
- Contact lenses and supplies \$ \_\_\_\_\_
- Prescription eyeglasses \$ \_\_\_\_\_
- Prescription sunglasses \$ \_\_\_\_\_
- Laser Eye surgery \$ \_\_\_\_\_

### Dental Expenses

- Deductibles \$ \_\_\_\_\_
- Examinations \$ \_\_\_\_\_
- Teeth cleaning \$ \_\_\_\_\_
- Crowns, bridges, root canals \$ \_\_\_\_\_
- Orthodontia \$ \_\_\_\_\_

### Over-the-Counter Medical Supplies

- Band Aids, First Aid Kits, etc. \$ \_\_\_\_\_

### Other Expenses

- In vitro fertilization \$ \_\_\_\_\_
- Insulin and insulin supplies \$ \_\_\_\_\_
- Psychiatric care \$ \_\_\_\_\_
- Medical mileage \$ \_\_\_\_\_
- \_\_\_\_\_ \$ \_\_\_\_\_
- \_\_\_\_\_ \$ \_\_\_\_\_
- \_\_\_\_\_ \$ \_\_\_\_\_

**TOTAL** \$ \_\_\_\_\_

### **Do NOT include expenses for the following services:**

- **“Boutique” Medical Access Fees** (Membership fees paid for access to a particular doctor)
- **Capital expenses** (including operating & maintenance costs)
- **Cosmetic services**
- **Electrolysis**
- **Expenses for your general health**
- **Expenses paid by another plan**
- **Food** (of any type)
- **Health club membership dues**
- **Insurance premiums**
- **Massage & massage therapy** (unless prescribed to treat a specific medical condition)
- **Marriage & family counseling**
- **Vitamins, supplements & herbal remedies** (unless prescribed by a physician)
- **OTC Drugs & Medicines** (without a written prescription)



**SAVE! SAVE! SAVE! SAVE! SAVE!**

## Over-The-Counter (OTC) Drugs, Medicines, and Supplies

- Saving taxes on your OTC drugs, medicine, and medical supply purchases is a great way to maximize the benefits of your Medical FSA or HSA. However, getting reimbursed for your OTC purchases may have some restrictions. OTC drugs and medicines require a prescription from a physician to be reimbursed through your Medical FSA. However, there are still 27,000 OTC medical products and supplies that can be reimbursed through your Medical FSA without requiring a prescription. The following is a sample list of OTC products that may be reimbursed through your Medical FSA. For a more comprehensive list of OTC products available, we recommend visiting <http://www.CBAdministrators.com/FSASore>.

### **NO PRESCRIPTION REQUIRED**

- Band Aids
- Birth Control
- Blood Pressure Monitor
- Braces & Supports
- Canes
- Catheters
- Colostomy Products
- Contact Lens Supplies & Solution
- Contraceptives
- Defibrillators
- Denture Adhesives
- First Aid Kits
- Glucose Meters
- Home Screening Tests (Cancer, Cholesterol, Fertility, Hepatitis C, HIV, Pregnancy, Prostate, Thyroid)
- Hot & Cold Packs
- Hydrogen Peroxide, Iodine
- Insulin & Diabetic Supplies
- Liquid Adhesive
- Medicated Bandages
- Reading Glasses
- Rubbing Alcohol
- Sleeping/Snoring Appliances
- Vapor rub
- Wheelchairs & Walkers

### **ITEMS THAT REQUIRE A LETTER OF MEDICAL NECESSITY FROM YOUR DOCTOR:**

- Herbs
- Herbal Remedies
- Minerals
- Other Natural Remedies
- Supplements
- Vitamins

### **PRESCRIPTION IS REQUIRED**

- Acne Medications
- Anti-Diarrhea Medications
- Anti-Inflammatory Treatments

### **PRESCRIPTION IS REQUIRED (cont'd)**

- Anti-Itch Treatments
- Antifungal Treatments
- Antiseptics & Topical Antibiotics
- Allergy, Cold, Flu, and Cough Medications
- Asthma Medications
- Bunion/Blister Treatments
- Cold Sore & Fever Blister Medications
- Corn & Callus Removal Medications
- Diaper Rash Ointment
- Digestion/Gas Aids
- Ear Drops
- Eye Drops
- Hemorrhoid Relief
- Laxatives
- Lice Control
- Motion Sickness Tablets
- Nasal Sprays, Drops & Strips
- Nicotine Gum or Patches
- Oral Pain Remedies
- Pain Relievers
- Sinus Medications
- Sleeping Medicines
- Throat Pain Remedies
- Wart Removal Medications

### **NEVER ELIGIBLE:**

- Aromatherapy products
- Baby bottles, cups, oil, wipes
- Cosmetics
- Cotton swabs or pads
- Deodorants and antiperspirants
- Diapers
- Facial care
- Feminine care
- Food (of any type)
- Fragrances
- Hair re-growth
- Low carb / low calorie / dietary foods
- Oral care (e.g. Sonicare)
- Shampoo and conditioner
- Skin care
- Spa salts
- Sun tanning products
- Toothbrushes

## Dependent Care Spending Accounts (FSA)

### What is the maximum I can elect?

- Dependent Care Flexible Spending Account: **\$5,000**

*\*The maximum tax exclusion permitted during a 12-month calendar year is \$5,000 per individual taxpayer or married couple filing a joint tax return. The maximum amount permitted could be reduced under the following circumstances: (1) If you are married and file a separate tax return, the maximum you may elect is \$2,500; (2) If your spouse earns less than \$5,000, you may not elect more than your spouse earns during the Plan Year; (3) If your spouse is a full-time student or incapable of self-care, the maximum you may elect is \$3,000 for one child in day care or \$5,000 if you have two or more children in day care.*

### Can I be reimbursed more than I've had deducted from my paycheck?

- **Dependent Care FSA:** At no time can you be reimbursed more than you have actually contributed to your account through payroll deduction.

### How do I use the Dependent Care FSA?

- The Dependent Care FSA allows you to be reimbursed for custodial or day care expenses for children that are your federal tax dependents under age 13, or for a disabled adult federal tax dependent that lives with you, so that you and your spouse (if applicable) can work, attend school or actively look for work.
- Your daycare provider may not be your dependent or child under the age of 19.
- Only the Custodial Parent is eligible to participate in the Dependent Care FSA. In the case of divorce, the Custodial Parent is the parent with whom the child lives for MORE THAN 50% of the year. Only one parent can qualify as the Custodial Parent.

### Qualified daycare expenses include:

- Actual reportable ("above the table") daycare expenses incurred during the plan year (separate fees for services such as transportation, meals, classes, lessons, trips or supplies are not reimbursable unless the charges are included as part of your base fee – not itemized.)
- Day camps, including day camps that focus on specific activities such as sports and arts (overnight camps are excluded even if the camp apportions the day camp and overnight charges.)
- Educational (tuition) charges for kindergarten and over are NOT eligible for reimbursement.
- The maximum amount you may elect is reduced for couples that file separate returns, when one spouse is a student or when a spouse earns little or no income.
- Determine your election amount for the entire plan year. Do NOT elect more than your actual expenses. Your annual election is then deducted pre-tax from your pay in equal installments throughout the plan year.

### What if the amount of my daycare expense changes during the year?

- In most cases, if you experience a change of status, or the cost for care changes during the plan year, you may be permitted to adjust your election. However, there are significant restrictions. Therefore, you need to choose your election wisely because you will not be permitted to change your election simply because you elect too much, make a mistake, or even if you just decide to change to a less expensive provider. In any event, you must notify your employer within 30 days of the event that is causing the change. Please refer to your SPD for additional details.

### What is the last date I can submit Dependent Care FSA claims for the plan year?

- If you are an active participant on the last day of the plan year, your designated final filing date is **March 31, 2017**. Please keep in mind that any unused amount left in your account is forfeited at the end of the plan year. This rule is called "use it or lose it."

### What happens if my employment terminates or I lose eligibility to participate in the plan(s)?

- **Dependent Care FSA:** Benefits will not be payable for services rendered after **the last day of the plan year during which** you lost your eligibility to participate.

**CITY OF MILPITAS FLEXIBLE BENEFIT PLAN**

**SUMMARY OF MATERIAL MODIFICATIONS**

The purpose of this Summary of Material Modifications is to inform you of a change that has been made to the City of Milpitas Flexible Benefit Plan. This change has affected the information previously provided to you in the Plan's Summary Plan Description. The Summary Plan Description is modified as described below.

**CITY OF MILPITAS FLEXIBLE BENEFIT PLAN**

**SUMMARY PLAN DESCRIPTION**

January 1, 2016

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## **ELECTIONS**

### Modification of Elections

Generally speaking, you may only revise your elections as of the start of a Plan Year. However, in certain situations you may modify your elections upon a "change in status". A brief listing of events that constitute a change in status follows. Please note that there are several conditions and/or limitations that apply to the events listed below. Please contact the Plan Administrator if you have any questions or believe that you may qualify for an election change. A change in status includes:

Change in your marital status.

Change in the number of your dependents.

Change in employment status.

A dependent satisfies or ceases to satisfy eligibility requirements.

Change in your place of residence.

Commencement or termination of an adoption proceeding.

Court judgment, decree, or order.

Entitlement to Medicare or Medicaid.

Significant cost or other coverage changes.

You take leave under the FMLA

If you have a change in status, you may modify an election in your Health Care Reimbursement Account but your new annual contribution amount may not be less than the amount previously reimbursed at the time of the election change.

You are permitted to revoke an election of coverage under a group health plan due to reduction in hours of service. In order to revoke an election of coverage under a group health plan due to reduction in hours of service, you must have been in an employment status under which you were reasonably expected to average at least 30 hours of service per week and there is a change in your status so that you will reasonably be expected to average less than 30 hours of service per week after the change. In addition, your revocation of the election of coverage under the group health plan must correspond to your intended enrollment (and any related individuals who cease coverage due to the revocation) in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

You are permitted to revoke an election of coverage under a group health plan due to enrollment in a qualified health plan offered through the Health Insurance Marketplace. In order to revoke an election of coverage under a group health plan due to enrollment in a qualified health plan offered through the Health Insurance Marketplace, you must be eligible for a special enrollment period to enroll in a qualified health plan through the marketplace or during the marketplace's annual enrollment period. In addition, the revocation of the election of coverage under the group health plan must correspond to your intended enrollment (and any related individuals who cease coverage due to the revocation) in a qualified health plan through a marketplace for new coverage that is effective no later than the day immediately following the last day of the original coverage that is revoked.

In addition, your election for your premiums will be automatically adjusted for any change in the cost of contracts as permitted by applicable law.

# Flexible Benefit Plan Enrollment Form

January 1, 2016 PLAN YEAR  
Administered by CBA

EMPLOYER: **City of Milpitas**

PLAN YEAR ENDING: **December 31, 2016**

<b>1 Employee Information</b> - Please print clearly				
FIRST NAME		LAST NAME		SOCIAL SECURITY NUMBER
MAILING ADDRESS			CITY	STATE ZIP CODE
DATE OF BIRTH	DAYTIME PHONE NUMBER	E-MAIL ADDRESS		
<b>2 Make Your Elections</b> - Enter your election for each account.				
<p><b><u>Medical FSA</u></b></p> <p><input type="checkbox"/> I elect to participate in the Medical FSA. The amount I elect for the PLAN YEAR is (maximum <b>\$2,550</b>):</p> <p style="text-align: center;">\$ _____ / Plan Year</p> <p>Your annual election will be deducted from your pay in equal installments throughout the plan year.</p>		<p><b><u>Dependent Care FSA</u></b></p> <p><input type="checkbox"/> I elect to participate in the Dependent Care FSA. The amount I elect for the PLAN YEAR is (maximum <b>\$5,000</b>):</p> <p style="text-align: center;">\$ _____ / Plan Year</p> <p>Your annual election will be deducted from your pay in equal installments throughout the plan year.</p>		
<b>3 Direct Deposit Authorization</b> – Complete the banking information if you wish to establish direct deposit with CBA (or change your current direct deposit banking information on file with CBA).				
<p>By completing the banking information below, I hereby authorize CBA to deposit all reimbursements directly into my personal bank account at the financial institution named below. I understand that I may cancel this authorization at any time by notifying CBA in writing. I further understand that I am responsible to notify CBA if, for any reason, my bank account information changes. If I do not sign up for Direct Deposit, I understand all reimbursements will be paid to me by check.</p> <p><b>Please Note:</b> If you previously signed up for Direct Deposit with CBA, <b>you will continue</b> to be reimbursed via Direct Deposit. If you wish to cancel your banking of record, please write CANCEL on the line below.</p> <p style="text-align: right;">Checking <input type="checkbox"/> Savings <input type="checkbox"/></p> <p>_____ Name of DEPOSITORY (Name of Financial Institution)</p> <p>_____ Bank Routing Number      _____ Account Number</p>				
<b>4</b> <i>By signing below, you are agreeing to the terms and conditions printed on the back of this form.</i>				
<p>I, the undersigned employee, hereby certify that I have read and agree to all the "Terms &amp; Conditions for Participation in the Flexible Benefit Plan" printed on the back of this Election Form. I hereby authorize my employer to deduct the amounts listed above from my compensation.</p> <p><b>EMPLOYEE SIGNATURE:</b> _____ <b>DATE:</b> ____ / ____ / ____</p>				
<b>5 To be completed by Employer</b>				
AUTHORIZED EMPLOYER SIGNATURE		BENEFITS EFFECTIVE DATE (May not precede the date employee signed form)	DATE OF HIRE	DATE OF 1 <sup>ST</sup> DEDUCTION

## ***Terms & Conditions for Participation in the Flexible Benefit Plan***

I fully understand and agree that:

- I may never be reimbursed for expenses “incurred” (the date services are actually performed) prior to the later of, the date I am eligible to participate or the date I complete the enrollment form.
- Once made, my elections are “irrevocable” during the plan year unless I experience a “qualifying and related change in status”. I understand that I must refer to my SPD for details.
- If I am an active employee as of the last day of the plan year, I will forfeit any remaining balance left in my reimbursement account(s) unless CBA “receives” my claim for qualified expenses by the last day of my “run-out period”.
- If I terminate employment, or otherwise lose my eligibility to participate in the reimbursement accounts during the plan year, I may be required to submit claims for reimbursement shortly after losing my eligibility (refer to your SPD for the filing deadline if you terminate participation during the plan year). If I do not submit my claim for reimbursement by the deadline, I understand and agree that I will forfeit any remaining balance left in my reimbursement account(s).
- I may only receive reimbursements for qualified expenses incurred (date services are performed) during the plan year and while I am an active employee (unless coverage is extended under COBRA).
- I may be reimbursed for expenses incurred by myself, my spouse, my dependent children, and any other individual who qualifies as my federal tax dependent.
- I may not be reimbursed for expenses incurred by my domestic partner and/or their dependent children, unless my domestic partner and/or their children also qualify as my federal tax dependent(s).
- I may never seek reimbursement before an expense is “incurred” (performed).
- By participating in my flexible benefit (cafeteria) plan, I may reduce my Social Security tax contribution, and therefore, could potentially reduce my future social security benefits.
- My employer may modify or revoke my elections at any time if required to maintain the Plan in compliance with all applicable provisions of the Internal Revenue Code (IRC).
- This agreement is subject to the terms and conditions of the Plan and revokes any prior agreement I may have completed.
- I must make a new election each year for my FSA accounts. My FSA elections will not automatically roll-over.
- I am not required to make a Pre-tax Premium election for my health insurance contributions. My employer will automatically deduct my health insurance premium contributions (if any) from my pay before-tax (tax-free). If I want to pay taxes on my health insurance premium contributions, I understand that I must complete an “opt-out” form available from my employer during my initial or any future annual open enrollment period.
- I am responsible to determine if the tax benefits provided by the Dependent Care FSA are superior to the federal tax credit.
- I am responsible to reimburse my employer for any benefits received, taxes, penalties or interest that may be imposed if I knowingly violate the terms of the Plan.
- I have received a Summary Plan Description (SPD) for the Flexible Benefit Plan.