It's Sign-Up Time! Enrollment Deadline is May 30th

Flexible Spending Benefits

Open Enrollment is NOW!

▶ *SAVE $$* on Eligible Health & Dependent Care Expenses ◀

City of Lynn

One of the Few Gifts the IRS Gives!

Discover the benefit that SAVES YOU MONEY. This perk allows you to set aside a portion of your pay—*BEFORE TAXES*—to cover out-of-pocket expenses in these categories:

- **HEALTH CARE.*** Includes co-pays (medical & prescription), deductible expenses, non-cosmetic dental work, orthodontics, prescription eyeglasses, contact lenses, laser eye surgery, alternative health therapies (e.g. acupuncture), mental health services, and *MORE!*

  Max. Health FSA Annual Election: $1,350.

- **DEPENDENT CARE.**** For children under 13 and dependents with special needs. Eligible expenses include: day care, pre-school, before- and after-school care, summer day camp, and elder day care.

  Max. Dependent Care FSA Annual Election: $2,500 per family.

Make Your Money Go UP TO 30% Further!
depending on your tax status

Who's Covered? The Health Care FSA plan covers you, your spouse, and dependents as defined by the IRS, including children claimed on the employee's tax return and living with the participant, as well as adult children to age 26 if on the employee's health plan.

HSA Ineligibility. If you or your spouse has a Health Savings Account ("HSA"), you are NOT ELIGIBLE for a Health Care FSA account.

* Not all Health Care expenses are FSA-eligible, such as cosmetic procedures or products, even if performed or dispensed by a doctor (i.e., Botox, teeth whitening, veneers, etc.), and general health expenses (i.e., toothbrushes, non-prescription sunglasses, massages, gym dues, etc.). Vitamins, supplements, over-the-counter ("OTC") medications, etc., require a physician's prescription to be FSA-eligible. Some expenses, such as medical equipment, may be FSA-eligible with a physician's Letter of Medical Necessity. You are advised to check on the eligibility of an item or service before incurring an expense. Visit *https://fsastore.com/FSA-Eligibility-List.*and search the "Eligible Products and Services List" for more info. on FSA-eligible products and services, as well as criteria for eligibility.

** Overnight camp, school tuition, extra-curricular programs, etc., that aren't daycare/childcare-based, are not FSA-eligible.

Enroll by 5/30/19
for the
7/1/19 – 12/31/19
Short Plan Year

It's easy! Simply complete an *"Authorization for Pre-Tax Deduction"* form and send it to us by the enrollment deadline.

***Already in the plan? Just* log-in** to your account via our website to re-enroll.

Note: Re-enrollment is not automatic.

NEW! File Claims and Track Your Account 24/7!

Log in to your account via our website to file claims, check balances, see claims history, update contact and direct deposit info., etc!

Or use our **handy app:**
CPA Flex Mobile.

Benefit Cards

New Health Care FSA enrollees will be sent **2 cards** that can be used at most medical and dental facilities, optical shops, and pharmacies for prescriptions. **Keep your cards!** They'll reload each time you enroll, for up to 5 years.

Flexible Spending Plans administered by...

CAFETERIA PLAN ADVISORS | 420 WASHINGTON ST., SUITE 100, BRAINTREE, MA 02184 | 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: 5/30/19

Personal Information

Name: _____ *Employer:* ***City of Lynn***

Street: _____ *Plan Year:* 07/01/2019- 12/31/2019
(Expenses must be incurred between these dates)

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

E-Mail: _____ *Phone:* _____

Payroll Information

I am paid: Weekly 52: ☐ Weekly 38: ☐ Monthly: ☐

IF APPLICABLE: I am a: Fire☐ Police ☐ City Hall ☐ City Hall- ISD ☐ DPW ☐ Library ☐ School Employee: ☐

Benefits Selected

☐ **FSA Dependent/ Day Care Account**	☐ **FSA Medical/Dental Care Account**
I elect to contribute $ _____ for the Plan Year. ($2,500 maximum)	I elect to contribute $ _____ for the Plan Year. ($1,350 maximum)
Confirm eligibility criteria prior to enrolling.	If you or your spouse are 'contributing' to a Health Savings Account (HSA), you are NOT ELIGIBLE for the FSA Health Care Account. *FSA Debit Card included.*

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 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.
- It is suggested you consult with a tax advisor since your participation will limit your ability to claim on your IRS taxes.
- If you or your spouse are 'contributing' to a Health Savings Account (HSA), you are NOT ELIGIBLE for FSA Health Care Account.

Signature: _____ **Date:** _____

Please see www.cpa125.com to download forms or for more information regarding the Flexible Spending Accounts. Rev. 10-2012

Return via email to info@cpa125.com

Dependent Care Claim
Certification 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

Plan Year: _____

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

Mailing Address: _____ ***SSN (Last four)*** ***XXX-XX-*** _____

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

Check if New Address ☐ ***Email:*** _____

Eligible Dependents:

The dependent care expenses must be employment related. Dependents eligible for FSA funding:

- -Must be under age 13
- -Reside with Participant
- -Physically or mentally incapacitated
- -Qualify as Dependent under IRS code section 151(c)
- -Earn less than $3800 per year unless qualifying child

Dependent Information:

Dependent Name	Relationship	Date of Birth		Dependent Name	Relationship	Date of Birth

Day Care Facility or Individual who provides care:

Name:	Name:
Address:	Address:
Corporate or Individual Tax ID (Required):	Corporate or Individual Tax ID(Required):

Claim Amount: $ _____ **Dates of Service:** _____ (Beg) - _____ (End)

This is to certify that I, the undersigned, have incurred expenses that qualify under IRC section 129 "Dependent Care Assistance Programs." I have not been, and will not be reimbursed for these expenses by 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. The undersigned reaffirms that all eligibility criteria set forth by the IRS, found on the reverse side of this form and at www.cpa125.com, continue to be met at the time these dependent care expenses were incurred. I acknowledge that I am solely liable for any taxes or penalties on ineligible expenses processed through the dependent care plan. I, and only I, am responsible for the accuracy and validity of the submitted expenses. It is my responsibility to retain ALL receipts. I hereby authorize Cafeteria Plan Advisors, Inc. to reimburse me for the "Claim Amount" listed above, and, if applicable, reaffirm the authorization provided to Cafeteria Plan Advisors, Inc. to directly deposit the reimbursement into my bank.

PARTICIPANT'S SIGNATURE: _____ DATE: _____

Return page 1 via mail, fax, or email to info@cpa125.com

Please return only the first page of the claim form to Cafeteria Plan Advisors, Inc.

Section 125 Dependent Care Eligibility Worksheet

	Yes	No
Married (as defined by IRS)?	☐	☐
If married, is your spouse employed?	☐	☐
If married, do you file a joint tax return?	☐	☐
If married, does your spouse have a Dependent Care Plan?	☐	☐
If not employed, is spouse		
Full-time student (5 months)	☐	☐
Disabled and unable to care for self/children	☐	☐

✓ If your spouse is not employed and is not actively seeking employment, you are not eligible for the Dependent Care plan unless he or she is a full-time student or is disabled.

✓ If your spouse has a dependent care plan, your combined election may not exceed $5,000

✓ Funds not claimed for will be forfeited or otherwise handled in accordance with the plan document and the current IRS regulation.

✓ **IRS form 2441 should be filed with your tax form 1040 when dependent care has been deducted from your pay. The Dependent Care deduction should be shown in box 10 of the W2 form from your employer.**

Dependent Care Reimbursement Plan Guidelines

Employer provided dependent care assistance is tax-free only if the following conditions are met:

1. Each individual for whom you receive dependent care assistance is;
    a. A dependent under the age of 13 whom you are entitled to claim as a dependent on your tax return, or
    b. A spouse or other tax dependent who is physically or mentally incapable of caring for him or herself.
2. The dependent care assistance is provided for the care of a dependent described above or for the related household service and is incurred to enable you to be gainfully employed.
3. If the dependent care services are provided outside your household, they are incurred for the care of a dependent who is described in 1.a) above or who regularly spends at least 8 hours per day in your household.
4. If the dependent care is provided by a dependent care center (i.e. a facility that provides care for more than 6 individuals not residing at the facility) the center complies with all applicable state and local laws and regulations.
5. If the services are provided by a camp, the dependent does not stay overnight at the camp.
6. Payment for the services are not made to a child of yours who is under the age of 19 at the end of the year for which the expenses are incurred or to an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent.
7. The reimbursement (or fair market value of the dependent care expenses) are provided for the applicable year and may not exceed the least of the following limits:
    a. $5000 ($2500 if you are married and do not file a joint tax return for the year).
    b. Your taxable compensation (after any reductions under the 401(k) plan, dependent care assistance plan and medical/dental plans).
    c. If you are married, your spouse's actual deemed earned income.

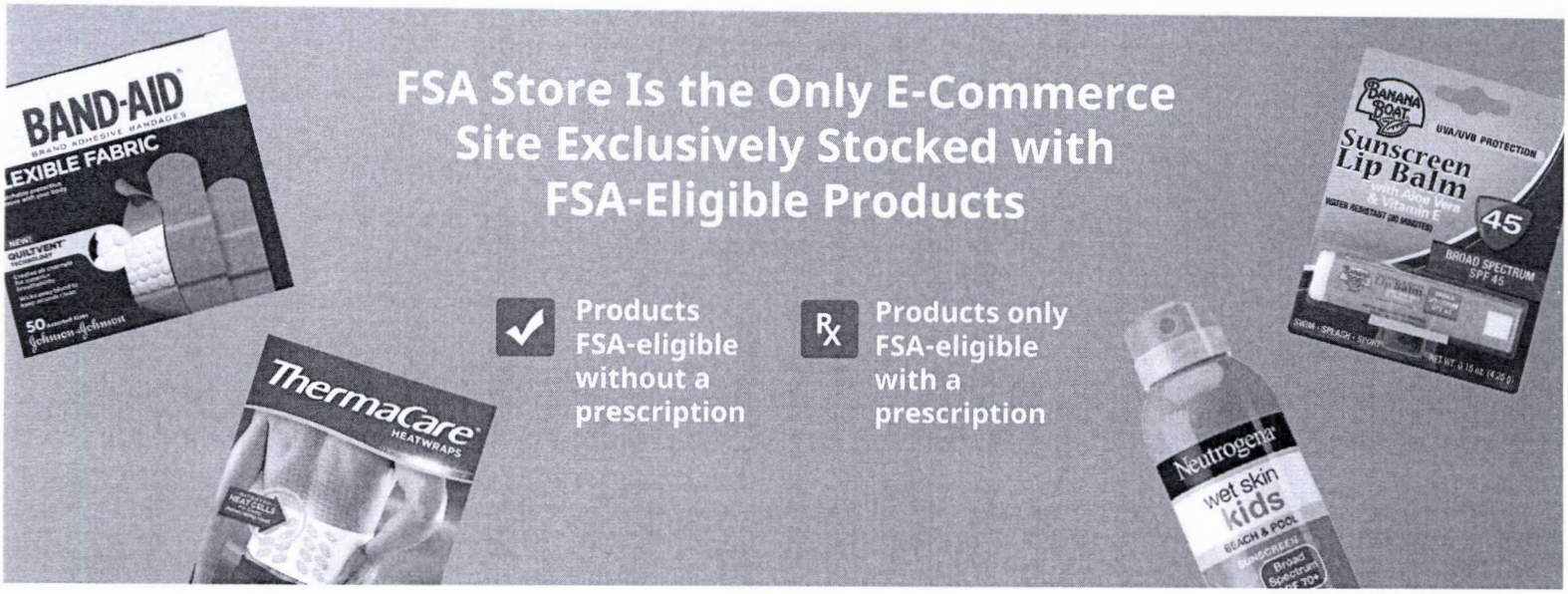
*For purposes of 7.a) above, if two employees are married to each other and file a joint tax return, a single $5000 limit applies to both spouses together. For purposes of 7.c) above, your spouse will be deemed to have earned income of $200 ($400 if you have 2 or more dependents described in paragraph 1) above, for each month in which your spouse is: physically or mentally incapable of caring for him or herself or a full time student at an educational institution. For all purposes of paragraph 7) above, certain separated spouses are not treated as married.

8. You must report to the IRS on your tax return the name, address and social security number (or other tax payer identification number, if required) of any dependent care service provider who provides services to you during the relevant calendar year).
9. If your Dependent Care needs experience a qualifying change during the plan year, you may make election changes within 30 days of the qualifying change.
10. Participation in the Dependent Care Spending Account will limit your reporting on your IRS taxes.
11. If you elected and were reimbursed more than your dependent care costs, you may need to report the difference on your taxes. It is suggested you contact a Tax Advisor.
12. All claims must be submitted within 90 days after the plan year ends or your termination date.

Return page 1 via mail, fax, or email to info@cpa125.com

FSA Store

THE FLEXIBLE SPENDING ACCOUNT SITE



FSA Store Is the Only E-Commerce Site Exclusively Stocked with FSA-Eligible Products

FSA Store Tools to Help Participants Better Manage their Funds

FSA Eligibility List

Eliminate Eligibility Guessing Games

FSA Deadline Tracker

Receive Deadline Reminders

FSA Learning Center

Get Answers to All Your FSA Questions!

Rx Process

Easily use Your FSA Card for OTC Items

FSA Store Features & Benefits

- **Largest Selection of FSA-Eligible Products Online**
- **Accepts All FSA, HSA and Major Credit Cards**
- **FREE Shipping on Orders $50+**
- **24/7 Customer Support**

To Access FSA Store Visit **cpa125.com/fsaextras.htm**

$10 OFF

Code: OECPA

Expires 12/31/19 • 1 use per customer

Health Care 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

Plan Year: _____

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

Mailing Address: _____ ***SSN (Last four)*** ***XXX-XX-*** _____

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

Check if New Address ☐ ***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 and funds are typically in your account by the end of the week; however, the bank has 3 business days to post it to your account.
- Checks are mailed bi-weekly.
- Expenses must be incurred during the plan year or before the termination date of employment to be reimbursed.
- Claims received by Monday are typically 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. 2016

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 (reimbursable after payment)
- ☐ 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*

Please Note: **The IRS will not allow 'OTC medicines or drugs' to be purchased with Health Care FSA or HRA funds *unless accompanied by a prescription*.** The following is a high level list of Over-the-Counter (OTC) items that clearly are not medicine or drugs and **are eligible** for purchase with Health Care FSA Plans.

Antiseptics, Wound Cleansers
☐ Alcohol, peroxide, Epsom salt,

Baby Electrolytes
☐ Pedialyte, Enfalyte

Denture Adhesives, Repair, and Cleansers
☐ PoliGrip, Benzodent, Efferdent

Diabetes Testing and Aids
☐ Insulin, Ascencia, One Touch, Diabetic Tussin, insulin syringes; glucose products

Diagnostic Products
☐ Thermometers, blood pressure monitors, cholesterol testing

Elastics/Athletic Treatments
☐ ACE, Futuro, elastic bandages, braces, hot/cold therapy, orthopedic supports, rib belts

Eye Care
☐ Contact lens care

Family Planning
☐ Pregnancy and ovulation kits

First Aid Dressings and Supplies
☐ Band Aid, 3M Nexcare, non-sport tapes

Hearing Aid/Medical Batteries

Incontinence Products
☐ Attends, Depend, GoodNites for juvenile incontinence

Reading Glasses and Maintenance Accessories

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 PREPAID BENEFITS CARD

If you're newly enrolled in the Flexible Spending Account Program, you will automatically receive the new blue Prepaid Benefits Card. You'll receive two cards at your home address for you and your family members to use. The Cards will arrive in a special envelope that looks like this – so please don't throw it out!

Your Prepaid Benefits Card is loaded with the value of your annual FSA\HSA election amount (less any amounts you have already spent in this plan year.) Using your Card helps you keep cash in your wallet and makes accessing your FSA funds easy. The Card can be used, instead of cash, to pay for qualified health care expenses such as:

- Prescription and health plan copayments, deductibles and coinsurance
- "Amount Due" on medical and dental statements
- Orthodontics
- Mail-order or online prescription invoices
- Vision services and eyeglasses
- LASIK surgery
- Eligible over-the-counter (OTC) items

You'll simply swipe your Card each time you incur a qualified health care expense and the amount of your purchase will be deducted from your FSA– automatically. You can also fill in your Card number on bills you receive from providers to pay the amount you owe. You'll have no claim forms to complete and you won't have to wait to get a check in the mail. You can check balances or account details anytime – online at www.cpa125.com or via the mobile app -- ***CPA FLEX MOBILE***. It's that easy!

It's Important to Save Your Receipts!
Your Prepaid Benefits Card will definitely improve your cash flow. However, be aware that the IRS requires the Card be used only for eligible expenses. Most of the time, we can verify the eligibility of the expense automatically. Yet, there are instances when you'll receive a letter/notification asking you to furnish an itemized receipt to verify the expense. When you receive such a request, make sure you submit the receipts as soon as possible to avoid having your Card suspended until receipts have been submitted and approved.

What is an itemized receipt?
An itemized receipt must include: merchant or provider name, services received or item purchased, date of service, and amount of the expense. Cancelled checks, handwritten receipts, card transaction receipts or previous balance receipts cannot be used to verify an expense.

Using Your Card is as Easy as 1-2-3!
Look for additional information about how to use your new Prepaid Benefits Cards included with your card packet in the mail. We hope you enjoy this new exciting feature of your plan! Remember, the Card will not work at gas stations or restaurants – only at health care related providers.

Save your card. Every year you re-enroll, the funds get loaded on to this card!

Cafeteria Plan Advisors, Inc.
420 Washington Street, Suite 100, Braintree, MA 02184 781.848.9848 www.cpa125.com