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

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.

Custom Benefit Administrators **FLEXIBLE BENEFIT PLAN**

Enrollment form & Salary Reduction Agreement

EMPLOYER: Sacramento City Unified School District PLAN YEAR: January 1, 2016

1 Employee Information

FIRST NAME	LAST NAME	SOCIAL SECURITY NUMBER

MAILING ADDRESS	CITY	STATE	ZIP CODE

DATE OF BIRTH	DAYTIME PHONE NUMBER	E-MAIL ADDRESS	SEX
			☐ Male ☐ Female

2 Making Your Elections - ***Enter your election for each account.***

Medical Expense FSA

☐ **Yes, I elect to participate in the Medical Expense FSA. The amount I elect for the PLAN YEAR is entered below (maximum election $2,550):**

$_____ *

* Your election will be deducted from your pay in equal installments each pay period throughout the Plan Year.

Dependent Care FSA

☐ **Yes, I elect to participate in the Dependent Care FSA. The amount I elect for the PLAN YEAR is entered below (maximum election $5,000):**

$_____ *

* Your election will be deducted from your pay in equal installments each pay period throughout the Plan Year.

Pre-Tax Premium Plan ("POP")

If you contribute toward the cost of your group health insurance, you are automatically enrolled in the pre-tax premium plan (POP). You do not need to sign any forms to save taxes on your health insurance contributions.

3 Salary Reduction Agreement

I authorize my employer to reduce my taxable compensation as directed above each pay period during the year. I fully understand that:

- I understand that I must be "common law employee" (as defined by my employer) to participate in the Plan. I further understand that if I am "self-employed" (as defined under Code § 401©, which includes a sole proprietor, partner in a partnership, over 2% owner of a S-Corp {or the employee spouse or dependent of a more than 2% owner of an S-Corp}, I may not participate in the Plan.
- Once made, my elections are "irrevocable" during the plan year unless I experience a "qualifying and related change in status" or other permissible event as defined in the Plan and by the Internal Revenue code(IRS). I further understand that my employer may modify or revoke my elections in any way it deems necessary in order to maintain the flexible benefit plan in compliance with all applicable provisions of the IRS. I further understand that my elections are in addition to any other agreements I have with my employer.
- If my contributions for health insurance change by an insignificant amount during the plan year, my employer will automatically adjust my pre-tax contributions accordingly.
- I will forfeit contributions that I have not claimed from my FSA accounts after the end of each plan year (the run-out period). The length of the run-out period is stated in my Summary Plan Description.
- I may be offered COBRA for my Medical Expense FSA if I otherwise qualify.
- Tax-free reimbursements from my FSA's may only be made for qualified expenses incurred (date services are rendered) during the plan year and may not be carried over into future plan years. I understand that reimbursements are based on the amount I owe for qualified expenses and NOT on the amount I pay or have paid.
- Services must be rendered (performed) before I may be reimbursed.
- By participating in my flexible benefit (cafeteria) plan, I could potentially reduce my social security benefits.
- This agreement is subject to all the terms and conditions of our flexible benefit plan, as amended and revokes any prior election and redirection agreement I may have completed.
- Prior to the start of each plan year, I will have the opportunity to change my premium (POP) election for the following plan year. If I do not change my POP election, my current election will automatically renew for the new plan year. However, I understand that I must make a new election for the reimbursement accounts prior to each future plan year in order to continue my participation from year to year.
- If applicable, electing to pay the premium for disability insurance with pre-tax dollars will result in my having to pay taxes (including wage taxes during the first six months of benefit payments) on any benefits received under the disability insurance policy.
- Prior to the start of each plan year, I will have the opportunity to change my elections for the following plan year.
- I am responsible to compare (or obtain assistance from a qualified tax advisor) the benefits provided by applicable tax credits and have determined that my election is in my best interest.
- I am responsible to reimburse my employer for benefits paid, taxes, penalties or interest that may be imposed as a result of my knowingly violating the terms of the Plan.
- If I participate in one or more of the reimbursement accounts, I understand that (1) My employer will deduct a fee from my pay each pay period to offset the administrative expenses of the Plan; (2) I will not be charged an additional fee if I participate in more than one account; and (3) I pay nothing to participate in the premium (POP) account.

I authorize the above elections and subsequent adjustments to my base annual salary. I understand and agree to abide by the rules and restrictions of the plan.

EMPLOYEE SIGNATURE:_____ **DATE:** ____/____/____

To be completed by Employer

AUTHORIZED SCUSD SIGNATURE	BENEFITS EFFECTIVE DATE (May not precede date employee signed form)	BARGAINING UNIT	HIRE DATE	NUMBER OF PAY PERIODS (CIRCLE ONE): **12 / 11 / 10**