

See you at the  
**BENEFITS FAIR**  
at CITY HALL on  
Thursday,  
March 21<sup>st</sup>

# Flexible Spending Benefits: Open Enrollment is NOW!

▶ **SAVE \$\$** on Eligible Health & Dependent Care Expenses ◀  
*City of Lowell*

## 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. Annual Election: \$2,700.**

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

**Max. Annual Election per Family/Household: \$5,000.**

**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 adult children to age 26 if covered under 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, etc.). Vitamins, supplements, non-prescription/over-the-counter 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 5/1/19**  
*for the*  
**7/1/19 – 6/30/20**  
**Plan Year**

**It's easy!** Simply complete an "Authorization for Pre-Tax Deduction" form and return it by 5pm on May 1<sup>st</sup> to City Hall H.R. Office.

**Already in the plan? Log in** to your account via the employee portal at **CPA125.com** to re-enroll.

**Note: Re-enrollment is not automatic.**

### Rollover Option

**Up to \$500** in unused Health Care FSA monies can be rolled over to the next plan year if you re-enroll.

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

Log in to your **employee portal** via our website, 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 have a 5-year shelf life and will reload each time you enroll until they expire.



# Health Care FSA Eligible Expenses

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        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| <p><b>BABY/CHILD TO AGE 13</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Lactation Consultant*</li> <li><input type="checkbox"/> Lead-Based Paint Removal</li> <li><input type="checkbox"/> Special Formula*</li> <li><input type="checkbox"/> Tuition: Special School/Teacher for Disability or Learning Disability*</li> <li><input type="checkbox"/> Well Baby /Well Child Care</li> </ul> <p><b>DENTAL</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Dental X-Rays</li> <li><input type="checkbox"/> Dentures and Bridges</li> <li><input type="checkbox"/> Exams and Teeth Cleaning</li> <li><input type="checkbox"/> Extractions and Fillings</li> <li><input type="checkbox"/> Oral Surgery</li> <li><input type="checkbox"/> Orthodontia (reimbursable after payment)</li> <li><input type="checkbox"/> Periodontal Services</li> </ul> <p><b>EYES</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Eye Exams</li> <li><input type="checkbox"/> Eyeglasses and Contact Lenses</li> <li><input type="checkbox"/> Laser Eye Surgeries</li> <li><input type="checkbox"/> Prescription Sunglasses</li> <li><input type="checkbox"/> Radial Keratotomy</li> </ul> <p><b>HEARING</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Hearing Aids and Batteries</li> <li><input type="checkbox"/> Hearing Exams</li> </ul> <p><b>LAB EXAMS/TESTS</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Blood Tests and Metabolism Tests</li> <li><input type="checkbox"/> Body Scans</li> <li><input type="checkbox"/> Cardiograms</li> <li><input type="checkbox"/> Laboratory Fees</li> <li><input type="checkbox"/> X-Rays</li> </ul> | <p><b>MEDICAL EQUIPMENT/SUPPLIES</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Air Purification Equipment*</li> <li><input type="checkbox"/> Arches and Orthotic Inserts</li> <li><input type="checkbox"/> Contraceptive Devices</li> <li><input type="checkbox"/> Crutches, Walkers, Wheel Chairs</li> <li><input type="checkbox"/> Exercise Equipment*</li> <li><input type="checkbox"/> Hospital Beds*</li> <li><input type="checkbox"/> Mattresses*</li> <li><input type="checkbox"/> Medic Alert Bracelet or Necklace</li> <li><input type="checkbox"/> Nebulizers</li> <li><input type="checkbox"/> Orthopedic Shoes*</li> <li><input type="checkbox"/> Oxygen*</li> <li><input type="checkbox"/> Post-Mastectomy Clothing</li> <li><input type="checkbox"/> Prosthetics</li> <li><input type="checkbox"/> Syringes</li> <li><input type="checkbox"/> Wigs*</li> </ul> <p><b>MEDICAL PROCEDURES/SERVICES</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Acupuncture</li> <li><input type="checkbox"/> Alcohol and Drug/Substance Abuse (inpatient treatment and outpatient care)</li> <li><input type="checkbox"/> Ambulance</li> <li><input type="checkbox"/> Fertility Enhancement and Treatment</li> <li><input type="checkbox"/> Hair Loss Treatment*</li> <li><input type="checkbox"/> Hospital Services</li> <li><input type="checkbox"/> Immunization</li> <li><input type="checkbox"/> In Vitro Fertilization</li> <li><input type="checkbox"/> Physical Examination (not employment-related)</li> <li><input type="checkbox"/> Reconstructive Surgery (due to a congenital defect, accident, or medical treatment)</li> <li><input type="checkbox"/> Service Animals</li> <li><input type="checkbox"/> Sterilization/Sterilization Reversal</li> <li><input type="checkbox"/> Transplants (including organ donor)</li> <li><input type="checkbox"/> Transportation to Medical Facility</li> </ul> | <p><b>MEDICATIONS</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Insulin</li> <li><input type="checkbox"/> Prescription Drugs</li> </ul> <p><b>OBSTETRICS</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Doulas*</li> <li><input type="checkbox"/> Lamaze Class</li> <li><input type="checkbox"/> OB/GYN Exams</li> <li><input type="checkbox"/> OB/GYN Prepaid Maternity Fees (reimbursable after date of birth)</li> <li><input type="checkbox"/> Pre- and Postnatal Treatments</li> </ul> <p><b>PRACTITIONERS</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Allergist</li> <li><input type="checkbox"/> Chiropractor</li> <li><input type="checkbox"/> Christian Science Practitioner</li> <li><input type="checkbox"/> Dermatologist</li> <li><input type="checkbox"/> Homeopath</li> <li><input type="checkbox"/> Naturopath*</li> <li><input type="checkbox"/> Optometrist</li> <li><input type="checkbox"/> Osteopath</li> <li><input type="checkbox"/> Physician</li> <li><input type="checkbox"/> Psychiatrist or Psychologist</li> </ul> <p><b>THERAPY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Alcohol and Drug Addiction</li> <li><input type="checkbox"/> Counseling (not marital or career)</li> <li><input type="checkbox"/> Exercise Programs*</li> <li><input type="checkbox"/> Hypnosis*</li> <li><input type="checkbox"/> Massage*</li> <li><input type="checkbox"/> Occupational</li> <li><input type="checkbox"/> Physical</li> <li><input type="checkbox"/> Smoking Cessation Programs*</li> <li><input type="checkbox"/> Speech</li> <li><input type="checkbox"/> Weight Loss Programs*</li> </ul> |
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Please Note: **The IRS will not allow 'Over the Counter (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 OTC items that clearly are not medicine or drugs and **are eligible** for purchase with Health Care FSA Plans.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Denture Adhesives, Repair, and Cleansers</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> PoliGrip, Benzodent, Efferdent</li> </ul> <p><b>Diabetes Testing and Aids</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Insulin, Ascencia, One Touch, Diabetic Tussin, insulin syringes; glucose products</li> </ul> <p><b>Diagnostic Products</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Thermometers, blood pressure monitors, cholesterol testing</li> </ul> | <p><b>Elastics/Athletic Treatments</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> ACE, Futuro, elastic bandages, braces, hot/cold therapy, orthopedic supports, rib belts</li> </ul> <p><b>Eye Care</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Contact lens care</li> </ul> <p><b>Family Planning</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Pregnancy and ovulation kits</li> </ul> | <p><b>First Aid Dressings and Supplies</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Band Aid, 3M Nexcare, non-sport tapes *without antibiotic strip</li> </ul> <p><b>Hearing Aid/Medical Batteries</b></p> <p><b>Incontinence Products</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Attends, Depend, GoodNites for juvenile incontinence</li> </ul> <p><b>Reading Glasses and Maintenance Accessories</b></p> |
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*Note: This list is not meant to be all-inclusive. Other expenses not mentioned may also qualify. 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.*

**For a detailed list, log in to our website at [www.cpa125.com](http://www.cpa125.com) and click on the link to the FSA Store to view the eligibility list.**

Cafeteria Plan Advisors, Inc.  
420 Washington St. Suite 100  
Braintree, MA 02184  
Phone 781.848.9848  
[www.CPA125.com](http://www.CPA125.com)  
email: [info@cpa125.com](mailto:info@cpa125.com)  
Fax 781.848.8477

## AUTHORIZATION FOR PRE-TAX PAYROLL REDUCTION

**Please return completed form City Hall HR by 5PM: 5/1/19**

### Personal Information

**Name:** \_\_\_\_\_ **Employer:** CITY OF LOWELL

**Street:** \_\_\_\_\_ **Plan Year:** 7/1/2019– 06/30/2020

**City, ST, Zip:** \_\_\_\_\_ **SSN:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**E-Mail:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

### Payroll Information:

I am paid: Weekly:  Bi-Weekly:  Semi-Monthly:  Monthly:  Other: \_\_\_\_\_

|                                                                                                                                                                                                                                                                                                                  |                                                                                                                                       |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> <b>FSA Dependent/ Day Care Account</b><br><br>I elect to contribute \$ _____ for the Plan Year.<br>(\$5,000 maximum)<br><br><i>Confirm eligibility criteria prior to enrolling.<br/>A new Dependent Care Cert Form must be completed to<br/>continue with automatic reimbursements.</i> | <input type="checkbox"/> <b>FSA Health Care Account</b><br><br>I elect to contribute \$ _____ for the Plan Year.<br>(\$2,700 maximum) |
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### Direct Deposit Information (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](http://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.
- If you or your spouse is 'contributing' to a Health Savings Account (HSA), you are NOT ELIGIBLE for FSA Health Care Account.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# 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](mailto: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
- Physically or mentally incapacitated
- Reside with Participant
- 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](http://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: \_\_\_\_\_

**Section 125 Dependent Care Eligibility Worksheet**

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

- ✓ 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.