Peralta Community College District

Section 125 / Flexible Benefit Plan Handbook

2012

"Going Green"

In an effort to be more environmentally friendly we are sending communications to participants via our website and/or email. Payments will be processed via direct deposit so you do not need to go to the bank. If you have not signed up for direct deposit from past years there is a form to complete in this packet.

Presented by

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About This Handbook

This handbook is a brief description of the terms of the Plan in common language designed to describe the highlights of the Plan. It is not meant to replace the Plan Document which is on file with the Plan Administrator. If you would like a copy of the Plan Document please request one from your Human Resources Department. The Plan Document governs in the event of any discrepancy between the two documents. Please read this summary carefully so that you understand the provisions of your Plan and the benefits you will receive. If you have any questions, contact your Plan Administrator or Benefit Dynamics as soon as possible. We want you to understand the plan fully prior to enrolling.

What Is A Flexible Benefit Plan?

A Flexible Benefit Plan, also known as Section 125 Plan, is part of a cafeteria plan that allows employees to purchase certain benefits with pre-tax dollars. This plan is put into place to assist in paying for Company Sponsored Group Insurance Premiums as well as allowing you to put aside an elected amount for Flexible Spending Accounts (FSAs). The FSA accounts have two options, the Medical Expense Reimbursement Account and the Dependent Daycare Reimbursement Account. These accounts are described in further detail below but whatever amount you elect will be deducted from your pay in equal amounts over the number of pay periods in the Plan Year. Each year you must elect your benefits again (except for Company Sponsored Group Insurance Premiums) and the amount you elect at that time will remain in effect for the entire Plan Year unless you have a qualified change in status (described in more details later in this document).

If you choose to enroll in the Company Sponsored Group Insurance Premiums benefit, your premiums will be deducted from your paycheck and paid directly to the insurance company on your behalf.

If you choose a Flexible Spending Account benefit, you will need to determine at the beginning of each Plan Year (as well as when you first become eligible) how much you will spend for each type of expense. There is a worksheet further in this handbook to assist with this. The amounts you determine will be deducted from your paycheck pre-tax and set aside for reimbursement when expenses are incurred. When eligible expenses are incurred, you simply complete the request for reimbursement form and you will be paid with tax-free dollars from your account. Since you are getting this tax-free benefit, you will not be able to take a tax credit or deduction on your tax return for any expenses reimbursed under this Plan.

How Will The Plan Benefit Me?

You may elect to participate in any of the accounts listed below, and by doing so, will save Federal, State, Social Security and Medicare taxes on every dollar contributed to the plan. For most people in the state of California, that means a savings of 30-40% on every dollar put into this plan. Enrollment in these plans will reduce your reportable income; therefore your Social Security Benefits/Disability may be affected by your election. However, most will find that the tax savings far out-weigh the potential negative impact.

Why Should I Participate?

To pay less in taxes and have more spendable income! The Flexible Benefit Plan allows you to convert many expenses that were previously not deductible into expenses that can be paid with pre-tax dollars. You do this by making pre-tax contributions to the Flexible Benefit Plan. These contributions reduce your gross or taxable income so you pay less in taxes. When you pay for qualifying expenses with money that is now tax-free, the end result is that your spendable income will increase. An example is shown in the table below.

	Without Flex	With Flex
Monthly Base Salary	$3,000.00	$3,000.00
FLEX Contribution	**(0.00)**	**(500.00)**
Adjusted Taxable Income	3,000.00	2,500.00
Federal Withholding	(342.00)	(267.00)
State Withholding	(91.00)	(59.00)
Social Security Tax	(186.00)	(155.00)
Medicare	(43.50)	(36.25)
CA SDI	(36.00)	(30.00)
Subtotal	$2,301.50	$1,952.75
Expenses		
Company sponsored Insurance Premiums	(50.00)	**Paid (FLEX)**
Medical/Dental/Vision	(150.00)	**Paid (FLEX)**
Daycare/month	(300.00)	**Paid (FLEX)**
Spendable Income	**$1,801.50**	**$1,952.75**

Monthly increase in personal spendable income is $151.25.
This translates into an annual take home increase of **$1,815.00.**
For many of us, this is equivalent to a $2,500 (taxable) annual salary raise.

What Benefits are Available?

Company Sponsored Group Insurance Premiums

Your portion of the premiums for your Company Sponsored Group Insurance, including Medical, Dental and Vision insurance, may be paid with pre-tax dollars through the Flexible Benefits Plan. Note that this is only for premiums paid to a group insurance carrier through your employer. The Flexible Benefit Plan does not cover premiums paid for individual policies, or paid through other employers (i.e. a spouse's employer or COBRA premiums).

If you elect to participate, these premiums will be contributed to the Plan through payroll deductions and paid directly to the insurance company. Since you are not paying taxes on this money, your net cost for insurance will be reduced.

Your payroll deductions will be adjusted automatically for any changes in premiums charged by the insurance company during the Plan Year.

In general, if you participate in the Plan, you cannot change your insurance mid-year and make a corresponding change to the amount being deducted from your paycheck. There are two exceptions to this rule. You may change insurance mid-year if you plan these changes prior to completing your election form and your election form reflects these changes or if you have a qualified change in status (discussed later). Your contributions will cease upon termination of employment or when you become ineligible for the chosen coverage.

Elections for this portion of the plan will roll over from year to year (unlike the medical and/or dependent daycare elections), so if you want to make a change you will need to contact your HR department. Except as noted above, any changes to your insurance must be done during your Open Enrollment period before the beginning of each plan year.

Medical Expense Reimbursement

You may choose to enroll in the Medical Expense Reimbursement portion of the FSA for medical, dental and vision expenses incurred while you were an eligible participant during the Plan Year. These are expenses that are not reimbursed by your insurance or any other source and they can be for you, your spouse (as defined by federal, not state, regulations), and your dependents. Expenses for a Domestic Partner or same sex spouse are not eligible unless they are also your tax dependent because this is a federal program. The maximum you can contribute is listed on the attached enrollment form. Expenses are incurred when the medical care is provided, not when you pay or are billed for the expense.

Although your employer provides you with health insurance options, chances are it doesn't cover 100% of your expenses. If you do not participate in the Flexible Benefit Plan, the IRS allows you to itemize your out of pocket health related expenses. However, you will only receive a federal tax credit for any amount in excess of 7.5% of your adjusted gross income. Therefore, for most people this means the Flexible Benefit Plan is a better program.

There is a list of eligible expenses in this handbook. Please refer to this list as well as the Annual Expense Worksheet to help determine how much you should elect for the Plan Year. You will have 90 days from the end of the Plan Year to submit a request for reimbursement of expenses incurred during the Plan Year. Any amount not used and/or claimed will be forfeited back to the Plan. The account cannot be used for ineligible expenses, including those incurred after the Plan Year ends. If your employment terminates mid-year, either voluntarily or involuntarily, your coverage in this plan will terminate as of that date. If you have an unused balance in your Medical Expense Reimbursement Account at this time, you will have a right under COBRA to continue your benefits through the end of the Plan Year via after-tax contributions. Your employer will notify you of any COBRA rights you may have.

Remember, if you and/or your spouse contribute or have an employer contribution into a Health Savings Account (HSA), you are not eligible to participate in the Medical Expense Reimbursement Plan.

Dependent Daycare

You may choose to enroll in a Dependent Daycare FSA for dependent daycare expenses which are incurred in order for you and your spouse (if married) to work. These expenses must be for a dependent child under the age of 13 who lives with you, or for the care of any tax-qualified dependent who lives with you and is physically or mentally incapable of caring for himself. The care can be either inside your home or outside.

In order for you to participate in the daycare account, your daycare provider must be over the age of eighteen, not your dependent, and willing to declare the income. Your dependent must also live with you at least 50% of the calendar year and you may not claim daycare expenses for days when your dependent is not living with you. Your daycare deferrals will not appear as taxable wages on your W-2; however, the amount deducted from your pay is reported in Box 10. You will need to complete Form 2441 with your tax return to report the provider's name, address, and Tax I.D. number. Additionally, the amount from Box 10 of your W-2 needs to be entered on line 17 of Form 2441.

The maximum amount you may elect to reduce your salary under the Dependent Daycare Plan is equal to the lesser of:

- Your earned income for the Plan Year up to $5,000;
- The actual or deemed earned income of your Spouse for the Plan Year; or
- $2,500 if you are married and filing a separate federal income tax return.

If your Spouse is a full-time student at an educational institution or is physically or mentally incapable of caring for himself or herself, your Spouse shall be deemed to have earned income of not less than $250 per month if you have one Dependent and $500 per month if you have two or more Dependents. (For taxable years beginning after 2012, these amounts will change to $200 and $400, respectively.)

If you elect the Dependent Daycare FSA, you are not entitled to the dependent daycare credit on your tax return for expenses paid through your FSA, but you may receive a tax credit for expenses in excess of the amounts paid through your FSA. Claiming the same amounts in both places is considered "double dipping" and is not permitted. Most of the time money is saved by paying dependent daycare expenses through the Plan rather than taking the credit, especially if you make more than $20,000 in annual household income. Later in this handbook, there is a Section titled "Flex Plan vs. the Federal Daycare Credit" that may help determine which would be most beneficial for you. You may also want to consult your tax professional as each person's situation is different and it is important to understand which program is better for you and provides the most savings.

Dependent Daycare cannot be reimbursed until the expense has been fully incurred. This means, even if you pay your provider on January 1 for services for the month of January, we will not be able to release reimbursement to you until January 31. We also are only able to reimburse what is currently in your account so if you send in a claim for $500.00 for services in the month of January and you have $208.33 deducted twice a month we will reimburse $416.66 once the January contributions are posted and the full month has passed. The remaining $83.34 will be reimbursed once additional contributions are posted to your account.

Claim Reimbursements

When do I become eligible to participate?

Once you meet the eligibility requirements for our health insurance benefits you automatically qualify to participate in the Flexible Benefit Plan.

How do I enroll in the plan?

Once you are eligible to participate you will have 30 days to complete a salary redirection agreement and return it to your Human Resources representative. Please contact your Human Resources representative for enrollment forms and details on how to begin your payroll deductions. Your enrollment begins the date the form is signed and/or the first day of your eligibility, whichever is later so it is better to complete the form soon. You will not be able to submit expenses incurred prior to the enrollment date.

Who is covered under my plan?

You, your spouse, and anyone who qualifies as your tax dependent at the end of the year as defined by the IRS is eligible to participate in the Plan. They need not be covered under your company sponsored health insurance for you to be able to submit claims for them; in fact they need not be covered by insurance at all. The only requirements are that they be your dependents and incur eligible out-of-pocket expenses. Domestic Partners and same sex spouses are not recognized as spouses by the regulations. They would only qualify if they are your financial dependent. Children up to the age of 26 can be covered under this plan due to Health Care Reform.

What constitutes an "eligible expense"?

1) The expense must be incurred during the current plan year. This means the service was *actually provided* during the plan year, not that you paid for or were billed for the service during the plan year.

2) The expense must have been incurred during your coverage period, i.e. after you joined the plan, and before you terminate from the plan.

3) The expense must be for eligible services provided to you or one of your eligible tax dependents and the portion claimed must not be reimbursed by any other benefit plan or itemized on any tax return. This means you should only claim the portion of your expense not reimbursed or paid for by insurance.

4) The expense must have been incurred for the diagnosis, cure, or treatment, of a disease, injury, illness, or diagnosed medical condition. General health items are not eligible.

5) The expense must be substantiated with "proof" (i.e., an invoice from an independent third party showing the provider, the date of service, the amount of the expense, the person for whom the service was provided, and any applicable insurance reimbursements). If insurance is in force for the expense incurred, a copy of the insurance explanation of benefits should be included, even if the expense has been applied to the deductible. If the expense is not covered by insurance, you must include a statement of non-insurance. This can be accomplished by simply circling "NO" on the claim form in the area entitled "Insurance Coverage". If an expense is not covered by your insurance and can be considered "dual purpose" we may request a Letter of Medical Necessity from the medical provider.

6) In order for daycare expenses to qualify they must be necessary to allow you and your spouse (if any) to work, look for work, or to go to school full time. If care is provided by a daycare center, the center must comply with all federal and state regulations. If an individual provides care, the provider must be over the age of eighteen and not claimed as a dependent on your tax return. You must provide the Tax Identification Number (T.I.N.) or Social Security Number of your daycare provider to the Internal Revenue Service. The maximum age of a dependent to qualify for daycare is 12 (unless disabled).

How Am I Reimbursed?

Insurance Premium Account

No reimbursement is necessary for the group health insurance premiums. The premium is deducted pre-tax from your paycheck, and paid directly to the insurance carrier. The tax savings will be reflected in your take home pay.

Medical Reimbursement Account

When you wish to claim an expense through the Medical Reimbursement Account, you should make a copy of the explanation of benefits from your insurance (if insurance coverage is in force), or a detailed receipt from the provider of service (if no insurance is in force). Then, attach that information to a fully completed and signed claim form (Request for Reimbursement) and submit it to Benefit Dynamics for payment. You will receive reimbursement within a few days. You will be reimbursed up to your full annual election at any point during the plan year regardless of the amount you have contributed to date.

Expenses must be submitted within 90 days of the end of the plan year. You should always keep the original claim and submit a copy to us via email to benefits@pensiondynamics.com or via fax at 1-866-320-1931. Reimbursement will be made by direct deposit into your bank account when you submit a completed Direct Deposit Form.

Dependent Daycare Account

When you wish to claim an expense through the Dependent Daycare Account, you should submit copies of your daycare receipts for reimbursement along with a fully completed and signed claim form (Request for Reimbursement). If no receipt is available you may have your daycare provider indicate dates of service, the provider's name, and the amount of the expense on a claim form, along with the provider's signature. If care is provided by an individual, the provider must be over the age of eighteen and not claimed as a dependent on your tax return. You will need to provide their Social Security Number to the Internal Revenue Service when you file your taxes at the end of the year. The age limit for dependent children to qualify for care is 12 (unless disabled).

Expenses must be submitted within 90 days of the end of the plan year. You should always keep the original claim and submit a copy to us via email to benefits@pensiondynamics.com or via fax at 1-866-320-1931. Reimbursement will be made by direct deposit into your bank account when you submit a completed Direct Deposit Form.

***Please note** that Dependent Care claims are reimbursed differently from Medical claims in that you can only be paid what is currently available in your account. Claims that exceed your current account balance will be held in our system, and will be paid out automatically as you continue to have funds redirected from each payroll. Additionally, the I.R.S. prohibits making advance reimbursements, which means you cannot be reimbursed for a daycare expense until after the services have been provided. You cannot be paid for February daycare services in January, even if your provider requires you to pay in advance.

What Happens If I Go On An Unpaid Leave Of Absence or FMLA Leave?

Your election into a Flexible Spending Accounts is based on your commitment to contribute a specific dollar amount over the course of the plan year. If you go on an unpaid leave of absence you will not have spending account deductions taken on the missed pay dates. In order to continue your eligibility through your leave you will need to make up these missed deduction amounts.

You may either "front load" your account (double up on your per pay period contributions) in anticipation of your leave or, if you expect to return to work well in advance of the close of the plan year, you can double up your per pay period contributions after you return to work. If you "front load" your account you will have continuous, uninterrupted coverage during your leave.

If you do not front load your account and plan on returning to work before the close of the plan year, you may choose to make up missed contributions upon your return, Medical reimbursements will be suspended during your leave until missed contributions have been made up. Once all required contributions have been made your eligibility will be reinstated retroactively and claims incurred during your leave will be processed.

If you are not returning by the end of the year and you do not front load your account, you can either make the missed deductions on an after-tax basis by sending monthly payments to your employer or your account will be terminated on the effective date of your leave of absence.

These options can be examined in greater detail with your Human Resources representative, or your Client Account Manager at Benefit Dynamics, should the need arise. You will need to complete a Revision Form in order to tell us which option you are selecting. This form is included in this packet.

Specific Guidelines That Must Be Followed

Because the Flexible Benefit Plan is a "qualified" or pre-tax plan, the Internal Revenue Service has some very specific guidelines we must follow to ensure the plan will retain its favorable tax treatment. You should pay close attention to the following:

Annual Elections Are Irrevocable

You may not change your elections or cease participation during the plan year without a qualifying change in family status. If an employee undergoes a qualified family status change, you may make changes to your elections accordingly. For example, if you gain a dependent your medical expenses might increase. In this example you could increase, but not decrease your election. The following is a list of qualifying changes in family status:

- Legal Marital Status
- Gain or loss of a dependent (birth, adoption, death, exceed age limit, etc.)
- Significant change in participant's employment status or work schedule
- Termination or significant change in participant's spouse's employment status
- Significant change in participant's spouse's company sponsored benefits/eligibility
- Significant change in cost for daycare expenses (for changing daycare elections only)

Upon the occurrence of one of these qualifying events, you will need to complete a Revision Form and submit it to the Human Resources Department within 30 days of that event. All requests for election changes are subject to approval by the Plan Administrator. This form is included in this packet.

Use It or Lose It

Be conservative when making your election. It is better to reach your maximum election amount early in the year than to have funds left over at the end of the year that you cannot claim. The I.R.S. requires any unused funds in the account at the end of the plan year be turned over to the employer, not the employee who forfeited them. The I.R.S. has very strict guidelines on how these funds can be used by the employer. It is not to anyone's benefit to have employees forfeit funds. Our plan service provider, Benefit Dynamics, will make every effort to help you "use up" your annual elections but you need to contact them prior to the end of the plan year.

Separation from Service

Regardless of whether you are terminated or voluntarily leave your job, this will result in the termination of your participation in the Flexible Benefit Plan. You cannot submit claims for services rendered after your date of termination even if you have unused funds in your Medical Reimbursement Account. However, you can still submit the paperwork for services provided to you prior to your last date of employment and receive reimbursement. If, at the point of termination, you have a positive account balance available in your Medical Reimbursement Account, you will be eligible to elect COBRA and continue the benefit through the end of the plan year. (See your Human Resources Department for details on COBRA).

Limitations May Apply To Highly Compensated/Key Employees

Under the Internal Revenue Code, "highly compensated employees" and "key employees" generally are participants who are officers, shareholders, or highly paid as defined by the IRS. You will be notified by the Administrator each Plan Year whether you are a "highly compensated employee" or a "key employee".

If you are within these categories, the amount of contributions and benefits for you may be limited so that the Plan as a whole does not unfairly favor those who are highly paid, their spouses or their dependents. Plan experience will dictate whether contribution limitations on "highly compensated employees" or "key employees" will apply. You will be notified of these limitations if you are affected. This could happen at any point of the plan year, including the last month. If you have been reimbursed already, you will be responsible for returning the excess deductions back to the plan.

Proof of Expense

There are a number of required items that must be included in every claim, either on the Explanation of Benefits from the Insurance Company, or the itemized bill from the provider:

- Date(s) of service
- Name of provider(s)
- Description of services provided
- Condition requiring treatment (for medical claims)
- Amount of expense and any insurance payments (if applicable)
- Signature of provider on claim form if no receipt is available (for Dependent Daycare claims only)

You will find a list of these criteria at the top of the claim form (Request for Reimbursement).

Please note that you need only show proof that an expense was incurred and any amounts paid by insurance. You are not required to show that you have made payment to the provider. In fact, most payment receipts do not contain sufficient information and are not considered acceptable proof of expense.

Canceled Checks

Canceled checks and credit card receipts are not valid proof of expense. These items are proof of payment but do not have descriptions of services rendered or items purchased. Likewise, they document the date of payment, which may or may not be the same as the actual date services were rendered. Please see the first four items listed under Medical Reimbursement Account at the top of your claim form (Request for Reimbursement) for the information required to submit an eligible claim.

Balance Forward Statements

Balance forward statements are not valid proof of expense since they do not show the original date of service or a description of the services provided. Please see the first four items listed under Medical Reimbursement Account at the top of your claim form (Request for Reimbursement) for the information required to submit an eligible claim.

Personal Tax Worksheet

The first step toward a full appreciation of the opportunity provided by the Flexible Benefit Plan is to gain an understanding of how the government taxes your income. Remember the last time you received what was supposed to be a $100 pay raise? You probably noticed that your take home pay increased by only about $65. The reason the increase was so small compared to your gross wage increase was because the raise was the last $100 of your income and was taxed at the highest rate you pay. This is referred to as your Marginal Tax Rate. In order to calculate how much you would be saving by participating in the flexible spending programs you can calculate it by completing the following form.

Calculate Your Tax Savings Here:

$_____	X _____	% Federal Tax Withholding	=	$_____
Annual Election	X _____	% State Tax Withholding	=	$_____
	X 6.20%	FICA Tax Withholding	=	$_____
	X 1.45%	Medicare Withholding	=	$_____
	X 1.20%	CA SDI Withholding	=	$_____

TOTAL ESTIMATED TAX SAVINGS = $_____

This is only an estimate of your tax savings. Your spouse's income, the graduated federal tax system, as well as other factors will affect your actual savings.

Flex Plan vs. the Federal Dependent Care Credit

Each family's daycare situation varies and it is a good idea to look at both options carefully to make sure you are saving the maximum for your particular situation. The Dependent Care Tax Credit was enhanced in 2003, without a corresponding increase to the amount available under the Dependent Daycare Reimbursement Account. Therefore it is important that you complete the following worksheet to help you decide which method will be most beneficial for you. This is only an estimate; the following figures are subject to change. Please see your tax consultant for advice on your individual tax situation.

Dependent Care Credit Percentage (for 2003-2012)

Adj. Gross Income	%	Adj. Gross Income	%
$17,000 -- $19,000	33%	$31,000 -- $33,000	26%
$19,000 -- $21,000	32%	$33,000 -- $35,000	25%
$21,000 -- $23,000	31%	$35,000 -- $37,000	24%
$23,000 -- $25,000	30%	$37,000 -- $39,000	23%
$25,000 -- $27,000	29%	$39,000 -- $41,000	22%
$27,000 -- $29,000	28%	$41,000 -- $43,000	21%
$29,000 -- $31,000	27%	$43,000 +	20%

Federal Dependent Care Credit

***Maximum allowable expense is <u>$3000 for one child</u> or <u>$6000 for 2 or more children</u>.**

_____	x	_____	=	_____
*Estimated Annual Expenditure		Your Marginal Tax Rate % (use table above)		Tax Credit Amount

Flexible Benefit Plan

Maximum allowable expense is $5000 regardless of number of children.

_____	x	_____	=	_____
*Estimated Annual Expenditure		Your Marginal Tax Rate % (use table on previous page)		Approx. Tax Savings

Compare the "Federal Dependent Care Credit" amount to the "Approximate Tax Savings" you would receive from using the Dependent Daycare portion of the Flexible Benefit Plan. The method which results in the highest amount will be most beneficial for you.

Annual Expenses Worksheet

This worksheet will help you estimate your annual medical and dependent care costs. Check the following list to identify expenses that pertain to you. This list is not intended to be comprehensive, but it contains some of the more common medical and dependent care expenses. Please refer to the list of eligible expenses for your Medical Reimbursement Account for additional qualifying expenses. Remember to be conservative when calculating your election and list only expenses not covered by your insurance.

Qualifying Daycare Expenses	**Estimated Annual Expense**
Amounts paid to a daycare center	$
Amounts paid for daycare inside your home	$
Subtotal	**$**
Qualifying Medical Expenses	**Estimated Annual Expense**
Co-payments and deductibles	$
Mental health counseling	$
Chiropractic and acupuncture	$
Prescription drugs	$
Over-the-counter drugs and medications*	$
Laboratory fees, annual check-ups	$
X-rays, hospital services	$
Orthodontia	$
Prescription glasses, eye exams, contacts	
Subtotal	**$**
Total Annual Expenses	**$**

Note: Qualifying expenses under Code Section 125 are different from those listed in I.R.S. Publication 502. Please consult your Client Account Manager at Benefit Dynamics if you have any question as to what constitutes an eligible expense.

*Over-The-Counter Drugs and Medications only qualify for reimbursement under a Flexible Benefit Plan if they are primarily used for the treatment of a medical condition, injury, or illness. Prescriptions will be required due to Health Care Reform.

Eligible Expenses for Your Medical Reimbursement Account

The following list identifies eligible medical, dental, and vision related expenses as defined by the Internal Revenue Service. These expenses are eligible for reimbursement through your Medical Reimbursement Account provided they are incurred by you and/or your dependents during the plan year, are not covered by your insurance, and have not been reimbursed through any other benefit plan. You can also see a more comprehensive list on our website at www.PensionDynamics.com. Click on Login/Forms in the upper right hand corner and then OTC List in the center bottom of the next screen. You will be required to enter the access code which is: **list**.

- Alcoholism and drug addiction treatment
- Ambulance transportation
- Artificial limbs and teeth
- Birth control/ contraceptives
- Braces (wrist, knee, etc.)
- Contact lenses and solution (See Stockpiling)
- Deductibles (medical Insurance)
- Dental Implants & dental treatments (excluding cosmetic procedures)
- Eye examination
- Eyeglasses (corrective lenses)
- Fees to doctors and hospitals including:

Anesthesiologist	Ophthalmologist
Chiropractor	Optometrist
Clinic	Osteopath, licensed
Dermatologist (1)	Practical Nurse
Gynecologist	Psychiatrist/ Psychologist
Midwife	Neurologist

- Hearing aids and batteries (including upkeep and maintenance)
- Infertility treatment
- Insulin and related supplies
- Laboratory fees
- Laser/Lasik eye surgery
- Mentally challenged (special tutoring/care of)
- Nursing care
- Office visit copayments (for medical appointments)
- Orthodontia (Note 2)
- Oxygen equipment
- Physical therapy
- Pregnancy tests
- Prescription drugs and medicines
- Radial Keratotomy / Orthokeratology
- Sterilization
- Support or corrective devices (i.e. orthopedic shoes)
- Surgery (excluding cosmetic procedures)
- Transportation expenses for medical care (mileage, parking, tolls, bus, taxi)
- Wheelchair / crutches
- X-rays

The Following Expenses are considered DUAL PURPOSE. These items are only covered with a diagnosis code from a medical professional. This is not meant to be a comprehensive list but rather a list of items commonly submitted for reimbursement.

- Capital expenses primarily for medical purposes (to the extent the value of your home is not increased)
- Massage
- Over-the-counter drugs and medications including vitamins and supplements (Note 3)
- Psychotherapy
- Smoking cessation programs and related drugs
- Weight loss programs

The Following Expenses Are NOT ELIGIBLE: This is not meant to be a comprehensive list but rather a list of ineligible items commonly submitted for reimbursement.

- COBRA payments
- Cosmetics / toiletries
- Cosmetic surgery / procedures
- Dental supplies including toothbrushes
- Electrolysis / hair loss treatments / Rogaine
- Insurance premiums
- Multi-vitamins
- Teeth bleaching (cosmetic)
- Tinted clips for prescription eyewear

NOTE: Stockpiling is NOT permitted. No more than **TWO** formulations of the same OTC will be reimbursed in any given month.

Note 1: Services cannot be cosmetic and a diagnosis is required.

Note 2: Please contact Benefit Dynamics for information on how to submit Orthodontia claims.

Note 3: Due to Health Care Reform a prescription is required for all over-the-counter drugs and medications. They must be purchased for the treatment of a medical condition, illness or injury. A diagnosis is required.

Glossary of Terms

Annual Election

The amount of money you wish to redirect to the Flex Plan annually. For example, if you contribute $25 each pay period for 24 pay periods, your annual election would be $600.

Contribution Amount

The amount redirected from *each paycheck* into a Flexible Benefit Plan Account.

Date of Service

This refers to the date the service was incurred. The I.R.S. considers an expense incurred when the services are provided, not when you are billed or pay for the service. The advantage of this is that you can be reimbursed before you actually pay your doctor.

Explanation of Benefits (E.O.B.)

When you, or your provider, submit expenses to your insurance company for payment, you receive an E.O.B. detailing what portion of the expenses was covered and what portion is your responsibility. The E.O.B. should be submitted with your claim whenever insurance coverage is in force.

Family Status Changes

You may not change your elections or cease participation during the plan year without a qualifying change in family status. If an employee undergoes one of the following family status changes, they may make changes to their elections only in accordance with the family status change. For example, if you gain a dependent your medical expenses might increase. In this example you could increase, but not decrease your election. The following is a list of qualifying changes in family status:

- Legal marital status
- Gain or loss of a dependent (birth, adoption, death, exceed age limit, etc.)
- Significant change in participant's employment status or work schedule
- Termination or significant change in participant's spouse's employment status
- Significant change in participant's spouse's company sponsored benefits/eligibility

Final Claim Submission "Run-Out" Period

There is a 90-day "run-out" period after the close of the plan year during which you may continue to submit the paperwork for services provided to you during the plan year. We understand that it can be difficult to obtain information from insurance companies in a timely manner for procedures performed toward the end of the year and we make every effort to work with you to get all of your claims submitted before we close the plan year.

Itemized Bills from Your Provider

If you do not have insurance coverage for a particular expense, be sure to circle "NO" where indicated on the claim form. An itemized bill can then be used as proof of expense provided it includes all of the required items listed under "Proof of Expense." Balance forward statements are not acceptable.

Plan Service Provider

We have appointed Benefit Dynamics, a division of Pension Dynamics Corporation, as our Plan Service Provider for this benefit plan. They will assist us in the administration of this plan in accordance with the regulations set forth by the IRS.

Plan Year

Each plan year is separate and only expenses incurred during the current plan year can be reimbursed from your current account. Unused funds cannot be rolled over to the next plan year.

Peralta Community College District has set up this plan to run from 01/01 - 12/31 each year.

Point Of Service Receipt

Often you will not receive an explanation of benefits if you have HMO coverage for your medical services. In this case you should get a hand-written receipt from your doctor's office, at the time services are rendered, showing the date of service and your co-payment amount.

Provider of Service

The person(s) or institution (company) which provided the actual service (i.e.... Lens Crafters, UCSF Med. Center, Dr. Smith, etc.)

Proof of Expense

There are a number of required items that must be included in every claim, whether on the Explanation of Benefits from the Insurance Company or the itemized bill from the provider:

- Name of patient
- Date(s) of service
- Name of provider(s)
- Description of services provided
- Condition requiring treatment (for Medical claims only)
- Amount of expense and any insurance payments (if applicable)
- Signature of provider on claim form if no receipt is available (for Dependent Daycare claims only)

[You will find a list of these criteria at the top of any claim form (Request for Reimbursement)].

Please note that you need only show proof that an expense was incurred (and any amounts paid by insurance) not that you have made payment to the provider. In fact, most payment receipts do not contain sufficient information and are not considered to be acceptable proof of expense.

Attachments:

- Enrollment Form
- Direct Deposit Form
- Website Log On Instructions
- Request for Reimbursement Form
- Letter of Medical Necessity
- Revision Form

BENEFIT DYNAMICS

Peralta Community College District

Flexible Benefits Plan Enrollment Form

Plan Year: 1/1/2012 through 12/31/2012

If you wish to participate in any portion of the flexible benefit plan **you must complete the following section.** You may elect to participate in one, or any combination of the three benefits out lined below.

Return this completed form to your Benefits/ Human Resources Representative

SECTION A – EMPLOYEE DATA (PLEASE PRINT OR TYPE)

Name:	**SSN:**	**Home Phone:**
Street Address:		
City:	**State:**	**Zip Code:**
DOB (date of birth):	**Date of Hire:**	**Date of First Contribution (payroll date):**
Email (required):		

SECTION B – Dependent Information- Please list your **Dependent Information** below:

Spouse: _____ **DOB:** _____ **Dependent:** _____ **DOB:** _____

Dependent: _____ **DOB**: _____ **Dependent:** _____ **DOB:** _____

SECTION C - I ELECT TO PARTICIPATE IN THE PLAN. I authorize my employer to reduce my salary by the amounts indicated below.

1. **COMPANY SPONSORED INSURANCE PREMIUMS**
   I understand my employer will reduce my salary on a pre-tax basis to pay for my share of the premium for those Health Insurance benefits in which I have enrolled on separate benefit enrollment form(s). If I wish to change this I must tell my payroll department in writing prior to the first of the plan year.

2. **MEDICAL REIMBURSEMENT ACCOUNT (annual maximum of $2500.00 each plan year)** ☐ **YES** ☐ **NO**
   This includes all eligible health related expenses not covered by my health insurance or any other benefit plan for me and my dependents. *This account does NOT cover any type of Insurance Premiums.*

   I elect $_____ as my ANNUAL Medical Reimbursement election for 01/01 - 12/31.

   For office use only $_____ / _____ = _____
   Annual Election ***remaining pay periods*** ***per paycheck contribution***

3. **DEPENDENT DAYCARE ACCOUNT** ☐ **YES** ☐ **NO**
   If you are single, or married and file a joint return, *you may not have more than $5,000 in this type of account per calendar year. This limit is reduced to* $2,500 if you are married and file a separate return. Only dependent children under age 13 (unless physically or mentally handicapped) and/or a dependent adult requiring daycare qualify. Care must be for the hours when you and your spouse (if any) are at work.

   I elect $_____ as my ANNUAL Dependent Care election for 01/01 - 12/31.

   For office use only $_____ / _____ = _____
   Annual Election ***remaining pay periods*** ***per paycheck contribution***

I understand that:

- I cannot change this election during the plan year unless I undergo a change in family status.
- Any unused funds left in my account at the end of the plan year are forfeited.
- If I terminate my employment, whether voluntarily or involuntarily, and do not elect to COBRA my Medical Reimbursement Account, I can only submit expenses incurred prior to my termination date.
- My Social Security Benefits/Disability may be affected by this election.
- I cannot claim a tax credit for any expenses paid for by this Plan.
- If I elect to participate in the Dependent Daycare Account I must file IRS Form 2441 with my tax return.
- This election replaces any prior elections and will terminate at the end of the plan year, or if this plan is terminated.

Employee Signature: _____ Date:_____

Benefit Dynamics
Direct Deposit Authorization Form

Employer Name: Peralta Community College District

Employee Name: _____ **Social Security #:** _____-____-_____

Daytime Phone Number: _____ **Email (required):** _____

Please check the appropriate item: Initiate Direct Deposit ___ Change Account ___ Cancel Direct Deposit __

Bank Information

Account Number: _____ **Type of Account (check one): Checking** ____ **Savings** _____

Nine Digit Routing Number: _____ **Bank Name** _____

I ACKNOWLEDGE THE FOLLOWING:

1. I must include a copy of a voided check in order for direct deposit to be established. Deposits slips cannot be accepted as the routing numbers are often different on these slips.
2. My financial institution can receive transactions via electronic transfer and the bank information provided can serve this purpose.
3. I authorize Pension Dynamics Corporation to initiate electronic credit entries and, if necessary, debit entries to reverse erroneous credits to the above account, and to allow the financial institution indicated above to credit and / or debit the same to such account.
4. Direct deposit of my reimbursement accounts shall commence within 2 (two) weeks of receipt of this form. This direct deposit will be for all reimbursement accounts that I have established with Benefit Dynamics.
5. My direct deposit may be terminated by any of the following: an online or written cancellation request submitted by me (when allowed by my employer), a failed bank transmittal due to incorrect bank information, or cancellation of direct deposit by my employer.
6. I understand that I must notify Benefit Dynamics immediately if I make any changes in my banking situation. Not doing so can delay my payment greatly.
7. I will not assume payment has been made to my bank account at any time. I am solely responsible for checking with my bank as to the deposit amount and date of direct deposits made. I am also responsible for any fees my bank may charge for direct deposits.

I hereby acknowledge that I understand the information on this form and authorize Pension Dynamics Corporation to complete my request as indicated:

Employee Signature: _____ **Date:** _____

Please send to:
Email: Benefits@pensiondynamics.com
Fax: 1-866-320-1931

BENEFIT DYNAMICS
A division of
Pension Dynamics Corporation

Web Site Registration and Login Instructions:

1. Go to www.PensionDynamics.com (Internet Explorer Required)
2. Click the **LOGIN/FORMS** button (upper right corner of home page)
3. Click on **FLEX** (Left side of screen)
4. Click on **REGISTER** (Below login boxes)
5. Click on **PENSION DYNAMICS CORP. TEMPORARY LOGIN ID & EMPLOYER CODE**

Follow the instructions on the registration page:

6. Enter your SSN (no dashes or spaces) in the Login ID field.
7. Enter your Employer Code (**84641082**) in the Employer Code field and click CONTINUE.
8. Enter a login ID of your choice that is at least 6 but not more than 100 characters in length. Note: Since Social Security Numbers are no longer used as the login ID, the login ID you create may not be 9 characters in length.
9. Enter an e-mail address to be used to receive e-mails re: forgotten passwords.
10. Enter a secret question or use a predefined secret question to prompt your memory of your password.
11. Enter the answer to the secret question.
12. Click **SUBMIT**.
13. Click the continue link.
14. Enter a new password in the New Password field.
15. Re-enter the password in the Confirm New Password field.
16. Click **CHANGE PASSWORD**.
17. You are now logged on to the **Benefit Dynamics** web page powered by *my*RSC.

If you have any questions, please call (925) 956-0514 or e-mail us at Benefits@PensionDynamics.com

Flexible Benefit Plan Claim Instructions

Tips for Completing the Request for Reimbursement Form

- Fill out each section completely. Incomplete forms cannot be processed.
- Type or write legibly.
- Don't forget to sign your form. It is the employee who is participating in the plan who needs to sign the form, not their spouse or and other dependent covered under the plan.
- Insurance Coverage: If insurance is paying ANY portion of the services that you are requesting reimbursement for, please circle YES. If you do not have insurance or if this item is not covered by your insurance, please circle NO.

Things to Include with your Request for Reimbursement Form

- All Medical substantiation must include:
  - Name of patient (you, your spouse or tax dependent) incurring the expense
  - The date services were provided or the date the item was purchased
  - Service Provider or Merchant Name
  - Description of Service/Purchase
  - Amount of Service/Purchase
- An Explanation of Benefits (EOB) is recommended. If you have insurance coverage that is covering a portion of the services the EOB is sometimes required.
- All Dependent Daycare substantiation must include the following:
  - Dates of Service
  - Dependent Name
  - Care Provider's Name
  - Provider's Tax ID or SSN
  - Amount of Claim

  If your provider does not provide receipts they can sign the claim form in the Provider Signature area verifying that what is on the claim is accurate.
- Cancelled checks, credit card receipts, and statements including "Previous Balance", "Balance Forward, or "Paid on Account" are NOT acceptable as they do not contain all of the required information.
- Handwritten statements must be on provider's letterhead or have a provider stamp containing their information.
- Do NOT use a highlighter to highlight items or dollar amounts on substantiation.

Reminders for Submitting your Request for Reimbursement:

- Retain the original of all requests including the substantiation, sending us a copy of the documents only. Benefit Dynamics cannot be responsible for providing copies.
- Please allow 2 business days for your claim to be processed.
- If your claim is denied, you will receive a written statement explaining why the item could not be processed. If we need further information, the denial letter will state what you can do in order to have your item re-processed.
- Do NOT combine your claim with your co-workers claim. It will cause a delay in processing and may not be processed at all.
- If possible scan your Request for Reimbursement and all substantiation and email the documents to us at Benefits@PensionDynamics.com. This is the preferred method of claim submission as you will get a personal response back stating your claim was received.
- You may also Fax your Request for Reimbursement to 1-866-320-1931
- If you mail your Request for Reimbursement please be sure to send only copies, not originals, to: Benefit Dynamics, 2300 Contra Costa Blvd, Ste 400, Pleasant Hill, CA 94523-3987.

Benefit Dynamics Customer Service

- The best way to check your claim status is to log into your account online at www.pensiondynamics.com. If you have not registered for an account yet please contact us for log on instructions including your temporary user ID and Employer Code. The website is available 24/7 and a great resource once you have registered. Customer Service is available at 925-956-0514 from 8 AM – 5 PM PST, Monday – Friday. You can also email us at Benefits@PensionDynamics.com. Please include your name and your employer name on any correspondence sent to us but do not include confidential information such as your Social Security Number.

Request for Reimbursement Form

FAILURE TO COMPLETE THIS FORM IN FULL MAY DELAY PAYMENT

SECTION A – EMPLOYEE DATA (PLEASE PRINT)

Peralta Community College District

Last 4 Digits of SSN:	Name:	Daytime Phone:

SECTION B – CLAIM ENTRY- PLEASE BE SURE ALL INFORMATION IS ENTERED.

Miscellaneous Health

1. Attach copy of Explanation of Benefits (EOB's) for deductible and coinsurance reimbursement requests.
2. Attach **itemized bills** for expenses not covered by medical/dental insurance. Itemized bills **must include** the date of service, provider's name, services provided, "condition being treated" and amount of expense.
3. Please contact Benefit Dynamics with information on how to submit Orthodontia claims.
4. **Balance Forward Statements, Canceled Checks And Credit Card Receipts Are Not Acceptable.**

Provider / Vendor	Name of dependent who incurred the expense	Date(s) of Service	Insurance Coverage		Requested Amount
_____	_____	_____	YES	NO	$_____
_____	_____	_____	YES	NO	$_____
_____	_____	_____	YES	NO	$_____
_____	_____	_____	YES	NO	$_____

If you need additional space to list expenses please use another form. **TOTAL** $_____

Dependent Daycare

Proof of expense **must include** dates of service, provider's name, amount of expense and provider's tax identification number (T.I.N) or social security number. If no receipt is available, complete the claim form and have your provider sign where indicated.

Dependent Care Provider	Name of dependent of whom expense incurred	Date(s) of Service From / To	SSN / TIN	Requested Amount
_____	_____	_____/_____	_____	$_____
_____	_____	_____/_____	_____	$_____

Provider Signature: _____ **TOTAL** $_____

SECTION C - DISCLOSURE. PLEASE READ AND SIGN BELOW

I certify the above expenses qualify for reimbursement under the terms of the Flexible Benefit Plan. I specifically state that the expenses listed have been incurred for the benefit of me and/or my eligible dependents. I have attached acceptable proof of expense to this form. I certify that the above is correct and complete and that all out-of-pocket expenses reimbursed to me under this program will not be deducted on my, or my spouse's personal tax return or be reimbursed to me or my dependents by any other means.

Date:	Employee Signature:

Attach proof of expense and send completed form to:

BENEFIT DYNAMICS
Fax: (866) 320-1931
Email: Benefits@PensionDynamics.com

Letter of Medical Necessity for your Flexible Benefit Plan

SECTION A – EMPLOYEE DATA (PLEASE PRINT OR TYPE)		
Peralta Community College District		
Employee Name:	**Patient Name:**	**Home Phone:**

SECTION B – ATTENDING PHYSICIAN TO COMPLETE

Detailed explanation of diagnosed medical condition being treated:

Recommended treatment: Specific item and/or treatment being recommended including frequency and dosage.

Duration of treatment: ** **Please note that this letter is valid only for the current plan year. Ongoing treatment will require a new letter every plan year.**

SECTION C - DISCLOSURE

The treatment listed above is medically necessary to treat the specific medical condition. This treatment is not for General Health and/or cosmetic purposes.

Date:	**Attending Physician Signature:**

Physician's Name, Address and Phone Number (Please print or Stamp):

PLEASE FORWARD COMPLETED FORM TO:
BENEFIT DYNAMICS
Email: Benefits@PensionDynamics.com
Fax (866)-320-1931

NOTE: You will also need to submit a fully completed Request for Reimbursement Form along with the proper substantiation for the items/services listed above. Over the Counter (OTC) Drugs and Medications will need a prescription on the provider's Rx pad in order to be accepted under new regulations.

Peralta Community College District
FLEXIBLE BENEFIT PLAN

REVISION FORM

Employee Name: _____ Social Security Number: _____

Employer to Complete

_____**Termination of Employment**

Date of termination _____ Date of final contribution _____

COBRA Medical Reimbursement Account? YES_____ NO_____

Employee to complete:

Please use this form to notify us of any changes that may affect your participation in the Flexible Benefit Plan. You need to complete the form and return it to Peralta Community College District's personnel office within 30 days of your qualifying event.

[Check Applicable Item]

Date of Qualifying Event: _____

_____ **Changed name to:** _____

_____ **Changed address to:** _____

_____

_____ **Qualifying Family Status Change:**

____ Marriage ____ Legal Separation

____ Divorce ____ Death of Spouse

____ Addition of a dependent(s) to coverage *

____ Loss of a dependent(s) from coverage*

*Please list affected dependents DOB

_____ _____

_____ _____

_____ **Change In Employment Status That Affects Eligibility**

____ **Significant** change in my employment status (please explain below)

____ **Significant** change in my spouse's employment status (please explain below)

____ **Significant** change in my spouse's company sponsored benefits.

Please explain: _____

_____

_____ **Significant Change to Cost for Dependent Daycare Expenses**

Please explain: _____

Change of Election

Your change in status may qualify you to change your coverage election. Changes cannot be retroactive, **must be in accordance with your family status change, and are subject to approval.** Please indicate the change in your Coverage Elections below.

Miscellaneous Health From $_____ to $ _____ **per pay period**.

Dependent Daycare From $_____ to $ _____ **per pay period**.

Date of Qualifying Event _____ Pay Date of First New Deduction Amount _____

_____ **Leave Of Absence**

I would like to:

☐ Have additional deductions taken **prior** to the commencement of my leave of absence sufficient to make up for the anticipated missed deductions.

☐ Have additional deductions taken **upon returning** from my leave of absence sufficient to make up for the missed deductions.

☐ Continue contributing to the spending accounts on an after-tax basis.

☐ **Terminate my participation** in the spending account portion of the plan as of the date my leave of absence commences, with the understanding that expenses incurred during my leave will not be reimbursable and that no further payroll deductions will be taken for the remainder of the year.

Date of Commencement of Leave _____ Date of Anticipated Return _____

_____ **Return from Leave**

Having previously elected to terminate my participation in the spending account portion of the plan upon commencement of my leave of absence, I would now like to be reinstated in the plan and understand that this election is from this point forward and that services provided to me during my leave of absence will not be eligible for reimbursement. I further understand that my available annual election will be prorated for the period during my leave for which no deductions were taken and reduced by any reimbursements that have previously been paid.

EMPLOYEE STATEMENT:

I understand that I may be required to provide the appropriate documentation for any of the changes that I have checked above. The status and participation changes must comply with Peralta Community College District's written plan document and the Plan Administrator has sole discretion to make this determination. If my change in participation is denied, I will have 60 days to appeal the decision.

I hereby elect the change(s) noted on this form and attest that the change(s) is made on account of, and conforms with, the change in status or change in cost or coverage event as indicated.

Employee Signature: _____ **Date**_____

Employer Representative Signature: _____ **Date** _____

Requested Change Of Status Is Hereby: Approved _____ **Denied** _____ **By:** _____

Please forward completed form to:
BENEFIT DYNAMICS
Fax: 1-866-320-1931
E-mail: Benefits@PensionDynamics.com