OFFICE of the CITY MANAGER
1700 WEST 162nd STREET / GARDENA, CALIFORNIA 90247-3732 / WWW.CITYOFGARDENA.ORG / PHONE (310) 217-9503

HEALTH FLEXIBLE SPENDING ARRANGEMENT (MEDICAL REIMBURSEMENT PLAN)

The Health Flexible Spending Account (FSA), provides employees a way to use tax-free dollars to pay for medical expenses. Throughout the year, you can use the funds to pay qualified medical expenses not covered by the health plan, including co-pays, deductibles and a variety of medical products and services ranging from dental and vision care to eyeglasses and hearing aids. The contribution amount for the year is elected prior to the start of the plan year. The amount is divided evenly among the remaining payrolls, twice per month. You must re-enroll into the Plan each year. The City of Gardena grants a grace period which allows employees to incur expenses into the month of February for the preceding plan year.

Attached is a form to be used to request reimbursement for qualifying medical care expenses from your Medical Reimbursement Account. **This form is available on the P-DRIVE under Forms & Templates – Employee Request Forms – Health Benefits – Medical Reimbursement (Section 125) Forms and Instructions.**

Note the following procedures when preparing requests for reimbursement:

1. Complete each section of the reimbursement request form where applicable. Only one form is required for each reimbursement which may include a variety of eligible expenses for more than one member of the family. No reimbursement request will be processed for less than $25 except during the last month of the Plan Year. Copies of appropriate bills showing services rendered must be attached.

2. Reimbursement requests will be processed twice per month to coincide with approval of warrant requests by the City Council.

3. **Current Enrollees Only:** To be eligible for reimbursement of eligible expenses for Plan Year 2019 (February 2019 thru January 2020) the Reimbursement Request & accompanying receipts must be received in the Human Resources Office no later than **February 28, 2020. The plan maximum for 2019 is $2,700.00.**

If you have any questions, please contact the Human Resources Office at (310) 217-9688.

Attachment (rev 1/2019)

REQUEST FOR REIMBURSEMENT FROM
EMPLOYEE MEDICAL REIMBURSEMENT ACCOUNT

Reimbursement Request

1. Complete each section of this request form. Only one form is required for each reimbursement which may include a variety of eligible expenses for more than one member of the family. No reimbursement request will be processed for less than $25 except during the last month of the Plan Year. Copies of appropriate bills showing service rendered must be attached.
2. Reimbursement requests will be processed twice per month to coincide with approval of warrant requests by the City Council.
3. Reimbursement requests for eligible expenses must be received no later than February 28. following the completion of the Plan Year to be eligible for payment. **Current Enrollees from Plan Year (February 2019 through January 2020) must submit final eligible expenses no later than February 28, 2020.**
4. Reimbursement requests should be submitted to the Human Resources Office for processing.

Employee Name _____

Home Address _____
Number/Street City State Zip Code

_____
Expense Incurred by: Last Name First Middle Date of Birth

1. Employee _____ / / ___

2. Spouse _____ / / ___

3. Child _____ / / ___

4. Child _____ / / ___

Name of Service Provider	Type of Service Rendered	Date	Amount Charged
1.			
2.			
3.			
4.			

Reimbursement Request Total: _____

_____

To the best of my knowledge and belief, my statements in this Request for Reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable Plan Year and for eligible Plan participants. I certify that these expenses have not been previously reimbursed under this or any other benefit Plan and will not be claimed as an income tax deduction. I authorize my Flexible Compensation Account be reduced by the amount requested.

I hereby release City of Gardena and any of its subsidiaries and representatives from any obligations or tax consequences that my arise if I fail to meet the requirements or become ineligible to claim part or all of these expenses. I agree to notify the City of any changes in my circumstances that could affect my qualifications to claim these expenses.

EMPLOYEE SIGNATURE _____ DATE _____

FOR OFFICE USE ONLY 018-131-000-_____ **APPROVED:_____**
Administrative Officer

Coverage Amount for Plan Year Jan. 1 - Dec. 31, 20____ _____

Amount of this reimbursement request: _____

Balance in Medical Reimbursement Account: _____

Processed By: *(Finance Dept.)* _____ DATE: _____

MEDICAL REIMBURSEMENT PLAN

COMPENSATION REDUCTION AGREEMENT

NAME: _____ SOC. SEC. NO. _____

ADDRESS: _____

I elect to receive medical reimbursements for the following Plan Year up to the following coverage amount:

PLAN YEAR **February 2019 – January 2020**

CONTRIBUTION AMOUNT NOT TO EXCEED $2,700 $ _____

The City of Gardena and I hereby agree that my regular compensation will be reduced by the amount set forth above in approximately equal installments twice per month for the remainder of the calendar year.

I understand that:

- The coverage amount elected above will be credited to a medical reimbursement account for the year on the books of the City and I will be reimbursed, up to the balance in that account, for my qualifying medical care expenses (as set forth on pages 3 & 4 of this form) incurred during the year.

- **PLEASE NOTE: Reimbursement will be available only for "qualifying medical care expenses" as described on pages 3 and 4 of this form. I agree to notify the City if I have reason to believe that any medical care expense for which I have obtained reimbursement is not a qualifying expense. I also agree on demand to indemnify and reimburse the City for any liability it may incur for failure to withhold federal and state income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me.**

- I cannot change or revoke this **Compensation Reduction Agreement** at any time during the Plan Year.

- The Plan Administrator may reduce or cancel my compensation reduction, limit my reimbursements, or otherwise notify this Agreement in the event the Administrator believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.

- The reduction in my cash compensation under this Agreement shall be in addition for any reductions under other agreements or benefit plans.

- **I understand that any amount I declare to be withheld which is not used or not claimed pursuant to the Flexible Compensation Plan will be foregone as compensation.**

_____
INITIAL

- **I understand that is my responsibility to verify dependent eligibility as set forth by the IRS Publication 969 Health Savings Accounts and Other Favored Health Plans (https://www.irs.gov/pub/irs-pdf/p502.pdf)**

_____
INITIAL

I have read the qualifying medical care expenses on pages 3 & 4 and verify that the expenses I list will qualify for reimbursement. I understand and agree that any non-qualifying expenses that I list will not be considered.

_____
INITIAL

This Agreement is subject to the terms of the City of Gardenia Flexible Compensation Plan and Medical Reimbursement Plan as from time to time in effect, shall be governed by and construed in accordance with the laws of California, shall take effect as a sealed instrument under the laws of California, and revokes any prior election and Compensation Reduction Agreement relating to the Medical Reimbursement Plan.

_____ _____
Employee's Signature Date

_____
Please Print Name

Accepted and agreed to by the City of Gardena

By: _____ _____
Date

Please return this form to the Human Resources Office.

MEDICAL REIMBURSEMENT PLAN

SUPPLEMENTAL ENROLLMENT FORM

AUTHORIZATION TO WITHHOLD FROM FINAL PAYCHECK

I have elected to participate in the City of Gardena Flexible Compensation Plan. As a participant in the Plan, I have agreed to reduce my salary in an amount as set forth on my Election Form which amount shall be contributed to my account.

In the event that my employment is terminated before all of my agreed-upon contributions are made to my account, I hereby specifically authorize the City of Gardena to withhold from my final paycheck any contributions necessary to cover the difference between the amount I have been reimbursed and the amount I have contributed.

Pursuant to California Labor Code Section 224, I hereby knowingly and intelligently sign this Authorization on a voluntary basis and not under duress.

NAME (Print) _____

SIGNATURE OF EMPLOYEE _____

DEPARTMENT _____

DATE SIGNED _____

SOCIAL SECURITY NUMBER _____

QUALIFYING MEDICAL CARE EXPENSES

Under the *Medical Reimbursement Plan*, you will be reimbursed only for those types of medical expenses normally deductible on your Federal income tax return (without regard to the 7.5% adjusted gross income limitation). They include, for example, expenses you have incurred for:

- Medicine, drugs, birth control pills, vaccines, and vitamins your doctor prescribed.
- Medical doctors, dentists, eye doctors, chiropractors, osteopaths, podiatrists, psychiatrists, psychologists, physical therapists, acupuncturists and psychoanalysts (medical care only).
- Medical examination, X-ray and laboratory service, insulin treatment, and whirlpool baths the doctor ordered.
- Nursing help. If you pay someone to do both nursing and housework, you can be reimbursed only for the cost of the nursing help.
- Hospital care (including meals and lodging), clinic costs and lab fees.
- Medical treatment at a center for drug addicts or alcoholics.
- Medical aids such as hearing aids (and batteries), false teeth, eyeglasses, contact lenses, braces, orthopedic shoes, crutches, wheelchairs, guide dogs and the cost of maintaining them.
- Ambulance service and other travel costs to get medical care. If you used your own car, you can claim what you spent for gas and oil to go to and from the place you received the care; or you can claim mileage as allowed by IRS. Add parking and tolls to the amount you claim under either method.

You ***cannot*** obtain reimbursement for:

- Expenses for which reimbursements are already available under another medical plan.
- Premiums paid for health coverage under any plan maintained by the City or any other employer.
- The basic cost of Medicare insurance (Medicare Part A).
- Life insurance or income protection policies.
- The hospital insurance benefits tax withheld from your pay as part of the social security tax or paid as part of social security self-employment tax.
- Maternity clothes.

Qualifying Medical Care Expenses (continued)

You ***cannot*** obtain reimbursement for (continued):

- Diaper service.
- Nursing care for a healthy baby.
- Illegal operations or drugs.
- Travel your doctor told you to take for rest or change.
- Funeral expenses.

Qualifying medical expenses include only those expenses incurred for:

- Yourself.
- Your spouse.
- All dependents you list on your Federal income tax return.
- Any person that you could have listed as a dependent on your return if that person had not received $2,000 or more of gross income or had not filed a joint return.
- If you are divorced or separated, any child of yours that is listed as a dependent on his or her other parent's Federal income tax return (and certain other individuals in the case of a multiple support agreement).

IRS Publication 502, Medical and Dental Expenses, has a checklist of medical expenses that can and cannot be deducted under this Plan. Please visit the website at **https://www.irs.gov/pub/irs-pdf/p502.pdf**