CITY FLEX

FLEXIBLE SPENDING ACCOUNTS FOR HEALTH AND DEPENDENT CARE EXPENSESFOR EMPLOYEES OFTHE CITY AND COUNTY OF HONOLULU

INTRODUCTION

The City and County of Honolulu (the "City") has established the "City & County of Honolulu Flexible Benefit Plan" ("City Flex") for eligible City employees, their dependents and beneficiaries. If you anticipate paying for unreimbursed medical expenses such as physician office visits, hospital stays, dental or orthodontic treatment, prescription drugs, vision care or laser eye surgery or you have dependent care expenses, you may wish to redirect a portion of your salary under City Flex.

City Flex allows employees to pay for eligible health and dependent care expenses with TAX FREE money by redirecting a portion of their salary to a Health Flexible Spending Account ("HFSA") and/or a Dependent Care Flexible Spending Account ("DCFSA").

This pamphlet highlights important information concerning City Flex. The pamphlet provides you with eligibility requirements that you must satisfy before participating in City Flex and a brief description of how City Flex works. If the information contained in this pamphlet and the actual City Flex plan document conflict, the actual comprehensive City Flex plan document always governs.

For a copy of the comprehensive City Flex plan document, please visit: **https://www.honolulu.gov/hr/benefits.html** or contact National Benefit Services, LLC ("NBS"), City Flex's Third Party Administrator. The address for NBS is at the end of this summary. If you choose to enroll in either the HFSA and/or the DCFSA, City Flex requires employees to pay an administrative fee of up to $5.50 per month total to participate in one or both benefit accounts. Check the City Flex Website regularly for the latest City Flex updates. Please visit the website at **www.nbsbenefits.com/cityofhonolulu.**

I.
ELIGIBILITY

1. Who is eligible to participate in City Flex?

Most City employees are eligible to join City Flex after completing their first day of employment.

2. Are there any employees who are not eligible?

Yes, certain City employees are not eligible to join City Flex. They are:

- Employees who are leased employees.
- Non-resident aliens.
- Part-time and/ or temporary employees who are not eligible for membership in the Retirement System because their employment is for less than 20 hours per week and/or less than 90 days.

3. What is the best way to understand and get information about City Flex?

OPEN ENROLLMENT SESSIONS are the best way to obtain information on the plans, how to enroll and what expenses may qualify under either the HFSA or DCFSA plans.

If you are unable to attend an open enrollment session or you are a new employee where no open enrollment sessions are scheduled before you must decide to enroll or not, then you are advised to call NBS **TOLL FREE** at **(855) 399-9095** and they will explain in detail how the plan will work to your advantage.

4. When can I enroll in City Flex?

City Flex operates on a fiscal year which is also referred to as the "Plan Year". The Plan Year begins July 1 and ends June 30.

a) **New Employees**

New hires may enroll within 30 days of their hire/eligibility date. Upon enrollment into City Flex, your entry date will be the first day of the month following your first day of employment or the first day of the month following the date of your enrollment, whichever is later.

b) **Current Employees**

You must elect to enroll in City Flex before a new Plan Year begins. If you do not enroll during the open enrollment period, then you must wait until the following Plan Year to enroll.

(NOTE: City Flex does not have automatic enrollment from Plan Year to Plan Year. You must elect to re-enroll on an annual basis. If you do not make new elections during the open enrollment period, it will be deemed to mean you have elected not to participate in City Flex for the upcoming Plan Year.)

5. How do I to enroll in City Flex?

You must complete an application to participate in City Flex. The application allows you to enroll in the HFSA and/or the DCFSA. The application also contains your authorization for the City to redirect some of your earnings into your HFSA and/or DCFSA based upon your enrollment choice(s) as well as authorization for deduction of a City Flex

administration fee of up to $5.50 per month for one or both Plan accounts.

6. **Do I have to enroll in City Flex?**

No! Enrollment and participation in City Flex are purely optional.

7. **Can I stop participation or change the contributions for my Plan account(s) during the Plan year?**

Generally, no. Once you elect to participate in City Flex, you cannot stop your participation or change the contribution amounts during the Plan Year unless there is a "change in status." Currently, federal law considers the following events to be a change in status:

- Marriage, divorce, death of a spouse;
- Change in the number of dependents, including birth, adoption, placement for adoption, or death of a dependent;
- You, your spouse or dependent's termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, or any change in employment status that affects eligibility for benefits;
- One of your dependents satisfies or ceases to satisfy the requirements for coverage due to change in age, student status, or any similar circumstance.

8. **Can I change my Plan elections and contribution amounts after my first year of participation?**

Yes. Because you must re-enroll in City Flex each Plan Year, you may change the elections that you previously made each plan year. Additionally, you can increase or decrease the amount that you authorize to be redirected from your salary into either or both the HFSA and DCFSA Plan accounts. You may also choose not to participate in City Flex for the upcoming Plan Year.

II
OPERATION
How does City Flex work?

1. You elect to have some of your pay redirected to
2. the HFSA and/or the DCFSA accounts under City Flex.
3. Salary contributions into your HFSA and/or DCFSA Plan accounts are held in a trust account on your behalf with NBS, the Third Party Administrator. The money in your Plan account(s) will be used to reimburse you for qualified medical or dependent care out-of-pocket expenses based upon receipts submitted to NBS.
4. The amount of your salary that is redirected into your HFSA and/or DCFSA Plan account(s) is not subject to Federal, State, or Social Security income taxes. However, if you receive a reimbursement for an expense under City Flex, you cannot claim a Federal income tax credit or deduction on your return. (NOTE: You may want to consult with your tax advisor to help determine whether City Flex will benefit you.)
5. At the end of each Plan Year, any unused salary contributions remaining in your HFSA and/or DCFSA Plan accounts **<u>are forfeited</u>**.
5.

Hypothetical Example for City Employee

$1,200 Per check	**Currently**	**With City Flex**
Gross Pay	$1,200.00	$1,200.00
Dependent Care FSA	$ 0.00	$ 200.00
Plan Administration Fee	$ 0.00	$ 3.00
Taxable Income	$1,200.00	$ 997.00
Federal Withholding	$ 105.28	$ 75.05
State Withholding	$ 64.33	$ 49.43
FICA (Social Security & Medicare tax (1.65%)	$ 91.80	$ 76.27
Net Pay	$ 938.59	$ 796.25
Dependent Care Expenses	$ 200.00	$ 0.00
Spendable Income	$ 738.59	$ 796.25
Savings per Paycheck Savings Per Month Savings Per Year		$ 57.66 $ 115.32 $1,383.84

III
CONTRIBUTIONS

- **How much of my pay can I redirect into City Flex?**

a) HFSA (Medical expenses)

You may redirect a **<u>maximum of $2,750 per Plan Year</u>** of your salary into your HFSA. **b)** DCFSA (Dependent Care expenses)

If you have work-related dependent care expenses, you may redirect the lesser of: (a) $5,000 (if you are married filing a joint return or you are head of a household) or $2,500 (if you are married filing separate returns); (b) your taxable compensation; or (c) your spouse's actual or deemed earned income (a spouse who is a full time student or incapable of caring for himself/herself has a monthly earned income of $250 for one dependent or $500 for two or more dependents).

<u>Caution</u>: Employees must carefully determine the amounts they redirect because any amounts remaining in the employee's account at the end of the plan year will be forfeited.

- **Who is a qualified "dependent" under DCFSA?**

  An eligible dependent is someone you claim on your Federal Income Tax form 2441 "Credit for Child and Dependent Care Expenses." For example:
  - Children under age 13;
  - Dependents who are physically or mentally unable to care for themselves.
- **What *may* qualify as reimbursable dependent care expenses:**
  - Preschool;
  - Babysitter;
  - Before/after school care;
  - Intercession;
  - Summer Fun;
  - Child care in your home or at someone's home;
  - Adult day care in your home, someone else's home or at a care facility.
- **What may not qualify as reimbursable dependent care expenses?**
  - Payments to an unlicensed care giver/facility;
  - Babysitting provided by a sibling;
  - Payments paid in cash;
  - After school extra-curricular activities;
  - Summer school.
- **When do I have to decide whether to enroll in City Flex or to make changes in my enrollment (if permitted)?**

  If you are a new employee and meet participation eligibility requirements under City Flex, then you must elect to enroll within 30 days of your start date. For existing eligible employees, Federal law and plan provisions require that you decide during the open enrollment period before the Plan Year begins.

  If you have a change in status that enables you to stop participation or change your contributions, you must elect to stop participation or change your contributions within 90 days of the change in status event.
- **How can I tell by looking at my paycheck stub if my City Flex contributions are being deducted?**

  Your paycheck stub will show 2-3 codes under "Deductions/Reductions" column:
  - CODE "FLEX ADMIN" (Administrative fee)
  - CODE "FLEX ACT MED" (Health FSA)
  - CODE "FLEX ACT DEP CR" (Dependent care FSA)

IV
APPEAL RIGHTS

If your claim for benefits under City Flex is denied, NBS shall provide you with written notice **within 5 business days of the denial** detailing reasons for the denial of your claim.

You may file an appeal by writing NBS **within 60 days** after receiving notice of the denial. Your appeal must be made in writing and set forth all of your reasons for appealing the denial.

NBS shall act upon your appeal **within 60 days** after receipt of your request for review, unless special circumstances require an extension of time for processing (such as the need to hold a hearing), in which event a decision should be rendered as soon as possible, but in no event later than 120 days after such receipt.

You shall be provided a written decision by NBS and it will include specific reasons for the decision. The decision of NBS shall be final and conclusive on all persons.

V
HIGHLY COMPENSATED EMPLOYEES

Who are highly compensated employees (HCE)

Under the Internal Revenue Code, "highly compensated employees" and "key employees" generally are Participants who are officers, shareholders or highly paid.

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. Please refer to your Summary Plan Description for more information. You will be notified of these limitations if you are affected.

VI
MORE INFORMATION

If you have more questions about City Flex or wish to obtain a copy of the comprehensive City Flex Plan document, **go to: https://www.honolulu.gov/hr/benefits.html or contact:**

National Benefit Services, LLC
430 W 7th Street, Suite 219393
Kansas City, MO 64105-1407
TOLL FREE: (855) 399-3035
Fax: (800) 478-1528
NBS website:
www.NBSbenefits.com/cityofhonolulu
Email: Service@NBSbenefits.com

The City Flex comprehensive plan document can be made available to individuals who have special needs or who need auxiliary aids for effective communication (i.e., large print or audiotape), as required by the Americans with Disabilities Act of 1990, by contacting DHR Administration at: (808) 768-8536.

Flexible Spending Program
City and County of Honolulu

Compensation Reduction Agreement

For Plan Year: 7/1/_____ to 6//30/_____

Please type or print clearly.

Section A: EMPLOYEE INFORMATION

Last Name	First	Middle	Social Security Number (Required)

Mailing Address	City/State	Zip Code	Home Phone Number

Department	Date of Birth	EMAIL Address:	Work Phone Number

Check here if this is a new address ☐ **Date of Hire**_____

WOULD YOU LIKE DIRECT DEPOSIT? YES ☐ NO ☐

Are you planning to retire/terminate prior to the end of the Plan Year? ☐ **Yes** ☐ **No**

- If **YES**, what is the retirement/termination date? _____

Section B: DEPENDENT/CHILD CARE SPENDING ACCOUNT

(Babysitter, pre-school, after school care, etc.)

I elect to enroll in the ***Dependent Care Spending Account*** and authorize the following to be deducted from my paycheck on a pre-tax basis for the plan year:

$_____ Annual Amount

Maximum amount $5,000 - If you enroll in the Dependent Care Spending account only, the administration fee will be added to the amount you elect.

If enrolling after July 1st, designate amount to be deducted for remainder of plan year (thru June 30th).

Section C: MEDICAL SPENDING ACCOUNT

I elect to enroll in the ***Medical Spending Account*** and authorize the following to be deducted from my paycheck on a pre-tax basis for the plan year:

$_____ Annual Amount

Maximum amount $2,750 - The administration fee will be added to the amount you elect.

If enrolling after July 1st, designate amount to be deducted for remainder of plan year (thru June 30th).

- I hereby authorize the City and County to reduce my gross salary (before federal, state, and Social Security taxes are calculated) by the total amount indicated above.
- I have reviewed and understand the City Flex informational pamphlet provided to me with this form (including page 2 of this form).
- I understand that failure to exhaust flexible spending account funds within prescribed time limits will result in forfeiture of funds.

Section D: EMPLOYEE SIGNATURE:	Date:

Return a copy of this form to: **National Benefit Services, LLC (NBS)**

Address: 1314 S. King Street, Suite 305
Honolulu, HI 96814

Fax: 808.465.3712

Email: cityflex@nbsbenefits.com

It is recommended that you confirm receipt by calling NBS two business days after faxing / e-mailing or five days after mailing this form.

Instructions for Completing the Compensation Reduction Agreement

Section A: **Employee Information -** Complete all of Section A.

Section B: **Dependent Care Spending Account** – Complete only if you wish to enroll in the Dependent Care Spending Account

Section C: **Medical Spending Account** – Complete only if you wish to enroll in the Medical Spending Account.

Section D: **Employee Signature** – Sign and date this section.

Return a copy of the completed form to: National Benefit Services (NBS)

Plan Highlights

I understand that with the **Dependent Care** and **Medical Spending Accounts:**

- I must pay a monthly administration fee to participate. The fee will be deducted from my paycheck on a BEFORE-TAX basis. Whether I participate in one or both flexible spending accounts there will be one monthly fee. (Call NBS for the current administration fee.)
- The monthly administration fee shall be deducted from your account balance during the 2-month period as long as you still have money in your account(s).
- My election is **irrevocable** for the plan year unless I have an allowable status change. Examples of allowable status changes include but are not limited to: changes in legal marital status, changes in the number of dependents, and changes in employment status.
- The election change must be consistent with the status change and may be made on a **prospective** basis only after NBS's receipt and approval of the required status change forms.
- I must submit a written status change form to NBS within 90 days of the status change event. Otherwise, my election cannot be changed.
- My accumulated receipts must total at least $25 before I am reimbursed on my claim. The only exception is at the end of the plan year 1) if my available balance is less than $25, or if I mark my last claim as "FINAL CLAIM."
- **I will have until August 31st following the end of the plan year to file claims for expenses incurred during the plan year.**
- All receipts must contain complete information before my reimbursement can be processed, and this should be submitted before August 31. Otherwise, **corrected claim forms (i.e., additional or follow-up supporting documents) received after August 31 shall not be reimbursed.**
- **Any money left in my account after August 31st, (after I have claimed all eligible expenses for that year), will not be reimbursed to me and will be forfeited to the City and County pursuant to the IRC. The IRS considers the date of a claim as the date the service is rendered, not when the bill is actually paid.**
- I will inform NBS when I go out on any leaves of absence without pay or if I terminate my employment with the City and County.

I understand that with the **Dependent Care Spending Account**:

- Dependent care expenses are reimbursable if my spouse (if I am married) and I are both employed or if my spouse is a full-time student.
- I may not claim for services for periods I (or my spouse if I am married) did not work or while not on duty, (e.g., leaves of absence, vacation, sick leave, etc.).
- Dependent care expenses must be for my dependent child under age 13 or other dependents (e.g., a physically or mentally handicapped relative or other person living in my home who is unable to care for himself/herself and over half of whose support I pay).
- I can contribute up to $5,000 per year if I am a single parent or married and filing a joint return. This maximum is the total family contribution allowable and must include the annual administration fee. My maximum may be lower if:
  - I or my spouse earns less than $5,000
  - My spouse is a full-time student or incapable of self-care, or
  - I am married but file a separate federal tax return.

  If any of the above exceptions apply, please call National Benefit Services (NBS), at 855.399.3035.
  Care cannot be provided by my spouse or anyone I claim as a tax dependent.
- I cannot claim as a tax credit the same dependent care expenses that are reimbursed under this plan.
- My claims will be reimbursed for the amount of my eligible "out-of-pocket" expenses up to the amount in my account balance after service has been rendered.
- I will be required to identify the person or agency performing the childcare services to the IRS by providing his/her federal I.D. number or social security number.

I understand that with the **Medical Spending Account**:

- Health-related expenses are reimbursable if they can be considered "deductible" medical expenses on my tax return as defined under section 213(d) of the Internal Revenue Code ("IRC"). Insurance premiums and unnecessary cosmetic surgery are examples of ineligible expenses. See, IRS Publication 502 for guidelines. I cannot claim on my tax return the same health care expenses that are reimbursed under this plan.
- The maximum I may contribute is $2,750 per plan year, plus the annual administration fee. If my spouse and I are eligible for the ***City and County*** Medical Spending Account, we may each contribute up to $2,750 per plan year.
- My claims will be reimbursed for the amount of my eligible "out-of-pocket" expenses up to my annual election, minus previous claims paid.
- I may be eligible to continue in the Medical Spending Account on an after-tax basis through COBRA if a qualifying event occurs, such as separation from service.

Healthcare Expense Account

Sample Expenses

Medical Expenses

- At-Home COVID Testing
- Acupuncture
- Addiction programs
- Adoption (medical expenses for baby birth)
- Alternative healer fees
- Ambulance
- Body scans
- Breast pumps
- Care for mentally handicapped
- Chiropractor
- Copayments
- COVID-19 PPE (e.g., masks, hand sanitizer, and sanitizing wipes)*
- Crutches
- Diabetes (insulin, glucose monitor)
- Eye patches
- Fertility treatment
- First aid (e.g., bandages, gauze)
- Hearing aids & batteries
- Hypnosis (for treatment of illness)
- Incontinence products (e.g., Depends, Serene)
- Joint support bandages and hosiery
- Lab fees
- Menstrual Products
- Monitoring device (blood pressure, cholesterol)
- Physical exams
- Non-prescription medicines or drugs (vitamins/supplements without a prescription are not eligible)
- Pregnancy tests
- Prescription medicines or drugs
- Psychiatrist/psychologist (for mental illness)
- Physical therapy
- Speech therapy
- Vaccinations
- Vaporizers or humidifiers
- Weight loss program fees (if prescribed by physician)
- Wheelchair

**If purchased for the primary purpose of preventing the spread of COVID-19.*

Dental Expenses

- Artificial teeth
- Copayments
- Deductible
- Dental work
- Dentures
- Orthodontia expenses
- Preventative care at dentist office
- Bridges, crown, etc.

Vision Expenses

- Braille - books & magazines
- Contact lenses
- Contact lens solutions
- Eye exams
- Eyeglasses
- Laser surgery
- Office fees
- Guide dog and upkeep/ other animal aid

Items that generally do not qualify for reimbursement

- Personal hygiene (e.g., deodorant, soap, body powder, sanitary products. Does not include menstrual products)
- Addiction products**
- Cosmetic surgery**
- Cosmetics (e.g., makeup, lipstick, cotton swabs, cotton balls, baby oil)
- Counseling (e.g., marriage/family)
- Dental care - routine (e.g., toothpaste, toothbrushes, dental floss, anti-bacterial mouthwashes, fluoride rinses, teeth whitening/bleaching)**
- Exercise equipment**
- Haircare (e.g., hair color, shampoo, conditioner, brushes, hair loss products)
- Health club or fitness program fees**
- Homeopathic supplement or herbs**
- Household or domestic help
- Laser hair removal
- Massage therapy**
- Nutritional and dietary supplements (e.g., bars, milkshakes, power drinks, Pedialyte)**
- Skin care (e.g., moisturizing lotion, lip balm)
- Sleep aids (e.g., snoring strips)**
- Vitamins**
- Weight reduction aids (e.g., Slimfast, appetite suppressant)**

***Portions of these expenses may be eligible for reimbursement if they are recommended by a licensed medical professional as medically necessary for treatment of a specific medical condition.*

Direct Deposit Request Form

Please complete this form and return it to National Benefit Services, LLC

1 Personal Information

Employee Name (First Name, Last Name)

Company Name

Street Address, City, State, Zip

☐No ☐Yes
Address Change?

Current Date

Social Security Number

Email Address (for claim payment notification)

2 Direct Deposit Request

Your Financial Institution

☐Checking Account ☐Savings Account
Account Type

Financial Institution Address

Routing Number

Account Number

3 Employee Signature

I (We) authorize National Benefit Services, LLC to initiate credit entries and, if necessary, debit and adjustment entries for any credit entries and adjustments made in error to my (our) account indicated above and the financial institution named above.

Employee Signature

Date

IMPORTANT! If you have Direct Deposit information on file it carries forward unless corrected or rescinded in writing by you.

Please return to National Benefit Services, LLC

430 W 7th Street, Suite 219393, Kansas City, MO 64105-1407• (855) 399-3035 • service@nbsbenefits.com

Flexible Spending Account (FSA) Claim Form

Instructions For Quick Claim Processing:

- Fully complete & sign this claim form
- Attach copies of supporting EOB, receipts, vouchers, bills, etc.
- All receipts must include a date, description, and amount of the service
- Please list one expense per line
- Please print in dark blue or black ink when using this form
- Please allow 2 business days for claims to be processed

For Account Balance:
Go to my.nbsbenefits.com
or call (855) 399-3035

1 Personal Information

Employee Name _____ Company Name _____

Street Address, City, State, Zip _____ ☐No ☐Yes Address Change?

Phone Number _____ Social Security Number _____

2 Dependent Care Expenses *(Dates of Service are required in order to process claim)*

	Date of Service Start Date	Date of Service End Date	Service Provider Tax ID# or SS#	Dependent's Name	Age	Amount
1						
2						
3						
4						

Total Dependent Care Expenses _____

3 Health Care Expenses

	Date of Service MM	DD	YY	Medical	Rx	Dental	Vision	Hospital	Ortho dontia	Other Services: Please Specify	Person Receiving Service	Amount
1				☐	☐	☐	☐	☐	☐			
2				☐	☐	☐	☐	☐	☐			
3				☐	☐	☐	☐	☐	☐			
4				☐	☐	☐	☐	☐	☐			
5				☐	☐	☐	☐	☐	☐			
6				☐	☐	☐	☐	☐	☐			
7				☐	☐	☐	☐	☐	☐			
8				☐	☐	☐	☐	☐	☐			
9				☐	☐	☐	☐	☐	☐			

Total Health Care Expenses

4 Employee Signature

I, the undersigned, attest that to the best of my knowledge these statements are complete and true. I authorize the release of any medical information to my spouse. I certify these expenses are for valid services provided on the dates indicated and will not be reimbursed or claimed under any other Plan or claimed as a tax deduction.

Employee Signature _____ Date _____

Please fax, mail, or email your claim form and receipts to the following:
Mail: National Benefit Services, LLC, 430 W 7th Street, Suite 219393, Kansas City, MO 64105-1407
Email: service@nbsbenefits.com (PDF, TIFF, or JPG files only)

NBS Prepaid MasterCard Card

The Smart Way To Pay For The Things You Need

1 The NBS® Prepaid MasterCard® Card

As part of your cafeteria program, you can receive your own NBS card that makes using your flex dollars easier than ever. As long as the merchant or service provider accepts MasterCard credit cards, there's no need to pay cash up front and then wait for reimbursement.

2 Here's How It Works

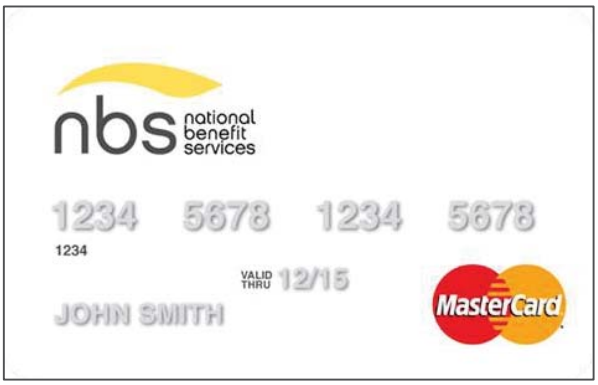
1. Enroll in the cafeteria benefit program and select an annual contribution amount.
2. Pre-tax funds are loaded into your account via payroll deduction.
3. You receive your NBS card in the mail, and can use it immediately for qualified expenses. Funds are deducted directly from your flex account. Purchases that exceed the available funds are declined, and you'll have to use another form of payment and submit a claim for reimbursement.
4. The NBS card is a debit card but similar to a credit card in that you always select "Credit" and sign for purchases. Your card does not require a PIN and you cannot withdraw cash. If the merchant or service provider does not accept MasterCard credit cards, you'll need to use another form of payment and submit a claim for reimbursement.
5. Use your card at doctors' offices, hospitals, dentist offices, optical centers, pharmacies and other health providers. Just swipe your card to pay for eligible items and then provide another tender for non-eligible purchases.

3 Approved Stores

Please see
http://sig-is.org/card-holders/store-locator
for a complete list of stores that accept the card.

4 Please Note

Debit cards will be ordered after all plan setup and enrollment materials are received by NBS. You are required to keep all receipts for purchases. You may be required to submit receipts for adjudication on transactions made on the card. Any use of the card for ineligible purchases will require you to refund money back to the plan.



Sign up for a flexible spending program today, and keep those hard earned dollars in your wallet. Contact your Human Resource Department for more information.

430 W 7th Street, Suite 219393, Kansas City, MO 64105-1407 • (855) 399-3035 • service@nbsbenefits.com