



Berkeley Unified School District Flexible Benefit Plan

CBA Contact Information:

Website:

www.cbadministrators.com

(24/7 information via Internet)

E-mail:

customerservice@cbadministrators.com

(For Customer Service questions & Claim Submission)

Phone:

(916) 303-7090 or

(800) 574-5448

Fax:

(916) 303-7083 or

(800) 584-4591

Mail:

P.O. Box 2170, Rocklin, CA 95677



Access to Your Account:

www.cbadministrators.com

If you have previously accessed your account, use your current username and password.

1st Time Users....

Default Username:

- The first two letters of your last name (in CAPITAL LETTERS), plus
- Your 4-digit year of birth, plus
- The last four digits of your social security number
- *Example: If your last name is Smith, you were born in 1962 & your SSN is 123-45-6789, your user name would be SM19626789.*

Default Password:

- **PASSWORD** (in CAPITAL LETTERS)

Things You Should Know

How often are claims processed? Claims are processed daily. Reimbursements are generated each Wednesday and Friday (except holidays). In order for your claim to be included in the reimbursement, it must be **received** by noon Pacific Standard Time on the previous business day (e.g. noon on Tuesday and Thursday). "Received" means that CBA has received all the information required to process your claim. For example, if you file a claim using the online portal, your claim is "received" only after CBA receives your supporting documentation (if required).

We make every effort to reimburse you as quickly as possible. However, sometimes a claim must be denied (returned) because additional information is needed. Whenever we have to deny a claim, we will send you a notification by e-mail or mail. Your notification will include an explanation as to why the claim was denied. In addition, we'll explain what information is needed to approve your expense (if applicable).

What methods of reimbursement are available? CBA pays reimbursements by direct deposit or check (mailed via 1st class U.S. mail). If you have not already signed-up for direct deposit, you may enroll at any time. A direct deposit form is attached. They are also available on our website or from your employer.

How soon can I access my funds? Reimbursements from the Medical FSA are not limited to the amount you have contributed. You may be reimbursed up to your annual election at any time during the plan year provided your expense is otherwise eligible. The Dependent Care FSA works differently. Funds are available only as they are contributed each pay period. Still, you should always request what you PAY for day care. By doing this we will automatically reimburse the difference as you continue to make contributions.

Does my Plan have a Grace Period to incur expenses? Yes! The Grace Period gives you an additional 2 ½ months after the end of the plan year during which you may continue to incur expenses that can be applied to a remaining balance in your account.

When is the deadline for filing claims? Active Participants have until March 31, 2013 following the end of the grace period to submit claims. If you become ineligible prior to the end of the plan year, you will have 60 days following your loss of eligibility to submit claims for services rendered prior to the date you lost your eligibility. Refer to your SPD for more details.

Where can I find more details about my Plan? Your Summary Plan Description (SPD) is available online & provides the most detailed information about your Plan. There is a lot of other helpful information online.



F.Y.I.

Claim Filing Tips and Suggestions

1. YOUR CLAIM MUST BE COMPLETE A completed and signed claim form AND adequate “third-party” documentation is required for all submissions.

2. “THIRD-PARTY” DOCUMENTATION EXPLAINED “Third-party” refers to documentation that is provided to you by your service provider (doctor, dentist, insurance carrier or day care provider). Your documentation must also be complete and legible.

For the Medical Expense FSA, documentation must include: 1) complete date of service, including the year; 2) patient name; 3) name or description of the service; 4) name of the service provider; and, 5) total charge or a clear indication of your portion of the charge.

For the Dependent Care FSA, you may obtain your provider’s signature on the claim form in-lieu of providing separate documentation.

3. DO NOT ALTER YOUR DOCUMENTATION “Third-party” documentation must stand-alone. Review the documentation at the point-of-service to ensure that all necessary information is included. It is your responsibility to make sure that the provider gives you what you need to receive your pre-tax reimbursement. Please avoid “highlighting” your paperwork. Highlighted areas often become illegible in transmission. BE AWARE: Colored, carbon or thermal-paper receipts may transmit too light to be legible. They may also fade over time. Copies are acceptable and even recommended in these circumstances.

4. KEEP YOUR ORIGINAL DOCUMENTATION Good, clean copies are fine! You should always retain your original documentation. The IRS requires you to retain all tax records for at least three (3) years!

5. DATE OF “SERVICE” IS WHAT WE NEED Reimbursements are based on the date of service. The date you pay for a service is not important. This is why check copies, credit card receipts and cash register receipts are not acceptable. PLEASE NOTE: For qualified Over-the-Counter (OTC) expenses, the IRS permits the use of “complete” cash register receipts. Keep in mind however, that this is a special exception that only applies to OTC expenses.

Although, in some cases, a provider may require pre-payment of services, reimbursement cannot be considered until the service has actually been performed. Documentation that only shows “pre-payment”, “payment on account” or “balance forward” is not adequate.

6. E-MAILED CLAIMS You may e-mail your claims to our Customer Service e-mail address as a single file in .pdf format. Claims submitted piece-meal, in multiple files or in different formats may be returned. *Please* send each claim only once (e.g., do not e-mail AND fax the same claim).

7. DON’T PANIC IF AN EXPENSE IS DENIED If we have to deny a claim, we will e-mail or mail you a notice explaining why the expense(s) could not be reimbursed. In many cases, we

have to deny expenses simply because documentation is illegible or incomplete. When this occurs, all you need to do is send a NEW CLAIM with complete, clear documentation and your expense will be reconsidered. Remember, your documentation must be clear and complete. If you can’t read your documentation, chances are, we can’t either.

8. EXPENSES COVERED BY INSURANCE MUST BE PROCESSED BY YOUR CARRIER BEFORE YOU REQUEST REIMBURSEMENT If you have insurance coverage for an expense, your insurer must process the claim before you are permitted to request reimbursement from your FSA. Most insurance carriers issue “Explanation of Benefits” (EOBs) after they process a claim. EOB’s are excellent “third-party” documentation to use for your FSA reimbursement request.

9. PRESCRIPTION DRUGS The most common error we see is submitting a cash register receipt as documentation for prescription drugs. Generally, the patient name will not be included on a cash register receipt. Without the patient name, your expense will be denied. Instead, use your pharmacy tag or tax receipt provided with your prescription. If you misplace your tax receipt, most pharmacies can provide you with a printout of all your prescriptions.

10. OVER-THE-COUNTER (OTC) DRUGS, MEDICINES & SUPPLIES Commencing January 1, 2011, you must obtain a prescription to be reimbursed for your OTC drug and medicine purchases. Remember though, there are still thousands of supplies and products available



E-mail
→ Me ←



OTC that do not require a prescription for you to be reimbursed. Review your enrollment packet from CBA for detailed information about OTC drugs, medicines and supplies.

11. NO PERSONAL USE ITEMS

Only OTC drugs, medicines & medical supplies are eligible for reimbursement under your Medical FSA. Personal use items, such as soap, toothpaste, toothbrush, cosmetics, cream, shampoo, lotion, etc. are not reimbursable, even if they contain a medicated component (e.g. dandruff shampoo).

12. ORTHODONTIA CLAIMS

EXPLAINED Orthodontia is one of the most popular expenses in a Medical FSA, and for good reason. You know exactly how much you owe and exactly when you owe it. However, obtaining complete documentation can be confusing.

Commonly, orthodontia is either paid for in-full at the start of treatment or monthly payments are extended over time. IRS guidance allows for reimbursement in either of these circumstances based on the payment contract you and your provider agree upon. This will determine your allowable reimbursement for the current plan year.

If full payment is made at the start of treatment, you can claim 100% of your cost once treatment begins (treatment is usually considered “started” once bands have been placed or in the case of Invisalign®, when the first trays are delivered).

If you have a monthly payment contract with your provider, we can set-up an automatic reimbursement. Just include a copy of your orthodontia contract with a completed claim form and

request the amount you will owe for the entire plan year. You will receive your reimbursement once a month throughout the plan year. If you do not have a contract, your provider can complete an Orthodontia Information Form located online under the “Forms” tab.

13. MASSAGE THERAPY, WEIGHT-LOSS PROGRAMS, & VITAMINS & SUPPLEMENTS REQUIRE MEDICAL NECESSITY

Some general health services and items may be used to treat a specific medical condition and, therefore, may be reimbursable through your Medical FSA. However, you are responsible to establish the medical necessity of such an expense (refer to “MEDICAL NECESSITY” below).

Examples include: massage therapy to treat sciatica; weight-loss programs (no food) to treat diabetes; or Vitamin C to treat scurvy.

14. PRESCRIPTION DRUGS OBTAINED OUTSIDE THE U.S. ARE NOT REIMBURSABLE

Only medications and remedies that are legally procured in the United States are eligible for reimbursement. Currently, the Federal government deems drugs that are mail-ordered from a source outside the United States to be obtained illegally. We will deny claims for drugs purchased from a source outside the U.S. The only exception is if you refill an existing prescription while you are visiting another country.

15. MEDICAL NECESSITY In order to establish “medical necessity” for a product or service that would normally be considered a personal use expense, you must submit a “prescription” (statement) from your treating physician on your physician’s letterhead that: 1) identifies the medical condition being treated; 2) recommends the specific course of treatment (e.g.,

massage therapy, weight-loss, etc.); and, 3) states the duration of the treatment (e.g. “12 sessions”, “3 months”, “lifetime”). In addition, for expenses such as classes, massages, and memberships, the expense may not commence until you obtain your “prescription”. In other words, you can only be reimbursed for this type of expense if you incur this type of expense solely to treat your medical condition.

For example, let’s say you get a weekly massage. Then one day you injure your lower back. Even though your doctor may recommend you continue with your weekly massage, you MAY NOT be reimbursed for this expense. Why? Because you did not “incur” the expense solely to

treat your medical condition. Rather the medical benefits were simply a by-

product of a non-medical expense that you choose to incur regardless of a medical condition.



16. MEDICAL EXPENSES OBTAINED OUTSIDE THE U.S. REQUIRE SPECIAL CONSIDERATION

You may find it necessary to obtain medical care while outside the U.S. Expenses you incur abroad may be considered for reimbursement under the following circumstances: 1) The service must be considered “legal” in the U.S.; 2) The documentation must be in English or translated to English by the “third-party” provider of service; 3) The cost for the service must be expressed in US dollars on the date the service is rendered. If the provider cannot bill you in US dollars, you will need to have the cost of the expense(s) converted

into US dollars by a banking institution on the date the expense was incurred; 4) All other documentation requirements must also be met (refer to Tip #2).

17. CLAIMING EXPENSES FOR YOUR DEPENDENTS Under Federal law, only expenses for you, your spouse or your IRS tax dependents are eligible for reimbursement. You may NOT be reimbursed for expenses incurred by a **domestic partner** unless your domestic partner qualifies as your federal tax dependent. Contact your tax professional for assistance in determining eligibility of your dependent(s).

18. DAY CARE EXPENSES MAY ONLY BE REIMBURSED IF YOU ARE THE “CUSTODIAL” PARENT You must be the “custodial” parent to qualify for pre-tax reimbursement of day care expenses. If your situation changes during the plan year, contact your tax professional for assistance in determining if you remain the “custodial” parent.

19. FOR DAY CARES EXPENSES, ALWAYS REQUEST THE AMOUNT YOU PAY, REGARDLESS OF THE AMOUNT IN YOUR PRE-TAX ACCOUNT We encourage participants to submit claims for their entire day care expense regardless of your payroll deduction. If the amount of a claim exceeds the amount in your account, the excess portion will be automatically reimbursed to you as you continue to make payroll contributions.



FILING A NON-DEBIT CARD CLAIM

Now that you have enrolled in one or more of your employer's flexible spending accounts, you may begin to file claims against your account(s) upon the start date of the Plan Year (or the date you enrolled, if later).

You may access your plan dollars by the following methods:

1. **Online Claim Filing:** File your claims online via our participant portal website. Login to your account at www.cbadministrators.com. Your user name and password is shown on the first page of this document.
 - Click on **FILE CLAIMS**.
 - Select **File Claim** next to the appropriate account.
 - You must mark "YES" that you have a valid receipt to continue online filing.
 - Note: Under "Type of Product/Service", if more than one Product/Service seems right, select the one that best fits the expense.
 - Make sure to click **Submit** on the bottom of the screen.
 - If you have more than one expense/claim, choose **Add New Claim**. Repeat as needed.
 - Once all claims are entered, check the box to agree to the Terms & Conditions and click **Submit**.
 - **Final Step** - Click **Print Confirmation** and send the confirmation to CBA with your documentation via e-mail, fax or mail. This confirmation page serves as your claim form and verifies that all claims have been successfully submitted. Your claim is considered "received" by CBA only after CBA receives your supporting documentation.
 - **NEVER USE A PAPER CLAIM FORM FOR A CLAIM YOU HAVE ALREADY FILED ONLINE.**

2. **Paper Claim Form Filing:** You may opt to file claims using a paper claim form available on the website under the "Forms" tab.
 - Complete the claim form in full including your "certification" (signature).
 - Do not highlight, alter or write on your documentation.
 - Consider photocopying colored, carbon or thermal-paper receipts, as they may transmit too light to be legible. They may also fade over time, so photocopying may help to preserve the long-term integrity of the document.
 - Retain a complete copy for your records (IRS recommendation is three years).
 - Submit via e-mail, fax or mail along with your required documentation.
 - **NEVER SUBMIT A PAPER CLAIM IF YOU HAVE ALREADY FILED A CLAIM ONLINE.**



YOUR DEBIT CARD AND YOU

- ❖ If this is the first year that you have chosen to use a debit card as your primary reimbursement option, you (and any dependents for which you have ordered cards) will receive your card(s) at your address on record with CBA (usually your home). In addition, we (CBA) may issue replacement cards on a periodic basis. In most cases, your cards will arrive within two weeks from the date you received this material.
- ❖ You do not have to activate your card. It will automatically activate the first time you use it.
- ❖ Although it is a “debit card”, there is no PIN number. If a merchant has trouble swiping your card (and you know you have funds available), suggest the merchant swipe it as a credit card.
- ❖ Whenever you use your card, you agree to retain complete records of your purchase. While over 70% of all “Flexible Spending Account” (FSA) swipes can be “auto-approved” (i.e. we will not require you to submit supporting documentation after your purchase), 30% of debit card FSA purchases DO REQUIRE supporting documentation. By far, the biggest “gripe” people have with the debit card when used for their FSA, is that they wrongfully assume they will never be required to produce supporting documentation. Then, when they receive a request, they become agitated because they either did not retain their documentation or they simply feel they are being inconvenienced. Unfortunately, this also means that these particular people probably never took the time to read their enrollment material. To avoid this situation, you should ALWAYS ASSUME you will be required to provide supporting documentation after you use your card for an FSA purchase. If you approach using your card in this manner, you will be happy when you are not asked but also ready to respond when you are asked.
- ❖ Under current law, the requirement to provide supporting documentation only applies to a Health Flexible Spending Account (FSA). If you have an HSA, CBA will not request supporting documentation after you use your debit card. This does not mean you are permitted to use your HSA funds for non-qualified purchases. On the contrary, the types of expenses that may be reimbursed from an HSA are virtually identical to an FSA. The difference is that your employer (and by extension, CBA) is required to “police” your FSA expenses while you are individually responsible to substantiate your HSA expenses if audited by the IRS.
- ❖ Remember, supporting documentation is not a credit card receipt that only shows the amount you paid (we already know how much you paid). Your supporting documentation must include the five pieces of information required by the IRS (i.e. date of service, patient name, name of service provider, amount paid, and a description or name of the service or item purchased). Look at your statement when you swipe your card. If it is missing any information, tell your service provider that you need a more complete receipt.
- ❖ In order to use the debit card, you must agree to always maintain an active email address on file with CBA. We need your address to ensure that we can communicate with you timely and efficiently. If your email changes, you are required to notify CBA immediately in writing (email is fine). If you do not maintain an email address, your card privileges will be suspended or terminated without further notice until you provide us with a new address.
- ❖ If CBA requires supporting documentation, you will receive an email notification approximately 6 days after your date of purchase. When you receive the request, simply print it, place it at the front of your supporting documentation and mail, fax or email (PDF only) the information back to us at the address on the request. We will then review your documentation and approve or deny your purchase(s). If your expense(s) is denied, you will need to repay the debit card charge.
- ❖ If you do not respond to our first request in a timely manner, you will receive a second “courtesy” request approximately 20 days after your original purchase. If you fail to respond to this second request, you will receive one last (not so pleasant) request approximately 40 days after your original purchase. This final request will include a warning that your claim will

automatically be denied after 60 days (from your date of purchase) if you fail to provide the required documentation. If you fail to repay the denied charge before 90 days from your original purchase date (or the date your plan year ends, if sooner), your card privileges will be suspended or terminated without further notice until such time as you clear your account. An extra fee may be charged to re-activate your card. If your claim is denied, you still have the ability to provide us with the required documentation instead of paying back the charge. In addition, whenever you have an outstanding “denied” claim that has not been repaid or cleared, you agree to allow CBA to automatically deduct the amount due from a future claim.

- ❖ It is your responsibility to report a lost or stolen card to CBA immediately. If you fail to notify CBA immediately, you may be responsible for all amounts paid up to the date you report the loss.
- ❖ PLEASE NEVER SUBMIT A PAPER CLAIM FORM OR FILE A CLAIM ONLINE FOR AN EXPENSE THAT YOU PAID WITH YOUR DEBIT CARD.
- ❖ **USING YOUR DEBIT CARD AT A RETAILER THAT SELLS MEDICAL SUPPLIES:** Effective January 1, 2008, debit cards were no longer allowed to be used at retailers unless the retailer was “IIAS Compliant”. IIAS stands for Inventory Identification Approval System. In simple terms, this means the system can identify each item and determine if it qualifies for tax-free reimbursement from your Flexible Spending Account (FSA). The IIAS works like this:
 - ✓ Whenever you make a retail purchase (including online retailers) that includes items you believe are eligible for reimbursement from your FSA, be sure to use your CBA debit card as your **PRIMARY** (first) form of payment. When you swipe your CBA debit card first, the card system will recognize your card and look to see if the retailer is IIAS compliant.
 - ✓ If the retailer is not IIAS compliant, your CBA debit card will not work and you will need to use another form of payment for your entire purchase (you can then submit a manual claim to be reimbursed for the medical items you purchased). If this occurs and you want to frequent the particular retailer, be sure to let the Manager know that you want them to become “IIAS Compliant”.
 - ✓ If the retailer is IIAS Compliant, the system will automatically determine which items can be paid for using your CBA debit card. The clerk will then ask you for a second form of payment for those items that cannot be reimbursed from you FSA account.
 - ✓ That’s it! When you use the IIAS system at a participating retailer (the overwhelming majority of retailers are IIAS compliant) the system pre-approves your purchases, so you should never be required to submit supporting documentation after you pay. Still, please understand that no system works perfectly. So if you do receive a request for supporting documentation of an approved IIAS purchase...don’t panic...just give us a call and we’ll correct it together.
 - ✓ Please note that when you choose to use your debit card at a retailer, you are agreeing to abide by the decisions made by the IIAS system. In other words, you may not “appeal” the system’s determination of an expense; the IIAS’s decisions are final. This is just a necessary part of the convenience afforded to you by this new technology. If you do not wish to abide by the decisions made by the IIAS system, you are free to pay for your entire purchase using another form of payment and then submit a traditional claim for reimbursement with CBA.
 - ✓ Please note that while all other retailers were required to be IIAS compliant on January 1, 2008, “pharmacies” were given an extension of time to become compliant. Effective July 1, 2009, all pharmacies are now required to be IIAS compliant. Therefore, if your card no longer works at your neighborhood pharmacy, be sure to encourage the owner/manager to become compliant.





YOUR PERSONAL HOME PAGE

HOME ACCOUNTS PROFILE NOTIFICATIONS FORMS Test Test Logout

Welcome, Test

Welcome to your single source for all you need to know about your pre-tax benefits. Request payment, check payment status, view account balance and summary information, access important notifications about your account, and more!

Questions?
Contact Custom Benefit Administrators at: (916) 303-7090 Or toll free at: (800) 574-5448 or customerservice@cbadministrators.com.

Accounts	Profile	Notifications	Forms
Account Summary	Profile Summary	Notification History	
Plan Descriptions	Dependents		
	Login Information		

Accounts: You can view up-to-date account information at any time.

- Choose **Account Summary** to check the balances of any account. You can also check the claims history of any account by clicking the History link.
- Select **Profile** to review and update your personal and dependent information that's on file in the system.
- Select **Payment History** to see a detail of the claims that have been paid. You can click **View Detail** for more information about any claim.



Plan Descriptions: Your Pre-tax plan information is available at any time. To view this information, log on and click on the **Accounts** tab.

Forms: There are many forms available on the website, including your Notice of Privacy Practices and Summary Plan Description (SPD). Log on and click on the **Forms** tab, and select the form you would like to download.

The forms are in .pdf format, requiring Adobe Acrobat Reader. You may download a free version of acrobat reader from the Adobe website: <http://www.adobe.com/products/acrobat/readermain.html>.

EMPLOYEE NOTICE HIPAA PRIVACY RIGHTS & PRACTICES FOR THE

BERKELEY UNIFIED SCHOOL DISTRICT Health Flexible Spending Account (FSA)

The Berkeley Unified School District FSA (“Plan”) has the duty to protect your medical information. The Plan further has the duty to provide you with a notice of its privacy practices, which follows. The Plan has the right to change or modify this notice, at any time, and any modifications will be communicated to you. This notice describes how your medical information may be used and disclosed, and how you can get access to it. Please review it carefully.

The Health Insurance Portability and Accountability Act limits how a covered entity can use and disclose protected health information (PHI). Generally, a covered entity, including your health plan, your health care provider, or a health care clearinghouse, can share information without your authorization, for purposes of treatment of you, payment for your medical services, and for the health plan’s operation. In all other instances, you must authorize any disclosure of your health information.

Permitted Disclosures

The Plan can use and disclose your PHI for the following purposes, without your authorization, for making or obtaining payment for your health care, and for conducting health plan operations.

Examples of when and how your PHI can be used and disclosed for payment purposes, without your authorization, are:

- ◆ For coordination of benefits among multiple plans that cover you
- ◆ For utilization review purposes
- ◆ For case management purposes
- ◆ For precertification purposes
- ◆ Any other purpose necessary to ensure coverage for you, and to obtain or make payment for services rendered to you.

Examples of when and how your PHI can be used and disclosed for health plan operations, without your authorization, are:

- ◆ To ensure coverage for you
- ◆ For quality assessment purposes
- ◆ For cost containment purposes
- ◆ To ensure compliance with the terms of the Plan, or with clinical or other relevant medical guidelines and protocols
- ◆ To provide you with treatment alternatives
- ◆ For health plan and provider accreditation verification, licensure, or any other credentialing purposes
- ◆ For underwriting, premium rating, and related functions
- ◆ To create, renew, or replace your health insurance or health benefits
- ◆ To conduct audits, including compliance, medical, legal, business planning, cost containment, or customer service audit functions.

The Plan can share your PHI with the plan sponsor for certain administrative activities, without your authorization.

Examples of sharing PHI include, but are not limited to:

- ◆ Seeking premium bids for current or future coverage
- ◆ Obtaining reinsurance
- ◆ Amending, modifying, or terminating the plan
- ◆ Participant and enrollment information

Your PHI can be released in summary form, or, as a part of “de-identified” information, in accordance with the Code of Federal Regulations. Other instances, in which your PHI may be released, without your authorization, include:

- ◆ When legally required by federal, state, or local law. This instance would include the release of PHI upon the receipt of an order, subpoena, or other judicial or administrative process that would compel the disclosure of your PHI. However, your PHI would only be disclosed after a reasonable effort has been made to notify you of the request for such information.
- ◆ For law enforcement purposes, such as investigation of a crime.
- ◆ To respond to a threat to public health or safety.
- ◆ For workers compensation purposes, or other no fault law.
- ◆ To a government authority, such as a social service or other protected services organization, authorized to receive reports of abuse, neglect, or domestic violence.

Authorization for Use and Disclosure

Except as provided above, the Plan will not release any of your PHI without your authorization. If you authorize the release of some, or all of your PHI, you may revoke the authorization at any time. If you authorize release of your PHI, your authorization must include the following items:

1. A description of information used or disclosed
2. Identification of the parties releasing, and the parties requesting the information.
3. An expiration date of the authorization
4. Your signature
5. Information about how to revoke the authorization

Your Individual Rights

You have certain individual rights regarding your PHI; specifically:

1. If the Plan maintains your PHI, you have the right to inspect and request a copy it. The plan may charge a reasonable fee for copying this information. If the Plan does not maintain the PHI, which is the subject of your request, you will be directed to the appropriate party who can assist you with your inquiry.
2. You have the right to restrict the use and disclosure of your PHI, although the Plan is not required to agree with your request.
3. You have the right to receive confidential communications. You have the right to limit or restrict where, or how, the Plan may contact you regarding your PHI.
4. You have the right to request amendments or modifications to your PHI. If you believe your PHI is inaccurate or incomplete, you have the right to request an amendment to your records. In order to be entitled to amend the records, the Plan must maintain the relevant records, and you must make the request for amendment in writing. The Plan has the right to deny your request to amend or modify your PHI if:
 - ◆ You do not have a substantive reason for the request
 - ◆ The relevant records were not created by the Plan
 - ◆ The request falls within an exception to the amendment rights provided by the law
 - ◆ It is determined that the information is complete or accurate
5. You have the right to obtain an accounting of any disclosure that has been made of your PHI, other than those disclosures made for health care payment, treatment, or other health care plan operations. To exercise this right, or if you would like to pursue any of your individual rights regarding your PHI, contact:

Name & Title:	Privacy Officer
Employer Name:	Berkeley Unified School District
Address:	2134 Martin Luther King Jr. Way
City, State, Zip:	Berkeley, CA 94704
Phone:	510-644-6674 / Fax: 510-644-8549

You have the right to contact U.S. Department of Health and Human Services’ Office for Civil Rights (OCR) if you have any complaints about how the Plan has handled your PHI. You can submit your complaint on-line, or download a complaint form at this OCR website (<http://cms.hhs.gov/hipaa>). Or, you can send your complaint or question to this e-mail address: askhipaa@cms.hhs.gov. Or, you can call the CMS HIPAA Hotline: 1-866-282-0659.

Supplemental Enrollment Form

FLEXIBLE BENEFIT PLAN

Use this form to request a debit card, order a 2nd debit card for your spouse, or to sign up to receive your non-debit card reimbursements by direct deposit.

Administered by CBA

ENTER EMPLOYER NAME: **Berkeley Unified School District**

PLAN YEAR ENDING: _____

1	Employee Information			
	FIRST NAME	LAST NAME	SOCIAL SECURITY NUMBER	
	MAILING ADDRESS		CITY	STATE ZIP CODE
	DATE OF BIRTH	DAYTIME PHONE NUMBER	E-MAIL ADDRESS (required with debit card)	
2	Complete this section to request a debit card for your personal use			
	<input type="checkbox"/> I, the Employee signing below, REQUEST A DEBIT CARD . Check this box if you want to use a debit card.			
3	Complete this section to receive a second debit card – (Not all plans permit participants to order a second debit card. In addition, there may be a charge for a second card. Refer to your enrollment materials for details and restrictions.)			
	Do you want a debit card for your spouse or legal dependent? * <input type="checkbox"/> Yes - If yes, complete the following information: * Under federal tax law, a domestic partner must be your federal tax dependent to have a debit card. Name of Spouse or dependent: _____ Enter Spouse or dependent's date of birth (include year): _____			
4	Direct Deposit Authorization – Some expenses cannot be paid using a debit card. For these expenses, you will need to file a manual claim in order to be reimbursed. Non-debit card claims can be reimbursed by check or direct deposit into your personal bank account. If you select direct deposit, you will receive an email notification whenever CBA deposits a reimbursement into your bank account (this feature requires you to have an email address on file with CBA). Complete this section if you want to receive your non-debit card reimbursements by direct deposit. By completing the banking information below, I hereby authorize CBA to deposit all non-debit card reimbursements directly into my personal bank account at the financial institution named below. I understand that I may cancel this authorization at any time by notifying CBA in writing. I further understand that I am responsible to notify CBA if, for any reason, my bank account information changes. If I do not sign up for direct deposit, I understand all non-debit card reimbursements will be paid to me by check. <input type="checkbox"/> Check this box if you have already completed a separate direct deposit form with CBA (if you have already completed a separate form you are not required to enter your bank account information again). <div style="display: flex; justify-content: space-between;"> _____ Checking <input type="checkbox"/> Savings <input type="checkbox"/> </div> <div style="display: flex; justify-content: space-between;"> Name of DEPOSITORY (Name of Financial Institution) </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> Bank Routing Number (must be 9 digits) _____ Account Number _____ </div>			
5	By signing below, you are agreeing to the terms and conditions printed on the back of this form.			
	I, the undersigned employee, hereby certify that the information I have provided is true and correct. I further certify that I have read and agree to all the "Terms & Conditions" printed on the back of this Supplemental Enrollment Form. EMPLOYEE SIGNATURE: _____ DATE: ____ / ____ / ____			
6	What should I do after I complete this form?			
	First , please review the form and make sure your information is both complete and legible. Second , make a copy of the form for your records. Third , you may submit this form to your Human Resource Department or send it directly to CBA via fax, email or regular mail.			

Supplemental Enrollment Form

FLEXIBLE BENEFIT PLAN

Use this form to request a debit card, order a 2nd debit card for your spouse, or to sign up to receive your non-debit card reimbursements by direct deposit.

Administered by CBA

Terms & Conditions

I fully understand and agree that:

- The spouse or dependent for whom I ordered a “second” debit card (if applicable) must be my Federal Tax Dependent.
- Should my spouse or legal tax dependent use a debit card to pay for an item or service, I am solely responsible (both financially and legally) to substantiate the expense in a timely manner upon request by the administrator.
- I may be reimbursed for expenses incurred by myself, my spouse, my dependent children, and any other individual who is my federal tax dependent.
- I may not be reimbursed for expenses incurred by my domestic partner and/or their dependent children, unless my domestic partner and/or their children are my federal tax dependents.
- I may never seek reimbursement before an expense has been “incurred” (performed). Should I use my debit card prior to the date a service is actually performed, I agree to repay the charge upon request by the administrator.
- I am responsible to reimburse my employer for any benefits received, taxes, penalties or interest that may be imposed if I knowingly violate the terms of the Plan.
- I will only use my debit card for eligible expenses [including “medically necessary” [not cosmetic] expenses as defined in § 213(d) of the Internal Revenue Code]. In addition, I certify that any expenses paid for with my debit card have not been, and will not be reimbursed by any other source.
- I will repay any debit card payment that has been declined by the Plan in a timely manner.
- I am fully responsible for the debit card activity of my spouse or other federal dependent for which I have authorized to receive an additional debit card.
- The administrator has the right and responsibility to temporarily suspend or permanent terminate the use of my debit card(s) should I fail to comply with the rules of the Plan in a timely manner.

Flexible Spending Account (FSA)

Page ___ of ___ (including this claim form)

Reimbursement Claim Form

Custom Benefit Administrators

Employer: Berkeley Unified School District

FAX TO: (916) 303-7083 or (800) 584-4591
EMAIL TO: customerservice@cbadministrators.com

Employee Name: _____

Social Security Number: _____

Phone: _____

E-mail: _____

Dependent Care Expense Claims				
Name & Date of Birth of Dependent(s)	Period Covered		Name, Address, and Taxpayer Identification Number (or SSN) of Service Provider	Amount Incurred
	From	To		
→ Attach a receipt from your daycare provider, or include the daycare provider's signature.			Provider's Signature:	
			Total Dependent Care Expense Claim* \$	

*NOTE: The total amount claimed under the Plan for any coverage period must not exceed the lesser of your earned income for the Plan Year or the earned income of your spouse. (If your spouse is either a full-time student or is incapable of taking care of himself or herself, then he or she is deemed to have monthly earnings of \$250 if there is one (1) child or dependent, or \$500 if there are two (2) or more.) No payment may be made under the Plan if the service provider is your dependent for federal income tax purposes; or is your child or stepchild and is under age 19.

Medical Expense Claims				
Date Expense Incurred (mm/dd/yyyy)	Name of Service Provider	Expense Description (Medical, Dental, Vision, Rx, OTC, etc.)	Person for Whom Expense was Incurred	Net Amount
→ Attach appropriate receipt(s) and submit with this claim form.			Total Medical Care Expense Claim \$	

REQUIRED DOCUMENTATION: All claims must include "complete" – "third-party" documentation. "Complete" documentation must include the: (1) patient's name; (2) service provider's name; (3) full date of service (including year); (4) description of service; (5) charge or patient portion for the service. If you have insurance, your carrier must process your claim prior to being reimbursed from your FSA. An Explanation of Benefits (EOB) from your insurance carrier is considered "complete" documentation. "Third-party" means provided to you by your service provider (e.g. doctor, pharmacy, day care, etc.) or insurance carrier.

CERTIFICATION: The undersigned participant in the Plan certifies that all services for which reimbursement is claimed by submission of this form were provided during a period while the undersigned was covered under the Plan with respect to such expenses and that the expenses have not been reimbursed and employee will not seek reimbursement from any other plan covering health benefits or from any other source. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim, which is provided by the undersigned, and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes, including federal and state income tax, on amounts paid from the Plan which relate to such expense.

***DO NOT USE THIS FORM IF YOU HAVE FILED YOUR CLAIM ONLINE (or used your CBA Debit Card)**

Employee's Signature _____

Date _____

Flexible Spending Account (FSA)

Claim Form & Filing Instructions

When filing your claim, you must include copies of complete “third-party” documentation.

Your documentation must include:

- (1) the service date (including the year);
- (2) the name of the service provider;
- (3) the patient’s name;
- (4) a description of the service provided; and,
- (5) your total financial obligation for the service provided.

A statement from your service provider or an Explanation of Benefits (EOB) from your insurance carrier will usually include all of the required information.

The following documentation/receipts are NOT acceptable for reimbursement:

- Canceled Checks are never acceptable or needed. Please do not send them.
- Cash Register receipts for anything **other than over-the-counter** drugs and medicine UNLESS the patient name is indicated on the receipt.
- Credit Card receipts that do not contain the above (5) requirements.

NOTE: If your claim is returned because your documentation is incomplete or illegible, simply submit a new claim with complete and legible documentation.

You may send your claims to CBA using any of the following methods:

E-MAIL - E-mail claims to: customerservice@cbadministrators.com

You must send us a scanned copy of your signed claim form and documentation as a single file to the e-mail address above in “PDF” format exclusively. No other format can be accepted. Claims that do not meet these requirements may be returned or delayed. Please be aware that e-mailing information over the Internet may not be secure.

FAX - Local - **(916) 303-7083** / Long Distance - **(800) 584-4591**

Please refrain from calling us immediately to confirm receipt of your fax. Faxed claims are not instantly available to our customer service representatives. In most cases, you will be able to view the status of your claims online within 2-business days at www.cbadministrators.com.

MAIL - Mail to: **CBA Claims Processing, P.O. Box 2170, Rocklin, CA 95677**

Please DO NOT mail your claims “signature required” or it could delay your reimbursement up to a week or even more. We cannot be held responsible for mail that is lost or misrouted by the postal service. Mail received “postage due” will be returned.

If you register claims using the online portal, your claims are considered “received” only after CBA receives your supporting documentation.

Regardless of how you choose to send a claim, please send each claim ONCE ONLY. For example, please do not mail a claim that you have already faxed.

Keep a copy of your entire claim for your records.

You may make copies of this claim form for future use.

BERKELEY UNIFIED SCHOOL DISTRICT
PARKING & TRANSIT PLAN REIMBURSEMENT CLAIM FORM
PLAN YEAR JANUARY 1, 2012 through DECEMBER 31, 2012

Section I – Employee Information

Last Name, First Name _____ MI _____ Day Phone _____				Employee SSN □ □ □ - □ □ - □ □ □ □
Address _____ City _____ St _____ Zip _____				Email Address _____
<input type="checkbox"/> Check here if this is a new address				

Instructions

1. Complete Section I – Employee Information. This form can only be used for services incurred during the plan year shown above.
2. **Do not staple any documentation to claim form, please tape to separate sheet or include loosely in envelope. Do not send originals (all claims are stored electronically and paper copies will be shredded).**
3. Complete Section II if you are submitting a claim for **PARKING** expenses. Attach proper documentation showing the date(s) of service and cost of service for the parking expense. Indicate if a receipt is not provided in the normal course of business and sign the affidavit below.
4. Complete Section III if you are submitting a claim for **MASS TRANSIT** expenses. Attach proper documentation showing the date(s) of service and cost of service for the mass transit expense. Indicate if a receipt is not provided in the normal course of business and sign the affidavit below.
5. Complete Section IV - Signing the claim form. Email, Fax, or Mail the signed claim form, but do not send it more than once. Online claims status is available at www.cbadministrators.com.

Section II – Parking Account – (\$240 maximum reimbursement per month during 2012)

Start Date	End Date	Receipt (YES or NO)	Parking Provider	Cost
- -	- -			
- -	- -			
- -	- -			
- -	- -			
Total Parking Account Request				\$

Section III – Mass Transit Account – (\$125 maximum reimbursement per month during 2012)

Start Date	End Date	Receipt (YES or NO)	Transit Agency	Cost
- -	- -			
- -	- -			
- -	- -			
- -	- -			
Total Transit Account Request				\$

Section IV – Signature

To the best of my knowledge and belief, my statements on this claim form are complete and true. I understand that I am solely responsible for the validity of claims submitted to my Parking & Transit Reimbursement Accounts. I am claiming reimbursement only for eligible expenses incurred by myself during the plan year shown above and certify that these expenses have not been reimbursed under this plan or by any other source and that they will not be reimbursed by any other source. By providing my email address, I am requesting that all possible communications regarding this claim may be sent via email. I hereby authorize my Parking and/or Transit Reimbursement Account(s) to be reduced by the amount(s) shown above.	
Participant's Signature X	Date
Expense Certification: I hereby certify that for each expense listed above, for which I have not attached documentation verifying the expense, that a receipt, bill or documentation was not available as part of the normal business transaction from the provider of the service. (2 nd signature required below)	
Participant's Signature X	Date

Send completed form and documentation to:
customerservice@cbadministrators.com (pdf only)
 or FAX to: (916) 303-7083 or toll-free (800) 584-4591

OR

Mail completed form and documentation to:
 Custom Benefit Administrators (CBA)
 P.O. Box 2170, Rocklin, CA 95677

CBA Customer Service: (916) 303-7090 or toll-free (800) 574-5448 - Visit our Web site at www.cbadministrators.com

