LD&B Benefits Administrators

WHAT IS A FLEXIBLE SPENDING ACCOUNT (FSA)?

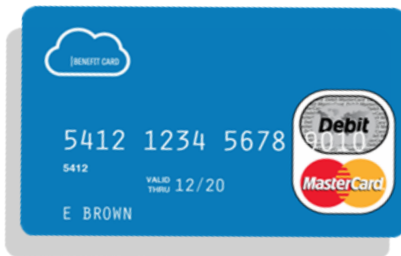
With an FSA, you elect to have your annual contribution (up to the limit set by the IRS) deducted from your paycheck each pay period, in equal installments throughout the year, until you reach the yearly maximum you have specified. The amount of your pay that goes into an FSA will not count as taxable income, so you will have immediate tax savings. FSA dollars can be used during the plan year to pay for qualified expenses and services. Health Care FSA funds are available day one of the plan year; Dependent Care FSA funds are available as they accrue from your pay.

- A **Healthcare FSA** allows reimbursement of qualifying medical, dental, vision and prescription expenses.
- A **Limited Purpose Medical FSA** works with a qualified high deductible health plan (HDHP) and Health Savings Account (HSA). A limited FSA only allows reimbursement for vision and dental expenses.
- A **Dependent Care FSA** allows reimbursement of dependent care expenses, such as daycare) incurred by eligible dependents.

Out-of-Pocket Expenses	Annual Average	Taxes Saved (27% Tax Bracket)
Inpatient Hospital	$1,115	$301
Pharmacy	$555	$150
Outpatient Hospital	$560	$151
Other	$130	$35
Total	**$2360**	**$637**

2 Tax savings is dependent upon your annual income and tax bracket. Example for demonstration purposes only.

Since an FSA is an IRS-regulated plan, there are some important rules to keep in mind when participating. Elections cannot be changed during the plan year without a qualifying life event. Dates of service must be within your plan year dates (see pg. 2 for plan year specifics). Generally, FSA funds can be used for you, your spouse or dependent's expenses. Want to know more? Contact your benefits administrator or visit www.ldbbenefitsadmin.com for more information.



HOW DO I ACCESS MY ELECTION?

LD&B Benefits Cards will be loaded with your new election. **Your card is good for five years; please do not destroy it.** There is a $10 fee for two replacement or additional cards. You will need to activate your card to use it. Please save ALL your benefit card receipts, requests for documentation may be sent via email. If no email address is on file, you will receive the requests via mail.

Your Benefits Administrator: Kristen Gochenour
Phone: 540.437.1468 / Toll-free: 877.532.5478
Email: kgochenour@LDBbenefitsadmin.com

Fax: 540.438.4133 / Toll-free fax: 866.292.8331
205C South Liberty Street
Harrisonburg, VA 22801

About your plan

Hampden-Sydney College

Plan Year: 1/1/2022 to 12/31/2022

**Dates of service must fall within the plan year dates.*

Health Care FSA contribution limit: $2,750.00

- Any monies remaining in your account at the end of the plan year – up to **$550** maximum – will rollover into the new plan year
- Run-Out Period to file claims for the Health Care Account after the end of the plan year: **90 days (until 3/31/2023)**

Dependent Care FSA contribution limit: $5,000.00

- Grace Period to incur expenses for the Dependent Care Account after the plan year ends: **2½ months (until 3/15/2023)**
- Run-Out Period to file claims for the Dependent Care Account after the end of the grace period: **90 days (until 6/15/2023)**
- Unused funds remaining in the Dependent Care Account after the end of the Run-Out Period will be forfeited.

Please complete the attached enrollment form and return to Debbie Herndon in Human Resources by Friday, November 12, 2021.

Visit www.LDBbenefitsadmin.com for more information, including:

- FSA eligible expense list
- Educational videos
- Benefits calculators
- Consumer Portal access
- Mobile App info
- Claim forms
- FSA FAQs
- and more

FLEX ENROLLMENT FORM

Plan Year: 1/1/2022 to 12/31/2022

Name: ______________________________ Employer: Hampden-Sydney College

Address: ______________________________ Email: ______________________________

______________________________ Social Security #: ______________________________

______________________________ Date of Birth: ______________________________

I authorize my employer to make the following salary reductions:

❑ **Limited-Purpose Heath Care Flexible Spending Account (FSA)**

(ELECT IN CONJUNCTION WITH A HIGH DEDUCTIBLE HEALTH PLAN & HSA)

I elect to have $____________ annually, ($____________ per pay period) reduced from my salary before taxes to reimburse me for eligible expenses I incur during the plan year specified above that are not covered under my qualified High Deductible Health Plan (such as dental and vision). I further authorize my employer to reduce from my salary the amount of any improper or unsubstantiated expenses that are paid from my health care reimbursement account.

❑ **Traditional Health Care FSA**

(DO NOT ELECT IF YOU PARTICIPATE IN A QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN & HSA)

I elect to have $____________ annually, ($____________ per pay period) reduced from my salary before taxes to reimburse me for eligible health care expenses I incur during the plan year specified above. I further authorize my employer to reduce from my salary the amount of any improper or unsubstantiated expenses that are paid from my health care reimbursement account.

❑ **Dependent Care FSA**

I elect to have $____________ annually, ($____________ per pay period) reduced from my salary before taxes to reimburse me for eligible daycare expenses I incur during the plan year specified above.

Note: Reimbursement from this (and other dependent care plans for which I may be eligible) is limited to $5,000/year or $2,500/year if I am married filing separately. Reimbursement is further limited to earned income or my spouse's earned income, whichever is less.

I understand that:

- I cannot change this election during the plan year unless I have a change in family status.
- Any amounts remaining in my reimbursement accounts at the end of the year will be forfeited unless my employer has elected the carryover option (please check your plan design for specifics regarding how the carryover works). Participants who enroll in a HDHP with HSA and have balances in the FSA at the end of the plan year will forfeit their carryovers unless the employer offers an HSA compatible health FSA.
- My Social Security benefits may be reduced by this election.
- This election replaces any previous elections and will terminate on the earlier of: 1) the end of the plan year, 2) when I am no longer a qualified employee eligible to participate in the plan, 3) termination of the plan.
- My employer may reduce or cancel this election if necessary to comply with provisions of the Internal Revenue Code.

I further understand, with regard to LD&B Benefits Card transactions, that:

- Once I receive my benefits card, I will only use it for payment of qualifying health and dependent care FSA expenses for myself or my eligible dependents.
- Any expense that I pay with the benefits card will not have been reimbursed, nor will I be seeking reimbursement, under any other plan or program of benefit coverage.
- I must save all invoices and receipts for any expenses I pay with the benefits card and upon request, will submit these documents for review by the plan.
- If I make an improper payment from my benefits card or fail to provide documentation to my employer as required, the amount of such payments must be reimbursed to my employer. If I fail to reimburse my employer, my salary may be reduced by the employer in the amount of the improper payment.
- Each time I use or permit my benefits card to be used for payment, I will renew and reaffirm the "My Use of Card Promises" that I will receive with the benefits card.

Due to HIPAA regulations, LD&B is not allowed to discuss your account with your spouse or dependents (18 and older) unless you sign this form and list them below. To allow LD&B to release information to your spouse or dependents (18 and older) regarding processing claims, content of claims, account balances, and any other information regarding your accounts, please list them below.

Signature: ______________________________ Date: ______________________________

Spouse: ______________________________ Dependent(s) (18 and older): ______________________________

TO BE COMPLETED BY EMPLOYER

Eligibility Date: ____________________ Salary Reduction to Begin on Payroll Date: ______________________________

Accepted By: ______________________________ Date: ______________________________