2024 Payroll Deduction Authorization

EMPLOYER:	
NAME:	**SSN:**
ADDRESS:	
EMAIL ADDRESS:	

EFFECTIVE PERIOD
JANUARY 1, 2024 THROUGH DECEMBER 31, 2024

Type of Reimbursement	Deduction Per Pay Period	Total Deduction For Year
Medical/Dental/Vision Reimbursement (max $3,200/yr)		
Dependent Care Reimbursement (family max $5,000/yr)		

PLEASE READ THE FOLLOWING THEN SIGN AND DATE BELOW:

I Understand The Following And Agree To The Terms:

1. Federal regulations state that I must remain a participant for the entire 12-month period unless I terminate my employment.

2. To participate, I must complete a new Payroll Authorization form for each new Plan Year.

3. The amounts I have elected to have deducted for medical/dental/vision expenses and/or dependent care expenses are allocated to separate accounts. If there are any monies remaining in either account at year-end, the monies are not transferable to meet expenses in the other account.

4. I cannot increase or decrease these deductions during the Plan Year unless I experience a qualifying change in status permitted under the terms of the plan.

5. I understand that I cannot submit claims with a date of service prior to January 1, 2024 or after March 15, 2025.

6. I understand that I have until April 15, 2025 after the extended deadline of the Plan Year to submit claims to Benefit Administrators, Inc. for reimbursement. Any monies remaining in this account after that date and after all eligible expenses have been reimbursed from my account will be forfeited.

7. I hereby authorize the company to reduce my compensation in the amounts stated above for the period of January 1, 2024 through December 31, 2024.

8. I understand that I must submit copies of ***itemized receipts or statements*** to Benefit Administrators, Inc. for any and all covered services in order to receive reimbursement from the Plan.

I certify, with my signature below, that I have examined this form and understand the above-stated information. I further certify that to the best of my knowledge and belief, the information I have supplied is true, correct and complete.

Signature _____ Date _____

EMPLOYEE SURVEY FORM FOR FLEXIBLE SPENDING PLANS

A section of the Internal Revenue Code allows you to increase your bottom line, pay less taxes, and therefore, have more income. This can be done by redirecting your taxable income to a non-taxable status to help you pay for certain expenses, such as unreimbursed medical, dental, vision, and childcare expenses.

1. ESTIMATE YOUR UNREIMBURSED MEDICAL, DENTAL, AND VISION EXPENSES:

All Insurance Deductibles ..... $ _____

All Co-Payments, co-insurance ..... $ _____

Prescription Drugs Co-Payments
(Including birth control) ..... $ _____

Dental Care
(Such as examinations, cleaning, x-rays, fillings, crowns, braces, etc.)..... $ _____

Vision Care
(Eye exams, contacts, eyeglasses) ..... $ _____

Other Eligible Expenses
(visit www.benefitadministrators.com for a list of eligible expenses)..... $ _____

TOTAL OF MEDICAL, DENTAL, AND VISION EXPENSES ..... $ _____

2. ESTIMATE YOUR DEPENDENT CARE EXPENSES ANNUALLY:

If you are a single parent or if your spouse works, how much do you pay annually for Dependent Day Care for children 12 years or younger? ..... $ _____

3. TOTAL SECTION (1) AND SECTION (2)* ..... $ _____

*This is the amount you may wish to deposit into the Reimbursement Account. Please be conservative when choosing an amount, as any unused dollars in your account at the end of the plan year must be forfeited.

Remember, to receive reimbursement, you must submit a copy of the itemized statement or EOB that includes the patients name, date of service, description of service, reimbursement amount and provider name. For the over-the-counter medications, please circle item name, amount paid, and date of purchase on the receipt. If the receipt does not include the place of purchase, please include the name.

Flexible Spending Account (FSA) Questions and Answers

What is a Flexible Spending Account (FSA)?

A Flexible Spending Account is an employer benefit that allows you to set aside money from your paycheck on a pre-tax basis to pay for health care and/or dependent care expenses.

How does it benefit me?

The money you set aside in your account is deducted from your gross pay BEFORE the following taxes are calculated: Federal Income tax, Social Security, Medicare, State and Local tax.

How do I elect to participate?

To participate, estimate your expected unreimbursed medical, dental, and childcare expenses for the plan year, then complete and sign a Payroll Authorization Form. The specified amount will be deducted uniformly from each paycheck throughout the Plan Year.

What type of expenses qualify as covered expenses for reimbursement?
(visit www.benefitadministrators.com for a comprehensive list)

Medical FSA Covered Expenses:

- Medically necessary expenses you have incurred and paid which are not reimbursed by any insurance plan. Treatment or prevention must be prescribed by a physician.
- Medically necessary dental expenses you have incurred and paid which are not covered or reimbursed by any dental program.
- Corrective vision care expenses incurred and paid which are not reimbursed by any insurance plan.
- Specialty foods will only be reimbursed for *the difference in cost* between the unaltered food and the specialty food version, and only for foods that do not require an alteration to safely consume with a Letter of Medical Necessity from a physician.
  *Example #1: If the food is naturally gluten-free and not requiring an altered version to safely consume, it is NOT considered eligible.
  *Example #2: If loaf of regular white bread costs $1.99 and the gluten-free white bread version costs $4.99 you can only be reimbursed for the $3.00 difference (not the entire $4.99 cost of the gluten-free version). The employee must submit their receipts with the specialty items circled and the cost of the unaltered food item written beside it from a vendor of their choice.
- Gym memberships/personal training and nutrional/weightloss subscription services are only eligible for reimbursement with a Letter of Medical Necessity from a physician.
- A Letter of Medical Necessity (LOMN) must contain the name of the patient, description of medical condition, description of recommended treatment (including the specific service/item, frequency and/or dosage, and duration of treatment).

Dependent Care FSA Covered Expenses:

- Dependent care expenses such as daycare, after school care, in home care, etc. to enable you and your spouse to work, actively look for work, or attend school full-time.

Who can my FSA funds be used for?

Medical FSA funds can only be used for you and your dependents claimed on your taxes. Dependent Care FSA reimbursements are for those dependents up to age 13, or adult dependents who are claimed on your federal tax return.

When are my funds available?

Medical FSA funds are available to you on the first day of the benefit period. Dependent Care FSA funds become available only as contributions are made through your payroll deductions and are not available on the first day of the benefit period.

How do I file a claim to be reimbursed for medical, dental, vision, and day care expenses?

Complete a Claim Supporting Statement then send it with a copy of the **itemized statement or Explanation of Benefits (EOB) that includes the patients name, date of service, description of service, reimbursement amount and provider name** to Benefit Administrators, Inc. (BAI). Claims supporting statements can be found on our website www.benefitadminstrators.com

What items are not acceptable documentation and should not be submitted with the Claims Supporting Statement to request reimbursement?

Documentation including cash register receipts for prescriptions, receipts from debit/credit card machines, and cancelled check copies are not acceptable documentation.

For prescriptions, please submit the prescription bag tag that contains all the information needed to process for reimbursement instead of the cash register receipt. You can also submit a printout from the pharmacy with your prescriptions listed instead of submitting each individual bag tag.

How do I submit my Claim Supporting Statement and itemized statement or EOB?

There are 4 ways to submit

1. Snap Claim Submission*: my*RSC Mobile App
2. Email: thr.hb.FSA@hubinternational.com
3. Fax: 814-459-2250
4. Mail: BAI: Spending Account, 1250 Tower Lane, Erie, PA 16505

How are claims processed?

Claims are processed by the date the service is performed, not the date they are billed or paid. This standard is set by the IRS who governs the regulations for the flexible spending account.

When am I reimbursed for eligible expenses?

Your employer has chosen the frequency that your group's claims are processed. If your reimbursements are received via paper check via USPS, you can anticipate receiving it within 7-10 business days of your processing date. If you have questions about your processing date, please contact FSA Customer Service.

Who do I contact if I have questions about my FSA?

You can contact our FSA Customer Service department by email at thr.hb.FSA@hubinternational.com, by phone at 814-454-0167 or 800-777-2524 or by fax at 814-459-2250. The Customer Service hours of operation are 8:00AM to 4:00PM Monday-Friday, excluding most major holidays.

You can also access your FSA account online at www.*my*RSC.com or in the *my*RSC mobile app. Here you can view claims, manage personal information, and check account balances.

When do I get my money back if I do not have as many expenses as I originally estimated?

You have an additional 2 ½ months after the end of the plan year to pay for non-covered or unreimbursed medical costs or dependent care expenses. If your expenses in any year do not equal your account balance after this extended deadline, any remaining balance is forfeited to the employer. You have 30 days after the end of the extended deadline to submit your receipts for reimbursement.

Can I change my Reimbursement Account payroll deductions once I have started the plan?

You may change your deductions annually. You can increase, decrease, or stop your deductions during the plan year ***only*** if you have a status change, i.e., birth, death, loss of job, marriage, divorce.

Where can I find more information?

Please visit the Benefit Administrators, Inc. website at www.benefitadministrators.com or reach out to our customer service department at thr.hb.FSA@hubinternational.com

mySourceCard® Enrollment Agreement

As a participant in one or more of your Employer Plans or as an account holder under the FSA program, you will receive a mySourceCard® MasterCard® Debit Card issued by Benefit Bank, and agree to use it according to this Agreement and the Cardholder Agreement that will be provided to you with the Card.

You understand that the Card is restricted to certain merchant categories and is not accepted at all MasterCard® acceptance locations. You understand that you may not obtain a cash advance with the Card at any merchant, bank or ATM. You understand that the Card is to be used ***exclusively*** for Qualified Expenses as defined by the plan(s) in which you participate. If the Card is issued pursuant to Employer Plans and you use the Card for an expense that is not a Qualified Expense, you are indebted to your employer and must repay the full amount of the non-qualified expense.

You agree to save all invoices and receipts related to any expense paid with the Card; upon request you must submit these documents for review by the Plan Service Provider. Failure to submit the receipt(s) will cause the expense to be treated as a non-qualified expense and you will be required to remit payment to your employer. Payment may be in the form of an offsetting claim, a personal check, electronic draft from your personal checking or savings account, a post-tax deduction from your paycheck, or other options established by your employer.

Please Note: Additional terms and conditions would apply if you use the Card to access your funds in your FSA under the FSA program. In such event, these additional terms and conditions would be set forth in an FSA Addendum to your FSA custodial account agreement.

For proper Cardholder Identification, please complete the following information.
Your Card will not be issued until this form is received by your Plan Service Provider.

Name on Card: _____
21 characters maximum including spaces

Address: _____ City:_____ State: _____ Zip: _____

Social Security Number:_____ Date of Birth:_____ Home Phone: _____

Email Address: _____

Name on Second Card (Please Print) _____
21 characters maximum including spaces

Mother's Maiden Name (Security purposes only):_____

Signature: _____ Date: _____

ALL FIELDS ARE REQUIRED

For Official Use Only

Plan Service Provider Initials:	Receive Date:	Process Date:

Flex Debit Card / *my*SourceCard®

Flexible Spending Plan Questions and Answers

What is a Flexible Spending Account debit card?

A FSA debit card also referred to as "*my*SourceCard®"

The *my*SourceCard® debit card is a debit MasterCard which has full access to the funds in your Medical Flexible Spending Account (FSA) and used to directly pay an eligible provider or merchant for IRS eligible expenses. You do not need to use your out-of-pocket funds to pay for the expense and then request a reimbursement.

How does the *my*SourceCard® debit card work?

You will present the card to the qualified merchant or provider. They will then swipe the card to pay for the purchase or service. You can use the debit card to pay for office visit co-pays, deductibles, co-insurance, glasses, prescription co-pays, and non-cosmetic dental expenses. These expenses may be for you, your spouse or your dependent(s).

When can I start to use the *my*SourceCard® debit card?

Before using your card, you must activate and sign your card. Just follow the instructions you receive with your card. You also must wait until your effective date in the Flexible Spending Account plan to use the card.

How is this different than a credit card?

The *my*SourceCard® debit card utilizes funds from your Medical Flexible Spending Account (FSA) and can be used only for qualified expenses. Even though this is an off-line debit card, it is treated as a credit card at the merchant or provider's terminal. There is no PIN number required to approve the transaction.

Can I use my card when ordering my prescriptions through an online or mail order program?

Yes, you can use your *my*SourceCard® debit card. You use it just like any other credit card. You simply provide your *my*SourceCard® information in the space provided for the credit card information.

Can I use the *my*SourceCard® to pay for a service before it is provided?

No. The IRS regulation states that the service must be provided *before* using any FSA funds.

Can I use my card to pay for services that were provided prior to participating in the Flexible Spending Account plan year?

No. The IRS regulations states that the *date of service* determines the eligibility of the expense, not the date billed to the participant, or the date paid.

Does the *my*SourceCard® work for my dependent care (daycare) expenses?

No. It only works for Medical Flexible Spending Account eligible expenses.

Do I need to submit paper receipts in addition to the card being swiped?

No, you do not need to submit paper receipts if the card is swiped at a qualified merchant or provider's terminal. The only time you will have to submit paper receipts is in the event of a questionable expense. *It is very important to save your receipts in case a question should arise.*

Is there any reason why the card would not be available to me?

Yes, if you do not have enough funds in your FSA for your purchase, if the debit card system is not working, or any other unique circumstance. Your *my*SourceCard® will be deactivated if you become a terminated employee or are negligent in responding to requests from Benefit Administrators, Inc. (BAI) to submit receipts or repay the plan for any ineligible reimbursements, your card will be deactivated. Also, if you choose not to participate in Flexible Spending Account the following year, the card will be deactivated.

Can I get a second card for my spouse?

Yes, you can request a second card for your spouse or dependent child by completing the application and forwarding the completed application to Benefit Administrators, Inc. (BAI) 1250 Tower Lane, Erie PA 16505 Attn: Flexible Spending Account or **email to thr.hb.FSA@hubinternational.com**

What if my card is lost or stolen?

You should contact Card Services immediately at (814) 454-0167 or 800-777-2524 to deactivate the card.

Will I get a new card automatically each year?

No. The *my*SourceCard®card is good for 38 months, as long as you are enrolled in the plan. Once you use all your funds for each year, save the card for the next plan year. At that time, the amount you have elected for that plan year will be available to you the first day of the plan year. If you are a current participant when your card expires, you will automatically be issued a new card.

Can I still submit paper receipts for reimbursement for expenses that are paid for with my out-of-pocket funds, even if I have the debit card?

Yes. Complete a Claim Supporting Statement then send it with a copy of the **itemized statement or EOB that includes the patients name, date of service, description of service, reimbursement amount and provider name** to Benefit Administrators, Inc. (BAI). Claims Supporting Statements can be found on our website www.benefitadministrators.com

Benefit Administrators, Inc.
1250 Tower Lane
Erie, PA 16505

Phone: (814) 454-0167
Fax: (814) 461-9402

FLEXIBLE SPENDING PLAN
CLAIM SUPPORTING STATEMENT

Employer's Name	
Employee's Name	**SSN** (last four)
Address	
Email	

Enclosed are copies of all supporting documents, receipts, vouchers, etc., to document the expenses listed below. The original receipts have been retained for my records.

Medical/Dental/Vision Reimbursements	$
Dependent Care Reimbursements (day care)	$

Any unused amounts in my account will be forfeited at the end of the plan year. I certify that I have not requested reimbursement under this plan or from any other source for these charges.

I CERTIFY that the above information is correct and complete.

Signature Date

PLEASE KEEP A COPY OF THIS CLAIM FORM AND SUBMITTED RECEIPTS FOR YOUR RECORDS

Submit your claim(s) one of three ways:

Email: thr.hb.FSA@hubinternational.com, **Fax:** 814-461-9402, **USPS: BAI: Spending Account, 1250 Tower Lane, Erie, PA 16505**

STOP!

BEFORE YOU SUBMIT YOUR FSA OR DEPENDENT CARE CLAIM(S), PLEASE TAKE A MOMENT TO VERIFY THAT ALL OF YOUR DOCUMENTATION SATISFIES THE FOLLOWING REQUIREMENTS; OTHERWISE, YOUR ENTIRE CLAIM MAY NOT BE PROCESSED IF IT HAS TO BE REUTRNED FOR INSUFFICIENT DOCUMENTATION.

1. Provider/Merchant Name
2. Patient/Dependent Name
3. Date(s) of Service (NOT date of payment)
4. Description of Service/Purchase
5. Amount owed/due/paid

Please list the FSA eligible expenses for reimbursement

Date of Service	Claim Type	Amount
TOTAL		$ 0.00