



Wellmark Blue Cross Blue Shield of Iowa
Wellmark Blue Cross Blue Shield of South Dakota

Independent Licensees of the Blue Cross and Blue Shield Association

Flexible Benefits
PO Box 14585
Des Moines, Iowa 50306-3585
For questions or assistance with this form, call (800) 624-2755 ext. 4661 or 5209 Fax (515) 376-9002

For forms and information, visit our website at www.wellmark.com/flex

Reimbursement Account Flexible Benefits Employer Application

General Information

Form fields for General Information: Full Legal Name of Employer, Federal Tax I.D., Street Address, City, State, Zip Code, Contact Person, Contact Phone, Contact Fax, E-Mail Address

Business Entity: [] C. Corporation [] LLC [] Subchapter S [] Partnership [] Proprietorship [] Tax-Exempt Employer

List any subsidiaries or affiliates to be included in this plan. If more space is necessary, attach a separate sheet.

Name _____ Federal Tax I.D. _____

Effective Date of the Plan

Administration of this plan will begin on ____/____/____ and end on ____/____/____.

(The plan year shall mean a 12 month period. The initial plan year may be less than 12 months.)

If a plan is now in place: current plan year is ____/____/____ to ____/____/____. Original eff. date ____/____/____.

Termination Employees

Employees who terminate employment are considered terminated on:

- [] The date of termination
[] The first of the month following the date of termination

Benefits to be Offered Under the Plan

A. [] Pre-Tax Premium for: [] Medical [] Dental [] HSA [] Prescription drugs [] Term Life insurance
[] Disability [] Cancer [] Vision [] Accident [] Other _____

All premiums through payroll deduction will be pre-taxed.

B. [] Medical Reimbursement Account (both General Purpose and Limited Purpose Accounts)

Maximum \$ _____ Minimum \$ _____

Automatic reimbursement option will be provided according to the details on the back of this application.

C. [] Dependent Care Reimbursement Account Maximum \$5,000 Minimum \$ _____

D. [] Pre-Tax Contribution to Health Savings Account (HSA): If pre-tax HSA contributions are elected, a Participant may change their contribution election:

- [] By filing a new election form pursuant to the administrative rules established by the Employer
[] Only in connection with a Change in Status of other event permitting benefit elections to be changed mid-year under the Plan

E. [] Cash Option/Flexible Credits: Each Plan Year a Participant may elect to receive in cash up to \$ _____ of the Flexible Dollars, if any, allocated by the Employer to the Plan for the benefit of the Participant.

F. [] Prepayment of Orthodontia Claims Option (see the back of this application for more details)

G. [] The Qualified Reservist Distribution is available for Reservist's Medical Expense Reimbursement Account.

Reimbursement Account Processing

For both Medical and Dependent Care Reimbursement Accounts:

- For non-register groups, disbursements will be processed bi-weekly OR weekly.
- Bi-weekly processing for register groups.
- Direct Deposit of disbursements will be available to all employees.
- All IRS qualified status changes will be allowed for election changes during the plan year.
- All expenses allowed by the IRS will be eligible except for Limited Purpose Medical Reimbursement Accounts.
- Check minimum during the plan year is \$25.
- Claims runout period should be specified below where noted. This is generally 90 days after the end of the plan year unless you are adopting the grace period. If offering Blue Priority HRAs, run out period is 180 days after the end of the plan year.

Grace Period Processing Information

Claims grace period following the end of the plan year: Yes No

If Yes: Length of grace period _____ months, which is _____ (date).

Maximum is 2 ½ months following the end of the plan year.

Grace Period will apply to:

Both Medical & Dependent Care Reimbursement Accounts

Claims run out period following the end of the grace period (or following the end of the Plan year if you do not choose to use a grace period)

90 days, which is ____/____/____ (date)

120 days, which is ____/____/____ (date)

Eligibility

Note: Notwithstanding the below, the following Employees can not participate in the Plan, based on the Internal Revenue Code and the Plan terms: self-employed individuals described in Code section 401(c), "2-percent shareholders" of an S corporation (and their family members), sole proprietors, partners in a partnership, and individuals classified by the Employer as independent contractors.

All Employees shall be eligible to participate in the Plan except the following Employees shall *NOT* be eligible to participate:

- No exclusions
- Employees who have not attained age _____
- Employees who have not completed _____ days/months/years of service
- Employees who do not work as least _____ hours per week on a regular basis
- Employees covered under a collective bargaining agreement (Note: If the Employer excludes union employees from the Plan by checking this box, the Employer must be able to produce evidence that welfare benefits were the subject of good faith bargaining)
- Commission salespersons
- Employees compensated on an hourly basis
- Employees compensated on a salaried basis
- Employees who are temporary or seasonal, or who are employed with the understanding that their employment is for a specific period of time or will be terminated upon completion of a specific project
- Other employees (specify) _____

Forfeitures of Medical Expense Reimbursement Accounts

Forfeitures shall be used first, to offset any losses experienced by the Employer as a result of making reimbursements in excess of contributions paid by participants, and then as follows:

- Reduce the cost of administering the Medical Expense Reimbursement Account during the plan year and the subsequent plan year.
- Reduce salary reduction amounts (commonly referred to as a "premium holiday") for the immediately following plan year on a reasonable and uniform basis.
- Increase the annual benefits or coverage amount for the immediately following plan year on a reasonable and uniform level.
- Allocate to participants in cash.
- The Plan Administrator, at its discretion, will determine each year how to apply the forfeitures based upon the permissible uses under the IRS regulations and ERISA.

Forfeitures of Dependent Care Expense Reimbursement Accounts

Forfeitures shall be used first, to offset any losses experienced by the Employer as a result of making reimbursements in excess of contributions paid by participants, and then as follows:

- Reduce the cost of administering the Dependent Care Expense Reimbursement Account during the plan year and the subsequent plan year.
- Reduce salary reduction amounts (commonly referred to as a "premium holiday") for the immediately following plan year on a reasonable and uniform basis.
- Increase the annual benefits or coverage amount for the immediately following plan year on a reasonable and uniform level.
- Allocate to participants in cash.
- The Plan Administrator, at its discretion, will determine each year how to apply the forfeitures based upon the permissible uses under the IRS regulations and ERISA.

Plan Entry Date

Employees who have met the eligibility requirements may become Participants in the Plan as of such Effective date.

An Employee who meets the eligibility requirements may become a Participant (please choose one of the following):

- On the first of the month following the date of hire.
- On the first date of the first payroll period following the date on which the employee meets the eligibility requirements of the Plan.
- On the first day of the first month following the date on which the employee meets the eligibility requirements of the Plan.
- _____ number of days / months / years (please circle one) following the date on which the employee meets the eligibility requirements of the Plan.
- Immediately on the date on which the employee meets the eligibility requirements of the Plan.
- Other (please specify the waiting period) _____

Definition of Compensation

Following is the generally accepted definition of compensation: the total amount of all payments made by, or on behalf of, an Employer to an Employee for services rendered to the Employer, including bonuses, commissions, overtime pay and salary reduction contributions made under the Flexible Benefits Plan or any other plan of the Employer, but does not include expense reimbursements, fringe benefits provided by the Employer, director's fees, severance pay, contributions made by the Employer for group insurance, self-insured benefits, or to any employee benefit plan.

The above definition is satisfactory OR is not satisfactory.

If not, specify your acceptable definition: _____

Payroll Deduction Schedule

Flex deduction information is vital to the proper administration of your plan. These dates are used to post flex deductions to your employees' accounts on the dates in which the deductions are actually taken from the employees' payroll check. Timely notifications of any deduction change is crucial to make sure that flexible benefit claims are paid correctly and timely for your employees. If a deduction date falls on a holiday, your flexible benefit deductions will be processed the prior business day.

Total Number of Different Flex Deduction cycles for the plan year: _____

Complete deduction schedule information for each deduction cycle identified above. If more than three, attach a separate sheet. If "Other", submit a separate sheet listing each deduction date for the plan year.

1. Deduction Cycle (select one):

- Monthly (12) Monthly (9) Weekly (52) Bi-weekly (26)
- Bi-weekly (24) Semi Monthly (24) Semi Monthly (18) Other

First deduction date: ____/____/____ Second deduction date: ____/____/____ Last deduction date: ____/____/____

Dates deductions are not taken: ____/____/____, ____/____/____, ____/____/____, ____/____/____

Payroll Deduction Schedule (cont)

2. Deduction Cycle (If applicable, select one):

- Monthly (12) Monthly (9) Weekly (52) Bi-weekly (26)
 Bi-weekly (24) Semi Monthly (24) Semi Monthly (18) Other

First deduction date: ____/____/____ Second deduction date: ____/____/____ Last deduction date: ____/____/____

Dates deductions are not taken: ____/____/____, ____/____/____, ____/____/____, ____/____/____

3. Deduction Cycle (If applicable, select one):

- Monthly (12) Monthly (9) Weekly (52) Bi-weekly (26)
 Bi-weekly (24) Semi Monthly (24) Semi Monthly (18) Other

First deduction date: ____/____/____ Second deduction date: ____/____/____ Last deduction date: ____/____/____

Dates deductions are not taken: ____/____/____, ____/____/____, ____/____/____, ____/____/____

Administrative Fees

Standard flexible benefits services will be performed according to the fees agreed upon below:

Annual administrative fee: \$ _____

Please select paper or PDF enrollment materials to determine applicable Administrative Services Fee:

- Paper enrollment kits \$ _____
 PDF files of enrollment materials \$ _____

This annual fee includes consulting, IRS non-discrimination testing, standard plan documents, enrollment materials, and plan set up*.

Monthly claims processing fee : \$ _____/participant

- Bill me annually
 Bill me monthly

* An additional charge may be incurred for modifications to our standard documents. Enrollment materials are based on number of eligibles plus 25%; any additional materials will be charged at cost. Forms and brochures are available in PDF format upon request.

Funding Options Available

Wellmark Blue Cross and Blue Shield will not accept transfer of funds from plan sponsors until after it has reviewed and determined the validity of benefit claims. Because funds will not be transferred to Wellmark Blue Cross and Blue Shield until required to pay approved benefit claims, plan sponsors may need to accumulate funds collected through payroll deduction in a segregated account owned by the plan sponsor. The account should not be titled in the name of the plan in order to avoid characterization of funds in the account as plan assets.

- All Flex Benefit payments, whether paid by check or direct deposit, will be made from a bank account maintained by Wellmark's Flexible Benefit Department. No reimbursements will be released until plan sponsor funds are received by Wellmark Blue Cross and Blue Shield

For funding of the benefit payments, plan sponsor must choose one of the following:

- Authorize Wellmark's Flexible Benefit Department to initiate an ACH withdrawal of funds from the plan sponsor's bank account into a bank account maintained by Wellmark's Flexible Benefit Department. An ACH Funding Authorization Form will need to be completed.
- Plan sponsor will wire transfer/ACH funds into a bank account maintained by Wellmark's Flexible Benefit Department (we will supply our banking information)
- All benefits, whether paid by check or direct deposit, will be made by the plan sponsor (termed a "register" group). Wellmark's Flexible Benefit Department will provide a report detailing participant reimbursement amounts.

Note: If a plan sponsor chooses ACH fund transfers to fund payment of benefits, the funds transfer will be initiated and effective the day prior to the day benefit claims are paid in order to ensure funds are received prior to payment of benefits. Wellmark Blue Cross and Blue Shield will not release disbursements until plan sponsor funds are received.

Claim payment notification should be sent to _____ via email. Please provide the email address for the above person _____. To ensure this information is received by plan sponsors in the event that the above person is out of the office, please provide the name and email of a back up person to whom the information can be sent: _____

Enrollment Information

Employer will prepare their own enrollment materials using PDF's provided by Wellmark. Please send these PDF's via email to _____.

Wellmark will prepare enrollment materials based on the following information.

Number of eligible employees: _____ Number of enrollment brochures needed: _____

Send enrollment materials to (name): _____ by date: ____/____/____

Employees should return enrollment forms to (name): _____ by date: ____/____/____

Assistance requested for enrollment meetings: Yes No

Date(s) scheduled for employee meeting(s) if known: ____/____/____

ERISA Plan Number

If this plan has chosen to have Medical Expense Reimbursement ERISA Plan Number assigned to the portion of the Plan representing health care reimbursement is (check one)

501

Other _____

Additional Options

Automatic Reimbursement Option

This option allows eligible* medical expenses that have been submitted to your employees' Wellmark Blue Cross and Blue Shield health insurance plan to also be considered as a Medical Reimbursement Account claim. After claims are processed by Wellmark Blue Cross and Blue Shield any remaining unpaid eligible medical expenses will automatically be directed to their Medical Reimbursement Account for further consideration. This option is not available for Limited Purpose Medical Reimbursement Accounts (i.e., if your employee, their spouse, or dependents make contributions to an HSA or receive HSA contributions from anyone else)

Program provisions include:

1. **If you offer a Partial Self-Funded plan or do not have Wellmark health coverage you will not be able to utilize this option.**
2. **Employees may not participate in this program if they, their spouse, or dependents make contributions to an HSA or receive HSA contributions from anyone else. However, participants with a Blue Priority HRA can still participate.**
3. Employees may not participate in this program if they or anyone in their family has other insurance coverage.
4. If a health insurance claim is adjusted after the original submission, there is a possibility of an incorrect payment. Overpayments will be requested to be returned from participants or offset against future claim submission when possible.
5. Individual Employee authorization is needed to select this option. Employee authorization can be selected on the enrollment form.

Claims to be automatically reimbursed can include any of the following plans **administered** by Wellmark Blue Cross and Blue Shield:

- Medical *OR* This option is not applicable as we currently offer partial self-funding or do not have Wellmark health coverage.
- Blue Dental
- Prescription Drug Plan

* Only co-payments, co-insurance, and deductibles are eligible to be reimbursed through the automatic reimbursement program. Contract limitations need to be filed manually by the participant.

Prepayment of Orthodontia Claims Option

This option provides employees with the ability to have eligible pre-paid (i.e. not yet incurred) orthodontia expenses reimbursed from their Medical Reimbursement Accounts instead of reimbursing the pre-paid amount as services are rendered during the term of the orthodontia contract. If this option is selected, it will be available for all employees. Please note: It is recommended by IRS Prop. Treas. Reg § 1.125-2 that the reimbursement of orthodontia expenses not occur until services are actually rendered to avoid violating the "expense incurred" requirement. The more liberal approach offered by this option which reimburses orthodontic costs when they are paid is based on informal, non-binding remarks of an IRS representative at a Cafeteria Plan Administrators Symposium in 2001. There is no formal authority which endorses the payment of medical expenses prior to the time services are actually rendered.

Qualified Reservist Distribution

If provided in the Adoption Agreement, effective June 17, 2008, a Participant may request all or any portion of a Participant's Medical Expense Reimbursement Account if (a) the Participant is a Reservist called to active duty for a period of at least 180 days or for an indefinite period; and (b) the distribution is made during the period beginning with the call to active duty and ending on the last date reimbursement of expenses could otherwise be made for the Plan Year that includes the date of the call to active duty. For this purpose, a Reservist is a participant who is a member of a reserve component, defined as the Army National Guard of the United States of America, the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air National Guard of the United States, the Air Force Reserve, the Coast Guard Reserve, or the Reserve Corps of the Public Health Service.

Service Agreement

I certify that I am legally authorized to sign this flexible benefits employer application on behalf of the employer named herein. The employer hereby agrees to purchase those services indicated on this application at the cost provided in the flexible benefits proposal or fee schedule. The cost quotation provided to the employer was calculated based upon certain representations previously made by the employer including, but not limited to, the flexible benefits services requested by the employer and the number of eligible participants. Wellmark Blue Cross and Blue Shield reserves the right to revise the cost quotation previously provided to the employer if such representations differ from the flexible benefits plan implemented by the employer. A minimum fee of \$150 will be payable if an application is processed but subsequently cancelled.

Signature: _____ Title: _____ Date: ____/____/____

Wellmark Blue Cross and Blue Shield Representative: _____

Broker Name: _____ Company/Agency: _____