



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

Flexible Benefits
PO Box 14585
Des Moines, Iowa 50306-3585

BluePriority HRASM

For questions or assistance with this form,
call (800) 624-2755 ext. 4661 or 5209
Fax (515) 376-9002

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

Health Reimbursement Account Employer Application

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: <input type="checkbox"/> C. Corporation <input type="checkbox"/> LLC <input type="checkbox"/> Subchapter S <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship <input type="checkbox"/> Tax-Exempt Employer			

List any subsidiaries or affiliates to be included in this plan:

Name _____ Federal Tax I.D. _____

Name _____ Federal Tax I.D. _____

Effective Date of the Plan

Date you would like us to begin administration of this plan: _____

(This must mirror your Health Plan and FSA plan, it must run concurrent)

The coverage period shall mean period ending annually every: _____

(Short plan year acceptable if runs concurrent with health plan year)

Benefits to be Offered Under the Plan

Designated Health Plan	Coverage	Annual HRA Dollar Allocation		
	Employee Only	Two-Person Coverage	\$	\$
	Family Coverage	Other Coverage_____	\$	\$
	Employee Only	Two-Person Coverage	\$	\$
	Family Coverage	Other Coverage_____	\$	\$
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	Family Coverage	Other Coverage_____	\$	\$

- There are no federal income tax law contribution limits, however, employers typically allocate an amount equal to or less than the amount of the health plan deductible.
- The plan must be funded solely by the employer and cannot be funded by salary reduction.

Health Reimbursement Account Processing

For the Health Reimbursement Account:

- Checks will be processed bi-weekly or weekly, if funds received electronically (aligning with Flexible Spending Account processing if providing that option)
- If participant has both an FSA and HRA the order of payment will be:
 - FSA pays first
 - HRA pays first
- Check minimum during the plan year is \$25.00
- The run out period will be 90 days (if providing the Flexible Spending Account Option, run out period will need to be 90 days as well)
- Direct Deposit of reimbursements will be available to all employees
- Yes No HRA funds remaining at end of plan year will be rolled to subsequent plan year.

Any requests for non-standard processing must be communicated through marketing proposal process and may result in increased administrative fees.

Eligibility

Employees are eligible who participate in the following designated health plans:

- I wish to provide Retiree coverage
 - Employer will continue to make allocations to HRA account
 - Employee will continue to make allocations to HRA account

Allocation Amounts

- Full annual amount of HRA Dollars will be allocated to account on the first day of each plan year
- HRA funds will be allocated _____ in the amount of \$ _____
(semi-annually, monthly, quarterly, etc.) (dollar amount)

Mid-Year Elections

- Full allocation available regardless of hire date
 - Prorate HRA based on hire date
- The amount of allocation per month of eligibility is \$ _____

Qualifying Events

- Do not change the annual allocation amount for the plan year
- Change the annual allocation amount for the plan year to allocation applicable to the new participation status
- Change the annual allocation amount for the plan year only if the new allocation amount is greater than original allocation

Eligible Health Care Expenses

Unreimbursed 213(d) medical expenses are eligible for reimbursement from HRA Account. This is to include:

- Deductible and coinsurance amounts under the Health Plan
- Copay amounts under the Health Plan
- Premium expenses for continuation coverage (COBRA) under an eligible Wellmark health plan
- Premium expenses for Wellmark group retiree coverage that are not pretax
- Vision expenses
- Dental expenses
- Prescription drug expenses
- Premiums for eligible health insurance and long term care insurance
- Qualified over the counter items

ERISA Plan Number

If this plan has chosen to have Health Reimbursement Accounts, the ERISA Plan Number assigned to the portion of the Plan representing Health Reimbursement Accounts: _____

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 Health 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 Health Reimbursement Account for further consideration.

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.**
3. 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.
4. 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.

Service Agreement

I certify that I am legally authorized to sign this Health Reimbursement Account 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 Health Reimbursement Account 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 Health Reimbursement Account 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 Health Reimbursement Account 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: _____

COBRA

HRA's are considered health plans under ERISA, and are therefore considered "plans" to which COBRA applies. As a practical matter, this means the employee can continue to access the remaining balance in his or her HRA to cover any eligible health care expenses through the COBRA period as long as they pay the COBRA premium.

Employer may collect ½ of the annual HRA allocation from member monthly if member elects COBRA coverage.

Administrative Fees

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

Number of eligible employees _____

Annual administrative service fee: \$ _____

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 plan documents.

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 Benefits 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.

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: _____

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

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

Date(s) scheduled for employee meeting(s) if known: _____