



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

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 including the Flex Debit Card

### 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:

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
	<input type="checkbox"/> Employee Only <input type="checkbox"/> Two-Person Coverage <input type="checkbox"/> Family Coverage <input type="checkbox"/> Other Coverage_____	\$ \$ \$ \$
	<input type="checkbox"/> Employee Only <input type="checkbox"/> Two-Person Coverage <input type="checkbox"/> Family Coverage <input type="checkbox"/> Other Coverage_____	\$ \$ \$ \$
	<input type="checkbox"/> Employee Only <input type="checkbox"/> Two-Person Coverage <input type="checkbox"/> Family Coverage <input type="checkbox"/> 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.

**Blue Priority Flex Debit Cards for Health Reimbursement Accounts**

- Eligibility for this option is based on HRA plan design complexity
- Not available for participants who are offered and choose automatic reimbursement
  - Annual Fee and Extra Card Fee paid by Employer
  - Annual Fee and Extra Card Fee paid by Employee
  - I am a register group which writes checks from my bank account. I will supply my bank account information in Funding Options Available section below. The annual fee and extra card fee will be paid by Employer
  - I am a register group which writes checks from my bank account. I will supply my bank account information in Funding Options Available section below. The annual fee and extra card fee will be paid by Employee

**Prepayment of Orthodontia Claims Option (see the back of this application for more details) This option must be selected if Blue Priority Flex Debit Cards are being offered to employees.**

## Health Reimbursement Account Processing

For the Health Reimbursement Account:

- Daily processing for non register groups (aligning with Flexible Spending Account processing if providing that option)
- Bi-weekly processing for register groups
- Automatic reimbursement claims will be processed weekly
- 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
- HRA funds remaining at end of plan year will be rolled to subsequent plan year.  Yes  No

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:

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- 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. Recommended when opting for Blue Priority Flex Debit cards.
- 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 \$ \_\_\_\_\_
- No mid-year elections

## 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

## 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:

**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

Blue Priority Flex Debit Card service Fees:

**Annual fee per debit card participant for two debit cards:** \$ \_\_\_\_\_

Fee for extra cards (lost, stolen, additional dependents) \$ \_\_\_\_\_ per card

\*An additional charge may be incurred for modifications to our standard plan documents.

## Funding Options Available

Please refer to the below funding options for claim reimbursements and select option A. 1, A. 2, or B accordingly. Briefly with Options A. 1 and A. 2, employer HRA funds are electronically transferred to an escrow account from which Wellmark/Visa issues payments to employees. Option B, Employer maintains the HRA funds and issues payments directly to their employees. With this option, banking information is also required if opting for Debit Cards.

A.  All benefits, whether by check, direct deposit, or via the Blue Priority Flex Debit Card, will be made from an escrow account maintained by Wellmark for direct deposit of Plan Sponsor contributions. Wellmark will account for each Employer's funds separately. For funding of the benefit payments, plan sponsor must choose one of the following:

1.  Authorize Wellmark's Flexible Benefit Department to initiate an ACH withdrawal of funds from the plan sponsor's bank account into the escrow account. An ACH Funding Authorization Form will need to be completed.

**NOTE:** If a plan sponsor chooses this ACH option, the ACH funds transfer will be initiated on the payroll release date(s) based on Payroll Deduction Schedule if FSA plan is also in place. Otherwise a bi-weekly (26) schedule will be used, beginning with the first Monday of the plan year.

2.  Plan sponsor will wire transfer/ACH funds into an escrow account. (Wellmark will supply the employer with the applicable escrow account and bank information)

**IMPORTANT:** If adequate funds are not supplied by the plan sponsor in a timely manner, claims payments may be suspended until HRA funding is current.

In addition, if at any time during the plan year, disbursements to employees exceed the amount of HRA funds collected, Wellmark may notify plan sponsor and initiate a request for additional funds to cover the excess.

Claim payment information for plan sponsors selecting Option A can be accessed 24/7 at your plan sponsor password protected website [www.eflexonline.com](http://www.eflexonline.com).

B.  Flex benefit payments will be processed and paid by the Plan Sponsor (termed a "Register group"). The plan sponsor is responsible for all reconciliation of the plan sponsor bank account. Bi-Weekly processing frequency is required for this funding method.

**PAYMENTS FOR THEIR EMPLOYEES.** Under this option, Wellmark will make available to plan sponsor a report of claims needing payment on a bi-weekly basis.

## Funding Options Available (cont)

B. (cont)

If you select Option B and have selected the Blue Priority Flex Debit card above, benefit payments via the Blue Priority Debit Card will be withdrawn from the following plan sponsor bank account. The National Flex Trust will withdraw funds needed to pay the HRA debit card transactions on a daily basis. An adequate level of funds must be available in this account daily so as to avoid being assessed a settlement failure fee.

Name of Bank: \_\_\_\_\_

Address of Bank: \_\_\_\_\_

Account Representative: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Account Number: \_\_\_\_\_

Routing Number: \_\_\_\_\_

Printed name of authorized individual: \_\_\_\_\_

Signature of authorized individual: \_\_\_\_\_

Claim payment notification for plan sponsors selecting Option B should be sent to \_\_\_\_\_ via e-mail. Please provide the e-mail address for the above person \_\_\_\_\_.

To ensure this information is received by plan sponsors in the event of the above person is out of the office, please provide the name of a back up person \_\_\_\_\_ and their e-mail address \_\_\_\_\_.

## 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: \_\_\_\_/\_\_\_\_/\_\_\_\_

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 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. This option is not available for employees with a Blue Priority Flex Debit Card.

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. Employees may not participate if they order a Blue Priority Flex Debit Card.
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 Health 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. Treat. Re § 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. **This option must be selected if Blue Priority Flex Debit Cards are being offered to employees.**

## 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: \_\_\_\_\_