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412 Water Street
Sioux City, IA 51103
P 712-277-2424
F 712-277-2622

HRA, Flex and Dependent Care Employer Form

SECTION 1: EMPLOYER INFORMATION			
Employer Name	Woodbury County	**Primary Contact Name**	Melissa Thomas
Employer Address	620 Douglas Street Sioux City IA 51101	**Title**	Human Resource Director
		Contact Phone	712-279-6480
		Contact Email	melissathomas@woodburycountyiowa.gov
Federal Tax ID	42-6005221	**Corporate Phone Number**	712-279-6480
Business Entity Type	☐ C Corporation ☐ S Corporation ☐ Sole Proprietor ☐ LLC ☐ Partnership ☐ Non-Profit Organization ☒ Government Entity or Church		

SECTION 2: FLEX PLAN DESIGN	
Plan Type	☒ Renewal ☐ New
Plan Year	01/01/2025 - 12/31/2025
Plan Options	Dependent Care Account ☒ Yes ☐ No Flexible Spending Account ☒ Yes ☐ No HRA Employer Funded Account ☒ Yes ☐ No
Payment Features	☒ Benny Debit Card *(Funding on a weekly basis)* ☒ Pay Provider ☒ Pay Member *Claims reimbursement submitted in person, via fax, mail or online* Minimum check Amount $20.00 Claims Reimbursed: ☒ Daily ☐ Weekly Frequency of Electronic Fund Transfers: ☐ Daily ☒ Weekly
Runout Period *Last date to submit claims for services received in the plan year*	Do you offer a 90-day runout period for both Flex and Dependent Care? ☒ Yes ☐ No ☐ Other: Do mid-year terms have the same runout period as above? ☒ Yes ☐ No If no, provide runout timing:
Divisions *For reporting purposes*	☒ Yes ☐ No
Carryover Option *Applies to Flex only*	☒ Yes ☐ No $660 Maximum Carryover Amount

Grace Period	Grace Period offered and applied to both HC and DC FSA Plans? ☐ Yes ☒ No ☐ Only Flex Spending ☐ Only Dependent Care Grace Period, if applicable, 2.5 months? NA ☐ Yes Other:
Flex Spending Account	Minimum: $0 Max: $3,300
Dependent Care Account	Minimum: $0 Max: $5,000

SECTION 3: HRA PLAN DESIGN

Health Reimbursement Arrangement An HRA may not provide tax-free benefits to self-employed individuals (e.g. sole proprietors, partners, and more-than-2% Subchapter S corporation shareholders and their spouse, child, parent, or grandparent). Individuals not allowed participation in a Cafeteria Plan include self-employed individuals (but they can sponsor a plan); partners in a partnership (but the partnership can sponsor a plan); and a more-than-2%-shareholder in a Subchapter S corporation.	☒ Option 1: HRA pays 100% of health insurance premium to member ☐ Option 2: Upfront Member HRA Deductible ________ to plan maximum ____________ ☐ Option 3: Upfront Member HRA Deductible ____HRA Pays ___% to plan maximum ______ Aggregate Deductible: ☐ All family members or any one member could satisfy the deductible or entire funding Embedded Deductible: ☐ Yes ☒ No ___2x Individual amount ____3x Individual amount (Embedded: a specific number of family members must meet the HRA individual deductible along with the family meeting an HRA deductible) Individual Cap: ☐ Yes Amount $ _______ ☒ No (Limits funding on each individual within a family) HRA Expense List: ☐ Deductible ☐ Coinsurance ☐ Prescriptions ☐ Copay X retiree premium In-network Claims only? ☐ Yes ☐ No Pro-Ration of HRA- I would like new enrollees to receive a pro-rated HRA amount for the months that they are enrolled in the plan year. ☒ Yes ☐ No Pro-Ration Method: ☒ Monthly (1/12) ☐ Quarterly (1/4) Divisions by Location: ☐ Yes ☒ No

SECTION 4: ENROLLMENT INFORMATION

Open Enrollment Dates	November
Collecting Enrollment Information	How will enrollment information be collected by the employer from the employee *(please describe)*: Online enrollments – may have some paper enrollments
Providing Enrollment Information to IBC	How will enrollment information be provided to IBC (select one): ☒ IBC Online Portal ☐ Excel file to be uploaded to IBC ☒ Manual enrollments If contact responsible for this is different than the Primary Contact, please provide information below: Contact Name: Melissa Thomas Title: Human Resource Director Contact Phone: Contact Email: melissathomas@woodburycountyiowa.gov

SECTION 5: ELIGIBILITY	
New Hire Waiting Period	Healthcare FSA: first of the month following 30-days Dependent Care FSA: first of the month following 30-days HRA: 20 years or 500 hours Waiting period applies to new hires during OE? ☒Yes ☐ No
Who is eligible	☒ Full Time Only Per union contract
# of Hours Required for Eligible Status	Follows medical plan eligibility rules HRA: 20 years of service and 500 hours.
Effective Date	☒ 1st of the month after meeting eligibility requirements
Termination	When does coverage end upon termination? ☒ Termination Date ☐ End of month following termination

SETION 6: QUALIFIED CHANGES	
Election Changes	Election changes must be submitted within **30** days after the date of the event.
Coverage Begins	If qualified changes allowed, coverage following a qualified life change will begin: *(select one)* ☐ On any day of the month following request for new enrollment or change in enrollment. ☒ On the first of the month following request for new enrollment or change in enrollment (with the exception of changes resulting from birth, adoption, or placement for adoption, which will be made as of the date of the qualified event in accordance with HIPAA).

SECTION 7: PAYROLL DEDUCTIONS	
Payroll Frequency *deductions taken*	FLEX: ☐ Monthly (12) ☒ Bi-Weekly (24) ☐ *Bi-Weekly* (26) ☐ Weekly (52) ☐ Semi-Monthly HRA: ☐ Beginning of Plan Year ☒ Other: Per eligibility guidelines for retirees
First payroll date in plan year	01/10/2025

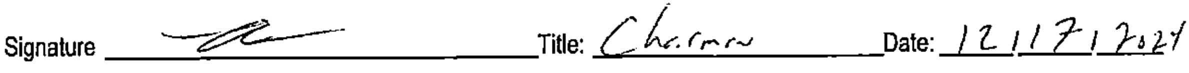
SECTION 8: OTHER CONTACTS		
Contact: Melissa Thomas		Human Resource Director
(712) 234-2901	Fax #:	melissathomas@woodburycountyiowa.gov

SECTION 9: PLAN DOCUMENT	
The Plan is *(check one)*	☐ ERISA Plan ☒ Non-ERISA Plan
Federal Employer ID #	42-6005221
State of Controlling Law	IA
3-digit Plan Number *i.e., 501, 502, etc.*	501

SECTION 10: BANK ACCOUNT INFORMATION	
Bank Name	NA - group will push funds into the IBC Admin account weekly
Lost Check *Fee paid by consumer*	Stop Payment Option: ☒ Yes ☐ No If yes, waiting period 30 days Bank Fee: $25.00

SECTION 11: INNOVATIVE BUSINESS CONSULTANTS ADMINISTRATION FEES		
Annual Fee	$200	
PMPM Plan Fees	$4.50	Per plan or Aggregate? Plan
Billing Frequency	☒ Quarterly ☐ Annually	

I certify that I am legally authorized to sign this Health Reimbursement Arrangement, Flexible Spending and Dependent Care Employer Application on behalf of the employer named herein.


Signature ______________ Title: Chairman ______________ Date: 12/17/2024