



Innovative
Business
Consultants

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12/16/25

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	<input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> LLC <input type="checkbox"/> Partnership <input type="checkbox"/> Non-Profit Organization <input checked="" type="checkbox"/> Government Entity or Church		
SECTION 2: FLEX/PLAN DESIGN			
Plan Type	<input checked="" type="checkbox"/> Renewal <input type="checkbox"/> New		
Plan Year	01/01/2026 - 12/31/2026		
Plan Options	Dependent Care Account	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	Flexible Spending Account	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	HRA Employer Funded Account	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Payment Features	<input checked="" type="checkbox"/> Benny Debit Card (<i>Funding on a weekly basis</i>)		
	<input checked="" type="checkbox"/> Pay Provider		
	<input checked="" type="checkbox"/> Pay Member <i>Claims reimbursement submitted in person, via fax, mail or online</i>		
	Minimum check Amount \$20.00		
Runout Period	Claims Reimbursed: <input checked="" type="checkbox"/> Daily <input type="checkbox"/> Weekly		
	Frequency of Electronic Fund Transfers: <input type="checkbox"/> Daily <input checked="" type="checkbox"/> Weekly		
	Do you offer a 90-day runout period for both Flex and Dependent Care? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:		
Divisions	Do mid-year terms have the same runout period as above? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, provide runout timing:		
	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
Carryover Option	<input checked="" type="checkbox"/> Yes		
	<input type="checkbox"/> No		
		\$680 Maximum Carryover Amount	

Grace Period	Grace Period offered and applied to both HC and DC FSA Plans? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Only Flex Spending <input type="checkbox"/> Only Dependent Care Grace Period, if applicable, 2.5 months? NA <input type="checkbox"/> Yes Other:
Flex Spending Account	Minimum: \$0 Max: \$3,400
Dependent Care Account	Minimum: \$0 Max: \$7,500

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.	<input checked="" type="checkbox"/> Option 1: HRA pays 100% of health insurance premium to member <input type="checkbox"/> Option 2: Upfront Member HRA Deductible _____ to plan maximum _____ <input type="checkbox"/> Option 3: Upfront Member HRA Deductible _____ HRA Pays _____% to plan maximum _____ Aggregate Deductible: <input type="checkbox"/> All family members or any one member could satisfy the deductible or entire funding Embedded Deductible: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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: <input type="checkbox"/> Yes Amount \$ _____ <input checked="" type="checkbox"/> No (Limits funding on each individual within a family) HRA Expense List: <input type="checkbox"/> Deductible <input type="checkbox"/> Coinsurance <input type="checkbox"/> Prescriptions <input type="checkbox"/> Copay <input checked="" type="checkbox"/> retiree premium In-network Claims only? <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Pro-Ration Method: <input checked="" type="checkbox"/> Monthly (1/12) <input type="checkbox"/> Quarterly (1/4) Divisions by Location: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
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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): <input checked="" type="checkbox"/> IBC Online Portal <input type="checkbox"/> Excel file to be uploaded to IBC <input checked="" type="checkbox"/> 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? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Who is eligible	<input checked="" type="checkbox"/> 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	<input checked="" type="checkbox"/> 1 st of the month after meeting eligibility requirements
Termination	When does coverage end upon termination? <input checked="" type="checkbox"/> Termination Date <input type="checkbox"/> End of month following termination

SECTION 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) <input type="checkbox"/> On any day of the month following request for new enrollment or change in enrollment. <input checked="" type="checkbox"/> 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: <input type="checkbox"/> Monthly (12) <input checked="" type="checkbox"/> Bi-Weekly (24) <input type="checkbox"/> Bi-Weekly (26) <input type="checkbox"/> Weekly (52) <input type="checkbox"/> Semi-Monthly HRA: <input type="checkbox"/> Beginning of Plan Year <input checked="" type="checkbox"/> Other: Per eligibility guidelines for retirees
First payroll date in plan year	01/9/2026

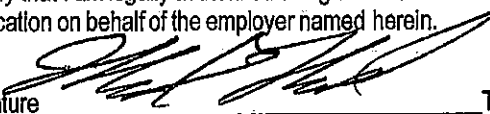
SECTION 8: OTHER CONTACTS		
Contact: Melissa Thomas	Human Resource Director	
(712) 234-2901	Fax #:	melissathomas@woodburycountyiowa.gov

SECTION 9: PLAN DOCUMENT	
The Plan is (check one)	<input type="checkbox"/> ERISA Plan <input checked="" type="checkbox"/> 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: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If yes, waiting period 30 days Bank Fee: \$25.00

SECTION III INNOVATIVE BUSINESS CONSULTANTS ADMINISTRATION FEES	
Annual Fee	\$200
PMPM Plan Fees	\$4.50 Per plan or Aggregate? Plan
Billing Frequency	<input checked="" type="checkbox"/> Quarterly <input type="checkbox"/> 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: 12/16/2025
Board of Supervisors