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Innovative
Business
Consultants

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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		
Corporate Name	Woodbury County				
Corporate Street Address (physical location)	620 Douglas Street				
City	Sioux City	State	IA	Zip	51101
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	01/01/2023 12/31/2023
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 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

	$610 Maximum Carryover Amount
Grace Period	*Grace Period offered and applies 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:** *$3050* **Employer contribution applies?** ☐ *Yes* ☒ *No* *If Yes, how much:* **$**
Dependent Care Account	**Minimum: $0** **Max** *$5000* **Employer contribution applies?** ☐ *Yes* ☒ *No* *If Yes, how much:* **$**
Employer Contribution Schedule *if applicable*	☐ *100% on Plan Year Start Date* ☐ *1st Day of the Month (divided by 12)* ☐ *Participants Payroll Frequency* ☒ *Customize: HRA paid FOM for EE health insurance premium- 1 year duration only*

SECTION 3: HRA PLAN DESIGN

Health Reimbursement Arrangement	☒ **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	*11/1/2022-11/30/2022*
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.* *(Enter 0 if midyear election changes are not allowed under this Plan)*
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).*
Coverage Ends	*If Coverage ends due to qualified event, coverage ends:* *Any day of the month* ☒ *End of the month*

SECTION 7: PAYROLL CONTRIBUTION REPORTING	
Payroll Frequency	**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	**12/30/2022 Every other Friday due to the 1st of Jan. falling on a Friday.**

SECTION 8: OTHER CONTACTS		
Contact: **Lisa Anderson**		*Secretary*
(712) 279-6480	*Fax #:*	*lisanderson@woodburycountyiowa.gov*
Contact:		
(712) 279-6480	*Fax #:*	

SECTION 9: PLAN DOCUMENT PREPARATION	
Additional Information required ONLY if electing IBC to create Plan Documents. *Additional fees may apply — note your contract.*	
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: ACCOUNT BANK SETUP (INCLUDE COMPLETED ACH FORM)	
Bank Name	*NA - group will push funds into the IBC Admin account weekly*
Address or Location	
Bank Routing Transit Number	
Bank Account Number	
Authorized Signer	
Lost Check *Fee paid by consumer*	*Stop Payment Option:* ☐ *Yes* ☐ *No* *If yes, waiting period* _____*days Bank Fee: $*_____

SECTION 11: INNOVATIVE BUSINESS CONSULTANTS ADMINISTRATION FEES:		
Annual Fee	*$200*	
Renewal Fees	*Waived*	
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:* HR Director *Date:* 12 / 20 / 2022