TERMS AND CONDITIONS
HEALTH SAVINGS ACCOUNT

I elect to participate and agree to be bound by the terms of the Plan.

I understand that:

- Health Savings Account (HSA) program is a benefit established for eligible state employees enrolled in one of the It's Your Choice High Deductible Health Plans. The HSA program is authorized under Internal Revenue Code Sections §125, §105, and §223 and Wisconsin Statutes §40.85-§40.875.
- A new enrollment must be completed each plan year. If I do not complete enrollment during Open Enrollment, I forfeit the opportunity to participate in the Health Savings Account benefit option.
- The contribution(s) I have elected will be made with pre-tax salary reductions and that such reductions reduce my compensation for Social Security benefit purposes.
- According to Wisconsin Statutes §40.87, participation in a Health Savings Account will not reduce my wages for calculating state retirement benefits. Also, my contributions in a Health Savings Account will not reduce my gross income for the purpose of calculating any other state benefits such as sick leave conversion credits, income continuation insurance, life insurance, deferred compensation, unemployment, or worker's compensation.
- Salary contributed into one account cannot be transferred and used for expenses in any other account.
- Contributing in a Health Savings Account is completely voluntary, and that payments from my Health Savings Account are independently reviewed for compliance with IRS regulations.
- Generally, contributions to the HSA account are made on a month-to-month rule basis depending on what coverage I am enrolled in under the It's Your Choice High Deductible Health Plan on the first day of the month. For each month that I am enrolled in individual coverage a total of $283.33 a month can be contributed. For each month that I am enrolled in family coverage a total of $562.50 a month can be contributed. If I change enrollment in the It's Your Choice High Deductible Health Plan during the plan year, I can change my contributions based on the month-to-month rule. For example, I am enrolled in individual coverage for 6 months of the year and for the other 6 months I have family coverage. My total contributions are: (6 X $283.33) + (6 X $562.50) or $1700 + $3375 = $5075.00.
- There is a limited exception to the month-to-month rule described above. This exception allows me to make the maximum annual contribution for the plan year based on my enrollment in the It's Your Choice High Deductible Health Plan on December 1st. Using the same 6 month example above, assume I change from individual to family coverage during the second half of the year. Under the month-to-month rule, I am limited to a maximum contribution of $5075.00. Since I was enrolled in family coverage on December 1st, I can use the limited exception and can contribute the full family contribution amount of $6750.00. IMPORTANT NOTE: In order to use this limited exception, I have to stay enrolled in the It's Your Choice High Deductible Health Plan at the same or higher level of coverage for the entire next plan year, called the 'testing period'. If I do not maintain this coverage, for instance I terminate employment or switch to a Non-High Deductible Health Plan the next plan year, then the excess funds contributed will be subject to a 10% excise tax.
- My eligible expenses must qualify as a medical deduction under Internal Revenue Service Publication 502.

I certify that:

- I am covered by one of the qualified It's Your Choice High Deductible Health Plan (HDHP), and that I am not covered by any other health insurance coverage. I certify that I have received a copy of the Application and Custodial Agreement and Disclosure Statement and amendments thereto. I assume sole responsibility for all consequences found in the Application and Custodial Agreement and Disclosure Statement. I understand that I may revoke the HSA on or before seven (7) days after the date of establishment. I have not received any tax or legal advice from the custodian, and I will seek the advice of my own tax or legal professional to ensure my compliance with related laws. I release and agree to hold the HSA custodian harmless against any and all claims or losses arising from my actions.

- I agree to have my compensation reduced by the contribution amount(s) I elected.
- That the information I have provided is complete and accurate to the best of my knowledge.
- I have reviewed and understand the benefits program eligibility and enrollment information and I agree to abide by all participation requirements.
- That all dependents listed meet the eligibility requirements of the program.
- I shall not claim a federal income tax deduction or credit for any expenses that were reimbursed through my Health Savings Account.
- I will inform my human resource benefit office as soon as reasonably possible when I am no longer eligible to contribute to the HSA Account, for instance if I obtain other non-permitted coverage such as coverage under my spouse's plan, and I understand any contributions made for any month in which I am not an eligible individual will be subject to an excise tax, and that my Employer will deduct any contributions it made for such an ineligible month from my account.
- That my use of the Card will comply with the terms and conditions of the cardholder agreement received with the card.
- That all expenses charged on the Card will qualify as reimbursable per IRS rules, will be incurred only for me or my eligible dependents, and will not be reimbursed through any other means, including my or my dependent's insurance Plans.
- I will keep all receipts and other documentation related to expenses charged on the Card. Upon request, within forty-five (45) days, I will fax, mail, or upload the required documentation of expenses to the Third Party Administrator.
- I understand additional Cards issued to my spouse or dependent(s) will provide the named individual with access to my Health Savings Account. I accept all responsibility for Card transactions incurred by the named individual and will submit supporting documentation, as requested, for those transactions.
- I acknowledge and agree that use of the Card in violation of this enrollment agreement or the Cardholder agreement may result in the invalidation and forfeiture of the Card.

Signature _____ **Date** _____