FURTHER℠

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HEALTH REIMBURSEMENT ARRANGEMENT (HRA) DIRECT PLAN DESIGN GUIDE

Please complete this form and return to Further 45 days before your effective date so we can properly administer your plan. If you have any questions, please call our Sales Line at 855-363-2583. When complete, email this form to Further.Group.Administration@hellofurther.com; fax it to 1-866-231-0214; or mail it to Further, PO Box 64193, St. Paul, MN 55164. **All fields are required, incomplete forms will cause delays setting up your plan.**

I. EMPLOYER INFORMATION

Employer's Name_____

Employer's Street Address _____

City _____ State _____ Zip Code _____

Employer's Tax I.D. Number (required) _____

Type of Corporation ☐ S Corporation* ☐ C Corporation ☐ Partnership* ☐ Sole Proprietor*
☐ Political Subdivision/Church ☐ LLC* ☐ Non-Profit ☐ Other_____

Number of Employees Eligible for Plan: _____

Person Responsible For Authorization of Plan Design:
(Responsible for signing the Plan Design Guide and approving the plan design)

Name _____ Title _____

Phone Number ( ) _____ Fax Number ( ) _____

Email Address _____

Main Contact Person:
(Has access to all plan information when calling Further and will automatically be granted full access to the Online Group Service Center)

Main Contact Person _____ Title _____

Phone Number ( ) _____ Fax Number ( ) _____

Email Address_____

Additional Contact Person:
(Has access to the plan information indicated below when calling Further. Access to the Online Group Service Center may be granted by the Main Contact who will decide what online access is assigned by logging into the Online Group Service Center)

Additional Contact Person _____ Title _____

Phone Number ( ) _____ Fax Number ( ) _____

Email Address_____

Additional Contact Person has access to when contacting Further:

☐ All plan information OR ☐ Fee billing information ☐ Claim billing information

* Log into the Online Group Service Center to grant access to additional users or to add more contacts.

II. AGENCY/BROKERAGE INFORMATION

Agent/Broker Name *(if applicable)* _____ Email Address _____

Agent/Broker Code _____ Agent/Broker Phone _____

Agency/Brokerage Name *(if applicable)* _____ Email Address _____

Agency/Brokerage Code _____ Agency/Brokerage Phone _____

Agency/Brokerage Tax ID _____-_____

Agency/Brokerage Address _____

III. TRANSFER OF ADMINISTRATION

Is Further taking over administrative services from another HRA administrator?

☐ Yes ☐ No *(If yes, Further will contact you)*

IV. HEALTH PLAN ADMINISTRATIVE INFORMATION

Health Plan Administrator

Health plan carrier *(Required)* _____

(Further will reach out to you to determine the submission method of enrollment data).

Are health plan accumulations calendar year or plan year? ☐ Calendar Year ☐ Plan Year

Is your plan fully insured or self insured? ☐ Fully insured ☐ Self insured

V. HEALTH REIMBURSEMENT ARRANGEMENT FUNDING OPTIONS

Plan Year

Is the HRA funded calendar year or plan year?

☐ Calendar Year - start date: _____ *(calendar year end date is always the last day of the calendar year)*
☐ Plan Year - start date: _____ end date: _____

Choose one of the funding options below:

☐ **Option #1 – HRA Pays First**

With this option, you, the employer, fund the HRA as expenses are reimbursed up to a predetermined amount. The HRA pays until the funds are exhausted. After that, the employee pays for medical services out of pocket until the health plan deductible is met. Once the deductible is met, the health plan starts to pay subject to any coinsurance amounts.

Indicate the annual funding amounts for the HRA Pays First Option:

1 - Participant/Single = $_____ *(required)*
2 - Participant + Child = $_____
3 - Participant + Spouse = $_____
4 - Participant + Children = $_____
5 - Family = $_____ *(required)*

Eligible Expenses

HRA dollars may be used to reimburse: *(Please check **all** that apply)*

☐ Health Plan eligible medical expenses
☐ Health Plan eligible drug expenses
☐ All IRC section 213(d) eligible expenses
☐ COBRA premiums and insurance premiums

Reimbursement Level – 100% of eligible expenses

V. HEALTH REIMBURSEMENT ARRANGEMENT FUNDING OPTIONS (continued)

☐ **Option #2 – Shared Payments HRA**

With this option, you, the employer, and your employee share in the medical costs until the account is exhausted. As expenses are incurred, the HRA reimburses the employee according to the cost-sharing level (e.g. 50/50, 80/20) until the HRA is exhausted. You, the employer, fund the HRA as expenses are reimbursed up to a predetermined amount. After that, the employee pays out of pocket until the health plan deductible is met. Once the deductible is met, the health plan starts to pay subject to any coinsurance amounts.

Indicate the annual funding levels for the Shared Payments HRA Option:

1 - Participant/Single = $_____ *(required)*
2 - Participant + Child = $_____
3 - Participant + Spouse = $_____
4 - Participant + Children = $_____
5 - Family = $_____ *(required)*

Eligible Expenses

HRA dollars may be used to reimburse: *(Please check **all** that apply)*

☐ Health Plan eligible medical expenses
☐ Health Plan eligible drug expenses
☐ All IRC section 213(d) eligible expenses
☐ COBRA premiums and insurance premiums

Reimbursement Level

Indicate the reimbursement level percentage that will be provided for claims paid by the HRA: *(select **only** one)*

☐ 80% of eligible expenses ☐ 50% of eligible expenses ☐ Other _____

☐ **Option #3 – Employee Pays First HRA**

With this option, the employee pays out of pocket until a preset amount has been paid. When this "threshold" has been reached, the HRA pays until exhausted. You, the employer, fund the HRA as expenses are reimbursed up to a predetermined amount. After that the employee pays out of pocket until the health plan deductible is reached. Once the deductible is met, the health plan starts to pay subject to any coinsurance amounts. Additional fee applies to all participants. Please refer to the fee schedule.

This option is not available if a debit card is offered.

Indicate your **health plan deductible amounts** by coverage tier:

1 - Participant/Single = $_____
2 - Participant + Child = $_____
3 - Participant + Spouse = $_____
4 - Participant + Children = $_____
5 - Family = $_____

Indicate the **Employee Responsibility Amount***: (This is the amount that the employee will pay out of pocket prior to reimbursement from the Employer Funding Amount.)

1 - Participant/Single = $_____
2 - Participant + Child = $_____
3 - Participant + Spouse = $_____
4 - Participant + Children =$_____
5 - Family = $_____

Indicate the **Employer Funding Amount***: (This is the amount that the employer will pay for each coverage tier after the employee has satisfied their Employee Responsibility Amount.)

1 - Participant/Single = $_____
2 - Participant + Child = $_____
3 - Participant + Spouse = $_____
4 - Participant + Children = $_____
5 - Family = $_____

***The combination of both the employee responsibility amount and the employer funding amount must be less than or equal to the deductible amount for that coverage tier.**

V. HEALTH REIMBURSEMENT ARRANGEMENT FUNDING OPTIONS (continued)

Eligible Expenses

HRA dollars may be used to reimburse: *(Please check **all** that apply)*

- ☐ Health Plan eligible medical expenses
- ☐ Health Plan eligible drug expenses
- ☐ All IRC section 213(d) eligible expenses
- ☐ COBRA premiums and insurance premiums

Reimbursement Level

Indicate the reimbursement level percentage that will be provided for claims paid by the HRA: *(select **only** one)*

☐ 100% of eligible expenses ☐ 80% of eligible expenses ☐ 50% of eligible expenses ☐ Other _____

VI. HEALTH REIMBURSEMENT ARRANGEMENT ADMINISTRATIVE REQUIREMENTS

Mid-Year Enrollees / Contract Changes

Indicate how mid-year enrollees and contract changes will be administered: *(select **only** one)*

- ☐ HRA funding is 100% regardless of date of enrollment/contract change.
- ☐ HRA funding is prorated in monthly increments back to the first of the month of the date of enrollment/contract change.
- ☐ HRA funding is a specified amount if the enrollment/contract change occurs in the last 6 months of the plan year.

If this option is selected, please enter the amounts below: *(not recommended if your plan year is less than 6 months)*

1 - Participant/Single = $_____ *(required)*

2 - Participant + Child = $_____

3 - Participant + Spouse = $_____

4 - Participant + Children = $_____

5 - Family = $_____ *(required)*

Rollover

Indicate what happens to unused balances at the end of the plan year. If funding option #3 is selected, rollover dollars can only be used AFTER the annual employee pays first pre-set threshold amount has been paid. (Select ***only*** one)

- ☐ Entire balance rolls over to subsequent plan year
- ☐ No balance rolls over
- ☐ A percentage of the balance rolls over to subsequent plan year _____%
- ☐ A dollar limit on the amount that can roll over to the subsequent plan year. Rollover amount cannot be the same as funding amount. Indicate limits below:

1 - Participant/Single = $_____

2 - Participant + Child = $_____

3 - Participant + Spouse = $_____

4 - Participant + Children = $_____

5 - Family = $_____

Cap on Health Reimbursement Arrangement Balance

Is there a cap on the overall balance (including Rollover) that can accumulate in the account? ☐ Yes ☐ No
If yes, the recommended cap is the annual deductible amount or total annual out-of-pocket amount.

Please indicate amounts below:

1 - Participant/Single = $_____ *(required)*

2 - Participant + Child = $_____

3 - Participant + Spouse = $_____

4 - Participant + Children = $_____

5 - Family = $_____ *(required)*

VI. HEALTH REIMBURSEMENT ARRANGEMENT ADMINISTRATIVE REQUIREMENTS (continued)

Runout Period

Participants have _____ months after the end of the plan year to submit claims incurred during that plan year. (The standard runout period is 6 months.)

The runout period noted above begins at termination date for terminated employees.

Terminations

Indicate what happens to the HRA balance when a participant terminates. NOTE: Account balance stays with terminated participant if COBRA has been elected ***(mandatory.)*** *Please check one of the following options:*

- ☐ Account balance returns to employer if terminated participant or eligible dependent does not elect COBRA. (default)
- ☐ Account balance remains with terminated participant or eligible dependent to spend-down until funds are depleted. If spend-down is selected, eligible expenses for terminated participants remain the same as for active participants. Spend-down is subject to any applicable rollover and runout period provisions and fees. (Only available for funding options #1 & #2 - not available for funding option #3.)

VII. HEALTH REIMBURSEMENT ARRANGEMENT OPTIONAL FEATURES

You may select any of the features listed below that best meet your needs and those of your participants:

- ☐ Participants will automatically be enrolled in a **debit card**. Members will have the option to submit claims on the Member Online Service Center.
- ☐ Members will submit claims on the **Member Online Service Center**.

Copay Amounts - The copay amounts provided below will allow these amounts to auto-substantiate when the debit card is used. Documentation will not be required for reimbursements..

Please indicate the health plan copay amounts below or attach a separate spreadsheet indicating the copay amounts.

Medical: _____ _____ _____ Vision: _____ _____ _____

Drug: _____ _____ _____

VIII.CLAIM REIMBURSEMENT PROCESSING

You will receive an automated e-mail notification with the claim reimbursement totals. Sign into the Online Group Service Center to view and print your complete invoice detail under Claim Reimbursement Invoices.

Automated Clearinghouse Information ***(completion of this section is mandatory)***

I hereby authorize Further to charge our bank account through Automated Clearinghouse for **claim reimbursements** made to our employees. The following bank account information is provided to Further for initiation of this procedure.

Bank Name:_____

Type of Account: ☐ Checking ☐ Savings

Bank ABA Number:_____
(The ABA number is the nine-digit number located in the lower left corner of your check or savings deposit slip)

Bank Account Number: _____

IX. ADMINISTRATIVE FEES

You will receive an automated e-mail notification when your detailed billing information is available and another e-mail notification two business days in advance of the scheduled ACH transaction confirming the amount of funds to be transferred. Sign into the Online Group Service Center to view and print your complete invoice detail under Administrative Fee Invoices.

Automated Clearinghouse Information (completion of this section is mandatory)

I hereby authorize Further to charge our bank account through Automated Clearinghouse for **Administrative Fees.** The following bank account information is provided to Further for initiation of this procedure.

Please select **one:**

☐ **Use same bank account as indicated for claim reimbursements; OR**

☐ **Use bank account information indicated below:**

Bank Name:_____

Type of Account: ☐ Checking ☐ Savings

Bank ABA Number:_____

(The ABA number is the nine-digit number located in the lower left corner of your check or savings deposit slip)

Bank Account Number: _____

(Funds will be drawn from your bank account on or after the 20th of each month.)

X. ADMINISTRATIVE TIPS AND DEFINITIONS

ONLINE ACCESS: hellofurther.com

With Further, your employees have access to a powerful tool for managing their HRA. By registering with hellofurther.com your employees can:

- Enroll in direct deposit
- View recent claims or reimbursement requests
- Create and view a customized statement
- Manage their personal profile

You can also access forms and enrollment materials at **hellofurther.com**

LOCATIONS: Multiple Further locations are available for 51+ groups only. If you want multiple Further locations, please complete and attach the Location Addendum (F8928). Locations must be the same across all products administered by Further. If you wish to have different ACH accounts by location, please complete the Group ACH Authorization Agreement form (F9055).

COORDINATING WITH AN HSA: For participants that have an HRA and an HSA, the HRA provides reimbursement for permitted benefits such as vision and dental care benefits until the health plan deductible is met. Once the health plan deductible is met, all Section 213(d) expenses, excluding deductible expenses, are eligible for reimbursement.

This affects only those participants who are eligible to contribute to their HSA. Participants who are not eligible to contribute to an HSA will have a full HRA.

Please note: If the HSA is not administered by Further, the group is required to manually notify Further which employees are contributing to the HSA. Participants are accountable for submitting the Deductible Verification Form (F8978) to Further to indicate that the deductible has been satisfied prior to receiving reimbursement for 213(d) eligible expenses.

COORDINATING WITH AN FSA:

If the HRA allows reimbursement for health plan eligible expenses only, the HRA is primary and the FSA is secondary.

If the HRA allows all 213(d) expenses to be reimbursed, the FSA is primary and the HRA is secondary because unused FSA funds are forfeited if not used for the applicable plan year.

ACCOUNT FEES: For participants who have an HRA stacked with a Further FSA, only one monthly participant fee will apply. Participant fees are billed monthly via mail and are payable by check or ACH. You will receive one bill for the entire group including the billed amount for each location (if applicable).

XI. SIGNATURES

It is agreed that necessary information concerning current and future participants and/or their dependents who participate in this Plan and participants whose participation is to be changed or discontinued, shall be provided to Further on a timely basis.

I HAVE READ AND UNDERSTAND THE CHOICES WITHIN THIS PLAN DESIGN GUIDE. INFORMATION ON THE PLAN DESIGN GUIDE AND ANY ANCILLARY INFORMATION PROVIDED FOR THE PURPOSE OF ENROLLING IN THIS PLAN ARE, TO THE BEST OF MY KNOWLEDGE, CORRECT AND COMPLETE.

Please Note: A health savings account (HSA) health plan paired with a health reimbursement arrangement (HRA) poses possible tax code concerns. An employee who enrolls in the HSA health plan and participates in the HRA may not be eligible to open or contribute to their own HSA. Employees must be advised.

Signature _____ Date _____

Printed Name _____ Title _____

XII. For Office Use Only:

Further Group Number _____

Market Segment _____

Health Plan Account Manager _____

Distribution Partner _____

Distribution Partner Account Manager _____

Sales Exec _____

Further Account Manager_____

Client Manager _____

Enrollment Specialist _____