HEALTH REIMBURSEMENT ARRANGEMENT (HRA) DIRECT PLAN DESIGN GUIDE

Please complete this form and return to Further 30 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.Sales.Support@HelloFurther.com; fax it to 1-866-231-0214; or mail it to Further, PO Box 982814, El Paso, TX 79998-2814.
All fields are required, incomplete forms will cause delays setting up your plan.

I. EMPLOYER INFORMATION

Employer's Legal 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: ____________

**2% or more shareholders of an S Corporation, along with partners in a partnership, sole proprietors and members of an LLC or PLLP do not have access to an FSA.*

Primary Contact Person:

(Has access to all plan information and can add, edit, or remove portal access for additional contacts).

Primary Contact Person ________________ Title ________________

Phone Number (   )____________________

Email Address____________________

Additional Contact Person:

(Has access to all plan information and edit access for group portal).

Additional Contact Person ________________ Title ________________

Phone Number (   )____________________

Email Address____________________

Additional Contact Email Notifications

☐ Fee Billing ☐ Claim Billing

II. AGENCY/BROKERAGE INFORMATION

Agency Name: ________________ Agency Code: ____________

Agent Name: ________________ Agent Code: ____________

Agency Contact Name *(if different than agent)*: ________________

Email: ________________ Phone: ____________

Address: ____________________

III. HEALTH PLAN ADMINISTRATIVE INFORMATION

Health Plan Administrator

Health Plan Carrier *(Required)* ____________________

IV. HEALTH REIMBURSEMENT ARRANGEMENT FUNDING OPTIONS

Plan Year

Plan Year - Start Date: __________ End Date: __________

Choose one of the funding options below:

OPTION #1 - EMPLOYER PAYS FIRST HRA

With this option, you (the employer), fund the HRA as your employee submits expenses for reimbursement up to the preset amount you choose. The HRA pays until the funds are depleted. After that, the employee is responsible for out-of-pocket health care expenses.

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 and reimbursement options -- choose only ONE of the following options:

Please note if you do offer an FSA along with your HRA, the default reimbursement method for your FSA will be set to match your HRA plan.

1. All Health Plan Eligible Medical (includes deductible, copay & coinsurance) Manual Claims Submission Required
2. All Health Plan Eligible Medical and Prescription (includes deductible, copay, coinsurance & prescriptions) Manual Claims Submission Required
3. Medical Deductible only (no medical coinsurance or copays) Manual Claims Submission Required
4. All IRS Eligible Medical (includes deductible, copay, coinsurance & all IRS eligible medical) Debit Card
5. All IRS Eligible Medical and Prescriptions (includes deductible, copay, coinsurance & all IRS eligible medical and prescriptions) Debit Card
6. All 213(d) eligible expenses (includes all IRS eligible medical, prescriptions, over-the-counter, vision and dental) Debit Card
7. Prescription expenses only Debit Card

OPTION #2 - SHARED PAYMENT 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.

Indicate the annual funding amounts for the Shared Payment HRA Option:

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

options continued on next page

IV. HEALTH REIMBURSEMENT ARRANGEMENT FUNDING OPTIONS (continued)

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 ___________

Eligible expenses and reimbursement options -- choose only ONE of the following options:

Please note if you do offer an FSA along with your HRA, the default reimbursement method for your FSA will be set to match your HRA plan.

1. All Health Plan Eligible Medical (includes deductible, copay & coinsurance)
Manual Claims Submission Required

2. All Health Plan Eligible Medical and Prescription (includes deductible, copay, coinsurance & prescriptions)
Manual Claims Submission Required

3. Medical Deductible only (no medical coinsurance or copays)
Manual Claims Submission Required

4. All IRS Eligible Medical (includes deductible, copay, coinsurance & all IRS eligible medical)
Manual Claims Submission Required

5. All IRS Eligible Medical and Prescriptions (includes deductible, copay, coinsurance & all IRS eligible and prescriptions)
Manual Claims Submission Required

6. All 213(d) eligible expenses (includes all IRS eligible medical, prescriptions, over-the-counter, vision and dental)
Manual Claims Submission Required

7. Prescription expenses only
Manual Claims Submission Required

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.

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 = $____________________ *(required)*
2 - Participant + Child = $____________________
3 - Participant + Spouse = $____________________
4 - Participant + Children =$____________________
5 - Family = $____________________ *(required)*

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 = $____________________ *(required)*
2 - Participant + Child = $____________________
3 - Participant + Spouse = $____________________
4 - Participant + Children =$____________________
5 - Family = $____________________ *(required)*

options continued on next page

IV. HEALTH REIMBURSEMENT ARRANGEMENT FUNDING OPTIONS (continued)

OPTION #3 - EMPLOYEE PAYS FIRST HRA (continued)

Eligible expenses and reimbursement options -- choose only ONE of the following options:

Please note if you do offer an FSA along with your HRA, the default reimbursement method for your FSA will be set to match your HRA plan.

1. All Health Plan Eligible Medical (includes deductible, copay & coinsurance) Manual Claims Submission Required
2. All Health Plan Eligible Medical and Prescription (includes deductible, copay, coinsurance & prescriptions) Manual Claims Submission Required
3. Medical Deductible only (no medical coinsurance or copays) Manual Claims Submission Required

V. HEALTH REIMBURSEMENT ARRANGEMENT ADMINISTRATION 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.

Rollover

Indicate what happens to unused balances at the end of the plan year. If funding option #2 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 ______________%

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)*

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.)

VI. DEBIT CARD COPAY SUBSTANTIATION

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. If you have more copays than what is listed below, please complete the Group Copay Form. Amounts must be indicated on the PDG or the Group Copay Form, otherwise the copay amounts will not be added.

Medical: _______ _______ _______ Vision: _______ _______ _______

Drug: _______ _______ _______

VII. TRANSFER OF ADMINISTRATION

Is Further taking over administrative services from another administrator? (This would include if your plan had rollover from the prior year).

☐ Yes ☐ No

If yes, fill out the fields below.

If no, skip to the signatures section.

PRIOR ADMINISTRATOR INFORMATION:

This information will only be used to provide information to your employees.

Prior Administrator's Name: ____________________

PLAN YEAR INFORMATION:

Please select one of the following and fill out the corresponding section.

☐ **TAKEOVER AT NEW PLAN YEAR:**

Please select the administrator that will be processing the runout claims for the previous plan year.

- ☐ The prior administrator
- ☐ Further (If Further is handling the runout, indicate runout and rollover for that plan year)
- ☐ Runout Period Months: ____________________
- ☐ Rollover (If Rollover was applicable, please ensure the ending balances transferred to Further includes the final rollover balances.)

☐ **TAKEOVER AT MIDYEAR:**

What is the last date the prior administrator will process claims? ____________________

What is the date that the enrollment data and balances will be submitted to Further? ____________________

Please note: There will be a blackout period between when the data is received and when Further will begin to process claims. The plan will be set up according to the plan design guide submitted to Further.

VIII. ENROLLMENT

Initial Enrollment Data will be sent via:

Online Group Service Center
Employer will enroll participants online using the Online Group Service Center at **hellofurther.com**

Secure File Transfer
Employer will enroll participants using a secure file transfer process

IX. CLAIM REIMBURSEMENT PROCESSING

You will receive an automated email 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: ______________________________

X. ADMINISTRATIVE FEES

You will receive an automated email notification when your detailed billing information is available and another email 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.)

XI. 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:

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.

XII. 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 ______________