FURTHER SM

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) 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 or 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

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_____

**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.*

Number of Employees Eligible for Plan: _____

Main Contact Person:

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

Main 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 information ☐ Claim billing information

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)* _____

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

IV. HEALTH REIMBURSEMENT ARRANGEMENT FUNDING OPTIONS

Plan 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

☐ **Option #2 – Shared Payments HRA (Debit Card not allowed with this HRA plan type)**

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 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 _____

IV. (Continued)

☐**Option #3 – Employee Pays First HRA (Debit Card not allowed with this HRA plan type)**

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.

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.**

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

IV. (Continued)
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)*

V. 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: _____

VI. 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.)

VII. REIMBURSEMENT

You may select any of the features listed below that best meet your needs and those of your participants *(see section XI for more information and definitions)*:

- ☐ **Option #1**- participants will automatically be enrolled in **medical autopay**. They may opt out of the autopay feature and elect a debit card, if they choose.
- ☐ **Option #2**- participants will automatically be enrolled in **medical autopay**. They will be unable to elect a debit card.
- ☐ **Option #3**- participants will automatically be issued a **debit card**. Participants have the option to discard their debit card and enroll in autopay, if they choose (if this option is selected, Further will contact you to provide more information).

Dental Autopay - Only available if you offer Delta Dental Insurance and have chosen all IRC section 213(d) expenses to be paid from the HRA.

- ☐ Yes, allow dental autopay.
- ☐ No, do not allow dental autopay.

Pay-the-Provider

Additional fee applies to all participants regardless of their pay-the-provider election. Please refer to the fee schedule.

Include the Pay-the-Provider (must select one)

- ☐ Yes - The pay-the-provider election must match the autopay election. (If members are **automatically enrolled** in autopay, then members will also be auto enrolled in the pay-the-provider. Participants may opt out of pay-the-provider by requesting online or completing the pay-the-provider election form F9089.
  If members choose to **elect** autopay, then members will also be allowed to elect pay-the-provider.)
- ☐ No (Do not offer pay-the-provider)

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: _____ _____ _____

VIII. TRANSFER OF ADMINISTRATION)

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

Is Further taking over administrative services from another administrator? ☐ Yes ☐ No

If yes, fill out the fields below.

If no, skip to the signatures section.

With your previous plan, was rollover allowed to carry over from year to year?

☐ Yes ☐ No

PRIOR ADMINISTRATOR INFORMATION:

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.

IX. 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 or the health plan is not with Blue Cross and Blue Shield of Minnesota, 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).

REIMBURSEMENT OPTIONS:

AUTOPAY: Offering autopay eliminates the need for participants to complete and file a claim form to be reimbursed for eligible health plan expenses.

MEDICAL AUTOPAY: Eligible health expenses (i.e. deductible and/or coinsurance) as indicated on the health plan Explanation of Benefits will be electronically transferred to Further. Claims will be processed and reimbursed according to the participant's available balance.

Please note: Autopay is not appropriate for participants who have secondary health coverage. Contact Further for a list of partners where autopay is available.

Along with medical autopay, any available account balance(s) are accessed when purchasing a prescription drug at the pharmacy point of service. This feature is only applicable when Prime Therapeutics is the pharmacy benefit manager and prescription drug benefits are allowed with the spending account plan.

DENTAL AUTOPAY: Eligible dental plan expenses (i.e. deductible and/or coinsurance) as indicated on the dental Explanation of Benefits, plus other patient responsibility amounts will be electronically transferred from Delta Dental of Minnesota to Further. Claims will be processed and reimbursed according to the participant's available balance. Please note that dental autopay is not appropriate for any participants that have secondary dental insurance coverage.

PAY-THE-PROVIDER: This feature allows a participant to have their medical claim reimbursements sent directly to their provider rather than to their home address or directly deposited into their bank account. This is only available for participants who have elected autopay.

X. 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 _____