WELLNESS INCENTIVE (HRA) PLAN DESIGN GUIDE

Please fill out this form in its entirety and return to Further 45 days prior to your effective date in order for us to properly administer your plan. If you have any questions on how to complete the form, please call our Sales Line at 855-363-2583. If you are a 51+ group, please contact your account manager. When complete, email this form to Further.Sales.Support@HelloFurther.com or fax it to 1-866-231-0214; or mail to Further, PO Box 982814, El Paso, TX 79998-2814.

All fields are required, incompleted 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 (not enrolled) for plan: ____________

Main Contact Person:

(This 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:

(This person has access to all plan information and edit access for group portal.)

Additional Contact Person ____________________ Title ____________________

Phone Number (   ) ______________________________

Email Address______________________________

Additional Contact

☐ Fee billing information ☐ Claim billing information

II. 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).

III. AGENCY/BROKERAGE INFORMATION

Agency Name: ____________________ Agency Code: ____________________

Agent Name: ____________________ Agent Code: ____________________

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

Email: ____________________ Phone: ____________________

Address: ____________________

IV. TRANSFER OF ADMINISTRATION

Is Further taking over administrative services from another administrator?

☐ Yes ☐ No *(If you've answered "yes", Further will contact you.)*

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

☐ Yes ☐ No

V. ACCOUNT ADMINISTRATIVE INFORMATION

☐ **Wellness Incentive HRA Pays First**

With this option, you, the employer, fund the Wellness Incentive HRA as expenses are reimbursed up to a predetermined amount. The Wellness Incentive HRA pays until the funds are exhausted.

Vendor for health and wellness incentive benefit plan:

☐ Blue Cross Blue Shield of Minnesota
☐ Other: (name) ____________________
(Further file format requirements must be used)

Eligible Expenses

Wellness Incentive 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

☐ **Employee Pays First Wellness Incentive HRA**

With this option, the employee pays out of pocket until a preset amount has been paid. When this "threshold" has been reached, the Wellness Incentive HRA pays until exhausted. You, the employer, fund the Wellness Incentive 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.***

Vendor for health and wellness incentive benefit plan:

☐ Blue Cross Blue Shield of Minnesota
☐ Other: (name) ____________________
(Further file format requirements must be used)

Requirements

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 = $__________

V. ACCOUNT ADMINISTRATIVE INFORMATION (continued)

Rollover

Indicate what happens to unused balances at the end of the plan year.

- ☐ 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 Wellness Incentive HRA Balance ***(Not Recommended)***

Is there a cap on the overall balance (including Rollover) that can accumulate in the account? ☐ Yes ☐ No

Please indicate amounts below:

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

Runout Period

Participants have ____________ months after the end of the plan year to submit claims incurred during that plan year.

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 and 2 - not available for funding option 3.)

Select one:
- ☐ Automatically enroll all participants in dental autopay. *(Participants may opt out of dental autopay by completing the dental autopay form F7854.)*
- ☐ Offer dental autopay to participants. *(Participants may elect autopay by completing the dental autopay form F7854.)*
- ☐ Do not offer dental autopay to participants

Pay-the-Provider *(This feature is only available if health plan is with Blue Cross Blue Shield of Minnesota)*

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)

VI. 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 Account Number:_____________________________

Bank ABA Number: _____________________________

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

VII. 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 in to the Online Group Service Center to view and print your complete invoice detail under Administrative Fee Invoices.

Automated Clearinghouse Information

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.)

VIII REIMBURSEMENTS

Autopay

Offering autopay eliminates the need for participants to complete and file a claim form to be reimbursed for eligible health plan expenses. The autopay election applies across all spending accounts (i.e. medical FSA, HRA (including a Wellness Incentive HRA), or HSA).

Medical Autopay

Eligible health plan expenses (i.e. deductible and/or coinsurance) as indicated on the 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 any participants who have secondary health coverage with Blue Cross or another carrier. *(This feature is only available if health plan is with Blue Cross and Blue Shield of Minnesota, Blue Cross and Blue Shield of Kansas, CCStpa, or BlueLink Tpa.)*

Along with medical autopay, any available spending account balance(s) are accessed when purchasing a prescription drug at the pharmacy at 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.

Select one:
☐ Automatically enroll all participants in medical autopay. *(Participants may opt out by completing the medical autopay form F7856.)*
☐ Offer medical autopay to participants. *(Participants may elect autopay by completing the medical autopay form F7856. Highest participant fee applies. Please refer to the fee schedule.)*
☐ Do not offer medical autopay to participants. Highest participant fee applies. Please refer to the fee schedule.

VIII. REIMBURSEMENTS (continued)

Dental Autopay - only available if eligible expenses chosen are all IRC section 213(d).

Do you offer dental coverage through Delta Dental of Minnesota?

☐ Yes - complete the dental autopay section below ☐ No - Default

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. They will be processed and reimbursed according to the participant's available balance. Please note dental autopay is not appropriate for any participants who have secondary dental insurance coverage. Electing this feature does not impact the monthly participant fees.

IX. ADMINISTRATIVE TIPS

Standard Stacking

With Option #1 Wellness Incentive HRA Pays First:

1. Health Plan HRA
2. Medical FSA (if participating)
3. Wellness Incentive HRA

With Option #2 Employee Pays First Wellness Incentive HRA:

1. Wellness Incentive HRA
2. Medical FSA (if participating)

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 ACH. You will receive one bill for the entire group including the billed amount for each location (if applicable).

X. SIGNATURES

It is agreed that necessary information concerning participants or participants and their dependents participating in or subsequent to the effective date of the Plan and participants whose participation is to be changed or discontinued shall be furnished 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.

Signature ______________________________ Date ______________

Printed Name ______________________________ Title ______________

XII. IN OFFICE USE ONLY:

Distribution Partner ______________________________

Market Segment ______________________________