



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) _____

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

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.

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**)

IV. HEALTH REIMBURSEMENT ARRANGEMENT FUNDING OPTIONS (continued)

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.

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.**

IV. 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

V. 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.

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 _____%

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. 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: _____

IV. 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: _____

IX. 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.

V. 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.)

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
- Create and view a customized statement
- View recent claims or reimbursement requests
- 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.

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 _____