FURTHER℠

FLEXIBLE SPENDING ACCOUNT (FSA) 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, fax this form to 1-866-231-0214; mail it to Further, PO Box 64193, St. Paul, MN 55164; or send via secure email, to Further.Sales.Support@HelloFurther.com.

All fields are required, incomplete forms will cause delays setting up your plan.

I. EMPLOYER INFORMATION

Legal Business 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 information ☐ Claim billing information

II. HEALTH PLAN ADMINISTRATIVE INFORMATION

Health Plan Carrier _____

A health plan is required in order to offer an FSA.

III. AGENCY/BROKERAGE INFORMATION

Agency Name: _____ Agency Code: _____

Agent Name: _____ Agent Code: _____

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

Email: _____ Phone: _____

Address: _____

IV. ACCOUNT ADMINISTRATIVE INFORMATION

Plan Year

Start date _____ End date _____

Plan Options *(select **all** that apply)*

- ☐ Medical Flexible Spending Account
- ☐ Dependent Care Flexible Spending Account

Eligibility Required for Plan documents *(generally matches that of the health plan)*

Employees must work at least _____ hours per week to be eligible

Benefits will begin on: (select **only** one):

- ☐ First of the month following date of hire
- ☐ Date of hire
- ☐ First *day* after completion of the waiting period ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other
- ☐ First of the *month* after completion of the waiting period ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other

Minimum and Maximum Employee Contribution Limits

	Minimum	Maximum
Medical FSA	$_____	$_____ **(IRS maximum is $2,700)**
Dependent Care FSA	$_____	$_____ **(IRS maximum is $5,000)**

Does the Employer contribute to any account(s)? ☐ **Yes** ☐ **No**

Note: The employer can contribute up to $500 to all employees without the employee contributing. When employer is contributing an amount over $500, the employer's contribution cannot exceed the employee's election.

Grace Period

The grace period only applies to Medical and/or Dependent Care FSAs. It is the additional time period in which members can incur out- of-pocket expenses in the new plan year if money is left over from the previous plan year. Claims incurred during the grace period may be submitted until the end of the runout period. A grace period is not recommended for dependent care FSA. You may choose grace period or rollover, but not both.

The grace period can be up to two months and 15 days from the end of the plan year. The grace period cannot exceed the runout period end date for a Medical FSA. A grace period is not recommended if you currently offer an HSA or if you are considering adding one in the future.

If you would like to offer a grace period, indicate the grace period end date below:

Medical FSA _____/_____/_____

Dependent Care FSA _____/_____/_____

Rollover (for Medical FSA only)

You have the option to allow employees to carry over up to $500 from the current plan year to their FSA for the following plan year. The rollover amount does not count towards the annual FSA contribution limit. Without the rollover or grace period, balances at the end of the plan year are forfeited. **You may choose rollover or grace period, but not both.**

- ☐ I would like to offer rollover (did not elect a grace period).

Runout Period

The runout period is the deadline for participants to submit claims for the previous plan year. All eligible claims must be received by the end of the runout period.

The suggested runout period for a Medical FSA is 3 months from the end of the plan year or 3 months from employee termination. If a grace period is selected, the runout period must be equal to or greater than the grace period elected.

If you selected **Medical FSA**:

Please indicate the length of the runout period for active Medical FSA employees: _____ (months)
(Length of runout period must be in whole and/or half month increments.)

Please indicate how you would like runout to apply to terminated employees *(select **only** one)*

- ☐ The runout period noted above begins at termination date *(recommended)*
- ☐ Same as active employees

If you selected **Dependent Care FSA** please indicate the length of the runout period: _____ (months)
(Length of runout period must be in whole and/or half month increments. Runout for terminated and active employees is the same for dependent care.)

V. 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, Further will reach out for more information)*

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 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_____

VII. ADMINISTRATIVE FEES

You will receive an email when your detailed billing information is available and another email 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

Please select **one:**

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

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.

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. REIMBURSEMENT

- Employees use the debit card to pay for expenses just as they would use a bank debit card. All participants will be issued one debit card. A debit card for dependent(s) may be requested online.
- Online Requests - Employees request reimbursement through our secure online member service center at hellofurther.com.

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 reimbursement.

Please indicate the health plan copay amounts below. If you have more copays that 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: _____ _____ _____

IX. ENROLLMENT DATA

Initial Enrollment Data will be sent via:

- ☐ Group Online Service Center. Employer will enroll participants online using the Group Online Service Center at **hellofurther.com**
- ☐ Secure File Transfer
  (File format requirements and secure file transfer setup will be provided via email).

X. DEDUCTION/CONTRIBUTION INFORMATION

Further is required to post payroll deduction information throughout the year for all employees choosing to participate in the plan. Funds should **not** be sent with any deduction information.

We offer two options for sending us your payroll deduction data:

- ☐ **Online Group Service Center (recommended)**: Upload your deduction information here.
- ☐ **Secure File Transfer**: This option allows employers or their vendors to create a file using Further format requirements via automated secure upload. (Choosing to use Secure File Transfer requires additional steps for setup).

XI. ADMINISTRATIVE TIPS

ONLINE ACCESS: hellofurther.com

With Further, your employees have access to a powerful tool for managing their FSA. 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 Locations 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 (X9055).

COORDINATING WITH AN HSA: For participants that have an FSA and an HSA, the FSA 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 general purpose (Full) FSA.

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 HRA:

* 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.

PLAN DOCUMENTS: Further will be preparing your Plan Document and Summary Plan Descriptions (SPD). The documents will be sent to the group contact within 60 days of receipt of the completed Plan Design Guide.

XII. SIGNATURES

It is agreed that necessary information concerning current and future employees or employees and/or their dependents who participate in this Plan and employees 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.

Signature _____ Date_____

Printed Name _____ Title _____