Louisiana | FURTHER

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) PLAN DESIGN GUIDE

Please complete this form and return to Further 45 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 866-231-0214; or mail it to Further, PO Box 14836, Lexington, KY 40511.
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 HRA.*

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 INFORMATION

If there is not enough space provided below, please fill out the Group Structure Form.

Group Number _____

Subgroup #(Ex.1111ZZ2)	Class ID (Ex. COBR or A001)	Plan ID (Ex.RFL20016)

IV. HEALTH REIMBURSEMENT ARRANGEMENT FUNDING OPTIONS

The HRA plans are only funded to one account for the employee and all dependents. Accumulations are based on all enrolled in the health plan and are not accumulated per dependent for embedded deductible plans.

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 - Subscriber Only = $_____ *(required)*
2 - Subscriber and Spouse = $_____
3 - Subscriber and Dependents = $_____
4 - Family =$_____

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

☐ **1. All Health Plan Eligible Medical** (includes deductible, copay & coinsurance)

Reimbursement method - select one:
- ☐ Medical/Rx Autopay
- ☐ Medical/Rx Autopay + Pay-the-Provider

☐ **2. All Health Plan Eligible Medical and Prescription** (includes deductible, copay, coinsurance & prescriptions)

Reimbursement method - select one:
- ☐ Medical/Rx Autopay
- ☐ Medical/Rx Autopay + Pay-the-Provider
- ☐ Medical Autopay + Rx Debit Card
- ☐ Medical Autopay + Pay-the-Provider + Rx Debit Card

☐ **3. Medical Deductible only** (no medical coinsurance or copays)

Reimbursement method - select one:
- ☐ Medical Autopay
- ☐ Medical Autopay + Pay-the-Provider

☐ **4. All IRS eligible Medical**

Reimbursement method - select one:
- ☐ Debit Card
- ☐ Medical Autopay
- ☐ Medical Autopay + Pay-the-Provider

☐ **5. All IRS eligible Medical and Prescription** (All IRS allowed medical and prescription*, including deductible, copay, and coinsurance)

Reimbursement method - select one:
- ☐ Debit Card
- ☐ Medical Autopay
- ☐ Medical Autopay + Pay-the-Provider

**All IRS allowed medical and/or prescription includes all 213(d) eligible expenses with exception to over-the-counter drugs, vision and dental*

☐ **6. All 213(d) Eligible** (Includes all IRS eligible medical, prescription, over-the-counter drugs, vision and dental)

Reimbursement method - select one:
- ☐ Debit Card
- ☐ Medical Autopay
- ☐ Medical Autopay + Pay-the-Provider

**options continued on next page*

IV. HEALTH REIMBURSEMENT ARRANGEMENT FUNDING OPTIONS (continued)

OPTION #1 - EMPLOYER PAYS FIRST HRA (continued)

☐ **7. Prescription Only**

Reimbursement method - select one:
☐ Debit Card
☐ Autopay

If you elected an option above from 4 to 7 and chose autopay, would you like for your employees to have an option to opt out of Automated Claim Payment and choose a debit card instead? ☐ Yes ☐ No

☐ **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 - Subscriber Only = $_____ *(required)*
2 - Subscriber and Spouse = $_____
3 - Subscriber and Dependents = $_____
4 - Family =$_____ *(required)*

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:

☐ **1. All Health Plan Eligible Medical** (includes deductible, copay & coinsurance)

Reimbursement method - select one:
☐ Medical Autopay
☐ Medical Autopay + Pay-the-Provider

☐ **2. All Health Plan Eligible Medical and Prescription** (includes deductible, copay, coinsurance & prescriptions)

Reimbursement method - select one:
☐ Medical/Rx Autopay
☐ Medical/Rx Autopay + Pay-the-Provider

☐ **3. Medical Deductible Only** (no medical copay & coinsurance)

Reimbursement method - select one:
☐ Medical Autopay
☐ Medical Autopay + Pay-the-Provider

☐ **4. All IRS Eligible Medical** (All IRS allowed medical*, including deductible, copay, and coinsurance)

Reimbursement method - select one:
☐ Medical Autopay
☐ Medical Autopay + Pay-the-Provider

☐ **5. All IRS Eligible Medical & Prescription** (All IRS allowed medical and prescription*, including deductible, copay, and coinsurance)

Reimbursement method - select one:
☐ Medical/Rx Autopay
☐ Medical/Rx Autopay + Pay-the-Provider

***** *All IRS allowed medical and/or prescription includes all 213(d) eligible expenses with exception to over-the-counter drugs, vision and dental.*

**options continued on next page*

IV. HEALTH REIMBURSEMENT ARRANGEMENT FUNDING OPTIONS (continued)

OPTION #2 - SHARED PAYMENT HRA (continued)

☐ **6. All 213 (d) Eligible** (Includes all IRS eligible medical, prescription, over the counter, vision and dental)

Reimbursement method - select one:

☐ Medical/Rx Autopay
☐ Medical/Rx Autopay + Pay-the-Provider

☐ **7. Prescription Expenses Only**

Reimbursement method:

✓ Reimbursement Method will be Rx Autopay

☐ **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 - Subscriber Only = $_____ *(required)*
2 - Subscriber and Spouse = $_____
3 - Subscriber and Dependents = $_____
4 - Family =$_____ *(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 - Subscriber Only = $_____ *(required)*
2 - Subscriber and Spouse = $_____
3 - Subscriber and Dependents = $_____
4 - Family =$_____ *(required)*

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

☐ **1. All Health Plan Eligible Medical** (Includes deductible, copay, coinsurance)

Reimbursement method - select one:

☐ Medical Autopay
☐ Medical Autopay + Pay-the-Provider

☐ **2. All Health Plan Eligible Medical and Prescriptions** (Includes deductible, copay, coinsurance and prescriptions)

Reimbursement method - select one:

☐ Medical/Rx Autopay
☐ Medical/Rx Autopay + Pay-the-Provider

☐ **3. Medical Deductible Only** (No medical coinsurance or copays)

Reimbursement method - select one:

☐ Medical Autopay
☐ Medical Autopay + Pay-the-Provider

**options continued on next page*

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 - Subscriber Only = $_____ *(required)*
2 - Subscriber and Spouse = $_____
3 - Subscriber and Dependents = $_____
4 - Family =$_____ *(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: _____ _____ _____ Dental: _____ _____ _____

VII. 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.

VIII. ADMINISTRATIVE FEES

Is your plan fully insured or self insured?

Fully Insured ☐ Self Insured (SBFS - Small Business Funding Solutions) ☐ Self Insured (Traditional)

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.)

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 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, 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.

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.

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.

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 _____