

Health Reimbursement Arrangement

Company Data:

Company Information:

1. Name of adopting employer (Plan Sponsor):
- 2a. Plan Sponsor address line 1:
- 2b. Plan Sponsor address line 2:
3. Plan Sponsor city:
4. Plan Sponsor state:
5. Plan Sponsor zip:
6. Plan Sponsor phone AC/Number:
7. Plan Sponsor fax AC/Number:
8. Plan Sponsor EIN:
9. Plan Sponsor fiscal year end:
- 10a. Plan Sponsor entity type:
 C Corporation S Corporation Non profit Partnership Limited Liability Company
Limited Liability Partnership Sole Proprietorship Union Government agency Other
- 10b. If 10a is "Union", enter name of the representative of the parties who established or maintain the Plan:
- 10c. If 10a is "Other", enter Plan Sponsor entity type:
11. State of organization of Plan Sponsor:
- 12a. The Plan Sponsor is a member of an affiliated service group:
 Yes No
- 12b. If 12a is "Yes", list all members of the group (other than the Plan Sponsor):
- 13a. The Plan Sponsor is a member of a controlled group:
 Yes No
- 13b. If 13a is "Yes", list all members of the group (other than the Plan Sponsor):

Contact Information:

21. Contact name:
22. Contact title:
23. Contact salutation:
24. Contact phone:
25. Contact fax:
26. Contact email:

Notes:

30. Notes

Plan Data:

A. GENERAL INFORMATION

General

1. Plan Number:
- 2a. First line of Plan name:
- 2b. Second line of Plan name:
- 3a. Original effective date of Plan:
- 3b. Is this a restatement of a previously-adopted plan?
[] Yes [] No
- 3c. If **A.3b** is "Yes", effective date of Plan restatement:
- 4a. Plan Year End (Month Day):
- 4b. The Plan has a short plan year:
[] Yes [] No
- 4ci. If **A.4b** is Yes", enter the start date of the short Plan Year:
- 4cii. If **A.4b** is Yes", enter the end date of the short Plan Year:

Miscellaneous

10. Enter date to place on cover of Summary Plan Description:
11. File Number:
12. User Defined Field #1
13. User Defined Field #2
14. User Defined Field #3
15. User Defined Field #4
16. User Defined Field #5

B. ELIGIBILITY

Other Company Benefit Plan

- 1a. An Employee is eligible to participate in the Plan under the same terms and conditions as under the Company benefit plan specified in **B.1b**:
[] Yes [] Yes - with limitations and modifications [] No
- 1b. If **B.1a** is not "No", enter name of other Company benefit plan:
- 1c. If **B.1a** is " Yes - with limitations and modifications", describe limitations and/or modifications:

Exclusions/Modifications

2. If **B.1a** is "No", exclude Employees covered under a collective bargaining agreement from definition of Eligible Employee:
[] Yes [] No
3. If **B.1a** is "No", exclude leased Employees from definition of Eligible Employee:
[] Yes [] No
4. If **B.1a** is "No", exclude nonresident aliens from definition of Eligible Employee:
[] Yes [] No
- 5a. If **B.1a** is "No", exclude part-time employees from definition of Eligible Employee:
[] Yes [] No
- 5b. If **B.1a** is "No" and **B.5a** is "Yes", a part-time employee is an employee who works less than the following number of hours per week:
- 6a. If **B.1a** is "No", exclude other Employees from definition of Eligible Employee:
[] Yes [] No

- 6b.** If **B.1a** is "No" and **B.6a** is "Yes", describe other Employees excluded from definition of Eligible Employee:
- 7a.** If **B.1a** is "No", allow immediate participation for all Eligible Employees employed on the date specified in **B.7b**:
 Yes No
- 7b.** If **B.1a** is "No" and **B.7a** is "Yes", the special participation rule shall apply to all Eligible Employees employed on:
- 8a.** If **B.1a** is "No", indicate whether the Plan will make any other revisions to the term "Eligible Employee":
 Yes No
- 8b.** If **B.1a** is "No" and **B.8a** is "Yes", describe any further modifications to the term "Eligible Employee":

Service Requirements

- 10.** If **B.1a** is "No", minimum age requirement for an Eligible Employee to become eligible to be a Participant in the Plan
 None 21 20-1/2 20 19 18
- 11a.** If **B.1a** is "No", minimum service requirement for an Eligible Employee to become eligible to be a Participant in the Plan:
 None Specified number of hours of service Specified number of days of service Specified number of months of service Specified number of years of service
- 11b.** If **B.1a** is "No" and **B.11a** is not "None" enter the number of hours/days/months/years required under **B.11a**:
- 12a.** If **B.1a** is "No", frequency of entry dates:
 Immediate first day of the calendar month first day of each plan quarter first day of the first month and seventh month of the Plan Year first day of the Plan Year
- 12b.** If **B.1a** is "No" and **B.12a** is not "Immediate", selection of entry date:
 coincident with or next following next following
- 13a.** If **B.1a** is "No", indicate whether the Plan will make any other revisions to the eligibility rules specified in **B.10 - B.12**:
 Yes No
- 13b.** If **B.1a** is "No" and **B.13a** is "Yes", describe any further modifications to the eligibility rules specified in **B.10 - B.12**:

C. BENEFITS

Eligible Expenses

- 1a.** Coverage under the Plan for Covered Persons is available for the following Eligible Expenses:
 All allowable medical expenses Health plan deductibles and coinsurance Health plan coinsurance Health plan deductibles Listed medical expenses
- 1b.** If **C.1a** is "All allowable medical expenses", exclude coverage for over the counter drugs:
 Yes No
- 1c.** Are there any other modifications to the definition of Eligible Expenses:
 Yes No
- 1d.** If **C.1c** is "Yes", describe modifications to the definition of Eligible Expenses:
- 1e.** If **C.1a** is "Listed medical expenses", list eligible expenses:

Covered Person

- 2a.** The definition of Covered Person under the Plan shall include the following persons:
 Participant, spouse and dependents Persons covered under Company medical plan Other
- 2b.** If **C.2a** is "Persons covered under Company medical plan", indicate the name of the Company-sponsored benefit plan:
- 2c.** If **C.2a** is "Other", indicate the definition of Covered Person:

Benefit Limitation

- 3a.i.** Enter the maximum annual amount that will be credited to a Participant's Health Reimbursement Account in any Plan Year for one Covered Person:
- 3a.ii.** Enter the maximum annual amount that will be credited to a Participant's Health Reimbursement Account in any Plan Year for two Covered Persons:
- 3a.iii.** Enter the maximum annual amount that will be credited to a Participant's Health Reimbursement Account in any Plan Year for more than two Covered Persons:
- 3b.i.** Enter the Health Reimbursement Account deductible in any Plan Year for one Covered Person:
- 3b.ii.** Enter the Health Reimbursement Account deductible in any Plan Year for two Covered Persons:
- 3b.iii.** Enter the Health Reimbursement Account deductible in any Plan Year for more than two Covered Persons:
- 4a.** The amounts in **C.3a** shall be credited to the Participant's Health Reimbursement Account at the following times:
 Beginning of Plan Year Semi annually Quarterly Monthly
- 4b.** If a Participant enters the Plan at a time other than the beginning of a period described in **C.4a**, the amounts credited to the Health Reimbursement Account shall be reduced to reflect the time of actual participation in the Plan:
 Yes No
- 5a.** The Plan allows a carryover of the balance in a Participant's Health Reimbursement Account to the next Plan Year:
 Yes Yes - limited to dollar amount Yes - limited to multiple of maximum annual benefit No
- 5b.** If **C.5a** is "Yes with limitations", enter the maximum dollar amount (or multiple of the maximum annual amount) that may be carried over to the next Plan Year:

Coordination with Other Plans

- 6.** Describe method to coordinate coverage in the Plan with a Health Care Reimbursement Account ("HCRA") in a Company-sponsored cafeteria plan for expenses that are reimbursable under both this Plan and the cafeteria plan:
 None HRA first Cafeteria plan first
- 7a.** Describe method to coordinate coverage in the Plan with Health Savings Accounts
 None Permitted Coverage Post Deductible Coverage Both Permitted and Post Deductible Coverage Suspended HRA
- 7b.** If **C.7a** is not "None", the limitations shall apply to:
 All Participants Only Participants eligible to participate in the HDHP Only Participants enrolled in the HDHP

D. PLAN OPERATIONS

Claims

- 1a.** Specify whether the deadline for filing claims is a specified number of days or by a specified date:
 Within specified number of days after end of Plan Year By a specified time
- 1b.** Enter the number of days after the end of the Plan Year or the specified date:
- 2a.** Specify whether the Plan provides for an earlier deadline for claims submission for Terminated Participants:
 Yes No
- 2b.** Specify whether the deadline for filing claims is a specified number of days or by a specified date:
 Within specified number of days after Termination By a specified time
- 2c.** Enter the number of days after Termination or the specified date:
- 3.** Indicate whether the Company will provide debit, credit, and/or other stored-value cards:
 Yes No

Plan Administration

- 4a.** Designation of Plan Administrator:
 Plan Sponsor Committee appointed by Plan Sponsor Other
- 4b.** If **D.4a** is "Other", Name of Plan Administrator:
- 5a.** Type of indemnification for the Plan Administrator:
 None Standard Custom
- 5b.** If **D.5a** is "Custom", enter indemnification for the Plan Administrator:

Other Provisions

- 6a.** Claims should be submitted to:
 Plan Sponsor Other
- 6b.i.** If **D.6a** is other, indicate name where claims should be sent:
- 6b.ii.** If **D.6a** is other, indicate address where claims should be sent:
- 6b.iii.** If **D.6a** is other, indicate phone where claims should be sent:
- 7a.** Indicate whether the Plan is subject to COBRA:
 Yes No
- 7b.** If **D.7a** is "Yes", the contact person listed in the COBRA Notice is the same person described in **D.6** regarding claims:
 Yes No
- 7c.i.** If **D.7a** is "Yes" and **D.7b** is "No", indicate the contact name listed in the COBRA Notice:
- 7c.ii.** If **D.7a** is "Yes" and **D.7b** is "No", indicate the contact address listed in the COBRA Notice:
- 7c.iii.** If **D.7a** is "Yes" and **D.7b** is "No", indicate the contact phone listed in the COBRA Notice:
- 7d.** If **D.7a** is "Yes", enter the number of days within which a Participant must notify the Plan Administrator of certain qualifying events such as divorce or legal separation or a dependent child's losing coverage:
- 8.** Indicate whether the Plan is subject to HIPAA privacy rules:
 Yes No
- 9.** Indicate whether the Plan is subject to HIPAA portability rules:
 Yes No
- 10.** Indicate whether the Plan is subject to FMLA:
 Yes No

CUSTOM LANGUAGE APPENDICES

Custom Effective Date

- 1.** Enter custom effective date(s) that are to be added to Section E of the Adoption Agreement:

Custom Language

- 2.** Enter custom language that is to be added as an Addendum to the Adoption Agreement.