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:

Additional Company Information:

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

A. 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:
5. Is the Plan subject to ERISA?
[ ] Yes **[ ]** No

A. 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

B. 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:

B. 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":

B. 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**:

B. Former Employees

15a. Permit Eligible Employees to participate in the Plan after Termination (Section 3.03; See item **C.10** to describe benefits available to former employees):
[ ] Yes - all Eligible Employees **[ ]** Yes - selected Eligible Employees **[ ]** No

15b. If **B.15a** is "Yes - selected Eligible Employees" are eligible to participate in the Plan after Termination, describe the Employees:

C. BENEFITS

C. Eligible Expenses

1a. Coverage under the Plan for Covered Persons is available for the following Eligible Expenses:
[ ] All allowable medical expenses **[ ]** Listed medical expenses **[ ]** Health plan deductibles **[ ]** Health plan coinsurance **[ ]** Health plan deductibles and coinsurance **[ ]** Schedule of expenses

1b. Are there any other modifications to the definition of Eligible Expenses:
[ ] Yes **[ ]** No

1c. If **C.1b** is "Yes", describe modifications to the definition of Eligible Expenses:

1d. If **C.1a** is "Listed medical expenses", list eligible expenses:

C. 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 **[ ]** Participants only **[ ]** 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:

C. Health Reimbursement Account - Maximum Benefit

3a. If **C.1a** is "Schedule of expenses", are the maximum annual amounts specified in the schedule of benefits?
[ ] Yes **[ ]** No

3b.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 (include dollar signs if applicable):

3b.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:

3b.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:

3c. FSA failsafe. Limit maximum benefit to 5 times the value of coverage and exclude long term care services:
[ ] Yes **[ ]** No

C. Health Reimbursement Account - Deductible

4a. Enter the Health Reimbursement Account deductible in any Plan Year for one Covered Person:

4b. Enter the Health Reimbursement Account deductible in any Plan Year for two Covered Persons:

4c. Enter the Health Reimbursement Account deductible in any Plan Year for more than two Covered Persons:

C. Health Reimbursement Account - Coinsurance

5. If **C.1a** is not "Schedule of expenses", once the HRA deductible is met (if any), indicate the level of coverage provided under the HRA until the annual amount under **C.3** is met:

C. Health Reimbursement Account - Procedures

6a. 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 **[ ]** Per payroll period **[ ]** Claims dependent

6b. If **C.6a** is not "Claims dependent" and a Participant enters the Plan at a time other than the beginning of a **C.20a** period, the amounts credited to the HCRA shall be reduced to reflect the time of actual participation in the Plan:
[ ] Yes **[ ]** No

6c. If **C.6a** is not "Claims dependent" and a change to the number of covered persons under **C.2** affects the amount credited to the HCRA at times other than that selected in **C.6a**, contributions will be prorated to accommodate the change:
[ ] Yes **[ ]** No

7a. 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

7b. If **C.7a** 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:

C. Coordination with Other Plans

8. 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

9a. 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

9b. If **C.9a** is not "None", the limitations shall apply to:
[ ] All Participants **[ ]** Only Participants eligible to participate in the HDHP **[ ]** Only Participants enrolled in the HDHP

C. Former Employees

10a. If **B.15a** is "Yes" (Eligible Employees may participate in the Plan after Termination), select what benefits the Employees described in **B.15** are eligible for after Termination:
[ ] Plan Year spend-down **[ ]** Other

10b. If **C.10a** is "Other", describe any unique Plan features that apply to Terminated Former Employees:

C. Health Reimbursement Account - Schedule of Expenses

20a. If **C.1a** is "Schedule of expenses", describe the first Eligible Expense covered by the HRA:

20b. If **C.1a** is "Schedule of expenses", describe the Schedule of HRA payments that applies to the first Eligible Expense:

21a. If **C.1a** is "Schedule of expenses", describe the second Eligible Expense covered by the HRA:

21b. If **C.1a** is "Schedule of expenses", describe the Schedule of HRA payments that applies to the second Eligible Expense:

22a. If **C.1a** is "Schedule of expenses", describe the third Eligible Expense covered by the HRA:

22b. If **C.1a** is "Schedule of expenses", describe the Schedule of HRA payments that applies to the third Eligible Expense:

23a. If **C.1a** is "Schedule of expenses", describe the fourth Eligible Expense covered by the HRA:

23b. If **C.1a** is "Schedule of expenses", describe the Schedule of HRA payments that applies to the fourth Eligible Expense:

24a. If **C.1a** is "Schedule of expenses", describe the fifth Eligible Expense covered by the HRA:

24b. If **C.1a** is "Schedule of expenses", describe the Schedule of HRA payments that applies to the fifth Eligible Expense:

25a. If **C.1a** is "Schedule of expenses", describe the sixth Eligible Expense covered by the HRA:

25b. If **C.1a** is "Schedule of expenses", describe the Schedule of HRA payments that applies to the sixth Eligible Expense:

26a. If **C.1a** is "Schedule of expenses", describe the seventh Eligible Expense covered by the HRA:

26b. If **C.1a** is "Schedule of expenses", describe the Schedule of HRA payments that applies to the seventh Eligible Expense:

27a. If **C.1a** is "Schedule of expenses", describe the eighth Eligible Expense covered by the HRA:

27b. If **C.1a** is "Schedule of expenses", describe the Schedule of HRA payments that applies to the eighth Eligible Expense:

28a. If **C.1a** is "Schedule of expenses", describe the ninth Eligible Expense covered by the HRA:

28b. If **C.1a** is "Schedule of expenses", describe the Schedule of HRA payments that applies to the ninth Eligible Expense:

29a. If **C.1a** is "Schedule of expenses", describe the tenth Eligible Expense covered by the HRA:

29b. If **C.1a** is "Schedule of expenses", describe the Schedule of HRA payments that applies to the tenth Eligible Expense:

D. PLAN OPERATIONS

D. 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

D. 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:

D. State Law Rules

10a. If **A.5** is "No" (non-ERISA Plan), is the Plan subject to other state law rules?
[ ] Yes **[ ]** No
10b. If D.10a is "Yes" enter any state law rules that apply:

E. CUSTOM LANGUAGE APPENDICES

E. Custom Effective Date

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

E. Custom Language

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

F. ADMINISTRATIVE ELECTIONS

J. General

1. Indicate the employee identification method that is used on all forms:
[ ] Employee ID **[ ]** Social Sec Number **[ ]** None

J. Plan Contacts

5a. Claims should be submitted to:
[ ] Plan Sponsor **[ ]** Other
5b. If **J.5a** is other, indicate name where claims should be sent:
5c. If **J.5a** is other, indicate address where claims should be sent:
5d. If **J.5a** is other, indicate phone where claims should be sent:

J. COBRA

6a. Indicate whether the Plan is subject to COBRA:
[ ] Yes **[ ]** No

6b. If the plan is subject to COBRA, 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:

6c. If the plan is subject to COBRA (**J.6a** is "Yes"), indicate the contact person to be listed in the COBRA Notice:
[ ] Plan Sponsor **[ ]** Person to whom claims are submitted **[ ]** Other

6d. If the plan is subject to COBRA and **J.6c** is "Other", indicate the contact name listed in the COBRA Notice:

6e. If the plan is subject to COBRA and **J.6c** is "Other", indicate the contact address listed in the COBRA Notice:

6f. If the plan is subject to COBRA and **J.6c** is "Other", indicate the contact phone listed in the COBRA Notice:

J. Other Provisions

7. Indicate whether the Plan is subject to HIPAA privacy rules:
[ ] Yes **[ ]** No

8. Indicate whether the Plan is subject to FMLA:
[ ] Yes **[ ]** No

9. Indicate whether the Summary Plan Description should include HIPAA portability language:
[ ] Yes **[ ]** No

10. If the Plan is subject to HIPAA Portability, indicate whether the SPD should include language regarding the Newborns' and Mothers' Health Protection Act:
[ ] Yes **[ ]** No

11. If the Plan is subject to HIPAA Portability, indicate whether the SPD should include language regarding the Women's Health and Cancer Rights Act:
[ ] Yes **[ ]** No

12. If the SPD includes HIPAA Portability language, indicate whether the Plan is grandfathered for the purposes of providing notice regarding grandfathered status and for claims procedures:
[ ] Yes **[ ]** No

J. Stored Value Card Restrictions - SPD

14. If **D.3** is "Yes" (the Company will provide stored value cards), indicate any restrictions or terms of use for the debit, credit, and/or other stored value cards (if terms are provided in other documents, you can reference those here):

J. Coordination with a Company sponsored health plan

20. Indicate whether the SPD should contain information about how the HRA coordinates with company sponsored health insurance:
[ ] No **[ ]** Deductible only **[ ]** Other information only **[ ]** Deductible and other information

21. Enter the Company health insurance plan deductible (do not enter the HRA deductible):

22. Enter information for the SPD about how this plan coordinates with a Company sponsored health insurance plan:

J. Children Under Age 27

24. If the Plan provides coverage for children, is coverage extended until the end of calendar year in which the child turns 26?
[ ] Yes **[ ]** No

J. Non-ERISA SPD language

25a. If the Plan is not subject to ERISA (**A.5** is "No") and not subject to HIPAA Portability (**J.9** is "No" or the plan is grandfathered at **J.12**), include claims language in the SPD?
[ ] Yes - include sample claims language **[ ]** Yes - as provided below **[ ]** No

25b. If the Plan is not subject to ERISA (**A.5** is "No"), not subject to HIPAA Portability (**J.9** is "No") and **J.25a** is "Yes - as provided below", enter any claims procedures language you would like to appear in the claims section of the SPD:

26a. If the Plan is not subject to ERISA (**A.5** is "No"), include ERISA-like rights language in the SPD?
[ ] Yes - include sample rights language **[ ]** Yes - as provided below **[ ]** No

26b. If the Plan is not subject to ERISA (**A.5** is "No") and **J.26a** is "Yes - as provided below", enter any language you would like to appear in the section "Your Rights" of the SPD:

J. Joinder Agreement

30. For purposes of generating a Joinder Agreement, enter the names of all employers who have adopted the plan other the lead plan sponsor separated by a semicolon:

J. SPD Custom Language

100. Enter custom language to appear as an addendum to the Summary Plan Description: