ADOPTION AGREEMENT FOR

HEALTH REIMBURSEMENT ARRANGEMENT

The undersigned self-employer Employer of only one employee, by executing this Adoption Agreement, elects to adopt the accompanying Health Reimbursement Arrangement (the "Plan") by adopting said plan document in full. The Employer makes the following elections granted under the provisions of the Plan.

1. **Name of the Employer/Plan Sponsor**:

_____

The Employer/Plan Sponsor shall be the Plan Administrator and the Named Fiduciary for the Plan.

2. **Effective Date:** (select only one)

❑ This Health Reimbursement Arrangement shall be effective as of _____.

❑ This amended and restated Health Reimbursement Arrangement shall be effective as of _____. If amended and restated, the Plan was originally effective on _____.

3. **Plan Year:**

The initial Plan Year shall begin on _____ and end on _____.

Future Plan Years will be based on a full twelve month period (select only one):

❑ Beginning each January 1st and ending each December 31st.

❑ Beginning each _____ and ending each _____.

4. **Plan Number**: _____ (typically, a three digit number beginning with a "5" for this type of benefit plan – e.g., "502" or "503")

5. **Employer's Principal Office**. This Health Reimbursement Plan shall be governed under the laws of the:

❑ State of _____.

❑ Commonwealth of _____.

6. **Eligible Employee**. The sole employee of the Employer, _____ ("Sole Employee") shall be eligible to participate in the Plan. No other individual is eligible to participate in the Plan.

For purposes of determining continued eligibility under the Plan, "**Retiree**" (select only one):

❑ shall be eligible to continue participation in the Plan

❑ shall not be eligible to continue participation in the Plan

"**Retiree**" shall only be considered as those employees who have satisfied the Employer's terms and conditions for retirement. For this Plan, "Retirement" shall be considered as being only the Sole Employee who (select only one):

❑ Has reached _____ years of age

❑ Has attained a combination of years of service and age, to equal _____

❑ Other: _____

7. **Plan Entry Date**. The Sole Employee is eligible to participate in and become Participant under the Plan immediately upon satisfying the Plan's eligibility requirements.

8. **Benefits**. The Plan shall reimburse the Sole Employee for the cost of Eligible Medical or Dental Expenses (as defined under Internal Revenue Code Section 213 and as further described below), subject to an annual limit of $ _____. Select one of the following:

❑ The entire portion of the Participant's remaining account balance as of the end of the Plan Year can be carried over and used in the subsequent year(s), to the extent not fully utilized in the year of contribution (None of this amount may be paid in cash or other form of distribution, other than through reimbursement of actual qualifying medical expenses incurred).

❑ The specified portion of the Participant's remaining account balance as of the end of the Plan year can be carried over and used in the subsequent year(s), to the extent not fully utilized in the year of contribution: _____

❑ The Participant's remaining account balance as of the end of the Plan year may not be carried over to the next Plan Year.

9. **Eligible Medical or Dental Expenses**. The following categories of expenses qualify for reimbursement under the Plan (select only one of a), b), c) or d)):

a) ❑ Comprehensive. All medical and dental expenses not otherwise covered by insurance (e.g., co-pays, deductibles, etc.), except as otherwise described as follows:

_____

_____

_____

_____

_____

_____

b) ❑ Bridge. Only those expenses that are covered under insurance, but subject to a deductible. Coverage will be provided for out-of-pocket costs of up to $_____ of the total deductible limit. Select one of the two following options:

❑ Benefits under this Plan shall be paid BEFORE the Sole Employee is responsible for his portion of the deductible limit;

❑ Benefits under this Plan shall be paid AFTER the Sole Employee's portion of the deductible limit is paid.

c) ❑ Limited. Only those expenses that are not otherwise covered by insurance (e.g., co-pays, deductibles, etc.), as further selected as follows (select all that apply):

❑ Dental Expenses;

❑ Vision Expenses;

❑ Preventive Care Expenses;

❑ Prescription Drugs;

❑ Other: _____

d) ❑ Premium Only. Only the Sole Employee's applicable premium of the following insurance coverages (select all that apply):

- ❑ Essential Health Benefit Plan Premiums
- ❑ Excepted Benefit Health Plan Premiums
- ❑ Disability Insurance Premiums;
- ❑ Dental Insurance Premiums;
- ❑ Other: _____

10. **Contributions**. The Employer shall make all contributions for this Plan. The Employer shall make contributions to the Plan in the following manner (select only one):

- ❑ On an annual basis at the beginning of the Plan Year.
- ❑ On a quarterly basis at the beginning of each quarter within the Plan Year.
- ❑ On a monthly basis at the beginning of each month within the Plan Year.
- ❑ On a pro rata basis, coordinating with Employee pay dates, within the Plan Year.

11. **Minimum Reimbursement Amount**. Except for a final claim for a period of coverage, a claim for reimbursement (select only one):

- ❑ May be any amount, regardless of the size of claim.
- ❑ May not be less than $_____. In order to be reimbursed, the Participant's aggregate claims submitted for reimbursement must satisfy this minimum threshold.

12. **Order of Benefit Payments**. Does the Employer sponsor a Section 125 Health Care Flexible Spending Arrangement (Health FSA), in addition to this Plan?

- ❑ Yes (complete a) below)
- ❑ No (skip to 14)

a) Which plan will pay first? (select only one):

- ❑ Eligible Medical or Dental Expenses must be paid under the Health FSA before this Plan.
- ❑ Eligible Medical or Dental Expenses must be paid under the Health FSA after this Plan.

13. **Leaves of Absence**. If the Participant goes on a leave of absence that is not subject to USERRA, will the Participant be treated as having terminated participation in the Plan?

❑ Yes

❑ No

14. **Forfeiture of Unclaimed Benefit Payments**. If a benefit payment under the Plan is unclaimed (e.g., an uncashed check) by the Participant by the close of the Plan Year following the Period of Coverage in which the Eligible Medical or Dental Expense was incurred, will the Participant's benefit payment be forfeited?

❑ Yes

❑ No

15. **Inability to Locate Payee**. If the Plan Administrator is unable to make payment because the Plan Administrator cannot ascertain the identity or whereabouts of the Participant or other person after reasonable efforts have been made to identify or locate such person, will that payment be forfeited following a reasonable time after the date that the payment first became due?

❑ Yes

❑ No

16. **HIPAA Privacy and Security Officials**

The self-employed Employer will serve as the Plan's HIPAA Privacy official:

The self-employer Employer will serve as the Plan's HIPAA Security official:

17. **HIPAA Authorized Workforce**

Only the self-employed Employer will have access to Protected Health Information under HIPAA in relation to the Plan.

18. **Authorized Signatures**:

Date _____ By _____

Employer Authorized Signature

CERTIFICATE OF CORPORATE RESOLUTION

The undersigned Secretary of _____ (the Employer) hereby certifies that the following resolutions were duly adopted by the Employer on _____ and that such resolutions have not been modified or rescinded as of the date hereof:

RESOLVED, that the form of Health Reimbursement Arrangement effective as of _____, presented to and reviewed by the Employer, is hereby approved and adopted and that the duly authorized agents of the Employer are hereby authorized and directed to execute and deliver to the Plan Administrator one or more counterparts of the Plan.

RESOLVED, that the Plan Administrator shall be instructed to take such actions that are deemed necessary and proper in order to implement the Plan, and to set up adequate accounting and administrative procedures to provide benefits under the Plan.

RESOLVED, that the duly authorized agents of the Employer shall act as soon as possible to notify the sole employee of the Employer of the adoption of the Health Reimbursement Arrangement by delivering to such sole employee a copy of the summary description of the Plan in the form of the Summary Plan Description presented to and reviewed by the Employer, which form is hereby approved.

The undersigned further certifies that attached hereto as Exhibits A and B, respectively, are true copies of the Health Reimbursement Arrangement and Summary Plan Description approved and adopted in the foregoing resolutions.

_____

Secretary/ Principal

Date: _____