HealthEquity Sample
1234 W 4567 S
West Jordan, UT 84088

HealthEquity Sample HRA Plan

Effective January 01, 2016

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INTRODUCTION

HealthEquity Sample hereby establishes effective January 01, 2016, a health reimbursement arrangement, known as the HealthEquity Sample HRA Plan (the "HRA"), the terms of which are set forth in this document. The HRA provides for the reimbursement of expenses as described in the Appendices of this document that have been incurred by Eligible Employees, their spouses and certain eligible Dependents of such Employees.

It is intended that the HRA meet the requirements for qualification under Code Section 105 with respect to Employees, and that benefits paid Employees hereunder be excludible from their gross incomes pursuant to Code Section 105(b).

I. ARTICLE - DEFINITIONS

As used in this HRA, the following words and phrases shall have the meanings set forth herein unless a different meaning is clearly required by the context:

01. **"Plan Administrator"** means the individual(s) or committee appointed by the Employer to carry out the administration of the HRA. In the event the Administrator has not been appointed, or resigns from an appointment, the Employer shall be deemed to be the Administrator.

02. **"Code"** means the Internal Revenue Code of 1986, as amended.

03. **"Coverage Period"** means the 12-consecutive-month period beginning on January 01 and ending December 31.

04. **"Dependent"** means any individual who qualifies as a dependent under Code Section 152 (as modified by Code Section 105(b)). Any child of a Participant who is an "alternate recipient" under a qualified medical child support order under ERISA Section 609 shall be considered a Dependent under this Arrangement.

05. **"Effective Date"** means January 01, 2016.

06. **"Eligible Employee"** means an Employee who is eligible to participate in the Employer's group medical plan.

    An individual shall not be an "Eligible Employee" if such individual is not eligible for the Employer's group medical plan.

07. **"Employee"** means any person who is employed by the Employer and is regularly scheduled to work a minimum of 30 hours per week. The term "Employee" shall also include any person who is a Leased Employee deemed to be an Employee as provided in Code Section 414(n) or (o).

08. **"Employer"** means HealthEquity Sample, any successor which shall maintain this HRA and any predecessor which has maintained this HRA. In addition, unless the context requires otherwise, the term "Employer" shall include any Participating Employer which shall adopt this HRA.

09. **"Employer Contribution"** means the amounts contributed to the HRA by the Employer.

10. **"ERISA"** means the Employee Retirement Income Security Act of 1974, as amended from time to time.

11. **"HRA"** means the HealthEquity Sample HRA Plan as adopted by the Employer, including all amendments thereto.

12. **"Leased Employee"** means, effective with respect to Plan Years beginning on or after January 1, 1997, any person (other than an Employee of the Employer) who, pursuant to an agreement between the Employer and any other person or entity ("leasing organization"), has performed services for the Employer (or for the Employer and related persons determined in accordance with Code Section 414(n)(6)) on a substantially full time basis for a period of at least one year, and such services are performed under primary direction or control by the Employer. Contributions or benefits provided to a Leased Employee by the leasing organization which are attributable to services performed for the Employer shall be treated as provided by the Employer. Furthermore, compensation for a Leased Employee shall only include compensation from the leasing organization that is attributable to services performed for the Employer.

    A Leased Employee shall not be considered an Employee of the Employer if:

    1. such employee is covered by a money purchase pension plan providing:

        i. a nonintegrated employer contribution rate of at least ten percent (10%) of compensation, as defined in Code Section 415(c)(3), but including amounts contributed pursuant to a salary reduction agreement which are excludable from the employee's gross income under Code Sections 125, 402(e)(3), 402(h) or 403(b),

        ii. immediate participation, and

        iii. full and immediate vesting; and

    2. leased employees do not constitute more than twenty percent (20%) of the recipient Employer's non-highly compensated workforce.

13. **"Participant"** means any Eligible Employee who has satisfied the requirements of the Section titled: "Eligibility" and has not for any reason become ineligible to participate further in the HRA.

14. **"Premiums"** mean the Participant's cost for any health plan coverage.

15. **"Qualifying Medical Expenses"** means any expenses as described in the Appendices of this document that meets the definition of "qualified medical expenses" (within the meaning of Code Section 213(d) and as allowed under Code Section 105 and the rulings and Treasury regulations thereunder) of the Participant, the Participant's spouse or a Dependent and that are not otherwise used by the Participant as a deduction in determining the Participant's tax liability under the Code or reimbursed under any other health coverage,

including a health Flexible Spending Account. If the Employer provides Health Savings Accounts for Participants, Qualifying Medical Expenses reimbursed shall be limited to those allowed under Code Section 223.

II. ARTICLE - PARTICIPATION

01. **Eligibility**

Any Eligible Employee shall be eligible to participate hereunder on the date such Employee is enrolled in the Employer's group medical plan.

02. **Effective Date of Participation**

An Eligible Employee who has satisfied the conditions of eligibility pursuant to the Section titled: "Eligibility" shall become a Participant effective as of the date the Eligible Employee enters or re-enters the Employer's group medical plan.

03. **Termination of Participation**

Retired Employees and other terminated Employees may not continue to participate in the HRA, and any unused amounts shall be forfeited. In the case of the death of the Participant, any remaining balances may only be paid out as reimbursements for Qualifying Medical Expenses and shall not constitute a death benefit to the Participant's estate and/or the Participant's beneficiaries. A Participant shall be permitted at least annually to opt out of the HRA and waive future reimbursements from the HRA. This Section shall be applied and administered consistent with any rights a Participant and the Participant's Dependents may be entitled to pursuant to Code Section 4980B or the Section of the HRA titled: "Continuation of Coverage".

III. ARTICLE - BENEFITS

01. **Establishment of HRA**

a. The HRA is intended to qualify as a Health Reimbursement Arrangement under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury regulations thereunder.

b. Participants in this Health Reimbursement Arrangement may submit claims for the reimbursement of Qualifying Medical Expenses as defined under the HRA.

c. The Employer shall make available to Participant an Employer Contribution in the amounts listed the Appendices of this document

d. This HRA shall not be coordinated or otherwise connected to the Employer's cafeteria plan (as defined in Code Section 125), except as permitted by the Code and the Treasury regulations thereunder in order for this HRA to be maintained as a Health Reimbursement Arrangement. No salary reduction contributions may be made to this Health Reimbursement Arrangement.

e. If the Employer maintains Health Savings Accounts for Participants, this Arrangement shall be operated in accordance with the restrictions under Code Section 223.

02. **Nondiscrimination Requirements**

a. It is the intent of this Health Reimbursement Arrangement to not discriminate in violation of the Code and the Treasury regulations thereunder.

b. If the Administrator deems it necessary in order to avoid discrimination under this Health Reimbursement Arrangement, it may, but shall not be required to reduce benefits provided to "highly compensated individuals" (as defined in Code Section 105(h)) in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner.

03. **Health Reimbursement Arrangement Claims**

a. The Administrator shall direct the reimbursement to each eligible Participant of all Qualifying Medical Expenses. Qualifying Medical Expenses shall be reimbursed, even though the submission of such a claim occurs after participation hereunder ceases, provided that the Qualifying Medical Expenses were incurred during a Coverage Period. In order to claim reimbursement, claims must include receipts or documentation that the expense being incurred is eligible for reimbursement. Expenses may be reimbursed in a subsequent Coverage Period, subject to subsection (b) below. However, a Participant may not submit claims incurred prior to beginning participation in the HRA and/or the Effective Date of the HRA, whichever is earlier.

b. Claims for the reimbursement of Qualifying Medical Expenses incurred in any Coverage Period shall be paid as soon after a claim has been filed as is administratively practicable. However, if a Participant fails to submit a claim within 90 days immediately following the end of the Coverage Period, those Medical Expense claims shall not be eligible for reimbursement by the Administrator.

c. Reimbursement payments under this HRA shall be made directly to the Participant.

d. If the maximum amount available for reimbursement for a Coverage Period is not utilized in its entirety, refer to Appendix A for information on how these funds will be handled.

IV. ARTICLE - ERISA PROVISIONS

01. **Claim for Benefits**

Any claim for Benefits shall be made to the Administrator. The following time frames for claims and the rules below apply:

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the claim:	
Notification of	15 days
Response by Participant	45 days
Review of claim denial	60 days

The Administrator will provide written or electronic notification of all claim denials. The notice will state:

1. Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.
2. The specific reason or reasons for the adverse determination.
3. Reference to the specific HRA provisions on which the determination is based.
4. A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary.
5. A description of the HRA's internal review procedures and time limits applicable to such procedures, available external review procedures, as well as the claimant's right to bring a civil action under Section 502 of ERISA following a final appeal decision.
6. That upon request and free of charge, the following will be provided: a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.
7. In the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.
8. The availability of and contact information for an applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793.

When the Participant receives a notice of a decision of denial, the Participant shall have 180 days following receipt of the notification within which to appeal the decision. The Participant may submit written comments, documents, records, and other information relating to the Claim. If the Participant requests, the Participant shall be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the HRA. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

1. was relied upon in making the claim determination;
2. was submitted, considered, or generated in the course of making the claim determination, without regard to whether it was relied upon in making the claim determination;
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that claim determinations are made in accordance with HRA documents and that HRA provisions have been applied consistently with respect to all claimants; or
4. constituted a statement of policy or guidance with respect to the HRA concerning the denied claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the HRA who is neither the individual who made the adverse determination nor a subordinate of that individual.

After receiving notice of an adverse benefit determination or a final internal adverse benefit determination, a claimant may file with the HRA a request for an external review. A claimant may request from the Administrator additional information describing the HRA's external review procedure.

02. **Named Fiduciary**

The "named Fiduciaries" of this HRA are (1) the Employer and (2) the Administrator. The named Fiduciaries shall have only those specific powers, duties, responsibilities, and obligations as are specifically given them under the HRA including, but not limited to, any agreement allocating or delegating their responsibilities, the terms of which are incorporated herein by reference. In general, the Employer shall have the sole responsibility for providing benefits under the HRA; and shall have the sole authority to appoint and remove the Administrator; and to amend or terminate, in whole or in part, the HRA. The Administrator shall have the sole responsibility for the administration of the HRA, which responsibility is specifically described in the HRA. Furthermore, each named Fiduciary may rely upon any such direction, information or action of another named Fiduciary as being proper under the HRA, and is not required under the HRA to inquire into the propriety of any such direction, information or action. It is intended under the HRA that each named

Fiduciary shall be responsible for the proper exercise of its own powers, duties, responsibilities and obligations under the HRA. Any person or group may serve in more than one Fiduciary capacity.

03. **General Fiduciary Responsibilities**

The Administrator and any other fiduciary under ERISA shall discharge their duties with respect to this HRA solely in the interest of the Participants and their beneficiaries and

a. for the exclusive purpose of providing Benefits to Participants and their beneficiaries and defraying reasonable expenses of administering the HRA;

b. with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and

c. in accordance with ERISA and the documents and instruments governing the HRA, insofar as such documents and instruments are consistent with ERISA.

04. **Nonassignability of Rights**

The right of any Participant to receive any reimbursement under the HRA shall not be alienable by the Participant by assignment or any other method, and shall not be subject to the rights of creditors, and any attempt to cause such right to be so subjected shall not be recognized, except to such extent as may be required by law.

V. ARTICLE - ADMINISTRATION

01. **HRA Administration**

The operation of the HRA shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the HRA is carried out in accordance with its terms, and for the exclusive benefit of Employees entitled to participate in the HRA. The Administrator shall have full power to administer the HRA in all of its details, subject, however, to the pertinent provisions of ERISA and the Code. The Administrator's powers shall include, but shall not be limited to the following authority, in addition to all other powers provided by this HRA:

a. To make and enforce such rules and regulations as the Administrator deems necessary or proper for the efficient administration of the HRA;

b. To interpret the HRA, the Administrator's interpretations thereof in good faith to be final and conclusive on all persons claiming benefits under the HRA;

c. To decide all questions concerning the HRA and the eligibility of any person to participate in the HRA and to receive benefits provided under the HRA;

d. To limit benefits for certain highly compensated individuals if it deems such to be desirable in order to avoid discrimination under the HRA in violation of the applicable provisions of the Code;

e. To approve reimbursement requests and to authorize the payment of benefits;

f. To appoint such agents, counsel, accountants, consultants, and actuaries as may be required to assist in administering the HRA; and

g. To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Section 609.

Any procedure, discretionary act, interpretation or construction taken by the Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall be consistent with the intent that the HRA shall continue to comply with the terms of Code Section 105(h) and the Treasury regulations thereunder.

02. **Examination of Records**

The Administrator shall make available to each Participant, Eligible Employee and any other Employee of the Employer, for examination at reasonable times during normal business hours, such records as pertain to that person's interest under the HRA.

03. **Indemnification of Administrator**

The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who previously served as Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the HRA, if such act or omission is or was in good faith.

VI. ARTICLE - AMENDMENT OR TERMINATION OF HRA

01. **Amendment**

The Employer, at any time or from time to time, may amend any or all of the provisions of the HRA without the consent of any Employee or Participant.

02. **Termination**

The Employer is establishing this HRA with the intent that it will be maintained for an indefinite period of time. Notwithstanding the foregoing, the Employer reserves the right to terminate the HRA, in whole or in part, at any time. In the event the HRA is terminated, no further reimbursements shall be made.

VII. ARTICLE - MISCELLANEOUS

01. **Adoption by Other Employers**

Notwithstanding anything herein to the contrary, and with the consent of the Employer, any other corporation or entity, whether an affiliate or subsidiary or not, may adopt this HRA and all of the provisions hereof, and participate herein and be known as a "Participating Employer", by a properly executed document evidencing said intent and will of such Participating Employer.

02. **HRA Interpretation**

All provisions of this HRA shall be interpreted and applied in a uniform, nondiscriminatory manner. This HRA shall be read in its entirety and not severed except as provided in the Section titled: "Severability".

03. **Gender and Number**

Wherever any words are used herein in the masculine, feminine or neuter gender, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

04. **Written Document**

This HRA, in conjunction with any separate written document which may be required by law, is intended to satisfy the written HRA requirement of Code Section 105 and any Treasury regulations thereunder.

05. **Exclusive Benefit**

This HRA shall be maintained for the exclusive benefit of the Employees who participate in the HRA.

06. **Not Employment Contract**

This HRA shall not be deemed to constitute an employment contract between the Employer and any Participant or Employee, or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this HRA shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge shall have upon him as a Participant of this HRA.

07. **Action by the Employer**

Whenever the Employer under the terms of the HRA is permitted or required to do or perform any act or matter or thing, it shall be done and performed by an authorized representative of Employer.

08. **No Guarantee of Tax Consequences**

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the HRA will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the HRA is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this HRA shall be legally enforceable.

09. **Indemnification of Employer by Participants**

If any Participant receives one or more payments or reimbursements under the HRA that are not for a permitted Medical Expense such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax (plus any penalties) that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

10. **Funding**

Unless otherwise required by law, amounts made available by the Employer need not be placed in trust, but may instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the HRA may be made.

11. **Governing Law**

This HRA and Trust shall be construed and enforced according to the Code, ERISA, and the laws of the state of Utah, other than its laws respecting choice of law, to the extent not pre-empted by ERISA.

12. **Severability**

If any provision of the HRA is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the HRA, and the HRA shall be construed and enforced as if such provision had not been included herein.

13. **Headings**

The headings and subheadings of this HRA have been inserted for convenience of reference and are to be ignored in any construction of the provisions hereof.

14. **Continuation of Coverage**

Notwithstanding anything in the HRA to the contrary, in the event any benefit under this HRA subject to the continuation coverage requirement of Code Section 4980B becomes unavailable, each qualified beneficiary (as defined in Code Section 4980B) will be entitled to continuation coverage as prescribed in Code Section 4980B.

15. **Health Insurance Portability and Accountability Act**

Notwithstanding anything in this HRA to the contrary, this HRA shall be operated in accordance with HIPAA and regulations thereunder.

16. **Uniformed Services Employment and Reemployment Rights Act**

Notwithstanding any provision of this HRA to the contrary, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with USERRA and the regulations thereunder.

17. **HIPAA Privacy Standards**

a. If this HRA is subject to the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), then this Section shall apply.

b. The HRA shall not disclose Protected Health Information to any member of Employer's workforce unless each of the conditions set out in this Section is met. "Protected Health Information" shall have the same definition as set forth in the Privacy Standards but generally shall mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

c. Protected Health Information disclosed to members of Employer's workforce shall be used or disclosed by them only for purposes of HRA administrative functions. The HRA's administrative functions shall include all HRA payment functions and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken to determine or fulfill HRA responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for health care.

d. The HRA shall disclose Protected Health Information only to members of the Employer's workforce who are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the HRA. "Members of the Employer's workforce" shall refer to all Employees and other persons under the control of the Employer. The Employer shall keep an updated list of those authorized to receive Protected Health Information.

1. An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the HRA.

2. In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by this Section and the Privacy Standards, the incident shall be reported to the HRA's privacy officer. The privacy officer, or the Employer, shall take appropriate action, including:

i. investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

ii. appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;

iii. mitigation of any harm caused by the breach, to the extent practicable; and

iv. documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

e. The Employer must provide certification to the HRA that it agrees to:

1. Not use or further disclose Protected Health Information other than as permitted or required by the HRA documents or as required by law;

2. Ensure that any agent or subcontractor to whom it provides Protected Health Information received from the HRA, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

3. Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Employer;

4. Report to the HRA any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section, or required by law;

5. Make available Protected Health Information to individual HRA members in accordance with Section 164.524 of the Privacy Standards;

6. Make available Protected Health Information for amendment by individual HRA members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

7. Make available the Protected Health Information required to provide an accounting of disclosures to individual HRA members in accordance with Section 164.528 of the Privacy Standards;

8. Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the HRA available to the Department of Health and Human Services for purposes of determining compliance by the HRA with the Privacy Standards;

9. If feasible, return or destroy all Protected Health Information received from the HRA that the Employer still maintains in any form, and retain no copies of such information, when no longer needed for the purpose for which disclosure was made, or, if and only if such return or destruction is not feasible, limit further uses and disclosures to those permitted purposes that make the return or destruction of the information infeasible; and

10. Ensure adequate separation between the HRA and members of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards and set out in (d) above.

18. **HIPAA Electronic Security Standards**

If this HRA is subject to the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), then this Section shall apply as follows:

a. The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the HRA. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

b. The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

c. The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in the Section titled: "HIPAA Privacy Standards".

d. The HRA shall not disclose Protected Health Information to any member of Employer's workforce unless each of the conditions set out in this Section is met. "Protected Health Information" shall have the same definition as set forth in the Privacy Standards but generally shall mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

e. Protected Health Information disclosed to members of Employer's workforce shall be used or disclosed by them only for purposes of HRA administrative functions. The HRA's administrative functions shall include all HRA payment functions and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken to determine or fulfill HRA responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for health care.

f. The HRA shall disclose Protected Health Information only to members of the Employer's workforce, who are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the HRA. "Members of the Employer's workforce" shall refer to all Employees and other persons under the control of the Employer. The Employer shall keep an updated list of those authorized to receive Protected Health Information.

    1. An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the HRA.

    2. In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by this Section and the Privacy Standards, the incident shall be reported to the HRA's privacy officer. The privacy officer, or the Employer, shall take appropriate action, including:

        i. investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

        ii. appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;

        iii. mitigation of any harm caused by the breach, to the extent practicable; and

        iv. documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

g. The Employer must provide certification to the HRA that it agrees to:

    1. Not use or further disclose Personal Health Information other than as permitted or required by the HRA documents or as required by law;

    2. Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the HRA, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

    3. Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Employer;

    4. Report to the HRA any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section, or required by law;

    5. Make available Protected Health Information to individual HRA members in accordance with Section 164.524 of the Privacy Standards;

    6. Make available Protected Health Information for amendment by individual HRA members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

    7. Make available the Protected Health Information required to provide an accounting of disclosures to individual HRA members in accordance with Section 164.528 of the Privacy Standards;

    8. Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the HRA available to the Department of Health and Human Services for purposes of determining compliance by the HRA with the Privacy Standards;

    9. If feasible, return or destroy all Protected Health Information received from the HRA that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, or, if and only if such return or destruction is not feasible, limit further uses and disclosures to those permitted purposes that make the return or destruction of the information infeasible; and

    10. Ensure the adequate separation between the HRA and members of the Employer's workforce, as required by Section

164.504(f)(2)(iii) of the Privacy Standards and set out in (d) above.

Execution Agreement

IN WITNESS WHEREOF, HealthEquity Sample has caused its authorized officer to execute this Plan document as of _____, the same to be effective **January 01, 2016**, unless otherwise indicated herein.

HEALTHEQUITY SAMPLE, A LLC

SIGN HERE By: _____

Name: _____

Title: _____

CERTIFICATE OF CORPORATE RESOLUTION

The undersigned Secretary or Principal of **HealthEquity Sample** (the Employer) hereby certifies that the following resolutions were duly adopted by the board of directors or similar governing body of 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 **January 01, 2016**, presented to this meeting (and a copy of which is attached hereto) is hereby approved and adopted, and that the proper officers of the Employer are hereby authorized and directed to execute and deliver to the Administrator of said Plan one or more counterparts of the Plan.

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

RESOLVED, that the proper officers of the Employer shall act as soon as possible to notify the Employees of the Employer of the adoption of the Plan and to deliver to each employee a copy of the Summary Plan Description of the Plan, which Summary Plan Description is attached hereto and is hereby approved.

HEALTHEQUITY SAMPLE, A LLC

By: _____

Name: _____

Title: _____

APPENDIX A

Employee Class: Individual

Qualified benefits are defined as:

- Deductible Expenses
- Co-Insurance Expenses

Reimbursement Schedule:

- First, the Employee will pay $500 of qualifying expenses.
- Last, the HRA will pay $500 of qualifying expenses.

Plan Coverage

- Medical

Total Deductible $1000

Max Out Of Pocket $5000

Unused HRA Funds:

- Unused benefits at the end of the coverage period shall be carried forward to the next coverage period with a maximum amout being carried over of $500.

Employee Class: Family

Qualified benefits are defined as:

- Deductible Expenses
- Co-Insurance Expenses

Reimbursement Schedule:

- First, the Employee will pay $1000 of qualifying expenses.
- Last, the HRA will pay $1000 of qualifying expenses.

Plan Coverage

- Medical

Total Deductible $2000

Max Out Of Pocket $10000

Unused HRA Funds:

- Unused benefits at the end of the coverage period shall be carried forward to the next coverage period with a maximum amout being carried over of $1000.

HealthEquity Sample
1234 W 4567 S
West Jordan, UT 84088

HealthEquity Sample HRA Plan

Summary Plan Description

Effective January 01, 2016

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INTRODUCTION

This is the Summary Plan Description (the "SPD") for the HealthEquity Sample HRA Plan, a Health Reimbursement Arrangement (the "HRA"). This SPD summarizes your rights and obligations as a participant (or beneficiary) in the HRA.

Read this SPD carefully so that you understand the provisions of our HRA and the benefits you will receive. You should direct any questions you have to the Plan Administrator. There is a plan document on file, which you may review if you desire. In the event there is a conflict between this SPD and the plan document, the plan document will control.

I. ARTICLE - ELIGIBILITY

01. **What Are the Eligibility Requirements for this HRA?**

    You will be automatically enrolled in the HRA when you enroll in the Employer's group medical plan, unless you have opted out of the HRA.

02. **When is My Entry Date?**

    Your entry date is the date you satisfy the eligibility requirements of and enroll in the Employer's group medical plan.

03. **Are There Any Employees Who Are Not Eligible?**

    Yes, employees who are not eligible to receive medical benefits under the group medical plan, or who are not enrolled in that plan, are not eligible to join the HRA.

II. ARTICLE - BENEFITS

01. **What Benefits Are Available?**

The HRA allows you to be reimbursed for expenses as described in the Appendices of this document. The expenses that qualify are those permitted by Section 213(d) of the Internal Revenue Code.

The amounts provided to the HRA by your employer will be made available on the first day of the plan year .

Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. Any amounts reimbursed to you under the HRA may not be claimed as a deduction on your personal income tax return or reimbursed by other health plan coverage.

If the maximum amount available for reimbursement for a Coverage Period is not utilized in its entirety, refer to Appendix A for information on how these funds will be handled.

02. **What is the "Coverage Period"?**

The "Coverage Period" begins January 01 and ends December 31 (the "Plan Year").

03. **When Will I Receive Payments From the HRA?**

You may submit requests for reimbursement of expenses you have incurred during the course of a Coverage Period. The Plan Administrator will provide you with further details. However, you must make your requests for reimbursements no later than 90 days after the end of the Coverage Period. The Plan Administrator will provide you with acceptable forms for submitting these requests for reimbursement. In addition, you must submit to the Plan Administrator proof of the expenses you have incurred and that they have not been paid by any other health plan coverage. If the request qualifies as a benefit or expense that the HRA has agreed to pay, you will receive a reimbursement payment soon thereafter.

Remember, reimbursements made from the HRA are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes.

04. **What Happens If I Terminate Employment?**

If your employment is terminated during the Plan Year for any reason, your participation in the HRA will cease on the date of your termination, and you will not be eligible to be reimbursed for any expenses incurred past that date. You must submit claims for any expenses incurred prior to your termination of employment within 90 days after you terminate employment. Any unused amounts will be forfeited.

05. **Family and Medical Leave Act (FMLA)**

If you take leave under the Family and Medical Leave Act, you may revoke or change your existing elections for health insurance. If your coverage in these benefits terminates, due to your revocation of the benefit while on leave or due to your non-payment of contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return.

06. **Uniformed Services Employment and Reemployment Rights Act (USERRA)**

If you are going into or returning from military service, the Uniformed Services Employment and Reemployment Rights Act of 1994 may give you special rights to health care coverage under the HRA. These rights can include extended health care coverage. USERRA continuation coverage is concurrent with COBRA continuation coverage. If you may be affected by this law, ask your Plan Administrator for further details.

07. **Newborn and Mothers Health Protection Act**

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the HRA or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

08. **Qualified Medical Child Support Order**

A medical child support order is a judgment, decree or order (including approval of a property settlement) made under state law that provides for child support or health coverage for the child of a participant. The child becomes an "alternate recipient" and can receive benefits under the health plans of the Employer, if the order is determined to be "qualified." You may obtain, without charge, a copy of the procedures governing the determination of qualified medical child support orders from the Plan Administrator.

III. ARTICLE - GENERAL INFORMATION ABOUT OUR HRA

This Section contains certain general information, which you may need to know about the HRA.

01. **General HRA Information**

"HealthEquity Sample HRA Plan" is the name of the Plan.

This HRA is integrated with a group health plan entitled the "HealthEquity Sample Health Plan", which has been assigned policy number 4564.

The company has adopted this Plan effective January 01, 2016.

Your Plan's records are maintained on the basis of a period of time known as the Plan Year. The Plan Year begins on January 01 and ends December 31 (the "Plan Year").

02. **Employer Information**

Your Employer's name, address, and identification number are:

HealthEquity Sample

1234 W 4567 S
West Jordan, UT 84088

EIN: 99-9999999

03. **Plan Administrator Information**

The name, address, and business telephone number of your Plan Administrator are:

HealthEquity Sample
1234 W 4567 S
West Jordan, UT 84088

The Plan Administrator will also answer any questions you may have about our HRA. The Plan Administrator has the exclusive right to interpret the appropriate HRA provisions. Decisions of the Plan Administrator are conclusive and binding. You may contact the Plan Administrator for any further information about the HRA.

04. **Agent for Service of Legal Process**

Should it ever be necessary, you or your personal representative may serve legal process on the agent for service of legal process for the HRA. The HRA Agent of Service is:

HealthEquity Sample
1234 W 4567 S
West Jordan, UT 84088

Legal process may also be served on the Plan Administrator.

05. **Type of Administration**

The HRA is a health reimbursement arrangement. The HRA is not funded or insured. Benefits are paid from the general assets of the Employer.

06. **Claims Administrator Information**

The name and address of your Claim's Administrator are:

HealthEquity Sample
1234 W 4567 S
West Jordan, UT 84088

The Claims Administrator keeps the claims records for the HRA and is responsible for the claims administration of the HRA. The Claims Administrator will also answer any claims-related questions you may have about the HRA.

IV. ARTICLE - ADDITIONAL HRA INFORMATION

01. **Your Rights Under ERISA**

HRA Participants, eligible employees and all other employees of the Employer may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. These laws provide that Participants, eligible employees and all other employees are entitled to:

a. Examine, without charge, at the Plan Administrator's office, all HRA documents, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the HRA with the U.S. Department of Labor (also, available at the Public Disclosure Room of the Employee Benefits Security Administration).

b. Obtain copies of all HRA documents and other HRA information upon written request to the Plan Administrator. The Plan Administrator may charge a reasonable fee for the copies.

c. Continue health care coverage for a HRA Participant, Spouse, or other dependents if there is a loss of coverage under the HRA as a result of a qualifying event. Employees and dependents may have to pay for such coverage.

d. Review this Summary Plan Description and the documents governing the HRA on the rules governing COBRA continuation coverage rights.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time frames.

If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court; provided, such suit may be filed only after the plan's review procedures described herein have been exhausted and only if filed within 90 days after the final decision on review is provided, or, if a later date is specified in a booklet, certificate or other documentation for a particular Welfare Program, only if filed by such later date.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the HRA and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may request the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

In addition, if a HRA Participant disagrees with the HRA's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

In addition to creating rights for HRA Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the HRA. The individuals who operate the HRA, called "fiduciaries" of the HRA, have a duty to do so prudently and in the interests of the HRA Participants and their beneficiaries. No one, including the Employer or any other person, may fire a HRA Participant or otherwise discriminate against a HRA Participant in any way to prevent the HRA Participant from obtaining benefits under the HRA or from exercising his or her rights under ERISA.

If it should happen that HRA fiduciaries misuse the HRA's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about the HRA, you should contact the Plan Administrator. If you have any questions about your rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA), or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

02. **How to Submit a Claim**

When you have a Claim to submit for payment, you must:

1. Obtain a claim form from the Plan Administrator.
2. Complete the Employee portion of the form.
3. Attach copies of all Explanation of Benefits (EOB) from your insurance carrier for which you are requesting reimbursement.

A Claim is defined as any request for a HRA benefit, made by a claimant or by a representative of a claimant that complies with the HRA's reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Unless otherwise specified, decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

Notification of whether Claim is accepted or denied 30 days

Notification of whether claim is accepted or denied	30 days
Extension due to matters beyond the control of the Plan	15 days

Insufficient information on the claim:

Notification of	15 days
Response by Participant	45 days

Review of claim denial	60 days

The Claims Administrator will provide written or electronic notification of any Claim denial. The notice will state:

1. Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.
2. The specific reason or reasons for the adverse determination.
3. Reference to the specific HRA or Welfare Program provisions on which the determination is based.
4. A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary.
5. A description of the HRA's internal review procedures and time limits applicable to such procedures, available external review procedures, as well as the claimant's right to bring a civil action under Section 502 of ERISA following a final appeal.
6. Upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.
7. In the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.
8. The availability of and contact information for an applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793.

When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision to the Claims Administrator. You may submit written comments, documents, records, and other information relating to the Claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the HRA. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

1. was relied upon in making the Claim determination;
2. was submitted, considered, or generated in the course of making the Claim determination, without regard to whether it was relied upon in making the Claim determination;
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that Claim determinations are made in accordance with HRA documents and HRA provisions have been applied consistently with respect to all claimants;
4. or constituted a statement of policy or guidance with respect to the HRA concerning the denied Claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial Claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the HRA who is neither the individual who made the adverse determination nor a subordinate of that individual.

After receiving notice of an adverse benefit determination or a final internal adverse benefit determination, a claimant may file with the HRA a request for an external review. A claimant may request from the Plan Administrator additional information describing the HRA's external review procedure.

V. ARTICLE - CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain employees and their families covered under this HRA will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the HRA would otherwise end. This notice is intended to inform Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator or its designee is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Participants who become Qualified Beneficiaries under COBRA. The HRA itself can provide group health benefits and may also be used to provide health benefits through insurance.

01. **What is COBRA Continuation Coverage?**

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Arrangement (the "Qualifying Event"). The coverage must be identical to the coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries). When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

02. **Are there other coverage options?**

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace, which coverage began effective January 1, 2014. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. You may be eligible for Medicaid. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

03. **Who Can Become a Qualified Beneficiary?**

In general, a Qualified Beneficiary can be:

1. Any individual who, on the day before a Qualifying Event, is covered under the HRA by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the HRA under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

2. Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the HRA as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the HRA under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the HRA due to his or her performance of services for the employer sponsoring the HRA. However, this provision does not establish eligibility of these individuals. Eligibility for HRA coverage shall be determined in accordance with HRA Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

04. **What is a Qualifying Event?**

A Qualifying Event is any of the following if the Arrangement provided that the participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

1. The death of a covered Employee.

2. The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

3. The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's HRA coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

4. A covered Employee's enrollment in any part of the Medicare program.

5. A Dependent child's ceasing to satisfy the HRA's requirements for a Dependent child (for example, attainment of the maximum

age for dependency under the Arrangement).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the HRA under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the HRA occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the HRA that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the HRA provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the HRA during the FMLA leave.

05. **What Factors Should Be Considered When Determining to Elect COBRA Continuation Coverage?**

Pre-existing Conditions. If there is more than a 63 day gap in health coverage you can lose the right to have pre-existing condition exclusions waived by other group health plans, and election of COBRA continuation coverage may help you avoid such a gap. If you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy that does not impose such pre-existing condition exclusions. These pre-existing condition exclusions will only apply during Plan Years that begin before January 1, 2014.

Enrolling in another Group Health Plan. You should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after HRA coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

COBRA vs. Marketplace. Other factors to consider when weighing your coverage options include: premium costs, whether a change in coverage will affect your access to certain providers, service areas or drug formularies and whether the coverage change will affect your cost sharing (i.e., new deductibles, etc.). See the discussion above under "Are there other coverage options?" for more information on your options for Marketplace coverage.

06. **Election for Obtaining COBRA Continuation Coverage?**

The HRA has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

07. **What is the Election Period and How Long Does It Last?**

The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the HRA. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

Note: If a covered employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available to them and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he or she and/or his or her family members may qualify for assistance under this special provision should contact the Plan Administrator or its designee for further information. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act index.asp.

08. **Is a Covered Employee or Qualified Beneficiary Responsible for Informing the Plan Administrator of the Occurrence of a Qualifying Event?**

The HRA will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer will notify the Plan Administrator or its designee of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

1. the end of employment or reduction of hours of employment,
2. the death of the employee,
3. commencement of a proceeding in bankruptcy with respect to the Employer, or enrollment of the employee in any part of Medicare,

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the employee and Spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any Spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Administrator or its designee.

NOTICE PROCEDURES:

Any notice that you provide must be **in writing**. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

HealthEquity Sample
1234 W 4567 S
West Jordan, UT 84088

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their Spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the Qualifying event that coverage would otherwise have been lost. The COBRA period begins on the date of the Qualifying Event, even though coverage actually ends at the end of the month. If you or your Spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

09. **Is a Waiver Before the End of the Election Period Effective to End a Qualified Beneficiary's Election Rights?**

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

10. **Is COBRA Coverage Available If a Qualified Beneficiary Has Other Group Health HRA Coverage or Medicare?**

Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

11. **When May a Qualified Beneficiary's COBRA Continuation Coverage Be Terminated?**

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

1. The last day of the applicable maximum coverage period.
2. The first day for which Timely Payment is not made to the Arrangement with respect to the Qualified Beneficiary.
3. The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.
4. The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other HRA that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
5. The date, after the date of the election that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
6. In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
    a. (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
    b. the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The HRA can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the HRA can terminate for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the HRA solely because of the individual's relationship to a Qualified Beneficiary, if the HRA's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the HRA is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

12. **What Are the Maximum Coverage Periods for COBRA Continuation Coverage?**

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

1. In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum

coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

2. In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

   a. 36 months after the date the covered Employee becomes enrolled in the Medicare program; or

   b. 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

3. In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

4. In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

13. **Under What Circumstances Can the Maximum Coverage Period Be Extended?**

If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is extended to 36-months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be extended to more than 36-months after the date of the first Qualifying Event.

The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator or its designee and in accordance with the procedures above.

14. **How Does a Qualified Beneficiary Become Entitled to a Disability Extension?**

A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the HRA Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice must be sent to the Plan Administrator or its designee and in accordance with the procedures above.

15. **Does the HRA Require Payment for COBRA Continuation Coverage?**

For any period of COBRA continuation coverage under the HRA, Qualified Beneficiaries who elect COBRA continuation coverage may be required to pay up to 102% of the applicable premium and up to 150% of the applicable premium for any extended period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. Your Plan Administrator will inform you of any costs. The Arrangement will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

16. **Must the HRA Allow Payment for COBRA Continuation Coverage to Be Made in Monthly Installments?**

Yes. The health coverage is also permitted to allow for payment at other intervals.

17. **What is Timely Payment for Payment for COBRA Continuation Coverage?**

"Timely Payment" means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the HRA on a later date is also considered Timely Payment if either (i) under the terms of the HRA covered employees or Qualified Beneficiaries are allowed to pay for their coverage for the period on that later date, or (ii) under the terms of an arrangement between the Employer and the entity that provides benefits on the Employer's behalf the Employer is allowed to pay for coverage of similarly situated non-COBRA beneficiaries for the period on that later date.

Notwithstanding the above paragraph, the HRA does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the HRA.

If Timely Payment is made to the HRA in an amount that is not significantly less than the amount the HRA requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the HRA's requirement for the amount to be paid, unless the HRA notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

18. **Must a Qualified Beneficiary Be Given the Right to Enroll in a Conversion Health HRA at the End of the Maximum Coverage Period for COBRA Continuation Coverage?**

If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the HRA will, during the 180 day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the HRA. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or its designee.

For more information about your rights under the Employee Retirement Income Security Act of 1974 (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272.

For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or its designee.

Appendix A

Employee Class: Individual

Qualified benefits are defined as:

- Deductible Expenses
- Co-Insurance Expenses

Reimbursement Schedule:

- First, the Employee will pay $500 of qualifying expenses.
- Last, the HRA will pay $500 of qualifying expenses.

Plan Coverage

- Medical

Total Deductible $1000

Max Out Of Pocket $5000

Unused HRA Funds:

- Unused benefits at the end of the coverage period shall be carried forward to the next coverage period with a maximum amout being carried over of $500.

Employee Class: Family

Qualified benefits are defined as:

- Deductible Expenses
- Co-Insurance Expenses

Reimbursement Schedule:

- First, the Employee will pay $1000 of qualifying expenses.
- Last, the HRA will pay $1000 of qualifying expenses.

Plan Coverage

- Medical

Total Deductible $2000

Max Out Of Pocket $10000

Unused HRA Funds:

- Unused benefits at the end of the coverage period shall be carried forward to the next coverage period with a maximum amout being carried over of $1000.