

Checklist for  
Health Reimbursement Arrangement Wrap Plan

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***Is this Plan considered Grandfathered under the PPACA?*** \_\_\_\_\_

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**GENERAL PLAN INFORMATION**

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Group's Full Name: \_\_\_\_\_

Group's Address: \_\_\_\_\_

\_\_\_\_\_

If above address is a post office box, street address: \_\_\_\_\_

\_\_\_\_\_

Group's Telephone Number: ( \_\_\_\_\_ ) \_\_\_\_\_

Internal Group Number or Billing Number (if any): \_\_\_\_\_

Employer Identification Number (EIN): \_\_\_\_\_

Plan Year (month to month): \_\_\_\_\_

Original Effective Date of Plan (month & year): \_\_\_\_\_

Date of this Restatement (month & year): \_\_\_\_\_

ERISA Plan Number: \_\_\_\_\_

Type of Plan: Health Reimbursement Arrangement under Code §§105 and 106

What is the full name of the Benefit Plan that we are wrapping: \_\_\_\_\_

\_\_\_\_\_

Is this a Limited Scope Plan (covering only certain out-of-pocket expenses from the benefit plan)? \_\_\_\_\_

***If so, please refer to the Library for these provisions.***

Participating Employers: \_\_\_\_\_

\_\_\_\_\_

Third Party Administrator: \_\_\_\_\_

Name, Address, Phone: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PURPOSE OF PLAN; ADOPTION OF THE PLAN DOCUMENT**

**Purpose of the Plan**

The purpose of this *Plan* is to allow *participants* to pay...

...Medical...	...Dental...
...Vision...	...Prescription drugs...
...group health insurance premiums for qualified long-term care insurance...	

**DEFINITIONS**

Does the plan have a debit card feature? \_\_\_\_\_

**“Health savings account” or “HSA”** means the tax-exempt trust or custodial account established in accordance with Section 223 of the Code to permit eligible *participants* to receive tax-favored contributions exclusively for the purpose of paying or reimbursing qualified medical expenses.

**OPTIONAL – KEEP or REMOVE**

**ELIGIBILITY FOR COVERAGE**

**When will my participation in this *Plan* terminate?**

	A former <i>participant</i> shall be entitled to submit a request for reimbursement of <i>qualified medical expenses</i> , in accordance with the procedure set forth under the “Administration” section of this <i>summary plan description</i> , provided such <i>qualified medical expenses</i> were <i>incurred</i> while the former <i>participant</i> participated in the <i>Plan</i> . With the exception of such expenses, a <i>participant’s</i> interest in a <i>health reimbursement account</i> shall terminate upon the <i>covered employee’s</i> retirement, other termination of employment, or termination of participation in the <i>benefit plan</i> . All requests for reimbursement of <i>qualified medical expenses</i> must be submitted within [_____] [days <b>OR</b> months] of the date of the termination of a <i>participant’s</i> participation.				
	[A former <i>participant’s</i> interest in a <i>health reimbursement account</i> shall not terminate upon the termination of that <i>participant’s</i> participation in the <i>Plan</i> . To the extent that a balance exists in the former <i>covered employee’s</i> <i>health reimbursement account</i> , the <i>participant</i> may continue to submit claims for the reimbursement of the <i>qualified medical expenses</i> <i>incurred</i> after the retirement or other termination of the <i>participant’s</i> participation in the <i>Plan</i> . All requests for reimbursement of <i>qualified medical expenses</i> must be submitted within [_____] [days <b>OR</b> months] of...				
	<table border="1" style="width: 100%;"> <tr> <td style="width: 15%;"></td> <td>...the date the <i>qualified medical expense</i> was <i>incurred</i></td> </tr> <tr> <td></td> <td>...the <i>plan year</i> in which the claim was <i>incurred</i></td> </tr> </table>		...the date the <i>qualified medical expense</i> was <i>incurred</i>		...the <i>plan year</i> in which the claim was <i>incurred</i>
	...the date the <i>qualified medical expense</i> was <i>incurred</i>				
	...the <i>plan year</i> in which the claim was <i>incurred</i>				

A former *participant* who elects *COBRA* continuation coverage under the *benefit plan* [**may OR must**] elect to continue coverage for *qualified medical expenses* under this *Plan*.

Does the plan want to include language for Optional Spend Down for Retirees Only? \_\_\_\_\_

**If NO, skip to the BENEFITS section. If YES, please complete the following:**

**For former *participants*:** All requests for reimbursement of *qualified medical expenses* must be submitted within [\_\_\_\_\_] (**days OR months**) of the date of the termination of a *participant’s* participation.

**For retiree’s:** All requests for reimbursement of *qualified medical expenses* must be submitted within [\_\_\_\_\_] (**days OR months**) of...

	...the date the <i>qualified medical expense</i> was <i>incurred</i> .
	...the <i>plan year</i> in which the claims was <i>incurred</i> .

A former *participant* who elects *COBRA* continuation coverage under the *benefit plan* (**may OR must**) elect to continue coverage for *qualified medical expenses* under this *Plan*.

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**BENEFITS**

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**Qualified medical expenses**

	If you also participate in a medical flexible spending account under <i>Code § 125</i> offered by the <i>Plan Sponsor</i> , the reimbursement of <i>qualified medical expenses</i> under this <i>Plan</i> is not available for <i>qualified medical expenses</i> that are covered by the medical flexible spending account until the amount available from the medical flexible spending account covering those same <i>qualified medical expenses</i> has been exhausted.
	If you also participate in a medical flexible spending account under <i>Code § 125</i> offered by the <i>Plan Sponsor</i> , you must first exhaust the amount available for the reimbursement of <i>qualified medical expenses</i> under this <i>Plan</i> before seeking reimbursement for such <i>qualified medical expenses</i> under the medical flexible spending account.

	All requests for reimbursement of <i>qualified medical expenses</i> must be submitted within [ ] [days <b>OR</b> months] of...
	[ ] ...the date the <i>qualified medical expense</i> was incurred.
	[ ] ...of the end of the <i>plan year</i> in which the claim was incurred

**What are examples of qualified and non-qualified medical expenses?**

Examples of non-qualified medical expenses include:

	Hormone therapy relative to gender identity disorders
	Sexual reassignment surgery, including all related expenses

**Debit Card Feature**

*(Please complete only if the Plan has a Debit Card Feature. If the Plan does not have a Debit Card Feature, please skip to the section "When Must a Claim be Submitted):*

The *debit card's* use is limited to

	...physicians		...vision care offices
	...pharmacies		...hospitals
	...dentists		...other medical care providers of service

Within [ ] days of using your *debit card*, you must submit an invoice or receipt from the merchant or provider of service, including:

**When must a claim be submitted?**

All claims for reimbursement must be submitted not later than [ ] days after...

	... the date on which the <i>qualified medical expense</i> was incurred.
	... the end of the <i>plan year</i> in which they were incurred or, if earlier, within [ ] days following the termination of a <i>participant's</i> participation in the <i>Plan</i> .

**Is there a minimum claim amount?**

The minimum amount a *participant* may submit for reimbursement for *qualified medical expenses* shall be \$[ ], except at the end of the *plan year* in which the expense was incurred.

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**FUNDING**

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**How is my health reimbursement account Funded?**

	The <i>Plan Sponsor</i> shall establish an individual <i>health reimbursement account</i> for each <i>covered employee</i> and shall credit to each <i>covered employee's</i> account <i>participating employer</i> contributions...
	[ ] ... in the amount of \$[ ] per pay period
	[ ] ...in the amount of \$[ ] per pay period if the <i>covered employee</i> has elected individual coverage under the <i>benefit plan</i> and \$[ ] per pay period if the <i>covered</i>

	<i>employee</i> has elected <i>family</i> coverage under the <i>benefit plan</i>
	The <i>Plan Sponsor</i> shall establish an individual <i>health reimbursement account</i> for each <i>covered employee</i> and shall credit to each <i>covered employee's</i> account <i>participating employer</i> contributions in the amount of \$[_____] per pay period for a <i>covered employee</i> who chooses single coverage under [ <i>benefit plan</i> option A], in the amount of \$[_____] per pay period for a <i>covered employee</i> who chooses <i>family</i> coverage under [ <i>benefit plan</i> option A], in the amount of \$[_____] per pay period] for a <i>covered employee</i> who chooses single coverage under [ <i>benefit plan</i> option B], in the amount of \$[_____] per pay period for a <i>covered employee</i> who chooses <i>family</i> coverage under [ <i>benefit plan</i> option B].

Despite the fact that more than one person may participate in this *Plan*, only one *health reimbursement account* will be established per *family*, unless more than one *family* members is a *covered employees*. In that event, a separate *health reimbursement account* shall be established for each *covered employee*.

**OPTIONAL – KEEP or REMOVE**

**How much can I be reimbursed for *qualified medical expenses*?**

	If a you, your <i>spouse</i> , and your <i>dependents</i> are entitled to receive benefits under this <i>Plan</i> , no person shall be reimbursed for <i>qualified medical expenses</i> in an amount greater than [ $\frac{1}{2}$ , $\frac{1}{4}$ , [_____] ] of the <i>participating employer's</i> contribution to your <i>health reimbursement account</i> .
	If you, your <i>spouse</i> , and your <i>dependents</i> are entitled to receive benefits under this <i>Plan</i> , the amount available for reimbursement of <i>qualified medical expenses</i> in your <i>health reimbursement account</i> shall be apportioned pro rata between you, your <i>spouse</i> , and your <i>dependents</i> who participate in the <i>Plan</i> .

**Rollover Amounts**

The *Plan* will reimburse you for *qualified medical expenses* incurred during the *plan year* not to exceed the annual *participating employer* contribution plus any amount carried over from the previous year or \$[\_\_\_\_\_].

If there is a balance in your *health reimbursement account* at the end of the *plan year*, and you continue participation in the *Plan* for a subsequent *plan year*...

	...the balance in your <i>health reimbursement account</i> shall be carried over
	...the balance in your <i>health reimbursement account</i> shall not be carried over
	... shall be carried over up to \$[_____] to the next <i>plan year</i>

If you, your *spouse*, and your *dependents* are entitled to receive benefits under this *Plan*, no individual *participant* shall be reimbursed for *qualified medical expenses* in an amount greater than...

	...[ $\frac{1}{2}$ , $\frac{1}{4}$ , [_____] ] of the amount carried over in the account.
	...the total contributions made to the account for the preceding [_____] years
	the amount available for reimbursement of an individual <i>participant's</i> <i>qualified medical expenses</i> of the amount carried over shall be apportioned pro rata between you, your <i>spouse</i> , your <i>dependents</i> .

The amount available your *health reimbursement account* shall at no time exceed...

	\$[_____].
	[_____] % of the <i>participating employer's</i> annual contributions.

Any amounts that exceed...

\$[	]	...
[	]	% of the <i>participating employer's</i> annual contributions...

...will be forfeited by you.

**Rollover to a health savings account**

Effective for *plan years* up to January 1, 2012, a one-time rollover transfer from your *health reimbursement arrangement* may be made to your *health savings account*. If you have elected coverage under a qualified High Deductible Health Plan (“HDHP”), as defined under Code Section 223, you may elect to have the balance in your *health reimbursement account* at *Plan year-end*, determined on a cash basis, to be contributed directly to your *health savings account* trustee. For this purpose, the *Plan year-end* balance is the balance of the *health reimbursement account* without regard to any expenses *incurred* but not paid. The maximum amount that you may roll over to your *health savings account* is limited to the lesser of the balance in your *health reimbursement account* as at September 26, 2006, or the balance at the end of the *plan year*.

If you elect this qualified *health savings account* distribution, you may not submit any additional claims to your *health reimbursement arrangement* after the end of the *plan year*, regardless of when the underlying expense was *incurred*, nor are any further claims payable under the *health reimbursement arrangement*, even if submitted prior to the end of the *plan year*.

To receive tax-favored treatment, the qualified rollover distribution must satisfy the following conditions:

- By the end of the *plan year*:
  - The *covered employee* must elect the rollover distribution; and
  - The year-end balance must be frozen
- The funds must be transferred by the *participating employer* within two and a half months after the end of the *plan year* and result in a zero balance in the *health reimbursement account*.

Coverage under the HDHP must be in effect on the first day of the month in which the distribution is made in order for the distribution to qualify for tax-favored treatment. Additionally, a rollover distribution made to a *health savings account* may result in tax consequences, including penalties, unless participation in the HDHP continues to qualify under *Code* Section 223 for at least 12 consecutive months following the distribution. Please refer to the HDHP and *health savings account* documents for the complete terms and conditions applicable to each, including other tax considerations and any maximum limits for contributions.

**OPTIONAL – KEEP or REMOVE**

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**CLAIMS REVIEW PROCEDURE**

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The...

... <i>third party administrator</i> ...
... <i>Plan Administrator</i> ...

...will determine if enough information has been submitted to enable proper consideration of the claim.

**Requirements for Appeal**

To file an appeal in writing, your appeal must be addressed as follows and mailed or faxed as follows:

Plan Administrator
Third Party Administrator

Address: \_\_\_\_\_

Fax Number: \_\_\_\_\_

**Decision on Review**

Any legal action for the recovery of any benefits must be commenced within [ ] after the *Plan's* claim review procedures have been exhausted.

**Independent Review Organization (IRO)**

Name of the IRO the TPA has contracts with: \_\_\_\_\_

Address of IRO the TPA has contracts with: \_\_\_\_\_

**IF THE PLAN HAS 2 APPEAL LEVELS PLEASE COMPLETE THE FOLLOWING. IF NOT PLEASE SKIP TO THE SECTION ENTITLED "HIPAA PRIVACY PRACTICES."**

**Full and Fair Review of All Claims**

- *Participants* at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination and [ ] days to appeal a second adverse benefit determination;

**Adverse Decision on First Appeal; Requirements for Second Appeal**

Upon receipt of notice of the *Plan's* adverse decision regarding the first appeal, you have [ ] days to file a second appeal of the denial of benefits.

**Decision on Review**

Any legal action for the recovery of any benefits must be commenced within [ ] after the *Plan's* claim review procedures have been exhausted.

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**HIPAA PRIVACY PRACTICES**

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**Disclosure of Protected Health Information ("PHI") to the *Plan Sponsor* for *Plan Administration* Purposes**

- The following employees, or classes of employees, or other persons under control of the *Plan Sponsor*, shall be given access to the *PHI* to be disclosed:
