ADOPTION AGREEMENT
FOR
HEALTH REIMBURSEMENT ARRANGEMENT

The undersigned Employer adopts this Health Reimbursement Arrangement and elects the following provisions:

EMPLOYER INFORMATION

1. EMPLOYER'S NAME, ADDRESS AND TELEPHONE NUMBER

Name: Town of East Montpelier, VT

Address: 40 Kelton Road
Street

East Montpelier | VT | 05651
City | State | Zip

Telephone: (802) 223-3313

2. EMPLOYER'S TAXPAYER IDENTIFICATION NUMBER: 03-6000456

3. TYPE OF ENTITY

a. [ ] Corporation
b. [ ] Professional Service Corporation
c. [ ] S Corporation
d. [ ] Limited Liability Company that is taxed as:
   1. [ ] a partnership or sole proprietorship
   2. [ ] a Corporation
   3. [ ] an S Corporation
e. [ ] Sole Proprietorship
f. [ ] Partnership (including Limited Liability)
g. [X] Governmental Entity
h. [ ] Non-profit Corporation
i. [ ] Other: _____(must be a legal entity recognized under federal income tax laws)

NOTE: S Corporation shareholders, partners, sole proprietors, and members of a Limited Liability Company generally cannot participate in the Heath Reimbursement Arrangement.

PLAN INFORMATION

4. PLAN NAME:
Town of East Montpelier, VT HRA Plan

5. EFFECTIVE DATE

a. [X] This is a new Health Reimbursement Arrangement effective as of 1/1/2019 (hereinafter called the "Effective Date").
b. [ ] This is an amendment and restatement of a previously established Health Reimbursement Arrangement of the Employer which was originally effective _____ (hereinafter called the "Effective Date"). The effective date of this amendment and restatement is _____.

6. NUMBER assigned by the Employer

a. [ ] 501
b. [ ] 502
c. [ ] 503
d. [X] Other: 510

6.5 Plan Year: 1/1-12/31

7. PLAN ADMINISTRATOR'S NAME, ADDRESS AND TELEPHONE NUMBER:
(If none is named, the Employer will become the Administrator.)
a. [X] Employer (Use Employer address and telephone number).
b. [ ] Use name, address and telephone number below:

Name: _____

Address: _____
Street

_____ _____ _____
City State Zip

Telephone: _____

8. CLAIMS ADMINISTRATOR'S NAME, ADDRESS AND TELEPHONE NUMBER:
(If none is named, the Employer will serve as the Claims Administrator.)
a. [ ] Employer (Use Employer address and telephone number).
b. [X] Use name, address and telephone number below:

Name: *Northeast Benefits Management, LLC*

Address: *P.O. Box 2363*
Street

South Burlington *VT* *05407-2363*
City State Zip Code

Telephone: *(802) 865-0239*

Claims eFax: *(802) 304-1009 (Burlington Exchange)*

Scan and email: *info@nbmus.com*

ELIGIBILITY REQUIREMENTS

9. ELIGIBLE EMPLOYEES
a. [ ] N/A. No exclusions.
b. [X] The following are excluded (select all that apply):
1. [ ] Union Employees
2. [ ] Non-resident aliens
3. [X] Employees who are not participants in the Employer's group medical plan
4. [ ] Salaried Employees
5. [ ] Hourly Employees
6. [ ] Leased Employees
7. [X] Part-Time Employees scheduled to work less than 24 hours per week.
8. [ ] Employees who are participants in an Employer sponsored Health Savings Account
9. [ ] Other: _____

10. THE FOLLOWING AFFILIATED EMPLOYERS will adopt this Health Reimbursement Arrangement as Participating Employers (complete a Participation Agreement for each Participating Employer:
a. [X] N/A
b. [ ] Name of Affiliated Employer (s): _____

11. CONDITIONS OF ELIGIBILITY
Any Eligible Employee will be eligible to participate in the Health Reimbursement Arrangement upon satisfaction of the following:
a. [ ] Date of Hire (No service required)
b. [X] Same conditions as Employer's group medical plan
c. [ ] _____months after date of hire
d. [ ] _____days after date of hire
e. [X] Enrolled in Employer's Group Medical Plan
f. [X] Complete the HRA Election Form
g. [ ] Other: _____

12. EFFECTIVE DATE OF PARTICIPATION

An Eligible Employee who has satisfied the eligibility requirements will become a Participant on

a. [ ] the day on which such requirements are satisfied.
b. [ ] the first day of the month coinciding with or next following the date on which such requirements are satisfied.
c. [ ] the first day of the calendar quarter coinciding with or next following the date on which such requirements are satisfied.
d. [ ] the first day of the pay period coinciding with or next following the date on which such requirements are met.
e. [ ] the first day of the Coverage Period coinciding with or next following the date on which such requirements are satisfied.
f. [X] same date as Employer's group medical plan.
g. [ ] Other: _____

BENEFITS

13. MAXIMUM BENEFIT PER COVERAGE PERIOD (EMPLOYER CONTRIBUTION):

a. [ ] $_____
b. [X] Other:_____

Coverage Category	Employer Reimbursement of BCBSVT Eligible Expenses at 100% to a maximum of*:
Single	$2,750
2 Person/Family	$5,500

*Debit Cards will be issued for prescription expenses.

The plan allows you to be reimbursed for any eligible BC/BS expenses you have to meet under your employer sponsored group medical plan, which are incurred by you or your dependents subject to the chart above.

A "Take Care" debit card will be issued to the Participant for prescriptions. If extra card(s) are needed, it is the Participant's responsibility to order them.

Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for.

Expenses should first be submitted for reimbursement under your HRA Plan, and any applicable balance can be submitted under any eligible reimbursement accounts.

Any amounts reimbursed to you under the HRA Plan may not be claimed as a deduction on your personal income tax return nor reimbursed by other health plan coverage including reimbursement accounts.

You may submit expenses for yourself, your spouse or your dependents. You may be reimbursed for expenses for any child until the end of the calendar year in which the child reaches age 26. A child is a natural child, stepchild, foster child, adopted child, or a child placed with you for adoption.

14. COVERAGE PERIOD is:

a. [ ] monthly
b. [ ] quarterly
c. [X] yearly (1/1-12/31)
d. [ ] Other: _____

15. THIS ARRANGEMENT SHALL REIMBURSE: (select all that apply)

a. [ ] co-payments under the Employer's group medical plan
b. [ ] deductibles under the Employer's group medical plan
c. [ ] all medical expenses within the meaning of Code Section 213
d. [ ] all medical expenses within the meaning of Code Section 213 that do not constitute "essential benefits"
e [ ] medical insurance premiums
f [ ] dental and/or vision expenses
g [ ] dental, vision and preventative care only or expenses in excess of the deductible (HSA also provided) with the following further limitations: _____
h [ ] the following types of medical expenses ONLY: _____
_____
i. [X] Other: See question #13.

16. IF THE EMPLOYER MAINTAINS A HEALTH FLEXIBLE SPENDING ACCOUNT, WHICH PLAN SHALL PAY EXPENSES FIRST?

a. [X] This Plan (Heath Reimbursement Arrangement).

b. [ ] The Health Flexible Spending Account under the Employer's Cafeteria Plan.

17. IS THE EMPLOYER SUBJECT TO THE FAMILY AND MEDICAL LEAVE ACT?
If b. is selected, FMLA will not apply

a. [ ] Yes.

b. [X] No.

18. IS THE PLAN SUBJECT TO COBRA?
If b. is selected, COBRA will not apply

a. [X] Yes.

b. [ ] No.

18.5 COBRA Administrator: In-House

a. [ ] Bundled

b. [X] Unbundled

19. CARRY FORWARD: Amounts not used during a Coverage Period shall:

a. [ ] Be carried forward to the next Coverage Period, in an amount up to $_____.
However, the maximum accumulation limit for a Coverage Period is $_____

b. [X] Be forfeited.

20. TERMINATED EMPLOYEES:

a. [X] Shall continue to be eligible for reimbursement of any remaining balances for eligible expenses incurred through the end of the month in which they terminate, if not subject to COBRA.

b. [ ] May opt not to participate and forfeit any unused amounts.

21. A CLAIM may be submitted up to 90 days after

a. [ ] the end of the Coverage Period

b. [X] the end of each calendar year

c. [ ] Other:_____

22. DEBIT/CREDIT CARDS will be provided by the Employer for Prescription Expenses:

a. [X] Yes

b. [ ] No

23. HEALTH SAVINGS ACCOUNT will be provided by the Employer:

a. [ ] Yes

b. [X] No

24. OPT OUT: The Plan permits a participant to elect out of the arrangement at least annually. If less than annually, please select below:

a. [ ] The Participant may opt out : _____

25. IS THE PLAN SUBJECT TO HIPAA?
If b. is selected, HIPAA will not apply

a. [X] Yes.

b. [ ] No.

25.5 HIPAA Contact Name: C. Bruce Johnson

26. COVERAGE OF DEPENDENTS: The Plan will cover the following (select all that apply):

a. [X] Participant

b. [X] Spouse

c. [X] Dependents:

1. [X] natural and adopted children
2. [X] stepchildren
3. [X] foster children
4. [ ] Other: _____

This Adoption Agreement may be used only in conjunction with The Health Reimbursement Arrangement Basic Plan Document. This Adoption Agreement and the Health Reimbursement Arrangement document shall together be known as the Town of East Montpelier, VT HRA Plan.

The Employer, by executing below, hereby adopts this Arrangement:

EMPLOYER: Town of East Montpelier, VT

By: _____ _____

DATE SIGNED