

HEALTH REIMBURSEMENT ARRANGEMENT PLAN AMENDMENT

ARTICLE I
PREAMBLE

- 1.1 **Adoption and effective date of Amendment.** The Employer adopts this Amendment to the _____ (enter name of Plan) ("Plan") to reflect a new claims submission address that allows Participants to mail claims for reimbursement to the Plan.
- 1.2 The Employer and plan sponsor intend this Amendment as good faith compliance with the Plan provision. This Amendment shall be effective on or after the date the Employer elects in Section 2.1 below.
- 1.3 **Supersession of inconsistent provisions.** This Amendment shall supersede the provisions of the Plan to the extent those provisions are inconsistent with the provisions of this Amendment.

ARTICLE II
CLAIMS SUBMISSION

- 2.1 **Effective Date.** This Amendment is effective as of _____.
- 2.2 **Change of Claims Submission address.** Notwithstanding any provision contained in this Health Reimbursement Arrangement
- 2.3 Plan to the contrary, the change in status terms are amended as follows:

Claims Submission – Where to Submit Claims

Claims for expenses should be submitted to:

HealthEquity, Inc.
P.O. Box 14374
Lexington, KY 40512

This Amendment has been executed this ____ day of _____, _____.

Name of Employer:

By: _____

EMPLOYER

[SAMPLE CERTIFICATE OF ADOPTING RESOLUTION]¹

ACTIONS TAKEN AND RESOLUTIONS ADOPTED BY CONSENT OF AUTHORIZED REPRESENTATIVE

[ENTER CLIENT NAME]

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rescinded as of the date hereof;

RESOLVED, that the Amendment to the _____
(name of the Plan) (the Amendment) is hereby approved and adopted, and that an authorized
representative of the Employer is hereby authorized and directed to execute and deliver to the
Administrator of the Plan one or more counterparts of the Amendment.

The undersigned further certifies that attached hereto is a copy of the Amendment approved
and adopted in the foregoing resolution.

Date: _____

Signed: _____

(print name/title)

¹ WARNING: The legal requirements for a valid Certificate of Adopting Resolution vary from state to state. The language herein is suggested resolution language. Each employer should consult with their own legal counsel to ensure compliance.

SUMMARY OF MATERIAL MODIFICATIONS (SMM)
For the

(Name of Plan)

(1) **General.** This is a Summary of Material Modifications regarding the above referenced Plan (“Plan”). This Summary of Material Modifications supplements and amends the Summary Plan Description (SPD) previously provided to you. You should retain this document with your copy of the SPD.

(2) **Identification of Employer.** The legal name, address and Federal Employer Identification number of the Employer are:

Employer name

EIN: _____

Employer street address

Employer city, state and zip code

FOR HEALTH REIMBURSEMENT ARRANGEMENTS:

(3) **Description of Modifications.** The Employer has amended your Plan effective as of _____.

If you have any questions regarding the application of this provision to you, contact your Employer.

CLAIMS SUBMISSION

Claims Submission – Where to Submit Claims

Claims for expenses should be submitted to:

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