CPNFLEX

DL ___ / KR ___

HEALTH REIMBURSEMENT ARRANGEMENT

PLAN DESIGN AND ADOPTION AGREEMENT

EMPLOYER INFORMATION:

1. Legal name of Entity Sponsoring Plan: _____
2. Business Entity type: ☐ C Corporation ☐ Sole Proprietorship ☐ Partnership
   ☐ S Corporation ☐ LLC ☐NonProfit
   ☐ Gov. Entity or Church
3. Principal Business Activity: _____
4. Federal Employer Identification Number: _____ - _____
5. Contact Person: _____ Title: _____
6. Street Address (No P.O. Boxes): _____
   City, State, Zip: _____
7. Phone: _____ Fax: _____ E-mail:_____
8. Employer's Principal Office. This HRA shall be governed under the laws of:
   ☐ State of _____ ☐ Commonwealth of _____

Additional Contacts for Access to your Employer Portal:

1. First Name _____ Last Name: _____ Phone: _____
   Email address: _____
2. First Name _____ Last Name: _____ Phone: _____
   Email address: _____
3. First Name _____ Last Name: _____ Phone: _____
   Email address: _____

BROKER:

Name of Company: _____

Broker Contact Name: _____ **Phone:** _____

Broker Contact Email: _____

PLAN DESIGN:

1. **Effective Date**.
   ☐ Initial adoption of the HRA, Effective Date _____
   ☐ Amendment to an existing HRA, Original Effective Date _____
   ☐ Amendment and restatement of HRA, Original Effective Date _____

2. **Plan Year.** The initial Plan Year shall begin on _____, and end on _____ Future Plan Years will be based on a twelve-month period beginning each _____ and ending each _____.

3. **Plan Number**. _____.

4. **Eligible Employees**. All Employees shall be eligible to participate in the Plan, except:
   - ☐ Employees not eligible under Employer group health insurance plan.
   - ☐ Part-time employees expected to work less than _____ Hours per week.
   - ☐ Commission Salespersons.
   - ☐ Employees covered under a collective bargaining agreement/union employees.
   - ☐ Temporary or seasonal employees. (working less than 6 months of the year).
   - ☐ Leased Employees
   - ☐ Nonresident Aliens
   - ☐ Other _____

   For purposes of determining continued eligibility under the Plan,
   Retirees ____ shall ____ shall not be eligible to continue participation in the Plan.

5. **Plan Entry Date**. Employees eligible to participate may become Participants:
   - ☐ Same as Employer's group health insurance plan.
   - ☐ Employee is eligible first day following completion of waiting period. Waiting Period: _____ Days
   - ☐ Employee is eligible first of the month following completion of waiting period. Waiting Period: ____ Days

6. **Benefits**. The Plan shall reimburse Eligible Employees for the cost of Eligible Medical Expenses (as defined under Internal Revenue code Section 213 and as further described below).

	Employee Coverage	**Family Coverage**
Annual Plan Limit	$ _____	$ _____

Rollover Amount $ _____ (All/None/Specific amount)
This amount can be carried over and used in the subsequent year(s), to extend funds not fully utilized in the year of contribution. None of this amount may be paid in cash or other form of distribution, other than through reimbursement of actual expenses incurred.

Newly-eligible participants may have access to:
- ☐ The full Annual Limit at the time of Plan entry, or
- ☐ A pro-rated amount based on the number of months remaining in the Plan Year at the time of Plan entry.

7. **Eligible Medical Expenses**. The following categories of expenses qualify for reimbursement under the Plan:

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

☐ **Bridge.** Only those deductible expenses that are covered under the employer-sponsored insurance coverage will be provided.

- ☐ Benefits under this Plan shall be paid **BEFORE** the employee is responsible for his portion of the deductible limit;
- ☐ Benefits under this Plan shall be paid **AFTER** the employee's portion of the deductible limit is paid.

☐ **Limited.** Only those expenses that are not otherwise covered by insurance (e.g., co-pays, deductibles, etc.) as further selected as follows:

- ☐ Dental Expenses;
- ☐ Vision Expenses;
- ☐ Prescription Drugs;
- ☐ Other: _____

□ Embedded deductible
□ Shared deductible

□ Used for In Network Only
□ Used for In & Out of Network

□ Used for Medical Deductible
□ Used for Medical Co-Insurance

Health Reimbursement Arrangement:

Employer Pays First $ _____ Single _____ Family

OR

Employee Pays 1st $ _____ Single _____ Family
Employer Pays $ _____ Single _____ Family
Employee Pays (back end) $ _____ Single _____ Family

Please indicate any co-payments:

This is used for auto-substantiation and if not listed charges will require follow-up documentation.

Medical: _____
Coinsurance: _____
Dental: _____
Vision: _____

8. **Contributions.** Other than for Retiree/COBRA continues, the employer shall make all contributions for this Plan.

Method of payment:

CPN will pull funds weekly (appropriate document to be completed)

9. **Order of Benefit Payments.** If the Employer sponsors a Section 125 Flexible Spending Arrangement, in addition to this Plan;

☐ Eligible Medical Expenses must be paid under the Section 125 Plan ***before*** this Plan

☐ Eligible Medical Expenses must be paid under the Section 125 Plan ***after*** this Plan

☐ Not applicable.

10. **Claims Grace Periods.**

Terminated employees shall have _____ days to submit claims for expenses incurred prior to their termination date.

Employees shall have __☐ **60** __☐ **90** days ***after*** the end of each plan year to submit expenses against their prior plan year for dates of service that incurred during that eligibility period.

Debit Card Feature. ___☐ Check to offer this option to your plan.

Please indicate the claim type linkage you wish to be applied to the debit card:

☐ MEDICAL
☐ RX
☐ DENTAL
☐ VISION
☐ ALLOW OTC EXPENSES
☐ DO NOT ALLOW OTC EXPENSES

Affiliated Employers. The following Employers have adopted this Plan:

_____

_____

11. **Authorization**:

The Employer hereby agrees to the provisions of this Adoption Agreement, and in witness of its agreement, the Employer by its duly authorized officers, has executed this Adoption Agreement on this _____ day of _____, 20_____.

EMPLOYER: _____

BY: _____
Authorized Officer

Corporate Planning Network, Inc.
P. O. Box 1748 / Cordova, TN 38088
(901) 756-8244 / (800) 737-0125 / (901) 756-8322 Fax
www.cpnflex.com
For information, contact Alan Lane or e-mail alan@cpnflex.com

Doc Fee $_____

Compliance Fee $_____

Monthly Admin Fee $_____

Other: _____