QUALIFIED SMALL EMPLOYER (HRA)
REIMBURSEMENT PLAN
PLAN DESIGN

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 _____

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 who have not completed 90 days of service
   ☐ Employees who have not attained age 25
   ☐ Employees who are part-time or seasonal
   ☐ Employees who are included in a collective bargaining agreement/union employees
   ☐ Employees who are considered nonresident aliens and receive no earned income from sources within the United States.
   ☐ Other _____
5. **Individual Insurance Premium**. The Plan shall reimburse Eligible Employees for the cost of their Individual Insurance Premium. Elections are not pre-funded. Reimbursement can only be made based on contributions received by employer and posted to the individual accounts. ***Starting 1.1.2025, IRS max for Employee only is $6,350 and Family $12,800.***

	Employee Coverage	**Family Coverage**
Annual Plan Limit	**$**_____	**$**_____
Monthly Contribution Limit:	**$**_____	**$**_____

Medical _____
RX _____
Dental _____
Vision _____
OTC _____
Insurance Premiums _____

6. **Eligibly Date:** ☐ Date of Hire ☐ First day of the month after ____ days of continuous employment.

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. **Contributions.** The employer shall make all contributions for this Plan.

Acceptance of contributions:	**Method of payment:**
☐ Employer will send monthly	☐ Employer will send via ACH to CPN
☐ Employer will send quarterly	☐ Employer accepts CPN to pull funds (appropriate document to be completed)
☐ Employer will send on 15th & EOM	

8. **Claims Grace Periods.**

Terminated employees shall have **30 days** to submit claims for insurance premiums incurred prior to their termination date.

Employees shall have **30 days *after*** the end of each plan year to submit insurance premiums against their prior plan year, for insurance premiums incurred during that eligibility period.

9. **Carryover:** Carryover of up to $_____ ☐ YES ☐ NO

10. **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

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CPN

Doc Fee: $275.00

Compliance Fee: N/A

Monthly Admin Fee: $125.00 minimum OR $4.50 per participant, whichever is greater.