

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 _____

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.
 - 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.

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

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

Method of payment:

- Employer will send via ACH to CPN
- Employer accepts CPN to pull funds (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.

11. **Debit Card Feature.** Check box to offer this option to your plan.

All HRA plans linked to the debit card are set up as an Employ**ER** paid debit card subscriber.

The fee of \$_____ will be the cost per take care card, per participant (fee includes 2 cards; one in the participants name and one in the name of a spouse or dependent). This is an annual card fee and will apply each renewal plan year.

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

- MEDICAL RX DENTAL VISION

12. **Affiliated Employers.** The following Employers have adopted this Plan:

12. **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.
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www.cpnflex.com
For information, contact Alan Lane or e-mail alan@cpnflex.com

<p>Doc Fee \$ _____</p> <p>Compliance Fee \$ _____</p> <p>Monthly Admin Fee \$ _____</p> <p>Other: _____</p>
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