CPNFLEX

DL ___ / KR ___ / SL ___

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: ______________________________

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.

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.
   - ☐ Employee is eligible first of the month following completion of waiting period.
   - ☐ Employer Waiting Period (# of 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

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:
Medical: _______________
Dental: _______________
Vision: _______________
RX: _______________
Coinsurance: _______________

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.

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:

____

____

13. **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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Doc Fee $_________

Compliance Fee $___________

Monthly Admin Fee $________

Other: ________________