

Checklist for  
Employer-Paid Premium Only Plan

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Person to Contact with Questions: \_\_\_\_\_

Telephone Number: ( \_\_\_\_\_ ) \_\_\_\_\_

Email Address: \_\_\_\_\_

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**GENERAL PLAN INFORMATION**

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Group's Full Name: \_\_\_\_\_

Group's Address: \_\_\_\_\_

If above address is a post office box, street address: \_\_\_\_\_

Group's Telephone Number: ( \_\_\_\_\_ ) \_\_\_\_\_

Internal Group Number or Billing Number (if any): \_\_\_\_\_

Employer Identification Number (EIN): \_\_\_\_\_

Plan Year (month to month): \_\_\_\_\_

Original Effective Date of Plan (month & year): \_\_\_\_\_

Date of this Restatement (month & year): \_\_\_\_\_

Type of Plan:  Premium Only Plan under IRC §125  \_\_\_\_\_

Participating Employers: \_\_\_\_\_

Third Party Administrator: \_\_\_\_\_

Name, Address, Phone: \_\_\_\_\_

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**PURPOSE OF THE PLAN; ADOPTION OF THE PLAN DOCUMENT**

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**Purpose of the *Plan***

Are employees permitted to make pre-tax contributions to pay for premiums in excess of what the employer is paying:

Yes     No

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**DEFINITIONS**

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**“Annual enrollment period”** means the period from [ \_\_\_\_\_ ] through [ \_\_\_\_\_ ] each year when eligible *employees* may enroll for participation and make elections under the *Plan* for the following *plan year*.

**“Benefit cost”** means the cost of premiums for...

...Medical...	...Hearing...
...Dental...	...Prescription drugs...
...Vision...	

...coverage for a *participant*, his spouse, and dependent children under the *benefit plan*.

**“Business associate”** shall generally have the same meaning as the term “business associate” at 45 CFR 160.103, and in reference to the party to this *plan*, shall mean \_\_\_\_\_

**VARIABLE – KEEP or REMOVE**

**“Covered entity”** shall generally have the same meaning as the term “covered entity” at 45 CFR 160.103, and in reference to the party to this *plan*, shall mean \_\_\_\_\_

**VARIABLE – KEEP or REMOVE**

**“Employee”** means a person who is an *employee* of the *participating employer*, regularly scheduled to work for the *participating employer* in an employer-*employee* relationship at least [ \_\_\_\_\_ ] hours per week.

**“Participation agreement”** means...

...a written agreement by a <i>participant</i> to allow the <i>participating employer</i> to make a contribution to his or her account in order to pay <i>benefit costs</i> ...
...a written agreement by a <i>participant</i> to allow the <i>participating employer</i> to make a contribution to his or her account in order to pay <i>benefit costs</i> [ , or for the <i>participant</i> to reduce his or her salary or wage to pay additional premiums under a <i>benefit plan</i> ].

If the *participant* elects not to participate in this *plan*, the *participating employer* may make an after-tax contribution to the *participant’s* salary or wage.

**OPTIONAL – KEEP or REMOVE**

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**ELIGIBILITY FOR PARTICIPATION**

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**Am I eligible to participate in the *Plan*?**

As a full-time *employee* regularly scheduled to work at least [ \_\_\_\_\_ ] hours per week, you are eligible to participate in this *Plan* when you...

...begin <i>active employment</i> .
...complete your <i>waiting period</i> of [ _____ ] days of continuous <i>active employment</i> .

If you are not a *participant* in this *plan*, and have decided to decline coverage because you have comparable health care coverage, you may elect to receive cash compensation as described in this section.

**OPTIONAL – KEEP or REMOVE**

Eligible *employees* who do not participate in this *Plan* will not receive contributions from the *participating employer*...

...and may not pay any additional premiums with pre-tax dollars.
...and are not eligible to choose the cash compensation.
Not applicable

If you become eligible during the *plan year*, you will be allowed to participate in this *Plan* ...

	...on your date of hire.
	...on the [ ] day of the month following your date of hire.
	...on the [ ] day of the month following [ ] days of continuous <i>active employment</i> .
	Other (please specify):

If you are enrolling during an *annual enrollment period*, your entry date will be [ ] following the *annual enrollment period*.

**May I elect not to participate in the *benefit plan*?**

You may elect not to participate in the *benefit plan* by completing and filing an appropriate election/declination form with the *Plan Sponsor* within [ ] days of your original eligibility period or an *annual enrollment period*.

**OPTIONAL – KEEP or REMOVE**

	If you elect not to participate in this <i>plan</i> , you will be entitled to receive \$[ ] in cash compensation from the <i>Plan Sponsor</i> .
	If you elect not to participate in this <i>plan</i> [due to the fact that you are currently enrolled in a different health plan], you will be entitled to receive \$[ ] in cash compensation from the <i>Plan Sponsor</i> .
	Not Applicable

	You will be required to provide evidence of the comparable coverage to the <i>Plan Sponsor</i> in order to receive cash compensation.
	Not Applicable

	Any such cash compensation paid to you will be on an after-tax basis within [ ] days from your election not to participate.
	Any such cash compensation paid to you will be paid on a pro rata basis on the [ ] day of each month.
	Not Applicable

**May I make mid-year changes in my *Plan* elections?**

Unless otherwise specified, any change in participation must be made within [ ] days after the change in status event occurs, and the change will remain in effect the balance of the *plan year*.

The change will become effective on the...

	...date of the event.
	...first day following the date the election change is made.
	...first day of the month following the date the election change is made.
	Other (please specify):

**May I continue participation during *FMLA leave*?**

The *participating employer*...

	...will...
	...will not...

...continue to pay your *benefit costs* if you are on *FMLA leave*.

**May I continue participation while I am absent under *USERRA*?**

The *participating employer*...

	...will...
	...will not...

...continue to pay your *benefit costs* if you are absent from employment because you are in the *uniformed services*.

If you have additional premiums, you may elect to continue your coverage under this *Plan* for up to 24 months by electing to pay your additional premiums using pre-tax dollars.

**OPTIONAL – KEEP or REMOVE**

**When does my participation end? *Please choose ONE***

	If your employment terminates, and you return to eligible employment with your <i>participating employer</i> within the same <i>plan year</i> , you will not be permitted to rejoin the <i>Plan</i> .
	If your employment terminates, and you return to eligible employment with your <i>participating employer</i> : <ul style="list-style-type: none"> <li>• Within 30 days, you may rejoin the <i>Plan</i> provided that you keep your original election for that <i>plan year</i>; or</li> <li>• More than 30 days following termination of your participation, you may rejoin the <i>Plan</i> and make a new election for the remainder of the <i>plan year</i>, as long as the termination was not for the purpose of altering the original election.</li> </ul>

Coverage for a rehired employee is effective on the:

	...date of rehire
	...first day of the month following the date of rehire
	Other:

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**PLAN CONTRIBUTION ELECTIONS**

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**How is the *Plan* funded?**

The *Plan* is funded by...

	... <i>participating employer</i> ...
	... <i>participating employer</i> [and <i>participant</i> ]...

...contributions under a *participation agreement*.

The *participating employer* will make a monthly contribution of \$[ ] to each *participants* account in order to pay *benefit costs*.

**How will the *Plan* distribute excess contributions?**

The *Plan Sponsor* may use excess contributions to uniformly decrease the *benefit costs* of all *participants* in the next *plan year*.

**OPTIONAL – KEEP or REMOVE**

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**CLAIMS REVIEW PROCEDURES**

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**Appeal of Claims or Disputed Claims**

However, should a *participant* have a claim for benefits under this *plan* because the wrong amount was taken from the *participant's* salary, the *participant* must notify the *Plan Administrator* within [ ] days after the pay-period in which the incorrect amount was taken from the *participant's* salary, so that the *Plan Administrator* may make the necessary adjustments.

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**MISCELLANEOUS INFORMATION**

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**Will the *Plan* provide a statement of benefits?**

Will the *Plan* provide a statement of benefits? \_\_\_\_\_

	On or before January 31 <sup>st</sup> of each year, the <i>Plan Administrator</i> will furnish each <i>participant</i> who received benefits under the <i>Plan</i> a written statement showing...
	[Throughout the <i>plan year</i> ], the <i>Plan Administrator</i> will provide access to a web-based online system to each <i>participant</i> who received benefits under the <i>Plan</i> which will show...
	Not Applicable

... the amounts paid or the expenses incurred by the *Plan Sponsor* in connection with the administration of the *plan* for the prior *plan year*.

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### HIPAA PRIVACY PRACTICES

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**Disclosure of Protected Health Information (“PHI”) to the *Plan Sponsor* for *Plan Administration* Purposes**

- The following employees, or classes of employees, or other persons under control of the *Plan Sponsor*, shall be given access to the *PHI* to be disclosed:
