Sample Plan Adoption Agreement and Description

Medical Expense Reimbursement Plan for (name of business or, if no separate name, your name)

1. PURPOSE: The purpose of the plan is complete and full medical care for the employees of (name of business). The plan is designed and intended to qualify as an accident and health plan within the meaning of Section 105 of the Internal Revenue Code of 1986, as amended. This section of the Code allows employees to exclude the benefits of this plan from their gross income.

2. EFFECTIVE DATE: The effective date of this plan shall be (date of the plan may not be earlier than the date of hire). The plan year shall be on a calendar-year basis. The plan year is the same as the tax year of this business and, like the business; the records of the plan shall be kept on a calendar-year basis.

3. ELIGIBLE EMPLOYEES: All full- and part-time employees of (name of business) may participate in this plan.

(If you expect to hire other employees after you hire your spouse, consider these discrimination rules that allow you to deny coverage to those employees who (1) do not have three years of service or (2) are not yet age 25 on the first day of the plan year. To use these requirements, insert them into your plan. For details on these rules, refer to Tax Reduction Letter, January 2009, Vol. 18., No. 1, Discriminate with Your 105 Plan)

4. BENEFITS: Within 15 days of reimbursement-request submissions, the employer shall reimburse the employee for medical expenses paid or incurred by the employee, his or her spouse, or his or her dependents (as defined in Section 152 of the Internal Revenue Code). Expenses eligible for reimbursement are itemized medical expenses as defined in Section 213(d) of the code. Generally, these are medical expenses for which individuals can claim itemized deductions on their personal tax returns and over-the-counter drugs and medicines.

(Name of business) shall not reimburse any expenses paid by another employer.

(Name of business) may pay the medical expenses directly to the medical provider or by purchasing insurance that pays employees' expenses. In cases where the company pays the expenses, employees shall not seek reimbursement.

5. LIMIT ON BENEFITS: The plan ceiling for reimbursements is $ _____. Amounts in excess of the ceiling shall not be reimbursed by the plan. *(When you cover employees other than your spouse, and even with your spouse, you may want a ceiling on plan benefits.)*

6. SUBMISSION OF EXPENSES: Eligible employees must submit claims for reimbursement not less than annually. Employees are encouraged to submit claims more frequently. Employees must submit claims that clearly show that the employee or his or her dependent incurred a valid medical expense. The employee need not have paid the claim for the employer to reimburse such claim, but the evidence must clearly show that the employee is liable for the expenses.

7. ADMINISTRATION: (Name of business) has both the authority and responsibility to control and manage plan operations and administration. (Name of business) shall keep a copy of this plan document at his or her office, where employees or participants may inspect and review it during (name of business) regular business hours. Also, should any employee or covered dependent desire a copy of the plan, (name of business) shall provide such copy within a reasonable time of the request.

8. AMENDMENT AND DISCONTINUATION: (Name of business) may amend this document at any time. Any amendment may not retroactively preclude any reimbursement. Similarly, (name of business) may terminate this plan anytime, but any such termination may not retroactively preclude benefits.

9. NOTIFICATION AND ACKNOWLEDGMENT: (Name of business) shall promptly notify all employees that this plan is available and give such employees a copy of the plan for their review. Eligible employees shall acknowledge acceptance or rejection of the plan with a signature, as set forth below.

(Name of business)
For the employer:

By _____

Title_____

Date _____

Acknowledgment by employee
(Circle choice — Accept Reject)

Employee _____

Printed name _____

Date _____

(As a Tax Reduction Letter subscriber, you have our permission to copy this plan and use it to help support your medical plan and reimbursements.)