This commentary is intended as a brief description of checklist options and language called in when certain choices are made. Actual language in the proof copy of the plan should always be carefully reviewed to ensure it meets specific client needs and reflects the plan design agreed to by the TPA and its client.

2015 CHANGES

Women's Health Care

Under the rulings issued by the Supreme Court earlier this year in the Hobby Lobby and Wheaton cases, some private, for-profit employers are eligible to claim a religious exemption from the requirement to cover contraceptives and/or abortifacients for women. An employer that intends to claim this exemption should determine whether it is qualified to do so and provide any required notices in compliance with the most recent guidance issued by Health and Human Services, the Department of Labor and the Internal Revenue Service. The checklist has been modified to allow qualifying employers to exclude coverage for contraceptives and abortifacients.

Essential Health Benefits

Although some additional guidance on what constitutes an "essential health benefit" has been issued over the course of the last year, there is still significant ambiguity in the standards that apply to self-funded plans. If the plan administrator determines that a particular procedure or service is not an essential health benefit, it is permissible to impose dollar limits on the benefit and it is not required to count any out of pocket expense incurred for that benefit to be counted against the out-of-pocket limits. The plan administrator should review available guidance to determine whether its characterization of a procedure or service as a non-essential health benefit is reasonable and should document its decision. (Note that a self-funded plan can exclude coverage altogether for essential health benefits, but it cannot impose dollar limits or exclude costs from the out-of-pocket limits unless it determines that the benefit is non-essential.) The checklist has been revised to permit the designation of any limits that apply to non-essential health benefits.

Mental Health Parity

As a general rule, plans must provide the same level of benefits for mental health coverage as they do for medical coverage. For example, office visits for mental health treatment must be paid in the same way as medical office visits, and benefits for inpatient care for medical and mental health treatment must be equal. Under the new rules, plans may establish an additional category of benefits for both medical and mental health care that consists of outpatient care that is more intensive than an office visit. This category of benefits may include services such as skilled nursing care for medical treatments and intensive outpatient or residential treatment for mental health. The checklist has been updated to allow benefit levels to be set for these intermediate outpatient care facilities.

Pre-existing Conditions

By January 1, 2015, no plan (including grandfathered plans) may impose pre-existing condition limits on benefits. These provisions have been removed from the plan document.

Prescription Drug Benefits: Specialty Drug Tier

A new tier has been added to the checklist to allow specific provisions for specialty drugs.

Definitions

The definition of "Hospital" has been updated to provide more flexible guidelines in determining whether a facility has the necessary credentials to be treated as a covered provider under the plan. In addition, a specific exclusion for "Cosmetic Procedures" has been added.

COBRA

The COBRA section has been revised to reflect the new language added to the Department of Labor's model form for the initial COBRA notice.

Checklist completed by ______________________ (Ext ________)

If unavailable, contact ______________________ (Ext. ________)

Telephone No. ( ) ______________________

Shipping Address: ☐ Check if new address

Firm ______________________

Address (no P.O. Box) ______________________

City ____________ State ________ Zip ________

County ______________________

Relius Account No. ______________________

Type of Firm: ☐ TPA ☐ Other ______________________

Fax No. ( ) ______________________

Postal Address: (if different) ☐ Check if new address

Firm ______________________

Address ______________________

City ____________ State ________ Zip ________

County ______________________

Plan Name ______________________

Email Address (Required) ______________________

In order to receive free Email alerts about any required plan document updates, subscribe to Consultants' Corner Updates. Go to Relius.net and select "Subscriptions."

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If we have any questions regarding the checklist, we will call you before processing the plan.

Place your name on the first line. On the second line, place the name of a coworker who is familiar with the plan. Put the telephone number at which you can be reached on the third line.

If we cannot reach you or your coworker, we will process the plan and send you a cover letter along with the requested documents. The letter will detail all questions, problem areas, omissions, etc., that you will need to address.

Fill in your six-digit Relius account number. If you do not have one, a number will be assigned to you upon receipt of your checklist.

If your postal address is a post office box, your shipping address must be a street address. All plans are delivered by UPS. UPS cannot deliver to a post office box.

Checklist plan information question number 5 requests the exact legal name of the plan. Place that name here under "Plan Name." Should you need to call us about the plan, please refer to this name.

DOCUMENT PACKAGE

a. ☐ Plan Document and Summary Plan Description and Summary of Benefits and Coverage [TPADOC] $650
b. ☐ Trust only [TPASEP] $300
c. ☐ Plan Document and Summary Plan Description, Trust Summary of Benefits and Coverage [TPADOC] $800

Is the Trust:
d. ☐ Taxable
e. ☐ Non-taxable (IRC Sec. 501(c)(9))

Documents Required. You are offered three choices. The Plan Document (PD) differs from the Summary Plan Description (SPD) only by having a signature page. Otherwise, they are identical. We supply you with an 8.5" x 11" document. The Trust is a completely separate document and is available only in 8.5" x 11" format. If the trust is a 501(c)(9) trust, it is non-taxable and that box should be checked. Otherwise check "taxable."

Before you receive your final documents, you will receive draft copies for your approval. Upon approval, the plan(s) will be sent to you in final form.

High Deductible Health Plan (HDHP) in coordination with Health Savings Account (HSA)
f. ☐ Yes
g. ☐ No

Claims and Appeal Procedures
h. ☐ Yes, unless otherwise selected below, will be in Plan/Summary
  1. ☐ Produce as separate document (leave blank if not applicable)
i. ☐ No

Summary of Benefits and Coverage
j. ☐ Yes
k. ☐ No

Statement that Foreign Language Assistance is Available
l. ☐ No
m. ☐ Yes (Select all that apply and complete contact information)

Language Access: (Insert the telephone number for the corresponding language.)
1. ☐ Spanish: ______________________.
2. ☐ Tagalog: ______________________.
3. ☐ Chinese: ______________________.
4. ☐ Navajo: ______________________.

PLANS REQUIRED (Select all that apply)
a. ☐ Short Term Disability
b. ☐ Freestanding Prescription Drugs
c. ☐ Vision Care
  Is this an excepted benefit under ACA?
  1. ☐ Yes
  2. ☐ No
d. ☐ Dental Benefits
  Is this an excepted benefit under ACA?
  1. ☐ Yes
  2. ☐ No

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e. ☐ Supplementary Accident
f. ☐ Medical/Major Medical (Must be selected with HDHP, **1f.**)

Plans Required is a listing of the self-funded plans currently available. Medical coverage is offered as either an indemnity plan and/or a managed care plan. The High Deductible Health Plan (HDHP) selection is designed to meet the regulatory requirements for plan design when used in conjunction with a Health Savings Account (HSA).

Other plans include short term disability, prescription drug, vision care, dental and supplementary accident.

Include Basic Coverage?
(Plans Patterned After BC-BS plans into a Base & Major Medical Plan) Do not fill in with a Managed Care Plan or HDHP **1f.**
g. ☐ No
h. ☐ Yes (Select all that apply)
1. ☐ Basic Hospital
2. ☐ Basic Surgical
3. ☐ Basic In-hospital Physician Medical
4. ☐ Basic Diagnostic Testing, X-Ray and Lab
5. ☐ Basic Radiation/Chemotherapy

These are the five basic plans. They are usually all written together. Basic coverages are first-dollar coverages, usually limited in scope and written in conjunction with a supplemental major medical plan. They are patterned after basic Blue Cross/Blue Shield plans and are seldom written today except in the northeastern part of the country. **They are never part of a managed care plan or a High Deductible Health Plan (HDHP) when in conjunction with a Health Savings Account (HSA).** If you have a question as to whether you have basic plans, please call Relius.

DOCUMENT FORMAT
a. ☐ Standard (letter size, single spaced, ragged margin)
b. ☐ Right justified margins

FONT OPTIONS (Please choose from available font/sizes below)
Documents (Plan and Summary, Trust) (Default: Arial font)
a. ☐ 10 pt. Arial
b. ☐ 10.5 pt. Times

Font Options. You have a choice of two different fonts. Arial is the default.

PLAN INFORMATION - REQUIRED BY ERISA
Name of Plan (Exact Legal Name)

a. ______________________________

b. ______________________________

c. ______________________________

The exact legal name -- including punctuation -- should be written here. This name will appear in the ERISA information. Please distinguish the plan name from the employer name; for example, add "Employee Benefit Plan" or "Medical Plan" on line b.

Tax number & Plan number

a. Tax number ______________________________
(Employer Identification Number)

b. Plan number ______________________________
(e.g., 501, 502, etc.)

Tax Number is the nine-digit Employer Identification Number assigned by the IRS.

Plan Number is the three-digit number assigned by the Employer to the plan for Form 5500 purposes. This number always begins with a "5."

If you would like a "group number" to appear in the document, write the number in the margin and identify it as a group number.

Type of Plan/Grandfathered Status
a. ☐ ERISA
b. ☐ Non ERISA

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Describe Grandfathered Status of Plan under PPACA/Health Care Reform: (Do not complete **c., d., e., f.** or **g.** unless the plan is a group health plan subject to PPACA/Health Care Reform)

c. ☐ Grandfathered Plan
d. ☐ Nongrandfathered Plan
AND if b. or d. selected, the Plan is:
e. ☐ subject to a binding State external review process
f. ☐ NOT subject to a binding State external review process but has elected to comply with a State external review process in lieu of the federal external review process
g. ☐ NOT subject to a binding State external review process, and has elected to use the federal external review process

Note: If "e." or "f." is elected, the plan document will indicate that the plan has elected the state process and will refer participants to the plan administrator for more information, but it will not identify the applicable state or describe the process.

A plan is **subject to ERISA** if the plan is established or maintained:
(a) by an employer engaged in commerce or any industry or activity affecting commerce; or
(b) by an employee organization or organization representing employees engaged in commerce or in any industry or activity affecting commerce; or
(c) by both.

A plan is **NOT subject to ERISA** if:
(a) such plan is a governmental plan (as defined in ERISA section 3(32));
(b) such plan is a church plan (as defined in ERISA section 3(33));
(c) such plan is maintained solely for the purpose of complying with applicable workers' compensation laws or unemployment compensation or disability insurance laws; or
(d) such plan is maintained outside of the United States primarily for the benefit of persons substantially all of whom are nonresident aliens.

Some of the new provisions of health care reform do not apply to plans that were in existence on March 23, 2010. These plans are known as "grandfathered plans". Regulations have been issued which describe the extent to which a grandfathered plan can change its benefit and cost-sharing structure and still maintain its grandfathered status. If a plan makes changes beyond those allowed under the regulations, or if it came into existence after March 23, 2010, it will be treated as a **"**non-grandfathered plan.**"**

Plan effective date a. ______________________
(month) (day) (year)

Plan Effective Date is the date the plan was adopted. Strictly speaking, this should be the original implementation date, when plan maximums started accumulating. If you would like to also list the date the plan was most recently stated in its present form, add a line to state the "Plan revision date" or something similar.

Plan Year ends a. ______________________
(month) (day)

Begins b. ______________________
(month) (day)

Plan Year Ends is the date that is the last day of the plan year. The plan year usually corresponds to a calendar year so as to coincide with the deductible and inside limitation accumulation periods. However, a plan year can be any 12-month period. Some employers prefer to have their plan years coincide with their fiscal years. Putting down the plan year is an ERISA requirement. The date is quite important since it decides when the plan comes under certain laws.

EMPLOYER INFORMATION

Employer

a. ______________________
(Name)

b. ______________________
(Street)

c. ______________ d. __________ e. __________
(City) (State) (Zip)

f. ______________________
(Telephone)

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g. ____
(website for plan information or copies of plan documents)

h. ____
(telephone number for plan information or copies of plan documents)

Name of Plan Administrator (not the Claim Administrator) if different than Employer:

i. ____
(Name)

j. ____
(Street)

k. ________________________ l. _______ m. ____________
(City) (State) (Zip)

n. ____ (Telephone)

Employer Name is ERISA information and should be exact. It will be used as the employer name and address as well as that of the plan administrator, plan fiduciary and legal agent, if it is an ERISA plan. You can also indicate a separate plan administrator for ERISA purposes.

Group entity (select one)
a. ☐ Corporation (includes non-profit, church & government groups)
b. ☐ Proprietor or partner
c. ☐ Taft-Hartley Trust Fund (attach eligibility requirements)

For **Group Entity**, select the one that best describes the corporate structure of the employer.
a. ☐ Regular Full-time Active
 1. __________ minimum hours per week worked
b. ☐ Regular Part-time
 1. __________ minimum hours per week worked
c. ☐ Quallifying employees (Note: This refers to employees such as variable hour and seasonal employees who become eligible based on a lookback period that determines they have worked an average of at least 30 hours per week. This section should be completed for any plan that is sponsored or maintained by an employer that is subject to the Employer Shared Responsibility penalties.

d. ☐ Other (please describe eligibility requirements)

 1. ____

 2. ____

 3. ____

For New Qualifying Employees:
e. ☐ The initial measurement period shall be a period of:
 1. ______ months (at least 3 and not more than 12)
 beginning on the
 2. ☐ date of hire
 3. ☐ first of the calendar month following date of hire
f. ☐ The initial stability period shall be a period of
 1. ______ calendar months (at least 6 and no more than the initial measurement period)

For Ongoing Qualifying Employees:
g ☐ The standard measurement period shall be a period of:
 1. ______ calendar months at least 3 and not more than 12)
 2. Beginning the first day of __________ (insert month)
h. ☐ The standard stability period shall be a period of
 1. ______ calendar months (at least 6 and no more than the standard measurement period)

Break in Service Rules
i. ☐ Is the plan sponsor an educational organization under the Employer Shared Responsibility rules?
 1. ☐ Yes
 2. ☐ No

Eligible Class of Employees is information that will be used in the eligibility section of the plan.

a. To comply with the ACA Employer Shared Responsibility provisions, an employee is considered to be "full-time" if he or she works, on average, at least 30 hours per week or 130 hours per month. The effective date of the Employer Shared responsibility provisions has been delayed until 2015. The checklist has been modified to allow you to choose different weekly-hours-worked standards for periods both before and after the delayed effective date.

d. This item allows the employer to exclude designated groups of employees. Note that imposing eligibility criteria on full-time employees may result in a failure to offer coverage to all full-time employees, as required by the ACA Employer Shared Responsibility provisions. It may also result in impermissible discrimination under the federal tax rules.

If the employer is a Taft-Hartley fund, select **"d."** and attach eligibility language if you are mailing the checklist to Relius. If you do not have eligibility language, call Relius and we will send you sample eligibility language that you can adapt for your own plan.

Are Retired Employees eligible?
a. ☐ No
b. ☐ Yes

If retirees are eligible for the plan, select **"Yes"** The plan defines a retiree as a former active employee who retired while employed by a covered employer under the formal written plan of the covered employer and who elects to contribute the required contribution to the plan. This class will be automatically entered in the eligibility section.

When coverage begins and ends: (Note: Excepted-benefit dental and vision plans may select any of the options offered below. All other plans: (1) should not select c., (2) if f. is selected, i. must also be selected, and (3) h., if selected, should be completed in accordance with the restrictions on waiting periods and effective dates of coverage in excess of 90 days.

Waiting Period (select one)
a. ☐ One month
b. ☐ Two months
c. ☐ Three months
d. ☐ 30 days
e. ☐ 60 days
f. ☐ 90 days
g. ☐ None
h. ☐ Other ____________________

When coverage starts
i. ☐ Immediately after waiting period
j. ☐ First of month after waiting period

When coverage ends
k. ☐ On date of termination
l. ☐ End of the month after termination

Must a rehired employee who has continued coverage under COBRA be required to satisfy the waiting period?
m. ☐ Yes
n. ☐ No

Select the waiting period required for coverage. If there are two waiting periods (e.g., one for salaried, one for hourly), write in the second one in the margin of the checklist if you are mailing the checklist to Relius and indicate the employee class for each.

When coverage starts. Does coverage under the plan begin the day after the end of the waiting period? If so, select box **"i."** If coverage starts the first of the month after the end of the waiting period, select box **"j."**

When coverage ends. This is separate from COBRA continuation and the section refers the employee and dependent to the COBRA section where appropriate. The question asks, when an employee's employment ends, does coverage end the last day of employment (select box **"k."**) or on the last day of the month of termination (select box **"l."**)?

Beginning in plan years that start on or after January 1, 2014, plans must not require a longer waiting period than 90 days following employment (or attaining other eligibility criteria) and, if the employee elects coverage, it must become effective no later than the 91st day. These rules should be kept in mind when completing Item 14. Also keep in mind that employees hired before the new waiting period restrictions become effective should be credited with days already served under a prior waiting period and should be offered coverage on or before the time they satisfy the maximum 90-day waiting period.

Coverage mandated under the federal Uniformed Services Employment and Reemployment Rights Act is automatically entered.

Is there Dependent coverage?
a. ☐ No (skip to **21.**)
b. ☐ Yes

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Are Spouses Covered?

a. ☐ No
b. ☐ Yes
c. ☐ legally married opposite sex only AND
 1. ☐ common law marriages are included OR
 2. ☐ common law marriages are not included
d. ☐ legally married same and opposite sex AND
 1. ☐ common law marriages are included OR
 2. ☐ common law marriages are not included
e. ☐ A Spouse will not be eligible for coverage if
 1. ☐ Spouse has other group coverage available
 2. ☐ Spouse is covered under other group coverage

Are Children covered? (Note: failure to offer coverage for dependent children in Plan Years beginning on or after Jan. 1, 2015 may trigger penalties under the Employer Shared Responsibility mandates.)

a. ☐ No
b. ☐ Yes, for all Plans EXCEPT excepted-benefit dental/vision (if excepted-benefit dental/vision, skip to **j.**)
 1. ☐ Employee's natural children, adopted children and children placed for adoption with Employee
 2. ☐ Employee's stepchildren
 3. ☐ Employee's foster children
 4. ☐ Domestic partner's natural children, adopted children and children placed for adoption with domestic partner

AND

c. ☐ until age _______ (not less than 26)
 AND, for Grandfathered plans only
 1. ☐ provided child is not eligible for other employer-sponsored coverage (Note: this item may not be selected for Plan Years beginning on or after January 1, 2014,.
d. ☐ after the limiting age if totally disabled

and ends:

e. ☐ on the date of the child's birthday (ending coverage prior to the end of the month in which the limiting age is reached may trigger penalties under the Employer Shared Responsibility mandates)
f. ☐ at the end of the Calendar Year
g. ☐ at the end of the month in which the eligibility requirements are no longer satisfied (last day of birthday month)

Newborn coverage (select all that apply)

h. ☐ Automatically for 30 days with existing Dependent coverage
i. ☐ Must enroll all newborns
j. ☐ Yes. For excepted-benefit dental/vision plans the following children will be covered:
 1. ☐ Employee's natural children, adopted children and children placed for adoption with Employee
 2. ☐ Employee's stepchildren
 3. ☐ Employee's foster children
 4. ☐ Children for whom the employee is a legal guardian
 5. ☐ Domestic Partner's natural children, adopted children and children placed for adoption with domestic partner
 6. ☐ Domestic Partner's Stepchildren
 7. ☐ Domestic Partner's foster children
 8. ☐ Children for whom the Domestic Partner is a legal guardian
 9. ☐ Other ________________________________

AND

k. ☐ until age _______ AND provided child:
 1. ☐ meets dependency requirements
 2. ☐ meets residency requirements
 3. ☐ is unmarried
 4. ☐ meets student requirements
  a. ☐ limiting age for students is ________

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AND
l. ☐ after the limiting age if totally disabled
and ends:
1. ☐ on the date
2. ☐ at the end of the Calendar Year
3. ☐ at the end of the month in which the eligibility requirements are no longer satisfied

Are Qualified Dependents covered? (if excepted-benefit dental/vision, complete **17j.** above)
a. ☐ No
b. ☐ Yes for
1. ☐ Children for whom the employee is a legal guardian
2. ☐ Children of Domestic Partner. "Children" shall include the Domestic Partner's:
a. ☐ Natural children, adopted children and children placed for adoption with Domestic Partner (do not complete if **17b4.** is checked).
b. ☐ Stepchildren
c. ☐ Foster children
d. ☐ Children for whom the Domestic Partner is a legal guardian
3. ☐ Other ______________________________

c. ☐ until age _________ AND provided child meets:
1. ☐ meets dependency requirements
2. ☐ meets residency requirements
3. ☐ meets student requirements
a. ☐ limiting age for students is _________
4. ☐ is unmarried

AND
d. ☐ after the limiting age if totally disabled
and ends:
1. ☐ on the date
2. ☐ at the end of the Calendar Year
3. ☐ at the end of the month in which the eligibility requirements are no longer satisfied (ending coverage prior to the end of the month in which the limiting age is reached may trigger penalties under the Employer Shared Responsibility mandates)

The dependent choices have been expanded due to health care reform. New options at 17. have been added to allow for choices for standalone dental and vision plans.

Natural and Adopted Children. If a plan offers dependent coverage for children, it must now permit coverage until age 26 without regard to the child's marital status, student status, residence status, or financial dependence status. It is clear that this new rule will apply to an employee's natural children and children adopted by or placed with the employee for adoption. The Checklist and Plan Document have been revised to reflect this requirement (Item 17.).

- Note that a special rule applies to grandfathered plans. These plans may limit this coverage to children who do not have access to other employer-sponsored coverage. (Item 17c1.)

Stepchildren and Foster Children. Plan sponsors are not required to offer coverage to stepchildren or foster children, but if they do so, the new guidance requires that they must follow the same rules that apply to natural and adopted children.

Other Dependent Children. If a plan offers coverage to other children – such as nieces, nephews, grandchildren, or legal wards – it may wish to impose the traditional restrictions based on age, marital, student, residence and dependency status. At this time, it appears that such restrictions may be permissible and the plan sponsor can choose this option. (Item 18.) However, it is possible that future guidance will disallow this choice and plan sponsors should be prepared to change the plan provisions if required.

Children of Domestic Partners. The new rules for dependent children do not apply to the children of domestic partners. A plan may choose to treat the children of domestic partners in the same manner as children of the employee (Item 17.) or it may impose restrictions based on age, marital, student and residency status (Item 18.).

Are Domestic Partners Covered?
a. ☐ No (skip to **21.**)
b. ☐ Yes

If Yes, select all that apply:
c. ☐ Opposite sex
d. ☐ Same sex

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And, should Domestic Partners be treated as Spouse and child(ren) of Domestic Partners be treated as dependents for COBRA rights?

a. ☐ No
b. ☐ Yes

If No, shall equivalent continuation coverage be provided?

c. ☐ No
d. ☐ Yes
   1. Please type description of continuation coverage:
   ____
   ____
   ____

If there is Domestic Partner coverage, select box **"b."** The plan's standard language for Domestic Partners includes the following requirements:

1. The Employee and individual are 18 years of age or older and are mentally competent to enter into a legally binding contract.

2. The Employee and the individual are not married to anyone.

3. The Employee and the individual are not related by blood to a degree of closeness that would prohibit legal marriage between individuals of the opposite sex in the state in which they reside.

4. The Employee and the individual share the same principal residence(s), the common necessities of life, the responsibility for each other's welfare, are financially interdependent with each other and have a long-term committed personal relationship in which each partner is the other's sole domestic partner. Each of the foregoing characteristics of the domestic partner relationship must have been in existence for a period of at least twelve (12) consecutive months and be continuing on the date that each signs an Affidavit of Domestic Partnership and during the period that the applicable benefit is provided. The Employee and the individual must have the intention that their relationship will be indefinite.

5. The Employee and the individual have common or joint ownership of a residence (home, condominium, or mobile home), motor vehicle, checking account, credit account, mutual fund, joint obligation under a lease for their residence or similar type ownership that the Employee and individual may describe in their Affidavit of Domestic Partnership.

   In order to apply for this benefit, the Employee and the individual are required to sign an Affidavit of Domestic Partnership. In the event that the domestic partnership is terminated, either partner is required to inform *[Employer Name]* of the termination of the partnership in accordance with the Affidavit of Termination of Domestic Partnership provided by *[Employer Name]* for such purpose.

If domestic partners are covered, the plan must determine whether they will include opposite sex, same sex or both domestic partners.

Federal law does not **require** COBRA continuation coverage for domestic partners. However, a Plan Sponsor may elect to treat domestic partners and child(ren) of domestic partners the same as other plan participants with respect to COBRA continuation coverage. If domestic partners and child(ren) of domestic partners should be covered by COBRA as stated in the document, select box **"b.".**

If domestic partners and child(ren) of domestic partners **should not** be covered by COBRA as stated in the document, but the Plan Sponsor elects to provide some other continuation coverage after termination, select **"d. "** and include a complete description of the continuation coverage benefits.

COBRA explanation needed?

a. ☐ No
b. ☐ Yes

The employers to whom COBRA does not apply are:

(a) those who normally employed fewer than 20 employees on a typical business day during the preceding calendar year;
(b) any governmental plan (except those maintained by the District of Columbia, territories, possessions, agencies, or instrumentalities of the United States and plans of the federal government); and
(c) church plans as defined in IRC section 414(e).

If the employer is other than one listed above, a COBRA explanation is needed.

COBRA coverage is

c. ☐ Contributory for the qualified beneficiary
d. ☐ Noncontributory for the qualified beneficiary

This question relates to whether the COBRA qualified beneficiary pays for the continuation coverage. If yes, select **"c.".**

Are Late Enrollees allowed on the Plan?

a. ☐ No, no provision (Note: Failure to offer open enrollment may lead to penalties under the Employer Shared Responsibility provisions of the ACA.)
b. ☐ Yes

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1. ☐ coverage immediately after enrollment
2. ☐ begins the first of the month after enrollment
3. ☐ allowed on the Plan during open enrollment only
   a. ☐ Date of open enrollment _____________
   b. ☐ Coverage effective date ______________

Since HIPAA, no underwriting is allowed on late enrollees; therefore, some plans are dropping late enrollment periods. If you wish to have late enrollments, check the appropriate boxes. This open enrollment is for only letting late enrollees on the plan.

Open enrollment for changing between health plan options only?

a. ☐ No
b. ☐ Yes
   1. Date of open enrollment ______________________________
      (month)
   2. Coverage effective date ______________________________
      (month) (day)

This open enrollment is written for situations when employees are moving from one plan (for example, an HMO) to another.

Phone number for Hospital and Physicians to verify coverage

a. ______________________________
b. ☐ N/A

This phone number appears at the front of the schedule of benefits and is for use by a hospital or physician to verify coverage before charges are incurred. The phone number is the number of the company that maintains the eligibility records -- either the employer or the TPA, as the case may be.

Employee contributions toward benefit cost

Employee coverage
a. ☐ Employee contributes
b. ☐ Noncontributory (Employer Pays All)

Dependent coverage
c. ☐ Employee pays all
d. ☐ Employee contributes
e. ☐ Noncontributory (Employer Pays All)

For **Employee Contributions,** select whether the plan is contributory or noncontributory. If there is a difference, for example, contributory for hourly, noncontributory for salaried, please indicate.

Continuation while still employed during disability, approved leave, or layoff

Disability continuance
a. ☐ No
b. ☐ Yes, then (select all that apply)
   1. ☐ Until terminated by Employer
   2. ☐ ________ months

Leave and layoff continuance
c. ☐ No
d. ☐ Yes, then (select all that apply)
   1. ☐ Until terminated by Employer
   2. ☐ ________ months

Does Employer have 50 or more Employees within a 75-mile radius of the place of employment? (A "Yes" answer indicates the Employer is covered under the Family and Medical Leave Act of 1993.)
e. ☐ Yes
f. ☐ No

Leave Periods
g. ☐ For any leave periods described in **30b.** or **30d.**, the 18-month COBRA period will begin:
   1. ☐ on the day leave begins (so COBRA is not extended beyond the 18 months)
   2. ☐ the day after the leave ends

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Put in leave information. If, however, you answer **"e."**, you are subject to the Family and Medical Leave Act of 1993 and language will come in indicating plan compliance with this Act. Requirements of the Act will supersede leave information you have chosen that is contrary to the federal law.

Claims filing
a. Suggested within ________ days of service rendered

The Relius standard language says the following: "Claims should be filed within ______ days of the date charges for the service were incurred. Claims filed later than that date may be declined or reduced unless it's not reasonably possible to submit the claim in that time and the claim is submitted within one year from the date incurred." The one-year period will not apply when the person is not legally capable of submitting the claim. Your answer to **"a."** fills in the blank above.

For ERISA plans or non-grandfathered plans, including non-ERISA plans, under the new claims procedure regulations, do you allow voluntary dispute resolution procedures, including arbitration? (Only applies if **7a.** or **7d.** selected)
a. ☐ No
b. ☐ Yes

For all plans, do you allow two levels of appeals?
c. ☐ No, only one level
d. ☐ Yes, two levels

These questions give choices the Department of Labor has allowed in the new claims procedures regulations.

NOTE: All tables will appear after the Introduction section of the document when selected with the Managed Care medical benefits schedule table format.

SHORT TERM DISABILITY (Only applies if **2a.** selected)
Would you like the schedule of benefits for Short Term Disability to appear in a table?
a. ☐ Yes
b. ☐ No (may not be selected with **57a.**)

Weekly benefits limit (select **c.**, **d.** or **e.**)
c. ☐ $________ per week
d. ☐ ________ % of basic weekly earnings
e. ☐ ________ % of basic weekly earnings up to
  1. $__________ per week

Minimum benefit included
f. ☐ No
g. ☐ Yes, $________

Benefits start from
h. ☐ Day after Employer-paid sick leave ceases for Injury or Sickness
i. ☐ A specified day for Injury or Sickness
  1. ___________ day after disability for Injury (first, second, etc.)
  2. ___________ day after disability for Sickness (first, second, etc.)

A short term disability plan is also known as a salary continuance plan. This question asks about the basic formula of the plan.

1. $_________ per week asks for the plan formula to the maximum weekly benefit, if any.

Minimum Benefit Included. If the plan is contributory, a minimum benefit is usually part of the formula so that offsets don't do away with the total payment from the plan.

"Benefits start from" asks when do benefits start under the plan.

Maximum period payable
j. _________ weeks per disability

Maximum Period Payable. For how long are the benefits payable? This answer is usually 26 weeks (the LTD elimination period) but can be longer or shorter.

Occupational coverage included?
a. ☐ No
b. ☐ Yes

Covered weekly earnings
Overtime included?
c. ☐ No
d. ☐ Yes

Commissions included?
e. ☐ No
f. ☐ Yes

Bonuses included?
g. ☐ No
h. ☐ Yes

Occupational Coverage Included. Is this a 24-hour plan -- that is, is occupational coverage included?

Covered Weekly Earnings. These three questions concern the definition of "earnings."

FREESTANDING PRESCRIPTION DRUGS (Only applies if **2b.** selected)
Would you like the schedule of benefits for Freestanding Prescription Drug to appear in a table?
a. ☐ Yes
b. ☐ No (may not be selected with **57a.**)

Website where more information is available. If no website, insert telephone number

c. ____

Pharmacy (retail) drug option
d. ☐ No (skip to **36.**)
e. ☐ Yes (30 day supply)
1. ☐ Third party payor

____
(Name)

2. ☐ N/A

Four-tier drug plan (if plan is two- or three-tier, fill out **f.**, **g.** and **h.** only, as appropriate)
(Note: When HDHP **1f.** is selected, all charges are subject to medical deductible)

		Copayment (if none, enter 0)	% payable (if none, enter 0)
f.	Generic	1. $________	2. _______%
g.	Formulary (preferred) brand name	1. $________	2. _______%
h.	Non-Formulary (non-preferred) brand name	1. $________	2. _______%
i.	Specialty drugs	1. $________	2. _______%

Note: If a "greater than" option is desired, complete 1. **AND** 2. (e.g.: $10 copay or 20% whichever is greater)

Per Prescription maximum?
j. ☐ No
k. ☐ Yes $__________

Non-Participating Pharmacy coverage? (Choose either **l.** or **m.**)
l. ☐ Only covered at Participating Pharmacies
m. ☐ Coverage for ingredient costs and dispensing fees only

This asks for information about a freestanding drug plan, not prescription drug coverage in the medical plan. There are two choices here -- a regular pharmacy plan and a mail-order plan.

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The regular pharmacy plan is asked about first. This language is written to cover either a card plan, such as PCS, or an agreement entered into between the TPA or employer and a pharmacy, such as a local drug store.

The choices are between a Generic/Formulary brand name plan (fill in lines **"f."** and **"g."**) or a Generic/Formulary brand name/non-Formulary brand name plan (fill in lines **"f."**, **"g."** and **"h."**) or Specialty Drugs (**"i."**). A plan may design a prescription drug benefit to include a "greater than" feature. For example, $10 copayment or 20% whichever is greater. To create this type of benefit, complete 1. **AND** 2.

If there is a per prescription maximum, fill in these lines.

Third Party Payor. Enter the name of the third-party payor, e.g., PCS, the name of the TPA, or check **"N/A"** if you do not want this information in the document.

For a HDHP in conjunction with a HSA, all prescription drug charges are subject to deductible before copayments or percentage payable can apply. The only exception is with preventive care drugs.

Non-Participating Pharmacy. This asks how the plan wants to consider charges at a Non-Participating Pharmacy. There are two choices here – no coverage or cover ingredient costs and dispensing fees only.

Mail Order Option
a. ☐ No (skip to **37.**)
b. ☐ Yes (90 day supply)
  1. ☐ Third party payor
  ____
  (Name)
  2. ☐ N/A

Four-tier drug plan (if plan is two- or three-tier, fill out **c.**, **d.** and **e.** only, as appropriate)
(Note: When HDHP **1f.** is selected, all charges are subject to medical deductible)

	Copayment (if none, enter 0)	% payable (if none, enter 0)
c. Generic	1. $________	2. ________%
d. Formulary (preferred) brand name	1. $________	2. ________%
e. Non-Formulary (non-preferred) brand name	1. $________	2. ________%
f. Specialty drugs	1. $________	2. ________%

Note: If a "greater than" option is desired, complete 1. **AND** 2. (e.g.: $10 copay or 20% whichever is greater)

Per Prescription maximum?
g. ☐ No
h. ☐ Yes $____________

Mail Order Prescription Drug Option asks about the presence of a mail order plan. If you have one, enter the name of the mail order pharmacy and the amount(s) of the copayment(s). A plan may design a prescription drug benefit to include a "greater than" feature. For example, $10 copayment or 20% whichever is greater. To create this type of benefit, complete 1. **AND** 2.

For a HDHP in conjunction with a HSA, all prescription drug charges are subject to deductible before copayments or percentage payable can apply. The only exception is with preventive care drugs.

Is there a separate Prescription Drug Deductible(s) (does not apply if HDHP, **1f.** is selected)
a. ☐ Yes b. ☐ N/A
Per Covered Person c. $__________
Per Family Unit d. $__________

Is there a Prescription Drug Maximum out-of-pocket amount (Note: For nongrandfathered plans, the OOP for Rx drugs, together with the OOP for medical expenses, may not exceed the maximum total OOP established under the ACA for the year.)
a. ☐ Yes b. ☐ N/A

Per Covered Person c. $__________
Per Family Unit d. $__________

e. ☐ including deductible
f. ☐ excluding deductible (grandfathered plans only)
g. ☐ including copays
h. ☐ excluding copays (grandfathered plans only)

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Prescription Drug Deductible.

If the plan has a yearly Prescription Drug deductible, complete **"c."** and/or **"d."**

Prescription Drug Out-of-Pocket

If the plan has a maximum out-of-pocket amount for Prescription Drug, complete **"c."** and/or **"d."**

The next question concerns coverage of certain specific types of medications. If you select, these medications will appear in the list of exclusions.

The Relius standard language has 18 exclusions under this plan.

There are standard exclusions in the Plan
Answer whether the following should be added to the exclusions.
a. ☐ Infertility drugs
b. ☐ Impotence medication
c. ☐ Smoking deterrent
d. ☐ Hair growth/loss drugs
e. ☐ Growth hormones
f. ☐ Off-Label Drugs
g. ☐ Injectable drugs (select **1.** or **2.**)
1. ☐ All injectable drugs will be excluded
2. ☐ All injectable drugs EXCEPT insulin will be excluded

VISION CARE (Only applies if **2c.** selected)
Would you like the schedule of benefits for Vision Care to appear in a table?
a. ☐ Yes
b. ☐ No (may not be selected with **57a.**)

Eye exam
c. Maximum $_________

Period separating exams (select one)
d. ☐ 12 months
e. ☐ 24 months
f. ☐ ______ months

Plan reimburses for eye exams only?
g. ☐ No
h. ☐ Yes (skip to **44.**)

Frame-type lenses
Maximum, per pair (complete all)
a. Single vision maximum $____________
b. Bi-focal maximum $________________
c. Tri-focal maximum $_______________
d. Lenticular maximum $______________

Period separating new lenses (select one)
e. ☐ 12 months
f. ☐ 24 months
g. ☐ _____ months

Frames
Maximum, per pair

a. $_________

Period separating new frames (select one)
b. ☐ 12 months
c. ☐ 24 months
d. ☐ _____ months

Vision Care Plan contains four major sections: examination, lenses, frames, and contact lenses. There are nine standard exclusions.

Maximum concern eye examinations.

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Maximum Per Pair/Period Separating New Lenses concern lenses other than contact lenses. If your plan does not cover lenticular lenses, select N/A.

Frames Maximum, Per Pair refer to frames.

Fill in the appropriate dollar amounts and frequency limitations.

Contact lenses
a. ☐ Excluded (skip to **44.**)
b. ☐ Included, and $________
c. ☐ Limited as shown in "**1.**" below
Maximum if included: (complete all)
1. To correct above 20/70, after cataract surgery, or as part of treating Keratoconus or Anisometropia $__________
2. Prescribed for other reasons $________
(put "0" if only "1." applies)

Period separating new contacts (select one)
d. ☐ 12 months
e. ☐ 24 months
f. ☐ _____ months

Contact lenses. If your plan has two levels of reimbursements for contacts -- one reimbursement rate for medically necessary lenses and one reimbursement rate for cosmetically prescribed lenses, enter the amounts under **"1."** and **"2."**

Period separating new contacts. This is the period that must separate the payment of one maximum benefit amount and the next.

DESCRIPTION OF DENTAL BENEFITS (Only applies if **2d.** selected)
Would you like the schedule of benefits for Dental Benefits to appear in a table?
a. ☐ Yes
b. ☐ No (may not be selected with **57a.**)

Services (select all that apply)
c. ☐ Class A-Preventive
d. ☐ Class B-Basic
e. ☐ Class C-Major
f. ☐ Class D-Orthodontia

All cost sharing features (deductibles, copays, coinsurance) and annual treatment or visit limits will accumulate on the basis of the:
g. ☐ Calendar Year
h. ☐ Plan Year

There are 26 standard exclusions under the dental plan. We have added a new feature that allows you to choose whether cost sharing provisions and annual day, treatment or visit limits should accumulate over the calendar year or the plan year.

First select the services covered under the dental plan.

Dental deductible
a. $_______ per person per year

b. $_______ per family unit per year

Deductible applies to these services (select all that apply)
c. ☐ Class A-Preventive
d. ☐ Class B-Basic
e. ☐ Class C-Major
f. ☐ Class D-Orthodontia

Dental Deductible.

"a.", "b." The amount of the yearly deductible. If this is a lifetime deductible, enter the amount of the deductible. If you are sending the checklist to Relius, cross out the word "year" and substitute "lifetime." If there is a separate orthodontia deductible, indicate that by writing it in.

"c.", "d.", "e.", "f." Select the services to which the deductible applies**.**

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Dental benefit limits
Major services waiting period provision
a. ☐ Not included
b. ☐ Included, and (select one)
1. ☐ No Class C Services in first _________ months
2. ☐ Only oral surgery paid in first ________ months
3. ☐ No dentures, partial dentures or bridges in first ________ months

Dental benefit limits. If there is a waiting period for major services, write it here. If there are any other underwriting restrictions, note them and attach on a separate page, if sending the checklist to Relius.

Dental Limits
c. ☐ N/A
d. ☐ The following services are limited as shown
1. ☐ Oral exams, ________ (Number) exam
   a. every __________________ (Interval)
2. ☐ Bitewing x-ray series, every ______________ (Interval)
3. ☐ Full mouth x-ray every __________________ (Interval)
4. ☐ Fluoride treatment, limiting age of under _________ (Number) years
5. ☐ Space maintainers, limiting age of under _________ (Number) years
6. ☐ Sealants, limiting age of under ________ (Number) years
   a. every __________________ (Interval)
7. ☐ Free adjustments to dentures within ______________ (Interval) of installation
8. ☐ Replacing temporary dentures with permanent dentures, within __________________ (Interval)

Dental Limits. For the eight services/supplies listed, please fill in the frequency limits.

Percentage payable
a. ☐ Class A-Preventive __________%

b. ☐ Class B-Basic _________%

c. ☐ Class C-Major _________%

d. ☐ Class D-Orthodontia _________%

Maximum amount
a. ☐ Per person per year $_________

Orthodontia
b. ☐ Maximum $________ Lifetime per person
1. ☐ limiting age, under age _________

Predetermination of benefits
a. ☐ $______________ is start of predetermination
b. ☐ No provision

Percentage Payable. Insert the percentage reimbursements for various services here.

Maximum Amount. Enter the calendar year plan maximum.

Then, if the plan covers orthodontia, answer the question concerning the orthodontia plan maximum.

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Predetermination of Benefits. If the administrator requires predetermination, insert the predetermination dollar threshold amount here. If predetermination is triggered by procedures rather than a dollar amount, indicate this on the checklist and list the procedures on a separate page, if sending the checklist to Relius.

NOTE: Do not fill in Basic Plans unless medical plan is a Basic & Major Medical Plan. Do not fill in Basic Plans with a Managed Care Plan.

BASIC HOSPITAL (Only applies if **2h1.** selected)
Room and Board rate
a. ☐ Average semiprivate room & board rate
b. ☐ Other $___________ per day
c. ☐ 100% UCR

d. Maximum days per confinement _________

Intensive Care Unit
e. ☐ Same as room and board rate
f. ☐ ________ times semiprivate room and board rate
g. ☐ Hospital's ICU charge
h. ☐ 100% UCR

NOTE: The following five plans, all called "basic" plans, are first dollar benefit plans. They are separate and distinct from a medical plan or major medical plan that pays 100% ONLY for certain selected services such as outpatient surgery or preadmission testing. If your plan is a medical plan with a deductible, coinsurance on most items and a few items paid at 100% or a managed care plan, do NOT fill in these basic plans but instead go to Supplementary Accident, question **55.** or Medical Benefits, question **56.**

Basic Hospital plan.

"c." The room rate payable.

"d." The maximum number of days payable for a single period of confinement -- e.g., 31, 120, etc.

"e." The rate payable for confinement in an intensive care unit.

i. Special charge maximum $________

For Employees-new confinement after: (select one)
j. ☐ One day active work
k. ☐ ________ days active work
l. ☐ N/A

For Dependents-new confinement after: (select one)
m. ☐ 90 days separation
n. ☐ ________ days separation
o. ☐ N/A

Ambulance service
p. ☐ No
q. ☐ Yes, then
  1. ☐ $___________ maximum per confinement
  2. ☐ No limit

"i." The maximum for hospital-billed medical services and supplies other than room and board. Also known as "hospital extras."

"j.", "k.", "l.", "m.", "n.", "o." The time separations necessary for a hospital stay to be considered a new confinement.

Ambulance Service. If there is coverage for ambulance service under the basic plan, enter the specifics here. If ambulance is paid for under major medical only, check **"p."**

BASIC SURGICAL (Only applies if **2h2.** selected)
Type of reimbursement
a. ☐ Scheduled
b. ☐ 100% UCR

c. Maximum (for series of related procedures) $___________

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Anesthesia coverage (select one)
d. ☐ None
e. ☐ _______% of surgery
f. ☐ 100% UCR

Assistant surgeon charges
g. ☐ None
h. ☐ ________% surgery

Enter the information as to the type of reimbursement -- scheduled or UCR -- and the maximums payable, if any, for the above basic plan.

"c." Enter the maximum amount which will be allowed for payment on any one procedure (or for a series of related procedures).

Anesthesia Coverage. Check **"d."** if no anesthesia coverage is payable under the surgical schedule. Check **"e."** if anesthesia payments are determined as a percentage of the amount paid for the surgical procedure. Check **"f."** if payments are tied to the Usual and Reasonable Charge.

Assistant Surgeon Charges. Check **"g."** if there is no separate coverage of an assistant surgeon's fees under the benefit. Check **"h."** if the payment is based on a percentage of the amount paid for the surgical procedure.

BASIC RADIATION/CHEMOTHERAPY (Only applies if **2h5.** selected)
a. ☐ 100% UCR
b. ☐ Scheduled

Enter the information as to the type of reimbursement -- scheduled or UCR.

SUPPLEMENTARY ACCIDENT (complete both) (Only applies if **2e.** selected)
(Note: When HDHP **1f.** is selected, all charges are subject to deductible.)
a. Care within ____________________________(show hours, days or months)
b. Maximum benefit (per accident) $___________

Supplementary Accident is a provision that pays a certain amount of money -- usually $300 or $500 -- on a first-dollar basis in the case of accidental injury.

For a HDHP in conjunction with a HSA, all charges are subject to deductible before copayments or percentage payable can apply. The only exception is preventive care benefits.

MEDICAL BENEFITS
If you have an indemnity plan, fill in the Column A spaces after each service. Ignore the Column B spaces. The schedule of benefits will appear in a text format.

If you have a managed care program, fill in both Column A (Network Providers) and/or Column B (Non-Network Providers) spaces after each service. The schedule of benefits will appear in a text format.

If you have a managed care program and want the schedule of benefits to be in a table, please answer "Yes" to this question below regarding the table and fill in all of the Column A (Network Providers) and/or Column B (Non-Network Providers) spaces after each service.

What kind of plan is this?
a. ☐ Indemnity
b. ☐ Managed care

If your plan is a managed care plan, would you like the schedule of benefits to be in a table? (Tables will appear after the Introduction)
a. ☐ Yes b. ☐ No

Please select the format of your table:
Note: 4 column (type of service, in-network, out-of-network, blank column to be used as you wish; also you may select 2-4 blank tables with 4 columns); 3 column (type of service, in-network, out-of-network; also you may select 2-4 blank tables with 3 columns); blank table (2, 3 or 4 column blank table to be customized as you wish).
1. ☐ **4 column** information
Do you want additional blank 4 column tables
a. ☐ No
b. ☐ 2 blank tables

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c. ☐ 3 blank tables
d. ☐ 4 blank tables

2. ☐ **3 column** information
Do you want additional blank 3 column tables
a. ☐ No
b. ☐ 2 blank tables
c. ☐ 3 blank tables
d. ☐ 4 blank tables

3. ☐ blank 2 column table
4. ☐ blank 3 column table
5. ☐ blank 4 column table

What term would you like used for providers under contract?
a. ☐ Panel
b. ☐ Network
c. ☐ Participating
Provide a website and telephone number where a list of contract providers can be obtained
d. Website: ____________________
e. Telephone No.: ____________________

Type of managed care option
a. ☐ Participating Provider Organization
b. ☐ Exclusive Provider Organization
c. ☐ Point of Service Managed Care Option

The system automatically handles either an indemnity plan or a managed care in- and out-of-network plan.

The indemnity plan is either a comprehensive medical plan, or if you have filled in the basic plans, a supplementary major medical plan.

If you have an indemnity plan, fill in the Column A answers after each service. Ignore the Column B Spaces. The schedule of benefits will appear in a text format.

The managed care plan accepts different reimbursement rates for in- and out-of-network options; therefore, **if you have a managed care plan, fill in the Column A answers for in-network provider reimbursement and/or fill in the Column B answers for out-of-network provider reimbursement.**

The managed care plan has two format options: a text format or a table format. For the table format, you have a choice of a three column table, a four column table or a blank table you may customize.
There is an automatically-generating table for managed care.

For clients who are submitting their checklists to Relius by mail, if you have a plan with several managed care options, please photocopy and fill out the schedule of benefits section of the checklist for each option, clearly differentiating each option. If your plan has an in-network, out-of-network and out-of-area options, requiring four columns, please check the box marked "fourth column information."

Please select the appropriate term for the providers in the managed care plans.

PPO/EPO/POS name, address and phone number
d. ☐ N/A
e. ☐ PPO/EPO/POS ____________________
(Name)
1. ____________________
(Street)
2. ____________________
(City, State Zip)
3. ____________________
(Telephone)
4. ____________________
(Fax number)
5. ____________________
(Email address)

Does the PPO/EPO/POS make exceptions and pay in-network benefits in the following conditions?
a. ☐ Participant has no choice of in-network provider
1. ☐ Yes
2. ☐ No

b. ☐ Medical Emergency (Note: Non-grandfathered plans must check Yes)
  1. ☐ Yes
  2. ☐ No

c. ☐ Services performed by out-of-network providers at in-network facility
  1. ☐ Yes
  2. ☐ No

d. ☐ Referrals by in-network provider to out-of-network provider
  1. ☐ Yes
  2. ☐ No

Does this managed care option have deductibles only on **ALL** out-of-network charges and copayments only on **ALL** in-network charges
a. ☐ Yes (Do not answer deductible and copayment questions that follow)
b. ☐ No (Select individually at questions **67.** to **98.**)

Please fill in the name, address and phone number of the PPO/EPO/POS, and indicate **"Yes"** or **"No"** for the exceptions listed. The checklist allows for up to four (4) PPO/EPO/POS to be listed.

Dollar Limits on non-Essential Health Benefits (This Question should be answered only if the Plan wishes to put dollar limits on specific Non-Essential Health Benefits.)
List services/supplies that the Plan has determined to be non-Essential Health Benefits, and indicate any limits that apply. (Do not list non-Essential Health Benefits if they are not subject to these dollar limits.)
a. ☐ ______________________
  1. ☐ Not counted toward Out-of-Pocket maximum
  2. ☐ $____________ annual benefit limit

b. ☐ ______________________
  1. ☐ Not counted toward Out-of-Pocket maximum
  2. ☐ $____________ annual benefit limit

c. ☐ ______________________
  1. ☐ Not counted toward Out-of-Pocket maximum
  2. ☐ $____________ annual benefit limit

d. ☐ ______________________
  1. ☐ Not counted toward Out-of-Pocket maximum
  2. ☐ $____________ annual benefit limit

Self-funded plans are permitted to exclude non-Essential Health Benefits or impose limits on those benefits, including annual dollar limits and/or not counting cost sharing toward Out of Pocket Limits. There are no clear guidelines on which benefits are permitted to be treated as non-Essential Health Benefits, so plans should use caution in imposing these limits until more guidance is available. If this section is completed, the limits will be reflected on the Schedule of Benefits but will not otherwise be discussed within the text of the document until the next release.

Deductible(s)
a. ☐ Yes b. ☐ N/A

Per Covered Person	c. _______	d. ________
Per Family Unit		
dollar amount	e. _______	f. ________
number of people	g. _______	h. ________

This question has to do with any deductibles the plan has. A deductible is defined as "an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any covered services. Each January 1st a new deductible amount is required."

Three-month carryover?
i. ☐ Yes
j. ☐ No

A three-month carryover is when covered expenses incurred in, and applied toward the deductible in October, November and December will be applied toward the deductible in the next Calendar Year. This provision does not apply for HDHP in conjunction with a HSA.

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Common accident provision?
k. ☐ Yes
l. ☐ No

A common accident provision is when two or more Covered Persons in a Family Unit are injured in the same accident, then only one deductible amount is required for treatment of injuries incurred in the accident. This provision does not apply for HDHP in conjunction with a HSA.

Waived for the following services: (Network Preventive Care Services must be included if nongrandfathered plan)
m. ☐ ________________
n. ☐ ________________
o. ☐ ________________

Please enter services, such as well child care or second surgical opinion, for which the deductible amount is waived.

Which expenses are excluded from satisfaction of the deductible?
p. ☐ coinsurance
q. ☐ copayments
r. ☐ penalties for failure to follow prior authorization and cost containment procedures
s. ☐ premiums

For a HDHP in conjunction with a HSA, all charges are subject to deductible before copayments or percentage payable can apply. The only exception is preventive care benefits.

Copayment(s), per visit
(When HDHP **1f.** is selected, copayment may only apply to preventive care type services numbered **92.** - **95.** on this checklist.)
a. ☐ Yes b. ☐ N/A

Hospital	c. _______	d. ________
Physician visit	e. _______	f. ________
Specialist visit	g. _______	h. ________
Outpatient service	i. _______	j. ________

Emergency room (for nongrandfathered plans, in-network co-pay must apply if for Medical Emergency)
k. ________________ l. ________

Waived if admitted to Hospital?
m. ☐ Yes
n. ☐ No

A copayment is defined as a smaller amount of money (smaller than a deductible amount) that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments. If your plan does not have any copayments, select **"N/A"**.

Maximum out-of-pocket amount, per Calendar or Plan Year , (For nongrandfathered plans, the in-network OOP for medical expenses, when added to the OOP for Rx drugs, may not exceed the maximum total OOP established under ACA for the year. The OOP maximum for out-of-network charges may be set at any level.)
a. ☐ Yes b. ☐ N/A

Per Family Unit

dollar amount	e. _______	f. ________
number of people	g. _______	h. ________

Network Charges for Out of Pocket Maximum applies to the following; (select all that apply, leave blank if none apply):
i. ☐ In-network charges apply to the out of pocket maximum for out-of-network charges
j. ☐ Out-of-network charges apply to the out of pocket maximum for in-network charges

All cost sharing features (deductibles, copays, coinsurance) and annual day or visit limits will accumulate on the basis of the:
k. ☐ Calendar Year
l. ☐ Plan Year

We have added a new feature that allows you to choose whether cost sharing provisions and annual day, treatment or visit limits should accumulate over the calendar year or the plan year. You can make this selection at Question 65.

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Which expenses are excluded from satisfaction of the out-of-pocket maximum? Note: If cost sharing for non-Essential Health Benefits is not counted toward the OOP limits, also complete Question 62 accordingly.)

a. ☐ deductible (must complete 1. or 2. below)
   1. ☐ in- and out-of network (grandfathered plans only)
   2. ☐ out-of network only
b. ☐ copayment (grandfathered plans only)
c. ☐ expenses for Prescription Drug benefits (must complete 1. or 2. below)
   1. ☐ in- and out-of-network (grandfathered plans only)
   2. ☐ out-of-network only
d. ☐ Cost containment penalties
e. ☐ Amounts over allowed amount
f. ☐ Other ____________________

If your plan has a maximum out-of-pocket amount, please answer the appropriate questions about this plan feature.

Hospital room and board

a. ☐ Yes

Semiprivate rate

b. ________	c. ________
Subject to	Subject to
1. ☐ deductible	1. ☐ deductible
2. ☐ copayment	2. ☐ copayment
3. ☐ N/A	3. ☐ N/A

For the rest of the medical plan questions, first indicate whether the service is subject to a deductible or copayment. If it is not, mark N/A. If the service has both copayments and deductibles on it - for example, copayments for in-network services and deductibles for out-of-network services, indicate this information either on a cover sheet or on the checklist itself. Then enter the appropriate reimbursement rate -- if an indemnity plan, fill this rate in Column A; if a managed care plan, fill the network provider rate in Column A and the non-network provider rate in Column B.

Emergency Room Visit/Urgent Care

a. ☐ Yes   b. ☐ Not covered

c. ☐ Medical emergency care (For Nongrandfathered plans, in-network benefit levels must be provided for out-of-network providers)

1. ________	2. ________
Subject to	Subject to
a. ☐ deductible	a. ☐ deductible
b. ☐ copayment	b. ☐ copayment
c. ☐ N/A	c. ☐ N/A

d. ☐ Medical non-emergency care

1. ________	2. ________
Subject to	Subject to
a. ☐ deductible	a. ☐ deductible
b. ☐ copayment	b. ☐ copayment
c. ☐ N/A	c. ☐ N/A

e. ☐ Medical non-emergency care not covered

Urgent Care

f. ☐ Yes   g. ☐ Not covered

Reimbursement rate

h. ________	i. ________
Subject to	Subject to
1. ☐ deductible	1. ☐ deductible
2. ☐ copayment	2. ☐ copayment
3. ☐ N/A	3. ☐ N/A

A plan may design the Emergency Room benefit to differentiate levels of coverage for Medical emergency and Medical non-emergency care. Medical Non-Emergency Care is defined as care which can be safely and adequately provided other than in a Hospital. This is an option in plan design. Please check the appropriate answer and then fill in the reimbursement rate(s).

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Intensive Care unit
a. ☐ Yes b. ☐ N/A

c. ☐ ICU charge
1. ________ Subject to a. ☐ deductible b. ☐ copayment c. ☐ N/A
2. ________ Subject to a. ☐ deductible b. ☐ copayment c. ☐ N/A

d. ☐ Same as semiprivate room rate
1. ________ Subject to a. ☐ deductible b. ☐ copayment c. ☐ N/A
2. ________ Subject to a. ☐ deductible b. ☐ copayment c. ☐ N/A

e. ☐ ________, per day
1. ________ Subject to a. ☐ deductible b. ☐ copayment c. ☐ N/A
2. ________ Subject to a. ☐ deductible b. ☐ copayment c. ☐ N/A

You have a choice of reimbursement rates for Intensive Care Units. Please check the appropriate answer and then fill in the reimbursement rate(s).

Skilled Nursing Facility
a. ☐ Yes b. ☐ N/A
(select reimbursement rate, time following Hospital stay, and Calendar Year limit)

c. ☐ One-half Hospital average semiprivate R&B
1. ________ Subject to a. ☐ deductible b. ☐ copayment c. ☐ N/A
2. ________ Subject to a. ☐ deductible b. ☐ copayment c. ☐ N/A

d. ☐ The facility's semiprivate room rate
1. ________ Subject to a. ☐ deductible b. ☐ copayment c. ☐ N/A
2. ________ Subject to a. ☐ deductible b. ☐ copayment c. ☐ N/A

e. ☐ ________ per day
1. ________ Subject to a. ☐ deductible b. ☐ copayment c. ☐ N/A
2. ________ Subject to a. ☐ deductible b. ☐ copayment c. ☐ N/A

Time following Hospital stay
f. ☐ Immediately follows
g. ☐ Within ______ days of a
1. ____________ day stay
h. ☐ Not tied to Hospital stay

Calendar Year limit--days i. ________ j. ________

There are four parts to this question and each must be answered. First, **is this service subject to the deductible or copayment?** Then, what is the **room and board reimbursement rate?** Third, is there a **hospitalization requirement** for reimbursement? And finally, how many **days are allowed per Calendar Year?**

The Relius language requires that the patient be confined as a bed patient and that the attending physician certify that the confinement "is needed for further care of the condition that caused the hospital confinement." In the definition section, there is a strict medical necessity clause as well as a custodial care definition.

Physician services
Inpatient services
Reimbursement rate
a. ________ Subject to 1. ☐ deductible 2. ☐ copayment 3. ☐ N/A
b. ________ Subject to 1. ☐ deductible 2. ☐ copayment 3. ☐ N/A

Office visits
Reimbursement rate

c. ______	d. ______
Subject to	Subject to
1. ☐ deductible	1. ☐ deductible
2. ☐ copayment	2. ☐ copayment
3. ☐ N/A	3. ☐ N/A

Specialist office visits
Reimbursement rate

e.______	f. ______
Subject to	Subject to
1. ☐ deductible	1. ☐ deductible
2. ☐ copayment	2. ☐ copayment
3. ☐ N/A	3. ☐ N/A

Surgical services
Reimbursement rate

g. ______	h ______
Subject to	Subject to
1. ☐ deductible	1. ☐ deductible
2. ☐ copayment	2. ☐ copayment
3. ☐ N/A	3. ☐ N/A

Allergy testing
Reimbursement rate

i. ______	j. ______
Subject to	Subject to
1. ☐ deductible	1. ☐ deductible
2. ☐ copayment	2. ☐ copayment
3. ☐ N/A	3. ☐ N/A

Allergy serum and injections
Reimbursement rate

k. ______	l. ______
Subject to	Subject to
1. ☐ deductible	1. ☐ deductible
2. ☐ copayment	2. ☐ copayment
3. ☐ N/A	3. ☐ N/A

Fill in the reimbursement rates for the six types of physician services.

Diagnostic Testing (X-ray and Lab)
a. ☐ Yes b. ☐ N/A
Reimbursement rate

c. ______	d. ______
Subject to	Subject to
1. ☐ deductible	1. ☐ deductible
2. ☐ copayment	2. ☐ copayment
3. ☐ N/A	3. ☐ N/A

Imaging (CT/PET scans, MRIs)
e. ☐ Yes f. ☐ N/A
Reimbursement rate

g. ______	h. ______
Subject to	Subject to
1. ☐ deductible	1. ☐ deductible
2. ☐ copayment	2. ☐ copayment
3. ☐ N/A	3. ☐ N/A

This benefit refers to outpatient diagnostic and preventive x-ray and laboratory testing and services.

Home Health Care visits
a. ☐ Yes b. ☐ N/A
Reimbursement rate

c. ______	d. ______
Subject to	Subject to
1. ☐ deductible	1. ☐ deductible
2. ☐ copayment	2. ☐ copayment
3. ☐ N/A	3. ☐ N/A

Calendar Year limit e. ______ f. ______

Home health is covered only in lieu of a Hospital or Skilled Nursing Facility confinement. A Home Health Care Plan is required.

If there is a Calendar Year limit on these services, please indicate.

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Inpatient Drugs only (in conjunction with freestanding Prescription Drug plan)
a. ☐ Yes b. ☐ N/A

Reimbursement rate	c. ____________	d. ____________
	Subject to	Subject to
	1. ☐ deductible	1. ☐ deductible
	2. ☐ copayment	2. ☐ copayment
	3. ☐ N/A	3. ☐ N/A

Inpatient and Outpatient Drugs (no separate freestanding Prescription Drug plan)
a. ☐ Yes b. ☐ N/A

Reimbursement rate	c. ____________	d. ____________
	Subject to	Subject to
	1. ☐ deductible	1. ☐ deductible
	2. ☐ copayment	2. ☐ copayment
	3. ☐ N/A	3. ☐ N/A

If HDHP **1f.** and **75c1.** or **75d1.** are selected, are Preventive drugs subject to the medical deductible?
e. ☐ Yes f. ☐ No

These two questions involve reimbursement for prescription drugs that are separate from the freestanding or mail-in drug plans.

Question **74.** has to do with drugs that are provided in connection with an inpatient stay and therefore not reimbursed under a drug plan even though the plan does have a freestanding drug option.

Question **75.** is the reimbursement rate for inpatient and outpatient prescription drugs when the plan has no freestanding option.

Federal law permits High Deductible Health Plans, when in conjunction with a HSA, to exclude preventive drugs from the medical deductible. If this is the desired choice, select **No**.

Private duty nursing outpatient
a. ☐ Yes b. ☐ N/A

Reimbursement rate	c. ____________	d. ____________
	Subject to	Subject to
	1. ☐ deductible	1. ☐ deductible
	2. ☐ copayment	2. ☐ copayment
	3. ☐ N/A	3. ☐ N/A
Calendar Year limit	e. ____________	f. ____________

If selected, this is covered only when Medically Necessary and not Custodial. Outpatient nursing is covered under Home Health Care. Inpatient is covered only when the Hospital Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

Hospice Care
a. ☐ Yes b. ☐ N/A

Reimbursement rate	c. ____________	d. ____________
	Subject to	Subject to
	1. ☐ deductible	1. ☐ deductible
	2. ☐ copayment	2. ☐ copayment
	3. ☐ N/A	3. ☐ N/A
Outpatient Lifetime maximum	e. ____________	f. ____________
Inpatient and outpatient Lifetime maximum	g. ____________	h. ____________

If selected, hospice is covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Bereavement counseling -- within 6 months of death
a. ☐ Yes b. ☐ N/A

Reimbursement rate	c. ____________	d. ____________
	Subject to	Subject to
	1. ☐ deductible	1. ☐ deductible
	2. ☐ copayment	2. ☐ copayment
	3. ☐ N/A	3. ☐ N/A

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Lifetime maximum visits e. __________ f. __________

Lifetime maximum g. __________ h. __________

If the Plan reimburses for bereavement counseling for the decedent's immediate family within six months of his or her death, please check **"Yes"** and fill in the appropriate information.

Ambulance
a. ☐ Yes b. ☐ N/A
c. ☐ Ground Only d. ☐ Ground and air

Reimbursement rate	e. __________ Subject to 1. ☐ deductible 2. ☐ copayment 3. ☐ N/A	f. __________ Subject to 1. ☐ deductible 2. ☐ copayment 3. ☐ N/A
Per trip maximum (ground)	g. __________	h. __________
Per trip maximum (air)	i. __________	j. __________

k. ☐ Limited to ______________ miles per one-way trip (ground only)

In order to be covered, the ambulance must be Medically Necessary, professional and the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided. If you want further limits on this service, select them on the checklist.

Wig after chemotherapy
a. ☐ Yes b. ☐ N/A

Reimbursement rate	c.__________ Subject to 1. ☐ deductible 2. ☐ copayment 3. ☐ N/A	d. __________ Subject to 1. ☐ deductible 2. ☐ copayment 3. ☐ N/A
Lifetime maximum	e. __________	f. __________

Wig after chemotherapy, Durable Medical Equipment, Prosthetics, Orthotics and **Spinal Manipulation/Chiropractic.** If there are no inside limits in your plan on these items, select **"N/A"**. Otherwise, fill in the desired amounts.

Occupational Therapy, Speech Therapy and Physical Therapy

If therapy benefits are provided, are Occupational, Speech and Physical therapy maximum visits combined?
a. ☐ Yes, indicate calendar year maximum number of visits allowed __________
b. ☐ N/A

Occupational therapy
a. ☐ Yes b. ☐ N/A

Reimbursement rate	c.__________ Subject to 1. ☐ deductible 2. ☐ copayment 3. ☐ N/A	d.__________ Subject to 1. ☐ deductible 2. ☐ copayment 3. ☐ N/A

Speech therapy
a. ☐ Yes b. ☐ N/A

Reimbursement rate	c.__________ Subject to 1. ☐ deductible 2. ☐ copayment 3. ☐ N/A	d.__________ Subject to 1. ☐ deductible 2. ☐ copayment 3. ☐ N/A

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Physical therapy
a. ☐ Yes b. ☐ N/A
Reimbursement rate

c.____________	d.__________
Subject to	Subject to
1. ☐ deductible	1. ☐ deductible
2. ☐ copayment	2. ☐ copayment
3. ☐ N/A	3. ☐ N/A

These questions provide for two benefit plan design choices – combined calendar year visit maximum for OT, ST and PT or separate benefit calendar year visit limits. If there are no inside limits in your plan on these items, select **"N/A"**. Otherwise, fill in the desired amounts.

Mental disorders
a. ☐ Yes b. ☐ N/A
Reimbursement rate

Inpatient	c. ____________	d. __________
	Subject to	Subject to
	1. ☐ deductible	1. ☐ deductible
	2. ☐ copayment	2. ☐ copayment
	3. ☐ N/A	3. ☐ N/A
Outpatient Office Visits	e. ____________	f. __________
	Subject to	Subject to
	1. ☐ deductible	1. ☐ deductible
	2. ☐ copayment	2. ☐ copayment
	3. ☐ N/A	3. ☐ N/A
Outpatient: Intermediate Care	g. ____________	h. __________
	Subject to	Subject to
	1. ☐ deductible	1. ☐ deductible
	2. ☐ copayment	2. ☐ copayment
	3. ☐ N/A	3. ☐ N/A

Substance abuse
a. ☐ Yes b. ☐ N/A
Reimbursement rate

Inpatient	c. ____________	d. __________
	Subject to	Subject to
	1. ☐ deductible	1. ☐ deductible
	2. ☐ copayment	2. ☐ copayment
	3. ☐ N/A	3. ☐ N/A
Outpatient Office Visits	e. ____________	f. __________
	Subject to	Subject to
	1. ☐ deductible	1. ☐ deductible
	2. ☐ copayment	2. ☐ copayment
	3. ☐ N/A	3. ☐ N/A
Outpatient: Intermediate Care	g. ____________	h. __________
	Subject to	Subject to
	1. ☐ deductible	1. ☐ deductible
	2. ☐ copayment	2. ☐ copayment
	3. ☐ N/A	3. ☐ N/A

Under the Mental Health Parity and Addiction Equity Act, plans with 50 or more participants may not impose financial requirements (deductibles, copays, coinsurance, etc.) or treatment limitations (visit limits, days of coverage, etc.) that are more restrictive than the predominant financial requirements and treatment limitations applicable to medical and surgical benefits. Please fill out the following sections in accordance with these requirements unless the plan is not subject to the Act. In that case, adjust the information as you desire.

Under health care reform, group health plans (of any size) may not impose lifetime or annual limits on mental health or substance abuse benefits. As a result, these options have been removed from the Relius document.

Outpatient Intermediate Care may include services such as partial hospitalization or intensive outpatient care, and benefits must be paid in parity with comparable intermediate outpatient medical services.

Routine well adult care **(Nongrandfathered plans must provide in-network Standard Preventive Care (that is, preventive care required under ACA) without cost sharing.)**

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a. ☐ Yes b. ☐ N/A
Reimbursement rate

c. ___________	d. __________
Subject to	Subject to
1. ☐ deductible	1. ☐ deductible
2. ☐ copayment	2. ☐ copayment
3. ☐ N/A	3. ☐ N/A

Services covered (Nongrandfathered plans should select from the following list if they wish to offer services not required under ACA and/or if they wish to specifically mention services required by ACA-Grandfathered-plans that wish to offer Standard Preventive Care with no cost-sharing should complete Item q. Employers that claim a religious exemption from the requirement to provide contraceptives should complete items u. or v, as applicable.)

a. ☐ Pap smear
b. ☐ Mammogram
c. ☐ Prostate exam
d. ☐ Gynecological exam
e. ☐ Routine physical exam
f. ☐ X-rays
g. ☐ Laboratory tests
h. ☐ Hearing tests
i. ☐ Vision tests
j. ☐ Immunizations/flu shots
k. ☐ Obesity/Weight Loss programs
l. ☐ Tobacco cessation program
If this is checked, check 1. or 2. below:
1. ☐ Program will follow DOL safe harbor guidelines
2. ☐ Program will offer coverage as required for Standard Preventive Care

Checking box 1 will generate language that covers:
1. Screening for tobacco use; and,
2. For those who use tobacco products, at least two tobacco cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
   - Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and
   - All Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.

Checking Box 2 will generate language that states the tobacco cessation program will provide coverage, including tobacco cessation products, as required by law.

m. ☐ Colonoscopies
n. ☐ Bone Density scans
o. ☐ Stress Tests
p. ☐ Sigmoidoscopies
q. ☐ Standard Preventive Care
For (1) employers with nongrandfathered plans who claim a religious exemption or (2) employers with grandfathered plans, complete 1., 2. and 3. as applicable. Leave blank if not applicable
1. ☐ Exclude contraceptives
2. ☐ Exclude abortifacients
3. ☐ Exclude sterilization procedures

r. ☐ Other ______________________________

If HDHP **1f.** and **92c1.** or **92d1.** are selected, are Preventive Care services subject to the medical deductible?
s. ☐ Yes t. ☐ No (Nongrandfathered plans must slelect **s.**)

If the plan covers routine testing, screening, and physical exams for adults, fill in these questions with the appropriate information.

Federal law permits High Deductible Health Plans, when in conjunction with a HSA, to exclude preventive drugs from the medical deductible. If this is the desired choice, select **No.**

Employers will need to determine whether they qualify for this exception and file appropriate notices. Note that this exclusion does not exclude contraceptive methods and pharmaceuticals from coverage except under this Preventive Care section. Specific exclusions should be listed in the medical and prescription drug exclusion sections as applicable.

Nursery/Physician well-baby newborn care
a. ☐ Yes b. ☐ N/A
Reimbursement rate

c. ___________	d. __________
Subject to	Subject to
1. ☐ deductible	1. ☐ deductible
2. ☐ copayment	2. ☐ copayment
3. ☐ N/A	3. ☐ N/A

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Physician visits while baby is in the Hospital after birth
e. ☐ First visit only
f. ☐ Unlimited visits
g. ☐ Visits for ____________ Hospital days covered

Costs applied toward plan of
h. ☐ Parent
i. ☐ Newborn

Hospital days for well-baby nursery care
j. ☐ Unlimited days
k. ☐ For ____________ Hospital days

Costs applied toward plan of
l. ☐ Parent
m. ☐ Newborn

The first question concerns nursery coverage after the birth of a child. If the plan has this coverage, check **a.** and answer the questions as to the extent of well baby coverage.

Then answer the next questions on **Physician visits** while the child is still in the Hospital as a result of his or her birth. This care is routine care for a newborn who is neither injured or sick.

Next answer the questions on Coverage of **Hospital days** for a well newborn.

Language to comply with the Mothers' and Newborns' Health Protection Act will automatically be added to the document.

Routine well child care (Nongrandfathered plans must provide in-network Standard Preventive Care (that is, preventive care required under ACA) without cost sharing.)
a. ☐ Yes b. ☐ N/A

Reimbursement rate	c. __________	d. __________
	Subject to	Subject to
	1. ☐ deductible	1. ☐ deductible
	2. ☐ copayment	2. ☐ copayment
	3. ☐ N/A	3. ☐ N/A

Services covered **(**Nongrandfathered plans should select from the following list if they wish to offer services not required under ACA and/or if they wish to specifically mention services required by ACA. Grandfathered plans that wish to offer Standard Preventive Care should complete Item l). **(select all that apply; leave blank if none apply)**
e. ☐ Routine physical exam
f. ☐ Laboratory tests
g. ☐ X-rays
h. ☐ Immunizations
i. ☐ Hearing tests
j. ☐ Vision tests
k. ☐ Through age _________ (18 for nongrandfathered)
l. ☐ Standard Preventive Care for children

If HDHP **1f.** and **95c1.** or **95d1.** are selected, are Preventive Care services subject to the medical deductible?
m. ☐ Yes n. ☐ No

If the plan covers routine testing, screening, and physical exams for children, fill in these questions with the appropriate information.

Federal law permits High Deductible Health Plans, when in conjunction with a HSA, to exclude preventive drugs from the medical deductible. If this is the desired choice, select **No.**

Organ transplant coverage
a. ☐ Yes b. ☐ N/A

Reimbursement rate	c. __________	d. __________
	Subject to	Subject to
	1. ☐ deductible	1. ☐ deductible
	2. ☐ copayment	2. ☐ copayment
	3. ☐ N/A	3. ☐ N/A

Donor coverage
e. ☐ Yes
f. ☐ No

Annual maximum g. ___________ h. ___________

Plan covers donor costs only when recipient is covered under this plan?
i. ☐ Yes
j. ☐ No

If your plan has transplant coverage, select **"a."**

Enter the appropriate information in the section on **reimbursement rates and separate transplant maximum**.

Donor coverage is the next set of questions. Fill in if the questions apply.

Coverage of Pregnancy

Reimbursement rate	a. ___________	b. ___________
	Subject to	Subject to
	1. ☐ deductible	1. ☐ deductible
	2. ☐ copayment	2. ☐ copayment
	3. ☐ N/A	3. ☐ N/A

Coverage for Dependents other than Spouse (Note: For nongrandfathered plans, if d. is checked, the document will reflect that prenatal and post natal care will be covered to the extent required under Standard Preventive Care, even if dependent daughter pregnancies are not covered.)
c. ☐ Yes
d. ☐ No
e. ☐ Complications only

Infertility coverage **(Note: Infertility treatments may be considered an Essential Health Benefit. Limits should be selected only if the Plan does not treat this benefit as an EHB. Grandfathred plans may select annual limits even if this is an EHB.)**
a. ☐ No
b. ☐ Yes
   1. ☐ all services
   2. ☐ diagnosis only
   3. ☐ diagnosis and basic services (prescription drugs and surgery to correct physiological abnormalities only)

Reimbursement rate	c. ___________	d. ___________
	Subject to	Subject to
	1. ☐ deductible	1. ☐ deductible
	2. ☐ copayment	2. ☐ copayment
	3. ☐ N/A	3. ☐ N/A
Lifetime maximum	e. ___________	f. ___________
Annual maximum	g. ___________	h. ___________

Surgical sterilization included?
a. For Men:
   1. ☐ No
   2. ☐ Yes
   3. ☐ Yes (reversal excluded)
b. For Women (For grandfathered plans only. Nongrandfathered plans should complete Question 93q.
   1. ☐ No
   2. ☐ Yes
   3. ☐ Yes (reversal excluded)

Enter the required information as to **pregnancy coverage, infertility coverage** and **surgical sterilizations.**

There are standard exclusions in the Plan. Are there any additional exclusions (select all that apply)
a. ☐ No additional exclusions
b. ☐ Yes (select all that apply)
   1. ☐ Loss due to Hazardous Hobbies or Activities
   2. ☐ Loss due to illegal drugs or misuse of prescription drugs
   3. ☐ Loss due to illegal use of alcohol

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4. ☐ Abortion
   a. ☐ Exclude except in case of rape, incest or endangerment of mother
5. ☐ Treatment/Medication for impotency
6. ☐ Biofeedback
7. ☐ Acupuncture
8. ☐ Morbid Obesity
   a. ☐ Exclude surgical and non-surgical treatment
   b. ☐ Exclude surgical treatment only

Are there any additional exclusions?
c ☐ No
d. ☐ Yes (enter any additional exclusions)
1. ☐ Item to be excluded__________________
   a. Item description _____________________________
2. ☐ Item to be excluded__________________
   a. Item description _____________________________
3. ☐ Item to be excluded__________________
   a. Item description _____________________________

These exclusions are put in the plan by some Relius clients. Please indicate if you want them in your document or if you would like to add your own.

Cosmetic procedures are now a standard exclusion. It is not necessary to list them here.

Cost management included?
a. ☐ No (skip to **108.**)
b. ☐ Yes

Outpatient pre-admission testing service included?
a. ☐ No
b. ☐ Yes
1. ☐ In-network reimbursement rate _______
2. ☐ Out-of-network reimbursement rate ____________
3. ☐ Deductible waived? (Note: When HDHP **1f.** is selected, deductible will not be waived.)
   a. ☐ Yes
   b. ☐ No

Answer **"Yes"** if the plan contains plan formula incentives for using certain types of services (e.g., pre-admission testing, second opinion) or if the plan reimbursement formula penalizes the participants for certain behaviors (e.g., not precertifying inpatient care).

Large case management will automatically come into the document.

The language requires this testing to be within seven days before a hospital confinement. Fill in the reimbursement rate and the deductible information. If you do not have a managed care plan, fill in question **"102b1."** and leave **"102b2."** blank.

Outpatient Preadmission Testing. The Relius language requires this testing to be within seven days before a hospital confinement. The reimbursement rate is 100% with the deductible waived. If your plan requirements are different, list them.

For a HDHP in conjunction with a HSA, all charges are subject to deductible before copayments or percentage payable can apply. The only exception is preventive care benefits.

Mandatory utilization review service included?
a. ☐ No (skip to **105.**)
b. ☐ Yes, and if procedure not followed (select one)
1. ☐ Allowed amount reduced to _______% of covered charges
2. ☐ Benefit payment reduced by ________%
3. ☐ Benefit payment reduced by ________% up to a maximum of a. $_____________
4. ☐ Benefit payment reduced by $__________

This refers to precertification of certain medical services and is designed to ensure the services are medically necessary. Fill in **"1."** if the percentage of covered charges payable is reduced if the review is not conducted (e.g., payment is 70% instead of 80%). Fill in **"2."** if the plan payment is reduced by a specific percentage if the review is not conducted. Fill in **"3."** if the plan payment is reduced by a specific dollar amount if the review is not conducted. Fill in **"4."** if the plan payment percentage reduction has a dollar maximum.

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Medical services subject to review:
a. ☐ Hospitalization
b. ☐ MRI/CAT scan
c. ☐ Inpatient Substance abuse/Mental treatment
d. ☐ Skilled nursing facility stay
e. ☐ Home health care
f. ☐ Hospice care
g. ☐ Durable medical equipment
h. ☐ Physical, speech and occupational therapy
i. ☐ Cardiac rehabilitation therapy
j. ☐ Outpatient surgical procedure
k. ☐ Other ____

The listing **"a."** through **"k."** are the various services which may be subject to mandatory review. Check all that apply.

Notification required:
l. ☐ Within _______________ **before** services rendered
(indicate number and days, weeks, hours: e.g., 48 hours)
m. ☐ In the case of emergency services, within _____________
after services rendered. (show number and days or hours)

Fill in the required information regarding prior notification or emergency situation notifications.

Second and third opinions
a. ☐ No
b. ☐ Yes, voluntary, and
1. ☐ paid as any other Sickness (must be selected with HDHP **1f.**)
2. ☐ paid at 100% before the deductible
c. ☐ Yes, mandatory, (100% Reimbursement, Deductible Waived)
(Note: When HDHP **1f.** is selected, deductible will not be Waived)
and surgeon's
1. ☐ Allowable expenses reduced to ______% of
covered charges
2. ☐ Benefit payment reduced by ________%
3. ☐ Benefit payment reduced by ________% up to a maximum of
a. $___________
4. ☐ Benefit payment reduced by $ _________

If these are not covered, select **"a."** If these are covered but not mandated by the plan design, select **"b."** If the second opinion program is mandatory, select **"c."** and either **"1.", "2.", "3."** or **"4."** The penalties reduce only the surgeon's charges, not room and board or other charges.

Plan language requires that the consultations be performed by a physician who is board certified in the area in which the operation is concerned and not financially associated with the surgeon originally recommending surgery.

If the second opinion does not confirm the need for surgery, the language requires a third opinion for plan benefits. If the third opinion does not confirm the need for surgery, plan benefits will be paid.

For a HDHP in conjunction with a HSA, all charges are subject to deductible before copayments or percentage payable can apply. The only exception is preventive care benefits.

Outpatient Surgery
a. ☐ Not covered
b. ☐ Yes

Reimbursement rate	c. ___________	d. __________
	Subject to	Subject to
	1. ☐ deductible	1. ☐ deductible
	2. ☐ copayment	2. ☐ copayment
	3. ☐ N/A	3. ☐ N/A

Plan language lists sample surgical procedures which are reimbursed at a higher percentage by the plan when performed on an outpatient basis.

For a HDHP in conjunction with a HSA, all charges are subject to deductible before copayments or percentage payable can apply. The only exception is preventive care benefits.

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Utilization review administrator
(Complete if Mandatory UR Service or Mandatory Second Opinion is selected)
a. ☐ No
b. ☐ Yes
1. ☐ ____________________ (Name)
2. ☐ ____________________ (Telephone)
3. ☐ Listed on Employee ID Card

Put the name and telephone number the employee has to call for utilization review certification or mandatory second opinion referrals. If the information is on the employees' I.D. cards, mark option **"3."**

Coordination of benefits (select one) (Only applies if **1f., 2b., 2c., 2d., 2e. or 2f. are** selected)
a. ☐ 100% of allowable charge
b. ☐ Nonduplication/carve-out

Questions **"a."** and **"b."** concern the **COB formula.** If the secondary plan pays up to 100% of allowable charges, select **"a."** If the secondary plan pays up to its own plan formula only, select **"b."**

ADDITIONAL PLAN INFORMATION
Is there a Trustee(s)?
a. ☐ No (skip to **111.**)
b. ☐ Yes
1st Trustee
1. ____________________ (Name)
2. ____________________ (Title)

c. ☐ Use Employer/trust fund address
d. ☐ Other
1. ____________________ (Street)
2. __________ (City) 3. ______ (State) 4. ______ (Zip)

If there is no trust involved with the plan, this question need not be answered. If there are trustees, enter the names, titles and addresses here. There may be up to five trustees.

Claims administrator/supervisor/processor

a. ____________________ (Name)
b. ____________________ (Street or P.O. Box)
c. __________ (City) d. ______ (State) e. ______ (Zip)
f. ____________________ (Telephone)

Which term is to be used in document:
g. ☐ Claims administrator
h. ☐ Claims supervisor
i. ☐ Claims processor

Unless the plan is self-administered by the employer, this is the TPA. Either a post office box number or a street number may be used. Select the term -- claims administrator, claims supervisor, claims processor -- by which the TPA will be identified throughout the document.

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Title of Plan Administrator (all Plans)
a. ______________________________

Title of Named Fiduciary (ERISA Plans only)
b. ______________________________

Title of Agent for Service of Legal Process (ERISA Plans only)
c. ______________________________

This is the person who has the authority to interpret the plan. In an ERISA plan, this is the employer.

These are required by ERISA and defined in ERISA.

Would you like the HIPAA Privacy plan document amendment to be generated?
a. ☐ No (will appear in the Responsibilities for Plan Administration section) (please complete **113a1.**)
   1. Please list (by name, by title, or by department) the employees in the employer's workforce who are authorized to receive Protected Health Information:
   ____
   ____
   ____
b. ☐ Yes
   1. Please list (by name, by title, or by department) the employees in the employer's workforce who are authorized to receive Protected Health Information:
   ____
   ____
   ____

Date amendment is effective:
a. ______________________________
(Month) (Day) (Year)

Number of signature lines needed:
a. ☐ As employer representative
   1. ☐ One
   2. ☐ Two
   3. ☐ Three
   4. ☐ Four
b. ☐ As witnesses
   1. ☐ One
   2. ☐ Two

HIPAA Privacy regulations require the plan documents be amended in order for protected health information to be given to the plan sponsor. This is the required amendment.

Would you like the HIPAA Security plan document amendment to be generated?
a. ☐ No (will appear in the Responsibilities for Plan Administration section)
b. ☐ Yes

HIPAA Security regulations require the plan documents be amended. This is the required language.

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Will Adopting Employers execute this Plan?
Note: Selecting "Yes" will generate a Supplemental Participation Agreement.
a. ☐ N/A or No
b. ☐ Yes

c. ______________________________
(Name)

d. ______________________________
(Street)

e.______________ f. _______ g. _________
(City) (State) (Zip)

h. ______________________________
(Telephone)

i. ______________________________
(Tax ID Number)

New options added to allow for up to ten adopting employers.

SUMMARY OF BENEFITS AND COVERAGE QUESTIONS

For "Common Medical Events" portion of Summary, complete the amount the Participant pays – Select all of the following that apply: (Note: coordinate amounts listed in questions noted below) (For Indemnity Plans, do not complete Out-of-Network columns)

Coinsurance – Amount PARTICIPANT pays		Copayments	
Network rate	**Out of network rate**	**Network rate**	**Out of network rate**

a. ☐ Primary care office visits: (coordinate with **64e./64f.** and **71c./71d.**)
1. ________% 2. ________% 3. $______ 4. $________

b. ☐ Other Practitioner office visits
1. ☐ Specialist: (coordinate with **64g./64h.** and **71e./71f.**)
a. ________% b. ________% c. $______ d. $________
2. ☐ Chiropractic visits: (coordinate with **89c./89d.**)
a. ________% b. ________% c. $______ d. $________
3. ☐ Other practitioner visits ____________________
a. ________% b. ________% c. $______ d. $________

c. ☐ Routine well care: (coordinate with **92c./92d.**)
1. ________% 2. ________% 3. $______ 4. $________

d. ☐ Diagnostic Testing: (coordinate with **64i./64j.** and **72c./72d.**)
1. ________% 2. ________% 3. $______ 4. $________

e. ☐ Imaging: (coordinate with **64i./64j.** and **72e.**)
1. ________% 2. ________% 3. $______ 4. $________

f. ☐ Outpatient Surgery Facility Fee: (coordinate with **64i./64j.** and **106b.**)
1. ________% 2. ________% 3. $______ 4. $________

g. ☐ Outpatient Surgery: Physician/Surgeon Fees: (coordinate with **64e./64f.** and **71g./71h.**)
1. ________% 2. ________% 3. $______ 4. $________

h. ☐ Emergency Room Services: Medical Emergency: (coordinate with **64k./64l.** and **68c.**)
1. ________% 2. ________% 3. $______ 4. $________

i. ☐ Emergency Room Services: Non-Medical Emergency: (coordinate with **64k./64l.** and **68d.**)
1. ________% 2. ________% 3. $______ 4. $________

j. ☐ Ambulance: (coordinate with **79e.**)
1. ________% 2. ________% 3. $______ 4. $________

k. ☐ Urgent Care: (coordinate with **68f.**)
1. ________% 2. ________% 3. $______ 4. $________

l. ☐ Hospital: Facility Fee: (coordinate with **67b./67c.** and **64c./64d.**)
1. ________% 2. ________% 3. $______ 4. $________

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m. ☐ Hospital: Physician/Surgeon Fees: (coordinate with **71a./71b.**)
1. ________% 2. ________% 3. $_______ 4. $_________

n. ☐ Mental health/Substance abuse:
1. ☐ Mental Health Outpatient: (coordinate with **90e./f.**)
a. ________% b. ________% c. $_______ d. $_________
2. ☐ Mental Health Inpatient: (coordinate with **90c./d.**)
a. ________% b. ________% c. $_______ d. $_________
3. ☐ Substance Abuse Outpatient: (coordinate with **91e./f.**)
a. ________% b. ________% c. $_______ d. $_________
4. ☐ Substance Abuse Inpatient: (coordinate with **91c./d.**)
a. ________% b. ________% c. $_______ d. $_________

o. ☐ Maternity (coordinate with **97.**)
1. ☐ Pre & Postnatal Care
a. ________% b. ________% c. $_______ d. $_________
2. ☐ Delivery and inpatient services
a. ________% b. ________% c. $_______ d. $_________

p. ☐ Home Health Care: (coordinate with **73c./d.**)
1. ________% 2. ________% 3. $_______ 4. $_________

q. ☐ Rehabilitation Services: (coordinate with **83c.**, **84c.** and **85c.**)
1. ☐ Occupational therapy: (coordinate with **83c./d.**)
a. ________% b. ________% c. $_______ d. $_________
2. ☐ Speech therapy: (coordinate with **84c./d.**)
a. ________% b. ________% c. $_______ d. $_________
3. ☐ Physical therapy: (coordinate with **85c./d.**)
a. ________% b. ________% c. $_______ d. $_________

r. ☐ Habilitation Services (Reserved for future use.)

s. ☐ Skilled Nursing: (coordinate with **70c.**, **d.** OR **e.**, as applicable)
1. ________% 2. ________% 3. $_______ 4. $_________

t. ☐ Durable medical equipment: (coordinate with **86c./d.**)
1. ________% 2. ________% 3. $_______ 4. $_________

u. ☐ Hospice Service (coordinate with **77c./d.**):
1. ________% 2. ________% 3. $_______ 4. $_________

v. ☐ Children's Eye Care (coordinate with **95.**)
1. ☐ Eye Exam
a. ________% b. ________% c. $_______ d. $_________
2. ☐ Eye Glasses
a. ________% b. ________% c. $_______ d. $_________

w. ☐ Children's Dental Checkup: (coordinate with **47a.**)
1. ________% 2. ________% 3. $_______ 4. $_________

x. ☐ Drug coverage:

RETAIL		MAIL ORDER	
Coinsurance	**Copayments**	**Coinsurance**	**Copayments**

1. ☐ Generic Drugs: (coordinate with **35f./36c.**)
a. ________% b. $________ c. ________% d. $_________
2. ☐ Preferred Brand Drugs: (coordinate with **35g./36d.**)
a. ________% b. $________ c. ________% d. $_________
3. ☐ Non-Preferred Brand Drugs: (coordinate with **35h./36e.**)
a. ________% b. $________ c. ________% d. $_________
4. ☐ Specialty Drugs: (coordinate with **35i./36f.**)
a. ________% b. $________ c. ________% d. $_________

Coinsurance		Copayments	
In-network rate	**Out of network rate**	**In-network rate**	**Out of network rate**

5. ☐ For Prescription Drug Coverage other than freestanding coverage: (coordinate with **75c./d.**)
a. ________% b. ________% c. $_______ d. $_________

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This question is designed to capture the cost sharing requirements for the healthcare services specified in the SBC regulations. Your answers to this question should be coordinated with other Checklist questions to make sure that the Summary of Benefits will be consistent with the SBC. You should also be aware that any overrides or individualized edits that you may make to a plan document/SPD will not be reflected on the SBC. If any such changes include plan terms that are required to be disclosed on the SBC, you will need to revise the SBC accordingly. Note that the SBC requires plans to enter the coinsurance percentage that the participant pays. This is contrary to the conventional practice for SPDs, which typically show the coinsurance the plan pays. As you complete the Checklist, bear in mind that the "% payable" items are asking what the plan pays – this will be the amount reflected in the Summary of benefits. But Checklist Question 129 asks for the percentage the participant pays –this will be the amount reflected in the SBC.

Coverage Examples:

a. ☐ Expected Maternity Costs (coordinate with **97.** and **129o.**):

NOTE: Do not include commas or decimals in your dollar amount total.

1. ☐ Deductibles $__________
2. ☐ Copays: $__________
3. ☐ Coinsurance: $__________
4. ☐ Limitations or Exclusions: $__________
5. ☐ Contact information for coverage information ____
6. ☐ Total amount to be paid by Plan: $__________
7. ☐ Total amount to be paid by patient: $__________
8. ☐ Does the plan impose a penalty for failure to follow notification procedures in case of pregnancy?
   a. ☐ Yes
   b. ☐ No

b. ☐ Expected Costs of Managing Diabetes:

1. ☐ Deductibles $__________
2. ☐ Copays: $__________
3. ☐ Coinsurance: $__________
4. ☐ Limitations or Exclusions: $__________
5. ☐ Contact information for coverage information ____
6. ☐ Total amount to be paid by Plan: $__________
7. ☐ Total amount to be paid by patient: $__________
8. ☐ Does the plan impose penalties on participants with diabetes if they fail to participate in a wellness program for diabetes?
   a. ☐ Yes
   b. ☐ No

In addition to the description of plan benefits and cost sharing provisions, the SBC requires each plan to give a total cost estimate of benefits for two conditions: maternity and diabetes management. CCIIO has provided an online calculator that is designed to help you determine the information to be entered for Question 130 on the Checklist. The calculator is available at the CCIIO website: http://cciio.cms.gov/resources/other/index.html. Go to the section marked Summary of Benefits and Coverage and Uniform Glossary; Instructions and Guidance, then click on Coverage Examples Calculator.

Language Access: (Insert the telephone number for the corresponding language.)

a. Spanish (Español): Para obtener asistencia en Español, llame al

   ____.

b. Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa

   ____.

c. Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**

   ____.

d. Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'

   ____.

The only foreign language that cannot be produced in the Relius Document system is Chinese – therefore, you can download the Chinese characters to be added to the Summary and insert them where the language in the Summary states (insert characters available online – see commentary)

The language is available at http://cciio.cms.gov/resources/other/index.html.

You should go to the section marked Summary of Benefits and Coverage and Uniform Glossary; Forms; Summary of Benefits and Coverage (SBC) Template. Then click on "Standard Format (Corrected, May 11, 2012)". The sample language can be found on the 4th page of the document.

Minimum Plan Requirements (select all that apply; leave blank if none apply

a. ☐ This plan/benefit option provides minimum essential coverage.

b. ☐ This plan/benefit option meets the minimum actuarial value standard of 60%.

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