Self-Funded
Checklist/Transmittal Form

09/30/2013

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 _____

SunGard 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."

1. DOCUMENT PACKAGE

a. ☐ Plan Document and Summary Plan Description and Summary of Benefits and Coverage $650
(one 8.5" x 11" document) [TPADOC]

b. ☐ Trust only (Trust available 8.5" x 11" only) [TPASEP] $300

c. ☐ Plan Document and Summary Plan Description, Trust and Summary of Benefits and Coverage $800
(two 8.5" x 11" documents) [TPADOC]

Is the Trust:

d. ☐ Taxable

e. ☐ Non-taxable (IRC Sec. 501(c)(9))

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

2. PLANS REQUIRED (Select all that apply)

a. ☐ Short Term Disability

b. ☐ Freestanding Prescription Drugs

c. ☐ Vision Care:

1. ☐ Standalone Plan
2. ☐ Integrated with Medical Benefits

d. ☐ Dental Benefits:

1. ☐ Standalone Plan
2. ☐ Integrated with Medical Benefits

e. ☐ Supplementary Accident

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

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

3. DOCUMENT BOOKLET FORMAT

Note: The plan document is in an 8.5" x 11" letter format. Booklets come in 5.5" x 8.5" format. Booklets are also available in 8.5" x 11" format (see page 3).

a. ☐ **5.5" x 8.5" BOOKLET**
(proof is sent before order is printed) [TPABSM]
No. of booklets: (prices on page 4) _____ $_____

5.5" x 8.5" BOOKLET COVER OPTIONS
1. ☐ Style I 2. ☐ Style II 3. ☐ Style III 4. ☐ Style IV

b. ☐ **8.5" x 11" FORMAT (Style V Only)**
No. of booklets: (prices on page 4) _____ $_____

FORMAT

d. ☐ Standard (letter size, single spaced, ragged margin)

e. ☐ Right justified margins

4. 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

Booklet

c. ☐ 8.5 pt. Arial

d. ☐ 9 pt. Times

DOCUMENT (Photocopies) [TPACPP]		Number	2-Sided
☐ Plan and Summary (8.5" x 11")	$15.00	_____	☐
☐ Trust (8.5" x 11")	$ 4.25	_____	☐
☐ Summary of Benefits and Coverage (8.5" x 11")	$ 1.00	_____	☐

PLAN PRESENTATION (Plan & Summary, Trust 8.5" x 11" format only) [TPABIN]

☐ 3-Ring Binder Qty _____ @ $25 ea. $_____

TURN-AROUND (following the date of receipt until mailing)

Type	Business Days		Add
☐ Normal	10		$ 0
☐ Rush	5*	[TPARUS]	$125
☐ Express**	2-3*	[TPAEXP]	$195

*Special language may delay turn-around, but plan will retain Rush or Express priority.

**Must be received by 10:30 a.m. ET and will be sent overnight delivery.

SPECIAL LANGUAGE [TPALNG]

☐ Special language attached or requested

Note: Additional turnaround time may be required for special language modification and checklist entries requiring telephone contact. Special Language will be charged at $150 minimum plus $75 for each half hour that exceeds one hour. SunGard Consulting will be charged at the current SunGard rate.

DELIVERY Documents are provided in PDF via Email unless otherwise indicated.

☐ Hardcopy of Documents [TPAHDC] $50
(Fed-Ex Ground delivery used unless otherwise indicated.)

☐ Overnight [PROPTG] $10

PAYMENT POLICY

SunGard understands the importance of processing your plans promptly. To avoid unnecessary delays, please read the following carefully:

(a) A prepayment of $400 is required with each order until a credit line has been approved by SunGard's credit department. (Additional charges for postage, special language and consulting will be billed when applicable.) IF YOU WISH TO ESTABLISH A CREDIT LINE, PLEASE REQUEST A CREDIT APPLICATION FROM CREDIT OR SALES. If you wish to increase an existing credit line, please submit your request in writing (Attn: Credit Department).
(b) ALL INVOICES ARE DUE UPON RECEIPT.
(c) WE CANNOT PROCESS ANY PLANS FOR ACCOUNTS 45 DAYS PAST DUE UNTIL PAYMENT IS RECEIVED.
(d) A monthly finance charge of 1.5% will be charged on invoices not paid within 30 days.
(e) If you wish to question an invoice, please call our Client Account Services immediately at 1-800-326-7235, option 6, upon receipt of the invoice. Have available all details of the nature of the dispute and any requested adjustment. The undisputed portion of the invoice is still due upon receipt.
(f) Please contact Client Account Services within 90 days of receipt of your document package if any problems should occur.
(g) Applicable sales tax will be added.

RERUN FEES

Because of the special computer processing required to compose booklets, it is important that you complete the Document Format Section when you initially send your checklist. **If you do not request booklets with your initial order and later request them after your documents have been processed, a $100 reprocessing fee will be incurred.**

Language modifications and changes will be charged at a rate of $150 minimum plus $75 for each half hour that exceeds one hour and SunGard Consulting will be charged at the current SunGard rate. There will be a $100 reprocessing charge for changes made after 6 months with no activity. Please note: if question(s) changes necessitate reprocessing the entire document, there will be an additional $225 fee.

Please Note: "Proof" will no longer be stamped on documents submitted for changes. Instead, each document will be delivered in final form, eliminating the need for another copy upon approval. If you need to make additional changes please indicate your changes on the actual document.

Mail To:
SunGard Relius
Attn: Order Processing
P.O. Box 47470
Jacksonville, Florida 32247

Fax to:
(904) 306-2221

Email to:
OTCProcessing.reljax@sungard.com

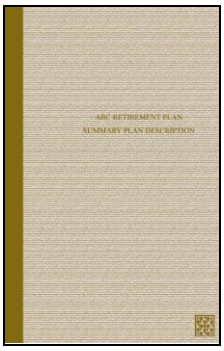
Contact us:
(800) 326-7235, ext 6

SPD BOOKLETS

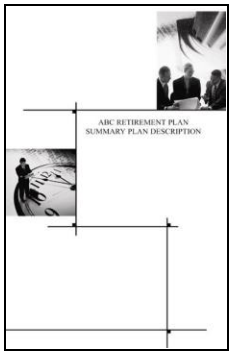
SunGard can provide you with professionally printed booklets at lower costs than photocopies. The 5.5" x 8.5" booklets are saddle stitched and trimmed--ready for distribution to plan participants. Also available are 8.5" x 11" booklets either stapled or thermal bind.

COVER DESIGNS

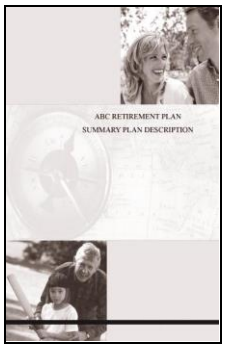
Please choose from these booklet cover styles when ordering your booklets.



a. ☐ Style I
Natural Fiber:
White cover stock;
Olive non-metallic gold edge;
Natural fiber background;
Black text

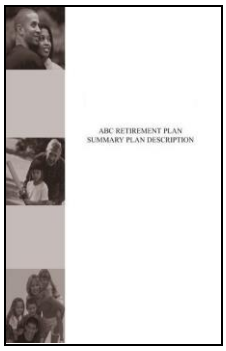


b. ☐ Style II
Black Lines:
White cover stock;
Black lines;
Black and white financial pictures;
Black text **(This style will be used if no box is checked.)**



c. ☐ Style III
Family/Life Pictures:
White cover stock;
Family photos;
Map photo in center;
Geometric shapes;
Black text

d. ☐ Style IV
Border:
White cover stock;
Black border;
Black text



e. ☐ Style V **(8.5 x 11 Only)**
Photo Border:
White cover stock;
Photos and squares
on edge;
Black text

BOOKLET FONT OPTIONS (Default: Times font)

☐ 9 pt. Times
☐ 8.5 pt. Arial

LOGO (Please include camera-ready art)

☐ Logo (camera-ready black) $35.00
☐ Color Logo (price upon request)
☐ On Front (all styles can accommodate up to a 2" x 2" logo)
☐ On Back (all styles can accommodate up to a 4" x 4" logo)

LOGO POSITION CENTERED ON

(If no position is selected bottom front will be used)

☐ Top Front ☐ Bottom Front ☐ Bottom Back
☐ Other-Please indicate placement on your cover choice above.

PRICING

Booklets can be ordered in the quantities and prices listed below. Orders for other quantities will be filled and invoiced at the next higher quantity level. Quantities and prices (includes proof fee). A proof will be sent prior to final printing. Additional fees apply for any booklets over 50 pages.

5.5" x 8.5" BOOKLET PRICING

Quantity	Price	Quantity	Price	Quantity	Price
20 – 49	$2.86 ea.	200 – 249	$1.98 ea.	450 – 499	$1.49 ea.
50 – 74	$2.75 ea.	250 – 299	$1.82 ea.	500 – 549	$1.43 ea.
75 – 99	$2.53 ea.	300 – 349	$1.71 ea.	550 – 999	$1.27 ea.
100 – 149	$2.37 ea.	350 – 399	$1.60 ea.	1000+	$1.05 ea.
150 – 199	$2.20 ea.	400 – 449	$1.54 ea.		

8.5" x 11" BOOKLET PRICING

Stapled

Quantity	Price
50 – 100	$3.03 ea.
101 – 200	$2.75 ea.
201 – 300	$2.48 ea.
301 – 400	$2.20 ea.
401 – 500	$1.95 ea.
501 – 1000	$1.65 ea.*

Thermal Bind

Quantity	Price
50 – 100	$3.41 ea.
101 – 200	$3.14 ea.
201 – 300	$2.86 ea.
301 – 400	$2.59 ea.
401 – 500	$2.31 ea.
501 – 1000	$2.04 ea.*

1001+ Call Client Account Services at (800) 326-7235, option 6, for pricing information.

SHIPPING FEES

Quantity	Price	Quantity	Price
20 – 50	$11.00	301 – 400	$44.00
51 – 100	$16.50	401 – 500	$55.00
101 – 200	$22.00	501 – 999	$66.00
201 – 300	$33.00	1000+	Call for shipping fee

NOTE: Mailing to individual participants is available. Please call Client Account Services for pricing information at (800) 326-7235, option 6.

* Turnaround time for proofs is 5 business days. We have a 10-day turnaround on final booklet printing (see above). A Rush turnaround (5 business days) is available for an additional 20% charge on your order. Turnaround times are calculated from the day we receive your request. Additional cost applies for glossy or custom covers.

Applicable sales tax will be added.

All prices subject to change without notice.

PLAN INFORMATION - REQUIRED BY ERISA

5. Name of Plan (Exact Legal Name)

a. _____

b. _____

c. _____

6. Tax number & Plan number

a. Tax number _____
(Employer Identification Number)

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

7. Type of Plan/Grandfathered Status

a. ☐ ERISA
b. ☐ Non ERISA

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.

8. Plan effective date a. _____
(month) (day) (year)

9. Plan Year ends a. _____
(month) (day)

Begins b. _____
(month) (day)

EMPLOYER INFORMATION

10. Employer

a. _____
(Name)

b. _____
(Street)

c. _____ d. _____ e. _____
(City) (State) (Zip)

f. _____
(Telephone)

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

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

11. Group entity

a. ☐ Corporation (includes non-profit, church & government groups)
b. ☐ Proprietor or partner
c. ☐ Taft-Hartley Trust Fund (skip to **15.**) (attach eligibility requirements)

12. Eligible classes of Employees covered

a. ☐ Full-time Active (Note: The Employer Shared Responsibility provisions become effective for Plan Years beginning on or after Jan. 1, 2015, and item a.2 should be completed accordingly.)
   1. _____ minimum hours per week worked (for Plan Years beginning before January 1, 2015)
   2. _____ minimum hours per week worked (for Plan Years beginning on or after January 1, 2015)
b. ☐ Part-time Active
   1. _____ minimum hours per week worked (for Plan Years beginning before January 1, 2015)
   2. _____ minimum hours per week worked (for Plan Years beginning on or after January 1, 2015)
c. ☐ Other (please describe eligibility requirements)

   1. _____
   2. _____
   3. _____

13. Are Retired Employees eligible?

a. ☐ No
b. ☐ Yes

14. When coverage begins and ends: (Note: Standalone dental and vision plans may select any of the options offered below. For Plan Years beginning on or after Jan. 1, 2014, all other plans: (1) should <u>not</u> 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

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

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

16. 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

17. 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 standalone dental/vision (if standalone 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
- 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 standalone 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 _____

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

18. Are Qualified Dependents covered? (if standalone 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

19. Are Domestic Partners covered?

a. ☐ No (skip to **21.**)
b. ☐ Yes

If Yes, select all that apply:

c. ☐ Opposite sex
d. ☐ Same sex

20. 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:

_____

_____

_____

_____

_____

21. COBRA explanation needed?

a. ☐ No (skip to **26.**)
b. ☐ Yes

COBRA coverage is

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

Does the Plan offer COBRA conversion rights for qualified beneficiaries to enroll in a conversion health plan?

e. ☐ No
f. ☐ Yes

Does the Plan Sponsor administer COBRA for this Plan?

g. ☐ Yes
h. ☐ No

Enter the name and address of the COBRA Administrator:

1. _____ (Name)
2. _____ (Street)
3. _____ (City) 4. _____ (State) 5. _____ (Zip)
6. _____ (Telephone)

22. The name and address of the person to whom the qualified beneficiary must send notification of covered event

a. ☐ Same as Plan Sponsor (same as **10a.**)
b. ☐ Same as COBRA Administrator (same as **21h1.**)
c. ☐ Other

1. _____ (Name)
2. _____ (Street)
3. _____ (City) 4. _____ (State) 5. _____ (Zip)
6. _____ (Telephone)

23. The name and address of the person to contact to answer COBRA questions

a. ☐ Same as Plan Sponsor (same as **10a.**)
b. ☐ Same as COBRA Administrator (same as **21h1.**)
c. ☐ Other

1. _____ (Name)
2. _____ (Street)
3. _____ (City) 4. _____ (State) 5. _____ (Zip)
6. _____ (Telephone)

24. The name and address of the person who is to receive requests for disability extensions

a. ☐ Same as Plan Sponsor (same as **10a.**)
b. ☐ Same as COBRA Administrator (same as **21h1.**)
c. ☐ Other

1. _____ (Name)
2. _____ (Street)
3. _____ (City) 4. _____ (State) 5. _____ (Zip)
6. _____ (Telephone)

25. The name and address of the person who is to receive notices of the second qualifying event

a. ☐ Same as Plan Sponsor (same as **10a.**)
b. ☐ Same as COBRA Administrator (same as **21h1.**)
c. ☐ Other

1. _____ (Name)
2. _____ (Street)
3. _____ (City) 4. _____ (State) 5. _____ (Zip)
6. _____ (Telephone)

26. Are Late Enrollees allowed on the Plan?

a. ☐ No, no provision
b. ☐ Yes
   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 _____ (month)
      b. ☐ Coverage effective date _____ (month) (day)

27. 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)

28. Phone number for Hospital and Physicians to verify coverage

a. _____
b. ☐ N/A

29. 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)

30. 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

31. Claims filing

a. Suggested within _____ days of service rendered

32. 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 ERISA or non-grandfathered plans, including non-ERISA plans, under the new claims procedure regulations, do you allow two levels of appeals? (Only applies if **7a.** or **7d.** selected)

c. ☐ No, only one level
d. ☐ Yes, two levels

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

33. 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.)

Maximum period payable

j. _____ weeks per disability

34. 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

35. FREESTANDING PRESCRIPTION DRUGS (Only applies if **2b.** selected)
(Note: When HDHP, **1f.** is selected, copayments may only apply to preventive drugs numbered **35.** – **36.** on this checklist.)
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

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

		Copayment	% payable
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?
l. ☐ Only covered at Participating Pharmacies
m. ☐ Coverage for ingredient costs and dispensing fees only

36. Mail Order Option
a. ☐ No (skip to **37.**)
b. ☐ Yes (90 day supply)
1. ☐ Third party payor

_____
(Name)

2. ☐ N/A

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

	Copayment	% payable
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 $_____

37. Is there a separate Prescription Drug Deductible(s), per Calendar Year
(does not apply if HDHP, **1f.** is selected)
a. ☐ Yes b. ☐ N/A

Per Covered Person c. $_____

Per Family Unit d. $_____

38. Prescription Drug Maximum out-of-pocket amount, per Calendar Year
(For Plan Years starting on or after January 1, 2014, non-grandfathered plans which currently have a separate OOP maximum for prescription drugs cannot have an in-network OOP that exceeds $6,350 single/$12,700 other, and all cost sharing features must be counted toward the OOP limit. The out-of-pocket maximum must be combined with out-of-pocket expenses for medical benefits as noted in option g. These rules do not apply to OOP limits for out-of-network charges. The OOP maximum for out-of-network charges may be set at any level.)
a. ☐ Yes
b. ☐ N/A (This option is available only to (1) grandfathered plans, or (2) non-grandfathered plans that do not currently have a separate prescription drug OOP. For these non-grandfathered plans, the option is only available for Plan Years beginning before January 1, 2015,)

Per Covered Person c. $_____

Per Family Unit d. $_____

e. ☐ including deductible
f. ☐ excluding deductible
g. ☐ including out of pocket expenses for medical benefits for Plan Years starting on or after:
   1. ☐ January 1, 2014 (Applicable to non-grandfathered plans that use the same vendor for medical claims and prescription benefit claims processing)
   2. ☐ January 1, 2015 (Applicable to non-grandfathered plans that use different vendors for medical and prescription drug claims processing)
   3. ☐ Not applicable (For grandfathered plans only)

39. 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 deterrents
d. ☐ Hair growth/loss drugs
e. ☐ Growth hormones
f. ☐ Non-Legend drugs
g. ☐ Injectable drugs (select **1.** or **2.**)
   1. ☐ All injectable drugs will be excluded
   2. ☐ All injectable drugs EXCEPT insulin will be excluded

---

40. 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
d. ☐ 12 months
e. ☐ 24 months
f. ☐ _____ months

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

41. 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
e. ☐ 12 months
f. ☐ 24 months
g. ☐ _____ months

42. Frames
Maximum, per pair
a. $_____

Period separating new frames
b. ☐ 12 months
c. ☐ 24 months
d. ☐ _____ months

43. 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

d. ☐ 12 months
e. ☐ 24 months
f. ☐ _____ months

---

44. 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

45. 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

46. Dental benefit limits

Major services waiting period provision

a. ☐ Not included
b. ☐ Included, and

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 limits

c. ☐ N/A
d. ☐ The following services are limited as shown

1. ☐ Oral exams, _____ exam (Number)
   a. every _____ (Interval)
2. ☐ Bitewing x-ray series, every _____ (Interval)
3. ☐ Full mouth x-ray, every _____ (Interval)
4. ☐ Fluoride treatment, limiting age of under _____ years (Number)
5. ☐ Space maintainers, limiting age of under _____ years (Number)
6. ☐ Sealants, limiting age of under _____ years, (Number)
   a. every _____ (Interval)
7. ☐ Free adjustments to dentures within _____ of installation (Interval)
8. ☐ Replacing temporary dentures with permanent dentures, within _____ (Interval)

47. Percentage payable

a. ☐ Class A - Preventive _____%

b. ☐ Class B - Basic _____%

c. ☐ Class C - Major _____%

d. ☐ Class D - Orthodontia _____%

48. Maximum amount

a. ☐ Per person per year $_____

Orthodontia

b. ☐ Maximum $_____ Lifetime per person
   1. ☐ limiting age, under age _____

49. Predetermination of benefits

a. ☐ $_____ is start of predetermination
b. ☐ No provision

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.

---

50. 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
i. Special charge maximum $_____

For Employees-new confinement after:
j. ☐ One day active work
k. ☐ _____ days active work
l. ☐ N/A

For Dependents-new confinement after:
m. ☐ 90 days separation
n. ☐ _____ days separation
o. ☐ N/A

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

51. BASIC SURGICAL (Only applies if **2h2.** selected)
Type of reimbursement
a. ☐ Scheduled
b. ☐ 100% UCR
c. Maximum (for series of related procedures) $_____

Anesthesia coverage
d. ☐ None
e. ☐ _____% of surgery
f. ☐ 100% UCR

Assistant surgeon charges
g. ☐ None
h. ☐ _____% of surgery

52. BASIC IN-HOSPITAL PHYSICIAN MEDICAL CARE
(Only applies if **2h3.** selected) (select all that apply)
a. ☐ 100% UCR
b. ☐ Daily limit $_____
c. ☐ Maximum $_____ per confinement

53. BASIC DIAGNOSTIC TESTING, X-RAY AND LAB
(Only applies if **2h4.** selected)
a. ☐ 100% UCR
b. ☐ $_____ Maximum per accident

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

55. 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) $_____

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.

56. What kind of plan is this?
a. ☐ Indemnity (skip to **62.**)
b. ☐ Managed care

57. 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
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

58. 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.: _____

59. Type of managed care option

a. ☐ Participating Provider Organization
b. ☐ Exclusive Provider Organization
c. ☐ Point of Service Managed Care Option

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)

Is there a 2nd PPO/EPO/POS

f. ☐ No
g. ☐ Yes
PPO/EPO/POS _____
(Name)

1. _____
(Street)
2. _____
(City, State Zip)
3. _____
(Telephone)
4. _____
(Fax number)
5. _____
(Email address)

Is there a 3rd PPO/EPO/POS

h. ☐ No
i. ☐ Yes
PPO/EPO/POS _____
(Name)

1. _____
(Street)
2. _____
(City, State Zip)
3. _____
(Telephone)
4. _____
(Fax number)
5. _____
(Email address)

Is there a 4th PPO/EPO/POS

j. ☐ No
k. ☐ Yes
PPO/EPO/POS _____
(Name)

1. _____
(Street)
2. _____
(City, State Zip)
3. _____
(Telephone)
4. _____
(Fax number)
5. _____
(Email address)

60. 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

61. **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 answer the following question(s) with percentages, dollar amounts, or frequency limits, whichever is appropriate during checklist entry.

62. **Maximum Aggregate Annual Benefit**
   a. ☐ Yes b. ☐ N/A
   c. ☐ for Plan Years beginning:
      1. ☐ $750,000 (for Plan Years beginning before 9/23/2011)
      2. ☐ $1,250,000 (for Plan Years beginning after 9/22/2011 and before 9/23/2012)
      3. ☐ $2,000,000 (for Plan Years beginning after 9/22/2012 and before 1/1/2014)
   d. ☐ Other amount (must be greater than **c.1**, **c.2**, or **c.3** for the relevant year)

	Column A	**Column B**
a. and b.		

63. **Deductible(s), per Calendar Year**
   a. ☐ Yes b. ☐ N/A

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

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

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

Waived for the following services: (Network Preventive Care Services must be included if nongrandfathered plan)

   m. ☐ _____
   n. ☐ _____
   o. ☐ _____

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

	Column A	**Column B**

64. **Copayment(s), per visit**
(Note: When HDHP, **1f.** is selected, copayments 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

65. **Maximum out-of-pocket amount, per Calendar Year (For Plan Years starting on or after January 1, 2014, nongrandfathered plans cannot have an in-network OOP that exceeds $6,350 single/$12,700 other, and all cost sharing features must be counted toward the OOP limit. The out-of-pocket maximum must be combined with out-of-pocket expenses for prescription drug benefits as noted in option g. These rules do not apply to OOP limits for out-of-network charges. The OOP maximum for out-of-network charges may be set at any level.)**
   a. ☐ Yes b. ☐ N/A

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

   i. ☐ including deductible
   j. ☐ excluding deductible
   k. ☐ including out of pocket expenses for Prescription Drug benefits for Plan Years starting on or after:
      1. ☐ January 1, 2014 (Applicable to non-grandfathered plans that use the same vendor for medical claims and prescription benefit claims processing)
      2. ☐ January 1, 2015 (Applicable to non-grandfathered plans that use different vendors for medical and prescription drug claims processing)
      3. ☐ Not applicable (For grandfathered plans only)

Network Charges for Out of Pocket Maximum applies to the following; (select all that apply, leave blank if none apply):

l. ☐ In-network charges apply to the out of pocket maximum for out-of-network charges

m. ☐ Out-of-network charges apply to the out of pocket maximum for in-network charges

66. Out-of-Pocket amount limits exclude the following charges?

a. ☐ N/A
b. ☐ Deductibles (Nongrandfathered plans may select this option only for Plan Years beginning before January 1, 2014.)
c. ☐ Cost containment penalties
d. ☐ Chiropractic charges
e. ☐ TMJ charges
f. ☐ Copayments (Nongrandfathered plans may select this option only for Plan Years beginning before January 1, 2014.)
g. ☐ Amounts over allowed amount
h. ☐ Other _____

67. Hospital room and board

a. ☐ Yes

Semiprivate rate — b. _____ — c. _____

Subject to (b): 1. ☐ deductible 2. ☐ copayment 3. ☐ N/A

Subject to (c): 1. ☐ deductible 2. ☐ copayment 3. ☐ N/A

68. 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. _____ — Subject to: a. ☐ deductible b. ☐ copayment c. ☐ N/A
2. _____ — Subject to: a. ☐ deductible b. ☐ copayment c. ☐ N/A

d. ☐ Medical non-emergency care

1. _____ — Subject to: a. ☐ deductible b. ☐ copayment c. ☐ N/A
2. _____ — Subject to: a. ☐ deductible b. ☐ copayment c. ☐ N/A

e. ☐ Medical non-emergency care not covered

Urgent Care

f. ☐ Yes g. ☐ Not covered

Reimbursement rate — h. _____ — i. _____

Subject to (h): 1. ☐ deductible 2. ☐ copayment 3. ☐ N/A

Subject to (i): 1. ☐ deductible 2. ☐ copayment 3. ☐ N/A

69. Intensive Care unit

a. ☐ Yes b. ☐ N/A

c. ☐ ICU charge — 1. _____ — 2. _____

Subject to: a. ☐ deductible b. ☐ copayment c. ☐ N/A

d. ☐ Same as semiprivate room rate — 1. _____ — 2. _____

Subject to: a. ☐ deductible b. ☐ copayment c. ☐ N/A

e. ☐ _____, per day — 1. _____ — 2. _____

Subject to: a. ☐ deductible b. ☐ copayment c. ☐ N/A

70. 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. _____ — 2. _____

Subject to: a. ☐ deductible b. ☐ copayment c. ☐ N/A

d. ☐ The facility's semiprivate room rate — 1. _____ — 2. _____

Subject to: a. ☐ deductible b. ☐ copayment c. ☐ N/A

e. ☐ _____ per day — 1. _____ — 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. _____

71. Physician services

Inpatient services

Reimbursement rate a. _____ b. _____

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

Office visits

Reimbursement rate c. _____ d. _____

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

Specialist office visits

Reimbursement rate e. _____ f. _____

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

Surgical services

Reimbursement rate g. _____ h. _____

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

Allergy testing

Reimbursement rate i. _____ j. _____

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

Allergy serum and injections

Reimbursement rate k. _____ l. _____

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

72. Diagnostic Testing (X-ray and Lab)

a. ☐ Yes b. ☐ N/A

Reimbursement rate c. _____ d. _____

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

Imaging (CT/PET scans, MRIs)

e. ☐ Yes f. ☐ N/A

Reimbursement rate g. _____ h. _____

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

73. Home Health Care visits

a. ☐ Yes b. ☐ N/A

Reimbursement rate c. _____ d. _____

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

Calendar Year limit e. _____ f. _____

74. Inpatient Drugs only (in conjunction with freestanding Prescription Drug plan)

a. ☐ Yes b. ☐ N/A

Reimbursement rate c. _____ d. _____

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

75. Inpatient and Outpatient Drugs (no separate freestanding Prescription Drug plan)

a. ☐ Yes b. ☐ N/A

Reimbursement rate c. _____ d. _____

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

If HDHP, **1f.** and **75c1.** or **75d1.** are selected, are Preventive drugs subject to the medical deductible?

e. ☐ Yes f. ☐ No

76. Private duty nursing outpatient

a. ☐ Yes b. ☐ N/A

Reimbursement rate c. _____ d. _____

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

Calendar Year limit e. _____ f. _____

77. Hospice Care

a. ☐ Yes b. ☐ N/A

Reimbursement rate c. _____ d. _____

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

Outpatient
Lifetime maximum e. _____ f. _____

Inpatient and outpatient
Lifetime maximum g. _____ h. _____

78. Bereavement counseling -- within 6 months of death

a. ☐ Yes b. ☐ N/A

Reimbursement rate c. _____ d. _____

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

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

Lifetime maximum visits e. _____ f. _____

Lifetime maximum g. _____ h. _____

79. Ambulance

a. ☐ Yes b. ☐ N/A

c. ☐ Ground only d. ☐ Ground and air

Reimbursement rate e. _____ f. _____

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

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)

80. TMJ coverage limits

a. ☐ Yes b. ☐ N/A

Reimbursement rate c. _____ d. _____

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

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

81. Wig after chemotherapy

a. ☐ Yes b. ☐ N/A

Reimbursement rate c. _____ d. _____

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

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

Lifetime maximum e. _____ f. _____

82. 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

83. Occupational therapy

a. ☐ Yes b. ☐ N/A

Reimbursement rate c. _____ d. _____

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

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

84. Speech therapy

a. ☐ Yes b. ☐ N/A

Reimbursement rate c. _____ d. _____

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

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

85. Physical therapy

a. ☐ Yes b. ☐ N/A

Reimbursement rate c. _____ d. _____

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

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

86. Durable medical equipment

a. ☐ Yes b. ☐ N/A

Reimbursement rate c. _____ d. _____

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

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

87. Prosthetics

a. ☐ Yes b. ☐ N/A

Reimbursement rate c. _____ d. _____

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

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

88. Orthotics

a. ☐ Yes b. ☐ N/A

Reimbursement rate c. _____ d. _____

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

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

89. Spinal Manipulation/Chiropractic

a. ☐ Yes b. ☐ N/A

Reimbursement rate c. _____ d. _____

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

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

90. Mental disorders

a. ☐ Yes b. ☐ N/A

Reimbursement rate

	c. _____	d. _____
Inpatient	Subject to	Subject to
	1. ☐ deductible	1. ☐ deductible
	2. ☐ copayment	2. ☐ copayment
	3. ☐ N/A	3. ☐ N/A
Outpatient	e. _____	f. _____
	Subject to	Subject to
	1. ☐ deductible	1. ☐ deductible
	2. ☐ copayment	2. ☐ copayment
	3. ☐ N/A	3. ☐ N/A

91. Substance abuse

a. ☐ Yes b. ☐ N/A

Reimbursement rate

	c. _____	d. _____
Inpatient	Subject to	Subject to
	1. ☐ deductible	1. ☐ deductible
	2. ☐ copayment	2. ☐ copayment
	3. ☐ N/A	3. ☐ N/A
Outpatient	e. _____	f. _____
	Subject to	Subject to
	1. ☐ deductible	1. ☐ deductible
	2. ☐ copayment	2. ☐ copayment
	3. ☐ N/A	3. ☐ N/A

92. Routine well adult care (Nongrandfathered plans must provide in-network Standard Preventive Care (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

93. 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 q.)

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
m. ☐ Colonoscopies
n. ☐ Bone Density scans
o. ☐ Stress Tests
p. ☐ Sigmoidoscopies
q. ☐ Standard Preventive Care
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 select s.)

94. Nursery/Physician well 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

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

j. ☐ Unlimited days
k. ☐ For _____ Hospital days

Costs applied toward plan of

l. ☐ Parent
m. ☐ Newborn

95. Routine well child care (Nongrandfathered plans must provide in-network Standard Preventive Care (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 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

96. 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 (skip to **97.**)

Annual maximum	g. _____	h. _____

Plan covers donor costs only when recipient is covered under this plan?

i. ☐ Yes
j. ☐ No

97. 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

c. ☐ Yes
d. ☐ No
e. ☐ Complications only

98. Infertility coverage

a. ☐ No (skip to **99.**)
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. _____

99. Surgical sterilization included?

a. ☐ No
b. ☐ Yes (reversal excluded)

100. 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
   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 _____
      _____

101. Cost management included?

a. ☐ No (skip to **108.**)
b. ☐ Yes

102. 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

103. Mandatory utilization review service included?
- a. ☐ No (skip to **105.**)
- b. ☐ Yes, and if procedure not followed
  - 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 $_____

104. Medical services subject to review:
- a. ☐ Hospitalization
- b. ☐ MRI/CAT scan
- c. ☐ Inpatient Substance abuse/Mental treatment (Permitted only if **104a.** is checked)
- 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 _____

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)

105. 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 $_____

106. Outpatient Surgery
- a. ☐ Not covered
- b. ☐ Yes

Reimbursement rate

c. _____ Subject to
- 1. ☐ deductible
- 2. ☐ copayment
- 3. ☐ N/A

d. _____ Subject to
- 1. ☐ deductible
- 2. ☐ copayment
- 3. ☐ N/A

107. 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

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

109. Pre-existing conditions (Only applies if **1f., 2b., 2d.**, or **2f.** selected)
- a. ☐ Provision is excluded
- b. ☐ Provision is included

ADDITIONAL PLAN INFORMATION

110. 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)

Is there a 2nd Trustee?
e. ☐ No
f. ☐ Yes

1. _____
(Name)

2. _____
(Title)

g. ☐ Use Employer/trust fund address
h. ☐ Other

1. _____
(Street)

2. _____ 3. _____ 4. _____
(City) (State) (Zip)

Is there a 3rd Trustee?
i. ☐ No
j. ☐ Yes

1. _____
(Name)

2. _____
(Title)

k. ☐ Use Employer/trust fund address
l. ☐ Other

1. _____
(Street)

2. _____ 3. _____ 4. _____
(City) (State) (Zip)

Is there a 4th Trustee?
m. ☐ No
n. ☐ Yes

1. _____
(Name)

2. _____
(Title)

o. ☐ Use Employer/trust fund address
p. ☐ Other

1. _____
(Street)

2. _____ 3. _____ 4. _____
(City) (State) (Zip)

Is there a 5th Trustee?
q. ☐ No
r. ☐ Yes

1. _____
(Name)

2. _____
(Title)

s. ☐ Use Employer/trust fund address
t. ☐ Other

1. _____
(Street)

2. _____ 3. _____ 4. _____
(City) (State) (Zip)

111. Claims administrator/supervisor/processor

a. _____
(Name)

b. _____
(Street or P.O. Box)

c. _____ d. _____ e. _____
(City) (State) (Zip)

f. _____
(Telephone)

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

112. 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. _____

It is suggested that either a department (e.g., Personnel Department) or a title (e.g., Corporate Attorney, Executive Vice President) be used for these positions.

113. 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:

_____

_____

_____

_____

_____

114. Date amendment is effective: (Only applies if **113b.** selected)

a. _____
(Month) (Day) (Year)

115. Number of signature lines needed: (Only applies if **113b.** selected)

a. ☐ As employer representative
1. ☐ One
2. ☐ Two
3. ☐ Three
4. ☐ Four

b. ☐ As witnesses
1. ☐ One
2. ☐ Two

116. 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

117. Date amendment is effective: (Only applies if **116b.** selected)

a. _____
(Month) (Day) (Year)

118. Number of signature lines needed: (Only applies if **116b.** selected)

a. ☐ As employer representative
1. ☐ One
2. ☐ Two
3. ☐ Three
4. ☐ Four

b. ☐ As witnesses
1. ☐ One
2. ☐ Two

ADOPTING EMPLOYERS

119. 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)

120. Will there be a second Adopting Employer?

a. ☐ No

b. ☐ Yes

c. _____
(Name)

d. _____
(Street)

e. _____ f. _____ g. _____
(City) (State) (Zip)

h. _____
(Telephone)

i. _____
(Tax ID Number)

121. Will there be a third Adopting Employer?

a. ☐ No
b. ☐ Yes

c. _____
(Name)

d. _____
(Street)

e. _____ f. _____ g. _____
(City) (State) (Zip)

h. _____
(Telephone)

i. _____
(Tax ID Number)

122. Will there be a fourth Adopting Employer?

a. ☐ No
b. ☐ Yes

c. _____
(Name)

d. _____
(Street)

e. _____ f. _____ g. _____
(City) (State) (Zip)

h. _____
(Telephone)

i. _____
(Tax ID Number)

123. Will there be a fifth Adopting Employer?

a. ☐ No
b. ☐ Yes

c. _____
(Name)

d. _____
(Street)

e. _____ f. _____ g. _____
(City) (State) (Zip)

h. _____
(Telephone)

i. _____
(Tax ID Number)

124. Will there be a sixth Adopting Employer?

a. ☐ No
b. ☐ Yes

c. _____
(Name)

d. _____
(Street)

e. _____ f. _____ g. _____
(City) (State) (Zip)

h. _____
(Telephone)

i. _____
(Tax ID Number)

125. Will there be a seventh Adopting Employer?

a. ☐ No
b. ☐ Yes

c. _____
(Name)

d. _____
(Street)

e. _____ f. _____ g. _____
(City) (State) (Zip)

h. _____
(Telephone)

i. _____
(Tax ID Number)

126. Will there be an eighth Adopting Employer?

a. ☐ No
b. ☐ Yes

c. _____
(Name)

d. _____
(Street)

e. _____ f. _____ g. _____
(City) (State) (Zip)

h. _____
(Telephone)

i. _____
(Tax ID Number)

127. Will there be a ninth Adopting Employer?

a. ☐ No
b. ☐ Yes

c. _____
(Name)

d. _____
(Street)

e. _____ f. _____ g. _____
(City) (State) (Zip)

h. _____
(Telephone)

i. _____
(Tax ID Number)

128. Will there be a tenth Adopting Employer?

a. ☐ No
b. ☐ Yes

c. _____
(Name)

d. _____
(Street)

e. _____ f. _____ g. _____
(City) (State) (Zip)

h. _____
(Telephone)

i. _____
(Tax ID Number)

End HERE if Summary of Benefits and Coverage not selected

SUMMARY OF BENEFITS AND COVERAGE QUESTIONS

129. 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. $_

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

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. $_

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. $_

130. Coverage Examples:

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

NOTE: Do not include commas 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

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

a. Spanish (Espanol): Para obtener asistencia en Espanol, 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' _____.

132. 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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