Checklist for
Behavioral Health Plan Document and Summary Plan Description

Person to Contact with Questions: _____

Telephone Number: (____) _____

Email Address: _____

GENERAL PLAN INFORMATION

Group's Full Name: _____

Group's Address: _____

_____

If above address is a post office box, street address: _____

_____

Group's Telephone Number: (____) _____

Internal Group Number or Billing Number (if any): _____

Employer Identification Number (EIN): _____

Plan Year (month to month): _____

Original Effective Date of Plan (month & year): _____

Date of this Restatement (month & year): _____

Is this an ERISA Plan? _____
If so, ERISA Plan Number: _____

Type of Benefits Offered (please circle): Mental Health Substance Abuse

Participating Employers: _____

_____

Third Party Administrator: _____

_____

Is this a Union Plan: _____
If so, what is the Name of the Union: _____
What is the Local Number: _____

Is this a Government Plan: _____
If so, is HIPAA applicable: _____
Does the Plan comply with any state mandated benefits: _____
List all states in which the Plan has Participants: _____

Is this a Church Plan: _____
If so, is HIPAA applicable: _____
Does the Plan comply with any state mandated benefits: _____
List all states in which the Plan has Participants: _____

ELIGIBILITY FOR PARTICIPATION

Am I eligible to participate in the *Plan*?
As a full-time *employee* regularly scheduled to work at least [_____] hours per week, you are eligible for coverage when you…

	Complete your *waiting period* of [_____] days of continuous *active employment.*
	Begin *active employment.*
	Other (please specify):

As a part-time *employee* regularly scheduled to work at least [_____] hours per week, you are eligible for coverage when you…

	Complete your *waiting period* of [_____] days of continuous *active employment.*
	Begin *active employment.*
	Other (please specify):

You are eligible to continue to participate in the *Plan* if you are a retiree of the *participating employer* and you have completed [_____] years of service with the *participating employer* before retirement. You and any eligible *dependents* must have been covered under the *Plan* on the date immediately before your retirement in order to continue your participation. Retirees who were not covered under the *Plan* on the date immediately before retirement will not be allowed to enter the *Plan* during the annual open enrollment period or as described in the section, "Special Enrollment Periods."
OPTIONAL – KEEP or REMOVE

	After you become covered under the Plan, if your employment ends and you return to *active employment* within [_____], your coverage will take effect on the first day you return to *active employment*.
	After you become covered under the Plan, if your employment ends and you return to *active employment* within [_____], your coverage will take effect on the first day you return to *active employment*
	Eliminate completely

If you had not satisfied your *waiting period* before your employment ended and you return to *active employment* within [_____], you will be given credit for the period of time previously credited toward satisfaction of your *waiting period* on the first day you return to *active employment*.
OPTIONAL – KEEP or REMOVE

Are my *dependents* eligible to participate in the *Plan*?
No *dependent child* may be covered as a *dependent* of more than one *employee* who is covered under the *Plan*.
OPTIONAL – KEEP or REMOVE

No person may be covered simultaneously under this *Plan* as both an *employee* and a *dependent.*
OPTIONAL – KEEP or REMOVE

Spouses eligible for coverage under another group plan are not eligible for coverage under this *Plan*, except if your spouse must wait to enroll during an open or special enrollment period of the other group plan. Then, your spouse may continue coverage under this *Plan* until your spouse is able to enroll in the other group plan at the time of an open or special enrollment period.

OPTIONAL – KEEP or REMOVE

When will we become *covered persons* in the plan?

- Coverage will become effective on the…

	first day of the month following the date you or your *dependents* are eligible…
	first day following the date you or your *dependents* are eligible…
	Other (please specify):

…provided you and your *dependents* have enrolled for coverage on a form satisfactory to the *Plan Administrator* within [_____] days following the date of eligibility.

- For a *dependent child who* is born after the date your coverage becomes effective:

	If your plan requires that newborn children must be enrolled within a specified time period from birth, use this section: you must make written application and agree to any required contributions during the first [_____] days from the *child's* birth. Coverage for the *dependent child* will then become effective from the moment of birth.
	If your plan allows a newborn child to be covered for a specified number of days from birth, then requires enrollment to continue coverage beyond this initial period of coverage, use this section: the *dependent child* will be covered from the moment of birth for [_____] days. If you wish to continue coverage beyond this [_____]-day period, you must make written application for coverage and agree to any required contribution **during the first [_____]-day period from birth**.
	If your plan allows a newborn child to be covered for a specified number of days from birth, then requires enrollment to continue coverage beyond this initial period of coverage except when the employee is already making the maximum contribution for dependent coverage, use this section: the *dependent child* will be covered from the moment of birth for [_____] days. If you wish to continue coverage beyond this [_____] -day period, you must make written application for coverage and agree to any required contribution **during the first [_____] -day period from birth**. However, if you already have coverage for *dependents* and are making the maximum required contribution for *dependent* coverage under the *Plan,* the requirement for written application will be waived.

- If you acquire a *dependent* while you are eligible for coverage for *dependents*, coverage for the newly acquired *dependent* will be effective on the…

	first day of the month following the date the *dependent* becomes eligible…
	first day following the date the *dependent* becomes eligible…
	Other (please specify):

…provided you make written application for the *dependent* and agree to make any required contributions, within [_____] days of the date of eligibility.

What if I do not enroll during my original eligibility period and later decide to apply for coverage?

	If your plan allows late enrollment, you may use this section: You may use both this section and the following one, if the plan allows both late enrollees at any time and has an annual enrollment period as well: If you did not enroll during your original [_____]-day eligibility period, and have now decided to apply for coverage, you may do so by making written application to the *Plan Administrator*. Likewise, if you declined to enroll any of your eligible *dependents* during the original enrollment period, you may apply for coverage for them at a later date in the same manner. In these circumstances, you and/or your eligible *dependents* will be considered *late enrollees*. Coverage will be come effective at 12:01 A.M. on the:
	If your plan allows late enrollment through an annual open enrollment period, use this section. You may use both this section and the one above, if the plan allows both late enrollees at any time and has an annual enrollment period as well: You and your *dependents* may enroll for coverage during the *Plan's* annual open enrollment period, which is the month of [_____] in each *plan year*. If you or your *dependents* enroll during an open enrollment period, coverage will be effective at 12:01 A.M. on the first day of the month following the open enrollment period, unless you have not satisfied the *waiting period*. In that case, coverage for you and your eligible *dependents* will be effective on the…
	If your plan does not permit late enrollment (except Special Enrollment), use this section: If you and your *dependents* do not enroll for coverage when you are first eligible, you are not permitted to enroll in the *Plan* at a later time, except as set forth below in the section entitled "Special Enrollment Periods."

	First day following enrollment
	First day of the month following enrollment
	Other (please specify):

	First day following your completion of the *waiting period.*
	First day of the month following your completion of the *waiting period.*
	Other (please specify):

Are there any other exceptions for enrollment?

An *employee* who is already enrolled in a benefit package may enroll in another benefit package under the *Plan* if a *dependent* of that *employee* has a special enrollment right in the *Plan* because the *dependent* lost eligibility for other coverage. You must make written application for special enrollment in the new benefit package within 30 days of the date the other health coverage was lost.

OPTIONAL – KEEP or REMOVE

The following conditions apply to any eligible *employee* and *dependents:*

If the conditions for special enrollment are satisfied, coverage for you and your *dependent(s)* will be effective at 12:01 A.M.:

- For a marriage, on the…

	Date of the marriage
	First day of the calendar month following enrollment
	Other (please specify):

What if I was covered under a *prior plan*?

Eligible *employees* of an acquired company who are *actively at work* and who were covered under the prior health plan of the acquired company will be eligible for the benefits under this *Plan* on the date of acquisition. Any *waiting period* previously satisfied under the prior health plan will be applied toward satisfaction of the *waiting period* of this *Plan*. In the event that an acquired company did not have a prior health plan, you will be eligible on the date of the acquisition.

OPTIONAL – KEEP or REMOVE

When you and your spouse are both *covered persons*

When both you and your spouse are covered *employees*, and you have family coverage for *dependent children*, the *Plan* will allow one spouse to be treated as a *dependent* for purposes of calculating the *family unit deductible* and

out-of-pocket expense amount. This will allow for the full benefit of family coverage and reduce the *out-of-pocket expenses* for the *family unit*. The spouse with the later date of hire will be treated as a *dependent* for the purposes stated in this section unless the *Plan Administrator* determines otherwise.
OPTIONAL – KEEP or REMOVE

Changing status
When you change your coverage status between that of an *employee* and a *dependent*, and there is no break in coverage, full credit will be given for any amounts applied toward satisfaction of the current *plan year deductible* and *out-of-pocket expense* limit, and any amounts applied toward *Plan* maximums will be carried forward.
OPTIONAL – KEEP or REMOVE

SELECTION OF YOUR HEALTH CARE PROVIDER

Overview of PPO/Non-PPO Option
If you reside outside the *PPO network* area, ([_____] miles from the nearest *PPO hospital* or *PPO physician*), and use a non-*PPO network provider*, your benefits will be based on the "Out of Area" level shown in the "Schedule of Benefits."

This also applies to *dependent children* who are covered by this *Plan,* and reside outside the *network* area.
OPTIONAL – KEEP or REMOVE

Services which are covered by this *Plan* and which are **not available** through a *PPO network provider* are paid at the *PPO network provider* percentage payable for *usual, customary and reasonable fees,* even when the services are provided by an non-*PPO network provider*.
OPTIONAL – KEEP or REMOVE

Services provided through a referral by *PPO network provider hospital*, which are rendered and billed by a non-*PPO network provider*, are reimbursed at the *PPO network provider* percentage payable for *usual, customary and reasonable fees*.
OPTIONAL – KEEP or REMOVE

A current list of *PPO network providers* is available, without charge, through the *third party administrator* or through the website located at [_____].

If you do not have access to a computer at your home, you may access this website at your place of employment.
OPTIONAL – KEEP or REMOVE

If you have any questions about how to do this, please contact your employer.
OPTIONAL – KEEP or REMOVE

Many *PPO network providers* will require that the *Plan* offer incentives, or "steerage," in order to encourage *covered persons* to use their member *providers*. This *Plan* defines "steerage" as lower costs to the *covered person* through reduced charges, resulting in lower out-of-pocket amounts, or higher rates of reimbursement under the *Plan*. The *Plan Administrator* reserves the right to negotiate discounts with *providers* of service, and those discounts will be used to reduce the amount of otherwise *covered expenses* considered for payment by the *Plan*. In certain cases, the *Plan Administrator*, in its sole discretion, may determine that the benefit payable for a discounted claim will be at the *PPO network provider* reimbursement level, and such payments will be considered to be in full compliance with the terms of the *Plan*.
OPTIONAL – KEEP or REMOVE

EMPLOYEE ASSISTANCE PROGRAM

Does the plan have an Employee Assistance Program? _____

If so, should the employee contact the employer for more detailed information about this Program? _____

What is the name, address and phone number of the EAP administrator: _____

_____

Can the employee contact the EAP administrator for information? _____

YOUR COSTS

If you use a combination of *PPO network providers* and non-*PPO network providers,* your total *deductible* amount required will not exceed the amount shown for non-*PPO network providers*. In other words, the amount of *deductible* expense you pay for both *PPO network providers* and non-*PPO network providers* will be combined, and the total will not exceed the amount shown for non-*PPO network providers* during a single *plan year.*
OPTIONAL – KEEP or REMOVE

The *Plan* limits the amount of *deductible* and out-of-pocket expense you must pay for your *family unit*, as shown in the "Schedule of Benefits."
OPTIONAL – KEEP or REMOVE

Do the following *expenses* accumulate toward the *out-of-pocket expense* limit:

	Rx copayments		*Substance abuse treatment*
	Penalty for non-*emergency* use of *hospital* emergency room		Amounts applied toward *deductibles*
			Others:

SCHEDULE OF BENEFITS

Primary Care Providers
[For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries:] This Plan generally [requires OR allows] the designation of a primary care Provider. You have the right to designate any primary care Provider who participates in the Network and who is available to accept you or your family members.
VARIABLE – KEEP OR REMOVE

[If the plan or health insurance coverage designates a primary care provider automatically, insert:
Until you make this designation, the *Plan* designates one for you.
VARIABLE – KEEP OR REMOVE

OR

[For plans and issuers that require or allow for the designation of a primary care provider for a child:] For children, you may designate a pediatrician as the primary care Provider.
VARIABLE – KEEP OR REMOVE

OR

[For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add:] You do not need prior authorization from the Plan or from any other person (including a primary care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator.
VARIABLE – KEEP OR REMOVE

Deductibles, Percentage Payable and Out-of-Pocket Expense Limits
The following amounts are applied per *covered person* per *plan year*:

	PPO Network Providers	**Non-*PPO Network Providers***	**Out-of-Area *Providers***
Deductible • Individual • *Family Unit*			
Percentage Payable (unless otherwise stated)			
Out-of-Pocket Expense Limit* • Individual • *Family Unit*			

**** If any payment levels differ from what is listed here, please see the attached chart and fill in only the differences.**

Does the plan have a 3-month carryover for deductibles? _____
If so, is it for the individual deductible or family deductible? _____

***Hospital Mental or Nervous Disorder & Substance Abuse* Services**			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Mental or Nervous Disorder Partial *Hospitalization* ❖ 2 days equal to 1 *inpatient* day			
Mental or Nervous Disorder Inpatient Room & Board & Ancillary			
Substance Abuse Care Partial *Hospitalization* ❖ 2 days equal to 1 *inpatient* day			
Substance Abuse Care *Inpatient* Room & Board & Ancillary			

***Physician* In-*Hospital* Services**			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Mental or Nervous Disorder Hospital Visit			
Substance Abuse Hospital Visit ❖ 2 partial days equal to 1 *inpatient* day			

Outpatient Therapy Services			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Couples Therapy			
Family Therapy			
Group Therapy			
Hypnotherapy			
Individual Therapy			
Occupational Therapy			

Physician's Office Services			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Office Visit			

Outpatient *Mental or Nervous Disorder* and *Substance Abuse* Services			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Biofeedback – *Mental or Nervous Disorder* or *Substance Abuse*			
Neuro-biofeedback – *Mental or Nervous Disorder or Substance Abuse*			
Mental or Nervous Disorder Office Visit - Outpatient			
Mental or Nervous Disorder Testing and Evaluation			
Social Worker Visit			
Substance Abuse Visit Outpatient			

COVERED BENEFITS

Hospital Inpatient Benefits

***Inpatient* Care**

If the *hospital* does not have semi-private accommodations, the *Plan* will allow coverage for…

	…an amount equal to the average semi-private rate for other *hospitals* in that geographic area.
	…the cost of the private accommodations.
	…an amount equal to 90% of the private room rate.

Rehabilitation Facilities Benefits

The confinement must begin following an *inpatient* stay of at least [_____] days in a *hospital* and must be for continued treatment of the *illness* or *injury* being treated in the *hospital*.

Mental or Nervous Disorder and Substance Abuse Inpatient and Partial Hospitalization Services

Mental or Nervous Disorder Inpatient* and Partial *Hospitalization

If the *hospital* or *psychiatric treatment facility* does not have semi-private accommodations, the *Plan* will allow coverage for…

	…an amount equal to the average semi-private rate for other *hospitals* in that geographic area.
	…the cost of the private accommodations.

Substance Abuse *Inpatient* and Partial *Hospitalization*

If the *hospital* or *substance abuse treatment facility* does not have semi-private accommodations, the *Plan* will allow coverage for…

	…an amount equal to the average semi-private rate for other *hospitals* in that geographic area.
	…the cost of the private accommodations.

Outpatient Facility Fees

Biofeedback Services

Benefits…

	…are provided for biofeedback…
	…are not provided for biofeedback…

…as part of a program approved by the *Plan Administrator* for pain management.

Therapy

Benefits are provided for…

	…occupational…
	…individual…
	…family…
	…couples…
	…group…

…therapy to restore a *covered person* to health, or to social or economic independence.

Other Covered Expenses

	Services provided by a licensed social worker (M.S.W.).
	Services provided by a home health aide.

COST CONTAINMENT PROVISIONS

Pre-certification Program for *Inpatient* Services

This program does not apply to *inpatient* stays in facilities other than *hospitals*.

OPTIONAL – KEEP or REMOVE

The role of the Pre-certification Program is to establish the *medical necessity* for the **setting** of the treatment, not for the treatment itself.

OPTIONAL – KEEP or REMOVE

Urgent Care or *Emergency* Admissions

For urgent, *emergency* admissions, follow your *physician's* instructions carefully, and contact the Pre-certification Program administrator within [_____] of the admission.

Notification is still encouraged at the time of admission, and is required for any *hospital* stay that is in excess of the minimum length of stay. Failure to notify the Pre-certification Program administrator of any stay that is in excess of the minimum length of stay will result in application of a penalty to the *hospital* expenses.

OPTIONAL – KEEP or REMOVE

Concurrent *Inpatient* Review

Name, address and phone number of UR Company: _____

_____

Penalty

Covered expenses will be reduced by $[_____] per admission, and this amount will not accumulate toward any *out-of-pocket expense* limits.

OPTIONAL – KEEP or REMOVE

Covered expenses will be reduced by [_____]% to a maximum of $[_____] per admission, and this amount will not accumulate toward any *out-of-pocket expense* limits.

OPTIONAL – KEEP or REMOVE

Benefits otherwise payable will be calculated, then reduced by $[_____] per admission, and this penalty amount will not accumulate toward any *out-of-pocket expense* limits.

OPTIONAL – KEEP or REMOVE

Benefits otherwise payable will be calculated, then reduced by [_____]% to a maximum of $[_____] per admission, and this penalty amount will not accumulate toward any *out-of-pocket expense* limits.

OPTIONAL – KEEP or REMOVE

Pre-certification Program for Outpatient Services

Because communication is the basis for the Program, the *Plan* requires that you contact the…

	…Pre-certification Program administrator at least [_____] days before the commencement of non-*emergency* services of the types listed in this section.
	…Utilization Review Program administrator within [_____] following the commencement of any of the listed outpatient services.

Non-*emergency* outpatient care and services of the types listed below require…

	…pre-certification:
	…Utilization Review:

Penalty

	Covered expenses will be reduced by… …$[_____]… …[_____]% to a maximum of $[_____]… …and this amount will not accumulate toward any *out-of-pocket expense* limits.
	Benefits otherwise payable will be calculated, then reduced by… …$[_____]… …[_____]% to a maximum of $[_____]… …and this penalty amount will not accumulate toward any *out-of-pocket expense* limits.

[Pre-determination of Medical/*Surgical* Benefits]

THIS ENTIRE SECTION IS OPTIONAL – KEEP or REMOVE

This is a service offered by the *Plan* to help you determine, in advance, whether a proposed treatment…

	…is expected to cost $[_____] or more…
	…will be a *covered expense* under the *Plan*.

It is a voluntary provision, and you are under no obligation to obtain pre-approval of your treatment. However, you are encouraged to use this service to avoid incurring non-*covered expenses* for which you will be responsible.

In order to evaluate the proposed treatment, the *Plan Administrator* will require detailed medical information from your *physician*, including:

- The identity of the patient (including date of birth and sex);
- The diagnosis code (ICD-9);
- The procedure code (CPT); and
- The amount of the proposed charge.

This information should be submitted to:

	Utilization Review Company

	Third Party Administrator
	Other (please specify name, address & phone):

You will receive a written response with the *Plan Administrator's* determination, which you may furnish to your *physician* if you so desire.

A pre-determination under this section will not be a guarantee of eligibility, coverage or benefits. All benefit determinations will be based upon the provisions of this *Plan* and the decision of the *Plan Administrator* in its sole discretion.

Do not delay seeking medical care for any *covered person* who has a serious condition that may jeopardize his life or health in order to pre-determine benefits. Pre-determination of benefits is not recommended under these circumstances.]

Are Second *Surgical* Opinions Voluntary or Mandatory? _____
Please complete the appropriate sections below:

Case Management Program
Does the Plan have a Case Management Program? _____
If so, who administers it ? _____
What is the contact phone number? _____

TERMINATION OF COVERAGE

When does my participation end?
Your participation will end at 12:01 A.M. on the earliest of the following dates:

	The date of termination
	The last day of the month following the termination.

When does participation end for my *dependents*?
The coverage for your *dependents* will end at 12:01 A.M. on the earliest of the following dates:

- The date your *dependent* becomes…

	…eligible…
	…covered…

…as an *employee* under the *Plan*;

- In the case of a *child* other than a *child* for whom coverage is continued due to mental or physical inability to earn his own living, the date on which the *child* reaches age [_____], or age [_____] in the case of a *child* who is regularly attending an accredited high school, junior college, college, university or licensed trade school;

Will my *participating employer* continue our coverage?
Coverage will be continued for you and your *dependents* should the following occur:

	In the event of a layoff, coverage will continue for [_____] **(days, weeks, months)** following the date of layoff;
	In the event of *total disability*, coverage will continue for [_____] **(days, weeks, months)** following the date of the disability;
	In the event you take a *leave of absence* which does not meet the requirements of *FMLA*, your coverage will continue for [_____] **(days, weeks, months)** following the date of the leave;

The period of continued coverage under this section **(will** OR **will not)** reduce the maximum time for which you may elect to continue coverage under COBRA.

Does the *Plan* have an *annual enrollment period*? _____

Would you like condensed or detailed language for USERRA? _____

Is legal separation a qualifying event? _____

Are retirees covered under the *Plan*? _____

How long does *COBRA continuation coverage* last?
When the *qualifying event* is "entitlement to *Medicare*," the 36-month continuation period is measured from the date of the original *qualifying event*.
OPTIONAL – KEEP or REMOVE

CLAIM PROCEDURES

Does the plan have one or two appeal levels? _____

Should questions regarding claims be directed to the Plan Administrator or the TPA? _____

Post service claims must be filed within [_____] days of the date charges were incurred.

When Health Claims Must Be Filed
Post-service health claims must be filed with the *third party administrator* within [_____] of the date charges for the service were *incurred*.

Failure to file a claim within this time limit will not invalidate the claim provided that the *covered person* submits evidence satisfactory to the *Plan Administrator* that it was not reasonably possible to file the claim within the time limit. In no event will the time limit be extended beyond [_____] **(months OR year(s))** from the date the charges were *incurred* except in the case of legal incapacity of the *covered person*.
OPTIONAL – KEEP or REMOVE

Any legal action for the recovery of any benefits must be commenced within [_____] days after the Plan's claim review procedures have been exhausted.

Second Appeal Level
Covered persons at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination and [_____] days to appeal a second adverse benefit determination;

Upon receipt of notice of the *Plan's* adverse decision regarding the first appeal, the *covered person* has [_____] days to file a second appeal of the denial of benefits.

External Review
Name of unit that administers the external review program: _____
_____

Address: _____
_____

Phone: _____
_____

COORDINATION OF BENEFITS

Which COB language should the Plan contain:

	COB with full "allowable expenses" and COB recoverable on a calendar year basis
	"Carve-out" on a per-claim basis
	Full allowable expenses on a per-claim basis

Order of Benefit Determination

- If the person on whose expenses the claim is based is an inactive employee (e.g. retired or on layoff) or the dependent of an inactive employee, the benefits of the plan covering the person in an active status will be determined before the benefits of a plan covering the person in an inactive status; and
  OPTIONAL – KEEP or REMOVE

DEFINITIONS

"Dependent" means one or more of the following person(s):

- An *employee's domestic partner* who has the same principal place of abode for more than one-half of the calendar year, and who relies on the employee for more than one half of his or her support for the calendar year in which the *domestic partner* is enrolled for coverage under the *Plan*;
  OPTIONAL – KEEP or REMOVE

- An e*mployee*'s unmarried *child* who is less than [_____] years of age;

- An e*mployee*'s unmarried *child* who is at least [_____] years of age but less than [_____] years of age, who is dependent upon the e*mployee* for support and who is a full-time student at an accredited high school, junior college, college, university, or licensed trade school.;

	An e*mployee*'s unmarried *child,* regardless of age who is mentally or physically incapable of sustaining his own living.
	OR An e*mployee*'s unmarried *child,* regardless of age, [who was continuously covered prior to attaining the limiting age under the bullets above,] who is mentally or physically incapable of sustaining his own living.

  Such *child* must have been mentally or physically incapable of earning his own living prior to attaining the limiting age under the fourth and fifth bullets above.
  OPTIONAL – KEEP or REMOVE

- The time limit for written proof of incapacity and dependency is [_____] days following the original eligibility date for a new or re-enrolling employee.
  OPTIONAL – KEEP or REMOVE

"Domestic partner" means a person of the same sex sharing the same residence with the *employee*, and living as a couple in a committed relationship with the *employee* for…

	…a significant period of time.
	…Other (please specify):

A domestic partner must be at least 18 years of age, not married or related to the *employee* by blood, and consent to a domestic partnership.
OPTIONAL – KEEP or REMOVE

"Employee" means…Such person must be scheduled to work at least [_____] hours per week in order to be considered "full-time."

"Experimental" means services, supplies, care, procedures, treatments or courses of treatment, which:

- Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or

- Are rendered on a research basis as determined by the United States Food and Drug Administration and the *AMA*'s Council on Medical Specialty Societies. [All phases of clinical trials shall be considered experimental.] [Phase I, II and III clinical trials shall be considered experimental.]
  OPTIONAL – CHOOSE ONE

"Plan year" means the period commencing [_____] and continuing until the next succeeding anniversary.

"Total disability" or "totally disabled" means…

	…the inability of an employee to perform substantially all of the duties of his occupation due to an illness or injury.
	…the inability of an employee to perform the duties of any occupation for which he may be qualified by reason of training, education or experience.

HIPAA PRIVACY PRACTICES

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

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