Checklist for
CAM Benefit Plan
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): Dental _____

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):

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*. [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

When will we become *participants* 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.
	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. 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 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?
What if I do not enroll during my original eligibility period and later decide to apply for coverage?

	If your plan allows late enrollment, 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:

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

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

Loss of Other Coverage
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

Are there any other exceptions for enrollment?

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 *participants*
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 Panel
The *Plan Administrator* offers a full CAM panel which consists of:

	…chiropractors…
	…acupuncturists…
	…naturopathic physicians…
	…massage therapists…

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

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

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

Each *participant* has a free choice of any provider, and the *participant*, together with his provider, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the *Plan* will pay for all or a portion of the cost of such care. The *PPO network providers* are independent contractors; neither the *Plan* nor the *Plan Administrator* makes any warranty as to the quality of care that may be rendered by any *PPO network provider*.
OPTIONAL – KEEP or REMOVE

Many *PPO network providers* will require that the *Plan* offer incentives, or "steerage," in order to encourage *participants* to use their member *providers*. This *Plan* defines "steerage" as lower costs to the *participant* 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

SCHEDULE OF BENEFITS

Lifetime Maximum Benefits for:	
Lifetime Maximum Benefit for All Benefits	

	The total payments for all benefits under [any options of a plan sponsored by the *Plan Sponsor*] will not exceed that maximum, whether or not the *participant* is continuously covered under the *Plan*.
	The total payments for all benefits under [this *Plan* option] will not exceed that maximum, whether or not the *participant* is continuously covered under the *Plan*.

***Plan Year* Maximum Benefits**
The following *plan year* maximums apply to each *participant*:

***Plan Year* Maximum Benefits for:**	
Acupuncture	
Chiropractic	
Massage Therapy	
Naturopathic Medicine	
Acupuncture, Chiropractic, Massage Therapy, and Naturopathic Medicine Combined	

Percentage Payable and Out-of-Pocket Expense Limits
The following amounts are applied per *participant* per *plan year*:

	Benefits
Percentage Payable (unless otherwise stated)	

	Covered expenses incurred during the last three months of a *plan year* that were applied toward the *deductible* will be allowed as credit toward satisfaction of the *deductible* in the following *plan year*.
	Covered expenses incurred during the last three months of a *plan year* that were applied toward the [individual] *deductible* will be allowed as credit toward satisfaction of the [individual] *deductible* in the following *plan year*.]
	Do not include this language

	Benefits
Out-of-Pocket Expense Limit* • Individual • *Family Unit*	

Payment Levels and Limits
Maximums stated apply to the amount of…

	…benefit payments…
	…covered expenses…

…unless otherwise indicated.

Chiropractic Services		
Percentage Payable For:	**Benefits**	**Limits**
Acupuncture		
Chiropractic Visit and Therapies		
Chiropractic X-ray		
Massage Therapy		
Naturopathic Medicine		

COVERED EXPENSES

	Acupuncture
	Chiropractic Care Services
	Massage Therapy
	Naturopathic Medicine

Acupuncture
OPTION 1:
Covered expenses include acupuncture.

OPTION 2:
Acupuncture services are covered as follows:

- A *participant* has direct access to Licensed Acupuncturists (LAc) and MD/DO's who are contracted with CHP to provide acupuncture;
- All services must be *medically necessary*; and
- New and established patient examinations and all therapeutic services that are within the legal scope of practice for the LAc are covered, except as specifically excluded under the section entitled "Exclusions and Limitations."

OPTION 1 or OPTION 2 (please circle one)

***Chiropractic Care* Services**
OPTION 1:
Covered expenses include spinal manipulation and other related therapy treatments, and X-rays. *Chiropractic care* must be rendered for the active treatment of an *illness* or *injury*.

OPTION 2:
***Chiropractic Care* Services**
Chiropractic Care Services are covered as follows:

- A *participant* has direct access to Chiropractic Physicians (DC) who are contracted with CHP;
- All services must be *medically necessary*;
- A new patient examination and all therapeutic services that are within the legal scope of practice for the DC are covered, except as specifically excluded under the section entitled "Exclusions and Limitations";
- One "established patient" examination per *participant* per calendar year is covered;
- Diagnostic x-rays that are performed by a contracted *provider* or contracted facility are covered; and
- Clinical laboratory tests when performed by a contracted *provider* or contracted facility.

OPTION 1 or OPTION 2 (please circle one)

Massage therapy
OPTION 1:
A referral is needed from your primary care provider, chiropractor, or naturopathic *physician* on panel to show *medical necessity* for massage.

OPTION 2:
When a health plan specifically includes massage therapy services provided by a Licensed Massage Therapist (LMT) or Licensed Massage Practitioner (LMP), these services may be accessed in one of two ways:

- Direct access. Certain plans include a direct access massage therapy benefit. In direct access plans, massage therapy is covered as follows:
  - A *participant* has direct access (no referral is required) to Licensed Massage Therapists (LMT) and Licensed Massage Practitioners (LMP) who are contracted with CHP to provide massage therapy;
  - All massage therapy services must be ;
  - A new patient examination and all therapeutic services that are within the legal scope of practice for the DC are covered, except as specifically excluded under the section entitled "Exclusions and Limitations";
- Referred massage. Certain plans include coverage of a referred massage therapy benefit. Referred massage is covered as follows:
  - A *participant* may receive massage therapy from a LMT or LMP credentialed and contracted with CHP only with a referral from a Chiropractic or Naturopathic Physician (DC or ND);
  - The referral must specify the treatment plan including the diagnosed condition, the number of visits, and the goals of the treatment;
  - Massage therapy must be *medically necessary*; and
  - Massage therapy services that are within the legal scope of practice for the LMT/LMP are covered, except as specifically excluded under the section entitled "Exclusions and Limitations."

OPTION 1 or OPTION 2 (please circle one)

EXCLUSIONS AND LIMITATIONS

- **Court-ordered services.** That are ordered by a court, unless determined by the *Plan Administrator*, in its discretion, to otherwise be appropriate and covered.
  OPTIONAL – KEEP or REMOVE

- **Educational.** That are related to education or vocational training.
  - This exclusion does not apply to educational services rendered for diabetic counseling, peritoneal dialysis, or any other educational service deemed to be *medically necessary* by the *Plan*.
    OPTIONAL – KEEP or REMOVE

- ***Experimental.*** That are *experimental.*

  - In some cases, the application of an established procedure, as a course of treatment for a specific condition, may be considered *experimental*, and hence, not covered by this *Plan*.

  - [This exclusion will not apply to expenses directly related to a non-*experimental*, *medically necessary* transplant procedure which is performed during the course of a clinical trial for off-label use of drugs, or the use of *experimental* drugs. Expenses related to the drugs and the clinical trial are excluded.]
    OPTIONAL – KEEP or REMOVE HIGHLIGHTED SECTION

- **Illegal act.** Related to *injuries* sustained, or an *illness* contracted, during the commission, or attempted commission, of a felony…

	…or misdemeanor, or any illegal act or illegal occupation.
	This exclusion will apply only if the participant is convicted of the illegal act;

- **Immediate relative.** Provided by an *immediate relative…*

	….or an individual residing in your home;

- **Malpractice.** That are required as a result of malpractice, malfeasance or misfeasance or that are to treat *injuries* that are sustained or an *illness* that is contracted, including infections and complications, while the *participant* was under the care of a provider for a condition wherein such *illness, injury*, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the *Plan Administrator* in its sole discretion, gave rise to the expense.
  OPTIONAL – KEEP or REMOVE

- **Tax and shipping.** For taxes and shipping charges levied on *medically necessary* items and services.

	This exclusion does not apply to surcharges required by law to be paid by the *Plan* in applicable states.

- **Trusses, corsets and other support devices.**
  OPTIONAL – KEEP or REMOVE

- **War.** Resulting from war or an act of war, whether declared or undeclared, or any act of aggression, and any complication therefrom.

	This exclusion does not apply to *participants* who are not members of the *uniformed services*.

- **Work-related *illness* or *injury.*** Related to an *illness* or *injury*…

	…arising out of, or in the course of, any employment for wage or profit, including that of previous employers, without regard to whether such *illness* or *injury* entitles the *participant* to workers' compensation or similar benefits.
	… for which the *participant* is entitled to benefits under any workers' compensation or similar law.

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*? _____

Is legal separation a qualifying event? _____

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.

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

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

"Annual enrollment period" means the period from [_____] through [_____] each year during which *employees* may make new coverage elections.

"Chiropractic care" means…

	office visits
	x-rays
	Manipulations
	Ultrasound
	Hot or cold packs
	Electrical stim (unattended)
	Massages
	All services related to a chiropractic visit

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

- 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.;
- 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…

	At least 18 years of age, not married or related to the *employee* by blood, and consent to a domestic partnership;
	Unmarried and constitute each other's sole domestic partner; and
	Legally competent to consent to contract.

[The *Plan Administrator* reserves the right to require such evidence as it deems necessary that a *domestic partner* satisfies this definition.]
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."

"Physician" means a…

	Doctor of Medicine (M.D.)
	Doctor of Osteopathy (D.O.)
	Doctor of Chiropractic (D.C.)
	Psychologist (Ph.D.)

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

"Provider" means a *physician, a…*

	Licensed speech therapist		Physiotherapist
	Licensed occupational therapist		Licensed professional counselor
	Licensed professional physical therapist		Certified nurse practitioner

…or other practitioner or facility defined or listed herein, or approved by the *Plan Administrator*.

"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:
