Checklist for
Dental Only 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: ____________________
Name, Address, Phone:

____

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*. [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 dental plan are not eligible for coverage under this *Plan.*
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:

<table>
<tr><td></td><td>If your plan requires that newborn children must be enrolled within a specified time period from birth, use this section:
<table>
<tr><td></td><td>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.</td></tr>
<tr><td></td><td>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.</td></tr>
</table></td></tr>
<tr><td></td><td>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.</td></tr>
<tr><td></td><td>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.</td></tr>
</table>

- 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?

<table>
<tr><td></td><td>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:
<table>
<tr><td></td><td>First day following enrollment</td></tr>
<tr><td></td><td>First day of the month following enrollment</td></tr>
<tr><td></td><td>Other (please specify):</td></tr>
</table></td></tr>
<tr><td></td><td>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…
<table>
<tr><td></td><td>First day following your completion of the waiting period.</td></tr>
<tr><td></td><td>First day of the month following your completion of the waiting period.</td></tr>
<tr><td></td><td>Other (please specify):</td></tr>
</table></td></tr>
<tr><td></td><td>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."</td></tr>
</table>

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

LIMITATIONS FOR FIRST-YEAR ENROLLEES

During your first 12 months of coverage under the Plan, your benefits will be limited as follows:

	Prosthodontic services (initial installation or replacement of bridgework or dentures)…	
		…will not be covered.
		…will be limited to a maximum benefit of $[__________].
	Class III Major Repair and Restorative Services…	
		…will not be covered.
		…will be limited to a maximum benefit of $[__________].
	Class IV Orthodontia Services…	
		…will not be covered.
		…will be limited to a maximum benefit of $[__________].
	Only Class I services will be covered.	

YOUR COSTS

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

Once you have paid the *out-of-pocket expense* limit for eligible expenses *incurred* during a *plan year,* the *Plan* will reimburse additional eligible *covered expenses incurred* during that year at 100%.
OPTIONAL – KEEP or REMOVE

	The *Plan* will not reimburse any expense that is not a *covered expense.* In addition, you must pay any expenses to which you have agreed that are in excess of the *usual, customary and reasonable fees*, and any penalties for failure to comply with requirements for pre-determination or penalties that are otherwise stated in the *Plan*. **OR**
	The *Plan* will not reimburse any expense that is not a *covered expense.* In addition, you must pay any expenses to which you have agreed that are in excess of the *usual, customary and reasonable fees*, and any penalties for failure to comply with requirements for pre-determination or penalties that are otherwise stated in the *Plan*. None of these amounts will accumulate toward your *out-of-pocket expense* limit.

	If you have any questions about whether an expense is a *covered expense,* please contact the *third party administrator* for assistance.
	If you have any questions about whether an expense is a *covered expense*, or whether it is eligible for accumulation toward your *out-of-pocket* expense limit, please contact the *third party administrator* for assistance.

SCHEDULE OF DENTAL BENEFITS

Maximum Benefits
The following maximums apply to each *participant*:

Maximum Benefits for:	
Class I Dental Services	
Class II Dental Services	
Class III Dental Services	
Class IV Dental Services	
Class I, II, III Combined Dental Services	

COMPLETE THE FOLLOWING SECTION ENTITLED "OVERVIEW OF PPO/NON-PPO OPTION" ONLY IF THE PLAN IS A PPO DENTAL PLAN:

Overview of PPO/Non-PPO Option
The *Plan Administrator* has entered into an agreement with one or more networks of *dentists,* called *"PPO networks."* These *PPO networks* offer *participants* dental care services at discounted rates. Using a *PPO network provider* will normally result in a lower cost to the *Plan* as well as to the *participant.* There is no requirement for any *participant* to seek care from a *dentist* who participates in the *PPO network*. The choice of *dentist* is entirely up to the *participant*.

	A current list of *PPO network dentists* 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.

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 dental 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*.

Deductible[and Out-of-Pocket Expense Limits]
The following amounts are applied per *plan year*:

	PPO Network Providers	**Non-*PPO Network Providers***	**Out-of-Pocket Expense Limit**
Class [_____] Expenses • Individual • *Family Unit*			
Class [_____] Expenses • Individual • *Family Unit*			
Class [_____] Expenses • Individual • *Family Unit*			

Covered expenses incurred during the last three months of a *plan year* that were applied toward the…

	..individual *deductible…*
	…deductible…

...will be allowed as credit toward satisfaction of the [individual] *deductible* in the following *plan year*.
OPTIONAL – KEEP or REMOVE

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

	…benefit payments…
	…covered expenses…

…unless otherwise indicated.

The following types of *covered expenses* are **not** subject to the *deductible* unless otherwise indicated:

Dental Expenses		
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***
Class I Dental Expenses		
Class II Dental Expenses		
Class III Dental Expenses		
Class IV Dental Expenses		

Covered expenses incurred by…

	…any *participant*…
	…any *participant* and *family unit*…

…in the last three months of any *plan year* which are applied to satisfy the *deductible* for that *plan year* may also be used toward satisfaction of the *deductible* in the next *plan year*.

OPTIONAL – KEEP or REMOVE

DENTAL COVERED EXPENSES

Class I Services (Preventive Care)

Move to Class	**Coverages**
	Routine oral examinations and prophylaxis (cleaning, scaling and polishing teeth), but not more than… [ ] …once in any period of [__________] consecutive months; [ ] …twice per plan year;
	Periapical x-rays, as required, and bitewing x-rays once in any period of six consecutive months;
	Sealants for dependent children under age [__________], but not more than once in any period of [__________] consecutive months;
	Topical application of fluoride for dependent children under age [__________], but not more than once in any period of [__________]consecutive months;
	Space maintainers (not made of precious metals) that replace prematurely lost teeth for dependent children under age [__________]. No payment will be made for duplicate space maintainers; and
	Palliative emergency treatment of an acute condition requiring immediate care.

Class II Services (Repair and Restoration)

Move to Class	**Coverages**
	Full mouth x-rays, but not more than once in any period of [__________] consecutive months;
	Panoramic x-rays, but not more than once in any period of [__________] consecutive months;
	Amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations to restore diseased or accidentally broken teeth. Gold foil restorations… [ ] …are eligible; [ ] …are not eligible;
	Simple extractions, except for orthodontia;
	Endodontics, including pulpotomy, direct pulp capping and root canal treatment;
	Anesthetic services (except local infiltration or block anesthetics) performed by, or under the direct personal supervision of, and billed for by a provider other than the operating dentist or his assistant;
	Periodontal examinations, treatment and surgery; and
	Consultations.

Class III Services (Major Dental Repair and Restoration)
[Prosthodontic services (initial installation or replacement of bridgework or dentures) will be covered only when a *participant* has been covered under this *Plan* continuously for at least 12 months, unless otherwise required by applicable law.]
OPTIONAL – KEEP or REMOVE

Move to Class	Coverages
	Inlays, gold fillings, crowns, and initial installation of full or partial dentures or fixed bridgework to replace one or more natural teeth;
	Inlays, gold fillings, crowns, and initial installation of full or partial dentures or fixed bridgework to replace one or more natural teeth, [extracted while the participant was covered under the Plan];
	Repair or re-cementing of crowns, inlays, bridgework or dentures and relining of dentures;
	Replacement of an existing denture or fixed bridgework, or the addition of teeth to an existing partial removable denture or bridgework, to replace one or more natural teeth: Where the existing denture or bridgework was installed at least five years prior to its replacement and it cannot be made serviceable; or Where the existing denture is an immediate temporary denture, and necessary replacement by the permanent denture takes place within 12 months;
	Periodontal root scaling and planing;
	Veneers, for *dependent children* under age [__________] only;
	Oral surgery.

Class IV Services (Orthodontics)
Orthodontic services will be eligible only when provided to covered *dependent children* who are under age [__________] when expenses are *incurred*.
THIS ENTIRE SECTION IS OPTIONAL – KEEP or REMOVE

DENTAL EXCLUSIONS AND LIMITATIONS

This Plan does not cover any charge for the following services or supplies:

	Adjustments. Charges for services to alter vertical dimension (work done or appliance used to increase the distance between nose and chin); to restore or maintain occlusion (work done or appliance used to change the way the top and bottom teeth meet or mesh); to replace tooth structure lost as a result of abrasion or attrition; for splinting; or for treatment of disturbances of the temporomandibular joint;
	Experimental. Charges for *experimental* dental care… …implantology… …or dental care which is not customarily used or which does not meet the standards set by the *ADA*;
	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; **OPTIONAL – KEEP or REMOVE**
	Immediate relative. Provided by an *immediate relative*… …or an individual residing in your home
	Late enrollee. "Late enrollee" means a person who enrolls for coverage during an *annual enrollment period* because he failed to enroll when first eligible for coverage;
	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.

	For implants, including any appliances and/or crowns and the surgical insertion or removal of implants;
	Tax and shipping. For taxes and shipping charges levied on items and services. This exclusion….. [ ] …does… [ ] …does not… …apply to surcharges required by law to be paid by the *Plan* in applicable states;
	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… [ ] …does not… …apply to *participants* who are not members of the *uniformed services*.

PRE-DETERMINATION OF DENTAL BENEFITS

If a *participant's* proposed course of treatment reasonably can be expected to involve dental charges of $[__________] or more, a description of the procedures to be performed and an estimate of the charges therefor may be filed with the *Plan Administrator* or *third party administrator* prior to the commencement of the course of treatment. **However, approval is <u>not required</u> prior to treatment.** Any pre-determination of dental benefits is provided only as a convenience to the *participant*.

If requested, the *Plan Administrator* or *third party administrator* will notify the *participant*, and the *dentist* or physician, of the pre-determination based upon such proposed course of treatment. In determining the amount of benefits available, consideration will be given to alternate procedures, services, supplies and courses of treatment which may be performed to accomplish the required result. **The pre-determination is not a guarantee of payment or approval of a benefit. After treatment is received, a claim must be filed as a post-service claim, which will be subject to all applicable *Plan* provisions.]**
THIS ENTIRE SECTION IS OPTIONAL – KEEP or REMOVE

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? ______________________________

Are retirees covered under the *Plan*? ____

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? ______________
Please list the fax number of the appropriate party: ____________________________

Dental claims must be filed within [__________] days of the date charges were incurred.

Failure to file a claim within this time limit will not invalidate the claim provided that the *participant* 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 [_______________] of the date the charges were *incurred* except in the case of legal incapacity of the *participant*.
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.

COMPLETE THE FOLLOWING ONLY IF THE PLAN HAS 2 LEVELS OF APPEAL

- *Participants* 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 *participant* has [__________] days to file a second appeal of the denial of benefits.

COORDINATION OF BENEFITS

Which COB would the plan like to use?

	Carve-out on a per-claim basis. ***This provision is designed to limit the amount paid by all plans (the "allowable expense") to the actual benefit payable under your plan. In other words, as secondary payor, your plan would use the normal benefit amount payable and subtract from that any amount paid by the primary carrier(s). This will make any deductibles, copayments, etc., remain as an out-of-pocket amount to the plan member.***

	Full allowable expenses on a per-claim basis ***This provision is designed to allow for reimbursement of up to the full amount of covered charges for a single claim submission. In other words, as secondary payor, your plan may reimburse the full balance due after the primary carrier has paid (subject to the maximum you would have paid without COB). It is not applied to cumulative charges on a calendar year basis, and therefore eliminates COB recoverable.***

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

SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT

Does the Plan want to include a subrogation section? ____

If so, please complete the following. If not, please move on to the "Definitions" section.

	Check here if your plan requires the plan member and his attorney to sign a reimbursement agreement, and the plan agrees to pay a pro-rata share of the attorney's fees? Is so… *"Plan's Pro Rata Share of Attorneys' Fees"* shall mean an amount up to [__________]% of the amount subject to *reimbursement* to the *Plan* under this section, which may be deducted from any *recovery* as the *Plan's* pro rata share of the *participant's* attorneys' fees.
	Check here if your plan does not require the plan member's attorney to sign a reimbursement agreement, and your plan will not agree to pay a pro-rata share of the attorney's fees.
	Check here if your plan requires the plan member and his attorney to sign a reimbursement agreement, and your plan will not agree to pay a pro-rata share of the attorney's fees.

DEFINITIONS

"<u>Annual enrollment period</u>" means the period from [__________] through [__________] each year during which *employees* may make new coverage elections.

"<u>Dependent</u>" 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, who has the same principal place of abode as the employee for more than one-half of the calendar year, and who does not provide more than one half of his or her own support for the calendar year in which the *child* is enrolled for coverage under the *Plan*. **OR**
	An e*mployee*'s unmarried *child,* regardless of age, [who was continuously covered prior to attaining the limiting age under the fourth and fifth bullets above,] who is mentally or physically incapable of sustaining his own living, who has the same principal place of abode as the employee for more than one-half of the calendar year, and who does not provide more than one half of his or her own support for the calendar year in which the *child* is enrolled for coverage under the *Plan*.

	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.

- 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."

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

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: