Checklist for EAP
Plan Document and Summary Plan Description

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): Medical _____

Participating Employers: _____

_____

Third Party Administrator: _____
Name, Address, Phone:

_____

EAP Administrator: _____
Name, Address, Phone:

_____

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.*
OPTIONAL – KEEP or REMOVE

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

ABOUT THE PROGRAM

Who do employees contact for information:

	Participating Employer
	TPA
	EAP Administrator

The *EAP* provides *employees* and their *dependents* with a broad range of services, including:

	Face-to-face counseling services
	Work/life referral services and online resources, including *child,* elder care and legal/financial services
	Other:
	Other:

EAP* Counseling *Benefits
To provide the *EAP* service, the *participating employer* has retained the services of the *Third party administrator's* counselors, who are experienced in addressing the wide variety of problems and concerns that individuals can face in everyday life, are available to help 24 hours per day, seven days per week. Some of the types of issues and concerns addressed by the *EAP* include:

	Family/marital
	Parenting
	Legal
	Alcohol and drug abuse
	Emotional
	Stress
	Anxiety
	Depression
	Physical
	Financial
	Child care/elder care
	Other:
	Other:

The *EAP* provides:

	Confidential services
	Assessment
	Professional counseling
	Education
	Referral assistance (if needed)
	Follow-up
	Other:
	Other:

Eligible *participants* may contact the *EAP* service 24 hours per day, seven days per week by calling [_____].

Eligible *participants* who are located outside of the United States may contact the *EAP* service by calling the *EAP* at [_____].

Participants are eligible for up to [_____] counseling sessions (over the telephone or one-on-one with a counselor) per individual per problem or concern per year.

How to Access the Website

Where can employee's access information:

	TPA Website
	Plan Administrator Website
	EAP Administrator Website

The website is: www.[_____].com

Work/Life Services

The *third party administrator's EAP* consultants are available to help with a wide range of work/life issues as follows:

	Pre-natal care
	Child-care
	Health and wellness
	Summer child care
	Adoption
	Parenting
	Adult care and elder care
	Academic services
	Relocation
	Other:
	Other:

The work/life services can be accessed by calling:

	TPA
	Plan Administrator
	EAP Administrator

Phone: _____

TERMINATION OF COVERAGE

What is a *Qualifying Event*?
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

Does *COBRA continuation coverage* ever end earlier than the maximum periods above?
Are retirees covered under this plan? _____

CLAIM PROCEDURES

Who are claims submitted to:

	TPA
	Plan Administrator

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 *child,* regardless of age who is mentally or physically incapable of sustaining his own living.
	OR An e*mployee*'s *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

"Physician" means a**…**

	Doctor of Medicine (MD)
	Doctor of Osteopathy (DO)
	Doctor of Podiatry (DPM)
	Doctor of Chiropractic (DC)
	Psychologist (PhD)
	Other:
	Other:

"Provider" means a *physician, a***…**

	Licensed speech or occupational therapist
	Licensed professional physical therapist
	Physiotherapist
	Licensed professional counselor
	Certified nurse practitioner
	Other:
	Other:

MISCELLANEOUS INFORMATION

Who pays the cost of the *Plan*? *(please choose)*

	The *Plan sponsor* is responsible for funding the *Plan* and will do so as required by law. To the extent permitted by law, the *Plan sponsor* is free to determine the manner and means of funding the *Plan*. The amount of the *participant's* contribution (if any) will be determined from time to time by the *Plan sponsor*, in its sole discretion.
	Under the *EAP* counseling portion of the program, up to [_____] counseling sessions per individual per problem or concern per year with an *EAP* counselor are a free service and are prepaid by the *company*. Sometimes, additional counseling or specialized treatment is required that is outside of the *EAP* benefit. In this case, you would be responsible for any cost. This additional cost may be partly covered under the Health *Plan*. See the Health *Plan* text if you are a member of that *Plan*. The resource, educational and referral services provided by the *third party administrator's* work/life services are available free of charge to *participants*. Organizations and services that these programs refer you to may charge a fee. The services you may select that do charge a fee are not provided free and are not a covered benefit of the *EAP*. These fees would be your responsibility to pay. For example any dependent care services or adult care services you might select would be your financial responsibility.

Will the *Plan* release my information to anyone? *(please choose)*

	For the purpose of determining the applicability of and implementing the terms of these benefits, the *Plan administrator* may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or *participant* for benefits under this *Plan*. In so acting, the *Plan administrator* shall be free from any liability that may arise with regard to such action; however, the *Plan administrator* at all times will comply with the *privacy standards*. Any *participant* claiming benefits under this *Plan* shall furnish to the *Plan administrator* such information as may be necessary to implement this provision.
	The *company* recognizes that confidentiality is a cornerstone for the success and effectiveness of the *EAP*. The *EAP* was designed to benefit *participants*. Your participation in the *EAP* including on line services and work life services will be treated confidentially in accordance with all state and federal laws. Local counseling offices are located away from the work site. Except in very unusual circumstances as prescribed by law (such as life threatening events), any private discussions an employee has with a counselor will not be disclosed to anyone. The *company* will not be aware of an employee's participation in the *EAP* unless the employee requests it. Should an employee wish the *company* to be aware of their participation or progress in the *EAP*, the employee must sign a release of information form to that effect. The *company* receives only a quarterly statistical report of usage. No names or other individual identifying information are included in these reports. In certain circumstances, an employee may have a problem that so seriously impacts work performance they may be terminated if their work performance does not improve. In these cases, the employee's supervisor may refer the employee to the *EAP* as a condition of continued employment. Once the initial contact is made between the employee and the *EAP*, the supervisor will receive no information regarding the employee's participation and progress in the program, unless the employee signs the release of information form. As with voluntary use of the *EAP*, any case details will be held in strict confidence and will not be provided to the supervisor or the *company*, except as required by law, or as authorized by the employee.

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:

PLEASE LIST TITLES ONLY
