Checklist for
Medical & Vision Plan Document and Summary Plan Description

Is this Plan considered Grandfathered under the PPACA? _____

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: _____

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

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 *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:

	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.]
	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**.
	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: ☐ 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, you may 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."

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 *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

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		Amounts applied toward *deductibles*
	Chiropractic care		Penalty for non-*emergency* use of *hospital* emergency room

SCHEDULE OF MEDICAL BENEFITS

Please see the complete chart at the end of this checklist

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 *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

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 *participant* per *plan year*:

	PPO Network Providers	**Non-*PPO Network Providers***
Deductible • Individual	$[2,000 max for non-grandfathered]	$[_____]
• *Family Unit*	$[4,000 max for non-grandfathered]	$[_____]
Percentage Payable (unless otherwise stated)	[_____]%	[_____]%
Out-of-Pocket Expense Limit* for *essential health benefits* • Individual	$[6,350 max for non-grandfathered]	$[_____]
• Family Unit	$[12,700 max for non-grandfathered]	$[_____]
Out-of-Pocket Expense Limit* for all other benefits • Individual • Family Unit	$[_____] $[_____]	$[_____] $[_____]

*	Certain types of expenses are not accumulated toward this *out-of-pocket expense* limit. These expenses are identified in the section, "Your Costs."

**** 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? _____

Maximums stated apply to the amount of…

	…benefit payments unless otherwise indicated
	…covered expenses unless otherwise indicated

MEDICAL COVERED EXPENSES

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.

Skilled Nursing (or Extended Care) 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*.

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.

Surgical Inpatient and Outpatient Services

Anesthesia Services

Covered expenses do not include anesthesia administered by the surgeon *physician*.

OPTIONAL – KEEP or REMOVE

***Surgical* Assistants**

Coverage will be provided for these services only when rendered on an *inpatient* basis, and only when the *hospital* does not employ interns and residents qualified to perform the service.

OPTIONAL – KEEP or REMOVE

Does the Plan allow…

	…all secondary and subsequent procedures at a single UCR percentage
	…secondary procedures at a higher percentage than third and subsequent procedures

Hospital Emergency Room Services
Covered expenses include:

- *Emergency* treatment of an *accidental injury*.
  However, you must pay a $[_____] penalty if the *Plan* determines the charges include a non-*emergency* use of *hospital* emergency room facilities.
  OPTIONAL – KEEP or REMOVE

- *Emergency* treatment of an *illness.*
  [However, you must pay a $[_____] penalty if the *Plan* determines the charges include a non-*emergency* use of *hospital* emergency room facilities.
  OPTIONAL – KEEP or REMOVE

A penalty will be applied once to each…

	…*provider*...
	…emergency room visit…

…when the care does not qualify as *emergency* care.

A*ccident* Expense Benefit
Covered expenses in connection with *injuries* which are *incurred* within [_____] days of the *accident* will be reimbursed as shown in the "Schedule of Benefits." *Covered expenses incurred* more than [_____] days from the date of the *accident* will be reimbursed based on the type of service listed elsewhere in the "Schedule of Benefits." The benefits under this provision will be paid first before the benefits under other provisions of the *Plan* may be paid.
OPTIONAL – KEEP or REMOVE

Outpatient Facility Fees

Pre-Admission Testing
Benefits are provided for *pre-admission testing* for expenses *incurred* within [_____] days prior to the scheduled *hospital* admission, and only when the testing is not duplicated on admission.

Biofeedback Services
Benefits…

	…are provided for biofeedback.
	…are provided for biofeedback [as part of a program approved by the *Plan Administrator* for pain management.]
	…are not provided for biofeedback.
	…are not provided for biofeedback [as part of a program approved by the *Plan Administrator* for pain management.]

***Physician's* Office Services**

Office Visits
Covered services include the services of a *physician's* assistant ("P.A.") rendered under the supervision of the *physician*, and billed by the *physician*.
OPTIONAL – KEEP or REMOVE

Allergy Care
Covered services include the services of a *physician's* assistant ("P.A.") rendered under the supervision of the *physician*, and billed by the *physician*.
OPTIONAL – KEEP or REMOVE

Injections
Covered services include the services of a *physician's* assistant ("P.A.") rendered under the supervision of the *physician*, and billed by the *physician*.
OPTIONAL – KEEP or REMOVE

Diagnostic X-ray and Laboratory Services
Covered services include the services of a *physician's* assistant ("P.A.") rendered under the supervision of the *physician*, and billed by the *physician*.
OPTIONAL – KEEP or REMOVE

Other Covered Expenses

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

Infertility Treatment
Covered expenses for infertility treatment include, but are not limited to, in-vitro fertilization, gamete intrafallopian transfer (GIFT), fertility *drugs,* artificial insemination, zygote intrafallopian transfer (ZIFT), reversal of a sterilization procedure, surrogate mother or donor eggs.
OPTIONAL – KEEP or REMOVE

Other *Covered Expenses* Also Include:

- **Blood transfusions and blood products,** to the extent not replaced. The Plan…

	…will cover expenses in connection with autologous blood acquisition and storage.
	…will not cover expenses in connection with autologous blood acquisition and storage.

- **Cochlear implants**
  OPTIONAL – KEEP or REMOVE

- **Orthotics**
  OPTIONAL – KEEP or REMOVE

- **Growth hormone therapy** as part of a treatment program approved by the *Plan Administrator*.
  OPTIONAL – KEEP or REMOVE

- **Surgical extraction of bone-impacted teeth**.
  OPTIONAL – KEEP or REMOVE

- **Prenatal vitamins.**
  OPTIONAL – KEEP or REMOVE

- **Sterilization procedures, elective.**
  OPTIONAL – KEEP or REMOVE

- **Acupuncture.**
  OPTIONAL – KEEP or REMOVE

- **Oral *surgical* procedures**, including:
  - Excision of tumors and cysts of the jaws, cheeks, lips, tongues, roof and floor of the mouth.
  - *Emergency* repair due to *injury* to sound natural teeth.
  - *Surgery* needed to correct accidental *injuries* to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
  - Excision of benign bony growths of the jaw and hard palate.
  - External incision and drainage of cellulitis.
  - Incision of sensory sinuses, salivary glands or ducts.

  OPTIONAL – KEEP or REMOVE

- **Non-*surgical* treatment of temporomandibular joint dysfunction.**
  OPTIONAL – KEEP or REMOVE

- **Chelation therapy** for a diagnosis of lead poisoning, or a diagnosis of anemia for a *child*.
  OPTIONAL – KEEP or REMOVE

Replacement of Organs/Tissues and Related Services

Note: There is new optional wording in the library for this section. It does not require prior approval, and it contains the conditions under which the plan will review a proposed transplant for approval.

Insert Library Option M2? Yes_____ No_____

The *Plan Administrator* strongly recommends that any *participant* who is a candidate for any transplant procedure contact [_____] before making arrangements for the procedure. This communication may identify certain types of procedures, or expenses associated with the procedures, which will not be covered under the *Plan,* before the actual services are rendered.

In addition, the *Plan Administrator* has made arrangements with selected *providers*, called ["Centers for Excellence"], where a *participant* may receive care at a negotiated rate. Using a [Center for Excellence] will normally result in lower costs to the *Plan* and the *participant*. Please contact [UR firm/PPO] for additional information about [Centers for Excellence].

If "Centers for Excellence" is not the correct facility, please list: _____
What is the name of the UR Firm or PPO? _____
OPTIONAL – KEEP or REMOVE

Covered expenses include the following types of transplants:

Bone Marrow Transplants

Finding a donor who is an acceptable match for donation is important to the success of an allogenic/homologous bone marrow transplant. Because an immediate family member has the greatest chance of being a match, benefits for determining bone marrow matching are provided only for members of the immediate family and only if the proposed bone marrow transplantation is *medically necessary* and is not considered *experimental* or investigational. For purposes of this section, immediate family members include mother, father, biological *children* and biological siblings. If a donor match cannot be identified in the immediate family, the *Plan* will cover matching through a national registry.
OPTIONAL – KEEP or REMOVE

Other Benefits Related to Transplantation

Benefits are also provided for:

	The preparation, acquisition, transportation and storage of human organs, bone marrow, or human tissue.
	Transportation of the *participant*, if the organ recipient, to and from the site of the transplant procedure.
	Specific rules apply as to the payment of benefits for the donor and recipient of the transplanted organ, bone marrow, or tissue.

	When the transplant recipient and donor are **both** covered under this *Plan*, payment for *covered expenses* is provided for both, subject to each *participant's* respective benefit maximums.
	When the transplant recipient is covered under this *Plan* but the donor is not, payment for *covered expenses* is provided for both the recipient and the donor to the extent that charges for such services are not payable by any other source. Benefits payable on behalf of the donor are charged to the recipient's claim and applied to the recipient's maximums.

			When the transplant recipient is not covered under this *Plan* but the donor is covered, payment for *covered expenses* attributable to the donor is provided to the extent that charges for such services are not payable by any other source. Benefits are not provided for services attributable to the recipient.	
			No coverage is provided under this *Plan* for any expenses *incurred* by or on behalf of the donor.	

MEDICAL EXCLUSIONS AND LIMITATIONS

This Plan will not reimburse any expense that is not a *covered expense*. This *Plan* does not cover any charge for services or supplies:

- **Abortion.** That are *incurred* directly or indirectly as the result of an abortion except when the life of the mother would be threatened if the fetus were carried to term, or when complications arise.
  OPTIONAL – KEEP or REMOVE

- **Birth control *drugs* or devices.**

	For birth control *drugs* or devices, whether or not dispensed by prescription, that are purchased or prescribed for the sole purpose of preventing conception.
	For birth control *drugs* or devices, whether or not dispensed by prescription, that are purchased or prescribed for the sole purpose of preventing conception [unless covered by the provisions of your Prescription *Drug* Card Program].

- **Cochlear implants.** For cochlear implants.
  OPTIONAL – KEEP or REMOVE

- **Corrective shoes** For corrective shoes.
  OPTIONAL – KEEP or REMOVE

- **Dental *hospital* admissions.**

	Related to dental *hospital* admissions.
	Related to dental *hospital* admissions[, unless determined to be *medically necessary* because of a concomitant condition].

- **Dental prescriptions.** For dental prescriptions (e.g., Peridex, fluoride).
  OPTIONAL – KEEP or REMOVE

- **Eating disorders.** That are related to eating disorders (e.g., anorexia and bulimia). This does not apply to any care for an underlying *mental or nervous condition*.
  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

- **Excess over semi-private rate.** That are in excess of the semi-private room rate, except as otherwise noted.
  OPTIONAL – KEEP or REMOVE

- **Excluded providers and facilities.** That are rendered or provided by the following excluded providers or facilities:
  - Midwives;

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

    You should check your stop loss policy before implementing the option above in the exclusion and verify with the carrier that it is compatible with the policy exclusion. ***Otherwise, the plan may be obligated to cover expenses for which it has no stop loss coverage.***

- **Eye exercises or training and orthoptics.** For eye exercises or training and orthoptics.
  - This exclusion does not apply to benefits as noted in the Vision Care Benefits section.

  OPTIONAL – KEEP or REMOVE

- **Genetic testing and/or counseling.** For genetic testing or counseling.
  OPTIONAL – KEEP or REMOVE

- **Growth hormone therapy.** For growth hormone therapy.
  OPTIONAL – KEEP or REMOVE

- **Impotence; sexual dysfunction.** For impotence and sexual dysfunction treatment and medications, including, but not limited to, penile implants, sexual devices or any medications or *drugs* pertaining to sexual dysfunction or impotence.
  OPTIONAL – KEEP or REMOVE

- **Infertility treatment.** For infertility treatment, including, but not limited to, in vitro fertilization, gamete intrafallopian transfer (GIFT), fertility *drugs,* artificial insemination, zygote intrafallopian transfer (ZIFT), reversal of a sterilization procedure, surrogate mother or donor eggs.
  OPTIONAL – KEEP or REMOVE

- **Marital counseling.** For marital counseling.
  OPTIONAL – KEEP or REMOVE

- ***Never Events.*** In addition, serious preventable adverse events ("***never events***") will, in no event be covered under the *Plan*.
  OPTIONAL – KEEP or REMOVE

- **Obesity treatment.** For the purpose of weight loss.
  - This exclusion does not apply to benefits for surgical or non-surgical treatment of *morbid obesity* under a treatment plan that has been approved by the *Plan Administrator*.

  OPTIONAL – KEEP or REMOVE

- **Prenatal vitamins** For prenatal vitamins.
  OPTIONAL – KEEP or REMOVE

- **Vision correction.** For radial keratotomy, keratomileusis or other vision correction procedures.
  OPTIONAL – KEEP or REMOVE

- **Smoking cessation.** For smoking cessation programs, nicorette gum, nicotine transdermal patches or other treatment of tobacco dependency.
  OPTIONAL – KEEP or REMOVE

- **Travel.** For travel, even though prescribed by a *physician*.
  - This exclusion may not apply to a *participant* who is an organ transplant recipient to travel to and from the site of the transplant.
    OPTIONAL – KEEP or REMOVE

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

- **Vitamins.** For vitamins, except as specifically provided under this *Plan*.
  OPTIONAL – KEEP or REMOVE

- **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.

COST CONTAINMENT PROVISIONS

If pre-cert or utilization review is required for non-emergency inpatient admissions, please complete the following questions:

Which does the Plan have?

	Pre-cert Program *(Library Section 1)*
	Utilization Review Program *(Library Section 2)*

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

Because communication is the basis for the program, the *Plan* requires that you contact the Pre-certification Program administrator at least [_____] days before any non-*emergency inpatient* admission.

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: _____

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

	Adaptive services and equipment.
	Cardiac catheterization performed more than one time during any 12-month period.
	Cardiac rehabilitation programs.
	Chemotherapy.
	Cochlear implants.
	Corrective shoes.
	<table><tr><td></td><td>*Cosmetic* services for treatment of congenital malformations or *accidental injuries*.</td></tr><tr><td></td><td>*Cosmetic* services for treatment of congenital malformations or *accidental injuries*, [if *medically necessary*].</td></tr></table>
	Diabetic counseling.

	Dialysis.
	Durable medical equipment at or greater than a cost of $[_____]. This includes prosthetic, orthotic, or orthopedic appliances.
	Eating disorder programs.
	Growth hormone therapy.
	Home health care services.
	Hospice care services.
	Magnetic resonance imaging ("MRI").
	Morbid obesity – non-*surgical* treatment.
	Morbid obesity – *surgical* treatment.
	Occupational therapy.
	Pain management programs.
	Physical therapy.
	Positron emission tomography (PET) scan.
	Speech therapy.
	Stripping and ligation of varicose veins.

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

If the Plan has a pre-cert or utilization review program for outpatient services, please complete the following questions:

Which does the Plan have?

	Pre-cert Program *(Library Section 1)*
	Utilization Review Program *(Library Section 2)*

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 any non-*emergency inpatient* admission.

Concurrent *Outpatient* Review
Name, address and phone number of UR Company: _____

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

	Adaptive services and equipment.
	Cardiac catheterization performed more than one time during any 12-month period.
	Cardiac rehabilitation programs.

	Chemotherapy.
	Cochlear implants.
	Corrective shoes.
	<table><tr><td></td><td>*Cosmetic* services for treatment of congenital malformations or *accidental injuries*.</td></tr><tr><td></td><td>*Cosmetic* services for treatment of congenital malformations or *accidental injuries*, [if *medically necessary*].</td></tr></table>
	Diabetic counseling.
	Dialysis.
	Durable medical equipment at or greater than a cost of $[_____]. This includes prosthetic, orthotic, or orthopedic appliances.
	Eating disorder programs.
	Growth hormone therapy.
	Home health care services.
	Hospice care services.
	Magnetic resonance imaging ("MRI").
	Morbid obesity – non-*surgical* treatment.
	Morbid obesity – *surgical* treatment.
	Occupational therapy.
	Pain management programs.
	Physical therapy.
	Positron emission tomography (PET) scan.
	Speech therapy.
	Stripping and ligation of varicose veins.

Penalty

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

- *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 $[_____], and this penalty 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.

If the Plan has a voluntary pre-determination of benefits, please complete the following questions:

[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*.

This information should be submitted to:

	Utilization Review Company
	Third Party Administrator
	Other:

Please list name, address, and phone number of the above-selected item: _____

_____

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

Voluntary Second *Surgical* Opinions
This information should be submitted to:

	Utilization Review Company
	Third Party Administrator
	Other:

Please list name, address, and phone number of the above-selected item: _____

_____

Required Second *Surgical* Opinions - Penalty

	Covered expenses for the fees of…
	…the surgeon…
	…all *providers*…
	…will be reduced by…
	…$[_____].
	…[_____]% to a maximum of $[_____].
	Benefits otherwise payable for…
	…the surgeon…
	…all *providers*…
	will be reduced by…
	…$[_____].
	…[_____]% to a maximum of $[_____].

Surgical Procedures requiring Second Opinions
The following *surgical procedures* require a second opinion in order to avoid incurring a penalty to otherwise *covered expenses*.

	Carotid endarterectomy (cutting and cleaning of the main artery in the neck).
	Coronary bypass (fixing the blood flow for muscles of the heart).
	Dilation and curettage (D & C) (cleansing the surface of the uterus).
	Mastectomy (removal of breast) and other breast *surgery*, except aspiration biopsy.
	Prostatectomy (removal of the prostate).
	Transurethral resection (type of prostate *surgery*).

If the Plan has a Case Management program, please complete the following questions:

Who administers the Case Management Program? _____

What is the phone number: _____

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

Prescription *Drugs* – Medical Plan	
Prescription *Drug*s — Brand Name — Medical *Plan*	
Prescription *Drugs* — Generic — Medical *Plan*	

Prescription Drug Card Program	
Prescription Drug Card Program — Brand Name	
Prescription Drug Card Program — Brand Name, No Generic Available	
Prescription Drug Card Program — Generic	
Prescription Drug Card Program: Mail Service — Brand Name	
Prescription Drug Card Program: Mail Service — Brand Name, No Generic Available	
Prescription Drug Card Program: Mail Service — Generic	

Which of the following items are not covered under Rx benefits:

	Anorexiants (weight control *drugs*)**.**
	Fertility medications.
	Growth hormones.
	Non-legend *drugs*, other than insulin.
	Norplant.
	Oral contraceptives.
	Retin A.
	Rogaine.
	Smoking cessation products.
	Therapeutic devices or appliances, support garments, and other non-medical substances.
	Vitamins, except prenatal.
	Workers' Compensation: prescriptions which an eligible person is entitled to receive, without charge, under any workers' compensation law, or under any municipal, state or federal program.

VISION CARE BENEFITS

Limitations For First-Year Enrollees:
During the first 12 months of coverage under the Plan, benefits will be limited as follows:

	No coverage will be provided for lenses, including contact lenses, or frames during the first [_____] months of coverage under the Plan.
	The plan year maximum for all benefits payable will be limited to $[_____].

Maximum Benefits

Eye exam	
Frame-type lenses, per pair – single vision	
Frame-type lenses, per pair – bifocal	
Frame-type lenses, per pair – trifocal	
Frame-type lenses, per pair – lenticular	
Frames, per pair	
Contact Lenses, per pair	
All Vision Care Services	

Deductibles and Copayments

The following Deductible amounts are applied per *plan year:*

	***Deductible* Amount**
• Individual	

The following Copayment amounts are applied per service:

Type of Expense	**Copayment Amount**
Eye Exam	
Lenses	

• Family Unit	

Frames Contact Lenses	

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

Vision Care Expenses		
Type of Expense	**Payment Level**	**Limits:**
Eye Exam		
Lenses for Frames		
Contact Lenses		
Frames		

Covered expenses incurred by any…

	…*covered person*…
	…*covered person* 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

Vision Care Covered Expenses
The following is a brief description of the types of expenses that will be considered for coverage under the *Plan*…

	Tints, scratch resistant surfaces.
	Oversized lenses.

GENERAL EXCLUSIONS AND LIMITATIONS

- **Complications.**

	That result from complications arising from a non-covered *illness* or *injury*, or from a non-covered procedure.
	That result from complications arising from a non-covered *illness* or *injury*, or from a non-covered procedure. [This exclusion does not apply to *complications of pregnancy*.]

- **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

- **Illegal act.**

	Related to *injuries* sustained, or an *illness* contracted, during the commission, or attempted commission, of a felony
	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*.
	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.
  OPTIONAL – KEEP or REMOVE
  This exclusion does not apply to surcharges required by law to be paid by the *Plan* in applicable states.
  OPTIONAL – KEEP or REMOVE

- **War.**
  This exclusion does not apply to *participants* who are not members of the *uniformed services*.
  OPTIONAL – KEEP or REMOVE

- **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 or while self-employed, without regard to whether such *illness* or *injury* entitles the *participant* to workers' compensation or similar benefits.
	Related to an *illness* or *injury* 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*? _____

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, the TPA, or the Utilization Review Company ***(include address & fax number)***? _____

When Health Claims Must Be Filed
Post service 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 [_____] **(days, months OR year(s))** from 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.

Full and Fair Review of All Claims

- *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;

Adverse Decision on First Appeal; Requirements for Second Appeal – *if applicable*
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.

External Review – (ONLY complete if the Plan is a Non-Grandfathered Plan)
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

SUBROGATION, THIRD PARTY RECOVERY AND REIMBURSEMENT

Which subrogation language should the Plan contain:

	The Plan requires the plan member **and** the plan member's attorney to sign a reimbursement agreement, and it does **not** allow for any payment of pro-rata fees to that attorney. ***RECOMMENDED LANGUAGE***
	The Plan **requires** the attorney to sign a reimbursement agreement, but **allows** for payment of his fees
	The Plan does **not require** the attorney to sign a reimbursement agreement, and **does not allow** for payment of his fees

"Plan's Pro Rata Share of Attorneys' Fees"
"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.

DEFINITIONS

"Administrative period" means period of time immediately following an *initial measurement period* or a standard measurement period when the *participating employer* determines which "variable hour" and/or "ongoing" *employees* are eligible for coverage and to notify and enroll those eligible *employees.* The *administrative period* lasts [_____] ***[90 days is standard]*** days.

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

"Chiropractic care" means…

	All services related to a chiropractic visit

OR (choose covered services)…

	office visits
	x-rays
	Manipulations
	Supplies
	Heat treatment
	Cold treatment
	Massages

Does the plan cover complications of pregnancy for dependent children? _____

"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 *employee's child*, regardless of age, who is mentally or physically incapable of sustaining his or her own living.
	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 or her own living.

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

Written proof of such incapacity and dependency satisfactory to the *Plan* must be furnished and approved by the *Plan* within [_____]days after the date the *child* attains the limiting age under the 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."

"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

"Impregnation and infertility treatment" means…

	…artificial insemination,
	…fertility *drugs*,
	…G.I.F.T. (Gamete Intrafallopian Transfer),
	… impotency *drugs* such as Viagra™,
	… in-vitro fertilization,
	… sterilization,
	…reversal of a sterilization operation,
	… surrogate mother,
	…donor eggs,

… or any type of artificial impregnation procedure, whether or not such procedure is successful.

"Initial measurement period" means the initial [_____] [6-12 (that is no shorter in duration than the *standard measurement period*] consecutive calendar month period of employment for a variable hour *employee* that the *participating employer* will use to look-back and determine your employment status for benefit purposes.

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

"Stability period" means the [_____] [6-12 (that is no shorter in duration than the *standard measurement period*] consecutive calendar month period that begins after the *administrative period*.

"Standard measurement period" means the [_____] [3-12] consecutive calendar month period that your *participating employer* will use to look-back and determine your employment status for benefit purposes.

"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:

Payment Levels and Limits
The *deductible* will not apply to *covered expenses* unless otherwise noted in this section.

***Hospital Inpatient* Services**			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits:**
Medical/Surgical Room & Board & Ancillary			
Intensive Care Unit Room & Board			
Personal Items			
Extended Skilled Nursing Facility, Room & Board & Ancillary			
Rehabilitation Facility Room & Board & Ancillary			

***Hospital* Newborn Care**			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits:**
Neo-Natal Room & Board & Ancillary			
Newborn Nursery & Ancillary			

***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**
Physician Medical *Hospital* Visit			
Physician Newborn Visit			
Consultant Visit			

***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			

Surgical *Inpatient* Services			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Anesthesia			
Assistant Surgeon			
Obstetrical			
Surgeon			

Surgical Outpatient Services			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Anesthesia			
Assistant Surgeon			
Obstetrical			
Surgeon			

Professional Interpretation Services *Inpatient* and Outpatient			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Pathologist Fee			
Radiologist Fee			

***Hospital Emergency* Room Services**			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Emergency Room - Accident $[_____] penalty for non-*emergency* use of *emergency* facilities			
Emergency Room Physician – Accident			
Emergency Room – Illness $[_____] penalty for non-*emergency* use of *emergency* facilities			
Emergency Room Physician – Illness			

Accident Expense Benefit			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
All *Covered Expenses* Within [_____] days of the *Accident*			

Outpatient *Diagnostic Services*			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Diagnostic Laboratory			
Diagnostic X-ray			
Pre-Admission Testing Within [_____] days of admission			

Outpatient Facility Fees			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
*Ambulatory Surgery Cente*r			

Outpatient Therapy Services			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Biofeedback — Medical			
Cardiac Rehabilitation			
Chemotherapy			
Dialysis			
Intravenous Therapy			
Occupational Therapy			
Physical Therapy			
Radiation Therapy			
Speech Therapy			

Physician's Office Services			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Office Visit			
Allergy Care (extracts, serums, injections)			
Injections			
Diagnostic X-ray			
Diagnostic Laboratory			

Chiropractic Services			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Chiropractic Visit and Therapies			
Chiropractic X-ray			

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*			
Mental or Nervous Disorder Office Visit - Outpatient			
Mental or Nervous Disorder Testing and Evaluation			
Social Worker Visit			
Substance Abuse Visit Outpatient			

Preventive Care Services			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Gynecology Exam			
Immunization (up to [_____] years of age)			
Mammogram (for asymptomatic females over the age of [_____])			
Pap Test			
Preventive Lab Screening			
General Medical Examination			
Eye Examination			
Hearing Examination			
Preventive X-ray Screening			
Prostate Examination			
Well *Child* Care (for *children* up to [_____] [years/months] of age)			

Second Surgical Opinion Services			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Office Visit For Second Surgical Opinion			

Other *Covered Expenses*			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Ambulance — Air Transportation			
Ambulance — Ground Transportation			
Blood and Administration			
Durable Medical Equipment			
Home Health Services			
Hospice			

Other *Covered Expenses*			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Lenses Following Cataract *Surgery*			
Oxygen and Administration			
Prosthetic Devices			
RN & LPN Services Outpatient			
[For non-grandfathered plans ONLY] Routine Patient Costs for an Approved Clinical Trial			

Replacement of Organs/Tissues (Transplant Procedures)			
Percentage Payable For:	***PPO Network Provider***	**Non-*PPO Network Provider***	**Limits**
Organ procurement and acquisition			
Transplant Procedure			