MEGA WRAP CHECKLIST

General Information

Is this Plan considered Grandfathered under the PPACA? _____

Employer's Full Name: _____

Address: _____

_____

Telephone: _____

Employer Identification Number: _____

Plan Sponsor *(if different from Employer)*: _____

Plan Administrator *(if different from Employer)*: _____

Original Effective Date of this Plan (month & year): _____
(Date when you plan to distribute this document – must be at least 20 days following submission)

Restated Date of this Plan: _____

Plan Year: _____ through _____

ERISA Plan Number: _____

Agent for Service of Process: _____

Address: _____

_____

Telephone: _____

Trustees *(if any)*: _____

Address: _____

_____

Telephone: _____

Third Party Administrator *if any)*: _____

Address: _____

_____

Telephone: _____

Title or Name of Contact Person for Questions: _____

Telephone: _____
Fax: _____
Email: _____

Type of Benefits Covered under this Wrap: Self-funded **OR** Fully-Insured **OR** Both

Participating Employer(s): _____
_____
_____

(Employers whose employees are eligible to participate in this plan – must be affiliated companies – if you are unsure whether the entities meet ERISA's requirements for affiliation, please describe the relationship.)

Does HIPAA apply to the Employer(s)? Yes _____ No _____
(HIPAA applies to group health plans and group health insurance coverage for any plan year if, on the first day of the plan year, the plan has 2 or more participants who are current employees. It does not apply to any plan or coverage providing "excepted benefits," which include limited scope dental or vision benefits if offered separately from any other benefits.)

Does COBRA apply to the Employer(s)? Yes _____ No _____
(COBRA applies to all group health plans maintained by all public and private employers, other than churches; governmental entities of the U.S., the District of Columbia and U.S. territories and possessions; state and local government agencies that are not recipients of PHSA fund; and employers, including related employers, whose total number of employees (full-time and part-time), including leased employees, was less than 20 on at least 50% of the typical business days in the prior calendar year.)

Does FMLA apply to the Employer(s)? Yes _____ No _____
(FMLA applies to private sector employers of 50 or more employees and public agencies.)

Is this a Union Plan (maintained pursuant to a collective bargaining agreement): _____
If so, what is the Name of the Union: _____
If so, what is the Local Number: _____
If so, what is the Local Location: _____

Is this a Government Plan: _____
If so, is HIPAA applicable: _____
(A "Government Plan" is any plan established or maintained for its employees by the U.S. Government, the government of any state or political subdivision thereof, or by any agency or instrumentality of the foregoing. It also includes any plan to which the Railroad Retirement Act of 1935 or 1937 applies, and which is financed by contributions required under that Act, and any plan of an international organization which is exempt from taxation under the provisions of the International Organizations Immunities Act.)

Is this a Church Plan: _____

If so, is HIPAA applicable: _____

(A "Church Plan" is a plan established and maintained for its employees or their beneficiaries by a church or by a convention or association of churches which is exempt from tax under §501 of the Internal Revenue Code of 1954 ("IRC"). It does not include a plan where the employees or their beneficiaries are employed in connection with one or more unrelated trades or businesses (as described in IRC §513) or if less than substantially all of the individuals included in the plan are employees or beneficiaries. "Employee" means a duly ordained, commissioned or licensed minister of a church in the exercise of his ministry, regardless of the source of his compensation, or an employee of an organization which is exempt from tax under IRC §501 and which is controlled by or associated with a church or a convention or association of churches.)

Type of Benefit Plans (Administration): ***(Please list the names, addresses, and telephone numbers of all plans included in this Mega Wrap. Also note whether they are self-funded or fully insured):***

PLEASE NOTE that ALL of the benefits listed below MUST have a Certificate or fully complaint Summary Plan Description in order to be attached and incorporated to this Mega Wrap. If you are listing a benefit below that does not have a Certificate or SPD, one must be created so that it can be attached to this Plan Document.

FULLY INSURED BENEFITS:

SELF-FUNDED BENEFITS:

Eligibility for Participation

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

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.

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

"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.

"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.

The *standard measurement period* starts on [date]: _____ and ends on [date]: _____

Termination of Coverage

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

State Continuation Coverage
After exhausting your *COBRA continuation coverage*, you may be eligible for [_____] state continuation coverage for [_____] additional months. Please contact your *Plan Administrator* for additional information.
OPTIONAL – KEEP or REMOVE

Medical Benefits

Primary Care Providers
A current list of *PPO providers* is available, without charge, through the *Third Party Administrator's* website (located at www.[_____].com).

[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 *insurance carrier.*
VARIABLE – KEEP OR REMOVE

HIPAA Privacy

Please list the titles of all persons with access to PHI:

_____ _____

_____ _____

_____ _____