Checklist for
Prescription Drug 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): Prescription Drug _____

Participating Employers: _____

_____

Third Party Administrator: _____

_____

Is this a Union Plan: _____
If so, what is the Name of the Union: _____
What is the Local Number: _____

Is this a Government Plan: _____

If so, is HIPAA applicable: _____

Does the Plan comply with any state mandated benefits: _____

List all states in which the Plan has Participants: _____

Is this a Church Plan: _____

If so, is HIPAA applicable: _____

Does the Plan comply with any state mandated benefits: _____

List all states in which the Plan has Participants: _____

ELIGIBILITY FOR PARTICIPATION

Am I eligible to participate in the *Plan*?

As a full-time *employee* regularly scheduled to work at least [_____] hours per week, you are eligible for coverage when you…

	Complete your *waiting period* of [_____] days of continuous *active employment.*
	Begin *active employment.*
	Other (please specify):

As a part-time *employee* regularly scheduled to work at least [_____] hours per week, you are eligible for coverage when you…

	Complete your *waiting period* of [_____] days of continuous *active employment.*
	Begin *active employment.*
	Other (please specify):

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 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:

	If your plan requires that newborn children must be enrolled within a specified time period from birth, use this section: you must make written application and agree to any required contributions during the first [_____] days from the *child's* birth. Coverage for the *dependent child* will then become effective from the moment of birth.
	If your plan allows a newborn child to be covered for a specified number of days from birth, then requires enrollment to continue coverage beyond this initial period of coverage, use this section: the *dependent child* will be covered from the moment of birth for [_____] days. If you wish to continue coverage beyond this [_____]-day period, you must make written application for coverage and agree to any required contribution **during the first [_____]-day period from birth**.
	If your plan allows a newborn child to be covered for a specified number of days from birth, then requires enrollment to continue coverage beyond this initial period of coverage except when the employee is already making the maximum contribution for dependent coverage, use this section: the *dependent child* will be covered from the moment of birth for [_____] days. If you wish to continue coverage beyond this [_____] -day period, you must make written application for coverage and agree to any required contribution **during the first [_____] -day period from birth**. However, if you already have coverage for *dependents* and are making the maximum required contribution for *dependent* coverage under the *Plan,* the requirement for written application will be waived.

- If you acquire a *dependent* while you are eligible for coverage for *dependents*, coverage for the newly acquired *dependent* will be effective on the…

	first day of the month following the date the *dependent* becomes eligible…
	first day following the date the *dependent* becomes eligible…
	Other (please specify):

…provided you make written application for the *dependent* and agree to make any required contributions, within [_____] days of the date of eligibility.

What if I do not enroll during my original eligibility period and later decide to apply for coverage?

	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, 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

SELECTION OF YOUR PRESCRIPTION DRUG PROVIDER

If the plan does not use a pharmacy network, you may delete this section in its entirety. If the plan uses a pharmacy network, or is a Pharmacy Benefit Manager drug card program, please complete the following:

	No coverage if purchased at a non-participating pharmacy.
	Purchases at a non-participating pharmacy are covered for emergencies (as defined)
	Other (please specify):

A current list of *PPO network providers* is available, without charge, through the *third party administrator* or through the website located at [_____].

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

There are three library options for coverage. Select one of the following:

_____ Library Option P1 is designed for a traditional plan that requires satisfaction of a deductible and applies coinsurance or copayments, and uses a pharmacy network for discounts.

_____ Library Option P2 is designed for a traditional plan that requires satisfaction of a deductible and applies coinsurance or copayments, and does not use a pharmacy network for discounts.

_____ Library Option P3 is designed for a drug card program with copayments, and includes a mail-order option.

Note: Covered drugs, excluded drugs and drugs that require prior authorization must be customized for each plan. A list of drugs in each of these categories should be created separately based upon the plan or program, and attached to this checklist for entry into the document. The document template contains some examples only.

If prescription drugs are part of a drug card program or the plan uses a pharmacy network for discounts, please complete the following sections:

If a *participant*, who is traveling and is at least [_____] miles from home, must purchase a prescription *drug* at a non-participating pharmacy due to an *emergency*, the *Plan* will reimburse the cost of the *drug* at the non-*PPO Network Provider* percentage payable after satisfaction of the non-*PPO Network Provider deductible,* shown in the "Schedule of Benefits."

If prescription drugs are not purchased through the Plan's Rx card program, will they be covered? _____

Who administers the *Plan's* Rx Card Program: _____

What is the administrators phone number: _____

Where are mail order forms obtained: _____

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? _____

Is legal separation a qualifying event? _____

Are retirees covered under the *Plan*? _____

How long does *COBRA continuation coverage* last?
When the *qualifying event* is "entitlement to *Medicare*," the 36-month continuation period is measured from the date of the original *qualifying event*.
OPTIONAL – KEEP or REMOVE

CLAIM PROCEDURES

Does the plan have one or two appeal levels? _____

Should questions regarding claims be directed to the Plan Administrator or the TPA? _____

Post service claims must be filed within [_____] days of the date charges were incurred.

When Claims Must Be Filed
Post-service claims must be filed with the *third party administrator* within [_____] of the date charges for the prescription *drugs* 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 [_____] **(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.

Second Appeal Level (ONLY complete 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 language should the Plan contain:

	COB with full "allowable expenses" and COB recoverable on a calendar year basis
	"Carve-out" on a per-claim basis
	Full allowable expenses on a per-claim basis

Order of Benefit Determination

- If the person on whose expenses the claim is based is an inactive employee (e.g. retired or on layoff) or the dependent of an inactive employee, the benefits of the plan covering the person in an active status will be determined before the benefits of a plan covering the person in an inactive status; and
  OPTIONAL – KEEP or REMOVE

DEFINITIONS

This section in the template document contains several definitions that are not currently part of the document text. They are being included so that they will be available should the need arise for customizing a particular plan. Unused definitions may be deleted. Please remember to italicize any definitions that you choose to use in the document text.

"Business associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this *plan*, shall mean _____
VARIABLE – KEEP or REMOVE

"Covered entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this *plan*, shall mean _____
VARIABLE – KEEP or REMOVE

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

- An e*mployee*'s lawfully married spouse possessing a marriage license who is not divorced from the e*mployee.*

  For purposes of this section, "marriage or married" means a legal union between one man and one woman as husband and wife
  OPTIONAL – KEEP or REMOVE

- 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.
	OR An e*mployee*'s unmarried *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 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."

"Impregnation and infertility treatment" means…

	…fertility *drugs*,
	… impotency *drugs* such as Viagra™,

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

"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:
