TAFT HARTLEY CHECKLIST

Representative _____

Articles I & II
Establishment of the Plan; Adoption of the Plan Document & Summary Plan Description and Introduction and Purpose; General Plan Information

Is this Plan considered Grandfathered under the PPACA? _____

Client's Full Name: _____

Internal Group Number: _____

Address: _____

_____

If above address is a post office box, street address: _____

_____

Telephone Number: (_____)_____

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: _____

Participating Employers: _____

_____

_____

Board of Trustees: _____
(name, address, phone) _____

_____

Third Party Administrator: _____
(name, address, phone) _____
_____

Union Trustees: _____
(name, address, phone) _____
_____

Employer Trustees: _____
(name, address, phone) _____
_____

Is this a Union Plan: _____

What is the Name of the Union: _____
If so, what is the Local Number: _____
What is the Local Location: _____

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: _____
_____

Article III
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.

"Chiropractic Care" shall mean…

Yes	No	Item
		Office visits
		X-rays
		Manipulations
		Supplies

Yes	No	Item
		Heat treatment
		Cold treatment
		Massages

"***Deductible***" shall mean…

An amount of money that is paid once a [_____] **(Plan or calendar)** year per Participant [_____] **(and Family Unit)**.

Each [_____] **(Plan or calendar)** year, a new Deductible amount is required…

Covered expenses incurred in, and applied toward, the Deductible in the last three months of a [_____] **(Plan or calendar)** year by a Participant [_____] **(and Family Unit)** will be applied toward the Deductible in the next [_____] **(Plan or calendar)** year.
VARIABLE – KEEP OR REMOVE

"***Dependent***" shall mean …

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;
VARIABLE – KEEP or REMOVE

An Employee's Child [who was continuously covered prior to attaining the limiting age under the bullets above,]…
VARIABLE – KEEP or REMOVE

[Such Child must have been mentally or physically incapable of earning his own living prior to attaining the limiting age under the bullets above.]
VARIABLE – 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.
VARIABLE – KEEP or REMOVE

"***Employee***" shall mean a person who is a regular full-time Employee of the Participating Employer, regularly scheduled to work for the Participating Employer in an employer-Employee relationship. Such person must be scheduled to work at least [_____] hours per week in order to be considered "full-time."

"***Impregnation and Infertility Treatment***"…

Are the following items covered:

Yes	No	Item
		Artificial insemination
		Fertility Drugs
		G.I.F.T. (Gamete Intrafallopian Transfer)
		Impotency Drugs, such as Viagra™

Yes	No	Item
		In-vitro fertilization
		Sterilization operation
		Reversal of a sterilization operation
		Surrogate mother
		Donor eggs

"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.

"***Out of Area***" shall mean a geographic area, as determined by the Plan Administrator, at the time each Participant becomes eligible for coverage under this Plan.
DEFINITION – KEEP OR REMOVE

"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)].

Article IV
Eligibility For Coverage

4.01 Eligibility for Individual Coverage

Each Employee will become eligible for coverage under this Plan with respect to himself on the…

	1st day of the month following completion of a Service Waiting Period of [_____] days
	day of completion of a Service Waiting Period of [_____] days
	1st day following completion of a Service Waiting Period of [_____] days
	Date of hire

As a full-time Employee regularly scheduled to work at least [_____] [no less than 30] hours per week or 130 hours of service in a calendar month, you are eligible for coverage when you…

	…complete your Service Waiting Period of [_____] days
	…begin Active Employment
	Other:

Each Employee who was covered under the Prior Plan, if any, will be eligible on the Effective Date of this Plan. Any Service Waiting Period or portion thereof satisfied under the Prior Plan, if any, will be applied toward satisfaction of the Service Waiting Period of this Plan. [If employment is terminated and the Employee returns to Active Employment within [_____] from the date of termination, the Service Waiting Period will be waived and coverage will take effect on the first day the Employee returns to Active Employment.

VARIABLE – KEEP OR REMOVE

If employment is terminated and the Employee returns to Active Employment within [_____] from the date of termination, the Service Waiting Period will be waived and coverage will take effect on the first day the Employee returns to Active Employment.

VARIABLE – KEEP OR REMOVE

4.02 Eligibility Dates for Dependent Coverage

Spouses eligible for coverage under another group plan are not eligible for coverage under the Plan, unless your spouse must wait to enroll during an open or special enrollment period of the other group plan. Such spouses may continue their coverage under the Plan until they are able to enroll in the other group plan at the time of an open or special enrollment period.

VARIABLE – KEEP OR REMOVE

4.03 Effective Dates of Coverage; Conditions

Option I - Birth of Dependent Child. If a Dependent Child is born after the date the Employee's coverage for himself under the Plan becomes effective, coverage shall take effect from and after the moment of birth, to the extent of the benefits provided herein. If the Employee does not have coverage under this Plan for any Dependents at the date of such Child's birth, then coverage for such Child shall continue for 31 days. After the 31-day period, coverage shall continue only if the Employee makes written application to the Plan for such Child and agrees to make any required contribution. Such written application is not required if the Employee has coverage under this Plan for Dependents at the date of such Child's birth.

OR

Option II - Birth of Dependent Child. If a Dependent Child is born after the date the Employee's coverage for himself under the Plan becomes effective and the Employee has coverage under this Plan for his Dependents, coverage shall take effect from and after the moment of birth, to the extent of the benefits provided herein. Such coverage shall continue for the 31-day period commencing on the date of birth. In order to continue such coverage after the 31st day, prior to the end of the 31-day period, the Employee must make written application to the Plan for such Child and agree to make any required contribution.

If the Employee does not have coverage under this Plan for any Dependents at the date of such Child's birth, then coverage for such Child shall be available only if, during the first 31 days following the date of birth, the Employee makes written application to the Plan for such Child and agrees to make any required contribution. In that event, coverage will be effective as of the moment of birth, to the extent of the benefits provided herein.

PLEASE CHOOSE ONE – OPTION I OR OPTION II

4.04 Special and Open Enrollment

4.04A Loss of Other Coverage

An Employee who is already enrolled in a benefit package may enroll in another benefit package under the Plan if a Dependent of that Employee has a special enrollment right in the Plan because the Dependent lost eligibility for other coverage. The Employee must make written application for special enrollment in the new benefit package within 30 days of the date the other health coverage was lost.

VARIABLE – KEEP OR REMOVE

4.04B New Dependent

If the conditions for special enrollment are satisfied, coverage for the Employee and his 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.

4.04D Open Enrollment

Participants may enroll for coverage during Open Enrollment Periods. Coverage for Participants enrolling during an Open Enrollment Period will become effective on [_____] 1, unless the Employee has not satisfied the Service Waiting Period, in which event coverage for the Employee and his Dependents will become effective on the day following completion of the Service Waiting Period.

"Open Enrollment Period" shall mean the month of [_____] in each Plan Year.

4.04E Effective Date of Coverage; Conditions

Coverage for Participants enrolling during a Special Enrollment Period will become effective on the first day…

	…following the enrollment…
	…of the month following the receipt by the Plan of the Participant's enrollment form, in the case of enrollment…

…due to loss of coverage or marriage, and on the date of birth, adoption or placement for adoption in the case of such events.

Article V
Termination of Coverage

5.01 Termination Dates of Individual Coverage

Coverage under the plan will terminate on the…

	…date of termination
	…last day of the month following termination

Article VI
Continuation of Coverage

6.01 Employer Continuation Coverage

Is coverage continued in the event of:

Yes	No	Item	For How Long
		Layoff	
		Total Disability	
		Leave of Absence which does not meet the requirements of FMLA Leave	

6.04I Duration of COBRA Continuation Coverage

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

6.06 Qualifying Events

Is legal separation a qualifying event? _____

Does the Plan provide retiree health coverage? _____

6.17 Coverage Replacement Benefits (No-loss, No-gain)

VARIABLE – KEEP OR REMOVE

Credit will be given for Deductibles, waiting periods and maximums satisfied, in whole or in part, under the Prior Plan, for those Participants receiving coverage under the Prior Plan and considered eligible Participants of this Plan on [Effective Date].

VARIABLE – KEEP OR REMOVE

Article VII
Limitations and Exclusions

(5) **Hazardous Hobby.** Are the following items covered:

Yes	No	Item
		Skydiving
		Auto racing
		Hang gliding
		Bungee jumping
		Water skiing
		Snow skiing
		Jet ski operating

Yes	No	Item
		Horseback riding
		Boating
		Motorcycling
		Snowmobiling
		All-terrain vehicle riding
		Team sports

Article IX

Claim Procedures

15.02G External Review – FOR NON-GRANDFATHERED PLANS ONLY

Name of unit that administers the external review program: _____

Address: _____

Phone: _____

Article X
Coordination of Benefits

Which language should be used in this Article?

	COB (100% or allowable charges) on a claim-by-claim basis
	COB (100% or allowable charges) on an annual basis
	MOB (carve out) on a claim-by-claim basis
	MOB (carve out) on an annual basis

Article XIV
Summary of Benefits

14.01 General Limits

The Plan provides different levels of benefits based on whether the Provider Participants use is a Network or Non-Network Provider. Unless one of the exceptions shown below applies, if a Participant elects to receive medical care from the Non-Network Provider, the benefits payable are generally lower than those payable when a Network Provider is used. The following exceptions apply:

a. [In the event a Network Provider refers a Participant to a non-Network Provider for diagnostic testing, x-rays, laboratory services or anesthesia, then charges of the non-Network Provider will be paid as though the services were provided by a Network Provider.]
VARIABLE – KEEP OR REMOVE

b. [The Network Provider level of benefits is payable for any Participant who cannot access Network Providers because they reside outside the Network service area. The Network service area is defined as [_____].]
VARIABLE – KEEP OR REMOVE

c. [The Network Provider level of benefits is payable when a Participant receives emergency care either Out of Area or at a Non-Network Hospital for an Accidental Bodily Injury or Emergency.]
VARIABLE – KEEP OR REMOVE

14.02 Primary Care Providers

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

If you do not have access to a computer at your home, you may access this website at your place of employment.
VARIABLE – KEEP OR REMOVE

If you have any questions about how to do this, contact the Human Relations Department or [_____].
VARIABLE – KEEP OR REMOVE

[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

14.03 Calendar Year Benefit
The following lifetime maximums apply to each Participant:

Lifetime Maximum Benefits for:	
All Essential Health Benefits	[no less than $750,000]

14.04 Summary of Medical Benefits
The following benefits are per Participant per [_____] **(Plan or calendar)** year:

	Network	**Non-Network**	**Out-of-Area**
Deductible • Individual • Family Unit			

Payment Level (unless otherwise stated)			
Maximum Out-of-Pocket[1] • Individual • Family Unit			

The following are excluded from Out-of-Pocket Expenses:

Yes	No	Item
		Deductibles
		Copayments
		Cost containment penalties
		Non-covered services

Yes	No	Item
		Amounts over Usual, Customary and Reasonable fees

Covered Medical Expenses:	Network	Non-Network	Out-of-Area	Limits
1. Allergy Services • Office Visit • Injections • Serum				
2. Ambulance				
3. Ambulatory Surgical Center				
4. Anesthesia				
5. Birthing Center				
6. Blood & Plasma				
7. Chiropractic Care				
8. Durable Medical Equipment				
9. Glaucoma, Cataract Surgery and Lenses (one set)				
10. Home Health Care				
11. Hospice Care • Inpatient • Outpatient • Family Bereavement Counseling				
12. Hospital • Inpatient Treatment				

Covered Medical Expenses: • Outpatient Treatment	**Network**	**Non-Network**	**Out-of-Area**	**Limits**
13. Impregnation and Infertility Treatment				
14. Newborn Care				
15. Outpatient Diagnostic X-ray and Lab				
PLEASE USE #16 ALONE, <u>OR</u> #'s 17 & 18 TOGETHER, BUT NOT ALL 3 OPTIONS				
16. [Outpatient Emergency Services]				
17. [Outpatient Emergency Services – Emergency Room • Emergency • Non-Emergency				
18. Outpatient Emergency Services – Other Providers]				
19. Physician Services • Office Visit • Lab, x-rays and Surgery				
20. Pregnancy Expenses				
PLEASE USE #'s 21 & 22 TOGETHER, <u>OR</u> #23 <u>OR</u> #24 ALONE				
21. **OPTION I** – Preventive Care – Well Adult Care • Routine Physical Exam • Mammograms – *must be over age 40, unless Medically Necessary* • Pap Smears • Prostate Exam – *must be over age 50, unless Medically Necessary* • Routine Immunizations]				
22. Preventive Care – Well Child Care • Routine Exam • Routine Immunizations				
23. [**OPTION II**] • Well Adult Care ([Employee and Spouse only]) • Routine Physical Exam				

Covered Medical Expenses: • Mammograms – *must be over age [_____], unless Medically Necessary* • Pap Smears • Prostate Exam – *must be over age [_____], unless Medically Necessary* • Routine Immunizations • Well Child Care • Routine Exam • Routine Immunizations	**Network**	**Non-Network**	**Out-of-Area**	**Limits**
24. [**OPTION III** - Preventive Care]				
25. Private Duty Nursing				
26. Prosthetics, Orthotics, Supplies and Surgical Dressings				
27. Routine Patient Costs for an Approved Clinical Trial				
28. Second Surgical Opinions				
29. Skilled Nursing Facility				
30. Surgery				
31. Temporomandibular Joint Disorder (TMJ)				
32. Therapy • Chemotherapy • Occupational Therapy • Physical Therapy • Radiation Therapy • Respiration Therapy • Speech Therapy				
33. Transplants				
34. All Other Covered Services				

14.05 Summary of Psychiatric Benefits

The following benefits are per Participant per [_____] (**Plan or calendar**) year:

Covered Psychiatric Expenses:	Network	Non-Network	Out-of-Area	Limits
1. Inpatient Physician				
2. Outpatient Physician				
3. Partial Day Program				
4. Residential Treatment				

14.06 Summary of Substance Abuse Benefits

The following benefits are per Participant per [_____] **(Plan or calendar)** year:

Covered Substance Abuse Expenses:	Network	Non-Network	Out-of-Area	Limits
1. Inpatient Physician				
2. Outpatient Physician				
3. Partial Day Program				
4. Residential Treatment				

14.07 Summary of Dental Benefits

Deductible per Participant	
Maximum benefit per [Plan Year/calendar year] for Class 1, 2 and 3 Services	
Maximum Lifetime benefit for Class 4 Services	

Covered Dental Expenses:	Benefits
Class 1 Services (Preventive Care)	
Class 2 Services (Repair and Restoration)	
Class 3 Services (Major Dental Repair)	
Class 4 Services (Orthodontics)	

14.08 Summary of Vision Benefits

Copayment	

Covered Vision Expenses:	Benefits
Eye exam, per person, in a [_____]-month period	

Frame-type lenses, per pair, in a [_____]-month period – Single vision	
Frame-type lenses, per pair, in a [_____]-month period – Bi-focal	
Frame-type lenses, per pair, in a [_____]-month period – Tri-focal	
Frame-type lenses, per pair, in a [_____]-month period – Lenticular	
Frames, per pair, in a [_____]-month period	
Contact Lenses in a [_____]-month period	

14.09 Summary of Prescription Drug Benefits

Covered Prescription Drug Expenses:	**Participating Pharmacy**	**Non-Participating Pharmacy**
Pharmacy Option:		
Copayment, per prescription or refill, for generic		
Copayment, per prescription or refill, for name brands*		
Mail Order Option:		
Copayment, per prescription or refill, for generic		
Copayment, per prescription or refill, for name brands*		
** Also includes cost difference between name brand and generic forms, unless prescription is not manufactured in generic form or Physician has indicated "dispense as written" or similar indication.* **FOOTNOTE – KEEP OR REMOVE**		

14.10 Summary of Short-Term Disability Benefits

Benefit limits:	
Weekly Benefit*	[_____]% of weekly base pay (not including overtime, bonuses or commissions) to a maximum of $[_____]
Minimum Benefit	$[_____]
Maximum Period Payable	[_____] weeks
[** In the case of Partial Disability, the benefit will be coordinated with any pay received by the Employee from his Participating Employer so that the total of the Employee's weekly disability benefit and pay are not greater than the Weekly Benefit above.*] **VARIABLE – KEEP OR REMOVE**	
Benefits are payable:	

For Illness	Beginning on the [_____] day following the Illness
For Injury	Beginning on the [_____] day [_____] **(of/following)** an Accident

Article XV
Medical Benefits

15.01 Medical Benefits

15.03 Exclusions

Are the following items covered or excluded under the Plan:

Abortion. Expenses incurred directly or indirectly as the result of an abortion
COVERED or NOT COVERED. LIMITED TO: _____

Biofeedback. Biofeedback
COVERED or NOT COVERED. LIMITED TO: _____

Dental. Emergency repair due to Injury to sound natural teeth, if the repair is made within 12 months from the date of the Injury (unless otherwise required by applicable law)
COVERED or NOT COVERED. LIMITED TO: _____

Eye Refractions. Eye refractions, eyeglasses, contact lenses, or the vision examination for prescribing or fitting eyeglasses or contact lenses (except for aphakic patients, and soft lenses or sclera shells intended for use in the treatment of Disease or Injury)
COVERED or NOT COVERED. LIMITED TO: _____

Gleevec. Gleevec, for treatment of any of the following conditions:

a. CML myeloid blast crisis;
b. CML accelerated phase; or
c. CML in chronic phase after failure of interferon treatment;

Prior authorization is required. In order to obtain such authorization, information from the patients' Physician indicating the condition being treated must be submitted to the Plan
COVERED or NOT COVERED. LIMITED TO: _____

Hospice Care. Bereavement counseling, which is a supportive service provided by the Hospice team to Participants in the deceased's Family after the death of the Terminally Ill person, to assist the Participants in adjusting to the death.
COVERED or NOT COVERED. LIMITED TO: _____

Benefits will be payable up to [_____] visits per Family…

Never Events. In addition, serious preventable adverse events ("Never Events") will, in no event be covered under the Plan.
COVERED or NOT COVERED. LIMITED TO: _____

Prescription Contraceptives. The Plan will also cover contraception-related services, including the initial visit to the prescribing Physician and any follow-up visits or Outpatient services, to the same extent, and on the same terms, as it offers coverage for other Outpatient services for preventative care
COVERED or NOT COVERED. LIMITED TO: _____

Temporomandibular Joint Disorder. Charges for the diagnosis and treatment of, or in connection with, temporomandibular joint disorders, myofacial pain dysfunction or orthognathic treatment, which are not in excess of $[_____] per [_____] **(Plan Year/calendar year)** and $[_____] per lifetime per Participant.
COVERED or NOT COVERED. LIMITED TO: _____

IF COVERED:
If a Physician or Dentist recommends treatment for or in connection with temporomandibular joint disorders, myofacial pain dysfunction or orthognathic treatment, a Participant must submit the treatment plan, including x-rays and study models, for pre-determination of benefits under the Plan. The pre-determination of benefits is required before any course of treatment is begun. The Plan Administrator will determine if the treatment is a Covered Expense and will notify the Participant. If treatment is begun before the pre-determination of benefits, no benefits are payable under the Plan
VARIABLE – KEEP OR REMOVE

Transplants. Surgical, storage and transportation costs[, including donor medical expenses,]…
VARIABLE – KEEP OR REMOVE

…directly related to the procurement of an organ or tissue used in a transplant described herein will be covered [up to $[_____] for each such procedure completed].
VARIABLE – KEEP OR REMOVE

15.04A Pre-Certification Procedures
Whenever a Participant is advised that Inpatient Hospital care is needed, it is the Participant's responsibility to call the pre-certification department at its toll-free number, which is [_____].

Pre-certification [_____] **(is OR is not)** required for Inpatient admission to skilled nursing facilities, convalescent or rehabilitation facilities unless otherwise stated in this document.

The pre-certification department hours of operations are [_____].

On weekends and evenings, the Participant can call [_____], and leave a message.

15.04B Pre-Certification Penalty
However, if a Participant fails to notify pre-certification department of any Inpatient Hospital stay as required in Section 15.04A, allowed charges will be reduced by [_____]% (to a maximum of $[_____]) for Room and Board, Hospital miscellaneous services, and any other charges related to that confinement which are billed by the Hospital. The Participant will be responsible for payment of the part of the charge that is not paid by the Plan.

15.04D Pre-Admission Testing
VARIABLE – KEEP OR REMOVE

15.04E Second Surgical Opinion
VARIABLE – KEEP OR REMOVE

15.04F Second Surgical Opinion Penalty
If a Participant does not obtain a second opinion on the Surgeries listed above, the benefits payable under the Plan will be **reduced by $[_____]** of the benefits otherwise available for the Surgeon and assistant Surgeon for that procedure.
VARIABLE – KEEP OR REMOVE

15.04G Pre-Surgical Approval
VARIABLE – KEEP OR REMOVE

Article XVI
Dental Benefits

The Deductible amount, if any, which is listed above, is the amount each Participant must pay each [_____] **(Plan Year/calendar year)** toward covered expenses.

Covered expenses incurred by any Participant [_____] **(and Family Unit)** in the last three months of any [_____] **(Plan Year/calendar year)** which are applied to satisfy the Deductible for that [_____] **(Plan Year/calendar year)** may also be used toward satisfaction of the Deductible in the next [_____] **(Plan Year/calendar year)**.

Following is a standard list of covered dental procedures, along with the Class that they are listed under. Please fill in the appropriate times and/or ages, and any change of class for the following:

Class 1 Services (Preventive Care)

Move to Class	Coverage
	Routine oral examinations and prophylaxis (cleaning, scaling and polishing teeth), but not more than once each in any period of [_____] consecutive months;
	Periapical x-rays, as required, and bitewing x-rays once in any period of [_____] consecutive months;
	Sealants for Dependent Children under age [_____], but not more than once in any period of [_____] consecutive months;
	Topical application of fluoride for Dependent Children under age [_____], but not more than once in any period of [_____] consecutive months;
	Space maintainers (not made of precious metals) that replace prematurely lost teeth for Dependent Children under age [_____]. No payment will be made for duplicate space maintainers; and
	Palliative Emergency treatment of an acute condition requiring immediate care.

Class 2 Services (Repair and Restoration)

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

Class 3 Services (Major Dental Repair)

Move to Class	Coverage
	Inlays, gold fillings, crowns, and initial installation of full or partial dentures or fixed bridgework to replace one or more natural teeth extracted while the Participant was covered

	under the Plan;
	Repair or recementing of crowns, inlays, bridgework or dentures and relining of dentures;
	Unless otherwise required by applicable law, replacement of an existing denture or fixed bridgework, or the addition of teeth to an existing partial removable denture or bridgework, to replace one or more natural teeth: a. Which were extracted while the Participant was covered under the Plan; b. Where the existing denture or bridgework was installed at least five years prior to its replacement and it cannot be made serviceable; or c. Where the existing denture is an immediate temporary denture, and necessary replacement by the permanent denture takes place within 12 months;
	Periodontal scaling;
	Oral Surgery;
	Re-lines;
	Post and core;
	Stainless steel crowns; and
	Veneers, for Dependent Children under age [_____] only.

Class 4 Services (Orthodontics)
Orthodontic services will be eligible only when provided to covered Dependents who are under age [_____] when treatment is received.

Move to Class	Coverage
	Preliminary study, including cephalometric radiographs, diagnostic casts and treatment plan;
	Interceptive, interventive or preventive orthodontic services;
	Fixed and removable appliance placement, and active treatment per month after the first month;
	Extractions in connection with orthodontic services.

16.03 Pre-determination of Dental Benefits
If a Participant's proposed course of treatment reasonably can be expected to involve dental charges of $[_____] or more, a description of the procedures to be performed and an estimate of the charges therefor may be filed with the Plan Administrator or Third Party Administrator prior to the commencement of the course of treatment.

Article XVIII
Prescription Drug Benefits

[_____] is the administrator of the prescription drug plan.

Because of the volume buying, [_____], the mail order pharmacy, is able to offer Participants significant savings on their prescriptions.

18.01 Covered Expenses

Are the following prescription drug items covered:

Yes	No	Item
		Accutane
		Allergy Sera
		Anorexiants (weight-loss drugs)
		Bee Sting Kits
		Blood and Blood Plasma
		Compounded Prescriptions
		DESI Drugs
		Devices of any type, even though such devices may require a prescription, including, but not limited to, therapeutic devices, artificial appliances, braces, support garments or any similar device
		Insulin
		Insulin syringes and needles
		Fertility Agents
		Gleevec
		Glucose Test Strips, when prescribed by a Physician
		Growth Hormones
		Imitrex Injection
		Immunizations
		Immunologicals
		Impotency medication, including Viagra™
		Injectables
		Legend Drugs
		• Class V Drugs
		• Diabetic Supplies
		• Diagnostics
		• Legend Drugs with over-the-counter equivalents
		• Pre-Natal Vitamins
		• Vitamins
		Non-Insulin Syringes/Needles
		Non-Prescription Drug or Medicine
		Over-the Counter Drugs
		• Class V Drugs
		• Diabetic Supplies
		• Diagnostics
		• Medical Devices and Supplies
		• Pre-Natal Vitamins
		• Vitamins
		Prescription Contraception
		• All Prescription Contraceptives

Yes	No	Item
		• Oral Contraceptives only
		• Other (please attach)
		Rogaine
		Smoking Deterrents
		Steroids
		Vitamins, except pre-natal

18.02 Limitations

1. Dosages

   a. With respect to the Pharmacy Option, any one prescription is limited to the greater of a [_____]-day supply or a [_____]-unit dose
   b. With respect to the Mail Order Option, any one prescription is limited to the greater of a [_____]-day supply or a [_____]-unit dose

Article XIX
Short-Term Disability Benefits

19.02 Eligibility for Benefits

Any Employee who has completed at least [_____] months of employment will be eligible for benefits for Short-Term Disability.

This benefit also applies when an Employee has a Partial Disability that meets all of these tests:

1. For purposes of this Article, "Partial Disability" and "Partially Disabled" means an inability to perform substantially all of the duties of the Employee's occupation or of a similar occupation for which the person is reasonably capable due to education and training, as a result of Illness or Injury, but, at the same time, the ability to work for the Participating Employer on a part-time or light-duty basis;
2. Such part-time or light-duty work is available for the Employee with his Participating Employer;
3. The Employee's Partial Disability begins while the Employee is covered for this benefit;
4. The Employee's Partial Disability is due to an Illness or Injury that, in either case, is non-occupational – that is, not arising from work for wage or profit; and
5. The Employee is under the continuous care of a Physician for the Partial Disability throughout the entire period of Partial Disability.

VARIABLE – KEEP OR REMOVE

19.03 Termination of Benefits

1. Acceptance of employment with any employer[, other than part-time or light-duty work with the Participating Employer];
   VARIABLE – KEEP OR REMOVE

6. Cessation of a Physician's certification of Total Disability [or Partial Disability];
   VARIABLE – KEEP OR REMOVE

7. Return to work [on a full-time basis]
   VARIABLE – KEEP OR REMOVE

19.04 Exclusions

3. Any days on which the Employee works full-time, part-time or light duty, for any employer, [other than part-time or light-duty work with the Participating Employer];
VARIABLE – KEEP OR REMOVE

Article XX
Hipaa Privacy

a. 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:

_____ _____

_____ _____

_____ _____

_____ _____

Additional Information

Does your current plan have any special provision that you would include? _____
If so, please attach.

If you are including the old PD and/or a separate Summary of Benefits, which should we use?

	Old Plan
	Separate Summary of Benefits
	Checklist Information
	Other: