Checklist for
Vision 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): Vision _____

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.
	…being active employment.

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.
	…being active employment.

OPTIONAL – KEEP or REMOVE

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 vision care plan are not eligible for coverage under this *Plan.*

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…
	Other:

…date you or your *dependents* are eligible, provided you and your *dependents* have enrolled for coverage on a form satisfactory to the *Plan Administrator* within [_____] days following the date of eligibility.

	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.

OR

	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**.

OR

- 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…
	Other:

…date the *dependent* becomes eligible, 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 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…
	…first day of the month…
	Other:

…following enrollment.

OR

	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… ☐ …first day of the month… ☐ Other: following your completion of the *waiting period*.

OR

	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

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:

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 vision care 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 vision care 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 vision care plan, you will be eligible on the date of the acquisition.
OPTIONAL – KEEP or REMOVE

<u>Limitations For First-Year Enrollees</u>
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.
OPTIONAL – KEEP or REMOVE

The plan year maximum for all benefits payable will be limited to $[_____].
OPTIONAL – KEEP or REMOVE

SCHEDULE OF VISION CARE BENEFITS

Maximum Benefits for:	
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	$[_____]
• *Family Unit*	$[_____]

The following Copayment amounts are applied per service:

Type of Expense	Copayment Amount
Eye Exam	$[_____]
Lenses	$[_____]
Frames	$[_____]
Contact Lenses	$[_____]

Covered expenses incurred during the last three months of a *plan year* that were applied toward the…

	…individual…
	…family unit…

…*deductible* will be allowed as credit toward satisfaction of the *deductible* in the following *plan year*.
OPTIONAL – KEEP or REMOVE

Payment Levels and Limits

Maximums stated apply to the amount of…

	…benefit payments…
	…covered expenses…

…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 *participant* 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

Covered	
	Eye examinations, including refraction.
	Single vision lenses for frames.
	Bifocal vision lenses for frames.
	Trifocal vision lenses for frames.
	Lenticular vision lenses for frames.
	Contact lenses, including disposable contact lenses.
	Frames.
	Tints, scratch resistant surfaces.
	Oversized lenses.
	Other:

VISION CARE EXCLUSIONS AND LIMITATIONS

This Plan does not cover any charge for the following services or supplies:

	Immediate relative. Provided by an *immediate relative*

OR

	Immediate relative. Provided by an *immediate relative* [or an individual residing in your home];

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

When Vision Care Claims Must Be Filed
Vision care claims must be filed with the *third party administrator* within [_____] of the date charges for the service 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 OR months OR years)** from the date the charges were *incurred* except in the case of legal incapacity of the *participant*.
OPTIONAL – KEEP or REMOVE

Requirements for Appeal
To file an appeal in writing, the *participant's* appeal must be addressed as follows and mailed or faxed as follows:

	Plan Administrator ***(please list fax number):***
	Third Party Administrator ***(please list fax number):***

Decision on Review to be Final
Any legal action for the recovery of any benefits must be commenced within [_____] after the *Plan's* claim review procedures have been exhausted.

PLEASE COMPLETE THE FOLLOWING ONLY IF THE PLAN HAS 2 LEVELS OF APPEAL:

Appeals of Adverse Benefit Determinations

- *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
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.

Decision on Second Appeal to be Final
Any legal action for the recovery of any benefits must be commenced within [_____] after the *Plan's* claim review procedures have been exhausted.

COORDINATION OF BENEFITS

Which COB would the Plan like to use?

	Carve-out on a per claim basis ***This provision is designed to limit the amount paid by all plans (the "allowable expense") to the actual benefit payable under your plan. In other words, as secondary payor, your plan would use the normal benefit amount payable and subtract from that any amount paid by the primary carrier(s). This will make any deductibles, copayments, etc., remain as an out-of-pocket amount to the plan member.***
	Full allowable expenses on a per claim basis **This provision is designed to allow for reimbursement of up to the full amount of covered charges for a single claim submission. In other words, as secondary payor, your plan may reimburse the full balance due after the primary carrier has paid (subject to the maximum you would have paid without COB). It is not applied to cumulative charges on a calendar year basis, and therefore eliminates COB recoverable.**

Order of Benefit Determination

	The benefits of a plan which covers the person on whose expenses claim is based, other than as a dependent, will be determined before the benefits of a plan which covers such person as a dependent.

OR

	The benefits of a plan which covers the person on whose expenses claim is based, other than as a dependent, will be determined before the benefits of a plan which covers such person as a dependent. [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;]

DEFINITIONS

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

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

- An *employee's domestic partner* who has the same principal place of abode for more than one-half of the calendar year, and who relies on the employee for more than one half of his or her support for the calendar year in which the *domestic partner* is enrolled for coverage under the *Plan*;
  OPTIONAL – KEEP or REMOVE

- An e*mployee*'s 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, who has the same principal place of abode as the employee for more than one-half of the calendar year, and who does not provide more than one half of his or her own support for the calendar year in which the *child* is enrolled for coverage under the *Plan*.

OR

	An e*mployee*'s unmarried *child,* regardless of age, [who was continuously covered prior to attaining the limiting age under the fourth and fifth bullets above,] who is mentally or physically incapable of sustaining his own living, who has the same principal place of abode as the employee for more than one-half of the calendar year, and who does not provide more than one half of his or her own support for the

	calendar year in which the *child* is enrolled for coverage under the *Plan*.

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

The time limit for written proof of incapacity and dependency is [_____] days following the original eligibility date for a new or re-enrolling employee.
OPTIONAL – KEEP or REMOVE

"Domestic Partner" means a person who has been in a domestic partnership with an *employee* for at least [_____].
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."

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

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:
