1. **DOCUMENT PACKAGE**
   a. [ ] Plan Document and Summary Plan Description and Summary of Benefits and Coverage
   b. [ ] Trust only
   c. [ ] Plan Document and Summary Plan Description, Trust and Summary of Benefits and Coverage

   Is the Trust:
   d. [ ] Taxable
   e. [ ] Non-taxable (IRC Sec. 501(c)(9))

   **High Deductible Health Plan (HDHP) in coordination with Health Savings Account (HSA)**
   f. [ ] Yes
   g. [ ] No

2. **Claims and Appeal Procedures**
   h. [ ] Yes, unless otherwise selected below, will be in Plan/Summary
      1. [ ] Produce as separate document (leave blank if not applicable)
   i. [ ] No

3. **Summary of Benefits and Coverage**
   j. [ ] Yes
   k. [ ] No

4. **Statement that Foreign Language Assistance is Available**
   l. [ ] No
   m. [ ] Yes (Select all that apply and complete contact information)
      Language Access: (Insert the telephone number for the corresponding language.)
      1. [ ] Spanish: ________________________________
      2. [ ] Tagalog: ________________________________
      3. [ ] Chinese: ________________________________
      4. [ ] Navajo: ________________________________

5. **PLANS REQUIRED (Select all that apply)**
   a. [ ] Short Term Disability
   b. [ ] Freestanding Prescription Drugs
   c. [ ] Vision Care:
      Is this an excepted benefit under ACA?
      1. [ ] Yes
      2. [ ] No
   d. [ ] Dental Benefits
      Is this an excepted benefit under ACA?
      1. [ ] Yes
      2. [ ] No
   e. [ ] Supplementary Accident
   f. [ ] Medical/Major Medical (Must be selected with HDHP, 1f.)
      Include Basic Coverage?
      (Plans Patterned After BC-BS plans into a Base & Major Medical Plan) Do not fill in with a Managed Care Plan or HDHP, 1f.
   g. [ ] No
   h. [ ] Yes (Select all that apply)
      1. [ ] Basic Hospital
      2. [ ] Basic Surgical
      3. [ ] Basic In-hospital Physician Medical
      4. [ ] Basic Diagnostic Testing, X-Ray and Lab
      5. [ ] Basic Radiation/Chemotherapy

6. **FORMAT**
   a. [ ] Standard (letter size, single spaced, ragged margin)
   b. [ ] Right justified margins

7. **FONT OPTIONS** (Please choose from available font/sizes below)
   Documents (Plan and Summary, Trust) (Default: Arial font)
   a. [ ] 10 pt. Arial
   b. [ ] 10.5 pt. Times

8. **PLAN INFORMATION - REQUIRED BY ERISA**
   a. [ ] Name of Plan (Exact Legal Name)
      ________________________________
   b. [ ] Tax number & Plan number
      a. Tax number ____________________________
         (Employer Identification Number)
      b. Plan number ____________________________
         (e.g., 501, 502, etc.)

9. **Type of Plan/Grandfathered Status**
   a. [ ] ERISA
   b. [ ] Non ERISA

      **Describe Grandfathered Status of Plan under PPACA/Health Care Reform:**
      (Do not complete c., d., e., f., or g. unless the plan is a group health plan subject to PPACA/Health Care Reform)
   c. [ ] Grandfathered Plan
   d. [ ] Nongrandfathered Plan

   **AND if b. or d. selected, the Plan is:**
   e. [ ] subject to a binding State external review process
   f. [ ] NOT subject to a binding State external review process but has elected to comply with a State external review process in lieu of the federal external review process
   g. [ ] NOT subject to a binding State external review process, and has elected to use the federal external review process

   **Note:** If “e.” or “f.” is elected, the plan document will indicate that the plan has elected the state process and will refer participants to the plan administrator for more information, but it will not identify the applicable state or describe the process.

10. **Plan effective date**
    a. ____________________________
      (month) (day) (year)

11. **Plan Year ends**
    a. ____________________________
      (month) (day)
    b. ____________________________
      (month) (day)
<table>
<thead>
<tr>
<th>EMPLOYER INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Employer</td>
</tr>
<tr>
<td>a. __________________ (Name)</td>
</tr>
<tr>
<td>b. __________________ (Street)</td>
</tr>
<tr>
<td>c. __________________ d. __________________ e. __________________ (City) (State) (Zip)</td>
</tr>
<tr>
<td>f. __________________ (Telephone)</td>
</tr>
<tr>
<td>g. __________________ (website for plan information or copies of plan documents)</td>
</tr>
<tr>
<td>h. __________________ (telephone number for plan information or copies of plan documents)</td>
</tr>
</tbody>
</table>

Name of Plan Administrator (not the Claim Administrator) if different than Employer:

i. __________________ (Name)  
j. __________________ (Street)  
k. __________________ l. __________________ m. __________________ (City) (State) (Zip)  
n. __________________ (Telephone)  

11. Group entity  
a. ☐ Corporation (includes non-profit, church & government groups)  
b. ☐ Proprietor or partner  
c. ☐ Taft-Hartley Trust Fund (skip to 15.) (attach eligibility requirements)  

12. Eligible classes of Employees covered  
a. ☐ Regular Full-time  
   1. ________ minimum hours per week worked  
b. ☐ Regular Part-time  
   1. ________ minimum hours per week worked  
c. ☐ Qualifying employees (Note: This refers to employees such as variable hour and seasonal employees who become eligible based on a lookback period that determines they have worked an average of at least 30 hours per week. This section should be completed for any plan that is sponsored or maintained by an employer that is subject to the Employer Shared Responsibility penalties.)  
d. ☐ Other (please describe eligibility requirements)  
   1. __________________  
   2. __________________  
   3. __________________  

Measurement and Stability Periods  
For New Qualifying Employees:  
e. ☐ The initial measurement period shall be a period of:  
   1. ________ calendar months (at least 3 and not more than 12) beginning on the:  
   2. ☐ date of hire  
   3. ☐ first of the calendar month following date of hire  

For Ongoing Qualifying Employees:  
g. ☐ The standard measurement period shall be a period of:  
   1. ________ calendar months (at least 3 and not more than 12)  
   2. Beginning the first day of ________ (insert month)  
h. ☐ The standard stability period shall be a period of:  
   1. ________ calendar months (at least 6 and no more than the standard measurement period)  

Break in Service Rules  
i. ☐ Is the plan sponsor an educational organization under the Employer Shared Responsibility rules?  
   1. ☐ Yes  
   2. ☐ No  

13. Are Retired Employees eligible?  
a. ☐ No  
b. ☐ Yes  

14. When coverage begins and ends: (Note: Excepted benefit dental and vision plans may select any of the options offered below. All other plans: (1) should not select c., (2) if f. is selected, i. must also be selected, and (3) h., if selected, should be completed in accordance with the restrictions on waiting periods and effective dates of coverage in excess of 90 days.)  

Waiting Period  
a. ☐ One month  
b. ☐ Two months  
c. ☐ Three months  
d. ☐ 30 days  
e. ☐ 60 days  
f. ☐ 90 days  
g. ☐ None  
h. ☐ Other  
   __________________  

When coverage starts  
i. ☐ Immediately after waiting period  
j. ☐ First of month after waiting period  

When coverage ends  
k. ☐ On date of termination  
l. ☐ End of the month after termination  

Must a rehired employee who has continued coverage under COBRA be required to satisfy the waiting period?  
m. ☐ Yes  
   1. ☐ No  
   2. ☐ No  

15. Is there Dependent coverage?  
a. ☐ No (skip to 21.)  
b. ☐ Yes
16. Are Spouses covered?
   a. [ ] No
   b. [ ] Yes

   If Yes, [ ] legally married opposite sex only AND [ ] legally married same and opposite sex
   1. [ ] common law marriages are included OR [ ] common law marriages are not included
   2. [ ] common law marriages are not included
   c. [ ] A Spouse will not be eligible for coverage if
      1. [ ] Spouse has other group coverage available
      2. [ ] Spouse is covered under other group coverage
   d. [ ] if totally disabled
   e. [ ] after the limiting age if totally disabled and ends:
      1. [ ] on the date
      2. [ ] at the end of the Calendar Year
      3. [ ] at the end of the month in which the eligibility requirements are no longer satisfied

17. Are Children covered? (Note: failure to offer coverage for dependent children in Plan Years beginning on or after Jan. 1, 2015 may trigger penalties under the Employer Shared Responsibility mandates.)
   a. [ ] No
   b. [ ] Yes, for all Plans EXCEPT excepted-benefit dental/vision (if excepted-benefit dental/vision, skip to j.):
      1. [ ] Employee's natural children, adopted children and children placed for adoption with Employee
      2. [ ] Employee's stepchildren
      3. [ ] Employee's foster children
      4. [ ] Domestic Partner's natural children, adopted children and children placed for adoption with domestic partner
   c. [ ] until age ______ (not less than 26)
      AND, for Grandfathered plans only
      1. [ ] provided child is not eligible for other employer-sponsored coverage (Note: this item may not be selected for Plan Years beginning on or after January 1, 2014).
   d. [ ] after the limiting age if totally disabled
   e. [ ] on the date of the child's birthday (ending coverage prior to the end of the month in which the limiting age is reached may trigger penalties under the Employer Shared Responsibility mandates)
   f. [ ] at the end of the Calendar Year
   g. [ ] at the end of the month in which the eligibility requirements are no longer satisfied (last day of birthday month)

Newborn coverage (select all that apply)
   h. [ ] Automatically for 30 days with existing Dependent coverage
   i. [ ] Must enroll all newborns
   j. [ ] Yes. For excepted-benefit dental/vision plans the following children will be covered:
      1. [ ] Employee's natural children, adopted children and children placed for adoption with Employee
      2. [ ] Employee's stepchildren
      3. [ ] Employee's foster children
      4. [ ] Children for whom the employee is a legal guardian
      5. [ ] Domestic Partner's natural children, adopted children and children placed for adoption with Domestic Partner
      6. [ ] Domestic Partner's stepchildren
      7. [ ] Domestic Partner's foster children
      8. [ ] Children for whom the Domestic Partner is a legal guardian
      9. [ ] Other ____________________________
   k. [ ] until age ______ AND provided child:
      1. [ ] meets dependency requirements
      2. [ ] meets residency requirements
      3. [ ] is unmarried
      4. [ ] meets student requirements
         a. [ ] limiting age for students is ______

18. Are Qualified Dependents covered? (if excepted-benefit dental/vision, complete 17j. above)
   a. [ ] No
   b. [ ] Yes for
      1. [ ] Children for whom the employee is a legal guardian
      2. [ ] Children of Domestic Partner. “Children” shall include the Domestic Partner’s:
         a. [ ] Natural children, adopted children and children placed for adoption with Domestic Partner (do not complete if 17b4 is checked).
         b. [ ] Stepchildren
         c. [ ] Foster children
         d. [ ] Children for whom the Domestic Partner is a legal guardian
      3. [ ] Other ____________________________
   c. [ ] until age ______ AND provided child:
      1. [ ] meets dependency requirements
      2. [ ] meets residency requirements
      3. [ ] meets student requirements
         a. [ ] limiting age for students is ______

19. Are Domestic Partners covered?
   a. [ ] No (skip to 21.)
   b. [ ] Yes

   If Yes, select all that apply:
   c. [ ] Opposite sex
   d. [ ] Same sex

20. And, should Domestic Partners be treated as Spouse and child(ren) of Domestic Partners be treated as dependents for COBRA rights?
   a. [ ] No
   b. [ ] Yes

   If No, shall equivalent continuation coverage be provided?
   c. [ ] No
   d. [ ] Yes

   Please type description of continuation coverage:
      1. ____________________________
         ____________________________
         ____________________________
21. COBRA explanation needed?
   a. ☐ No (skip to 26.)
   b. ☑ Yes

   COBRA coverage is
   c. ☐ Contributory for the qualified beneficiary
   d. ☑ Noncontributory for the qualified beneficiary
   e. ☐ Enter the name and address of the COBRA Administrator (This may be the Employer/Plan Sponsor, the Plan Administrator, or a third party COBRA Administrator)

   1. ____________________________  
      (Name)

   2. ____________________________  
      (Street)

   3. ____________________________  
      (City)          4. ____________________________  
      (State)        5. ____________________________  
      (Zip)

   6. ____________________________  
      (Telephone)

22. The name and address of the person to whom the qualified beneficiary must send notification of covered event
   a. ☐ Same as Plan Sponsor (same as 10a.)
   b. ☑ Same as COBRA Administrator (same as 21e1.)
   c. ☐ Same as Plan Administrator (same as 10i.)
   d. ☐ Other

   1. ____________________________  
      (Name)

   2. ____________________________  
      (Street)

   3. ____________________________  
      (City)          4. ____________________________  
      (State)        5. ____________________________  
      (Zip)

   6. ____________________________  
      (Telephone)

23. The name and address of the person to contact to answer COBRA questions
   a. ☐ Same as Plan Sponsor (same as 10a.)
   b. ☑ Same as COBRA Administrator (same as 21e1.)
   c. ☐ Same as Plan Administrator (same as 10i.)
   d. ☐ Other

   1. ____________________________  
      (Name)

   2. ____________________________  
      (Street)

   3. ____________________________  
      (City)          4. ____________________________  
      (State)        5. ____________________________  
      (Zip)

   6. ____________________________  
      (Telephone)

24. The name and address of the person who is to receive requests for disability extensions
   a. ☐ Same as Plan Sponsor (same as 10a.)
   b. ☑ Same as COBRA Administrator (same as 21e1.)
   c. ☐ Same as Plan Administrator (same as 10i.)
   d. ☐ Other

   1. ____________________________  
      (Name)

   2. ____________________________  
      (Street)

   3. ____________________________  
      (City)          4. ____________________________  
      (State)        5. ____________________________  
      (Zip)

   6. ____________________________  
      (Telephone)

25. The name and address of the person who is to receive notices of the second qualifying event
   a. ☐ Same as Plan Sponsor (same as 10a.)
   b. ☑ Same as COBRA Administrator (same as 21e1.)
   c. ☐ Same as Plan Administrator (same as 10i.)
   d. ☐ Other

   1. ____________________________  
      (Name)

   2. ____________________________  
      (Street)

   3. ____________________________  
      (City)          4. ____________________________  
      (State)        5. ____________________________  
      (Zip)

   6. ____________________________  
      (Telephone)

26. Are Late Enrollees allowed on the Plan?
   a. ☐ No, no provision (Note: Failure to offer open enrollment may lead to penalties under the Employer Shared Responsibility provisions of the ACA.)
   b. ☑ Yes

   1. ☐ coverage immediately after enrollment
   2. ☐ begins the first of the month after enrollment
   3. ☐ allowed on the Plan during open enrollment only

   a. ☐ Date of open enrollment ____________________________  
      (month)

   b. ☐ Coverage effective date ____________________________  
      (month)  (day)

27. Open enrollment for changing between health plan options only?
   a. ☐ No
   b. ☑ Yes

   1. Date of open enrollment ____________________________  
      (month)

   2. Coverage effective date ____________________________  
      (month)  (day)

28. Phone number for Hospital and Physicians to verify coverage
   a. ☐
   b. ☑ N/A
29. Employee contributions toward benefit cost
   Employee coverage
   a. ☐ Employee contributes
   b. ☐ Noncontributory (Employer Pays All)

   Dependent coverage
   c. ☐ Employee pays all
   d. ☐ Employee contributes
   e. ☐ Noncontributory (Employer Pays All)

30. Continuation while still employed during disability, approved leave, or layoff
   Disability continuance
   a. ☐ No
   b. ☐ Yes, then (select all that apply)
      1. ☐ Until terminated by Employer
      2. ☐ _______________________ months

   Leave and layoff continuance
   c. ☐ No
   d. ☐ Yes, then (select all that apply)
      1. ☐ Until terminated by Employer
      2. ☐ _______________________ months

   Does Employer have 50 or more Employees within a 75-mile radius of the place of employment? (A "Yes" answer indicates the Employer is covered under the Family and Medical Leave Act of 1993.)
   e. ☐ Yes
   f. ☐ No

   Leave Periods
   g. ☐ For any leave periods described in 30b. or 30d., the 18-month COBRA period will begin:
      1. ☐ on the day leave begins (so COBRA is not extended beyond the 18 months)
      2. ☐ the day after the leave ends

31. Claims filing
   a. Suggested within _______________________ days of service rendered

32. For ERISA plans or non-grandfathered plans, including non-ERISA plans, under the new claims procedure regulations, do you allow voluntary dispute resolution procedures, including arbitration? (Only applies if 7a. or 7d. selected)
   a. ☐ No
   b. ☐ Yes

   For all plans, do you allow two levels of appeals?
   c. ☐ No, only one level
   d. ☐ Yes, two levels

33. SHORT TERM DISABILITY (Only applies if 2a. selected)
   Would you like the schedule of benefits for Short Term Disability to appear in a table?
   a. ☐ Yes
   b. ☐ No (may not be selected with 57a.)

   Weekly benefits limit (select c., d., or e.)
   c. ☐ $_________ per week
   d. ☐ _________% of basic weekly earnings
   e. ☐ _________% of basic weekly earnings up to
      1. ☐ $_________ per week

   Minimum benefit included
   f. ☐ No
   g. ☐ Yes, $____________

   Benefits start from
   h. ☐ Day after Employer-paid sick leave ceases for Injury or Sickness
   i. ☐ A specified day for Injury or Sickness
      1. ☐ _________ day after disability for Injury
          (first, second, etc.)
      2. ☐ _________ day after disability for Sickness
          (first, second, etc.)

   Maximum period payable
   j. ☐ _________ weeks per disability

34. Occupational coverage included?
   a. ☐ No
   b. ☐ Yes

   Covered weekly earnings
   Overtime included?
   c. ☐ No
   d. ☐ Yes

   Commissions included?
   e. ☐ No
   f. ☐ Yes

   Bonuses included?
   g. ☐ No
   h. ☐ Yes

35. FREESTANDING PRESCRIPTION DRUGS (Only applies if 2b. selected)
   (Note: When HDHP, 1f. is selected, copayments may only apply to preventive drugs numbered 35. – 36. on this checklist.)
   Would you like the schedule of benefits for Freestanding Prescription Drug to appear in a table?
   a. ☐ Yes
   b. ☐ No (may not be selected with 57a.)

   Website where more information is available. If no website, insert telephone number
   c. ________________________________

NOTE: All tables will appear after the Introduction section of the document when selected with the Managed Care medical benefits schedule table format.
Pharmacy (retail) drug option

d. □ No (skip to 36.)
e. □ Yes (30 day supply)
    1. □ Third party payor

(Note: When HDHP, 1f. is selected, all charges are subject to medical deductible.)

f. Generic
   1. $_____ 2. _____%
g. Formulary (preferred) brand name
   1. $_____ 2. _____%
h. Non-Formulary (non-preferred)
   brand name
   1. $_____ 2. _____%
i. Specialty drugs
   1. $_____ 2. _____%

Note: If a "greater than" option is desired, complete 1. AND 2. (e.g.: $10 copay or 20% whichever is greater)

Per Prescription maximum?

j. □ No
k. □ Yes $__________

Non-Participating Pharmacy coverage? (Choose either l. or m.)

l. □ Only covered at Participating Pharmacies
m. □ Coverage for ingredient costs and dispensing fees only

Mail Order Option

36. a. □ No (skip to 37.)
b. □ Yes (90 day supply)
    1. □ Third party payor

(Note: When HDHP, 1f. is selected, all charges are subject to medical deductible.)

Coadayment % payable

f. Generic
   1. $_____ 2. _____%
g. Formulary (preferred) brand name
   1. $_____ 2. _____%
h. Non-Formulary (non-preferred)
   brand name
   1. $_____ 2. _____%
i. Specialty drugs
   1. $_____ 2. _____%

Per Prescription maximum?

j. □ No
k. □ Yes $__________

Is there a separate Prescription Drug Deductible(s) (does not apply if HDHP, 1f. is selected)

a. □ Yes b. □ N/A

Per Covered Person c. $__________
Per Family Unit d. $__________

37. Is there a Prescription Drug Maximum out-of-pocket amount (Note: For nongrandfathered plans, the OOP for Rx drugs, together with the OOP for medical expenses, may not exceed the maximum total OOP established under the ACA for the year.)

a. □ Yes b. □ N/A

Per Covered Person c. $__________
Per Family Unit d. $__________

38. Is there a separate Prescription Drug Deductible(s) (does not apply if HDHP, 1f. is selected)

a. □ Yes b. □ N/A

Per Covered Person c. $__________
Per Family Unit d. $__________

39. There are standard exclusions in the Plan

Answer whether the following should be added to the exclusions.

a. □ Infertility drugs
b. □ Impotence medication
c. □ Smoking deterrents
d. □ Hair growth/loss drugs
e. □ Growth hormones
f. □ Off-Label drugs
g. □ Injectable drugs (select 1. or 2.)
    1. □ All injectable drugs will be excluded
    2. □ All injectable drugs EXCEPT insulin will be excluded

40. VISION CARE (Only applies if 2c. selected)

Would you like the schedule of benefits for Vision Care to appear in a table?

a. □ Yes
b. □ No (may not be selected with 57a.)

Eye exam

c. □ Maximum $______________

Period separating exams

d. □ 12 months
e. □ 24 months
f. □ _________ months

Plan reimburses for eye exams only?

g. □ No
h. □ Yes (skip to 44.)

41. Frame-type lenses

Maximum, per pair (complete all)

a. □ Single vision maximum $______________
b. □ Bi-focal maximum $______________
c. □ Tri-focal maximum $______________
d. □ Lenticular maximum $______________

Period separating new lenses

e. □ 12 months
f. □ 24 months
g. □ _________ months
42. Frames
   Maximum, per pair
   a. $________________________

   Period separating new frames
   b. ☐ 12 months
   c. ☐ 24 months
   d. ☐ ____________ months

43. Contact lenses
   a. ☐ Excluded (skip to 44.)
   b. ☐ Included, and $________________________
   c. ☐ Limited as shown in ‘1.’ below

   Maximum if included: (complete all)
   1. To correct above 20/70, after cataract surgery, or as part
      of treating Keratoconus or Anisometropia $________________________
   2. Prescribed for other reasons $________________________
      (put ‘0’ if only ‘1.’ applies)

   Period separating new contacts
   d. ☐ 12 months
   e. ☐ 24 months
   f. ☐ ____________ months

44. DESCRIPTION OF DENTAL BENEFITS (Only applies if 2d. selected)
   Would you like the schedule of benefits for Dental Benefits to appear in a
   table?
   a. ☐ Yes
   b. ☐ No (may not be selected with 57a.)

   Services (select all that apply)
   c. ☐ Class A - Preventive
   d. ☐ Class B - Basic
   e. ☐ Class C - Major
   f. ☐ Class D - Orthodontia

   All cost sharing features (deductibles, copays, coinsurance) and
   annual treatment or visit limits will accumulate on the basis of the:
   g. ☐ Calendar Year
   h. ☐ Plan Year (defined at 9.)

45. Dental deductible
   a. $________________________ per person per year
   b. $________________________ per family unit per year

   Deductible applies to these services (select all that apply)
   c. ☐ Class A - Preventive
   d. ☐ Class B - Basic
   e. ☐ Class C - Major
   f. ☐ Class D - Orthodontia

46. Dental benefit limits
   Major services waiting period provision
   a. ☐ Not included
   b. ☐ Included, and
   1. ☐ No Class C Services in first ____________ months
   2. ☐ Only oral surgery paid in first ____________ months
   3. ☐ No dentures, partial dentures or bridges in first
      ____________ months
   4. ☐ The following services are limited as shown
      1. ☐ Oral exams, ____________ exam
         a. every ____________________________
      2. ☐ Bitewing x-ray series, every ____________________________
      3. ☐ Full mouth x-ray, every ____________________________
      4. ☐ Fluoride treatment, limiting age of under
         ____________ years
         (Number)
      5. ☐ Space maintainers, limiting age of under
         ____________ years
         (Number)
      6. ☐ Sealants, limiting age of under ____________ years,
         (Number)
         a. every ____________________________
      7. ☐ Free adjustments to dentures within ____________________________
         of installation
      8. ☐ Replacing temporary dentures with permanent
         dentures, within ____________________________

47. Percentage payable
   a. ☐ Class A - Preventive ____________ %
   b. ☐ Class B - Basic ____________ %
   c. ☐ Class C - Major ____________ %
   d. ☐ Class D - Orthodontia ____________ %

48. Maximum amount
   a. ☐ Per person per year $________________________
      Orthodontia
   b. ☐ Maximum $________________________ Lifetime per person
      1. ☐ limiting age, under age ____________

49. Predetermination of benefits
   a. ☐ $________________________ is start of predetermination
   b. ☐ No provision

NOTE: Do not fill in Basic Plans unless medical plan is a Basic & Major Medical
Plan. Do not fill in Basic Plans with a Managed Care Plan.

50. BASIC HOSPITAL (Only applies if 2h1. selected)
   Room and Board rate
   a. ☐ Average semiprivate room & board rate
   b. ☐ Other $________________________ per day
   c. ☐ 100% UCR
   d. Maximum days per confinement ____________________________
MEDICAL BENEFITS
If you have an indemnity plan, fill in the Column A spaces after each service. Ignore the Column B spaces. The schedule of benefits will appear in a text format.

If you have a managed care program, fill in both Column A (Network Providers) and/or Column B (Non-Network Providers) spaces after each service. The schedule of benefits will appear in a text format.

If you have a managed care program and want the schedule of benefits to be in a table, please answer “Yes” to this question below regarding the table and fill in all of the Column A (Network Providers) and/or Column B (Non-Network Providers) spaces after each service.

56. What kind of plan is this?
   a. ☐ Indemnity (skip to 62.)
   b. ☐ Managed care

57. If your plan is a managed care plan, would you like the schedule of benefits to be in a table? (Tables will appear after the Introduction)
   a. ☐ Yes  b. ☐ No

Please select the format of your table:
Note: 4 column (type of service, in-network, out-of-network, blank column to be used as you wish; also you may select 2-4 blank tables with 4 columns); 3 column (type of service, in-network, out-of-network; also you may select 2-4 blank tables with 3 columns); blank table (2, 3 or 4 column blank table to be customized as you wish).

1. ☐ 4 column information
   Do you want additional blank 4 column tables
   a. ☐ No  b. 2 blank tables  c. 3 blank tables  d. 4 blank tables

2. ☐ 3 column information
   Do you want additional blank 3 column tables
   a. ☐ No  b. 2 blank tables  c. 3 blank tables  d. 4 blank tables

3. ☐ blank 2 column table
4. ☐ blank 3 column table
5. ☐ blank 4 column table

58. What term would you like used for providers under contract?
   a. ☐ Panel  b. ☐ Network  c. ☐ Participating

Provide a website and telephone number where a list of contract providers can be obtained

d. Website: __________________________

e. Telephone No.: __________________________

59. Type of managed care option
   a. ☐ Participating Provider Organization
   b. ☐ Exclusive Provider Organization
   c. ☐ Point of Service Managed Care Option
PPO/EPO/POS name, address and phone number

d. N/A

e. PPO/EPO/POS  

1.  

2.  

3.  

4.  

5.  

Is there a 2nd PPO/EPO/POS

f. No

g. Yes

PPO/EPO/POS  

1.  

2.  

3.  

4.  

5.  

Is there a 3rd PPO/EPO/POS

h. No

i. Yes

PPO/EPO/POS  

1.  

2.  

3.  

4.  

5.  

Is there a 4th PPO/EPO/POS

j. No

k. Yes

PPO/EPO/POS  

1.  

2.  

3.  

4.  

5.  

60. Does the PPO/EPO/POS make exceptions and pay in-network benefits in the following conditions?

a. Participant has no choice of in-network provider

1. Yes

2. No

b. Medical Emergency (Note: Non-grandfathered plans must check Yes)

1. Yes

2. No

c. Services performed by out-of-network providers at in-network facility

1. Yes

2. No

d. Referrals by in-network provider to out-of-network provider

1. Yes

2. No

61. Does this managed care option have deductibles only on ALL out-of-network charges and copayments only on ALL in-network charges

a. Yes (Do not answer deductible and copayment questions that follow)

b. No (Select individually at questions 67. to 98.)

Please answer the following question(s) with percentages, dollar amounts, or frequency limits, whichever is appropriate during checklist entry.

62. Dollar Limits on non-Essential Health Benefits (This Question should be answered only if the Plan wishes to put dollar limits on specific Non-Essential Health Benefits.)

List services/supplies that the Plan has determined to be non-Essential Health Benefits, and indicate any limits that apply. (Do not list non-Essential Health Benefits if they are not subject to these dollar limits.)

a. Not counted toward Out-of-Pocket maximum

1.  

2.  

b. Annual benefit limit

1. Not counted toward Out-of-Pocket maximum

2. Annual benefit limit


<table>
<thead>
<tr>
<th>Column A</th>
<th>Column B</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. ☐ Yes b. ☐ N/A</td>
<td>c. _________ d. _________</td>
</tr>
<tr>
<td>Per Covered Person</td>
<td>Per Family Unit</td>
</tr>
<tr>
<td>dollar amount</td>
<td>e. _________ f. _________</td>
</tr>
<tr>
<td>number of people</td>
<td>g. _________ h. _________</td>
</tr>
<tr>
<td>Three-month carryover?</td>
<td></td>
</tr>
<tr>
<td>i. ☐ Yes</td>
<td>j. ☐ No</td>
</tr>
<tr>
<td>Common accident provision?</td>
<td></td>
</tr>
<tr>
<td>k. ☐ Yes</td>
<td>l. ☐ No</td>
</tr>
<tr>
<td>Waived for the following services: (Network Preventive Care Services must be included if nongrandfathered plan)</td>
<td></td>
</tr>
<tr>
<td>m. ☐</td>
<td>n. ☐</td>
</tr>
<tr>
<td>o. ☐</td>
<td></td>
</tr>
<tr>
<td>Which expenses are excluded from satisfaction of the deductible?</td>
<td></td>
</tr>
<tr>
<td>p. ☐ coinsurance</td>
<td>q. ☐ copayments</td>
</tr>
<tr>
<td>r. ☐ penalties for failure to follow prior authorization and cost containment procedures</td>
<td>s. ☐ premiums</td>
</tr>
<tr>
<td>t. ☐ Are family deductibles embedded (Plan pays expenses if individual meets single deductible before family deductible is met)</td>
<td></td>
</tr>
<tr>
<td>1. ☐ Yes</td>
<td>2. ☐ No</td>
</tr>
</tbody>
</table>

63. Deductible(s)

64. Copayment(s), per visit

(Complete 38 through 65)

65. Maximum out-of-pocket amount, per Calendar or Plan Year. (For non-grandfathered plans, the in-network OOP for medical expenses, when added to the OOP for Rx drugs, may not exceed the maximum total OOP established under ACA for the year. The OOP maximum for out-of-network charges may be set at any level.)

<table>
<thead>
<tr>
<th>Column A</th>
<th>Column B</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. ☐ Yes b. ☐ N/A</td>
<td>c. _________ d. _________</td>
</tr>
<tr>
<td>Per Covered Person</td>
<td>Per Family Unit</td>
</tr>
<tr>
<td>dollar amount</td>
<td>e. _________ f. _________</td>
</tr>
<tr>
<td>number of people</td>
<td>g. _________ h. _________</td>
</tr>
<tr>
<td>Network Charges for Out-Of-Pocket Maximum applies to the following; (select all that apply, leave blank if none apply):</td>
<td></td>
</tr>
<tr>
<td>i. ☐ In-network charges apply to the out-of-pocket maximum for out-of-network charges</td>
<td>j. ☐ Out-of-network charges apply to the out-of-pocket maximum for in-network charges</td>
</tr>
<tr>
<td>All cost sharing features (deductibles, copays, coinsurance) and annual day or visit limits will accumulate on the basis of the:</td>
<td></td>
</tr>
<tr>
<td>k. ☐ Calendar Year</td>
<td>l. ☐ Plan Year (defined at 9.)</td>
</tr>
<tr>
<td>Are OOP limits embedded? (Plan pays at 100% for individual that meets individual limit before family limit is met.) Note: Non-grandfathered plans and HSA-compatible HDHP plans are subject to statutory requirements with respect to embedded OOP limits. These requirements must be met before completing this item.</td>
<td></td>
</tr>
<tr>
<td>m. ☐ No</td>
<td>n. ☐ Yes</td>
</tr>
</tbody>
</table>

66. Which expenses are excluded from satisfaction of the out-of-pocket maximum? (Note: If cost sharing for non-Essential Health Benefits is not counted toward the OOP limits, also complete Question 62 accordingly.)

<table>
<thead>
<tr>
<th>Column A</th>
<th>Column B</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. ☐ deductible (must complete 1. or 2. below)</td>
<td>c. ☐ deductible (must complete 1. or 2. below)</td>
</tr>
<tr>
<td>1. ☐ in- and out-of-network (grandfathered plans only)</td>
<td>1. ☐ in- and out-of-network (grandfathered plans only)</td>
</tr>
<tr>
<td>2. ☐ out-of-network only</td>
<td>2. ☐ out-of-network only</td>
</tr>
<tr>
<td>b. ☐ copayment (grandfathered plans only)</td>
<td>d. ☐ Cost containment penalties</td>
</tr>
<tr>
<td>c. ☐ expenses for Prescription Drug benefits (must complete 1. or 2. below)</td>
<td>e. ☐ Amounts over allowed amount</td>
</tr>
<tr>
<td>1. ☐ in- and out-of-network (nongrandfathered plans must also complete Question 38.)</td>
<td>f. ☐ Other __________________________</td>
</tr>
<tr>
<td>2. ☐ out-of-network only</td>
<td></td>
</tr>
<tr>
<td>3. ☐ N/A</td>
<td></td>
</tr>
</tbody>
</table>

67. Hospital room and board

<table>
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<th>Column A</th>
<th>Column B</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. ☐ Yes</td>
<td>b. ☐ N/A</td>
</tr>
<tr>
<td>Semiprivate rate</td>
<td></td>
</tr>
<tr>
<td>Subject to</td>
<td>Subject to</td>
</tr>
<tr>
<td>1. ☐ deductible</td>
<td>1. ☐ deductible</td>
</tr>
<tr>
<td>2. ☐ copayment</td>
<td>2. ☐ copayment</td>
</tr>
<tr>
<td>3. ☐ N/A</td>
<td>3. ☐ N/A</td>
</tr>
</tbody>
</table>

Waived if admitted to Hospital? | |
### Self-Funded Checklist

#### 68. Emergency Room Visit/Urgent Care

<table>
<thead>
<tr>
<th>a. Yes</th>
<th>b. No</th>
<th>c. N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Medical emergency care (For Nongrandfathered plans, in-network benefit levels must be provided for out-of-network providers)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The facility's semiprivate room rate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Subject to</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Subject to</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>deductible</td>
</tr>
</tbody>
</table>

**Column A** | **Column B**
--- | ---
| | |
| | |
| | |

#### 69. Intensive Care unit

<table>
<thead>
<tr>
<th>a. Yes</th>
<th>b. No</th>
<th>c. N/A</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>ICU charge</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Same as semiprivate room rate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Subject to</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>deductible</td>
</tr>
</tbody>
</table>

**Column A** | **Column B**
--- | ---
| | |
| | |
| | |

#### 70. Skilled Nursing Facility

<table>
<thead>
<tr>
<th>a. Yes</th>
<th>b. No</th>
<th>c. N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>One-half Hospital average semiprivate R&amp;B</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Allergy serum and injections</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Subject to</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>deductible</td>
</tr>
</tbody>
</table>

**Column A** | **Column B**
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| | |
| | |
| | |

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SF-CLL-11
<table>
<thead>
<tr>
<th>Column A</th>
<th>Column B</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>72. Diagnostic Testing (X-ray and Lab)</strong></td>
<td></td>
</tr>
<tr>
<td>a. ☐ Yes ☐ N/A</td>
<td></td>
</tr>
<tr>
<td>Reimbursement rate</td>
<td></td>
</tr>
<tr>
<td>c. _________</td>
<td>d. _________</td>
</tr>
<tr>
<td>Subject to</td>
<td>Subject to</td>
</tr>
<tr>
<td>1. ☐ deductible</td>
<td>1. ☐ deductible</td>
</tr>
<tr>
<td>2. ☐ copayment</td>
<td>2. ☐ copayment</td>
</tr>
<tr>
<td>3. ☐ N/A</td>
<td>3. ☐ N/A</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td></td>
</tr>
<tr>
<td>e. ☐ Yes f. ☐ N/A</td>
<td></td>
</tr>
<tr>
<td>Reimbursement rate</td>
<td></td>
</tr>
<tr>
<td>g. _________</td>
<td>h. _________</td>
</tr>
<tr>
<td>Subject to</td>
<td>Subject to</td>
</tr>
<tr>
<td>1. ☐ deductible</td>
<td>1. ☐ deductible</td>
</tr>
<tr>
<td>2. ☐ copayment</td>
<td>2. ☐ copayment</td>
</tr>
<tr>
<td>3. ☐ N/A</td>
<td>3. ☐ N/A</td>
</tr>
<tr>
<td><strong>73. Home Health Care visits</strong></td>
<td></td>
</tr>
<tr>
<td>a. ☐ Yes ☐ N/A</td>
<td></td>
</tr>
<tr>
<td>Reimbursement rate</td>
<td></td>
</tr>
<tr>
<td>c. _________</td>
<td>d. _________</td>
</tr>
<tr>
<td>Subject to</td>
<td>Subject to</td>
</tr>
<tr>
<td>1. ☐ deductible</td>
<td>1. ☐ deductible</td>
</tr>
<tr>
<td>2. ☐ copayment</td>
<td>2. ☐ copayment</td>
</tr>
<tr>
<td>3. ☐ N/A</td>
<td>3. ☐ N/A</td>
</tr>
<tr>
<td>Annual limit</td>
<td></td>
</tr>
<tr>
<td>e. _________</td>
<td>f. _________</td>
</tr>
<tr>
<td><strong>74. Inpatient Drugs only</strong> (in conjunction with freestanding Prescription Drug plan)</td>
<td></td>
</tr>
<tr>
<td>a. ☐ Yes ☐ N/A</td>
<td></td>
</tr>
<tr>
<td>Reimbursement rate</td>
<td></td>
</tr>
<tr>
<td>c. _________</td>
<td>d. _________</td>
</tr>
<tr>
<td>Subject to</td>
<td>Subject to</td>
</tr>
<tr>
<td>1. ☐ deductible</td>
<td>1. ☐ deductible</td>
</tr>
<tr>
<td>2. ☐ copayment</td>
<td>2. ☐ copayment</td>
</tr>
<tr>
<td>3. ☐ N/A</td>
<td>3. ☐ N/A</td>
</tr>
<tr>
<td><strong>75. Inpatient and Outpatient Drugs</strong> (no separate freestanding Prescription Drug plan)</td>
<td></td>
</tr>
<tr>
<td>a. ☐ Yes ☐ N/A</td>
<td></td>
</tr>
<tr>
<td>Reimbursement rate</td>
<td></td>
</tr>
<tr>
<td>c. _________</td>
<td>d. _________</td>
</tr>
<tr>
<td>Subject to</td>
<td>Subject to</td>
</tr>
<tr>
<td>1. ☐ deductible</td>
<td>1. ☐ deductible</td>
</tr>
<tr>
<td>2. ☐ copayment</td>
<td>2. ☐ copayment</td>
</tr>
<tr>
<td>3. ☐ N/A</td>
<td>3. ☐ N/A</td>
</tr>
<tr>
<td>If HDHP, 1f. and 75c1. or 75d1. are selected, are Preventive drugs subject to the medical deductible?</td>
<td></td>
</tr>
<tr>
<td>e. ☐ Yes ☐ N/A</td>
<td></td>
</tr>
<tr>
<td><strong>76. Private duty nursing outpatient</strong></td>
<td></td>
</tr>
<tr>
<td>a. ☐ Yes ☐ N/A</td>
<td></td>
</tr>
<tr>
<td>Reimbursement rate</td>
<td></td>
</tr>
<tr>
<td>c. _________</td>
<td>d. _________</td>
</tr>
<tr>
<td>Subject to</td>
<td>Subject to</td>
</tr>
<tr>
<td>1. ☐ deductible</td>
<td>1. ☐ deductible</td>
</tr>
<tr>
<td>2. ☐ copayment</td>
<td>2. ☐ copayment</td>
</tr>
<tr>
<td>3. ☐ N/A</td>
<td>3. ☐ N/A</td>
</tr>
<tr>
<td>Annual limit</td>
<td></td>
</tr>
<tr>
<td>e. _________</td>
<td>f. _________</td>
</tr>
<tr>
<td><strong>77. Hospice Care</strong> (Note: Hospice care may be considered an Essential Health Benefit. Limits should be selected only if the Plan does not treat this benefit as an EHB.)</td>
<td></td>
</tr>
<tr>
<td>a. ☐ Yes ☐ N/A</td>
<td></td>
</tr>
<tr>
<td>Reimbursement rate</td>
<td></td>
</tr>
<tr>
<td>c. _________</td>
<td>d. _________</td>
</tr>
<tr>
<td>Subject to</td>
<td>Subject to</td>
</tr>
<tr>
<td>1. ☐ deductible</td>
<td>1. ☐ deductible</td>
</tr>
<tr>
<td>2. ☐ copayment</td>
<td>2. ☐ copayment</td>
</tr>
<tr>
<td>3. ☐ N/A</td>
<td>3. ☐ N/A</td>
</tr>
<tr>
<td>Outpatient Lifetime maximum</td>
<td></td>
</tr>
<tr>
<td>e. _________</td>
<td>f. _________</td>
</tr>
<tr>
<td>Inpatient and outpatient Lifetime maximum</td>
<td></td>
</tr>
<tr>
<td>g. _________</td>
<td>h. _________</td>
</tr>
<tr>
<td><strong>78. Bereavement counseling -- within 6 months of death</strong></td>
<td></td>
</tr>
<tr>
<td>a. ☐ Yes ☐ N/A</td>
<td></td>
</tr>
<tr>
<td>Reimbursement rate</td>
<td></td>
</tr>
<tr>
<td>c. _________</td>
<td>d. _________</td>
</tr>
<tr>
<td>Subject to</td>
<td>Subject to</td>
</tr>
<tr>
<td>1. ☐ deductible</td>
<td>1. ☐ deductible</td>
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<tr>
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<td>3. ☐ N/A</td>
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<tr>
<td>Lifetime maximum visits</td>
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</tr>
<tr>
<td>e. _________</td>
<td>f. _________</td>
</tr>
<tr>
<td>Lifetime maximum</td>
<td></td>
</tr>
<tr>
<td>g. _________</td>
<td>h. _________</td>
</tr>
<tr>
<td><strong>79. Ambulance</strong></td>
<td></td>
</tr>
<tr>
<td>a. ☐ Yes ☐ N/A</td>
<td></td>
</tr>
<tr>
<td>c. ☐ Ground only d. ☐ Ground and air</td>
<td></td>
</tr>
<tr>
<td>Reimbursement rate</td>
<td></td>
</tr>
<tr>
<td>e. _________</td>
<td>f. _________</td>
</tr>
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<td>Subject to</td>
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<tr>
<td>Per trip maximum (ground)</td>
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</tr>
<tr>
<td>g. _________</td>
<td>h. _________</td>
</tr>
<tr>
<td>Per trip maximum (air)</td>
<td></td>
</tr>
<tr>
<td>i. _________</td>
<td>j. _________</td>
</tr>
<tr>
<td>k. ☐ Limited to _________ miles per one-way trip (ground only)</td>
<td></td>
</tr>
<tr>
<td><strong>80. TMJ coverage limits</strong></td>
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</tr>
<tr>
<td>a. ☐ Yes ☐ N/A</td>
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</tr>
<tr>
<td>Reimbursement rate</td>
<td></td>
</tr>
<tr>
<td>c. _________</td>
<td>d. _________</td>
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<td>1. ☐ deductible</td>
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<tr>
<td>2. ☐ copayment</td>
<td>2. ☐ copayment</td>
</tr>
<tr>
<td>3. ☐ N/A</td>
<td>3. ☐ N/A</td>
</tr>
<tr>
<td><strong>81. Wig after chemotherapy</strong></td>
<td></td>
</tr>
<tr>
<td>a. ☐ Yes ☐ N/A</td>
<td></td>
</tr>
<tr>
<td>Reimbursement rate</td>
<td></td>
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<td>c. _________</td>
<td>d. _________</td>
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<td>e. _________</td>
<td>f. _________</td>
</tr>
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<tr>
<td><strong>82. If therapy benefits are provided, are Occupational, Speech and Physical therapy maximum visits combined?</strong>&lt;br&gt;a. □ Yes, indicate annual maximum number of visits allowed _______&lt;br&gt;b. □ N/A</td>
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<tbody>
<tr>
<td><strong>83. Occupational therapy</strong>&lt;br&gt;a. □ Yes b. □ N/A&lt;br&gt;Reimbursement rate</td>
<td>c. □ N/A d. □ N/A&lt;br&gt;Subject to 1. □ deductible 2. □ copayment 3. □ N/A</td>
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<td><strong>84. Speech therapy</strong>&lt;br&gt;a. □ Yes b. □ N/A&lt;br&gt;Reimbursement rate</td>
<td>c. □ N/A d. □ N/A&lt;br&gt;Subject to 1. □ deductible 2. □ copayment 3. □ N/A</td>
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<tr>
<td><strong>85. Physical therapy</strong>&lt;br&gt;a. □ Yes b. □ N/A&lt;br&gt;Reimbursement rate</td>
<td>c. □ N/A d. □ N/A&lt;br&gt;Subject to 1. □ deductible 2. □ copayment 3. □ N/A</td>
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<td><strong>86. Durable medical equipment</strong>&lt;br&gt;a. □ Yes b. □ N/A&lt;br&gt;Reimbursement rate</td>
<td>c. □ N/A d. □ N/A&lt;br&gt;Subject to 1. □ deductible 2. □ copayment 3. □ N/A</td>
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<tr>
<td><strong>87. Prosthetics</strong>&lt;br&gt;a. □ Yes b. □ N/A&lt;br&gt;Reimbursement rate</td>
<td>c. □ N/A d. □ N/A&lt;br&gt;Subject to 1. □ deductible 2. □ copayment 3. □ N/A</td>
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<td><strong>88. Orthotics</strong>&lt;br&gt;a. □ Yes b. □ N/A&lt;br&gt;Reimbursement rate</td>
<td>c. □ N/A d. □ N/A&lt;br&gt;Subject to 1. □ deductible 2. □ copayment 3. □ N/A</td>
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<tr>
<td><strong>89. Spinal Manipulation/Chiropractic</strong>&lt;br&gt;a. □ Yes b. □ N/A&lt;br&gt;Reimbursement rate</td>
<td>c. □ N/A d. □ N/A&lt;br&gt;Subject to 1. □ deductible 2. □ copayment 3. □ N/A</td>
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<tr>
<td><strong>90. Mental disorders</strong>&lt;br&gt;a. □ Yes b. □ N/A&lt;br&gt;Reimbursement rate Inpatient</td>
<td>c. □ deductible d. □ copayment&lt;br&gt;Subject to 1. □ deductible 2. □ copayment 3. □ N/A</td>
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<tr>
<td><strong>91. Substance abuse</strong>&lt;br&gt;a. □ Yes b. □ N/A&lt;br&gt;Reimbursement rate Inpatient</td>
<td>c. □ deductible d. □ copayment&lt;br&gt;Subject to 1. □ deductible 2. □ copayment 3. □ N/A</td>
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<tr>
<td><strong>92. Routine well adult care (Nongrandfathered plans must provide in-network Standard Preventive Care (preventive care required under ACA) without cost sharing.)</strong>&lt;br&gt;a. □ Yes b. □ N/A&lt;br&gt;Reimbursement rate</td>
<td>c. □ deductible d. □ copayment&lt;br&gt;Subject to 1. □ deductible 2. □ copayment 3. □ N/A</td>
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<tr>
<td><strong>93. Services covered (Nongrandfathered plans should select from the following list if they wish to offer services not required under ACA and/or if they wish to specifically mention services required by ACA. Grandfathered plans that wish to offer Standard Preventive Care with no cost-sharing should complete Item q. Employers that claim a religious exemption from the requirement to provide contraceptives should complete items u, v, or w, as applicable.)</strong>&lt;br&gt;a. □ Pap smear&lt;br&gt;b. □ Mammogram&lt;br&gt;c. □ Prostate exam</td>
<td></td>
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</tbody>
</table>
d. ☐ Gynecological exam 

94. Nursery/Physician well-baby newborn care 

a. ☐ Yes b. ☐ N/A 

Reimbursement rate c. _________ d. _________ 

Column A Column B 

Subject to Subject to 
1. ☐ deductible 1. ☐ deductible 
2. ☐ copayment 2. ☐ copayment 
3. ☐ N/A 3. ☐ N/A 

If HDHP, 1f. and 92c1. or 92d1. are selected, are Preventive Care services subject to the medical deductible? 

s. ☐ Yes t. ☐ No (Nongrandfathered plans must select s.) 

Physician visits while baby is in the Hospital after birth 

e. ☐ First visit only f. ☐ Unlimited visits 

g. ☐ Visits for _______ Hospital days covered 

Costs applied toward plan of 

h. ☐ Parent i. ☐ Newborn 

Hospital days for well-baby nursery care 

j. ☐ Unlimited days 

k. ☐ For _______ Hospital days 

Costs applied toward plan of 

l. ☐ Parent m. ☐ Newborn 

95. Routine well child care (Nongrandfathered plans must provide in-network Standard Preventive Care (preventive care required under ACA) without cost sharing.) 

a. ☐ Yes b. ☐ N/A 

Reimbursement rate c. _________ d. _________ 

Subject to Subject to 
1. ☐ deductible 1. ☐ deductible 
2. ☐ copayment 2. ☐ copayment 
3. ☐ N/A 3. ☐ N/A 

Coverage for Dependents other than Spouse (Note: For nongrandfathered plans, if d. is checked, the document will reflect that prenatal and postnatal care will be covered to the extent required under Standard Preventive Care, even if dependent daughter pregnancies are not covered.) 

c. ☐ Yes d. ☐ No e. ☐ Complications only 

96. Organ transplant coverage 

a. ☐ Yes b. ☐ N/A 

Reimbursement rate c. _________ d. _________ 

Column A Column B 

Subject to Subject to 
1. ☐ deductible 1. ☐ deductible 
2. ☐ copayment 2. ☐ copayment 
3. ☐ N/A 3. ☐ N/A 

Donor coverage 

e. ☐ Yes f. ☐ No (skip to 97.) 

Annual maximum g. _________ h. _________ 

Plan covers donor costs only when recipient is covered under this plan? 

i. ☐ Yes j. ☐ No 

97. Coverage of Pregnancy 

Reimbursement rate a. _________ b. _________ 

Subject to Subject to 
1. ☐ deductible 1. ☐ deductible 
2. ☐ copayment 2. ☐ copayment 
3. ☐ N/A 3. ☐ N/A 

Coverage for Infertility (Note: Infertility treatments may be considered an Essential Health Benefit. Limits should be selected only if the Plan does not treat this benefit as an EHB. Grandfathered plans may select annual limits even if this is an EHB.) 

a. ☐ No (skip to 99.) b. ☐ Yes 

1. ☐ all services 2. ☐ diagnosis only 

3. ☐ diagnosis and basic services (prescription drugs and surgery to correct physiological abnormalities only)


## 99. Surgical sterilization included?

**a.** For Men:
   1. ☐ No
   2. ☐ Yes
   3. ☐ Yes (reversal excluded)

**b.** For Women (For grandfathered plans only. Nongrandfathered plans should complete Question 93q.)
   1. ☐ No
   2. ☐ Yes
   3. ☐ Yes (reversal excluded)

## 100. There are standard exclusions in the Plan. Are there any additional exclusions? (select all that apply)

**a.** ☐ No additional exclusions

**b.** ☐ Yes (select all that apply)
   1. ☐ Loss due to Hazardous Hobbies or Activities
   2. ☐ Loss due to illegal drugs or misuse of prescription drugs
   3. ☐ Loss due to illegal use of alcohol
   4. ☐ Abortion
      a. ☐ Exclude except in case of rape, incest or endangerment of mother
   5. ☐ Treatment/Medication for impotency
   6. ☐ Biofeedback
   7. ☐ Acupuncture
   8. ☐ Morbid Obesity
      a. ☐ Exclude surgical and non-surgical treatment
      b. ☐ Exclude surgical treatment only

**c.** ☐ No

**d.** ☐ Yes (enter any additional exclusions)
   1. ☐ Item to be excluded
      a. Item description

   2. ☐ Item to be excluded
      a. Item description

   3. ☐ Item to be excluded
      a. Item description

## 101. Cost management included?

**a.** ☐ No (skip to 108.)

**b.** ☐ Yes

## 102. Outpatient pre-admission testing service included?

**a.** ☐ No

**b.** ☐ Yes

   1. ☐ In-network reimbursement rate

   2. ☐ Out-of-network reimbursement rate

   3. ☐ Deductible waived? (Note: When HDHP, 1f. is selected, deductible will not be waived)
      a. ☐ Yes
      b. ☐ No

## 103. Mandatory utilization review service included?

**a.** ☐ No (skip to 105.)

**b.** ☐ Yes, and if procedure not followed
   1. ☐ Allowed amount reduced to _______ % of covered charges
   2. ☐ Benefit payment reduced by _______ %
   3. ☐ Benefit payment reduced by _______ %
      up to a maximum of
      a. ☐ $__________
      b. ☐ Benefit payment reduced by $__________

## 104. Medical services subject to review:

   a. ☐ Hospitalization
   b. ☐ MRI/CAT scan
   c. ☐ Inpatient Substance abuse/Mental treatment (Permitted only if 104a. is checked)
   d. ☐ Skilled nursing facility stay
   e. ☐ Home health care
   f. ☐ Hospice care
   g. ☐ Durable medical equipment
   h. ☐ Physical, speech and occupational therapy
   i. ☐ Cardiac rehabilitation therapy
   j. ☐ Outpatient surgical procedure
   k. ☐ Other

**Notification required:**
   l. ☐ Within _________ before services rendered (indicate number and days, weeks, hours: e.g., 48 hours)
   m. ☐ In the case of emergency services, within _________ after services rendered. (show number and days or hours)

## 105. Second and third opinions

   a. ☐ No
   b. ☐ Yes, voluntary, and
      1. ☐ paid as any other Sickness (Must be selected with HDHP, 1f.)
      2. ☐ paid at 100% before the deductible
   c. ☐ Yes, mandatory, (100% Reimbursement, Deductible waived)
      (Note: When HDHP, 1f. is selected, deductible will not be waived)
      and surgeon’s
      1. ☐ Allowable expenses reduced to _______ % of covered charges
      2. ☐ Benefit payment reduced by _______ %
      3. ☐ Benefit payment reduced by _______ %
      up to a maximum of
      a. ☐ $__________
      b. ☐ Benefit payment reduced by $__________
106. Outpatient Surgery
   a.  □ Not covered
   b.  □ Yes

   Reimbursement rate
   c.  Subject to deductible
   d.  Subject to copayment
   1. □ 1. □
   2. □ 2. □
   3. □ 3. □

107. Utilization review administrator
   (Complete if Mandatory UR Service or Mandatory Second Opinion is selected)
   a.  □ No
   b.  □ Yes

   1. □ ____________________________
      (Name)
   2. □ ____________________________
      (Telephone)
   3. □ Listed on Employee ID card

108. Coordination of benefits (Only applies if 1f., 2b., 2c., 2d., 2e. or 2f. are selected)
   a.  □ 100% of allowable charge
   b.  □ Nonduplication/carve-out

   ____________________________
   SKIP TO 110.

ADDITIONAL PLAN INFORMATION

110. Is there a Trustee(s)?
   a.  □ No (skip to 111.)
   b.  □ Yes

   1st Trustee
   1. □ ____________________________
      (Name)
   2. □ ____________________________
      (Title)
   c.  □ Use Employer/trust fund address
   d.  □ Other

   1. □ ____________________________
      (Street)
   2. □ ____________________________
      (City)
   3. □ ____________________________
      (State)
   4. □ ____________________________
      (Zip)

   Is there a 2nd Trustee?
   e.  □ No
   f.  □ Yes

   1. □ ____________________________
      (Name)
   2. □ ____________________________
      (Title)
   c.  □ Use Employer/trust fund address
   d.  □ Other

   1. □ ____________________________
      (Street)
   2. □ ____________________________
      (City)
   3. □ ____________________________
      (State)
   4. □ ____________________________
      (Zip)

   Is there a 3rd Trustee?
   e.  □ No
   f.  □ Yes

   1. □ ____________________________
      (Name)
   2. □ ____________________________
      (Title)
   c.  □ Use Employer/trust fund address
   d.  □ Other

   1. □ ____________________________
      (Street)
   2. □ ____________________________
      (City)
   3. □ ____________________________
      (State)
   4. □ ____________________________
      (Zip)

   Is there a 4th Trustee?
   e.  □ No
   f.  □ Yes

   1. □ ____________________________
      (Name)
   2. □ ____________________________
      (Title)
   c.  □ Use Employer/trust fund address
   d.  □ Other

   1. □ ____________________________
      (Street)
   2. □ ____________________________
      (City)
   3. □ ____________________________
      (State)
   4. □ ____________________________
      (Zip)

   Is there a 5th Trustee?
   e.  □ No
   f.  □ Yes

   1. □ ____________________________
      (Name)
   2. □ ____________________________
      (Title)
   c.  □ Use Employer/trust fund address
   d.  □ Other

   1. □ ____________________________
      (Street)
   2. □ ____________________________
      (City)
   3. □ ____________________________
      (State)
   4. □ ____________________________
      (Zip)
111. Claims administrator/supervisor/processor
   a. __________________________ (Name)
   b. __________________________ (Street or P.O. Box)
   c. __________________________ d. __________________________ e. __________________________
      (City) (State) (Zip)
   f. __________________________ (Telephone)

Which term is to be used in document:
   g. ☐ Claims administrator
   h. ☐ Claims supervisor
   i. ☐ Claims processor

112. Title of Named Fiduciary (ERISA Plans only)
   a. __________________________

Title of Agent for Service of Legal Process (ERISA Plans only)
   b. __________________________

It is suggested that either a department (e.g., Personnel Department) or a title (e.g., Corporate Attorney, Executive Vice President) be used for these positions.

113. Would you like the HIPAA Privacy plan document amendment to be generated?
   a. ☐ No (will appear in the Responsibilities for Plan Administration section) (please complete 113a1.)
      1. Please list (by name, by title, or by department) the employees in the employer's workforce who are authorized to receive Protected Health Information:

114. Date amendment is effective: (Only applies if 113b. selected)
   a. __________________________ (Month) __________________________ (Day) __________________________ (Year)

115. Number of signature lines needed: (Only applies if 113b. selected)
   a. ☐ As employer representative
      1. ☐ One
      2. ☐ Two
      3. ☐ Three
      4. ☐ Four
   b. ☐ As witnesses
      1. ☐ One
      2. ☐ Two

116. Would you like the HIPAA Security plan document amendment to be generated?
   a. ☐ No (will appear in the Responsibilities for Plan Administration section)
   b. ☐ Yes

117. Date amendment is effective: (Only applies if 116b. selected)
   a. __________________________ (Month) __________________________ (Day) __________________________ (Year)

118. Number of signature lines needed: (Only applies if 116b. selected)
   a. ☐ As employer representative
      1. ☐ One
      2. ☐ Two
      3. ☐ Three
      4. ☐ Four
   b. ☐ As witnesses
      1. ☐ One
      2. ☐ Two

119. Will Adopting Employers execute this Plan?
    Note: Selecting "Yes" will generate a Supplemental Participation Agreement.
    a. ☐ N/A or No
    b. ☐ Yes
       c. __________________________ (Name)
       d. __________________________ (Street)
       e. __________________________ f. __________________________ g. __________________________
          (City) (State) (Zip)
       h. __________________________ (Telephone)
       i. __________________________ (Tax ID Number)

ADOPTING EMPLOYERS
<table>
<thead>
<tr>
<th>120. Will there be a second Adopting Employer?</th>
<th>123. Will there be a fifth Adopting Employer?</th>
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<tbody>
<tr>
<td>a. No</td>
<td>a. No</td>
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<tr>
<td>b. Yes</td>
<td>b. Yes</td>
</tr>
<tr>
<td>c. (Name)</td>
<td>c. (Name)</td>
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<tr>
<td>d.</td>
<td>d.</td>
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<tr>
<td>e. (City) f. (State) g. (Zip)</td>
<td>e. (City) f. (State) g. (Zip)</td>
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<th>121. Will there be a third Adopting Employer?</th>
<th>124. Will there be a sixth Adopting Employer?</th>
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<tbody>
<tr>
<td>a. No</td>
<td>a. No</td>
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<tr>
<td>b. Yes</td>
<td>b. Yes</td>
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<tr>
<td>c. (Name)</td>
<td>c. (Name)</td>
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<tr>
<td>d.</td>
<td>d.</td>
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<td>i. (Tax ID Number)</td>
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<th>122. Will there be a fourth Adopting Employer?</th>
<th>125. Will there be a seventh Adopting Employer?</th>
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<tbody>
<tr>
<td>a. No</td>
<td>a. No</td>
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<tr>
<td>b. Yes</td>
<td>b. Yes</td>
</tr>
<tr>
<td>c. (Name)</td>
<td>c. (Name)</td>
</tr>
<tr>
<td>d.</td>
<td>d.</td>
</tr>
<tr>
<td>e. (City) f. (State) g. (Zip)</td>
<td>e. (City) f. (State) g. (Zip)</td>
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<tr>
<td>i. (Tax ID Number)</td>
<td>i. (Tax ID Number)</td>
</tr>
</tbody>
</table>
126. Will there be an eighth Adopting Employer?
   a. [ ] No
   b. [ ] Yes
   c. ________________________________
      (Name)
   d. ________________________________
      (Street)
   e. ____________________________
      (City) [ ] f. [ ]
      (State) [ ] g. [ ]
      (Zip)
   h. ________________________________
      (Telephone)
   i. ________________________________
      (Tax ID Number)

127. Will there be a ninth Adopting Employer?
   a. [ ] No
   b. [ ] Yes
   c. ________________________________
      (Name)
   d. ________________________________
      (Street)
   e. ____________________________
      (City) [ ] f. [ ]
      (State) [ ] g. [ ]
      (Zip)
   h. ________________________________
      (Telephone)
   i. ________________________________
      (Tax ID Number)

128. Will there be a tenth Adopting Employer?
   a. [ ] No
   b. [ ] Yes
   c. ________________________________
      (Name)
   d. ________________________________
      (Street)
   e. ____________________________
      (City) [ ] f. [ ]
      (State) [ ] g. [ ]
      (Zip)
   h. ________________________________
      (Telephone)
   i. ________________________________
      (Tax ID Number)

End HERE if Summary of Benefits and Coverage not selected

SUMMARY OF BENEFITS AND COVERAGE QUESTIONS

129. For "Common Medical Events" portion of Summary, complete the
    amount the Participant pays – Select all of the following that apply:
    (Note: coordinate amounts listed in questions noted below)
    (For Indemnity Plans, do not complete Out-of-Network columns)
    NOTE: Failure to complete this Question will result in an incomplete
    Summary of Benefits and Coverage.

    | Coinurance – | Amount PARTICIPANT pays |
    | Network rate | Out-of-network rate | Network rate | Copayments | Out-of-network rate |
    |------------|----------------------|-------------|-----------|-----------|
    | a. [ ] | Primary care office visits: (coordinate with 64e/.64f, and 71c/.71d.) |
    | 1. % | 2. % | 3. $ | 4. $ |
    | b. [ ] | Specialist: (coordinate with 64g/.64h, and 71e/.71f.) |
    | 1. % | 2. % | b. % | c. $ | d. $ |
    | 2. [ ] | Chiropractic visits: (coordinate with 89c/.89d.) |
    | a. % | b. % | c. $ | d. $ |
    | 3. [ ] | Other practitioner visits: |
    | a. % | b. % | c. $ | d. $ |
    | c. [ ] | Routine well care: (coordinate with 92c/.92d.) |
    | 1. % | 2. % | 3. $ | 4. $ |
    | d. [ ] | Diagnostic Testing: (coordinate with 64l/.64j, and 72c/.72d.) |
    | 1. % | 2. % | 3. $ | 4. $ |
    | e. [ ] | Imaging: (coordinate with 64i/.64j, and 72e.) |
    | 1. % | 2. % | 3. $ | 4. $ |
    | f. [ ] | Outpatient Surgery Facility Fee: (coordinate with 64i/.64j, and 106b.) |
    | 1. % | 2. % | 3. $ | 4. $ |
    | g. [ ] | Outpatient Surgery: Physician/Surgeon Fees: (coordinate with 64e/.64f, and 71g/.71h.) |
    | 1. % | 2. % | 3. $ | 4. $ |
    | h. [ ] | Emergency Room Services: Medical Emergency: (coordinate with 64k/.64l, and 66c.) |
    | 1. % | 2. % | 3. $ | 4. $ |
    | i. [ ] | Emergency Room Services: Non-Medical Emergency: (coordinate with 64k/.64l, and 68d.) |
    | 1. % | 2. % | 3. $ | 4. $ |
    | j. [ ] | Emergency Medical Transportation: (coordinate with 79e.) |
    | 1. % | 2. % | 3. $ | 4. $ |
    | k. [ ] | Urgent Care: (coordinate with 68f.) |
    | 1. % | 2. % | 3. $ | 4. $ |
    | l. [ ] | Hospital Facility Fee: (coordinate with 67b/.67c, and 64c/.64d.) |
    | 1. % | 2. % | 3. $ | 4. $ |
    | m. [ ] | Hospital: Physician/Surgeon Fees: (coordinate with 71a/.71b.) |
    | 1. % | 2. % | 3. $ | 4. $ |
    | n. [ ] | Mental health/Substance abuse:
    | 1. [ ] | Mental Health Outpatient: (coordinate with 90e/.f) |
    | a. % | b. % | c. $ | d. $ |
    | 2. [ ] | Mental Health Inpatient: (coordinate with 90c/.d) |
    | a. % | b. % | c. $ | d. $ |
5. □ For Prescription Drug Coverage other than freestanding coverage: (coordinate with 75c.d.)
   a. _____ %  b. $_____  c. _____ %  d. $_____  

y. □ Plan’s overall coinsurance rate ______%  
   NOTE: This is the coinsurance rate that applies to most in-network services.

130. Coverage Examples:
   a. □ Expected Maternity Costs (coordinate with 97. and 129o.)
   NOTE: Do not include copays in your dollar amount total.
   NOTE: If the plan has a wellness program that might reduce these costs, assume that the patient does NOT participate in the program for purposes of calculating these costs.
   1. □ Deductibles $__________
      Does this deductible exceed the deductible reported in 63c?
      a. □ Yes  b. □ No  
   2. □ Copays: $__________  
   3. □ Coinsurance: ________%  
   4. □ Limitations or Exclusions: $__________

b. □ Expected Costs of Managing Diabetes:
   1. □ Deductibles $__________
      Does this deductible exceed the deductible reported in 63c?
      a. □ Yes  b. □ No  
   2. □ Copays: $__________
   3. □ Coinsurance: ________%  
   4. □ Limitations or Exclusions: $__________

b. □ Expected Costs of Emergency Room Treatment for Simple Fracture: [Note/Commentary to Users: If the plan has a wellness program that might reduce these costs, assume that the patient does NOT participate in the program for purposes of calculating these costs.]
   1. □ Deductibles $__________
      Does this deductible exceed the deductible reported in 63c?
      a. □ Yes  b. □ No  
   2. □ Copays: $__________
   3. □ Coinsurance: ________%  
   4. □ Limitations or Exclusions: $__________

   For Prescription Drug Coverage other than freestanding coverage: (coordinate with 75c.d.)
   a. _____ %  b. $_____  c. _____ %  d. $_____  

y. □ Plan’s overall coinsurance rate ______%  
   NOTE: This is the coinsurance rate that applies to most in-network services.
131. Language Access: (Insert the telephone number for the corresponding language.)
   a. Spanish (Español): Para obtener asistencia en Español, llame al
   ________________________________.
   b. Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa
   ________________________________.
   c. Chinese (中文): 如果需要中文的帮助，请拨打这个号码
   ________________________________.
   d. Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne'
   ________________________________.

132. Minimum Plan Requirements (select all that apply; leave blank if none apply)
   a. ☐ This plan/benefit option provides Minimum Essential Coverage.
   b. ☐ This plan/benefit option meets the Minimum Value Standards.

133. Tiered networks. If the plan provides more than one network tier, provide the name of the:
   a. ☐ Lowest cost tier: ________________________________
   b. ☐ the next lowest cost tier: ________________________________
   c. ☐ the next lowest cost tier: ________________________________
   d. ☐ the next lowest cost tier: ________________________________

134. If the plan has separate deductibles for specific services, list the dollar amount and type of service for each of the three most significant specific deductibles: (Select all that apply)
   a. ☐ Deductible 1
      1. ☐ $_________/person
      2. ☐ $_________/family
      3. ☐ for _______________________________ [describe services to which deductible applies]
   b. ☐ Deductible 2
      1. ☐ $_________/person
      2. ☐ $_________/family
      3. ☐ for _______________________________ [describe services to which deductible applies]
   c. ☐ Deductible 3
      1. ☐ $_________/person
      2. ☐ $_________/family
      3. ☐ for _______________________________ [describe services to which deductible applies]
   d. ☐ Are there additional specific deductibles not listed above?
      1. ☐ Yes
      2. ☐ No

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SIGNED
__________________________
(Required)