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

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

Summary of Benefits and Coverage

j. ☐ Yes
k. ☐ No

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: _____.

2. 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

3. FORMAT

a. ☐ Standard (letter size, single spaced, ragged margin)
b. ☐ Right justified margins

4. 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

PLAN INFORMATION - REQUIRED BY ERISA

5. Name of Plan (Exact Legal Name)

a. _____
b. _____
c. _____

6. Tax number & Plan number

a. Tax number _____
(Employer Identification Number)

b. Plan number _____
(e.g., 501, 502, etc.)

7. 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.

8. Plan effective date a. _____
(month) (day) (year)

9. Plan Year ends a. _____
(month) (day)

Begins b. _____
(month) (day)

EMPLOYER INFORMATION

10. Employer

a. _____
(Name)

b. _____
(Street)

c. _____ d. _____ e. _____
(City) (State) (Zip)

f. _____
(Telephone)

g. _____
(website for plan information or copies of plan documents)

h. _____
(telephone number for plan information or copies of plan documents)

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. _____ 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

f. ☐ The initial stability period shall be a period of:

1. _____ calendar months (at least 6 and no more than the initial measurement period)

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 <u>not</u> 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
n. ☐ No

15. Is there Dependent coverage?

a. ☐ No (skip to **21.**)
b. ☐ Yes

16. Are Spouses covered?
- a. ☐ No
- b. ☐ Yes

If Yes,
- c. ☐ legally married opposite sex only AND
  - 1. ☐ common law marriages are included OR
  - 2. ☐ common law marriages are not included
- d. ☐ legally married same and opposite sex AND
  - 1. ☐ common law marriages are included OR
  - 2. ☐ common law marriages are not included
- e. ☐ A Spouse will not be eligible for coverage if
  - 1. ☐ Spouse has other group coverage available
  - 2. ☐ Spouse is covered under other group coverage

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

AND
- 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

and ends:
- 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 _____

AND
- 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 _____

AND
- l. ☐ 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

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 _____
  - 4. ☐ is unmarried

AND
- d. ☐ 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 (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)

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

NOTE: All tables will appear after the Introduction section of the document when selected with the Managed Care medical benefits schedule table format.

---

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. _____

Pharmacy (retail) drug option

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

_____
(Name)

2. ☐ N/A

Four-tier drug plan (if plan is two- or three-tier, fill out **f.**, **g.** and **h.** only, as appropriate)
(Note: When HDHP, **1f.** is selected, all charges are subject to medical deductible.)

		Copayment	% 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. _____%

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

36. Mail Order Option

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

_____
(Name)

2. ☐ N/A

Four-tier drug plan (if plan is two- or three-tier, fill out **c.**, **d.** and **e.** only, as appropriate)
(Note: When HDHP, **1f.** is selected, all charges are subject to medical deductible)

		Copayment	% payable
c.	Generic	1. $_____	2. _____%
d.	Formulary (preferred) brand name	1. $_____	2. _____%
e.	Non-Formulary (non-preferred) brand name	1. $_____	2. _____%
f.	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?
g. ☐ No
h. ☐ Yes $_____

37. 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. $_____

38. 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. $_____

e. ☐ including deductible
f. ☐ excluding deductible (grandfathered plans only)
g. ☐ including copays
h. ☐ excluding copays (grandfathered plans only)

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

Dental limits
c. ☐ N/A
d. ☐ The following services are limited as shown
1. ☐ Oral exams, _____ exam (Number)
a. every _____ (Interval)
2. ☐ Bitewing x-ray series, every _____ (Interval)
3. ☐ Full mouth x-ray, every _____ (Interval)
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 _____ (Interval)
7. ☐ Free adjustments to dentures within _____ of installation (Interval)
8. ☐ Replacing temporary dentures with permanent dentures, within _____ (Interval)

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 _____

Intensive Care Unit
e. ☐ Same as room and board rate
f. ☐ _____ times semiprivate room and board rate
g. ☐ Hospital's ICU charge
h. ☐ 100% UCR
i. Special charge maximum $_____

For Employees-new confinement after:
j. ☐ One day active work
k. ☐ _____ days active work
l. ☐ N/A

For Dependents-new confinement after:
m. ☐ 90 days separation
n. ☐ _____ days separation
o. ☐ N/A

Ambulance service
p. ☐ No
q. ☐ Yes, then
1. ☐ $_____ maximum per confinement
2. ☐ No limit

51. BASIC SURGICAL (Only applies if 2h2. selected)
Type of reimbursement
a. ☐ Scheduled
b. ☐ 100% UCR
c. Maximum (for series of related procedures) $_____

Anesthesia coverage
d. ☐ None
e. ☐ _____% of surgery
f. ☐ 100% UCR

Assistant surgeon charges
g. ☐ None
h. ☐ _____% of surgery

52. BASIC IN-HOSPITAL PHYSICIAN MEDICAL CARE
(Only applies if **2h3.** selected) (select all that apply)
a. ☐ 100% UCR
b. ☐ Daily limit $_____
c. ☐ Maximum $_____ per confinement

53. BASIC DIAGNOSTIC TESTING, X-RAY AND LAB
(Only applies if **2h4.** selected)
a. ☐ 100% UCR
b. ☐ $_____ Maximum per accident

54. BASIC RADIATION/CHEMOTHERAPY (Only applies if **2h5.** selected)
a. ☐ 100% UCR
b. ☐ Scheduled

55. SUPPLEMENTARY ACCIDENT (complete both) (Only applies if **2e.** selected)
(Note: When HDHP, **1f.** is selected, all charges are subject to deductible)
a. Care within _____
(show hours, days or months)
b. Maximum benefit (per accident) $_____

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 _____
(Name)

1. _____
(Street)

2. _____
(City, State Zip)

3. _____
(Telephone)

4. _____
(Fax number)

5. _____
(Email address)

Is there a 2nd PPO/EPO/POS

f. ☐ No

g. ☐ Yes

PPO/EPO/POS _____
(Name)

1. _____
(Street)

2. _____
(City, State Zip)

3. _____
(Telephone)

4. _____
(Fax number)

5. _____
(Email address)

Is there a 3rd PPO/EPO/POS

h. ☐ No

i. ☐ Yes

PPO/EPO/POS _____
(Name)

1. _____
(Street)

2. _____
(City, State Zip)

3. _____
(Telephone)

4. _____
(Fax number)

5. _____
(Email address)

Is there a 4th PPO/EPO/POS

j. ☐ No

k. ☐ Yes

PPO/EPO/POS _____
(Name)

1. _____
(Street)

2. _____
(City, State Zip)

3. _____
(Telephone)

4. _____
(Fax number)

5. _____
(Email address)

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. ☐ _____
   1. ☐ Not counted toward Out-of-Pocket maximum
   2. ☐ _____ annual benefit limit

b. ☐ _____
   1. ☐ Not counted toward Out-of-Pocket maximum
   2. ☐ _____ annual benefit limit

c. ☐ _____
1. ☐ Not counted toward Out-of-Pocket maximum
2. ☐ _____ annual benefit limit

d. ☐ _____
1. ☐ Not counted toward Out-of-Pocket maximum
2. ☐ _____ annual benefit limit

	Column A	Column B

63. Deductible(s)

a. ☐ Yes b. ☐ N/A

Per Covered Person	c. _____	d. _____
Per Family Unit dollar amount	e. _____	f. _____
number of people	g. _____	h. _____

Three-month carryover?
i. ☐ Yes
j. ☐ No

Common accident provision?
k. ☐ Yes
l. ☐ No

Waived for the following services: (Network Preventive Care Services must be included if nongrandfathered plan)

m. ☐ _____

n. ☐ _____

o. ☐ _____

Which expenses are excluded from satisfaction of the deductible?
p. ☐ coinsurance
q. ☐ copayments
r. ☐ penalties for failure to follow prior authorization and cost containment procedures
s. ☐ premiums
t. ☐ Are family deductibles embedded (Plan pays expenses if individual meets single deductible before family deductible is met)
1. ☐ Yes
2. ☐ No

64. Copayment(s), per visit

(Note: When HDHP, **1f.** is selected, copayments may only apply to preventive care type services, numbered **92.** - **95.** on this checklist.)

a. ☐ Yes b. ☐ N/A

Hospital	c. _____	d. _____
Physician visit	e. _____	f. _____
Specialist visit	g. _____	h. _____
Outpatient service	i. _____	j. _____

Emergency room (for nongrandfathered plans, in-network co-pay must apply if for Medical Emergency)
k. _____ l. _____

Waived if admitted to Hospital?
m. ☐ Yes
n. ☐ No

	Column A	Column B

65. Maximum out-of-pocket amount, per Calendar or Plan Year. (For nongrandfathered 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.)

a. ☐ Yes b. ☐ N/A

Per Covered Person	c. _____	d. _____
Per Family Unit dollar amount	e. _____	f. _____
number of people	g. _____	h. _____

Network Charges for Out-of-Pocket Maximum applies to the following; (select all that apply, leave blank if none apply):
i. ☐ In-network charges apply to the out-of-pocket maximum for out-of-network charges
j. ☐ Out-of-network charges apply to the out-of-pocket maximum for in-network charges

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

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.**
m. ☐ Yes
n. ☐ No

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.)
a. ☐ deductible (must complete **1.** or **2.** below)
1. ☐ in- and out-of-network (grandfathered plans only)
2. ☐ out-of-network only
b. ☐ copayment (grandfathered plans only)
c. ☐ expenses for Prescription Drug benefits (must complete **1.** or **2.** below)
1. ☐ in- and out-of-network (nongrandfathered plans must also complete Question **38.**)
2. ☐ out-of-network only
d. ☐ Cost containment penalties
e. ☐ Amounts over allowed amount
f. ☐ Other _____

67. Hospital room and board

a. ☐ Yes

Semiprivate rate	b. _____	c. _____
	Subject to	Subject to
	1. ☐ deductible	1. ☐ deductible
	2. ☐ copayment	2. ☐ copayment
	3. ☐ N/A	3. ☐ N/A

68. Emergency Room Visit/Urgent Care

a. ☐ Yes b. ☐ Not covered

c. ☐ Medical emergency care (For Nongrandfathered plans, in-network benefit levels must be provided for out-of-network providers)

	1. _____	2. _____
	Subject to	Subject to
	a. ☐ deductible	a. ☐ deductible
	b. ☐ copayment	b. ☐ copayment
	c. ☐ N/A	c. ☐ N/A

	Column A	Column B

d. ☐ Medical non-emergency care

	1. _____	2. _____
	Subject to	Subject to
	a. ☐ deductible	a. ☐ deductible
	b. ☐ copayment	b. ☐ copayment
	c. ☐ N/A	c. ☐ N/A

e. ☐ Medical non-emergency care not covered

Urgent Care

f. ☐ Yes g. ☐ Not covered

	h. _____	i. _____
Reimbursement rate	Subject to	Subject to
	1. ☐ deductible	1. ☐ deductible
	2. ☐ copayment	2. ☐ copayment
	3. ☐ N/A	3. ☐ N/A

69. Intensive Care unit

a. ☐ Yes b. ☐ N/A

	1. _____	2. _____
c. ☐ ICU charge	Subject to	Subject to
	a. ☐ deductible	a. ☐ deductible
	b. ☐ copayment	b. ☐ copayment
	c. ☐ N/A	c. ☐ N/A

	1. _____	2. _____
d. ☐ Same as semiprivate room rate	Subject to	Subject to
	a. ☐ deductible	a. ☐ deductible
	b. ☐ copayment	b. ☐ copayment
	c. ☐ N/A	c. ☐ N/A

	1. _____	2. _____
e. ☐ _____, per day	Subject to	Subject to
	a. ☐ deductible	a. ☐ deductible
	b. ☐ copayment	b. ☐ copayment
	c. ☐ N/A	c. ☐ N/A

70. Skilled Nursing Facility

a. ☐ Yes b. ☐ N/A

(select reimbursement rate, time following Hospital stay, and annual limit)

	1. _____	2. _____
c. ☐ One-half Hospital average semiprivate R&B	Subject to	Subject to
	a. ☐ deductible	a. ☐ deductible
	b. ☐ copayment	b. ☐ copayment
	c. ☐ N/A	c. ☐ N/A

	1. _____	2. _____
d. ☐ The facility's semiprivate room rate	Subject to	Subject to
	a. ☐ deductible	a. ☐ deductible
	b. ☐ copayment	b. ☐ copayment
	c. ☐ N/A	c. ☐ N/A

	Column A	Column B

	1. _____	2. _____
e. ☐ _____ per day	Subject to	Subject to
	a. ☐ deductible	a. ☐ deductible
	b. ☐ copayment	b. ☐ copayment
	c. ☐ N/A	c. ☐ N/A

Time following Hospital stay

f. ☐ Immediately follows

g. ☐ Within _____ days of a

1. _____ day stay

h. ☐ Not tied to Hospital stay

	i. _____	j. _____
Annual limit--days		

71. Physician services

	a. _____	b. _____
Inpatient services Reimbursement rate	Subject to	Subject to
	1. ☐ deductible	1. ☐ deductible
	2. ☐ copayment	2. ☐ copayment
	3. ☐ N/A	3. ☐ N/A

	c. _____	d. _____
Office visits Reimbursement rate	Subject to	Subject to
	1. ☐ deductible	1. ☐ deductible
	2. ☐ copayment	2. ☐ copayment
	3. ☐ N/A	3. ☐ N/A

	e. _____	f. _____
Specialist office visits Reimbursement rate	Subject to	Subject to
	1. ☐ deductible	1. ☐ deductible
	2. ☐ copayment	2. ☐ copayment
	3. ☐ N/A	3. ☐ N/A

	g._____	h._____
Surgical services Reimbursement rate	Subject to	Subject to
	1. ☐ deductible	1. ☐ deductible
	2. ☐ copayment	2. ☐ copayment
	3. ☐ N/A	3. ☐ N/A

	i. _____	j. _____
Allergy testing Reimbursement rate	Subject to	Subject to
	1. ☐ deductible	1. ☐ deductible
	2. ☐ copayment	2. ☐ copayment
	3. ☐ N/A	3. ☐ N/A

	k. _____	l. _____
Allergy serum and injections Reimbursement rate	Subject to	Subject to
	1. ☐ deductible	1. ☐ deductible
	2. ☐ copayment	2. ☐ copayment
	3. ☐ N/A	3. ☐ N/A

	Column A	Column B
72. Diagnostic Testing (X-ray and Lab)		
a. ☐ Yes b. ☐ N/A		
Reimbursement rate	c. _____	d. _____
Subject to	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A
Imaging (CT/PET scans, MRIs)		
e. ☐ Yes f. ☐ N/A		
Reimbursement rate	g. _____	h. _____
Subject to	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A
73. Home Health Care visits		
a. ☐ Yes b. ☐ N/A		
Reimbursement rate	c. _____	d. _____
Subject to	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A
Annual limit	e. _____	f. _____
74. Inpatient Drugs only (in conjunction with freestanding Prescription Drug plan)		
a. ☐ Yes b. ☐ N/A		
Reimbursement rate	c. _____	d. _____
Subject to	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A
75. Inpatient and Outpatient Drugs (no separate freestanding Prescription Drug plan)		
a. ☐ Yes b. ☐ N/A		
Reimbursement rate	c. _____	d. _____
Subject to	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A
If HDHP, **1f.** and **75c1.** or **75d1.** are selected, are Preventive drugs subject to the medical deductible?		
e. ☐ Yes f. ☐ No		
76. Private duty nursing outpatient		
a. ☐ Yes b. ☐ N/A		
Reimbursement rate	c. _____	d. _____
Subject to	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A
Annual limit	e. _____	f. _____

	Column A	Column B
77. Hospice Care (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.)		
a. ☐ Yes b. ☐ N/A		
Reimbursement rate	c. _____	d. _____
Subject to	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A
Outpatient Lifetime maximum	e. _____	f. _____
Inpatient and outpatient Lifetime maximum	g. _____	h. _____
78. Bereavement counseling -- within 6 months of death		
a. ☐ Yes b. ☐ N/A		
Reimbursement rate	c. _____	d. _____
Subject to	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A
Lifetime maximum visits	e. _____	f. _____
Lifetime maximum	g. _____	h. _____
79. Ambulance		
a. ☐ Yes b. ☐ N/A c. ☐ Ground only d. ☐ Ground and air		
Reimbursement rate	e. _____	f. _____
Subject to	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A
Per trip maximum (ground)	g. _____	h. _____
Per trip maximum (air)	i. _____	j. _____
k. ☐ Limited to _____ miles per one-way trip (ground only)		
80. TMJ coverage limits		
a. ☐ Yes b. ☐ N/A		
Reimbursement rate	c. _____	d. _____
Subject to	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A
81. Wig after chemotherapy		
a. ☐ Yes b. ☐ N/A		
Reimbursement rate	c. _____	d. _____
Subject to	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A
Lifetime maximum	e. _____	f. _____

82. If therapy benefits are provided, are Occupational, Speech and Physical therapy maximum visits combined?
a. ☐ Yes, indicate annual maximum number of visits allowed _____
b. ☐ N/A

83. Occupational therapy
a. ☐ Yes b. ☐ N/A

	Column A	Column B
Reimbursement rate	c. _____	d. _____
Subject to	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A

84. Speech therapy
a. ☐ Yes b. ☐ N/A

	Column A	Column B
Reimbursement rate	c. _____	d. _____
Subject to	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A

85. Physical therapy
a. ☐ Yes b. ☐ N/A

	Column A	Column B
Reimbursement rate	c. _____	d. _____
Subject to	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A

86. Durable medical equipment
a. ☐ Yes b. ☐ N/A

	Column A	Column B
Reimbursement rate	c. _____	d. _____
Subject to	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A

87. Prosthetics
a. ☐ Yes b. ☐ N/A

	Column A	Column B
Reimbursement rate	c. _____	d. _____
Subject to	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A

88. Orthotics
a. ☐ Yes b. ☐ N/A

	Column A	Column B
Reimbursement rate	c. _____	d. _____
Subject to	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A

89. Spinal Manipulation/Chiropractic
a. ☐ Yes b. ☐ N/A

	Column A	Column B
Reimbursement rate	c. _____	d. _____
Subject to	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A

90. Mental disorders
a. ☐ Yes b. ☐ N/A

	Column A	Column B
Reimbursement rate Inpatient	c. _____	d. _____
Subject to	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A
Outpatient Office Visits	e. _____	f. _____
Subject to	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A
Outpatient: Intermediate Care	g. _____	h. _____
Subject to	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A

91. Substance abuse
a. ☐ Yes b. ☐ N/A

	Column A	Column B
Reimbursement rate Inpatient	c. _____	d. _____
Subject to	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A
Outpatient Office Visits	e. _____	f. _____
Subject to	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A
Outpatient: Intermediate Care	g. _____	h. _____
Subject to	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A

92. Routine well adult care (Nongrandfathered plans must provide in-network Standard Preventive Care (preventive care required under ACA) without cost sharing.)
a. ☐ Yes b. ☐ N/A

	Column A	Column B
Reimbursement rate	c. _____	d. _____
Subject to	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A	1. ☐ deductible 2. ☐ copayment 3. ☐ N/A

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.)
a. ☐ Pap smear
b. ☐ Mammogram
c. ☐ Prostate exam

d. ☐ Gynecological exam
e. ☐ Routine physical exam
f. ☐ X-rays
g. ☐ Laboratory tests
h. ☐ Hearing tests
i. ☐ Vision tests
j. ☐ Immunizations/flu shots
k. ☐ Obesity/Weight Loss programs
l. ☐ Tobacco cessation program (select **1.** or **2.**):
  1. ☐ Program will follow DOL safe harbor guidelines
  2. ☐ Program will offer coverage as required for Standard Preventive Care
m. ☐ Colonoscopies
n. ☐ Bone Density scans
o. ☐ Stress Tests
p. ☐ Sigmoidoscopies
q. ☐ Standard Preventive Care

For (1) employers with nongrandfathered plans who claim a religious exemption or (2) employers with grandfathered plans, complete **1.**, **2.** and **3.** as applicable. (Leave blank if not applicable)
  1. ☐ Exclude contraceptives
  2. ☐ Exclude abortifacients
  3. ☐ Exclude sterilization procedures

r. ☐ Other _____

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.**)

	Column A	Column B

94. Nursery/Physician well-baby newborn care
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

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

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 should complete **l.**) **(select all that apply; leave blank if none apply)**
e. ☐ Routine physical exam
f. ☐ Laboratory tests
g. ☐ X-rays
h. ☐ Immunizations
i. ☐ Hearing tests
j. ☐ Vision tests
k. ☐ Through age _____ (18 for nongrandfathered)
l. ☐ Standard Preventive Care for children

If HDHP, **1f.** and **95c1.** or **95d1.** are selected, are Preventive Care services subject to the medical deductible?
m. ☐ Yes n. ☐ No

	Column A	Column B

96. Organ transplant coverage
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

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 Dependents other than Spouse (Note: For nongrandfathered plans, if **d.** is checked, the document will reflect that prenatal and post natal 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

98. Infertility coverage (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)

	Column A	Column B
Reimbursement rate	c. _____ Subject to 1. ☐ deductible 2. ☐ copayment 3. ☐ N/A	d. _____ Subject to 1. ☐ deductible 2. ☐ copayment 3. ☐ N/A
Lifetime maximum	e. _____	f. _____
Annual maximum	g. _____	h. _____

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

Are there any additional exclusions?
- 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. ☐ $_____
  - 4. ☐ 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. ☐ $_____
  - 4. ☐ Benefit payment reduced by $_____

	Column A	Column B
106. Outpatient Surgery		
a. ☐ Not covered		
b. ☐ Yes		
Reimbursement rate	c. _____	d. _____
	Subject to	Subject to
	1. ☐ deductible	1. ☐ deductible
	2. ☐ copayment	2. ☐ copayment
	3. ☐ N/A	3. ☐ N/A

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)

g. ☐ Use Employer/trust fund address
h. ☐ Other

1. _____ (Street)
2. _____ (City) 3. _____ (State) 4. _____ (Zip)

Is there a 3rd Trustee?
i. ☐ No
j. ☐ Yes

1. _____ (Name)
2. _____ (Title)

k. ☐ Use Employer/trust fund address
l. ☐ Other

1. _____ (Street)
2. _____ (City) 3. _____ (State) 4. _____ (Zip)

Is there a 4th Trustee?
m. ☐ No
n. ☐ Yes

1. _____ (Name)
2. _____ (Title)

o. ☐ Use Employer/trust fund address
p. ☐ Other

1. _____ (Street)
2. _____ (City) 3. _____ (State) 4. _____ (Zip)

Is there a 5th Trustee?
q. ☐ No
r. ☐ Yes

1. _____ (Name)
2. _____ (Title)

s. ☐ Use Employer/trust fund address
t. ☐ Other

1. _____ (Street)
2. _____ (City) 3. _____ (State) 4. _____ (Zip)

111. Claims administrator/supervisor/processor

a. _____ (Name)

b. _____ (Street or P.O. Box)

c. _____ (City) d. _____ (State) e. _____ (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:

_____

_____

_____

_____

_____

b. ☐ Yes
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

ADOPTING EMPLOYERS

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. _____ (City) f. _____ (State) g. _____ (Zip)

h. _____ (Telephone)

i. _____ (Tax ID Number)

120. Will there be a second Adopting Employer?

a. ☐ No
b. ☐ Yes

c. _____
(Name)

d. _____
(Street)

e. _____ f. _____ g. _____
(City) (State) (Zip)

h. _____
(Telephone)

i. _____
(Tax ID Number)

121. Will there be a third Adopting Employer?

a. ☐ No
b. ☐ Yes

c. _____
(Name)

d. _____
(Street)

e. _____ f. _____ g. _____
(City) (State) (Zip)

h. _____
(Telephone)

i. _____
(Tax ID Number)

122. Will there be a fourth Adopting Employer?

a. ☐ No
b. ☐ Yes

c. _____
(Name)

d. _____
(Street)

e. _____ f. _____ g. _____
(City) (State) (Zip)

h. _____
(Telephone)

i. _____
(Tax ID Number)

123. Will there be a fifth Adopting Employer?

a. ☐ No
b. ☐ Yes

c. _____
(Name)

d. _____
(Street)

e. _____ f. _____ g. _____
(City) (State) (Zip)

h. _____
(Telephone)

i. _____
(Tax ID Number)

124. Will there be a sixth Adopting Employer?

a. ☐ No
b. ☐ Yes

c. _____
(Name)

d. _____
(Street)

e. _____ f. _____ g. _____
(City) (State) (Zip)

h. _____
(Telephone)

i. _____
(Tax ID Number)

125. Will there be a seventh Adopting Employer?

a. ☐ No
b. ☐ Yes

c. _____
(Name)

d. _____
(Street)

e. _____ f. _____ g. _____
(City) (State) (Zip)

h. _____
(Telephone)

i. _____
(Tax ID Number)

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.

	Coinsurance – Amount PARTICIPANT pays		Copayments	
	Network rate	**Out-of-network rate**	**Network rate**	**Out-of-network rate**
a. ☐ Primary care office visits: (coordinate with **64e./64f.** and **71c./71d.**)	1. _____%	2. _____%	3. $_____	4. $_____
b. ☐ Other Practitioner office visits				
1. ☐ Specialist: (coordinate with **64g./64h.** and **71e./71f.**)	a. _____%	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 **64i./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 **68c.**)	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. $_____

	Coinsurance – Amount PARTICIPANT pays		Copayments	
	Network rate	Out-of-network rate	Network rate	Out-of-network rate

3. ☐ Substance Abuse Outpatient: (coordinate with **91e./f.**)

a. _____% b. _____% c. $_____ d. $_____

4. ☐ Substance Abuse Inpatient: (coordinate with **91c./d.**)

a. _____% b. _____% c. $_____ d. $_____

o. ☐ Maternity (coordinate with **97.**)

1. ☐ Office Visits

a. _____% b. _____% c. $_____ d. $_____

2. ☐ Childbirth/Delivery professional services

a. _____% b. _____% c. $_____ d. $_____

3. ☐ Childbirth/Delivery facility services

a. _____% b. _____% c. $_____ d. $_____

p. ☐ Home Health Care: (coordinate with **73c./d.**)

1. _____% 2. _____% 3. $_____ 4. $_____

q. ☐ Rehabilitation Services: (coordinate with **83c.**, **84c.** and **85c.**)

1. ☐ Occupational therapy: (coordinate with **83c./d.**)

a. _____% b. _____% c. $_____ d. $_____

2. ☐ Speech therapy: (coordinate with **84c./d.**)

a. _____% b. _____% c. $_____ d. $_____

3. ☐ Physical therapy: (coordinate with **85c./d.**)

a. _____% b. _____% c. $_____ d. $_____

r. ☐ Habilitation Services (Reserved for future use.)

s. ☐ Skilled Nursing: (coordinate with **70c.**, **d.** OR **e.**, as applicable)

1. _____% 2. _____% 3. $_____ 4. $_____

t. ☐ Durable medical equipment: (coordinate with **86c./d.**)

1. _____% 2. _____% 3. $_____ 4. $_____

u. ☐ Hospice Service (coordinate with **77c./d.**):

1. _____% 2. _____% 3. $_____ 4. $_____

v. ☐ Children's Eye Care (coordinate with **95.**)

1. ☐ Eye Exam

a. _____% b. _____% c. $_____ d. $_____

2. ☐ Eye Glasses

a. _____% b. _____% c. $_____ d. $_____

w. ☐ Children's Dental Checkup: (coordinate with **47a.**)

1. _____% 2. _____% 3. $_____ 4. $_____

x. ☐ Drug coverage:

	RETAIL		MAIL ORDER	
	Coinsurance	Copayments	Coinsurance	Copayments

1. ☐ Generic Drugs: (coordinate with **35f./36c.**)

a. _____% b. $_____ c. _____% d. $_____

2. ☐ Preferred Brand Drugs: (coordinate with **35g./36d.**)

a. _____% b. $_____ c. _____% d. $_____

3. ☐ Non-Preferred Brand Drugs: (coordinate with **35h./36e.**)

a. _____% b. $_____ c. _____% d. $_____

4. ☐ Specialty Drugs: (coordinate with **35i./36f.**)

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 commas 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: $_____

5. ☐ Does the plan have a wellness program that may reduce these costs for plan participants who participate in the wellness program?

a. ☐ Yes. Contact information:

_____

b. ☐ No

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: $_____

5. ☐ Does the plan have a wellness program that may reduce these costs for plan participants who participate in the wellness program?

a. ☐ Yes. Contact information:

_____

b. ☐ No

c. ☐ 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: $_____

5. ☐ Does the plan have a wellness program that may reduce these costs for plan participants who participate in the wellness program?

a. ☐ Yes. Contact information:

_____

b. ☐ No

131. Language Access: (Insert the telephone number for the corresponding language.)

a. Spanish (Espanol): Para obtener asistencia en Espanol, 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): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo 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

These documents are being printed by FIS Relius at the direction of the person named on the transmittal form. It is understood that FIS Relius is not engaged in the practice of law or representing itself as experts in the area of self-funded health plans. Any unanswered questions may result in errors in the Plan produced by using the information from this worksheet. I understand that in preparing the document requested, FIS Relius is utilizing information shown on this checklist to produce documents using a format which has been designed by FIS Relius and programmed by FIS Relius on its FIS Relius® Documents system. FIS Relius has made NO REPRESENTATION OR WARRANTY OF ANY KIND, expressed or implied, including no warranties of MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE, nor is any opinion, expressed or implied, rendered as to the legal effect or sufficiency of any document utilizing FIS Relius's format. If a check is not enclosed, the undersigned agrees to pay FIS Relius upon receipt of such documents at the prices in effect when this order was received by FIS Relius. I hereby RELEASE FIS Relius and its attorneys from any and all liability attributable to any legal or other defect in the requested documents. I further understand that I must review the documents FIS Relius provides to determine their accuracy and suitability for the needs of the specific client.

SIGNED

_____

(Required)