© 2003 International Foundation of Employee Benefit Plans, Inc.

Plan Document of the Defined Benefit Self-Funded Health Care Plan

of

XYZ Company

Effective July 1, _________

© 2003 International Foundation of Employee Benefit Plans, Inc.

Commentary and Guide for the Schedule of Benefits

© 2003 International Foundation of Employee Benefit Plans, Inc.

TABLE OF CONTENTS

Document Execution Page
Limited Power of Attorney
General Comments
Medical (Not Mental or Nervous) Benefits
 Individual Lifetime Maximum Benefit
Annual Benefit Restoration
Deductibles
 How Determined
 Family Deductible
 Deductible Waived for Accidents
 Deductible Carryover
Special Deductibles
Plan Takeover Deductible
Plan's Copayment Rate
Benefit Year Out-Of-Pocket Maximum
Hospital Limitations
Emergency Room Limitation
Surgical Benefits
 Second Surgical Opinion
 Outpatient Surgical Benefits
Multiple Procedures and Assistant Surgeons
Anesthesiology Benefits
Convalescent Care
Home Health Care
Hospice Care
Organ Transplants
Coordination of Benefits
 Example One
 Example Two
Physician Extenders
TMJ Surgery and Temporomandibular Joint Dysfunction
Supplement Accident Benefit
Chiropractic Care
Alternate Therapies
Maternity Benefits
Elective Benefits
Prescription Drugs
Well Patient Care
Mental and Nervous Benefits
Miscellanous Benefit
 Dental Care
 Vision Care Benefits
 Hearing Care Benefits
Short Term Disability Benefits

© 2003 International Foundation of Employee Benefit Plans, Inc.

Coverage Continuation and Conversion
Retired Former Participants
Cost Containment-Traditional
Cost Containment-PPOs and Directed Care
- In General
- Advantages and Disadvantages
- Plan Structure

Preferred Provider Organization
- In General
- What is a PPO?
- Characteristics of a PPO
- Incentives in PPO Participation
- Four Types of PPO Options
- Large Case Management
- Maternity Management Program
- Elective Primary Care Physician

Cost Containment-Demand Management
- In General
- Disease Management

Plan Funding
- Participant Contributions and Risk Assumption
- Other Funding Variables
- Trusteed vs. Non-Trusteed
- Type of Plan

Certain Terms and Phrases
- Employer (Or Plan Sponsor)
- ERISA Compliance
- Participating Employers
- Plan Name
- Plan Number for Administration Purposes
- Plan Number for ERISA Purposes
- State of Delivery
- Effective Date of the Plan
- Plan Options
- Plan Supervisor
- Plan Administrator
- Plan Coordinator
- Type of Welfare Plan
- Plan Attachments
- Benefit Year
- Plan Year
- Employee
- Trust
- Trustees
- Qualifying Hours
- Eligibility Class
- Eligibility Waiting Period
- Retirees

© 2003 International Foundation of Employee Benefit Plans, Inc.

Termination of Coverage Date
Temporary Employees
Preexisting Conditions
Administrative Guides
Late Enrollment Procedure
Actively-at-Work
Claim Filing Period
Claim Processing Responsibility of the Plan Supervisor
Re-Employment Period
Leave of Absence Period
Disability Extension Period
Maximum Extended Coverage Period
Basis of Non-Occupational Coverage
Unmarried Child's Eligibility Age
Extensions and Limitations of Coverage

© 2003 International Foundation of Employee Benefit Plans, Inc.

Document Execution Page

The signatory will normally be the person who authoritatively represents the Plan Sponsor (Employer, e.g.). Such signature will not make trust person the Plan Administrator, as contemplated by ERISA. Some plan sponsors, for reason of convenience and efficiency are comfortable with having the Plan Supervisor (or similar) execute the Plan document under a limited power-of-attorney, a copy of which is attached hereto.

Amendments should be recorded chronologically and their nature in purpose noted. Plan document an amendment signatories need not be the same. Frequent Plan amending usually equates to good plan supervision.

When the document is executed by a power-of-attorney, the Plan Supervisor may possibly be deemed a plan fiduciary depending on other facts and circumstances. The advantage of the Plan Supervisor executing the document is the ease and speed of setting up Plan operating guides and getting the papers to the stop-loss carrier. The Employer is encouraged to take the executed document and carefully review it, and have its attorney carefully review it after which any changes may be made either by amendment of by slip-sheet. In effect, the Plan Supervisor's signature puts a temporary document in place on *Day One* of the Plan for ease of administration. The Employer will usually execute the document once its review (and its attorney's review) is completed; such double signature could possibly reflect the co-fiduciary relationship to the Plan of the Employer and the Plan Supervisor; such double-signature is desirable but not mandatory.

© 2003 International Foundation of Employee Benefit Plans, Inc.

Limited Power of Attorney

The undersigned officer of _________________________ (Employer) does hereby nominate, constitute, and appoint ____________________(Plan Supervisor) its true and lawful attorney-in-fact for the undersigned and in a name, place and stead, and for its use and benefit, to execute on behalf of the Employer with respect to the health care plan the following documents:

_____ Endorsement of Stop-Loss Benefit checks payable to Employer to be made payable to the health care plan.
_____ All insurance, stop-loss and other applications as necessary.
_____ Plan document.

The Plan Supervisor is hereby authorized to act on our behalf to obtain any and all information necessary to administer the Plan.

IN WITNESS OF, THE UNDERSIGNED Employer has hereunto signed its name and affixed its corporate seal this _______________ day of ___________________, _______________.

(Seal) By: ________________________________

____
Title

____
Employer

ACKNOWLEDGEMENT

STATE OF ____________________________)
)ss.
COUNTY OF ____________________________)

On ____________________, 200______, before me, the undersigned Notary Public, personally appeared, _________________________ a duly authorized officer or representative of the Employer named above, and acknowledged the execution of the foregoing power-of-attorney for and on behalf of said Employer.

____
Notary Public

____
Date my commission expires

(Seal)

02/01 Limited Power of Attorney

© 2003 International Foundation of Employee Benefit Plans, Inc.

General Comments

1a. The past practice of showing plan options, ($1,000,000 lifetime maximum for salaried and $700,000 for hourly, e.g.) is no longer acceptable. Rather, with multiple option plans, each Covered Person must see what benefits are applicable to such person without regard to the other options. This new discipline is applicable only to the SPD. The Plan document may retain the old practice (pre-2000 SPD Regulations) should it wish.

b. Where the same Schedules of Benefits are shown in the Booklet as in the Plan document the following is recommended as the most efficient way of handling the Schedules of Benefits for both the document and booklet. At the bottom of each Schedule Page in the Plan document, display as *footers* the following three items of information:

- Date of Preparation — August 1, 2002, e.g.
- Plan Sponsor — ABC Employer, e.g.
- Plan Options — Examples
  Option A or Option B
  Gold or Silver Plan otherwise use
  N/A or Plan A or Plan B
  100 for Option A, e.g.

In so doing, the Schedule pages are efficiently maintained on a current basis and as an integral part of the Plan document. The collating of the appropriate Schedule pages for *printer's copy* of the booklet which must be unique for each option may be easily done.

c. Plans that have *in-network* and *out-of-network* benefits may show such different benefits in either of three ways:

- **Columnar**
  Has benefits under this column headings
- **Per Benefit**
  Show benefits by deductible, copayment, etc.
- **By Plan**
  Provide a separate Schedule of Benefits for each benefit.

2. There are numerous benefits in the Plan document which are elective. The Schedule of Benefits permits such elections in a simple manner. Virtually every type of benefit combination is available with the one Schedule of Benefits.

- Comprehensive or base plus major medical.
- With or without disability, dental, managed care options, multiple benefits, etc.
- All manner of cost containment arrangements.
- The Coverage Extensions and Limitations pages of the Schedule of Benefit pages are exclusively devoted to extensions and limitations of coverage.

© 2003 International Foundation of Employee Benefit Plans, Inc.

3. **Use of Terms**

Company and Employer may be used in the Guide interchangeably. The Schedule of Benefits is part of the Document. The Plan is a health care plan as contemplated by the IRS/DOL Form 5500. The Schedule of Benefits set forth the Plan Name and Plan Number as required by ERISA.

Plan Name: Health Care Plan of ABC Company.

Plan Number: 501 (Welfare plans begin at 500 and run through 999).

The Document sets forth the funding policy of the Plan. It is funded by means of a Benefit Fund; such funds should usually be under a trust when they are *uncommingled* from Employer funds as required by Department of labor Asset Regulations.

The Plan may be divided in numerous ways:

- The Employer may have two plans, e.g., one for salaried (Department of Labor 501) and one for hourly (Department of Labor Number 502). In this instance, two plan documents would be needed.
- The Employer may have one plan for Department of Labor purposes (Number 503, e.g.) but two sets of benefits. Benefit A is for salaried and Benefit B is for hourly. The Employer may assign two sets of Plan numbers for administrative purposes (Plan Number 01 and Plan Number 02); also, the employer may have only one Plan number of administrative purposes (Plan 03) with a dual set of benefits within the plan.

© 2003 International Foundation of Employee Benefit Plans, Inc.

Medical (Not Mental or Nervous) Benefits

Individual Lifetime Maximum Benefit

Such figure as $1,000,000 is used. A modifying sentence is added which makes clear the effective date from which the $1,000,000 is measured; i.e., either the current date (for a new plan) or the original date (for an amended and restated plan). Where the Plan is amended and restated, the Lifetime Maximum for a particular Covered Person will be reduced from the $1,000,000 by those claims paid from the original to be restated Effective Date.

The Benefit may be modified as follows:

- For Participants and Dependents who provide to the Plan Supervisor a Medical Directive (Living Will) such benefit is $1,000,000.
- For all others, such benefit is $250,000.

Annual Benefit Restoration

This provision is decreasingly used in practice because of the high level major medical maximum and the relatively high turnover of participants. It provides that some amount, such as $10,000 is added back into the major medical maximum otherwise reduced for each plan year of experience of the covered plan.

© 2003 International Foundation of Employee Benefit Plans, Inc.

Deductibles

Deductible Per Individual
Enter, say, $250

Maximum Deductible Per Family
Enter, say, $750, or $500

Deductibles Waived for Accidents?
Enter *yes* or *no*
A *yes* entry would indicate that there was a supplemental accident benefit

Deductible Carryover Period
Enter *none* or *3 months*
Many plans no longer offer this benefit

The term *Deductible* refers to the amount of covered expenses which a Participant must incur before benefits become payable. The purpose of the Deductible is to eliminate small benefits, thereby reducing the overall cost of coverage. The Deductible also encourages the covered person to take an interest in the cost and necessity of the treatment received, since each person will be partially financially responsible.

Only those expenses covered under the Plan can be applied to the Deductible. Each covered person must meet the Deductible in accordance with the terms of the Plan.

The Deductible is a subtraction from covered expenses paid by the Participant. The balance is available for benefits subject to the Copayment Rate; numerous variations to the Deductible maybe found in the Plan as set forth.

How Determined

The Deductible Amount is deemed satisfied if accumulated over the Benefit Year. The Benefit Year is usually the calendar year or less often the Plan Year. The Benefit Year is set forth in the Schedule of Benefits.

Family Deductible

A Deductible has to be satisfied for each covered person. However, to prevent a burden of numerous deductibles for a large family, a family deductible of, say three deductibles is placed as a maximum per family deductible.

Deductible Waived for Accidents

The plan may waive the Deductible for Covered Expenses for accidents-if such expenses were incurred within seventy-two hours of the accident. The Schedule of Benefits sets forth whether or not such waiver is available.

© 2003 International Foundation of Employee Benefit Plans, Inc.

Deductible Carryover

The Schedule of Benefits sets forth this Carryover Period (usually three months) if any, where the Benefit Year is calendar year, and the deductible amount is $200, covered expenses during the month of October, November, and December are determined. If such are below $200, say $150, such $150 counts towards next Benefit Year deductible.

Special Deductibles

These deductibles are one-time in nature and apply in addition to the regular Deductibles.

Emergency Room Deductible
Enter say, $50 or $100

Per Hospital Admission Deductible
This deductible is often waived where a PPO hospital is used. Enter say, $250

Per Physician Office Visit Deductible
Enter say, *none* or $15

Plan Takeover Deductible

The Plan Year is July 1; the Benefit Year is calendar year. The plan goes from fully insured to self-funded July 1, 2001. Participant Jones had accumulated $150 during the first six months towards his 2001 deductible. The new self-funded plan would give Jones credit for the $150 deductible in determining benefits. This blank should show yes, no, or N/A.

Plan's Copayment Rate

Examples: 80%
90% In network; 70% out-of-network

Benefit Year Out-Of-Pocket Maximum

Individual (plus Deductible)	Enter, say, $1,000
Family (plus Deductible)	Enter, say, $3,000

© 2003 International Foundation of Employee Benefit Plans, Inc.

Hospital Limitations

The typical responses are these:

	Abbreviated Responses-Samples		
Maximum Room and Board	ASP	or	R&C
All Private Room Hospital	R&C	or	90% of Typical ASP
Hospital Intensive Care	3xASP	or	R&C

The all-private room rate of the hospital is an accounting device which permits the hospital to get more income without formally altering its basic room rate. The cost shift puts the burden on the payer and does not pass the hospital's balance-billing problem on to the patient.

Emergency Room Limitation

Where the Plan distinguishes between necessary and unnecessary emergency care (as defined in the Plan) the different benefits for each such admission should be set forth.

Surgical Benefits

Second Surgical Opinion

The Plan contemplates that the second surgical opinion may be either *optional* or *mandatory;* that a special allowance for the cost of that opinion will be made (100% up to $100, e.g.) and that if a second opinion is mandatory that there is a penalty for not obtaining such opinion.

Outpatient Surgical Benefits

Typical responses are these:

80%, No Deductible.
100%, No Deductible.
80%, Regular Deductible.

Multiple Procedures and Assistant Surgeons

The commonality of these surgery-related issues suggests that such should be dealt with in the Benefit Schedule and not in the Plan proper. The percentages are changeable; the percentages are both typical of the current industry practices and also similar to Medicare. The percentages are not designed to avoid the need to carefully review bills for upcoding and similar coding games.

Anesthesiology Benefits

Logic similar to that of Multiple Procedures applies to Anesthesiology Benefits. As with Multiple Procedures the applicable benefit percent may be easily modified.

Convalescent Care

The more typical requirements to quality for convalescent care include:

- Three days of inhospital care
- Entry into such convalescent facility within 14 days of discharge
- Maximum convalescent care of 30 days.

Home Health Care

The only two variables are maximum home care visits per Benefit Year and the number of permitted visits per day, a typical response to visits per Benefit Year is 100, visits per day is one (1).

Hospice Care

Plans typically will pay Hospice Benefits at Reasonable and Customary. The two more commonly found inside limits are $7,500 maximum for Room and Board and $3,000 maximum for miscellaneous.

Organ Transplants

The organ transplant section is sufficiently structured so that few elections are offered with the Benefit Schedule. Where there is a limitation ($100,000, e.g.) such figure would go into the right side as response. The *alert* language in the model Plan Document has the merit of having the Participant get advance authorization on the procedure so to avoid misunderstanding with third opinions, designated facilities, exclusions, inside limits with donor expenses, e.g. Because of the increasing popularity of designated transplant facilities, the Schedule of Benefits makes provision. Therefore, the typical inducement to using a designated facility is that (a) the deductible is waived and (b) the copayment rate is 100%.

Coordination of Benefits

These questions must be addressed in the Schedule of Benefits:

- **<u>Will Coordination be permitted?</u>**
  Increasing, plans are refusing to be a secondary payer.

- **<u>What benefits are subject to coordination?</u>**
  Typically, the response is medical only; however, dental may be coordinated or Rx may *not* be coordinated. Such distinctions should be made in the Schedule of Benefits.

- **<u>What constitute Submitted Charges?</u>**
  The patient has a legal responsibility to pay only the Submitted Charges from the primary plan. Yet, the secondary plan may argue that their obligation is measured against what their plan would deem Submitted Charges. In self-funded plans, both positions are defensible and must be recognized. This Submitted Charge issue arises where both the primary and secondary plan may be given PPO discounts which are different in the provider charges, while variations may be found any rules of the PPO or (PPOs) should be honored. Such rules, typically, are as follows:
  1. If the primary plan takes a discount, the secondary plan must use the primary plan's Submitted Charge. That is, no *dual-discounting* is permitted.
  2. If the primary plan does not take a discount, the secondary plan is free to do so.

- **<u>What secondary plan cutbacks should be preserved?</u>**
  The secondary plan should declare which of its cutbacks (it any) should be preserved. By preserving such cutbacks, their efficacy is retained but the purpose or need of coordination is diminished.

- **<u>Should the Benefit Bank be retained?</u>**
  The Benefit Bank was *standard fare* with fully insured plans at one time. Self-funded plans have tended to discard such for pragmatic reasons (computer complexities, difficulty in understanding, etc,).

- **<u>What rules are to be followed for dependent children?</u>**
  The Benefits Schedule, for simplicity, declares the *birthday rule* should be followed unless otherwise provided.

In understanding the COB election, consider this example:

- Mary, a participant is Plan A is also a covered dependant in Plan B. The Plan B allows coordination.

© 2003 International Foundation of Employee Benefit Plans, Inc.

- Mary has provider bills (Submitted Charges) which legally bind her to $1,000 as determined by Plan A; and $900 by Plan B. This is because Plan A and Plan B use different PPO's both of which include Mary's provider.
- Claim worksheets of Plan A and Plan B are as follows:

		Plan B	
	Plan A	Choice 1	Choice 2
Submitted Charges	1,000	1,000	900
Reductions or Cutbacks			
Deductibles/Copays	200	100	80
Cost-Contained Managed Care	**150**	**50**	**50**
Other	100	50	50
Paid Claim	550	800	720

Example One

Based on these choices:

• Submitted Charges	By Primary Plan
• Preserved Reductions	None
• Benefit Bank	Yes

The COB computation by Plan B is:

Submitted Charges	1,000
Preserved reductions	0
Allowable Expenses	1,000
Plan B benefit as primary	800
Plan A benefit as primary	550
Plan B benefit as secondary	450 (1,000-550)
To Plan B Benefit Bank	350 (800-450)

Example Two

Based on these choices:

• Submitted charges	Lesser of Plan A of Plan B
• Preserved reductions	Deductible/copay only
• Benefit Bank	No

The COB computation by Plan B is:

Submitted Charges	900
Preserved reductions	80
Allowable Expenses	820
Plan B benefit as primary	720
Plan A benefit as primary	550
Plan B benefit as secondary	270 (820-550)
To Plan B Benefit Bank	450 (720-270)

© 2003 International Foundation of Employee Benefit Plans, Inc.

Physician Extenders

So long as such physician extenders practice within the areas designated by the applicable state law, such extenders may file claims and be paid in their own right and under their own tax and professional ID number.

Examples of physician extenders are as follows:

- Nurse practitioners
- Physician assistant
- Certified registered nurse anesthesiologist.

TMJ Surgery and Temporomandibular Joint Dysfunction

In this instance, *covered* means that the condition is covered as a medical, as opposed to a dental benefit and if covered, whether or not there is a benefit maximum. Benefits, if not maximized, should be shown as reasonable and customary.

Supplement Accident Benefit

Typically, the benefit is the first $X of an accident claim without regard to any deductible.

Chiropractic Care

Importantly, Chiropractic Care, because of its commonality is not deemed by the plan document to be an *alternate* therapy. Inside limits to such care include copayment, maximum charge per treatment and maximum benefit per benefit year.

Alternate Therapies

Advantages to the plan and all the parties thereto is an illustrative listing of all of the so-called alternative therapies. The list, while extensive, is not exhaustive. Because chiropractic care is dealt with separately, it is not deemed an alternate therapy, albeit it is sometimes used as such.

Maternity Benefits

The Schedule might show, for a very small employer (under 20 employees) that normal maternity is *not* to be covered. Routine nursery care and birthing centers are usually covered but not always covered.

Note: newborns are not automatically enrolled.

Elective Benefits

Four types of benefits (dental, vision, hearing and short term disability) may be covered if elected by the Plan Sponsor. These four benefits all are additive to the regular plan benefits. Disability is normally referred to as *health* and not *medical* coverage. Where either one of the four benefits are elected, the Benefits Schedule pages entitled Elective Benefits are completed.

© 2003 International Foundation of Employee Benefit Plans, Inc.

Prescription Drugs

The Benefit Schedule makes provision for Rx benefits to be provided traditionally (i.e., no Rx card) or by a drug card.

For each choice, benefit options are available. The traditional electives are plan-created. The drug card electives are needed to fit into the pharmacy plan sponsor's computer system.

The drug care option is a sub-plan and may have its own special deductibles, limits, etc. Further, the election between the traditional and the drug care could be pick/choose with the participant. Also, the costing/funding of the drug care could be separate from that of the other medical benefits. That is, prescription drugs could be treated as a non-care benefit similar to dental or vision benefits.

The third section sets forth with reasonable specifically what drugs are/are not covered dealing only with the more common drugs (by type only-not name/designation.

Well Patient Care

The general rule is that well patient care is not covered by the Plan and unless specifically set forth otherwise. This section enumerates most, but not necessarily all, instances of well patient care indicating whether or not such is covered.

One of the purposes of this benefit grouping is to help avoid any health care discrimination now prohibited by Federal laws and regulations.

Mental and Nervous Benefits

Historically, such benefits have been limited in these six ways:

	Copayment:	For Example	
	Basis of Limitation	Mental/Nervous	Other Medical
A.	Copayment-hospital	70%	80%
B.	Copayment-physician	50%	80%
C.	Number of covered visits per year	40%	N/A
D.	Number of covered hospital days per year	60%	N/A
E.	Maximum Annual Benefit	$10,000	N/A
F.	Maximum Lifetime Benefit	$30.000	N/A

By new HIPAA rules, A-D are permitted; E-F are not permitted. Where plan has opted out of HIPAA, A-F are permitted.

Partial hospitalizations (so-called day treatments) may or may not be covered.

© 2003 International Foundation of Employee Benefit Plans, Inc.

Miscellanous Benefit

Dental Care

Dental care is an elective benefit; the Benefit Schedule follows the traditional four types of dental:

- A-Preventive (cleaning, e.g.)
- B-Basic (fillings, crowns, e.g.)
- C-Major (root canals, e.g.)
- D-Orthodontia (straightening, e.g.).

The options to the plan designer permit nearly all dental plans to be described. Benefits typical of dental include:

- Protracted waiting periods for major and or orthodontia care (newly covered only)
- Limited orthodontia to dependent children.

Dental coverage may be *pick/choose* or mandatory. Often COB is waived for dental because of administrative convenience.

Vision Care Benefits

The Benefit Schedule requires only that the Copayment rate and Annual Maximum be shown. As with dental care benefits, such benefits may be *pick/choose* or mandatory.

Hearing Care Benefits

The Benefit Schedule requires only that the Copayment Rate and the Maximum Lifetime Benefit be shown. As with dental care benefits, such benefits may be *pick/choose* or mandatory.

Short Term Disability Benefits

Short term disability, often is included as a self-funded benefit. The benefits are non-occupational and usually extended to maternity leave for uncomplicated deliveries. Such benefits are usually mandatory with the participant. Sample variables, of longstanding with such plans, include the waiting period (may vary by accident or sickness); maximum benefit period and weekly benefit provided.

Where the Plan may assert that the participant has contributed an amount to the Plan sufficient in amount and allocated to this short term benefit, the Plan benefit may be declared *fully contributory* on behalf of such Participant. This means that an IRS Form 941, transmitting FICA deductions to the U.S. Treasury need not be filed.

Coverage Continuation and Conversion

Important plan practices relative COBRA notification and manner of COBRA premium billing (coupon, individual invoice or none) are shown.

Also the Plan permits early retirees to be classed as extended COBRA beneficiaries who meet certain age/tenure requirements. Such extended benefit must not result in *de facto* discrimination (i.e. *not* favor the *prohibited* group, nor hurt the *protected* group).

The plan should declare how the COBRA premiums are calculated (i.e., actuarially or by the past cost method) See ERISA § 604 (2).

Conversion. Since conversion is a state-mandated benefit it *may* or *may not* be offered at the discretion of the Employer.

Retired Former Participants

The Plan makes clear whether coverage to former participants over age 65, with a Medicare Card, will be offered coverage. Three choices are available to the Employer:

1. **Offer no such coverage**
   This is the most common practice and increasing in commonality.

2. **Offer such coverage on a formula basis**
   This was the practice, particularly among larger employers but is decreasing in popularity due to (a) costs, (b) administrative burdens (professional fees may exceed cost of benefits) and (c) more favorable court decisions to the Plan (making it easier to opt out). Where the Employer has an audited financial statement and the retiree costs are not immaterial, the general practice is for FAS 106 to apply.

3. **Offer such coverage on a discretionary basis**
   In these instances, the names and Social Security numbers of each Covered Person should be listed out by Plan Amendment. Absent *de facto* discrimination (favoring the *prohibited* group and disfavoring the *protected* group), Employer contributions should be nontaxable to the Participant. Further, for the Employer with an audited financial statement, FAS 112 may apply unless otherwise exempt under the immateriality rule.

© 2003 International Foundation of Employee Benefit Plans, Inc.

Cost Containment-Traditional

These Benefit Schedule options all relate to what would be first generation cost control provisions.

Utilization Review Firm
In this subsection the name of the UR firm which provides the (a) precertification/recertification and (b) the large case management functions. A N/A response would indicate such function is not provided.

Precertification/Recertification Rules
Typical variables include (a) penalty for not precertifying, (b) reduction for charges not precertified and (c) bonus for early discharge. Such rules apply to all in hospital care including partial hospitalization for mental and nervous disorders.

Pre-Authorization of Certain Benefits
This paragraph alerts the Participant to the risk of embarking on certain volatile-cost procedures, services or items without learning ahead of time what will be paid by the Plan. The risk is that the benefit may be cut back.

Participant Audit Bonus
Such Financial inducement in an attempt by the Plan to have the Participant do a self-audit on medical bills thereby reducing Plan costs. The percent savings and minimal limitations are illustrative only.

© 2003 International Foundation of Employee Benefit Plans, Inc.

Cost Containment-PPOs and Directed Care

In General

Managed care programs attempt to direct the way health care is organized, financed and delivered. Such care is a direct alternative to an indemnity plan. Examples of managed are these:

- PPO.
- Directed Care.

The popularity of managed care is growing and its impact on health care delivery has become significant.

Advantages and Disadvantages

Plan sponsors (employers and unions) look favorably on managed care because of its control over both cost and quality as well as the accountability they have over the providers and insurers. Participants look favorably on managed care because it helps them both understand and better use the health care system; it assures them of quality care and lowers their costs.

The major disadvantages of managed care relate the difficulty in getting such a program started usually due to these factors:

- Diversity of employer sizes and geographic mix
- Lack of reliable data on utilization
- Nonexistent single in-place network
- Absence of existing base of quality providers.

These are the services which are normally part of managed care.

- Hospital, medical, surgical
- Outpatient diagnostic and rehabilitation
- Mental health
- Substance abuse
- Preventive care
- Large case management
- Utilization review
- Counseling and referral
- Health education and wellness.

Any plan of managed care must be monitored and controlled.

Plan Structure

In the Plan structure, there should be an inducement in the form of higher benefits to use the managed care program. The Participant should have a choice of managed vs. non-managed every time a provider or service is selected for use. Utilization review should be an integral part of managed care.

© 2003 International Foundation of Employee Benefit Plans, Inc.

Preferred Provider Organization

In General

The PPO option is growing in popularity and significance. The key point with the PPO is this: while physicians receive 20% of health care expenditures, they influence directly over 70% of the health care expenditures.

What is a PPO?

A PPO is a hospital, physician or ancillary health care provider combined in some type of organization which contracts with employers, unions, trust funds, TPAs and insurance carriers to provide services on a discounted or negotiated fee-for-service basis to a defined pool of patients. PPOs can be sponsored by physicians, hospitals, dentists, podiatrists, and other health professionals or by employers, unions, trust funds, TPAs and insurance carriers.

Employers are not locked into the PPO providers, but are allowed freedom of choice with built-in financial incentives to induce the employees to utilize PPO providers when health care is required. These incentives can be in the forms of a reduction or elimination of deductibles and copayments, or an increase in selected benefits, such as outpatient surgery and home health care.

PPOs must provide a utilization review program, which allows monitoring of hospitals and physician services for data collection and evaluation. In contrast to an HMO, PPOs do not normally require preselection or mandatory use of contract providers by the employees. They also do not require the policyholder to split plan costs between separate plans.

A PPO puts the employer, union or trust fund in a working relationship with the provider. The more cost effective the providers are, the more incentive there is for the contracting consumer organization or payer to support and promote the use of these providers. This allows the PPO provider to expect greater potential for acquisition of new patients. In reality, the concept of the PPO is not new; it is just now being evaluated as a viable approach in containing costs.

Some PPOs use a gatekeeper approach. This means the patient's first utilization of the PPO is through a primary PPO physician. This approach is intended to reduce self-referrals to specialists and limits potential unnecessary utilization of expensive specialist services. This is similar to the philosophy of most HMOs. This control in reducing unnecessary referrals to specialists and ancillary services, however, may not preclude a PPO patient from using his or her own family doctor or from using a PPO specialist for more intensive medical care. The PPO also allows an employee to use his or her own non-PPO doctor, while a dependent may still utilize a PPO provider. As stated previously, the PPO does not lock in a patient, as does an HMO which has a more rigid structure. Flexibility is one of the most positive features of a PPO, which substantially enhances its marketability.

© 2003 International Foundation of Employee Benefit Plans, Inc.

Characteristics of a PPO

The characteristics of a PPO are:

- A limited number of selected providers
- Discounted or negotiated fees
- Utilization review
- Patients not locked in
- Economic incentives to encourage utilization of PPO providers
- Rapid claims processing.

Incentives in PPO Participation

The incentives in PPO participation may be seen as follows:

Providers

Defensive strategy

- Protecting or maintaining their market share
- Competition

Offensive strategy

- Increasing their market share
- Competition

Improvement of their financial position by

- Increasing their market share by reducing claim expense through faster turnaround of claim payments

Plan Sponsor

- Anticipated reduction in total claim dollars spent
- Sense of control over health care expenses-cost containment
- Increase in benefits (for those employees electing the PPO) with no increase in premium
- Access to a selective and scrutinized provider network
- Agreement with providers committed to prudent medical/hospital care delivery behavior
- Negotiated rate structures
- Collection of claims data allowing monitoring of captive providers' performance and employee behavior

Plan Participants

- Reduced out-of-pocket expenditures
- Enriched benefits
- Increased access to providers
- Freedom to select providers within or outside the PPO option
- No preselection

Four Types of PPO Options

The Model Plan contemplates four types of managed care programs:

1. **Preferred Provider Organization (PPO)**
   This may be rented (plug-in) or administrator-owned (proprietary) PPO. The PPO may be for hospitals, physicians or both. The steerage, or penalty for out-of-network use, is a fill-in item. The PPO may be a choice item with all of the participants or, in the case of branch offices, for only a portion of the participants.

2. **Directed Provider Care-Regular Version**
   This managed care provision is attractive to the preferred hospital organization (PHO) in that it provides for steerage to the sponsoring hospital. The provision also steers participants to primary (and therefore lower cost) care by the 100% provision; however, the penalty for not using primary care is that only regular plan benefits are provided. To enhance the attractiveness of this managed care provision to the sponsoring hospital, consider these two significant features:
   - Special Hospital Provider is only the sponsoring hospital.
   - Acceptable primary care physicians are only those with hospital staff privileges.

3. **Directed Provider Care: Point-of-Service**
   This managed care provision divides the plan into two pieces:
   - **Piece Number One**
     Participants (and their covered dependents) who wish to remain with the regular benefits and keep full freedom of choice may do so.
   - **Piece Number Two**
     Participants (and their covered dependents) who wish to select from any of a fairly limited list of employer-selected clinics where care for all family members (family, pediatrics, OB/GYN, e.g.) is available. For Participants who select Piece Number Two, the benefits are attractive: only a per unit charge with no assignment hassle or balance-billing and with preventive care benefits. That is, the participants have an HMO-clone. The version presented has a dramatic reduction in benefits where point-of-service provider could, or should, have been covered but was not; namely, no benefits at all.

4. **Directed Provider Care: Exclusive Provider**
   This managed care provision divides the plan into two pieces:
   - **Piece Number One**
     Participants (and their covered dependents) who wish to remain with the regular benefits and keep full freedom of choice may do so.

© 2003 International Foundation of Employee Benefit Plans, Inc.

- **Piece Number Two**
  Participants (and their covered dependents) may select from an extensive list of area primary physicians. Each participant and covered dependent must make a specific election. A sample election form is attached hereto. As with a point-of-service option, the benefits to the covered person (and physician) are attractive. That is, the participant has an HMO-clone. The version presented has an election for the plan sponsor as to how much of a benefit reduction should be made where the primary physician/gatekeeper could, or should, have been used but was not. The Plan Supervisor has strong control over this provision due to its right to waive the penalty for hardship cases and also to remove any primary physician/gatekeeper *for cause.*

Large Case Management

This provision also referred to as Ongoing Health Problem Participants, while of the nature of managed care is not so classified but rather is included as a Cost Containment provision. The reasons are these:

- It is standard to all plans and not elective as with the four managed care option.
- It is of the *first generation* of cost containment provisions and not of a *later generation.*
- It is not displayed to the participants by Booklet Introductory page.

Maternity Management Program

This program, possibly called the *Healthy Mothers Program* has as its good the achievement of the healthiest births in the most cost effective manner. Only the name of the program, the 800-number, and the cost of the infant supplies which will be reimbursed need to be added.

Elective Primary Care Physician

The numbers in this possible benefit modification are customized for each plan. The intent of this modification is to encourage the participant by increasing benefits, to use a primary care physician thereby being a more prudent purchases of health care.

© 2003 International Foundation of Employee Benefit Plans, Inc.

Cost Containment-Demand Management

In General

Demand management might be called the third generation of cost containment (traditional being the first and managed, or directed, care being the second). As its name implies, it works on the demand side (as opposed to the supply side) by either eliminating (or reducing claims) before they become such.

There are dimensions to demand management:

- Disease management
- Wellness and prevention
- Behavior modifications
- Plan modifications.

Only disease management is referenced in this commentary.

Disease Management

In completing the form the variable are, e.g.:

A-Diabetes, hypertension and emphysema
B-XYZ Disease Management Company
C-Telephone Number
D-$250 to $500

Plan Funding

This Benefit Schedule section sets forth with specificity a number of important funding-related factors.

Participant Contributions and Risk Assumption

For each benefit, whether the risk-bearer is the Employer or an Insurer should be shown; also, for each benefit the sharing of the cost between the risk-bearer and the Participant should be shown separately for individual and for dependent coverage. Also, certain benefits, such as organ transplants, may be subcontracted out and funded fully insured.

Other Funding Variables

While not common, the factors of attained age and geography may be taken into account when funding practices are set. Geography may track the situs of residence or situs of work as indicated by the Schedule of Benefits. Geography would take into account that some areas (New York City, e.g.) are more expensive that other areas (Tupelo, MS, e.g.). Such factors must be consistently applied and not result in *de facto* discrimination.

Trusteed vs. Non-Trusteed

The Plan may be of two types

- Unfunded or general asset
- Funded or trusteed

A Plan Trust

- Is not used
- Is used and (is) (not) qualified (tax-exempt)

The Trustees

- N/A
- John Doe and Mary Smith

Type of Plan

There are two types of Plans

- **Defined Benefits**
  The benefits are set; the funding thereof must be the responsibility of the plan sponsor, with participant contributions, however. Similar to a pension plan.

- **Defined Contributions**
  The amounts contributed by the plan sponsor, and participants, are fixed. Such amounts are available to provide plan benefits until such amounts are exhausted. Similar to a 401(k) plan or a flexible spending account.

Certain Terms and Phrases

Employer (Or Plan Sponsor)

These two terms are used interchangeably; a Plan Sponsor may be defined, for all Plan purposes to be the Employer and vice versa. Examples of how such should be shown under this heading follow:

Single Employer	ABC Company
	Local City Board of Alderman (Government)
	John Doe Enterprises (Sole Proprietor)
	James Enterprises. LLP (Limited Partnership)
Controlled Group	XYZ Company and Designated Affiliates
	LMN Company/DEF Company
	FGA Group and Subsidiaries
MEWA	Local County Merchants Association
VEBA	Tri-City Employee Benefit Association
Taff-Hartley	Plumbers/Employers Joint Benefit Fund
Union	United Steel Workers-Local 125

No distinction for this designation need be made whether the ABC Company is non-profit or Sub-S although such distinction significantly affects the Employer's tax status. Note: a Sub-S owner is treated as a self-employed person for Federal tax purposes. As discussed under the MEWA chapter, the point of distinguishing a MEWA from a controlled group is the so-called 25% ownership test.

Affiliates and/or subsidiaries of employer do not have to participate in the plan. If they do participate, however, they should be shown as participating employers in the Schedule of Benefits. Only listed employers are covered employers.

Employer may be a corporation, partnership or individual proprietorship. In the document, as designed, the Employer is synonymous with Plan Sponsor. Were the Plan Sponsor to be an entity other than the Employer, a clarifying Plan amendment would be needed.

An officer owning 80% of shares is an *Employer*; an officer with only 50% is not an *Employer.* The *corporate veil* of a majority shareholder/officer may be *pierced* and such person held personally liable as the *Employer.* ERISA will rely on its own definition of *controlled group,* and not those of the IRS.

The *Employer* cannot hide behind a corporate cloak to avoid ERISA obligations.

An insurer may be deemed an *Employer* for ERISA purposes of the agent of such insurer who does business primarily with such insurer.

The courts will look to facts and circumstances tests to determine who the *Employer* is with controlled corporate arrangements. The courts have held that an *Employer* and Plan Administrator may be separate; as such, the Plan Administrator has the fiduciary duties, not the *Employer.*

© 2003 International Foundation of Employee Benefit Plans, Inc.

ERISA Compliance

These responses are possible:

1. <u>Plans not church/government plan</u>

- Plan is fully compliant with ERISA.

2. <u>Church/government plans</u>

- Plan voluntary elects to be ERISA compliant.
- Plan is ERISA-exempt and therefore non-compliant.

3. <u>MEWAs</u>

- Plan is ERISA-compliant as regards fiduciary rules and reporting/disclosure; Plan is not ERISA-compliant but subject to state jurisdiction for other regulatory matters.

Participating Employers

Where the Employer is shown as the ABC Company and Affiliates or the XYZ Group, the names of the Participating Employers should be listed.

Plan Name

Typically, the Plan Name is the Health Care Plan of LMN Manufacturing Company.

Guidelines-Meaning of Term Plan

- That a plan is discriminatory by IRS rules does not prevent it from being a *plan* by DOL rules.
- A labor union maintained and approved an insurance trust for its members; 30% of the participants were nonunion. This caused the plan to lose its status as an ERISA plan.
- Courts will interpret ERISA broadly; e.g., a letter or announcement of intent of benefits may be a *written plan* which means the benefits referred to are enforceable.
- Sick leave plans are not *welfare plans* by Department of Labor regulations; the court saw no reason to recognize the participant's claim that they were terminal or severance pay plans.
- A *plan* does not have to be funded, trusteed or written. The courts will look to the contents of the arrangement and the action of the parties when deciding whether there is a plan.
- Permitting ineligible persons to have the status of plan participants may result in the plan *not* being a *welfare plan.*
- When an employer performs only the mechanics of administering an employee-pay-all salary savings program, such an arrangement is not a *plan.* Where a plan covers independent contractors, it may lose its ERISA status. A vacation savings plan, like a Christmas savings account, is not a *plan.*
- A plan sponsored by a nonemployee/employer entity such as a social club, investment club, etc., is not a *welfare plan.*
- Plans covering retired lives of an employer are *welfare plans.*

Plan Name (Continued)

- A trade association sponsors a plan that is available *by joinder* to association members. The plan is self-funded and administered by a TPA. The *welfare plan* is *not* the association plan but the plan of each joining member.
- Where the employer provides a state-required fringe benefit, not created by the employer, as a benefit to the employees, such is not a *welfare plan.*
- A plan open to all persons who work 30 hours a week fails the employee/employer commonality test and is, not an ERISA *welfare plan.*

Rules and Guidelines

1. Distinguish between payroll practices *(not welfare)* and *other* benefits *are welfare*.
2. Distinguish between *welfare plans* (comply with ERISA reporting and disclosure) and *fringe benefit plans* (do not comply with reporting and disclosure).
3. There must be homogeneity of employees to qualify as a *welfare plan.*
4. Final determination of what is a *welfare plan* is essentially one of facts and circumstances.
5. To be a *welfare plan,* an arrangement must be sponsored by either an employer, union or employee association (VEBA).
6. What is a *welfare plan* is determined by the DOL, not the Internal Revenue Service.

Plan Number for Administration Purposes

This is the number typically assigned to the Plan by the Plan Supervisor and is used for internal purposes. The coding logic of such number often anticipates many subgroups of the Plan an Employer. Such subgroups could be as follows:

- Employee class (hourly vs. salaried)
- Location/Plant/Division
- Benefit or Plan Option (high/low, e.g.).

This number is not the ERISA-required number.

Plan Number for ERISA Purposes

This number designates the Plan for purposes of ERISA reporting and disclosure filing purposes remembering that such filing will be located by the DOL using these variables.

Variable	Identity (Example)
Employer	EIN (56-1415176)
Plan	ERISA Plan Number (503)
Effective Date	10-14-94

The numbers (001-499) are for pension or profit-sharing plans; the numbers (500-999) are for welfare plans.

© 2003 International Foundation of Employee Benefit Plans, Inc.

State of Delivery

The State of Delivery should be shown in the Schedule of Benefits even though the likelihood of it being germane in a self-funded plan is not common, non-ERISA legal issues are steadily arising from ERISA plans.

Effective Date of the Plan

Several options are available.

Usual Option
Use "October 1, 2001" where the lifetime maximum, e.g., will be reset to such date.

Other Option
Use "October 1, 1996 as amended and restated October 1, 2001" where the lifetime maximum will not be reset.

Plan Options

In this response the document shows there either to be no such option or there to be such option. Importantly, types of options should be displayed:

Automatic
The participants are either in or out by factors such as employee class or hours worked.

Elective
The participants may be in or out by their choice such as a PPO/EPO option.

Plan Supervisor

The Plan Supervisor is the entity that performs the claims/recordkeeping functions. These two functions are rarely done separately. Examples of a firm which could be Plan Supervisor:

- ABC TPA Company (typical self-funded plan)
- LMN Insurance Company (ASO arrangement)
- XYZ Employer, Inc. (self-administered)

The Contract Administrator is the Plan Supervisor; also, the Employer will be Plan Supervisor where the Employer does its own administration. The document contemplates that the Plan Supervisor is a party-in-interest, and not a fiduciary. Facts and circumstances will settle these questions regardless of what the document may state. The Schedule of benefits says who is the Plan Supervisor.

© 2003 International Foundation of Employee Benefit Plans, Inc.

Plan Administrator

This is the *chief fiduciary* as contemplated by ERISA; most plan problems will belong to this person. In naming such person we find:

Most Common	The *person* is the Employer (Plan Sponsor)
Less Common	The *person* is John Doe, as the Employer's representative
Possible but rare	The *person* is the Plan Supervisor. This choice may increase in popularity as plan burdens on Employer grow.

The ERISA Plan Administrator is named, usually as a person, in the Schedule of Benefits. The document shows that the final and sole authority for the Plan belongs to the Employer. Usual practice is to name the Employer rather than a particular person for liability reasons. The difficulty with naming an individual is that there is a considerable risk that should there be legal action involving an ERISA infraction, e.g., the penalties will fall on the person-even though such person were doing the work of the Employer. That is, the named individual Plan Administrator could go bankrupt by doing the Employer's bidding. This is sometimes handled as a compromise; and individual is named as Plan Administrator by the Employer gives such individual a *hold harmless* thereby protecting the individual from risk of loss to such individual's personal assets.

The Schedule of Benefits requires the Employer to declare by whom the actual Plan governance will be done (human resources, financial, CEO or Joint). The reason for this election by the Employer is to clarify ERISA's mandate that the purpose and funding methodology of the Plan be clearly indicated. A Plan totally dominated by human resources staff will have different purposes and financial experience from one totally dominated by the financial staff. Different does not mean better or worse-only different. For these reasons, a Plan document declaration is deemed prudent.

Plan Coordinator

The Plan Coordinator (Mary Smith, e.g.) is the *point person* who watches over plan-related questions, mailings, forms, etc. The Plan Coordinator's functions are generally ministerial only.

Type of Welfare Plan

The benefits offered should be enumerated. As an example:

"Medical, Rx dental and short term disability (Participants only)"

The document does not anticipate that life, AD&D or similar will be made part of the Plan. Since a Premium Option Plan is a *fringe* and not a *welfare* benefit, it need not be shown. Dental is a non-core benefit and should be shown even if *pick and choose* by the Participant.

© 2003 International Foundation of Employee Benefit Plans, Inc.

Plan Attachments

A Plan Attachment, while part of the document, meets the needs of the Employer and the Participant by (a) not being in the Benefit Schedule because of its bulk (even though such Attachment is driven by numerous variables and (b) not being in the Plan Document text because such Attachment is customized to each Employer's needs. The compromise is to make it an Attachment. The SPD sets forth the manner by which the Covered Persons may access the information in these Attachments.

The model plan considers six attachments.

A. Description/details, etc. on Precertification and recertification of hospital stays.

B. Listing of preferred providers and other types of cost containment support data/information.

C. Administrative Guide, customized to the specific Plan which set forth all of the significant practices incidental to Plan funding, recdordkeeping and general supervision of the Plans.

D. Claims Processing Guide, by which the detailed claims practices of the Plan Supervisor are set forth. Such practices will reflect the most recent Federal claims processing guidelines.

E. Encyclopedia of Questionable or Not Covered Items (procedures, conditions, supplies, etc.), by which nearly all request for benefit confirmation inquires may be answered *up or down* without regard to either (a) experimental/investigational or (b) medical necessity/appropriateness.

F. Privacy of Medical Information Guide, by which detailed practices of the Employer, fiduciaries and Plan vendor's as regards Medical information privacy are set forth.

G. Approved Foreign Hospitals Guide, in which Covered Persons, involved with foreign travel/residence may be assured that charges will be honored by the Plan.

Benefit Year

Benefit Year is that 12-month period over which the Deductible and Out-of-Pocket variables are measured. Because of its ease in understanding and administration the Benefit Year is nearly always the calendar year.

Plan Year

The Plan Year is that 12-month period which serves as the term period for the filing of the Annual Plan Report (Form 5500). It usually commences with the Effective Date anniversary but does not need to do so.

These time periods may be relevant to the Plan (if only indirectly) and may all be different.

12-Month Period	Impact on Plan
Employer Fiscal Year	Indirect
Trust Year (if a trust exists)	Indirect
Plan Year	Direct-basis of Form 5500
Benefit Year	Direct-determines benefits

© 2003 International Foundation of Employee Benefit Plans, Inc.

Employee

Typical responses are as follows:

- All full-time employees, permanent or temporary
- All full-time and part-time employees.

Additional clarification of the definition of Employee may be made for the special types of Employees.

- Independent contractors (not employees for plan purposes)
- Sole proprietors
- Partners
- Former employees
- Leased employees
- Employees on leave of absence
- Disabled employees
- All full-time employees, permanent or temporary who have not otherwise elected to be covered under Plan X (e.g., an optional HMO plan).

Trust

The words (is) or (is not) are inserted in the blank.

Trustees

The names of the trustee(s) are put in the blank where appropriate. Otherwise, the response is N/A.

Qualifying Hours

This variable determines the number of average hours per week required to attain full-time status. As an example *35 hours.*

Eligibility Class

Eligibility Class is used to separate participants by such work-related factors as (a) division, plant, location, etc, (b) union v. non-union or (c) hourly v. salaried. For example the response might be:

- All hourly employees
- Non-union employees only
- Employees of ABC Division only.

Eligibility Waiting Period

These variables, with regards to the Eligibility waiting period must be considered:

Variable A

The tolling of the period usually begins with the Date of Employment (which could be as a part-time/temporary employee). Alternately, the tolling of the period might begin with the date of becoming an eligible employee (when going from part-time to full-time status, e.g.). The later method is most commonly used.

Variable B

This is the tolling period such as 30 days, e.g. Further, the tolling period may end when the 30 days are reached, or may be the first of month on or after the end of the 30 day period.

The tolling period should be days and not months so as to avoid the lunar difficulty with different number of days in the month. Breaks in the Employee class (switching between part-time, temporary or full-time) during the waiting period or losing actively-at-work status (being out on temporary disability) during the eligibility waiting period would require such period to be restarted. A 3-day bout with the flu during a 90-day period would not, however, require the employee to restart the period.

Retirees

It is essential that a clear expression of what retirees are or are not to be covered. Retirees are those over 65 with their Medicare Cards. Early retirees under 65 without their Medicare Cards should, for all Plan purposes, be classed as extended COBRAs.

There are basically two ways by which retirees may become eligible for Plan Benefits:

Selective-Pick and choose by Employer
Formula-Automatic as age or years of service requirements are met.

Termination of Coverage Date

The typical fill-in wording is as follows: "The last day on which the Participant was actively-at-work unless COBRA was timely elected in which event the last day for which COBRA extended coverage applied.” The reason for this option is to allow for those rare instances where COBRA does not apply.

Temporary Employees

This makes clear that the Eligibility Waiting Period will toll while the employee is classed as a *temporary* employee. Such allowance applies to full-time *temps* and not part-time *temps.*

Preexisting Conditions

For each of the periods (postcoverage and precoverage) the months inserted may not exceed 18 according to HIPAA. A *minimum* amount ($500 e.g.) below which such preexisting limitations do not apply is a *convenience* benefit to all parties to the Plan.

© 2003 International Foundation of Employee Benefit Plans, Inc.

Administrative Guides

Any Guide, set of rules, etc, which are used to supervise the Plan should be disclosed, even if only such expression as "Plan Supervisor-prepared guidelines".

Late Enrollment Procedure

The document sets forth three possible Late Applicant Procedures:

A-Late Applicant Enrollment Period.
B-Never Covered.
C-Covered only subject to the preexisting provisions.

The designation A, B or C should be entered where the elective is A, the dates of the open enrollment period should be shown along with the effective date of coverage for those who actually enroll late.

Actively-at-Work

To be actively-at-work, the Employee must work at least, say 17½ hours, per week, on the average. This actively-at-work serves several useful purposes:

1. The actively-at-work test must be met for the Eligibility Waiting Period to either begin, or continue.
2. The Employee must be actively-at-work on the day Plan eligibility is met or such eligibility is deferred. However such deferral must not be the result of not being actively-at-work because of health-related reasons.
3. Failure of a participant to meet the actively-at-work is a COBRA qualifying event (reduction in hours).

Claim Filing Period

Typically, the period will be in the range of three months to twelve months. Because of practical need to expedite the claims process the most common entry is "three (3) months". This is quite achievable considering the great volume of claims which are either by drug care or provider-assigned and the increasing reliance on EDI transmission.

Claim Processing Responsibility of the Plan Supervisor

The response in this fill-in is to set forth, in rather broad terms, how the claims processing responsibilities are shared between the Plan Supervisor and the Employer. Also, a tie-in between the Benefit Schedule and the Appendix-Claims Processing Guide is made.

Re-Employment Period

This period, nearly always-six (6) months tolls the time from a Participant's date of termination to date of rehire during which such participant may reenroll in the Plan without having to reserve the Eligibility Waiting Period.

© 2003 International Foundation of Employee Benefit Plans, Inc.

Leave of Absence Period

The Plan provisions set the Leave of Absence at some period, like "three (3) months". However such period may never be less than that mandated by the Family Medical Leave Act. Obtaining such Leave of Absence requires specific Employer approval.

Disability Extension Period

A typical Disability Extension Period is "three (3) months". This benefit is earned as a *matter of right* (i.e., no requiring specific Employer approval). This benefit extension is available only to those Employees considered *off-work* with the expectation of returning thereto; it is not available to an Employee who deemed retired/terminated with no expectation of returning to work.

Maximum Extended Coverage Period

This benefit limitation is formed because some stop-loss carriers require such, most likely as a result of such carrier's retrocessor(s). The maximum works as follows:

Leave extension	4 months
Disability extension	4 months
Maximum extension	6 months

In determining such, the disability extension is generally allowed first because it is provided as a matter of right.

Basis of Non-Occupational Coverage

The typical response is that shown, namely "any occupational-related injury or illness". Were such basis to be "workers' compensation excluded" there would be a problem with coverage where the Plan's intention to exclude is thwarted by a denial by workers' compensation with the result that the Plan pays an occupational claim.

Unmarried Child's Eligibility Age

Typically the Plan will cover all children through age 18 (to 19th birthday) but extend such through age 23 (24th birthday) is such child is in college or similar.

Extensions and Limitations of Coverage

This Section either extends or limits coverages described in either the document text or the Benefit Schedule. Such Extensions or Limitations to the Attachments are affixed to such Attachment and made part thereof.

Plan Amendments which may extend or limit any of the three document sections (Benefit Schedule, Text and Attachments) are described and cataloged on the Document Execution Page.