BASIC®

HR Solutions Come Full Circle

DOL & ERISA Audits: What they are and what to expect!

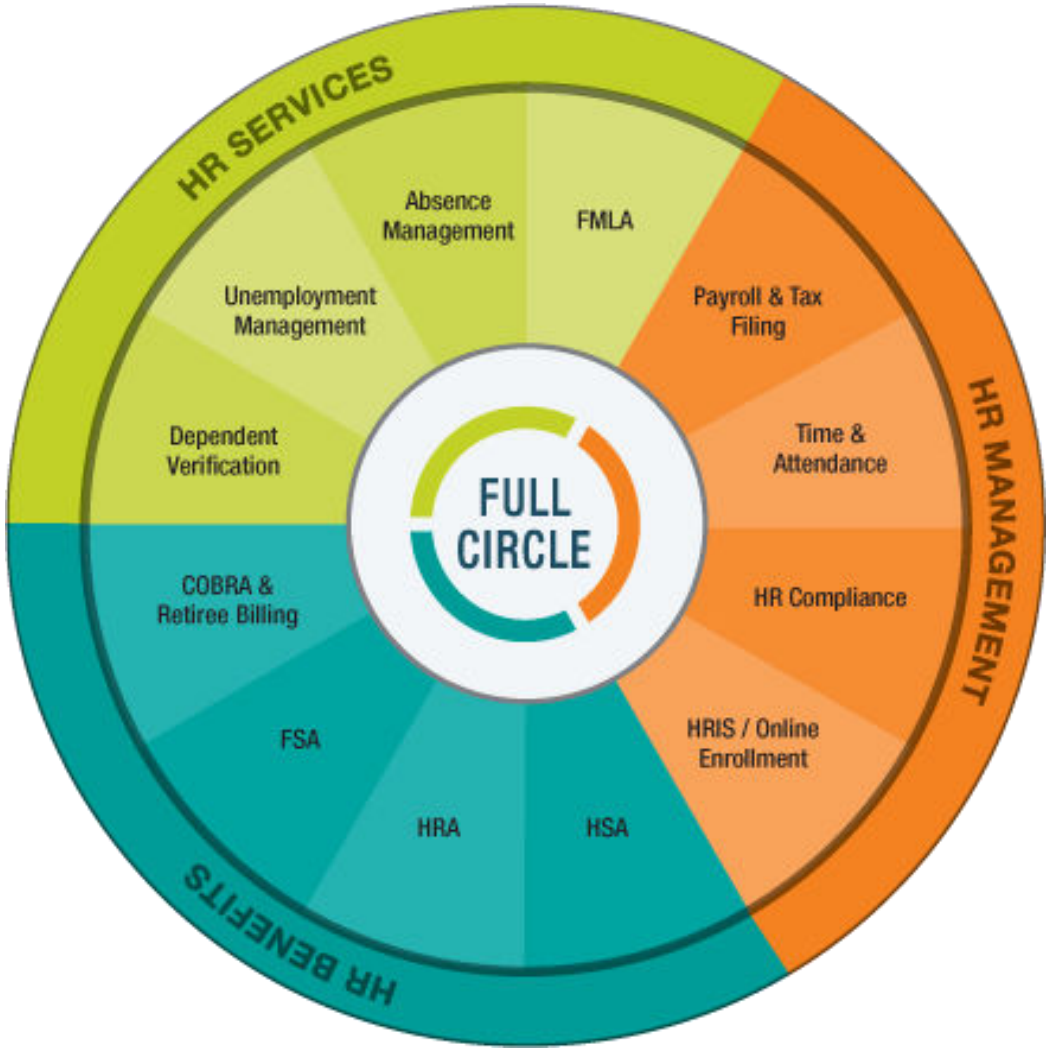
Presented by: Joe A. Aitchison

FULL CIRCLE

- HR Benefits
- HR Management
- HR Services

We're proud to offer a full-circle solution to your HR needs. BASIC offers collaboration, flexibility, stability, security, quality service and an experienced staff to meet your integrated HR, FMLA and Payroll needs.

HR Solutions Come Full Circle



HR solutions should be simple.
Keep it BASIC.

BASIC's integrated HR solutions come full circle for employers nationwide. Consistently recognized as an Inc. 5,000 Fastest Growing Private Company, our expertise allows you to control costs, manage risks and improve staff focus and effectiveness.

Presenter

Joe Aitchison, SPHR, SHRM-SCP, CHRS - BASIC Vice President.
Joe provides Business & HR client advisory services and HR out-source services nationally. He is a Human Resource professional with over twenty five years business management and HR consulting experience. He has worked with multi plant International Tier I Automotive Manufacturing, retail, food processing, health care, legal administration and professional services.

Mr. Aitchison is recognized as a leader in human resources and has obtained a lifetime certification as a senior professional in human resource management, SHRM – Senior Certified Professional and Healthcare Reform Specialist by the Healthcare Reform Center & Policy Institute. Mr. Aitchison Serves on several for profit and not for profit boards.

Agenda

- DOL & ERISA Audit Preparation and Expectations
  - ERISA / Welfare Benefit Plans
  - FMLA
- 6055/6056 Employer Reporting Requirement
- Best Practice Recommendations
- Q & A
- Closing

Employment Litigation Trends: 2010 to Present

- FLSA / Wage and Hour Matters: 18% increase
- Traditional Labor Union Matters: 11% increase
- Age Discrimination: 10% increase
- Race Discrimination: 7% increase
- ERISA Matters: 7% increase
- Gender Discrimination: 6% increase
- Disability Discrimination: 6% increase

Top 10 Reasons for FLSA/ Wage & Hour Lawsuits

Number 10: Employers' failure to compensate employees for training time

Number 9: Employers' failure to compensate employees who "volunteer" their time

Number 8: Employers' failure to include extra compensation in overtime pay

Number 7: Employers' failure to pay employees for short breaks

Number 6: Employers' failure to pay employees who work through lunch

Top 10 Reasons for FLSA/ Wage & Hour Lawsuits (cont'd)

Number 5: Employers' docking time for employees working on the clock

Number 4: Employers' failure to pay employees working off the clock

Number 3: Employers' misclassification of employees as independent contractors

Number 2: Employers' misclassification of employees as exempt employees

Number 1: FLSA favors employees through lower proof thresholds, statutory damages and attorneys' fees

Common UI Audit Issues

SUTA Dumping an UIA's High priority

- Detecting and dealing with Employee Leasing Companies ("***ELCs***")
- Successor Liability cases
- Detecting and dealing with Business Reorganizations
- Detecting and dealing with Business Sales and other "transfers of business"
- Employer failures to include all taxable wages in the UI tax base
- Detecting Unregistered Employers
- Misclassification of workers as "independent contractors" rather than as "employees".

UIA's Audit Process and Issues

ISSUES: Experience UI rating creates an incentive for some employers with bad layoff experience and a high UI tax rate to "dump" their tax liability on other employers, using one of three basic approaches:

1. **"Vertical" SUTA Dumping**. An employer creates a new entity (typically a limited liability company) that carries the new employer tax rate (2.7%) and transfers all or most of the employer's workers to the new entity.

2. **"Horizontal" SUTA Dumping**. An employer transfers some of its employees to an existing subsidiary entity with a better layoff experience and a lower UI tax rate.

3. **"Transfer" SUTA Dumping.** An employer transfers some of its employees to another employer with a better layoff experience and a lower UI tax rate, and the employees are then leased back to the former employer. The old entity continues to exist with the higher UI tax rate, but the old employer has little or no remaining payroll and therefore pays less UI tax. This is the technique sometimes used by professional employer organizations and employee leasing companies.

UI Audit/ Document Review

The following books / records, if maintained, must be made available to the UIA auditor:

- Forms UIA 1020, Employer's Quarterly Tax Reports, and Forms UIA 1017, Wage Detail Reports.
- Michigan Sales and Withholding Tax Reports (monthly, quarterly or annual return).
- Federal Form 940, Annual Federal Unemployment Tax Report.
- Federal Forms 941, Employer's Quarterly FICA & Withholding Tax Reports.
- Employer's Federal Income Tax Returns, Federal Schedule C for Sole Proprietors, Federal Form 1065 for Partnerships or Federal Form 1120/1120S for Corporations, LLCs and LLPs.
- Federal Forms W-2, Employee's Wage and Tax Statements, and Federal Forms W-3, Transmittal of Wage and Tax Statements (W-2 Summary).
- Federal Forms 1099 and Federal Forms 1096, Annual Summary and Transmittal of U.S. Information Returns (1099 Summary).
- Michigan Annual Corporation Return (corporations and LLCs).
- Employee's Individual Earnings Records, along with any monthly, quarterly and year-to-date summaries that are maintained regarding these records.
- Check Register and Cash Disbursement Records, both for general and payroll accounts.
- Receipts and Invoices for disbursements from the general account.
- Check stubs and/or canceled checks.
- General Ledger, General Journal and the list of accounts for these records.
- Petty cash records.
- Financial Statements (Profit and Loss, Income Statement, Balance Sheets, etc.).
- Master Vendor Files (Accounts Payable).
- Time cards.
- Proof of Workers' Disability Compensation Insurance.

UIA Investigations with Employers and it's Advisors

UIA's auditors ask:

- Why did you set up the new entity(s)?
- How is the new entity a distinct and severable portion of the former company? How is the new entity administered or managed?
- How many employees (and what percentage of your total employees) were transferred to the new company? And Why?
- What company name(s) appear on invoices, paychecks, bank accounts, contracts, letterhead, Phone lists, Internet web pages, etc?
- Has the new entity obtained bank loans independently of the former company?
- Are retirement and fringe benefit packages handled differently after the change in business structure?

Employer Group Welfare Benefit Plans/ Health Benefits

Sources of ERISA / EBSA Cases

- Participant complaints
- Form 5500 Reviews
- Referrals from other agencies
- Media
- Other

Source of DOL Enforcement Authority- 29 USC 1132

- Civil Enforcement
- ERISA 502(a) empowers DOL to bring civil actions.
- ERISA 502(l) requires 20% civil penalty on all DOL settlements (subject to limited exceptions).

- Criminal Enforcement
- ERISA 501 imposes criminal sanctions for willful violations (maximum of $100k/$500k and 10 years).

- Investigative authority
- ERISA 504 grants DOL broad authority and may subpoena books/records.

EBSA's National Enforcement Projects

- Contributory plans criminal project (CPCP)
  - Targets employers and providers who commit fraud and abuse resulting in unpaid contributions to plans.
- Rapid ERISA action team (REACT)
  - Targets plans of employers filing for bankruptcy.
- Employee stock ownership plans (ESOPs)
- Consultant/adviser project (CAP)
  - Targets providers with undisclosed compensation and fiduciary self-dealing (variable compensation).

Employee Benefits Security Administration (EBSA)

EBSA's Mission Statement

The Employee Benefits Security Administration protects the integrity of pensions, health plans, and other employee benefits for more than 150 million people. Our Agency mission is to:

- Assist workers in getting the information they need to exercise their benefit rights
- Assist plan officials to understand the requirements of the relevant statutes in order to meet their legal responsibilities
- Develop policies and regulations that encourage the growth of employment-based benefits
- Deter and correct violations of the relevant statutes through strong administrative, civil and criminal enforcement efforts to ensure workers receive promised benefits

DOL Investigation Process

- Reasons for initiating investigations
  - Participant complaints to Office of Participant Education
  - Referrals from other regulators (*e.g.*, SEC, IRS)
  - Enforcement initiatives (National Enforcement Projects)
  - Form 5500 filings / Employers having 100 or more ee's
- Procedure for DOL investigation
  - Initial Letter (Document Request or Appointment Letter)
  - Document Production and On-Site Interviews
  - Closing Letter: (1) No DOL action to be taken, (2) "Voluntary Compliance" notice, or (3) Litigation letter

Department of Labor Investigative Authority

- DOL has the right to conduct investigations
  - Compel the production of documents
  - Take sworn testimony
  - Issue administrative subpoenas and, if necessary, enforce them in Court

The U.S. Department of Labor

- Employee Benefits Security Administration (retirement & health)
  - 2.3 million health plans / 707,000 retirement plans
    - $6.7 trillion in assets
    - 2,200 compliance officers
- Enforce Fair Labor Standards Act

Potential Penalties for ERISA Violations

- Restitution and “make-whole” remedies for covered employee benefit Plans
- Civil monetary penalties
- Injunctive relief (including putting service providers out of business)
- Reversal of prohibited transactions
- Referrals to other agencies, such as the IRS
- Criminal sanctions

Form 5500

Title/Description: Annual Return/Report of Employee Benefit Plan**

Who Must File: Plan administrator of pension benefit plans (defined benefit or defined contribution) that are covered by ERISA.

** The Form 5500 reporting requirements vary depending on whether the filing is for a large plan or a small plan. Plans with fewer than 100 participants at the beginning of the plan year are considered “small plans”; plans with 100 or more participants are “large plans”. If the plan had between 80 and 120 participants at the beginning of the plan year and a return/report was filed for the prior year, the plan may complete the current filing using the same category (large or small plan) as was used for the prior plan year.

Form 5500

Penalty: The DOL may assess a civil penalty of up to $1,100 a day for a plan administrator's material failure or refusal to file an annual report *(ERISA §502(c)(2)).* For plans that do not take advantage of the DOL's Delinquent Filer Voluntary Compliance Program (DFVCP), DOL has indicated that it will assess a penalty of $50 a day (with no limit) for late filers, and a penalty of $300 a day (up to $30,000 per year) for nonfilers. Additional penalties apply for deficient filings. In addition, the IRS may also assess a penalty of $25 for each day of failure to file complete annual returns (up to $15,000) unless failure is due to reasonable cause. However, the IRS will not assess its penalty for plans that file under DFVCP.

Summary Annual Report w/5500 Filing

Description:	Summary of annual report. Contents prescribed by DOL Reg.
Who Must Furnish:	Plan Administrator
When Provided:	Nine months after end of plan year, or within two months after close of extension period for filing annual report, if applicable.

Form 5558

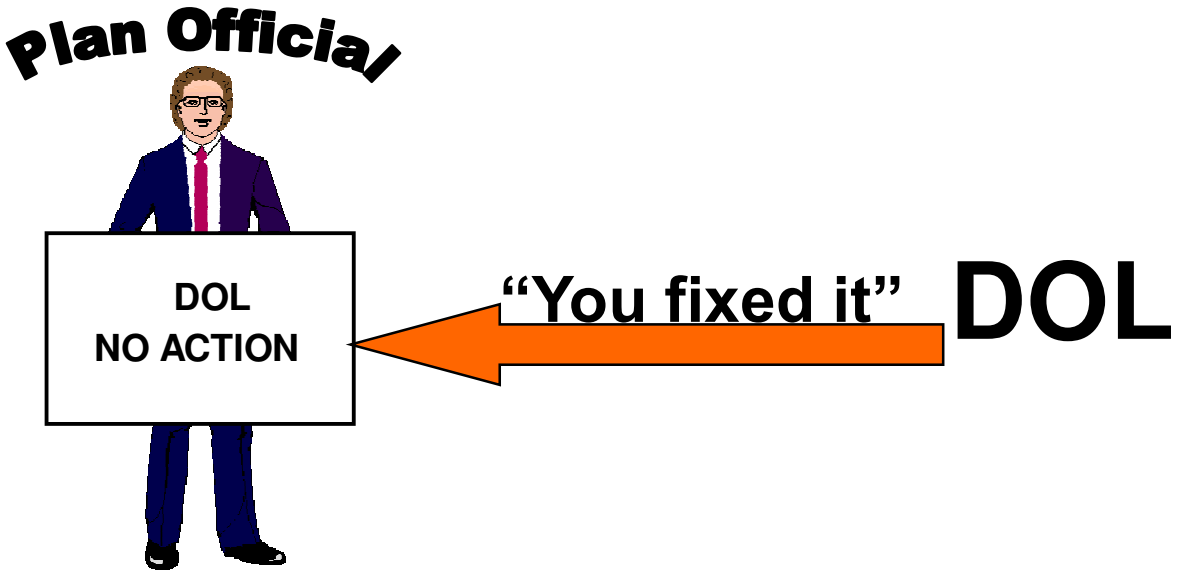
Title/Description: Application for Extension of Time to File Certain Employee Plan Returns

Who Must File: May be used to apply for a one-time extension of time to file Form 5500, Form 5500-SF, Form 5500-EZ, or Form 5330. For Forms 5500, 5500-SF and 5500-EZ, the IRS will automatically approve up to 2½ month extension; Form 5558 will not be returned to filers. A computer-generated notice will be sent informing filer if extension is approved or denied.

VFC Program

Voluntary Fiduciary Correction Program (VFCP)

Allows “Plan Officials” to correct certain violations before DOL investigates and if done properly, receive a “No-Action” letter from the Department.



SPD/ SMM

Penalty: A penalty of up to $110 a day (up to $1,100) per request for a plan administrator's failure to furnish requested information within 30 days, unless failure results from matters reasonably beyond the plan administrator's control. ***(ERISA §502(c)(6))***

Summary Plan Description (SPD)

Description: Summary of the provisions of the plan in language understandable to the average participant; gives details on the administrative operations of plan, claim procedures, and statement of ERISA-protected rights.

Who Must Furnish: Plan administrator must provide to participants and beneficiaries receiving benefits.

Note: *Insurance companies do not prepare or deliver the SPD to Plan Participants.*

Summary Plan Description (SPD)

When Provided:

New plans: Within 120 days after the later of when the plan becomes effective or is adopted. Updated SPD must be furnished every 5 years for plans that have been amended; otherwise SPD must be redistributed every 10 years.

New participants: Within 90 days after becoming a participant or after benefits commence (for beneficiaries).

Summary of Material Modifications (SMM)

Description:	Summary of any material modification to the plan and any change in information required to be included in the SPD.
Who Must Furnish:	Plan administrator must provide to participants and beneficiaries receiving benefits.
When Provided:	Within 210 days after the close of the plan year in which the modification was adopted unless changes or modifications are described in a timely distributed SPD.

Best Practices

Before the audit

1) Track all Welfare Benefit Plans subject to ERISA.
2) Formalize procedure for notices and updates.
3) Maintain “model” notice documents/records that reflect current law.
4) Ensure all Welfare benefit program agreements are signed and on file.

Health Benefits Model Notices

Annual participant notice requirements that apply to group health plans:

Women's Health and Cancer Rights Act ("WHCRA")

Each year participants must receive a summary of a health plan's coverage for mastectomies and breast reconstructive services. If the SPD is reissued each year, the notice can be included in the SPD.

Medicare Part D Notice of Creditable or Non-Creditable Coverage

This annual notice must be provided to any participant (employee or dependent) who has coverage under Medicare Part A or coverage under Medicare Part B and who lives in the service area of a Medicare Part D prescription drug plan. While employers usually know whether an employee is eligible for Medicare, employers often do not have this information regarding dependents. As a result, providing the notice to all participants ensures compliance. Notice should have been provided by October 15. Again, if the SPD is reissued each year, the notice can be included in/with the SPD.

Health Benefits Model Notices

Children's Health Insurance Program Reauthorization Act ("CHIPRA")

CHIPRA imposes a notice requirement on employers who maintain health plans with participants residing in one or more states providing a premium assistance subsidy (Michigan does not) . The notice must be provided annually to all employees residing in each premium assistance subsidy state, including employees not enrolled in the plan. If you have participants living outside of Michigan, you may be required to comply with this notice obligation.

HIPAA Notice of Privacy Practices

The notice of privacy practices must include an explanation of a covered entity's obligation to notify affected individuals following a breach in unsecured PHI and must address the Genetic Information Nondiscrimination Act ("GINA").

Health Benefits Model Notices

Summary of Benefits and Coverage

The purpose of the SBC is to provide certain information in a prescribed format to participants in an employer's medical plan so they can compare the information to other plans which they may be eligible for, including the benefits offered on the Health Insurance Marketplaces / Exchanges. The SBC is most often provided by the health insurance company if fully insured. It incudes information on minimum essential coverage and whether the plan provides "minimum value."

Notice Regarding Grandfathered Plan Status

Plans that were in effect prior to the enactment of Health Care Reform are exempt from some of the new insurance market reforms under Health Care Reform so long as they retain "grandfathered plan" status. One of the requirements to retain grandfathered plan status is including certain disclosures in SPDs and other plan materials (such as annual open enrollment materials) provided to participants describing the plan's benefits. The disclosure must state that the plan is grandfathered and must provide contact information for questions and complaints.

6055/6056 Employer Reporting-
what's the Status?

- **Companies with 50 to 99 employees** will report on their workers and coverage in 2015, but have until 2016 before any employer responsibility payments could apply. These employers must certify that they meet the following conditions:

  - **Limited workforce size** – employs on average at least 50 full-time equivalent employees but fewer than 100 full-time equivalent employees during 2014.

  - **Maintenance of workforce and hours of service** – during the period Feb. 9, 2014 until Dec. 31, 2014, the employer may not reduce the size of its workforce or the overall hours of service of its employees in order to qualify for the transition relief.

  - **Maintenance of previously offered health coverage** – during the period Feb. 9, 2014 until Dec. 31, 2015, the employer does not eliminate or materially reduce the health coverage it offered as of Feb. 9, 2014.

Companies with 100 or more full-time equivalent employees were also provided some relief in the announcement. To avoid payment for failing to provide health coverage, these employers need to offer coverage to at least 70 percent of their full-time employees (as defined by ACA) in 2015 and 95 percent in 2016 and beyond. This helps employers who may offer coverage to employees with 35 or more hours, but not yet to that portion of their workforce who work 30 to 34 hours.

** The Treasury Department announcement stated: "As these limited transition rules take effect, we will consider whether it is necessary to further extend any of them beyond 2015.

6055/6056 Employer Reporting

Insurance Company (Providers) Reporting Requirements

- Under the ACA, health insurance providers (includes employer self-insured plans) are required to report information to the Insured Individual and the IRS about :
  - each "covered" individual (member) and covered dependents, and their health benefits to both the insured individual and the IRS, or face penalties.
- **Taxpayers will receive two new forms** to include in their filing at the end of each year. They will receive a 1095-B from their insurance provider as well as a 1095-C from their employer if they work for a large company (50 or more FTEs).
- If the taxpayer does not work for a large employer who offers insurance and obtained coverage from the Exchange, they will receive a 1095-A from the Exchange (marketplace).

Section 6055 - Insurance Company & Self Insured Plans

- Transmits coverage information to IRS using **Form 1094-B**
- Provides information to insured individuals using **Form 1095-B**
- Includes information on covered dependents

6055/6056 Employer Reporting

- **More Information on the New Forms**
- **1095-A**
- Form 1095-A will be used by Health Care Exchanges and Web-based health insurance marketplaces. This form will provide information on each individual enrolled in "qualified health plans" (QHPs). Every year, the Health Care Exchanges will be required to provide Form 1095-A to the individual. This form will include information such as the level of coverage, identifying information for the primary insured, premiums amounts and advance credit payments for coverage. Other information necessary to determine if a taxpayer has received the appropriate advance credit payments will also be reported on the form. Every month, marketplaces will be required to report to the Department of Health and Human Services, who will in turn report to the IRS.
- **1095-B:** The Health Insurance Provider will provide Form 1095-B to the covered member in order to report on the type of coverage provided, period of coverage, and for whom coverage was provided– including each dependent.
- The health insurance provider will also send a transmittal (1094-B) of coverage information to the IRS.
- **1095-C:** Large Employers (50 FTEs or more) will provide Form 1095-C to their employees reporting on the type of coverage provided as well as identification information for each employee and their dependents.
- **1094-C:** Large employers will also be required to send a transmittal (1094-C) of coverage information to the IRS.

Note: *This review is being provided as "general information only" and is not intended to be a detailed overview of the 6055 and 6056 reporting requirements. It is recommended that employers and others seek legal and/or accounting expertise to assess your organizations reporting requirements*.

FMLA Compliant Investigation

FMLA Investigation

Most Investigations occur when an employee complains to the DOL that that their FMLA rights have been **interfered with** "or" they have been **retaliated against** for taking FMLA.

FMLA Leave Administration:

- **Evidence what documentation you provided to the employee.**
  - FLMA Certification form – **Date** from was given to the employee
  - Rights and Responsibility Notice – **Date** it was given
  - Return of the Certification form by employee – **Date** Returned
  - Notice of Approval / Denial of FMLA Leave Request – **Date** Provide to EE
  - Out of time Notice

FMLA Compliant Investigation

- **Provide documentation supporting the start and end date for employee FMLA Leaves**
  - Provide Tracking documentation of each individual Intermitted call off from work for every employee's FMLA Leave.
  - Provide documentation for Tracking **"ALL"** Days/Dates employee called of work for **"all FMLA" Time in the past 3 years** – by department or by company….
- **Provide all the above information for all employees (all departments) who have taken FMLA Leave**

Note: *if you are not able to provide the above information possibly going back 3 years – you will be at a high risk level of failing the audit/investigation and subject to fine and penalty on an Individual complaint and also failing to administer FLMA according to regulatory requirements.*

In most cases, Employers will not meet the requirements above which often requires them to reach a financial settlement with an employee (through the Department of Labor) rather than enter into a protracted court case which inevitably increases legal fees, penalties, fine and payment to the Employee, if the employer loses the claim. Most often, the cost to litigate will be in excess of $200,000 (conservatively) and take over 2 years to complete the process.

The AUDIT/ Examination Process

1. The employer is notified by letter
2. In the letter, the examiner requests plans records and documents
3. The examiner and employer schedule a date for an appointment
4. Preliminary meeting with examiner to discuss audit overview and planning
5. The examiner conducts an on-site audit
6. Resolution of audit findings that require a change
7. A “closing letter” is issued

Breaking Down the Document Request

The document request often consists of three parts:

1. Plan documents to be provided prior to the exam:
   - Plan documents and plan communications
   - Nondiscrimination testing, corporate tax returns, etc.
2. Questionnaire concerning plan administration, HR personnel responsibilities and payroll function/ deductions
3. Documents to be made available during the exam
   - Employee census reports and account statements
   - Employer records to determine employee eligibility, vesting and calculation of plan contributions
   - Demonstrations for sample group of participants

The Letter

U.S. Department of Labor Employee Benefits Security Administration
2300 Main Street, Suite 1100

DELIVERED VIA MAIL

Dear REDACTED,

The Department of Labor has responsibility for the administration and enforcement of Title I of the Employee Retirement Income Security Act of 1974 (ERISA). Title I establishes standards governing the operation of employee benefit plans such as the REDACTED
Plan).

The Plan is scheduled for investigation by this office. Investigative authority is vested in the Secretary of Labor by Section 504 of ERISA, 29 U.S.C. 1134, which states in part:

The Secretary [of Labor] shall have the power, in order to determine whether any person has violated or is about to violate any provision of this title or any regulation or order thereunder...to .make an investigation, and in connection therewith to require the submission of reports, books, and records, and the filing of data in support of any information required to be filed with the Secretary under this title....

The Letter (continued)

Additionally, the Plan will be examined for the purpose of determining whether it is complying with the laws contained in Part 7 of ERISA, including the Health Insurance Portability and Accountability Act of 1996, the Newborns' and Mothers' Health Protection Act, the Women's Health and Cancer Rights Act (WHCRA), the Mental Health Parity and Addiction Equity Act, the Genetic Information Nondiscrimination Act, and the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act (together, the Affordable Care Act). These laws amended Part 7 of ERISA and provide requirements for group health plans.

We have found in the past that submission of relevant documents to our office prior to the possible inception of an on-site field investigation can lessen the time subsequently spent with, and the administrative burden placed on the plan and corporate officials. To that end, we ask that you submit the documentation listed on the enclosed attachment to this office within 10 working days from your receipt of this letter. After our office receives and reviews the requested documents, you will be contacted about the possibility of setting up the onsite portion of our investigation. Additional records and copies may be requested as needed at a later date. For reference and your information when preparing the documents for our review, **the period to be examined for the Plan is the period from July 1, 2011 through the present.**

An initial background interview will also eventually be conducted with yourself, and/or any other Plan or corporate official as is necessary to complete our review. The interview will be conducted in the later stages of my review and can be conducted over the telephone if necessary. Any other interviews that may be necessary will be conducted as needed.

Thank you in advance for your cooperation. Should you have any questions, please feel free to contact me at REDACTED.

Requested Documents

COPIES OF ITEMS IDENTIFIED BELOW SHOULD BE PROVIDED AS INDICATEDI N THE COVER LETTER

ATTACHMENT A

1. Plan document.
2. Summary Plan Description (SPD), including any changes in Plan benefits and entitlement to benefits.
3. All contracts with insurance companies for the provision of health benefits.
4. If self-insured, all contracts for claims processing, administrative services, and reinsurance.
5. Documents which describe the responsibilities of both the employer and employees with respect to the payment of the costs associated with the purchase and maintenance of health and welfare benefits.

Requested Documents (continued)

6. In accordance with the Health Insurance Portability and Accountability Act of 1996, please provide the following records:

   - A copy of the Plan's rules for eligibility to enroll under the terms of the Plan (including continued eligibility).
   - A sample of the certification provided to those employees who have lost health care coverage since **January 1, 2011** or to be provided to those who may lose health care coverage under this plan in the future, which certifies creditable coverage earned under this plan;
   - A copy of the record or log of all **Certificates of Creditable Coverage** for individuals who lost coverage under the Plan or requested certificates;
   - A copy of the written procedure for individuals to request and receive certificates;
   - A sample general notice of preexisting condition informing individuals of the exclusion period, the terms of the exclusion period, and the right of individuals to demonstrate creditable coverage (and any applicable waiting or affiliation periods) to reduce the preexisting condition exclusion period, or proof that the plan does not impose a preexisting condition exclusion;

Requested Documents (continued)

- Copies of individual notices of preexisting condition exclusion issued to certain individuals per the regulations (including any lists or logs an administrator may keep of issued notices), or proof that the Plan does not impose a preexisting condition exclusion;
- A copy of the necessary criteria for an individual without a certificate of creditable coverage to demonstrate creditable coverage by alternative means;
- Records of claims denied due to the imposition of the preexisting condition exclusion (as well as the Plan's determination and reconsideration of creditable coverage, if applicable), or proof that the Plan does not impose a preexisting condition exclusion;
- A copy of the written procedures that provide special enrollment rights to individuals who lose other coverage and to individuals who acquire a new dependent, if they request enrollment within 30 days of the loss of coverage, marriage, birth, adoption, or placement for adoption, including any lists or logs an administrator may keep of issued notices; and
- A copy of the Written appeal procedures established by the plan

Requested Documents (continued)

7. A copy of the Plan's rules regarding coverage of medical/surgical and mental health benefits, including information as to any aggregate lifetime dollar limits and annual dollar limits.
8. The Plan's Newborns' Act notice (**this should appear in the plan's SPD**), including lists or logs of notices an administrator may keep of issued notices.
9. A copy of the Plan's rules regarding pre-authorization for a hospital length of stay in connection with childbirth.
10. A sample of the written description of benefits mandated by WHCRA required to be provided to participants and beneficiaries upon enrollment.
11. A sample of the written description of benefits mandated by WHCRA required to be provided to participants and beneficiaries annually.
12. Materials describing any wellness programs or disease management programs offered by the plan. If the program offers a reward based on an individual's ability to meet a standard related to a health factor, the plan should also include its wellness program disclosure statement regarding the availability of a reasonable alternative.

Requested Documents (continued)

13. If the Plan is claiming or has claimed grandfathered health plan status within the meaning of section 1251 of the Affordable Care Act, please provide the following records:

a. A copy of the grandfathered health plan status disclosure statement that was required to be included in plan materials provided to participants and beneficiaries describing the benefits provided under the Plan.

b. Records documenting the terms of the Plan in effect on March 23, 2010 and any other documents necessary to verify, explain or clarify status as a grandfatheredhealth plan. This may include documentation relating to the terms of cost sharing (fixed and percentage), the contribution rate of the employer or employee organization towards the cost of any tier of coverage, annual and lifetime limits on benefits, and if applicable, any contract with a health insurance issuer, which were in effect on March 23, 2010.

Requested Documents (continued)

14. Regardless of whether the Plan is **claiming grandfathered status**, please provide the following records in accordance with section 715 of ERISA as added by the Affordable Care Act:

    a. In the case of a plan that provides dependent coverage, please provide a sample of the written notice describing enrollment opportunities relating to dependent coverage of children to age 26.

    b. If the Plan has rescinded any participant's or beneficiary's coverage, supply a list of participants or beneficiaries whose coverage has been rescinded, the reason for the rescission, and a copy of the written notice of rescission that was provided 30 days in advance of any rescission of coverage.

    c. If the Plan imposes a lifetime limit or has imposed a lifetime limit at any point since September 23, 2010, please provide documents showing the limits applicable for each plan year on or after September23, 2010.

    Please provide a sample of any notice sent to participants or beneficiaries stating that the lifetime limit on the dollar value of all benefits no longer applies and that the individual, if covered, is once again eligible for benefits under the plan.

    d. 1f the Plan imposes an annual limit or has imposed an annual limit at any point since September 23, 2010, please provide documents showing the limits applicable for each plan year on or after September 23, 2010.

Requested Documents (continued)

15. If the Plan is **NOT claiming** grandfathered health plan status under section 1251 of the Affordable Care Act, please also provide the following records:
    a. A copy of the choice of provider notice informing participants of the right to designate any participating primary care provider, physician specializing in pediatrics in the case of a child, or health care professional specializing in obstetric or gynecology in the case of women, and a list of participants who received the disclosure notice.
    b. If the Plan provides any benefits with respect to emergency services in an emergency department of a hospital, please provide copies of documents relating to such emergency services for each plan year on or after September 23, 2010.
    c. Copies of documents relating to the provision of preventive services for each plan year on or after September 23, 2010.
    d. Copy of the Plan's Internal Claim and Appeals and External Review Processes.
    e. Copies of a notice of adverse benefit determination, notice of final internal adverse determination notice, and notice of final external review decision.
    f. If applicable, any contract or agreement with any independent review organization or third party administrator providing external review.
16. All documents relating to any bankruptcy filings involving the Health Plan
17. Insurance premium billing statements for the examination period and schedules of insurance premium rates for employees and employers

Best Practices

During the audit

1) Choose one point person to serve as liaison.
2) Ask DOL for permission to bring in ERISA counsel.
3) Negotiate scope of document request (*e.g.*, limit to sampling of documents).
4) Perform legal review of any requested materials before delivery to DOL.
5) If any discrepancies are uncovered, provide explanation and/or proposed remedial action.
6) Prepare personnel for on-site interviews.

Best Practices to Manage the Audit

- Be responsive to requests
  - Obtain extensions when needed
  - Negotiate scope of overly broad requests
- Involve your ERISA counsel and consultants
- Review responses to identify problems before the examining agent discovers them
- Propose appropriate corrective actions to known problems
- Be proactive to negotiate appropriate resolutions of audit findings

In Closing

PREPARING YOUR ORGANIZATION FOR A DOL AUDIT

- Be mindful of DOL's national enforcement initiatives and broad investigative powers.
- employers should be pro-active in preparing for a potential future audit.
- Remember the best practices for both before and during any DOL audit.

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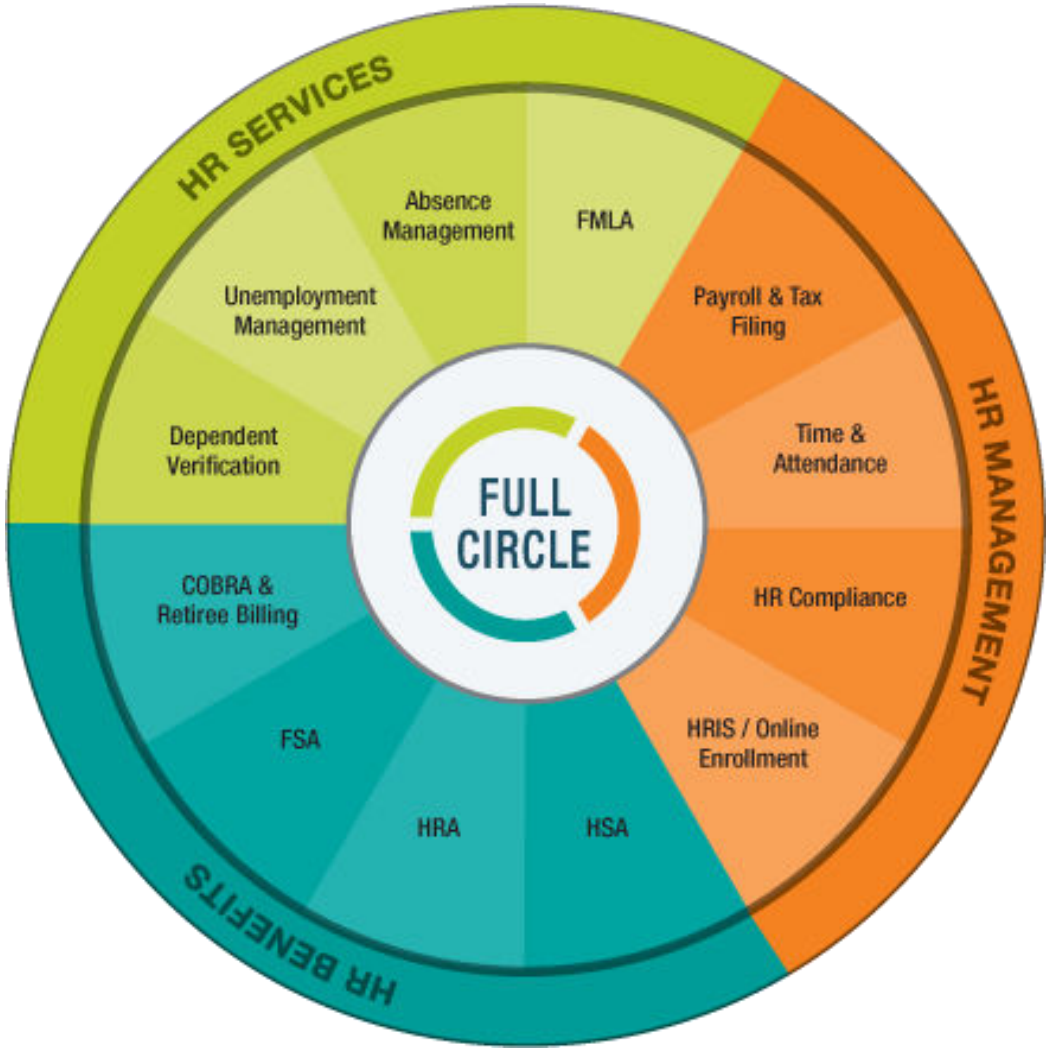

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