Compliance Documentation Audit

A Comprehensive Analysis of Health & Welfare Benefit Plans

Presented to [Employer]

[Date]

In partnership with

[Date]
[HR Contact]
Director, Human Resources
[Employer]
123 Main Street
Anytown, FL 12345

RE: **[Employer]** Compliance Documentation Audit

Dear **[Name]**,

We are pleased to present our comprehensive review of your health and welfare benefit plans in partnership with **Assurex Global**.

During the course of this review, we were fortunate enough to have the exceptional support of the **Assurex Global** organization, and through their diligent and professional efforts, we were able to collect all of the relevant data needed to cover a broad spectrum of areas for our review.

Each document included in this review has been carefully evaluated for compliance with federal regulations such as ERISA, COBRA, HIPAA, and the provisions of ACA that are currently in force. Included with our review are specific recommendations to remedy areas identified as non-compliant, as well as suggestions for streamlining the administration of your program. Medcom Benefit Solutions would be pleased to assist further in implementing any corrective measures that fall within the range of our services if desired.

On behalf of Medcom Benefit Solutions and **Assurex Global**, we appreciate this great opportunity to work with **[Employer]** in evaluating your health and welfare programs. It has been a privilege to serve your organization, and we look forward to providing any additional assistance you may request.

Best regards,

[Name]

Director, Health & Welfare Compliance Division

Enclosures

Cc: **[Name]**, President, **[Broker/Consultant]** **[Name]**, Account Manager, **[Broker/Consultant]**
Michael J. Bracken, President, Medcom Benefit Solutions

HEALTH PLAN COMPLIANCE REVIEW

for

[Employer]

Health and Welfare Benefit Plans

Prepared by [Reviewing Attorney]

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[Employer] Group Health and Welfare Benefit Plans Compliance Review

Overview

This Compliance Review was conducted on **[EMPLOYER]** (referred to herein as "**[EMPLOYER]**") group health plan, dental/vision plan, disability plan, and life insurance plans. The Compliance Review has been performed with documents provided in **[MONTH/YEAR].** We reviewed all documents that were provided for review by **Assurex Global** and **[EMPLOYER]**.

The documents we have reviewed are listed in the Scope of Review, which begins on page 6. Our review of the health and welfare plans sponsored by **[EMPLOYER]** was based on the following information that we received about these plans:

1) The plans are sponsored by a single employer, and there are no other employers that participate

2) The plans are not grandfathered under the Affordable Care Act

3) The plans are subject to ERISA

The review performed included compliance with all relevant federal laws that affect employee health and welfare plans. Compliance by an insurance company with state insurance law was beyond the scope of this review.

Summary of Findings

[EMPLOYER] sponsors a number of benefit plans that are in various stages of compliance with applicable employee benefit laws. Therefore, we suggest that the benefits be "wrapped" into a single plan to provide all plans the necessary ERISA compliance wording.

Although the review for each item provided, as shown on the Scope of Review, contains a detailed analysis of the issues relating to that topic and its related documents, we have provided a summary of all pertinent changes as a reference guide for implementation. The items are listed under Action Items on page 9. Please note that this summary only includes the most important changes or those that need to be corrected.

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Scope of Review:

Item #	Documents Reviewed	Funding Type	Effective Date
1	**Flexible Benefit Plan Documents** **[EMPLOYER]** Flexible Benefit Plan **[EMPLOYER]** Flexible Benefit Plan SPD Election Form Reimbursement Request Forms	NA	**[DATE]** **[DATE]**
2	**Medical Plan Documents** **[CARRIER]** Health and Financial Change Application **[CARRIER]** Enrollment Form **[CARRIER]** Health Care Reform Endorsement **[CARRIER]** Benefits Booklet Policy 1 **[CARRIER]** Benefits Booklet Policy 2 **[CARRIER]** Large Group Health Benefit Plan 4321- Summary of Benefits **[CARRIER]** Large Group Health Benefit Plan 1234- Summary of Benefits **[CARRIER]** Pharmacy Benefits SG LG 10 25 40 **[CARRIER]** Pharmacy Benefits SG LG CF 600 DED 10 60 NC	Insured	Not dated
3	**Dental/Vision Benefits** **[CARRIER]** Group Health Benefits Dental, Vision option A **[CARRIER]** Group Health Benefits Dental, Vision option B **[CARRIER]** Benefits Plan Dental, Vision	Insured	**[DATE]** **[DATE]**
4	**Life Benefits** **[EMPLOYER]** Group Life and AD & D Benefits Group Voluntary Term Life Benefits (Executives) Group Voluntary Term Life Benefits (All other eligible employees) **[CARRIER]** Voluntary Term Life Policy	Insured Insured Insured	**[DATE]** **[DATE]** **[DATE]** **[DATE]**

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5	**Disability Benefits** **[EMPLOYER]** Group Long-Term Disability Benefits (Executives) **[EMPLOYER]** Group Long-Term Disability Benefits (All other eligible employees) **[CARRIER]** Short-Term Disability Policy **[CARRIER]** Short-Term Disability Insurance Summary of Coverage (Executives) **[CARRIER]** Short-Term Disability Insurance Summary of Coverage (All other Eligible Employees)	Insured Insured Insured	**[DATE]** **[DATE]** **[DATE]** **[DATE]** **[DATE]**
6	**Employment Policies** **[EMPLOYER]** Personnel Policies and Procedures Chapter 5 - Employee Leave and Benefits *Section 1 Employee Leave* 1.4 Military Leave 1.9 Family and Medical Leave *Section 3 Insurance* 3.1 Health Insurance 3.2 Life Insurance 3.3 Disability Insurance *Section 5 Benefits* 5.1 Medical and Dental Services Availability 5.2 Worker's Compensation 5.5 Consolidated Omnibus Budget Reconciliation (COBRA)	NA	**[DATE]**
7	**COBRA Notices** Initial Notice Election Notice - **[COBRA Administrator]**	NA	Not provided 10/11
8	**HIPAA Privacy and Portability** Special Enrollment Notice HIPAA Privacy Notice HIPAA Privacy Policy HIPAA Privacy Forms	NA	Not provided Not provided Not provided Not provided

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<table>
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Patient Protection Notice
Women's Health and Cancer Rights Act (W HCRA) Notice
Newborns and Mothers Health Protection Act Notice
QMCSO Policy
Medicare Part D - Creditable Coverage Notice
Medicare Part D - Non-Creditable Coverage Notice</td><td>NA</td><td>Not provided
Not provided
Not provided
Not provided

Not provided
Not provided
[DATE]
[DATE]</td></tr>
<tr><td>10</td><td>Wellness Plan
Wellness Documents – Online Health Assessment</td><td>NA</td><td>Not provided</td></tr>
<tr><td>11</td><td>5500 Filings – Welfare Plans
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Action Items:

Item #	Document	Action Needed
1	Flexible Benefit Plan Document	The plan document should be updated to: • Include pre-tax premium payments • Add additional termination provisions • Update the election change provisions • Update the claim denial wording • Include HITECH Act wording • Remove grace period for the dependent care account
	Flexible Benefit Plan SPD	The SPD should be amended to: • Remove election change provisions that are not applicable to flexible spending accounts Add wording limiting reimbursement for over-the-counter drugs to those for which the individual has a prescription
2	Medical Benefits	The **[CARRIER]** Booklets are not compliant with ERISA. A wrap SPD should be adopted for at least the medical Plan, though **[EMPLOYER]** may want to include other coverages in the wrap.
		Ensure that an SBC is delivered to participants, beginning with the September 2013 renewal. The SBC should be distributed with open enrollment materials.
3	Dental/Vision Benefits	The leave wording in the certificate should be updated, or the Personnel Policy should be changed to consistently refer to coverage during a leave of absence *other* than FMLA leave. The Personnel Policy currently does not address continued coverage during these leaves.
		The termination/continuation provisions are not consistent with the Personnel Policies and Procedures. The certificate will need to be changed to allow continuation during a leave of absence (non-FMLA), or the Policies should indicate that dental and vision coverage will not be continued.
		The Dental certificate does not comply with ERISA. A wrap SPD will resolve this issue.

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4	Life Insurance	Clarify with the carrier whether individuals who are on FMLA due to their own serious health condition will continue to be covered under the Plan.
		The certificates do not comply with ERISA. A wrap SPD will resolve this issue.
5	Disability Insurance	The LTD certificate does not comply with ERISA, but a wrap SPD will resolve this issue.
6	Employment Policies	**[EMPLOYER]** should adopt a plan document for its medical/dental credit for services performed at its facilities.
7	CHIPRA Notice	Provide CHIPRA Notice to participants
	Patient Protection Notice	Provide Patient Protection Notice to Enrollees
	QMCSO Policy and Procedures	Adopt a policy for complying with the requirements relating to QMCSO's.
	Pre-existing condition notice	Ensure that this notice is provided if a pre-existing condition provision is included in the Plan (see group application).
8	Wellness Plan	Determine if the wellness plan is part of an overall ERISA plan and include it in a wrap document if needed.
9	5500 Filing	Make corrections as recommended in report.
10	Nondiscrimination Testing	No issues found

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Item 1: Cafeteria Plan Documents

DOCUMENTS REVIEWED

We reviewed the following for the **[EMPLOYER]**'s Flexible Benefit Plan, which includes a premium payment component, a health flexible spending account, and a dependent care assistance plan:

1) **[EMPLOYER]** Flexible Benefit Plan
2) **[EMPLOYER]** Flexible Benefit Plan SPD
3) Election Form
4) Reimbursement Request Forms

ELIGIBILITY

Common-law employees eligible for coverage under the Medical Plan are eligible for coverage under the Flexible Benefit Plan. This Plan includes explicitly leased employees. The Medical Policy specifies a 30-day waiting period before the employee is eligible to enroll and that employees working at least 30 hours per week are eligible for benefits.

Employees are required to complete a Salary Redirection Agreement to enroll. In addition, the employee must complete an Enrollment Form that is entitled "Flexible Benefits Plan Election Form."

FINDINGS

Plan Document

The Plan described in this document includes a health flexible spending account and a dependent care account, but neither describes pre-tax premium contributions nor indicates that it was intended to function in this capacity. The Employer's Plan, as described in the 5500 Filing (See Item #12), is a Premium-only Plan.

1) Section 2.4 - Termination (page 8): The termination provision does not specify that participation will terminate when an employee is no longer eligible and/or when the employee fails to complete an election form to participate in a subsequent plan year. It should also include termination when the employee revokes their election to participate when permitted to do this in accordance with the election change rules.
2) Section 5.4 - Change in Status (pages 8-11): The Plan Document does not include information about special enrollments required by CHIPRA for loss of coverage under Medicaid or CHIP or for eligibility for premium assistance under CHIP and does not discuss election changes under the FMLA. In addition, several election change reasons are included but do not apply to either a health flexible spending account or a dependent care account.

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3) Article 7 – Dependent Care Flexible Spending Account (pages 15-20): The provisions in this section are unclear as to how the Plan works with respect to the grace period. Section 7.8 states that the amount remaining at the end of the plan year is considered to be forfeited. In addition, the Grace Period provision allows expenses incurred during the grace period to be considered incurred during the prior taxable year. The concern here is that if expenses are paid during a calendar year that exceeds the statutory limit of $5,000, the employee will use the tax benefits. This could happen where an employee incurs over $5,000 of expenses in one calendar year and some of those expenses are paid out of prior year funds (due to the grace period). We recommend removing the grace period for Dependent Care expenses.
4) Section 8.1(d) Health FSA Claims (pages 21-23): This section needs to be updated to comply with the amendments to the ERISA claim requirements promulgated under ACA.
5) Section 11.17 Compliance with HIPAA Privacy Standards (page 31): This section needs to be updated to comply with the HITECH Act, which amended HIPAA. This Act creates an obligation for the Plan to notify affected individuals of a breach of unsecured protected health information. All health plan documents that are subject to HIPAA are required to contain wording that includes these requirements. The HITECH Act, which stands for Health Information Technology for Economic and Clinical Health Act, became effective on February 17, 2010.
6) Section 11.17: This section and HIPAA require that the Employer provide a certification of HIPAA compliance to the Plan. This certification was not provided for review.

Summary Plan Description

1) Election Changes (page 2): This section describes election changes that are not applicable to either the health FSA or dependent care account.
2) FMLA (page 6): The SPD contains provisions for CHIPRA – The special enrollment rights required by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) are not included in the Summary Plan Description.
3) Benefits (page 2): This section states that over-the-counter drugs are eligible. This description needs to be amended to clarify that a prescription is required for reimbursement of over-the-counter drugs.

Flexible Benefits Plan Election Form and Reimbursement Request Form

No issues were found with these documents.

General Comments

HEART Act wording: The Heart Act provided for an optional benefit that would allow an employee being called to active duty to receive a disbursement of funds from the FSA. [EMPLOYER] may choose to include this benefit in the future.

Item 2: Medical Plan Documents

DOCUMENTS REVIEWED

We reviewed the following for the **[EMPLOYER]** Group Health Insurance Plan:

- **[CARRIER]** Change Form
- **[CARRIER]** Health Care Reform Endorsement
- **[CARRIER]** Benefits Booklet Policy 1
- **[CARRIER]** Benefits Booklet Policy 2
- **[CARRIER]** Large Group Health Benefit Plan 4321- Summary of Benefits
- **[CARRIER]** Large Group Health Benefit Plan 1234- Summary of Benefits
- **[CARRIER]** Pharmacy Benefits SG LG 10 25 40
- **[CARRIER]** Pharmacy Benefits SG LG CF 600 DED 10 60 NC

An SBC for the Plan was not provided for review.

ELIGIBILITY

Eligibility is not defined in the Benefits Booklets, but the Personnel Policies and Procedures indicate that only permanent full-time and certain contracted employees working 30 hours per week are eligible for medical benefits. Full-time is defined in Section 2.1 as those employees who work at least 40 hours per week. Benefits are not available until after the 90-day orientation period.

FINDINGS

Benefits Booklets

1) ERISA Compliance: The Benefits Booklets are not compliant with ERISA. They do not have the required ERISA notice or other information that must be provided to employees in a Summary Plan Description. We suggest that the Employer adopt a wrap plan document to include the ERISA required elements and ensure ERISA compliance.
2) Eligibility (page 40): The Plan provides that eligibility is determined based on the criteria shown on the group application. The Employer should confirm that the group application eligibility provisions are consistent with its policies described above.
3) Open Enrollment Period (page 42): The Benefits Booklets state that the insurance carrier will determine the annual enrollment period. **[EMPLOYER]** should confirm that they are using the required time period.
4) Termination (page 45): The Benefits Booklets indicate that coverage will end when an employee no longer meets the eligibility requirements, but it is not clear what is meant by that in the case of a leave of absence, illness, or another event that keeps the employee

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from working for a period of time. **[EMPLOYER]** may want to get clarification from the carrier as to when coverage will terminate in these situations and confirm that coverage can be continued during the leave provided in the Personnel Policies and Procedures. Alternatively, **[EMPLOYER]** could clarify when coverage will not be continued in the Personnel Policies and Procedures. More information about the leave provisions in the Personnel Policies and Procedures is included in Item 6 below.

5) Dependent Eligibility Endorsement (page 99): This endorsement provides for coverage of children until the end of the year in which the child turns age 30. **[EMPLOYER]** should be aware that coverage of any child beyond the end of the year when they turn age 26 will require the Employer to impute income to the employee equal to the coverage value. In other words, coverage for that child cannot be provided on a tax-free basis. In addition, the termination dates for dependents will vary for each line of coverage.

Item 3: Dental/Vision Plan Documents

DOCUMENTS REVIEWED

We reviewed the following for the company's dental Plan:

- **[CARRIER]** Group Health Benefits Dental, Vision option A
- **[CARRIER]** Group Health Benefits Dental, Vision option B
- **[CARRIER]** Benefits Plan Dental, Vision

ELIGIBILITY

Employees are eligible for dental coverage if they are working full-time as defined by the Employer. Coverage becomes effective at the end of the waiting period. The Personnel Manual & Policies indicate that only permanent full-time and certain contracted employees working 30 hours per week are eligible for dental benefits.

FINDINGS

1) Domestic Partner Coverage (page 24): The Certificates include domestic partners as eligible for coverage. [EMPLOYER] should understand that in any case in which a domestic partner is not a tax dependent of the employee, it will need to impute income to the employee (who covers a non-dependent domestic partner) equal to the value of that coverage.

2) Dependent Coverage (page 19): The Certificates include coverage for dependents through the end of the year in which a child turns age 26 as long as the child is a full-time student after age 20. This provision will allow some consistency with the medical coverage, but full-time student status will need to be verified for continued coverage.

3) When Coverage Ends (17): The Certificate indicates that coverage will terminate at the end of any month in which the employee is no longer a full-time active employee, including due to retirement, layoff, leave of absence (except as provided by the FMLA), or the end of employment. Coverage also

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terminates on the date of the employee's death. The Personnel Policies & Procedures provide for non-FMLA leave up to 90 days and for personal leave up to a month. Either the certificate and/or the Policy should be updated to clarify whether dental and vision benefits are continued during these leaves. If **[EMPLOYER]** wants to maintain coverage based on the certificate, the Policy should indicate that coverage for dental/vision will terminate at the end of the month the leave begins.

4) ERISA Compliance: The Certificates are not compliant with ERISA. They include the required ERISA notice but do not have the other information that must be provided to employees in a Summary Plan Description. We suggest that the Employer adopt a wrap plan document to include the ERISA required elements and ensure ERISA compliance.

Item 4: Life Plan Documents

DOCUMENTS REVIEWED

We reviewed the following for the **[EMPLOYER]** 's life insurance plan:

- **[CARRIER] [EMPLOYER]** Group Life and AD & D Benefits Certificate of Insurance
- Group Voluntary Term Life Benefits (Executives)
- Group Voluntary Term Life Benefits (All other eligible employees)
- **[CARRIER]** Voluntary Term Life Policy

ELIGIBILITY

Employees working at least 30 hours per week are eligible for group coverage after a 60-day waiting period. Voluntary life coverage is available for employees working 30 hours per week after a 90-day waiting period.

FINDINGS

Group Life Certificate

1) Eligibility (page 3): It is unclear whether **[EMPLOYER]** intended to offer life insurance benefits to a different class of employees with a shorter waiting period than those eligible for medical, dental, and vision. The Personnel Policy and Procedures do not specify any eligibility requirements for life insurance. **[EMPLOYER]** should confirm and update this if necessary.

2) Layoff or Leave of Absence (page 4, page 11, page 21, page 24): The Certificate indicates that coverage can continue until the end of any month in which the employee has been laid off or began a leave of absence. However, it also allows continuation during a non-FMLA leave unless the reason is due to the employee's own serious health condition but then later states that coverage may be continued during FMLA without the employee's own serious health condition limit. In another location, the certificate allows continuation for up to 12 months during the individual's sickness or injury (as long as the Employer provides notice to

the carrier of the continuation). These provisions appear to be inconsistent, and we recommend that **[EMPLOYER]** receive clarification on when coverage can be continued for employees who are not actively at work under this Policy.

The Personnel Policies & Procedures provide for non-FMLA leave up to 90 days and for personal leave up to a month. Either the Certificate and/or the Policy should be updated to clarify whether life benefits are continued during these leaves.

3) ERISA Compliance: The Certificate is not compliant with ERISA. It does not have the required ERISA notice or other information that must be provided to employees in a Summary Plan Description. We suggest that the Employer adopt a wrap plan document to include the ERISA required elements and ensure ERISA compliance.

Voluntary Life Certificate

1) Continuation of Coverage. Coverage under this Policy can be continued for up to 12 weeks during a layoff or leave of absence and in accordance with the FMLA. Another provision (that indicates that it controls any conflicting provision) allows coverage to continue during an injury or sickness that prevents active work for up to 12 months. No changes need to be made as long as these provisions are consistent with the Employer's expectations.

Item 5: Disability Plan Documents

DOCUMENTS REVIEWED

We reviewed the following for the **[EMPLOYER]** 's disability plan:

- **[CARRIER]** Long-Term Disability Benefits Certificate of Coverage (Executives)
- **[CARRIER]** Group Long-Term Disability Benefits Certificate of Coverage (All other Eligible Employees)
- **[CARRIER]** Short-Term Disability Policy
- **[CARRIER]** Voluntary Short-Term Disability Insurance Summary of Coverage (Executives)
- **[CARRIER]** Voluntary Short-Term Disability Insurance Summary of Coverage (All other Eligible Employees)

ELIGIBILITY

All full-time employees working at least 30 hours per week after a 90-day waiting period are eligible for long-term disability coverage and short-term disability coverage. Coverage becomes effective on the first day of the month, coinciding with or after the end of the waiting period.

FINDINGS

1) Neither of the plans contained the required ERISA wording, but the STD, as a voluntary plan, may not be subject to ERISA.

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2) Neither the LTD certificate nor the STD summary clearly defines when active work terminates. This should either be clarified or **[EMPLOYER]** should confirm that its policies will be followed by the carrier.

Item 6: Employment Policies

DOCUMENTS REVIEWED

We reviewed the following provisions that were included in the Personnel Policies and Procedures, and that relate to the health and welfare plans offered by the Employer:

- **[EMPLOYER]** Personnel Policies and Procedures
  - Chapter 5 - Employee Leave and Benefits
    - Section 1 Employee Leave
      - 1.4 Military Leave
      - 1.9 Family and Medical Leave
    - Section 3 Insurance
      - 3.1 Health Insurance
      - 3.2 Life Insurance
      - 3.3 Disability Insurance
    - Section 5 Benefits
      - 5.1 Medical and Dental Services Availability
      - 5.5 Consolidated Omnibus Budget Reconciliation (COBRA)

FINDINGS

Personnel Policies and Procedures

Our review of the Personnel Policies and Procedures covered all areas that affect the employee welfare benefit plans offered to employees of **[EMPLOYER]**. Only those sections with comments are shown below.

1) Section 1 – Employee Leave (Pages 50-52): The leave provisions in the Personnel Policies and Procedures allow for the following:

   a. One month of personal leave

   b. 12 or 26 weeks of FMLA

   c. Non-FMLA leave with benefits available for up to 90-days

   The FMLA section should clarify that additional time may be granted as an accommodation in accordance with the Americans with Disabilities Act. In addition, there should be a clear

statement as to when benefits terminate when an employee fails to return to work at the end of the leave.

2) Section 3 – Insurance (pages 55-56): No issues were found with this section, except that **[EMPLOYER]** may want to provide more detail on the coverage provided.

3) Section 5 – Benefits (page 57): The $2,000 service credit provided to employees is most likely an employee welfare benefit plan that is subject to ERISA. As a result, **[EMPLOYER]** should adopt a basic plan document and issue an SPD to covered employees

Item 7: COBRA

DOCUMENTS REVIEWED

We reviewed the following documents relating to COBRA:

- **[COBRA Administrator]** Election Notice

FINDINGS

We found no issues with the Election Notice from [COBRA Administrator]. **[EMPLOYER]** should be aware that an Initial Notice must be sent to all new plan participants (this may be done by **[COBRA Administrator]**) and that if it sponsors a Health Flexible Spending Account, it should be included as part of the COBRA offer when the employee has a positive balance (remaining funds) in their account at the time of termination.

Item 8: HIPAA Privacy and Portability

DOCUMENTS REVIEWED

None of the following documents required for compliance with HIPAA were provided or reviewed as part of the [EMPLOYER] Compliance Review.

- Special Enrollment Notice (See Item 9 – Miscellaneous Notices and Policies)
- HIPAA Privacy Notice
- HIPAA Privacy Policy
- HIPAA Privacy Forms
- Business Associate Agreements

FINDINGS

1) The HIPAA documents provided as part of the Compliance Review pertain to **[EMPLOYER]** 's compliance with HIPAA as a provider.

2) Based on the information provided, **[EMPLOYER]** does not need to comply with HIPAA privacy for its health plans at present. If at some point, **[EMPLOYER]** sponsors a self-funded plan such as a health flexible spending account or health reimbursement arrangement, or if **[EMPLOYER]** has

access to protected health information, it will need to comply with HIPAA privacy rules for its health plans.

Item 9: Miscellaneous Notices and Policies

DOCUMENTS REVIEWED

We received a copy of the Creditable and Non-Creditable Coverage Notices that **[EMPLOYER]** has provided to its plan participants. In addition to these notices, the notices described in the chart below are required to be distributed to plan participants as indicated.

FINDINGS

[EMPLOYER] needs to adopt a policy for complying with the QMCSO requirements. In addition, the following chart describes the Employer's compliance with the other notice requirements:

Notice	Status	Distribution Timing	Additional Distribution	[EMPLOYER] Compliance
Pre-Existing Condition Notices	Not provided	Upon enrollment	After enrollment if a limitation applies.	It is unclear whether the Employer has elected a pre-existing exclusion (see Employer application).
HIPAA Special Enrollment Rights Notice	Not provided	On or before first opportunity to enroll	Open Enrollment	May be included on the benefits enrollment form that was not provided as part of this review.
COBRA Initial Notice **COBRA Election Notice**	Not provided Provided and reviewed	Enrollment	At a qualifying event	No issues found with the election notices
Medicare Part D Creditable Coverage Notice	Provided and reviewed	Enrollment	Annually by October 14	Notices are in compliance with the requirements of Medicare.
Women's Health & Cancer Rights Act Notice	**Provided**	**Enrollment**	**Open enrollment**	In compliance

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Patient Protection Notice	**Not provided**	**Enrollment**	**Open enrollment (if plan summaries are distributed)**	These notices were not provided and are not included in the Medical Benefits Booklets
CHIPRA Notice	Not provided	Annual (or at open enrollment)		
Certificate of Creditable Coverage	NA	Upon Termination		This document will be provided to terminated employees and dependents by **[CARRIER]**

Item 10: Wellness Plan

DOCUMENTS REVIEWED

We reviewed the following documents relating to the Employer's Wellness Plan:

- **[EMPLOYER]** Wellness Plan Document

FINDINGS

The wellness benefits provided do not appear to be subject to the provisions of HIPAA because the benefit merely involves certain health-related initiatives, such as flu shots, cholesterol screenings, and blood pressure screenings. However, because the Plan pays for medical care, it could be considered a health plan and may be subject to ERISA. This would depend on whether the wellness offerings are part of an overall scheme, Plan, or program that provides or pays for medical care.

The Employer can address this issue by adopting a wrap plan document and including the wellness offerings as part of the overall Plan.

Item 11: 5500 Filing

DOCUMENTS REVIEWED

We reviewed the **[Year]** Plan Year 5500 Filing for the following **[EMPLOYER]** Plans:

- **[Employer]** Group Benefit Plan (Plan 501)

FINDINGS

The **[YEAR]** annual report return indicates this is a first-year return, which may not be the case since the original Plan began on **[DATE]**. The **[YEAR]** annual report was filed with an extension and submitted

on **[DATE]**. A check with DOL 5500 Filing Search does not indicate that this return has been amended. This appears to represent a filing error. The annual report also indicates that this filing contains a reporting for the ASO Stop-Loss insurance underwritten by **[CARRIER]**, which may not be necessary if the medical and dental coverage plans are self-funded through cafeteria plan deductions.

Although we do not have a copy of the cafeteria plan document which would validate the existence of pre-tax contributions that may fund these plans, the Plan Sponsor should be made aware that if this is the case, the Stop-Loss coverage is exempt from filing altogether, including the Schedule C. This treatment only holds up if cafeteria plan assets are used to fund these programs. The Plan Sponsor should investigate this possibility and perhaps, amend the **[YEAR]** annual report return.

The **[YEAR]** annual report return has the same characteristics as the **[YEAR]** annual report return with regard to possible cafeteria plan contributions through an ASO Stop-Loss Agreement.

A Schedule C is not required for a welfare plan when the Employer pays expenses to service providers directly from its plan assets (such as under an ASO agreement) or when the Plan is maintained with a Section 125 plan (per DOL Technical Release 92-01). Neither is a Schedule A required for stop-loss coverage when an ASO agreement is in place. With regard to 5500 instructions that are issued every year for filing purposes, the following is listed with regard to Schedule A:

Note: Employers sponsoring welfare plans may purchase a stop-loss insurance policy with the Employer as the insured to help the Employer manage the risk associated with its liabilities under the Plan. These employer contracts with premiums paid exclusively out of the Employer's general assets without any employee contributions generally are not plan assets and are not reportable on Schedule A.

Additionally, the 5500 instructions read as follows:

Do not file Schedule A for a contract that is an Administrative Services Only (ASO) contract, a fidelity bond or policy, or a fiduciary liability insurance policy.

Item 12: Nondiscrimination Testing

DOCUMENTS REVIEWED

We reviewed the following documents related to Nondiscrimination Testing:

- **[EMPLOYER]** 2014 Plan Year NDT Results

FINDINGS

There were no issues found

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APPENDIX A: Applicable Laws and Consequences

The following list of penalties and potential consequences for violation of an applicable employee benefit law is a summary only and does not describe the full extent of the penalties or the consequences of failure to comply. **[EMPLOYER]** could be subject to greater or lesser penalties depending on the facts and circumstances of the situation. This table should not be regarded as legal advice but be used as a guide for understanding the potential consequences of noncompliance.

Typically, penalties are imposed after a complaint initiated by an employee or after an audit initiated by the Department of Labor, CMS, or the IRS. In addition, an Employer is required to report violations of the laws in any of the shaded rows below and pay the applicable penalty regardless of an audit or complaint. As noted, the penalty may be lower if the failure was due to reasonable cause and not willful neglect. This payment must be made annually by filing Form 8928 and must include interest payments, if applicable.

Law or Requirement	Applicable Benefits	[EMPLOYER] Compliance Obligation	Penalties for Noncompliance
ACA - Shared Employer Responsibility Provisions	Medical Plan	**[Current Regulatory Guidance]**	$2,000 per full-time (average 30 hours) employee penalty if coverage is not offered to at least 95% of all full-time employees $3,000 per full-time employee who is offered unaffordable coverage or coverage that is not at least 60% actuarial value and the employee purchases coverage on the Exchange and receives a cost-sharing subsidy or advance premium credit (available only to those under 400% of federal poverty level)
ACA - Plan Design Requirements	Medical	**[Current Regulatory Guidance]**	$100 per day penalty can be assessed for failure to comply with the pre-existing condition provisions of ACA. Additional penalties may be applied to failure to provide other mandated benefits.
ACA - Provision of SBC	Medical	**[Current Regulatory Guidance]**	$1,000 per willful failure to provide per participant and $100/day per participant in excise taxes. During the first year, no penalties will be applied.

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HIPAA Privacy, including HITECH	Self-funded plans and insured plans with access to PHI (other than enrollment information)	**[Current Regulatory Guidance]**	Administrative remedies through the Department of Health and Human Services upon receipt of a complaint, followed by (if the issue is not resolved) potential imposition of civil monetary penalties on the group health plan and/or business associate from $100 to $50,000 per violation. Criminal penalties for willful violation could also be imposed. Criminal penalties could be up to $250,000 and 10 years in jail.
HIPAA Portability Special Enrollment	Medical, dental, vision	**[Current Regulatory Guidance]**	Penalties are $100 per day per individual paid as an excise tax.
GINA	Medical	**[Current Regulatory Guidance]**	Compensatory and punitive damages, reinstatement, back pay, and attorney's fees. GINA is enforced by the Equal Employment Opportunity Commission.
FMLA	Medical, dental, vision	**[Current Regulatory Guidance]**	An employee may bring a lawsuit against an employer who violates the FMLA or file a complaint with the Department of Labor.
Medicare Secondary Payer	Medical	**[Current Regulatory Guidance]**	Penalty is 25% of the total expenses incurred during the year for all health plans to which that Employer contributes. In addition, there is a $5,000 penalty per participant for offering improper financial incentives to encourage rejection of Employer-sponsored health coverage. In addition, CMS can bring suit to recover twice the amount paid under Medicare, and the employee can bring suit to recover double damages.
CHIPRA	Medical	**[Current Regulatory Guidance]**	HHS can impose a penalty of up to $100 a day for failure to provide the notice or provide information to a state about premiums for employee/dependent coverage.

COBRA	Medical, dental, vision	**[Current Regulatory Guidance]**	If failure to provide COBRA was due to reasonable cause, no excise tax is due unless the failures were not corrected prior to receipt of a notice of examination from the IRS. In this case, the minimum tax will be $2,500, and the maximum tax will be $2,000,000. If failure was due to willful neglect, the number of days of noncompliance (up to 6 months) times the number of qualified beneficiaries affected times $100. There is no maximum for this penalty. ERISA also imposes a penalty of up to $110 per day for any failure to comply.
ERISA Fiduciary Responsibilities	All group plans	**[Current Regulatory Guidance]**	Penalty is 20% of the amount paid to an individual or the Plan as a result of a violation.
ERISA 5500 Filing and Summary Annual Report (SAR) Requirements	Funded plans and unfunded plans with 100 or more participants at the beginning of the plan year. Summary annual report is only required for insured plans.	**[Current Regulatory Guidance]**	Penalties can be up to $1,100 per day for failure to file a 5500 on time. If the Employer participates in the Delinquent Filer Voluntary Compliance Program, the penalties are reduced and capped, but the filing must be made before a request is made by the Department of Labor.
ERISA Provision of SPD and Plan Document Upon Request	All group health plans	**[Current Regulatory Guidance]**	$110 a day penalty for failure to provide SPD or Plan document within 30 days of request. In addition, a lawsuit may be brought by a participant or a beneficiary to enforce this provision.
QMCSO	Medical	**[Current Regulatory Guidance]**	Failure to comply with a QMCSO can result in the state agency bringing suit in federal court to enforce the terms of the QMCSO. Also, a willful violation can result in criminal penalties of: • up to $100,000 and/or imprisonment of up to ten years for willful violations by an individual • up to $500,000 for willful violations by an entity other than an individual

Mental Health Parity Act (MHPA) and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)	Medical	**[Current Regulatory Guidance]**	ERISA contains no specific penalty or enforcement rule for violations of the MHPAEA. However, participants, beneficiaries, and the DOL may use ERISA's civil enforcement provisions to file lawsuits to enforce the MHPA's and the MHPAEA's requirements, which could include damages for unpaid benefits, interest, and attorney's fees under ERISA Section 502. Additionally, the IRS may impose excise taxes for a group health plan's failure to comply with the MHPA's and the MHPAEA's requirements of $100 per day for each individual to whom a failure relates, which increases to $200 per day for multiple violations.
IRC, Section 125 Nondiscrimination	Flexible Benefits Plan	**[Current Regulatory Guidance]**	A highly compensated participant or key employee participating in a discriminatory cafeteria plan must include in gross income the value of the taxable benefit with the greatest value that the employee could have elected to receive, even if the employee elects to receive only the nontaxable benefits offered.
IRC, Section 105 Nondiscrimination	All self-funded plans	**[Current Regulatory Guidance]**	A discriminatory plan design results in adverse tax consequences for HCIs, who are taxed on their "excess reimbursements." When the requirements become effective, penalties under the ACA can result in an excise tax of $100 for each day in the noncompliance period with respect to each individual to whom the failure relates (subject to a reasonable cause exception). There is also the potential for a civil action compelling the Employer to provide nondiscriminatory benefits.

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ADA and the ADAAA	Medical Plan	**[Current Regulatory Guidance]**	Employees must pursue administrative remedies but then can sue for damages, which could include monetary loss, emotional pain, suffering, inconvenience, mental anguish, and attorney's fees. Compensatory and punitive damages are capped based on the size of the Employer from $50,000 to $300,000. The EEOC enforces the ADA.
ADEA	Medical Plan	**[Current Regulatory Guidance]**	Civil penalties available through lawsuit by employee who believes Employer violated ADEA. Damages can include lost benefits, back pay, promotion, reinstatement,

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APPENDIX B: Affordable Care Act Compliance

NOTE: This chart is in compliance based on the laws and regulations in effect on the date of this compliance review and includes only those provisions that apply to **[EMPLOYER]** medical Plan as in effect on this date.

Effective Date for [EMPLOYER]	Requirement Topic	Description	[EMPLOYER] Compliance
[DATE]	**Mandated Benefits**	The following plan requirements must be reflected in the medical Plan: • Annual limits on essential health benefits cannot be below $2 million for plan years beginning in 2013. • Lifetime limits must be removed. • Plan must cover children, whether or not dependent, to age 26. • Plan must allow for an external appeal process. • Plan cannot exclude pre-existing conditions for children under age 19 and beginning in **[YEAR]** cannot exclude pre-existing conditions for any participants. • Plan must include certain preventive care benefits (with no cost-sharing).	In compliance
[DATE]	**Patient Protections**	The Plan must provide direct access to obstetrical or gynecological care without a referral. The rule also prohibits prior authorization or increased cost-sharing for out-of-network emergency services. A notice of these protections is also required to be provided to enrollees.	In compliance
[DATE]	**Notice of Rescission**	A rescission is a retroactive termination of coverage. Rescissions are only permitted if the participant failed to pay the required premium contributions, or the participant committed fraud or made an intentional misrepresentation of a material fact. A 30-day notice is required prior to the rescission.	Medical COCs contain required notice of rescission language. Need to ensure notice is provided should circumstances arise
[DATE]	**Additional Preventive Care Services for Women**	The Plan must cover an array of women's preventive services without cost-sharing by participants.	Included

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[DATE]	**PCORI Fees**	Insurers and employers with self-insured health plans will have to begin paying a fee to fund the Patient-Centered Outcomes Research Institute, which will use the fees to support clinical effectiveness research. The fee applies to the 2012 plan year. The fee will be $1 per average covered life for the first year and then increase to $2 per average covered life for subsequent years. Fees are not required for plan years after 2019. PCORI fees will be due by July 31 each year for any plan year that ended prior to that date.	No information was provided as to whether PCORI fees were submitted prior to due date.
[DATE]	**Transitional Reinsurance Fees**	From 2014-2016, HHS will establish a transitional reinsurance program to help stabilize premiums for coverage in the individual market during the first three years of Marketplace operation. Proposed regulations issued on December 7, 2012, remove the states' obligation to set reinsurance fees and collect payments and require that all carriers pay the reinsurance fees directly to HHS on a federally determined formula.	May be obligation of administrator to transmit fees.
[DATE]	**90-Day Waiting Period Limitation**	DPH Services may not impose a waiting period that exceeds 90 days. A special rule applies if eligibility is based on the number of hours an individual works during a pay period and the individual is not regularly scheduled to work the same number of hours each pay period. Coverage must become effective no later than 13 months after the employee's start date (if the employee is determined to have worked an average of 30 hours per week during a standard measurement period).	In compliance
[DATE]	**Automatic Enrollment**	Employers with over 200 employees will be required to enroll all new employees who are eligible for coverage automatically.	Not yet applicable

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[DATE]	**Mandated Benefits**	The following mandates apply beginning in 2014: • Pre-existing condition exclusions are entirely prohibited. • Annual limits on essential health benefits will no longer be permitted. • Health plans must provide coverage for routine costs and services provided in connection with a clinical trial.	In compliance
[DATE]	**Comprehensive Health Insurance Coverage**	Out-of-pocket maximums may not exceed high-deductible health plan limits (indexed, currently for 2014 at $6,400 for self-coverage and $12,800 for family coverage).	In compliance
[DATE]	**Wellness Programs**	Permissible wellness program incentives will be increased to 30% of the cost of coverage (or 50% for those designed to reduce tobacco use). Also, under the new rules, a health-contingent wellness plan is not considered reasonable (and thus compliant with the law) if the initial qualification for the program involves the results of a measurement, test, or screening (unless there is another method provided for all individuals to qualify for the reward). This means that a physician note cannot be required to qualify for an alternative method of compliance in any health-contingent program. Other outcomes-based programs, such as those that are activity-only, can require physician approval for an alternative method of complying	Not applicable as no information was provided about wellness programs
[DATE]	**Coverage For Individuals Participating in Approved Clinical Trials**	Prohibits health insurance issuers from dropping coverage because an individual (who requires treatment for cancer or another life-threatening condition) chooses to participate in a clinical trial. Issuers also may not deny coverage for routine care that they would otherwise provide because an individual is enrolled in a clinical trial.	Not applicable Applies only to health insurance

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