U.S. Department of Labor

Employee Benefits Security Administration
J.F. Kennedy Federal Building, Room 575
Boston, MA 02203
Phone (617) 565-9600
Telefax: (617) 565-9666

[redacted]

Re: Health and Welfare Benefits
Plan EIN: Plan Number: [redacted]
EBSA Case No.: -

Dear [redacted]

The U.S. Department of Labor, Employee Benefits Security Administration (EBSA), has responsibility for 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] Health and Welfare Benefits Plan (the 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....

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 inception of an on-site field investigation can lessen the time subsequently spent with, and the administrative burden placed on, plan and corporate officials, and may eliminate the need for an on-site visit entirely. To that end, we ask that you submit to this office, ***within ten (10) business days*** of your receipt of this letter, the documentation indicated on the enclosed **ATTACHMENT** with respect to the above-mentioned plan. If any items are not applicable, please so indicate and provide an explanation.

If you have any questions, please contact Senior Investigator [redacted] directly at [redacted] or [redacted] Thank you in advance for your cooperation.

Sincerely,

[redacted]
Regional Director

By: [redacted]
Senior Investigator

Attachment

ATTACHMENT

COPIES OF ITEMS LISTED BELOW
SHOULD BE SUBMITTED AS INDICATED IN THE COVER LETTER

For each document or set of documents that you provide to us related to the Plan please number and label the front of each document, or set of documents, to correspond to the item numbers listed below. If any item listed below is not provided please provide a brief explanation as to why the item is not being provided.

1. Plan Documents, including all amendments (these documents should provide detailed descriptions of all of the services offered under the Plan as well as explain the restrictions and costs to participants);

2. Trust Agreement, including all amendments;

3. Most Recent Summary Plan Description, including any Summary of Material Modifications;

4. Fidelity Bond, including the effective dates page, declaration page and ERISA rider; (these documents should identify the Plan as a named insured, specify the amount of coverage with no deductible, the name of the surety company and provide the Plan with insurance coverage for employee dishonesty and crime);

5. Fiduciary Liability Insurance Policy (if any);

6. Minutes of all Meetings related to the Plan from January 1, 2011 to Present;

7. List of current Plan Administrator, Plan Trustees, Plan Committee members, Plan Subcommittee members or members of any other administrative group related to the Plan with contact information;

8. List of all Service Providers to the Health/Medical benefits portion of the Plan from January 1, 2010 to Present, including name, address and telephone number;

9. All Service Agreements/Contracts with all **current** Service Providers to the Health/Medical benefits portion of the Plan including current fee schedules;

10. All insurance contracts between the Plan or Plan Sponsor and insurance companies for the provision of Health/Medical benefits under the Plan;

11. If the Plan is self-insured, all contracts for claims processing, administrative services and reinsurance/stop loss insurance;

The name, address and telephone number of the contact person for the Plan Administrator;

13. A sample (i.e. blank) Certificate of Creditable Coverage for the Plan for participants who have lost health care coverage under the Plan since January 1, 2012;

14. A copy of the record or log of all Certificates of Creditable Coverage for individuals who lost coverage under the Plan or requested Certificates since January 1, 2012;

15. A copy of the Plan's written procedure for individuals to request and receive Certificates of Creditable Coverage;

16. 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;

17. 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) since January 1, 2012 or proof that the Plan does not impose a preexisting exclusion;

18. A copy of the necessary criteria for an individual without a Certificate of Creditable Coverage to demonstrate creditable coverage by alternative means;

19. 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), since January 1, 2012 or proof that the Plan does not impose a preexisting condition exclusion;

20. A sample (i.e. blank) COBRA Notice for the Plan;

21. A copy of the Plan's Newborn's Act Notice;

22. The Notice of Special Enrollment Rights distributed to employees;

23. Employer CHIPRA Notice to Plan participants and beneficiaries;

24. Documentation stating the eligibility criteria for enrolling in the Plan;

25. All documents related to any Breast Cancer benefits offered under the Plan;

26. The Plan's annual Women's Health and Cancer Rights Act notice to participants;

27. Documents describing any wellness programs or disease management programs offered by the Plan. If the Plan offers a reward based on an individual 's ability to meet a standard related to a health factor, the should also include its wellness program disclosure statement regarding the availability of a reasonable alternative;

28. A copy of the most recent monthly bill, premium request/invoice from the Plan's insurance carrier for the Health/Medical benefits portion of the Plan;

29. A copy of the check, wire transfer or other method of payment of the premium described in item 28 above;

30. If the Health/Medical benefits portion of the Plan; or part of the Plan, is self--funded, the most recent request for the payment of the participant claims from the Plan's administrative service provider;

31. A copy of the check, wire transfer or other method of payment of the participant claims described in item 30 above;

32. Brief narrative statement detailing the Health/Medical benefits portion of the Plan's funding method;

33. If both employer and employee contributions pay for the cost of the Health/Medical benefits portion of the Pan, the percentage or fixed dollar amount of each part's contribution toward the cost of the Health/Medical benefits portion of the Plan;

34. All Enrollment Forms, Health Assessments or any other documents that participants and/or their dependents are required to complete to enroll in the Health/Medical benefits portion of the Plan or to obtain any benefit or reward offered under the Plan;

35. Portion of Employee Handbook related to employee benefits;

36. All documents related to the Health/Medical benefits portion of the Plan s Claim Procedures (i.e. description of the claims process steps for appealing a denied claim, timeframes for appealing a denied claim timeframes for appealing a claim and receiving a response to the appeal and a description of any grievance procedure for participants who feel their claims have been processed or paid incorrectly, etc.);

37. If the Health/Medical benefits portion of the Plan **IS CLAIMING OR HAS CLAIMED** grandfathered health plan status as defined by 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 grandfathered health 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 was in effect on March 23, 2010;

38. 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 September 23, 2010;

d) 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;

e) If 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.

39. If the Plan is **NOT CLAIMING** grandfathered health plan status under section 1251 of the Affordable Care Act, please provide the following documents:

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 a 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 the 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

If any additional documents are required, you will be notified during the review.