U.S. Department of Labor

Employee Benefits Security Administration
33 Whitehall Street, Suite 1200
New York, NY 10004
Phone: (212) 607-8600
Telefax:(212) 607-8681

December 11, 2014

Plan Administrator
COMPANY
Employee Benefit Plan
Street Address
New York, NY
00000

RE: Company Name. Employee Benefit Plan
Case No.: 00-000000(00)

Dear Sir or Madam

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 Company Name Health and Welfare Program (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 business days*** of your receipt of this letter, the documentation listed on the enclosed Attachment A. If any items are not applicable, please so indicate and provide an explanation. It is requested that you produce the documents listed in the enclosed attachment by uploading them on the following link https://www.askebsa.dol.gov/fileupload/home.aspx?controlIdPre=201330&controlIdPost=03789 which, once accessed, provides instructions for doing so. If the volume of documents exceeds 1000 pages, you are requested to use the following link: http://dol.leapfile.net which also provides instructions. If you are

unable to use either of these links, you may mail the requested documents to U.S. Department of Labor, Employee Benefits Security Administration, 33 Whitehall Street, Suite 1200, New York, NY 10004 to the attention of the undersigned Investigator.

Thank you in advance for your cooperation. Should you have any questions, please contact MXxxxxx via email at Xxxxxx.xxxx@dol.gov.

Xxxxxx Xxxxxxx

ATTACHMENT A

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

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.

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

    a. A copy of the Plan's rules for eligibility to enroll under the terms of the Plan (including continued eligibility).

    b. A sample of the certification provided to those employees who have lost health care coverage since January 1, 2009 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;

    c. A copy of the record or log of all Certificates of Creditable Coverage for individuals who lost coverage under the Plan or requested certificates;

    d. A copy of the written procedure for individuals to request and receive certificates;

    e. 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;

f. 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;

g. A copy of the necessary criteria for an individual without a certificate of creditable coverage to demonstrate creditable coverage by alternative means;

h. 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;

i. 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

j. A copy of the written appeal procedures established by the Plan.

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.

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, 2012 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 were in effect on March 23, 2012.

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, 2012, please provide documents showing the limits applicable for each plan year on or after September 23, 2012.

       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. If the Plan imposes an annual limit or has imposed an annual limit at any point since September 23, 2012, please provide documents showing the limits applicable for each plan year on or after September 23, 2012.

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, 2012.

    c. Copies of documents relating to the provision of preventive services for each plan year on or after September 23, 2012.

    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.