EMPLOYEE BENEFITS SECURITY ADMINISTRATION

Chapter 50, Health Plan Investigations – Case Opening and Initial Review

1. **Purpose**. The purpose of this chapter is to provide guidance on health plan investigation case openings and initial reviews.

2. **Criteria and Special Consideration**. Any investigation, other than a criminal investigation, involving a group health plan or service provider should be opened as a program 50.

While health investigations may include a review of all applicable ERISA provisions including the fiduciary provisions under part 4, a major component of many of these investigations will be a compliance review of ERISA's group health plan requirements under ERISA parts 6 and 7 relating to all applicable health laws including, but not limited to:

- Consolidated Omnibus Budget Reconciliation Act (COBRA);
- Health Insurance Portability and Accountability Act (HIPAA);
- Mental Health Parity Act (MHPA);
- Mental Health Parity and Addiction Equity Act (MHPAEA);
- Women's Health and Cancer Rights Act (WHCRA);
- Newborns' and Mothers' Health Protection Act (Newborns' Act);
- Genetic Information Nondiscrimination Act (GINA);
- Michelle's Law;
- Children's Health Insurance Program Reauthorization Act (CHIPRA);
- Patient Protection and Affordable Care Act (Affordable Care Act).

The Memorandum of Understanding (MOU) between the Departments of Labor, Treasury and Health and Human Services formally establishes an interagency agreement to ensure regulations, rulings, and interpretations relating to HIPAA and other laws are administered in a consistent and uniform manner among the Departments. To the extent an enforcement action raises issues under the shared provisions of part 7, it must reflect interpretations of the laws that have been cleared by the three Departments.

ERISA also requires group health plans to provide participants with plan information including important information about plan features and funding; provides fiduciary responsibilities for those who manage and control plan assets; requires plans to establish a grievance and appeals process for participants to get benefits from their plans; gives participants the right to sue for benefits and breaches of fiduciary duty; and includes rules relating to plan eligibility and coverage requirements.

3. **Targeting -** Enforcement strategies, annual operating plans, and National Office policy statements will provide direction to targeting efforts and may, from time to time, emphasize the review and investigation of certain types of plan-level cases, service providers,

multiple employer welfare arrangements (MEWAs), or other specific matters. All targeting efforts will reflect, and be consistent with, such direction. Additionally, RO initiated targeting efforts which supplement national enforcement strategies, annual operating plans, and policy guidance should be considered for implementation by field offices. Supplemental efforts may reflect such factors as local economic conditions, geographical coverage within an RO/DO jurisdiction, and specialized plan types.

a. Sources for Potential Health Plan Investigations.

1. Computer generated compilations of selected employee health benefit plans or service providers derived from reports filed with EBSA.

2. Information derived from detailed review and analysis of annual reports, supporting financial statements, schedules, exemption application files, ERISA section 502 complaints, and other internal EBSA sources.

3. Information concerning employee health benefit plans or service providers derived from other governmental agencies such as HHS and state insurance agencies.

4. Information concerning employee health benefit plans or service providers derived from non-governmental sources such as newspapers, industry journals and magazines, or leads from knowledgeable parties such as patient advocacy groups, or private litigation.

5. Information received as a result of complaints from participants, fiduciaries, informants, or other sources in the community, other than allegations of acts against a participant or beneficiary for exercising any right to which he/she is entitled under the provisions of an employee benefit plan, or interfering with the attainment of any right to which the participant may become entitled, which should be handled as described in Chapter 43.

6. Compilations of selected employee health benefit plans or service providers derived by using combinations of the sources listed in (1) through (5) above.

b. Methods for Using Sources to Identify Targets.

1. An entire compilation of employee health benefit plans or service providers can be targeted without further refinement of the initial compilation. Generally, this method will be used when the compilation itself is small. For example, an RO may request a printout from the National Office of all exemption applications granted, denied or withdrawn for plans having at least fifty (50) participants located within that RO's jurisdiction. Such a compilation would probably be small in number and, generally, would not require any additional analysis to afford a reasonably good basis for health investigations.

2. More sizeable compilations can be refined through the use of "inquiry letters" (Figure 1) whereby certain additional information is obtained from employee benefit plan officials prior to opening a health investigation. Such inquiry letters, however, should be used with caution and only in a manner consistent with the guidelines in paragraph 4 below. Each RO using inquiry letters will review responses to such letters in order to determine

which employee benefit plans appear to merit further review, either by opening a health investigation or through the use of additional case development efforts.

3. Telephonic contacts may also be used to assist in refining compilations in order to select specific cases for investigation. Such contacts may be used to further refine large compilations after receipt and analysis of "inquiry letters." However, as indicated in paragraph 4 below, such contacts much be made with caution.

4. **Inquiry Letters**. Inquiry letters are often a very effective initial contact with an employee benefit plan or service provider.

a. *Standardized Inquiry Letters*. Standardized inquiry letters must be used with extreme caution because of the strict requirements of the Paperwork Reduction Act (PRA). The PRA prohibits the use of certain standardized letter requests for information without prior approval of the Office of Management and Budget. Inquiry letters containing requests for identical information may not be sent to more than 9 persons unless individual investigations have already been opened. Any standardized inquiry letter sent by the RO must be reviewed by DFO before it is sent.

b. *Telephone Calls*. For the purpose of PRA, telephone calls are the same as inquiry letters. Follow-up calls should be made only after an initial inquiry letter is sent.

c. *Filing Inquiry Letters*. Where the inquiry letters merely request data in support of particular information contained in a filing with the Secretary, such as a Form 5500, that has been the subject of EBSA review, the inquiry letter may request the creation of documents that contain such supporting data. For example, if an RO obtained a computer printout of the 100 employee benefit plans within its jurisdiction with the largest percentage of assets invested in real estate (as derived from the most recently available Forms 5500), that RO could prepare and distribute an inquiry letter to those 100 plans inquiring into and requesting an explanation of the specific nature of each plan's real estate investments after individual investigations have been opened for these plans (see Figure 1). The RO could not, however, request the creation of documents beyond that necessary to explain the entry on the Form 5500.

5. **Internally (EBSA) Obtained Information**. Each field office will maintain lines of access to information maintained in the National Office, such as filed reports and attachments, exemption application files, advisory opinion files, and Solicitor of Labor information.

6. **Routinely Available External Information**. The RO should, on a regular basis, initiate and maintain contacts with other governmental agencies (e.g., OLMS, OIG/OLR, IRS, FBI, U.S. Attorney's offices, state insurance agencies, and other appropriate agencies). The RO/DO also should develop and maintain current listings indicating the locations and responsible officials of important sources of records (e.g., federal and state court records, real estate and UCC filings, assessors' offices, and specialized libraries). Moreover, each RO/DO should routinely review industry publications and other media coverage for information, seeking to identify actual or potential items of health enforcement concern.

7. **Contact Records for Targeting/Case Development Efforts**. For all contacts made under targeting/case development, such as telephone calls, participant interviews, or inquiry letters, a record must be maintained in the RO/DO. The record of each contact shall indicate the date of contact and the party contacted, summarize what occurred, indicate any action taken by the RO/DO (i.e., no action taken, case opened, etc.), and contain sufficient back-up documentation (e.g., annual reports, financial statements, correspondence) to allow for a subsequent statute of limitations analysis.

8. **Opening Health Plan Investigations** The case opening form should describe briefly the reasons for opening the case. The summary section of this form will contain a description of the pertinent facts that form the basis for opening an investigation, including an explanation of the nature of the complaint or other information received; whether a service provider is involved; the ERISA-related issues raised by such complaint or information; and the specific ERISA sections potentially involved. The summary information provided on the case opening form should include a statement setting forth the results of the preparer's search of the global indices. Any materials reviewed prior to the case opening should be identified and dated, and maintained in the case file.

Plan-level Investigations - Plan-level investigations of fully-insured and self-insured group health plans must be conducted to ensure compliance with group health plan requirements under ERISA Title I provisions and pursue widespread compliance opportunities when appropriate. In addition to part 7 of Title I, these cases will also examine compliance with other ERISA provisions such as claims administration, failure to provide promised benefits at the plan level, reasonable administrative fees, potential prohibited transactions, and other issues.

Service Provider Investigations - Generally, any service provider that exercises discretionary authority or discretionary control respecting the management or administration of the plan is a fiduciary. For many self-insured plans and most fully-insured plans, this would frequently include a health insurance issuer that exercises discretion or control over benefit claims decisions.

Issuers offering health insurance coverage in connection with group health plans are also subject to part 7 provisions through parallel state and federal laws, and states maintain primary enforcement authority over issuers regarding these rules.

Service provider investigations will typically include a determination of systemic ERISA violations to ensure service providers, servicing numerous ERISA-covered group health plans, do so according to plan documents and health benefit claims are appropriately paid according to plan terms and in accordance with applicable claims processing regulations. These cases will focus on procedural, substantive and disclosure violations related to the denial of promised health benefits. Service provider cases may involve the same investigative issues as plan-level cases, although will generally be more complex than plan-level cases due to their large format.

9. **Standard Review Steps**.

a. *Document Request Letters*. Document request letters may be used to request information beyond that which is necessary to support information required to be filed with the Secretary under Title I of ERISA only after an investigation has been opened. Such letters may not request the creation of documents, but rather may request the production of existing documents. Figure 2 is an example of a model health plan document request letter and requests information beyond that which is necessary to support an entry in a plan's Form 5500.

b. *Full review*. Health investigations should include a review for compliance with all applicable ERISA provisions. This includes review for compliance with the fiduciary provisions, claims procedure rules, and parts 6 and 7. Generally, every health plan/benefit package option offered should be evaluated for part 7 compliance.

c. *Other Checksheets.* Routinely, reporting and disclosure, and bonding are to be reviewed in employee health benefit plan cases when appropriate (e.g., when a trust is present). See Chapter 48, Figure 3 and Figure 4.

d. *Case Conversion.* Investigations should be converted to Program 48 if violations of part 4 or part 7 are found.

10. **Additional Investigative Steps when a Plan Sponsor is in Bankruptcy**. Upon learning of a current or pending bankruptcy of the plan sponsor or the plan fiduciary the following additional investigative steps should be taken:

- Contact the Bankruptcy Court and obtain the Bankruptcy case number. This information can also be obtained from the Pacer internet access system.
- Once the Bankruptcy case number is obtained, take the necessary steps to obtain an up-to-date Docket, Petition, Schedules, Statement of Financial Affairs, list of all the creditors and any other information which may assist the Investigator/Auditor in the investigation of the plan sponsor or the plan’s fiduciaries.
- Check the bankruptcy filing for the deadline for filing proof of claims (Bar Date) and the date, time and place of the Meeting of Creditors (341 meeting). This information should be recorded pursuant to case management procedures.
- When reviewing the Bankruptcy filing, the Investigator/Auditor should determine if the plan is listed as a creditor to the bankruptcy estate and if the debt listed is consistent with the amount of any delinquent contributions.
- Ask if the entity in bankruptcy sponsors any additional employee benefit plans.

The goal of an investigation when a bankruptcy is involved is to obtain as much information as possible to enable the Investigator/Auditor to determine if a fiduciary breach has occurred. The Investigator/Auditor, in consultation with his/her Supervisor, should determine

whether the RSOL should be informed of the pending bankruptcy proceedings. At all times the Investigator/Auditor should be mindful of the time frames of the bankruptcy proceeding and the time periods available to file a proof of claim.

11. **Written Investigative Plan, Guidelines, and IRS Checksheets**. A written investigative plan may, at the discretion of the Supervisor, be required for any given health investigation; however, investigative plans are not routinely required for Program 50 cases.

Sample investigative guidelines which may be helpful in conducting investigations involving an employee health benefit plan as the direct subject of review are set forth at Figure 3. Also consult Chapter 48 for other similar investigative guidelines. ROs may create other investigative guidelines for use in health plan investigations.

12. **Case Dispositions (Program 50)**

a. *No Violation(s) Found*. In those instances where the health plan investigation identifies no violations, a closing Checksheet ROI will be prepared. Such ROIs will include sufficient narrative detail to describe the basis for the review, the area(s) reviewed, the documents reviewed, and the reason(s) for concluding that no violation(s) exists. See Form 203G for a sample closing ROI format for health plans. Employee benefit plan officials or appropriate officials of service providers will be informed of the results by letter. See Figure 4 for the pattern closing letter.

b. *Violation(s) Found: Reporting and Disclosure, Administrative Practices, Corrected Prohibited Transaction(s)*. In those instances where the health plan investigation identifies violations in areas such as reporting and disclosure, improper administrative practices of a de minimis nature, or prohibited transaction(s) already corrected, the case should generally remain as a Program 50. The same closing ROI form used in no violation cases can be used provided that corrective action(s) taken are documented in the case file. Closing letters will be drafted in a manner which sufficiently details the violation(s) found and corrective action(s) taken, or to be taken.

In instances when reporting violations pursuant to part 1 of ERISA are discovered, and there are no other ERISA violations, the violation should be included in a voluntary compliance letter. Part 1 includes providing summary plan descriptions to participants and filing annual reports such as the Form 5500 and Form M-1. The voluntary compliance letter should require the plan to correct the violation identified. If the plan fails to correct the deficient report violation as requested in the voluntary compliance letter and there are no other unresolved issues involved in the investigation which would mandate a referral for civil litigation, or in situations where there are unresolved issues but a decision has been made not to pursue the investigation, the investigation should be forwarded to OCA. The Regional Office may close the investigation at the time of transmittal. If a referral is made to OCA prior to closing the investigation, the RO should indicate the status of the investigation at the time of the referral so that OCA can coordinate its review with other enforcement actions. A closing letter, which details the reporting violation and contains the following notification, should be issued to the Plan Administrator:

> You must be aware that the responsibility for the acceptance or rejection of any Annual Report (Form 5500) or any part thereof is delegated to the EBSA Office of the Chief Accountant (OCA). [The final decision whether the reporting violations described above have been adequately corrected will be made by the OCA pursuant to the federal regulations set forth at 29 C.F.R. 2570.61 et seq.] Accordingly, the reporting issues will be referred to the OCA for whatever action they deem appropriate.

This same language (without the sentence in brackets) should be included in all closing letters involving a health plan that is required to file an annual report. If a referral is made to OCA prior to closing the investigation, the RO should indicate the status of the investigation at the time of the referral so that OCA can coordinate its review with other enforcement actions.

c. *Apparent Violations Found: Conversion to Program 48*. If evidence of fiduciary breaches or part 7 violations is uncovered, the Investigator/Auditor will notify his/her supervisor and consideration will be given to converting the investigation to a Program 48 case. An ROI is not required for the conversion. The conversion should be done in accordance with case management requirements. Special care should be given to ascertaining a reasonable administrative statute control date. If any substantial delay in conducting an on-site review in the Program 48 investigation is foreseen, the subject of the case should be advised in writing (see Figure 5).

d. *Apparent Criminal Violations Found*. Whenever the health plan investigation uncovers evidence of possible criminal violation(s), the assigned Investigator/Auditor must apprise the group supervisor at the earliest possible time. Normally, the civil case will proceed and no investigation of the criminal case will be performed until the RD has decided whether and by whom such criminal investigation(s) will be conducted.

e. *Apparent Violations of Participant Rights*. If the health plan investigation discloses possible ERISA section 510 violations involving acts against a participant or beneficiary for exercising any right to which he/she is entitled under the provisions of an employee benefit plan, or interfering with the attainment of any right to which the participant may become entitled, a Program 43 case will be opened immediately.

f. *Prohibited Persons*. Whenever the health plan investigation indicates that a person who is barred from serving as an employee benefit plan fiduciary or service provider because he or she has been convicted of certain crimes (see section 411 of ERISA) is acting in such a capacity, a Program 47 case will be opened.

13. **General Investigative Considerations for Health Plan Investigations**

a. Generally, other than stating that the purpose of the investigation is to determine whether a violation of Title I of ERISA has occurred or is about to occur, the Department has adopted the policy of not informing plan officials or others as to the basis of its investigation.

b. Normal operating requirements as reflected elsewhere in the Manual for conducting and documenting interviews, receiving and maintaining records, and similar functions are to be followed.

14. **SBREFA Notice**. In accordance with the provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA), the Small Business Administration has established a National Small Business and Agriculture Regulatory Ombudsman and 10 Regional Small Business Regulatory Fairness Boards to receive comments from small businesses about federal agency enforcement actions. The Ombudsman annually evaluates enforcement activities and rates each agency's responsiveness to small businesses. If a small business wishes to comment on the enforcement actions of EBSA, it may call 1-888-REG-FAIR (1-888-734-3247) or write to the Ombudsman at 409 3rd Street SW, MC 2120, Washington, DC 20416.

Notice of the right to comment to the SBREFA Ombudsman will be provided by copy of the EBSA Customer Service Standards pamphlet to all plan sponsors, plans, or plan service providers with less than 100 participants or employees during the course of ERISA Title I civil investigations. Discretion is granted to EBSA Regional Directors regarding the timing of the delivery of the pamphlet/notice on a case-by-case basis. The case file must reflect appropriate documentation of the SBREFA notice.

The right to file a comment with the Ombudsman does not affect EBSA authority to enforce or otherwise seek compliance with ERISA. The filing of a comment by a small business with the Ombudsman is not a substitute for complying with an EBSA subpoena or addressing EBSA proposed corrective action in a timely manner to protect the business' interests.

SAMPLE INQUIRY LETTER

Plan Administrator
XYZ Corporation
234 N. Fairfield Street
Somewhere, Illinois 12345

Re: XYZ Plan

Dear Sir:

The Employee Benefits Security Administration is undertaking an inquiry of selected private employee benefit plans in order to determine whether those plans are in compliance with Title I of the Employee Retirement Income Security Act of 1974 (ERISA). In connection with this inquiry, we request that, within the next fifteen days, you send copies of the materials listed below to: [EBSA field office address]

The requested items are as follows:

1. The most recent financial statement for the XYZ Plan;

2. The latest Form 5500 (together with any attachments or enclosures) for the plan;

3. Data supporting line number _____ of the plan's [Year] Form 5500 which indicates that $_____ of plan assets are invested in real estate;

4. Data supporting line number _____ of the plan's [Year] Form 5500, which indicates total plan assets at the end of the reporting year were $_____.

If you have any questions, please feel free to call (200) 321-1234 or write to the above address.

Thank you in advance for your cooperation.

Sincerely,

Enclosure

MODEL HEALTH PLAN DOCUMENT REQUEST LETTER

Certified Mail No.
Return Receipt Requested

xx
Plan Administrator
xx Health Plan
xx
xx

RE: **xx** Health Plan

Case No.

Dear Plan Administrator:

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 xx Health 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 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.

Thank you in advance for your cooperation. Should you have any questions, please contact the undersigned at XXX-XXX-XXXX.

Sincerely,

Attachment

(Figure 2)

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. Summary of Benefits and Coverage (SBC), Notices of Material Modifications, and Uniform Glossary.

4. All contracts with insurance companies for the provision of health benefits.

5. If self-insured, all contracts for claims processing, administrative services, and reinsurance.

6. 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.

7. 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.

8. 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.

9. 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.

10. A copy of the Plan's rules regarding pre-authorization for a hospital length of stay in connection with childbirth.

11. A sample of the written description of benefits mandated by WHCRA required to be provided to participants and beneficiaries upon enrollment.

12. A sample of the written description of benefits mandated by WHCRA required to be provided to participants and beneficiaries annually.

13. 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.

14. 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 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, 2010.

15. 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.

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, 2010, please provide documents showing the limits applicable for each plan year on or after September 23, 2010.

16. 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.

INVESTIGATION GUIDELINES

Employee Benefit Plans

I. BACKGROUND

A. Plan sponsor:

Name: _____

Address: _____

_____

Nature of business: _____

B. Type of plan:

_ PENSION
_ Defined Benefit
_ Defined Contribution:
  _ a. Profit Sharing
  _ b. Money Purchase
  _ c. ESOP
_ Other (Specify)

_ WELFARE
_ Medical
_ Life Insurance
_ Vacation
_ Apprenticeship Training
_ Legal Aid
_ Other (Specify)

C. Other plans maintained by plan sponsor

D. Number of participants

Active _____ Total Assets $ _____

Retired _____ Total Income $_____

E. Trustee(s)

F. Plan Administrator ("PA")

1. Name _____

Address _____

_____

Telephone _____

Relationship of PA to Plan:

_____ Contract Administrator

_____ Employee of Plan

_____ Other

2. If PA is paid by plan, state arrangement (salary, retainer, commission, fees, amounts) for most current year.

3. If PA is paid by plan, does PA also receive compensation from plan sponsor/labor organization? YES ____ NO ____

If yes, provide details (amount paid, full or part-time employment, etc.) in Section VI - Narrative.

G. **Service Providers**

	If paid by Plan State Amount
Attorney	_____
Accountant	_____
Actuary	_____
Investment Advisor (Broker)	_____
Custodian	_____
Insurance Consultant	_____
Other (Specify)	_____

H. **Funding**

-- Trust
Funds are accumulated/held by:
Disbursement authority held by:

-- Self insured
Funds are accumulated/held by:
Disbursement authority held by:

-- Fully insured
Insurance company:

-- Other (specify)

II. **INVESTMENTS/ASSETS/EXPENSES:**

Source: — 5500 — Financial Statements — Other (Obtain Copy Whenever Possible)

A. **Asset Analysis** - As of _____
(should be most current year)

BEGINNING % ENDING % (+-) CHANGE*

Cash

Non Interest Bearing
(see Item III.B)

Receivables

Contributions
(See Item III.E)

Other

Stocks:

common 1. PII

2. Non-PII

preferred 1. PII

2. Non-PII

Bonds:

corporate 1. PII

2. Non-PII

government

Real Estate:

1. PII

2. Non-PII

Mutual Fund:

Insurance Company:

account type (explain)

Loans (to participants)

	BEGINNING %	ENDING %	(+-) CHANGE*
Loans (mortgages)			
1. PII			
2. Non-PII			
Loans (other)			
1. PII			
2. Non-PII			
Other (explain)			
1. PII			
2. Non-PII			
TOTALS	$ 100%	$ 100%	$

B. **CASH POSITION (Average)**

1. Total expenses FYE: _____
2. (#1 / 12) = Average monthly expenses _____
3. Non-interest bearing Cash (per the balance sheet) _____
4. If #3 is greater than 200% of #2, explain in narrative Section VI.

C. **RETURN ON INVESTMENTS**

1. Total assets beginning of year _____
2. Investment income/earnings (+-) realized gains/(losses) _____
3. Return on Investments (#2 / #1) _____
4. Unrealized Appreciation (depreciation) of assets _____
5. Does rate of return appear reasonable? Yes _____ No _____
   If no, explain in narrative Section VI.

D. **EXPENSE ANALYSIS**:

1. Disbursement for benefits $_____

2. Administrative expense $_____

3. Other $_____

4. Cost per participant $_____
(#2+#3)/(# of P's)

E. **CONTRIBUTIONS**

— Contributory $_____

— Non-contributory $_____

— Other (specify) $_____

— Non-cash contributions (specify) $_____

1. Total contribution FYE: _____

2. #1/12 = monthly contribution _____

3. Balance sheet
Contribution balance: _____

4. If balance in line 3 is 150% greater than line 2 is there a delinquency problem?
Explain in narrative Section VI.

1. Contributions are sent to:

Bank _____
(name)

Insurance _____
(name)

Plan Office _____
(name)

Union Office _____
(name)

Other _____
(name)

F. **Does the plan hold any employer securities?**
(Section 407(d))

— No

— Yes Explain in narrative Section VI.
(How acquired? FMV? etc.)

G. **Does the plan hold any employer real property?**
(Section 407(d))

— No

— Yes Explain in narrative Section VI.
(How acquired? FMV? Location(s)? etc.)

H. **Has the plan made loans/mortgages to:**

— participants

— beneficiaries

— plan sponsor

— party in interest

— fiduciary

— other (specify)

I. **If any item in H is checked get details**.
Including (as appropriate)

— Name of borrower

— Relationship to Plan

— Amount

— Date

— Interest rate

— Repayment schedule

— Due date

— Type of loan

— Security

— Written agreement

— Percentage of plan assets

— Are payment of interest and principle up to date?

— Current balance

— Does plan document permit loans?
(Available to all participants?)

J. **Records Reviewed**

— Plan/Trust document

— Summary Plan Description (SPD)

— Form 5500 (obtain copy for file) and schedules

— IRS Determination

— Cash receipts

— Cash disbursements

— Investment policies

— Investment portfolio (including most current)

— Contribution reports

— Accountants opinion (obtain copy for file)

— Minutes of trustee meetings

— Form 5330 if filed

— Summary Annual Reports (SAR)

— Participant account balances

— Other (specify)

K. **Has the plan applied for an exemption**?

— No

— Yes (explain)

III. **REPORTING/DISCLOSURE**

A. **Has the plan filed/distributed**:

— Form 5500

— SAR

— SPD (copy for file)

— Amendments (if adopted)

— COBRA notifications for welfare plans

B. **Are reports prepared/distributed on a timely basis?**

— Yes

— No (explain)

IV. **BONDING**

A. **Is plan covered by bonding provisions?**
(Section 412)

— Yes

— No (explain)

B. **Does bond meet requirements?**

— Yes

— No (explain)

PATTERN CLOSING LETTER - NO VIOLATIONS

Dear (Plan Administrator or Fiduciary):

The Department of Labor has recently conducted a limited review involving the (name of the plan) pursuant to the Employee Retirement Income Security Act of 1974 (ERISA). This is to advise you that our limited review is now concluded and no further action by the Department is contemplated at this time.

You must be aware that the responsibility for the acceptance or rejection of any Annual Report (Form 5500) or any part thereof is delegated to the EBSA Office of the Chief Accountant (OCA). [The final decision whether the reporting violations described above have been adequately corrected will be made by the OCA pursuant to the federal regulations set forth at 29 C.F.R. 2570.61 et seq. Accordingly, the reporting issues will be referred to the OCA for whatever action they deem appropriate.][1/]

(We appreciate the cooperation you and members of your staff have extended to us.)

Sincerely,

Enclosure: SBREFA Notice[2/]

cc: File
RO (for DO cases)

[1/] To be used when appropriate.

[2/] When the subject of the investigation is a plan, or other business entity, with fewer than 100 participants or employees and when the notice has not been provided previously.

PATTERN LETTER - FURTHER INVESTIGATION
TO BE SCHEDULED AT A LATER DATE

Dear:

This letter is sent as written confirmation of the fact that the Employee Benefits Security Administration is currently reviewing the _____ pursuant to the Employee Retirement Income Security Act of 1974 (ERISA). This is to advise you that personnel from EBSA will return for further on-site examination of plan records (contact you in regard to additional information) at a later date. You may expect telephonic contact from my staff around _____to make arrangements for this purpose.

Your cooperation in this matter is appreciated.

Sincerely,