EMPLOYEE BENEFITS SECURITY ADMINISTRATION

Chapter 53, Targeting and Limited Reviews

1. **Purpose**. The purpose of this chapter is to provide guidance in the use of targeting techniques and in the handling of limited review cases (Program 53) for pension plans and welfare plans other than health benefit plans. Health plan cases should be opened under Program 50. Targeting is the process whereby the limited investigative resources of EBSA are directed toward those plans and service providers with the highest potential for abuse, consistent with agency goals, objectives and priorities. Limited review cases are expedited inquiries into one or more specific facets of a plan or service provider's operation in order to determine quickly whether a violation exists and further investigation is merited or whether the matter should be closed.

2. **Criteria**. 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 financial institutions, service providers, specific sizes and types of plans, types of investments, 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.

3. **Targeting**.

a. Sources for Potential Limited Review Cases.

1. Computer generated compilations of selected employee 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 benefit plans or service providers derived from other governmental agencies such as the IRS, the SEC, and financial regulatory agencies.

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

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 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 Limited Review Targets.

1. An entire compilation of employee benefit plans or service providers can be targeted for limited review 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 limited review cases.

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 limited review case. 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 limited review case 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 limited review. Such contacts may be used to further refine large compilations after receipt and analysis of "inquiry letters."

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.

d. *Detailed Inquiry Letters*. Detailed inquiry 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 detailed inquiry letters may not request the creation of documents, but rather may request the production of existing documents. Figure 2 is an example of a detailed inquiry letter and requests information beyond that which is necessary to support an entry in a plan's 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, SEC, U.S. Attorney's offices, 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 media coverage compiled by its local Office of Public Information or reported in newspapers and industry journals, seeking to identify actual or potential items of enforcement concern.

7. **Relationship of Targeting to Limited Review Cases**. In making compilations for targeting purposes, in preparing inquiry letters, and in related case development work, Investigators/Auditors will normally charge their time to case development on EBSA Form 214. Once the targeting process has identified a potential target and the RO/DO decides to investigate that particular target, a limited review case should be opened. In those instances where the targeting process has uncovered a fiduciary issue, the RO/DO should open a fiduciary case (Program 48). It should be noted that, at the targeting stage, no commitment has been made under ERISA section 504 to conduct a limited review or fiduciary case.

8. **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.

9. **Opening Limited Review Cases**. 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; 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.

10. **Limited Review Cases** (Program 53). Limited review cases will be undertaken to inquire into one or more specific issues or aspects of plan or service provider operation. The purpose of such an inquiry is to explore one or more specified matters quickly in order to determine whether a complete fiduciary investigation is warranted. Therefore, an Investigator/Auditor will not be expected to examine every aspect of plan/service provider operation, but only those matters, which formed the basis for the original case opening. The sole objective of a Program 53 case is to look at one or more issues and to determine whether to convert the case to a Program 48 case or to conclude the inquiry as quickly as possible.

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 2is an example of a document request letter and requests information beyond that which is necessary to support an entry in a plan's Form 5500.

11. **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.

12. **Written Investigative Plan, Guidelines, and IRS Checksheets**. A written investigative plan may, at the discretion of the Supervisor, be required for any given limited review case; however, investigative plans are not routinely required for Program 53 cases.

Sample investigative guidelines which can be used in a limited review case involving an employee benefit plan as the direct subject of review are set forth at Figure 4. Also consult Chapter 48 for other similar investigative guidelines. ROs may create other investigative guidelines for use in limited review cases. Routinely, reporting and disclosure, individual benefit statement compliance, and bonding are to be reviewed in employee benefit plan limited review cases. See Chapter 48, Figure 3, Figure 4and Figure 5. Additionally, the IRS checksheet should be completed in limited review cases involving qualified plans.

13. **Limited Review Case Dispositions (Program 53)**.

a. *No Violation(s) Found*. In those instances where the limited review case 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 203D, Form 203E and Form 203F for sample closing ROI formats. Employee benefit plan officials or appropriate officials of service providers will be informed of the results by letter. See Figure 5 for the pattern closing letter.

b. *Violation(s) Found: Reporting and Disclosure, Administrative Practices, Corrected Prohibited Transaction(s)*. In those instances where the limited review case 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 53. 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 deficient report violation should be included in a voluntary compliance letter. 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 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.

- *Apparent Violations Found: Conversion to Program 48*. If evidence of 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 6).
- *Apparent Criminal Violations Found*. Whenever the limited review case 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.
- *Apparent Violations of Participant Rights*. If the limited review 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 whth the attainment of any right to which the participant may become entitled, a Program 43 case will be opened immediately.

- *Prohibited Persons*. Whenever the limited review 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.

14. **General Investigative Considerations under Limited Review Cases**.

a. Generally, other than stating that the purpose of the limited review 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. However, the scope of records reviewed, interviews conducted, and third-party verifications made will be substantially less under limited review cases than under fiduciary cases.

15. **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

(Figure 1)

SAMPLE DETAILED INQUIRY LETTER

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

Re: XYZ Plan

Dear Sir:

The Department of Labor 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 (the Plan).

The Plan is scheduled for review 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 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 ...."

We have found in the past that submission of relevant documents to our office prior to the inception of 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 the next ten working days the documentation indicated on the enclosed checklist with respect to the above-mentioned plan.

Thank you in advance for your cooperation. Should you have any questions, feel free to contact Investigator/Auditor _____ at 200.321.1234.

Sincerely,

Enclosures

Copies Of Items Checked Off Below Should Be Submitted As Indicated In The Cover Letter

☐ Plan document

☐ Trust agreement

☐ Summary Plan Description

(Figure 2)

☐ Summary Annual Report for Plan Years
Form 5500, 5500-C, or 5500-R, Annual Return/Report of Employee Benefit Plan, for _____, together with all attachments, including accountant's opinion, financial statements, and notes to the financial statement

☐ Fidelity bond (i.e., declaration page and loss payover rider, identifying the plan as a named insured and specifying the amount of coverage and name of surety company)

☐ Minutes of Plan Board of Trustees' Meetings from _____ to _____ as well as minutes of Trustee committees, subcommittees, or other administrative groups

☐ The most recent internal balance sheet/statement of assets and liabilities for the plan

☐ Investment Policies

☐ For all loans (including those secured by mortgages) made, held, or acquired by the plan during any portion of the period from _____ to the present:

a. promissory note, loan application, mortgage, etc.;
b. amortization/repayment schedule;
c. identification of collateral, if any, together with all applicable recorded documents (UCC-1 filings, trust deeds, etc.); and
d. document(s) showing date of acquisition by plan (for any loans/ mortgages not originated by plan); from whom acquired and identity of originator, if different; value at acquisition; and cost paid by plan. Note: If loan/mortgage was contributed to the plan by sponsor, so specify and indicate date and value of contribution

☐ For all real property (including land, buildings, equipment, motor vehicles, etc.) and coins, gems, artwork, etc., held or acquired by the plan during any portion of the period from _____ to the present:

a. description, including location with street address where applicable;
b. acquisition date and from whom acquired;
c. value at acquisition and current value;
d. information on debt financing, including amount financed, current balance or date paid in full, identity of lender, interest rate, payment terms, due date, etc.;
e. use, if any, made of property and by whom;
f. sources and amounts of income on any income-producing property;
g. disposition date, if applicable, and details of disposition, including identity of purchaser and relationship to plan, terms of sale, value received, financing, etc.

☐ Other:

INVESTIGATIVE GUIDE

Investigative Guide for HIPAA and Other Health Care-Related Statutes Added to Part 7 of ERISA.

INVESTIGATION GUIDELINES
EMPLOYEE BENEFIT PLANS

I. Background

A. Plan sponsor:

Name: _____

Address: _____

_____

Nature of business: _____

B. Type of plan:

Pension

☐ Defined Benefit
☐ Defined Contribution
- Profit Sharing
- Money Purchase
- 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)

Asset	**Beginning %**	**Ending %**	**(+-) Change**
Cash			
Non Interest Bearing (see item III. B)			
Receivables			
Contributions (see item III. E)			
Other			
Stocks: common 1. PII			
Stocks: common 2. Non-PII			
Stocks: preferred 1. PII			
Stocks: preferred 2. Non-PII			
Bonds: corporate 1. PII			
Bonds: corporate 2. Non-PII			
Bonds: government			
Real estate: 1. PII			
Real estate: 2. Non-PII			
Mutual Fund:			
Insurance Company:			
Account type (explain)			
Loans (to participants)			
Loans (mortgages) 1. PII			
Loans (mortgages) 2. Non-PII			

Asset	Beginning %	Ending %	(+-) Change
Loans (other) 1. PII			
Loans (other) 2. Non-PII			
Other (explain) 1. PII			
Other (explain) 2. Non-PII			
Totals			

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.
5. 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?

☐ No
☐ Yes (explain)

IV. Bonding

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

☐ No
☐ Yes (explain)

B. Does bond meet requirements?

☐ No
☐ Yes (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,

PATTERN LETTER
VIOLATIONS OF PART 7 FOUND

RE: ABC Health Plan

EBSA Case No. xx-xxxxxx

Dear NAME:

The Department of Labor 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 ABC Health Plan (the "Plan").

This office has concluded its investigation of the Plan and of your activities as Plan Administrator. Based upon the facts gathered during this investigation, and subject to the possibility that additional information may lead us to revise our views, it appears that the Plan failed to meet requirements imposed by Title I, Part 7 of ERISA. The specific provisions which we believe have been violated are described more fully below. The purpose of this letter is to advise you of our findings and to give you an opportunity to comment before the Department determines what, if any, action to take.

I. Failure to Comply with the Rules Regarding Preexisting Condition Exclusion Periods under the Health Insurance Portability and Accountability Act (HIPAA)

ERISA section 701(b)(1)(A) defines a preexisting condition exclusion with respect to coverage as a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

Plans that contain a preexisting condition exclusion must comply with ERISA section 701 which provides, among other things, the following:

(a) Limitations on Preexisting Condition Exclusion Period; Crediting for Periods of Previous Coverage.—Subject to subsection (d), a group health plan, and a health insurance issuer offering group health insurance coverage, may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if—

(1) such exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date;

(2) such exclusion extends for a period of not more than 12 months (or 18 months in the case of a late enrollee) after the enrollment date; and

(3) the period of any such preexisting condition exclusion is reduced by the length of the aggregate of the periods of creditable coverage (if any, as defined in subsection (c)(1)) applicable to the participant or beneficiary as of the enrollment date.

(b) Definitions.—For purposes of this part—

(2) Enrollment Date.—The term "enrollment date" means, with respect to an individual covered under a group health plan, or health insurance coverage, the date of enrollment of the individual in the plan or, if earlier, the first day of the waiting period for such enrollment.

(d) Exceptions.—

(1) Exclusion Not Applicable to Certain Newborns.—…a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage.

(2) Exclusion not Applicable to Certain Adopted Children.—…a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage…

(3) Exclusion not Applicable to Pregnancy.—A group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

Moreover, under 29 CFR 2590.701-3(c) of the Department's regulations, a general notice of the Plan's preexisting condition exclusion is required to be provided before a preexisting condition exclusion may be imposed. Specifically, as part of the written application materials, the Plan must notify enrollees of the existence and terms of any preexisting condition exclusion (including the Plan's look-back period, look-forward period, and how the plan will offset the look-forward using creditable coverage), the right to demonstrate creditable coverage to reduce a preexisting condition exclusion period (including a description of the right to demonstrate creditable coverage, a description of the right of the individual to request a certificate of creditable coverage from a prior plan or issuer, and a statement that the plan will assist in obtaining a certificate from a prior plan or issuer if necessary), and a person to contact for more information.

Further, under 29 CFR 2590.701-3(e) of the Department's regulations, if the Plan receives a certificate or other evidence of creditable coverage that is not enough to offset the preexisting condition exclusion period, an individual notice must be provided by the earliest date that the Plan, acting in a reasonable and prompt fashion, can provide the notice. The individual notice must disclose the Plan's determination of any preexisting condition exclusion period that applies to that individual (including the last day on which the preexisting condition exclusion applies). Such notice must also disclose the basis of the determination, including the source and substance of any information on which the plan relied, an explanation of the individual's right to submit

additional evidence of creditable coverage, and a description of any appeals procedures available.

A. Failure to Comply with HIPAA's Rules with Respect to Calculating the Preexisting Condition Exclusion Period from the Enrollment Date

The Plan states on page XX of the SPD:

You become eligible for benefits described in this booklet when you have completed 3 calendar months of employment in a job classification covered by a collective bargaining agreement that requires your employer to contribute to the Plan on your behalf during this period of time…

Preexisting Conditions…The preexisting condition exclusion shall not apply once twelve (12) months have passed from the date upon which contributions are first made on behalf of such member or dependent. This period of exclusion shall be reduced by the period the member had creditable coverage.

These provisions are in violation of section 701 of ERISA, which provides that the preexisting condition exclusion period should be calculated from the "enrollment date," not from the date of the initial contribution on behalf of the employee. The Plan's 3-month waiting period and the 12-month preexisting condition exclusion period must run concurrently and, therefore, the maximum preexisting condition exclusion period that can be imposed after the 3-month waiting period is 9 months. Because the plan calculates the HIPAA 6-month look-back period and the 12-month look-forward period from a date that is 3 months after the enrollment date, it is the Department's view that this Plan provision currently is in violation of ERISA sections 701(a)(1) and (2).

B. Impermissible "Hidden" Preexisting Condition Exclusions

The Plan contains the following provisions that function as a preexisting condition exclusion, even though they are not designated as such:

(1) Any dependent confined to a hospital when the dependent would normally become eligible will first become eligible for benefits only after discharge from the hospital. (SPD page XX.)

(2) The Plan provides that if an employee or dependent is diagnosed with or treated for an injury, sickness, or pregnancy within the three months before medical coverage starts, coverage will be limited to $50,000 for that condition. (SPD page XX.)

(3) The Plan excludes coverage for an accidental injury which took place before coverage begins. (SPD page XX.)

(4) The Plan excludes expenses in connection with cosmetic surgery except as a result of an accident that occurred while covered by this plan or to repair a birth defect for a dependent covered from birth. (SPD page XX.)

(5) The Plan excludes dental procedures which were started prior to the individual becoming covered. (SPD page XX.)

(6) The Plan provides that to be eligible for maternity benefits, expectant mothers must enroll in the Baby Benefits program within the first trimester of their pregnancy. (SPD page XX.)

(7) The Plan provides coverage for reconstructive surgery following a mastectomy which is begun within three years after a mastectomy that was covered under this Plan. (SPD page XX.)

Since these Plan provisions operate to exclude benefits relating to a condition because the condition was present before an individual's enrollment date, these Plan provisions operate as a preexisting condition exclusion. Thus, these Plan exclusions must comply with ERISA sections 701(a) and 701(d) and 29 CFR 2590.701-3(c) and (e), which limit a plan's ability to impose a preexisting condition exclusion, as stated above, or be re-written to no longer function as a preexisting condition exclusion. Because these Plan provisions currently do not comply with the aforementioned limitations on preexisting condition exclusions, in our view, the Plan is in violation of ERISA section 701.

With respect to exclusion (1) listed above, as discussed later in section IV, under subheading D, this plan provision also violates ERISA section 702, which prohibits nonconfinement clauses.

With respect to exclusion (7) listed above, as discussed later in section VII, under subheading A, this plan provision also violates ERISA section 713, which requires plans offering mastectomy coverage to provide certain post-mastectomy benefits.

C. Failure to Comply with HIPAA's Rules Regarding General Notice of Preexisting Condition Exclusion

As stated above, 29 CFR 2590.701-3(c) of the Department's regulations imposes a general notice requirement for group health plans that impose a preexisting condition exclusion. The Plan's general notice of preexisting condition exclusion does not include any description of the individual's right to demonstrate creditable coverage (including a description of the right of the individual to request a certificate of creditable coverage from a prior plan or issuer and a statement that the plan will assist in obtaining a certificate from a prior plan or issuer if necessary) or any applicable waiting period information.

In addition, the notice is included in the Plan's SPD. However, the SPD is not provided to participants under the plan until several weeks after enrollment. It is our view that the Plan's general notice of preexisting condition exclusion does not meet all of the aforementioned content requirements and therefore does not comply with 29 CFR 2590.701-3(c)(2) of the Department's regulations. In addition, because the notice is not provided as part of the written application materials distributed by the plan, the plan also does not comply with the timing requirements in 29 CFR 2590.701-3(c)(1) of the Department's regulations.

D. Failure to Comply with HIPAA's Rules Regarding Individual Notice of Preexisting Condition Exclusion

As stated above, 29 CFR 2590.701-3(e) of the Department's regulations imposes an individual notice of preexisting condition exclusion requirement for group health plans that impose a preexisting condition exclusion. The Plan's individual notice of preexisting condition exclusion

does not provide an explanation of the individual's right to submit additional evidence of creditable coverage or a description of any applicable appeal procedures available. Accordingly, it is our view that failure to include these provisions in the individual notice of preexisting condition exclusion does not comply with 29 CFR 2590.701-3(e) of the Department's regulations.

II. Failure to Comply with the Certificate of Creditable Coverage Provisions under HIPAA

ERISA section 701(e), Certifications and Disclosure of Coverage, provides:

(1) Requirement for Certification of Periof of Creditable Coverage.—

(A) In General.—A group health plan, and a health insurance issuer offering group health insurance coverage, shall provide the certification described in subparagraph (B)—

(i) at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision,

(ii) in the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision, and

(iii) on the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in clause (i) or (ii), whichever is later.

Moreover, under 29 CFR 2590.701-5(a)(4)(ii) of the Department's regulations, a plan or issuer must establish a written procedure for individuals to request and receive certificates of creditable coverage.

It is the Department's understanding that the Plan does not issue automatic certificates of creditable coverage. However, the Plan does have the required written procedure by which individuals can request and receive certificates of creditable coverage, and the plan does provide certificates upon request. Accordingly, the Plan is in violation of ERISA sections 701(e)(1)(A)(i) and (ii) for failure to provide certificates automatically upon loss of coverage.

III. Failure to Comply with the Special Enrollment Provisions under HIPAA

ERISA section 701(f), Special Enrollment Periods, states in pertinent part:

(1) Individuals Losing Other Coverage.—A group health plan…shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee…) to enroll for coverage under the terms of the plan if each of the following conditions is met:

(A) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent.

(B) The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer . . . required such a statement…

(C) The employee's or dependent's coverage…

(i) was under a COBRA continuation provision and the coverage under such provision was exhausted; or

(ii) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions towards such coverage were terminated.

(D) Under the terms of the plan, the employee requests such enrollment not later than 30 days after the date of exhaustion of coverage…or termination of coverage or employer contribution…

(2) For Dependent Beneficiaries.—

(A) In General.—If—

(i) a group health plan makes coverage available with respect to a dependent of an individual,

(ii) the individual is a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period), and

(iii) a person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption,

the group health plan shall provide for a dependent special enrollment period described in subparagraph (B) during which the person (or, if not otherwise enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

A. Failure to Provide Special Enrollment Upon Termination of Employer Contributions

The Plan does not clearly provide for special enrollment upon termination of employer contributions, in violation of ERISA section 701(f)(1)(C)(ii), described above.

B. Failure to Provide Special Enrollment to Employees After Life Events

As described above, plans are required to offer special enrollment to employees, spouses, and new dependents upon marriage, birth, adoption, or placement for adoption. While the plan does provide for special enrollment spouses and new dependents, the Plan does not provide for special enrollment of employees upon these life events. The failure to provide special enrollment to

employees is a violation of ERISA section 701(f)(2), described above, and does not comply with 29 CFR 2590.701-6(b)(2)(i), (iii), (v), and (vi) of the Department's regulations.

C. Failure to Make Coverage Effective On Time

ERISA section 701(f)(2)(C) and the Department's regulations at 29 CFR 2590.701-6(b)(3)(iii) require that in the case of marriage, coverage must become effective no later than the first day of the first month following a completed request for enrollment, and in the case of birth, adoption, or placement for adoption, coverage must become effective as of the date of the birth, adoption, or placement for adoption.

However, for special enrollment upon adoption or placement of adoption, the Plan does not provide that coverage is effective retroactive to the date of the adoption or placement for adoption, in violation of ERISA section 701(f)(2)(C).

D. Impermissible Well-Baby Exclusion

The Plan also states, on page XX of the SPD, "newborn children are eligible for health care coverage from birth, excluding charges for hospital room and board during the first seven days unless necessitated by a diagnosed sickness or injury."

As written, this Plan provision violates ERISA section 701(f)(2)(C), which requires coverage for newborns enrolled within 30 days to be effective upon birth. As discussed later in section V, subheading A, this plan provision also violates ERISA section 711, which provides minimum hospital length of stay requirements following birth and prohibits plans from denying newborns eligibility for the purpose of avoiding the hospital length of stay requirements.

E. Failure to Provide Timely Special Enrollment Notice

Under 29 CFR 2590.701-6(c) of the Department's regulations, a plan is required to provide a notice of the plan's special enrollment rights at or before the time an employee is offered the opportunity to enroll in a group health plan. While the Plan uses the Department's model notice included in the Department's regulations at 29 CFR 2590.701-6(c)(1) and therefore satisfies the content requirements for the special enrollment notice, the notice is not provided timely. Specifically, the notice is provided in the Plan's SPD, which is not provided to participants under the plan until several weeks after enrollment. Accordingly, in our view, the Plan does not comply with 29 CFR 2590.701-6(c) of the Department's regulations.

F. Treatment of Special Enrollees

The Department's regulation at 29 CFR 2590.701-6(d)(2) provides:

Special enrollees must be offered all the benefit packages available to similarly situated individuals who enroll when first eligible. For this purpose, any difference in benefits or cost-sharing requirements for different individuals constitutes a different benefit package.

Nonetheless, page XX of the Plan's SPD states that any employee or dependent who does not enroll within 30 days of first becoming eligible will be subject to a $1,000 deductible per person.

On the other hand, employees and dependents who do enroll within 30 days of first becoming eligible have a $250 deductible per person. Because this increased deductible operates to reduce benefits for special enrollees as compared to initial enrollees, it violates ERISA section 701(f) and does not comply with 29 CFR 2590.701-6(d)(2) of the Department's regulations.

IV. Failure to Comply with the Nondiscrimination Provisions under HIPAA

ERISA section 702 prohibits group health plans and health insurance issuers from discriminating against individuals in eligibility and continued eligibility for benefits and in individual premium or contribution rates based on health factors.

Specifically, ERISA section 702(a), In Eligibility to Enroll, states in pertinent part:

(1) In General.—. . . a group health plan, and health insurance issuer offering group health insurance coverage in connection with a group health plan, may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

a. Health Status.
b. Medical condition (including both physical and mental illnesses).
c. Claims experience.
d. Receipt of health care.
e. Medical history.
f. Genetic information.
g. Evidence of insurability (including conditions arising out of acts of domestic violence).
h. Disability.

ERISA section 702(b), In Premium Contributions, states in pertinent part:

(1) In General.—A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

A. Impermissible Discrimination in Rules for Eligibility

Page XX of the Plan's SPD states, "for employees and dependents who do not enroll within 31 days after becoming eligible, evidence of good health will be required before coverage becomes effective."

The requirement to provide evidence of good health limits eligibility to enroll in the Plan based on health factors, violates ERISA section 702(a)(1) and does not comply with 29 CFR 2590.702(b)(1) of the Department's regulations.

B. Impermissible Source-of-Injury Exclusions

The Department's regulations at 29 CFR 2590.702(b)(2)(iii) provide that if a plan generally provides benefits for a type of injury, the plan may not deny benefits otherwise provided for the treatment of the injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions). This rule applies in the case of an injury resulting from a medical condition even if the condition is not diagnosed before the injury.

To illustrate this rule, Example 1 under section 29 CFR 2590.702(b)(2)(iii)(B) provides that a plan may not apply a blanket exclusion for self-inflicted injuries and injuries sustained in connection with suicide attempts because such an exclusion would deny benefits to an individual whose suicide attempt (or self-inflicted injury) was the result of depression, a medical condition.

Nonetheless, the Plan provides that benefits are not payable for the following:

(1) Self-inflicted injury or disease, whether sane or insane and whether or not under the influence of alcohol, narcotics, or other substance. (SPD page XX.)

(2) An injury or illness resulting from the participation in commission of a crime or illegal act or improper conduct (SPD page XX.)

These Plan provisions violate section 702(a) of ERISA and do not comply with 29 CFR 2590.702(b)(2)(iii) of the Department's regulations because these provisions can operate to exclude benefits otherwise provided by the plan for treatment of injuries that result from a medical condition (such as depression) or from an act of domestic violence.

C. Discrimination through an Impermissible Wellness Program

The Department's regulation at 29 CFR 2590.702(b)(2)(ii) provides an exception to the ERISA section 702(a) general prohibition against discrimination in eligibility for benefits based on a health factor. This provision allows plans and issuers to vary benefits, including cost-sharing mechanisms, based on whether an individual has met the standards of a wellness program that satisfies the requirements of 29 CFR 2590.702(f). Similarly, 29 CFR 2590.702(c)(3) provides an exception to the ERISA section 702(b) general prohibition against discrimination in premiums or contributions based on a health factor. This provision allows plans and issuers to vary premiums or contributions it requires similarly situated individuals to pay based on whether an individual has met the standards of a wellness program that satisfies the requirements of 29 CFR 2590.702(f).

As detailed in the Department's regulations at 29 CFR 2590.702(f)(1), if none of the conditions for obtaining a reward under a wellness program are based on an individual satisfying a standard that is related to a health factor (or if a wellness program does not provide a reward), the wellness program does not violate the HIPAA nondiscrimination requirements if participation in the program is available to all similarly situated individuals.

The Department's regulations at 29 CFR 2590.702(f)(2) states that if any of the conditions for obtaining a reward under a wellness program is based on an individual satisfying a standard that

is related to a health factor, the wellness program does not violate the HIPAA nondiscrimination requirements if these requirements are met:

i. The reward for the wellness program, coupled with the reward for other wellness programs with respect to the plan that require satisfaction of a standard related to a health factor, must not exceed 20 percent of the cost of employee-only coverage under the plan. However, if, in addition to employees, any class of dependents (such as spouses or spouses and dependent children) may participate in the wellness program, the reward must not exceed 20 percent of the cost of the coverage in which an employee and any dependents are enrolled.
ii. The program must be reasonably designed to promote health or prevent disease.
iii. The program must give individuals eligible for the program the opportunity to qualify for the reward under the program at least once per year.
iv. The reward under the program must be available to all similarly situated individuals.

(A) A reward is not available to all similarly situated individuals for a period unless the program allows—

(1) A reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

(2) A reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard.

(v)(A) The plan or issuer must disclose in all plan materials describing the terms of the program the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard).

1. Discrimination in Premiums through the Application of an Impermissible Wellness Program

The Plan includes a Healthy and Fit Wellness Program that targets overweight participants by increasing their monthly premium from $100 to $200 if they fail to keep a body mass index (BMI) below 25.

The Plan's wellness program requires individuals to meet a standard related to a health factor and therefore must meet the five criteria detailed in the Department's regulation at 29 CFR 2590.702(f)(2). To come into compliance with these rules, the plan must decrease the amount of the reward to 20% of the cost of employee-only coverage. The plan must allow eligible individuals to qualify for the reward at least once per year. The plan must also offer a reasonable alternative standard for those individuals for whom it is unreasonably difficult or medically inadvisable to satisfy or attempt to meet the standard. The plan must disclose the availability of the reasonable alternative standard in all plan materials describing the terms of the program. Because the Plan's wellness program does not meet the requirements of 29 CFR 2590.702(f)(2), it impermissibly varies premiums based on a health factor, which is a violation of ERISA section 702(b).

[Alternative "Warning" Language (this language should be substituted for the above underlined sentence if the wellness program rules are not yet applicable):

The Plan's wellness program currently does not meet the requirements of 29 CFR 2590.702(f)(2) and therefore is in danger of impermissibly varying premiums based on a health factor, which is a violation of ERISA section 702(b). The Department's regulation at 29 CFR 2590.702(i) states that the final rules on nondiscrimination and wellness programs are applicable for plan years beginning on or after July 1, 2007. Although the final wellness rules do not yet apply to this plan, the plan should make these changes to comply with the final rules when they become applicable on (Insert first date of plan year when applicable).]

2. Discrimination in Benefits (Cost-Sharing) through the Application of an Impermissible Wellness Program

The Plan offers a wellness program that varies the general deductible under the Plan based on health factors. Specifically, the plan has a general deductible of $1,500. Employees can earn $1,200 in credits towards the deductible by: (1) completing a health risk assessment, (2) meeting target cholesterol counts, (3) maintaining target blood pressure, (4) maintaining target glucose levels, (5) having a body mass index within prescribed levels, and (6) not being a tobacco user. Meeting the goals for these six items is worth a $200 credit each towards the deductible.

The first criterion of the Plan's wellness program does not require individuals to meet a standard related to a health factor and, as such, is permissible under 29 CFR 2590.702(f)(1). However, the second through sixth criteria require individuals to meet a standard related to a health factor and therefore those aspects of the wellness program must meet the five criteria detailed in the Department's regulation at 29 CFR 2590.702(f)(2). To come into compliance with these rules, the plan must decrease the $1,000 reward for compliance with wellness program criteria two through six to 20% of the cost of employee-only coverage. The plan must allow eligible individuals to qualify for the reward at least once per year. The plan must also offer a reasonable alternative standard for those individuals for whom it is unreasonably difficult or medically inadvisable to satisfy or attempt to meet the standard. The plan must disclose the availability of the reasonable alternative standard in all plan materials describing the terms of the program. Because the Plan's wellness program currently does not meet the requirements of 29 CFR 2590.702(f)(2), it impermissibly varies benefits (through cost-sharing) based on a health factor, which is a violation of ERISA section 702(a).

[Alternative "Warning" Language (this language should be substituted for the above underlined sentence if the wellness program rules are not yet applicable):

The Plan's wellness program currently does not meet the requirements of 29 CFR 2590.702(f)(2) and therefore is in danger of impermissibly varying benefits (through cost-sharing) based on a health factor, which is a violation of ERISA section 702(a). The Department's regulation at 29 CFR 2590.702(i) states that the final rules on nondiscrimination and wellness programs are applicable for plan years beginning on or after July 1, 2007. Although the final wellness rules do not yet apply to this plan, the plan should make these changes to comply with the final rules when they become applicable on (Insert first date of plan year when applicable).]

D. Impermissible Nonconfinement Provisions

As detailed in 29 CFR 2590.702(e)(1) of the Department's regulations, under ERISA section 702(a) a plan may not establish a rule for eligibility for benefits or set any individual's premium or contribution rate based on whether an individual is confined to a hospital.

The Plan's SPD on page XX contains the following impermissible nonconfinement clause:

Any dependent confined to a hospital when the dependent would normally become eligible will first become eligible for benefits only after discharge from the hospital.

Because confinement to a hospital constitutes one or more of these health factors, and because delaying the effective date of coverage based on confinement impermissibly denies eligibility for benefits based on a health factor, this provision violates section 702(a) of ERISA and does not comply with the corresponding Department regulation section 29 CFR 2590.702(e)(1).

In addition, because this Plan provision also excludes benefits relating to a condition because that condition was present before the first day of coverage, it also violates ERISA sections 701(a) and (d), and does not comply with the notice provisions in 29 CFR 2590.701-3(c) and (e) of the Department's regulations, which are described above in section I.

E. Impermissible Actively-at-Work Provisions

As detailed in 29 CFR 2590.702(e)(2) of the Department's regulations, under ERISA section 702(a), a Plan may not establish a rule for eligibility for benefits or set any individual's premium or contribution rate based on whether an individual is actively at work, unless absence from work due to any health factor (such as being absent from work on sick leave) is treated, for purposes of the plan, as being actively at work.

The Plan's SPD on page XX contains the following actively-at-work clause:

If you are not actively at work on the day you would ordinarily become covered, then coverage for you and your dependents will be delayed until you return to work.

The Plan provision, as written, does not provide an exception for absence from work due to a health factor, thus, the Plan provision violates ERISA section 702(a) and does not comply with the Department's regulation at 29 CFR 2590.702(e)(2).

V. Failure to Comply with Certain Provisions under the Newborns' and Mothers' Health Protection Act (the Newborns' Act)

ERISA section 711(a) prohibits a group health plan from restricting benefits for a hospital length of stay in connection with childbirth to less than 48 hours in the case of vaginal delivery or less than 96 hours in the case of a cesarean section.

Specifically, ERISA sections 711(a) and (b) state in pertinent part:

(a) Requirements for Minimum Hospital Stay Following Birth.—

(1) In General.—A group health plan, and a health insurance issuer offering group health insurance coverage, may not—

(A) except as provided in paragraph (2) —

(i) restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a normal vaginal delivery, to less than 48 hours, or

(ii) restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a cesarean section, to less than 96 hours; . . . .

(b) Prohibitions.—A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not-

(1) deny to the mother or her newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section; . . .

A. Impermissible Well-Baby Provisions

Page XX of the Plan's SPD provides, "newborn children are eligible for health care coverage from birth, excluding charges for hospital room and board during the first seven days unless necessitated by a diagnosed sickness or injury."

It is the Department's view that this plan provision violates ERISA sections 711(a)(1) and (b)(1) for failure to provide the minimum hospital length of stay requirements following birth and for denying newborns eligibility for the purpose of avoiding the hospital length of stay requirements. In addition, because this Plan provision also does not make coverage for newborns effective retroactive to birth, it also violates ERISA section 701(f)(2)(C)(ii), which is described above in section III, under subheading D.

B. Impermissible Preauthorization Requirement

ERISA section 711(a)(1)(B) and the Department's regulations at 29 CFR 2590.711(a)(4) provide that a plan may not require that a provider (such as a doctor) obtain authorization from the plan for prescribing any length of stay required under the general 48-hour (or 96-hour) rule.

However, page XX of the Plan's SPD provides that for all hospitalizations, benefits will not be provided unless the provider obtains preauthorization from the Plan. The Plan provision contains no carve-out for hospital stays in connection with childbirth and, therefore, violates ERISA section 711(a)(1)(B) and does not comply with 29 CFR 2590.711(a)(4) of the Department's regulations.

C. Failure to Comply with Newborns' Act Notice Requirements

Under ERISA section 711(d) and 29 CFR 2520.102-3(u) of the Department's regulations, certain information regarding participants' and beneficiaries' rights under the Newborns' Act is required to be incorporated into the Plan's SPD.

Specifically, 29 CFR 2590.102-3(u)(1) requires that group health plans providing maternity or infant coverage must provide:

… a statement describing any requirements under federal or state law applicable to the plan, and any health insurance coverage offered under the plan, relating to hospital length of stay in connection with childbirth for the mother or newborn child. If federal law applies in some areas in which the plan operates and state law applies in other areas, the statement should describe the different areas, and the federal or state law requirements applicable in each.

Model language that can be used to describe the federal Newborns' Act requirements is provided in 29 CFR 2520.102-3(u)(2).

Based on the facts gathered in our investigation, it appears that although the Plan provides maternity or newborn infant coverage, the Plan SPD does not provide any disclosure to participants and beneficiaries advising them of their rights under the Newborns' Act. Accordingly, it is our view that the Plan is in violation of ERISA section 711(d).

VI. Failure to Comply with the Mental Health Parity Act (MHPA)

Section 712 of ERISA and the Department's regulation at 29 CFR 2590.712 generally provide for parity in the application of aggregate lifetime and annual dollar limits on mental health benefits with dollar limits on medical/surgical benefits.

Specifically, ERISA section 712 provides:

(a) In General.—

(1) Aggregate Lifetime Limits.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits—

(A) No Lifetime Limit.—If the plan or coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on mental health benefits.

(B) Lifetime Limit.—If the plan or coverage includes an aggregate lifetime limit on substantially all medical and surgical benefits (in this paragraph referred to as the "applicable lifetime limit") the plan or coverage shall either—

(i) apply the applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits, and mental health benefits; or

(ii) not include any aggregate lifetime limit on mental health benefits that is less than the applicable lifetime limit.

(2) Annual Limits.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits—

(A) No Annual Limit.—If the plan or coverage does not include an annual limit on substantially all medical and surgical benefits, the plan or coverage may not impose any annual limit on mental health benefits.

(B) Annual Limit.—If the plan or coverage includes an annual limit on substantially all medical and surgical benefits (in this paragraph referred to as the "applicable annual limit") the plan or coverage shall either—

(i) apply the applicable annual limit both to the medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits, and mental health benefits; or

(ii) not include any annual limit on mental health benefits that is less than the applicable annual limit.

ERISA section 712 also provides:

(e) Definitions.—For purposes of this section—

(4) Mental Health Benefits.—The term "mental health benefits" means benefits with respect to mental health services, as defined under the terms of the plan or coverage (as the case may be), but does not include benefits with respect to treatment of substance abuse or chemical dependency.

Nonetheless, as we understand the facts, many of which you provided to this office during the course of our investigation, the Plan does not provide parity in the application of limits to mental health benefits.

A. Failure to Comply with MHPA Rules Regarding Parity in Lifetime Dollar Limits

As described in the Plan's current Certificates of Coverage, the Plan provides for a $1,000,000 lifetime benefit maximum per Covered Person. However, the lifetime benefit maximum for Inpatient and Outpatient Covered Services for Mental Health is limited to $50,000.

Therefore, it is our view that this Plan provision violates ERISA section 712(a)(1) and does not comply with 29 CFR 2590.712(b) of the Department's regulations.

B. Failure to Comply with MHPA Rules Regarding Parity in Annual Dollar Limits

1. Constructive Dollar Limit on Mental Health Benefits

The Plan provides:

Benefits for Doctor calls which are provided in an outpatient setting other than an outpatient Hospital facility shall be limited to coverage of 50 visits during any Calendar Year, payable at 50% to a maximum payment of $30 per visit per day.

The limitations on benefits for doctor calls for mental illness (50 visits per year at a maximum of $30 per visit per day) is an impermissible annual dollar limit of $1,500 in violation of ERISA section 712(a)(2)(B), because there are no similar dollar limitations on general medical and surgical benefits under the Plan.

2. Outpatient Dollar Limit on Mental Health Benefits

The Outpatient Mental Illness Maximum under the Plan is limited to $2,500 per calendar year. No such limitations are imposed with regard to other medical benefits.

Therefore, it is our view that this Plan provision violates ERISA section 712(a)(2)(A) and does not comply with 29 CFR 2590.712(b), which provide that inpatient and outpatient mental health dollar limits must separately be in parity with inpatient and outpatient medical/surgical dollar limits. This is clearly illustrated in the Department's regulation at 29 CFR 2590.712(b)(4), Example 2.

C. Failure to Comply with MHPA's Rules Regarding Treatment of Substance Abuse and Chemical Dependency

The Plan states that benefits for mental illness include those for chemical dependency treatment. Because mental health benefits are defined in ERISA 712(e)(4) and 29 CFR 2590.712(a) as excluding benefits for treatment of substance abuse and chemical dependency, the inclusion of benefits for treatment of substance abuse and chemical dependency in applying an aggregate lifetime limit or annual limit on mental health benefits violates ERISA section 712(a) and does not comply with 29 CFR 2590.712(b)(3). This principle is illustrated in the Department's regulation at 29 CFR 2590.712(b)(4), Example 4.

VII. Failure to Comply with the Requirements of the Women's Health and Cancer Rights Act (WHCRA)

ERISA section 713 provides:

Required Coverage for Reconstructive Surgery Following Mastectomies.

(a) In General.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits with respect to a mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for—

(1) all stages of reconstruction of the breast on which the mastectomy has been performed;

(2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) prostheses and physical complications of mastectomy, including lymphedemas;

in a manner determined in consultation with the attending physician and the patient. . . . Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.

A. Failure to Comply with WHCRA's Coverage Requirements

1. Exclusion for Durable Medical Equipment

The Plan states that benefits are not payable for "non-durable equipment." The Plan's exclusion conflicts with ERISA section 713(a)(3). Clarifying language should be added to the Plan to indicate that the exclusion for non-durable equipment does not apply in the case of non-durable equipment provided pursuant to the requirements of WHCRA.

2. Three-Year Limitation on WHCRA Benefits

The Plan provides that it will cover expenses for reconstructive surgery following a mastectomy only if it is begun within three years after a mastectomy that was covered under this Plan.

This Plan provision violates the preexisting condition exclusion requirements of section 701 of ERISA, as explained earlier in section I under subheading B. Further, this provision can operate to exclude benefits in violation of ERISA section 713(a)(1) and (2) for individuals that are receiving benefits under the Plan related to a mastectomy. ERISA section 713 does not include a time limit. Under certain facts and circumstances, individuals may receive benefits in connection with a mastectomy and may elect reconstructive surgery at some time later than three years after the mastectomy was performed and regardless of whether the mastectomy was performed while an individual was covered under the Plan. Such individuals would meet the requirements to be eligible for, and are entitled to, WHCRA's post-mastectomy benefits. Thus, as written, this provision violates ERISA section 713.

B. Failure to Comply with WHCRA's Enrollment and Annual Notice Requirements

WHCRA contains both enrollment and annual notice requirements. Specifically, under ERISA section 713(a), written notice of the availability of WHCRA's coverage benefits are to be delivered to the participant upon enrollment (the enrollment notice), as well as annually thereafter (the annual notice).

The enrollment notice must state that, in the case of a participant or beneficiary who is receiving benefits in connection with a mastectomy, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for: all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications of the mastectomy, including lymphedema. The enrollment notice must also describe any deductibles and coinsurance limitations applicable to such coverage. Under WHCRA, coverage of breast reconstruction and other WHCRA benefits may be subject only to deductibles and coinsurance

limits consistent with those established for other medical/surgical benefits under the plan. Enrollment notices may be included in the SPD only to the extent the SPD is provided at the time individuals are given the opportunity to enroll in the plan.

Although WHCRA does not require plans to use the same notice to fulfill the enrollment and annual notice requirements, plans may satisfy the annual notice requirement by using the enrollment notice and delivering it to participants on an annual basis. Alternatively, a plan may provide a different notice that describes the categories of coverage required and contains information on how to obtain a detailed description of the mastectomy-related benefits available under the plan.

Model disclosure language for both the WHCRA enrollment notice and the WHCRA annual notice are provided in the Department's publication, "Compliance Assistance Guide, Health Benefits Coverage Under Federal Law," available on the Internet at www.dol.gov/agencies/ebsa.

The Plan does not comply with WHCRA's enrollment or annual notice requirements as set forth in ERISA section 713(a). In particular, the Plan's enrollment notice is incomplete because it fails to include a statement that prostheses and treatment of physical complications (including lymphedema) are covered. In addition, the enrollment notice fails to state that the coverage will be provided in a manner determined in consultation with the attending physician and the patient. Finally, the notice does not describe any deductibles and coinsurance limitations applicable to the coverage. Accordingly, the Plan is in violation of ERISA section 713(a) for failure to provide a complete enrollment notice.

In addition, there is no evidence that the Plan is providing the annual WHCRA notice. Accordingly, the Plan is also in violation of ERISA section 713(a) for not providing the annual notice.

VIII. Conclusion

We have provided the foregoing statement of our views to help you evaluate your obligations under ERISA. Your failure to correct the violations may result in referral of this matter to the Office of the Solicitor of Labor for possible legal action. In addition to any possible legal action by the Department, you should also be aware that the Secretary, pursuant to section 504(a) of ERISA is authorized to furnish information to "any person actually affected by any matter which is the subject" of an ERISA investigation. Further, even if the Secretary decided not to take any legal action in this matter, you would nonetheless remain subject to suit by other parties including plan participants or their beneficiaries.

If you take proper corrective action the Department will not bring a lawsuit with regard to these issues. Further, you should understand that the Department is speaking only for itself and only with regard to the issues discussed above; the Department has no authority to restrain any third party or any other governmental agency from taking any action it may deem appropriate.

We hope this letter will be helpful to you, and that, in respect to the specific matters discussed, you will promptly take appropriate corrective action. Please advise me, in writing, within 10

days of the date of this letter what action you intend to take to correct the violations described above.

Sincerely,

Regional Director

(Figure 7)