January 6, 2015

RE: Increase in Department of Labor audit activities

As we start the New Year, I want to alert you to a trend I see developing in the Employee Benefits Security Administration at the Department of Labor (DOL). The government is on a hunt for money to pay for the Affordable Care Act (ACA) and, while the fines from the ACA don't fully kick in for another couple years, there is one law that applies to all health plans and that has been largely ignored by employers and the DOL — until now. Employee Retirement Income Security Act (ERISA) applies to every employer that offers a group health plan, regardless of size, and the DOL knows that almost all employers are non-compliant. We have seen more audits in the last 2 years than over the previous 26 years. This anecdotal experience seems to be supported by the reports that the DOL is hiring a large number of new agents.

I recently came into possession of an audit notice from an associate whose client is being audited. To my shock, I discovered that this group only has 11 employees and it appears this audit is random and not the result of a complaint filed by an employee.

If we have not already outlined a plan document service for your business, I will be contacting you soon to discuss benefit plan compliance and your plan for handling an audit. You may not have considered an additional expense concerning your insurance benefit coverage at this time, but it pays to be prepared. ERISA has been around for 40 years and has a substantial amount of case law. If your firm is audited and you do not have the required documents, your firm will be fined and there will be little recourse.

For clients currently using Visor's recommended document service, you already have all the required plan documents and notices. Please review the attached letter for a list of procedural records which will need to be created by your firm. My sense is that if you do receive an audit notice and can respond quickly with all the documents, the DOL will be satisfied and move on.

Please contact me if you have any questions or would like to get started on your plan documents to protect your business. Feel free to pass this letter and information on to any clients, vendors, or other business associates. Very few firms are prepared.
Let's get ready.

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NOV 24 2014

[redacted]
President
[redacted]c.
[redacted]
Alsip, IL 60803

Re: [redacted]

Dear Mr. [redacted]

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 [redacted]. Health Care Plan (the Plan).

The Plan is scheduled for a 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:

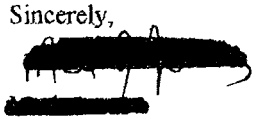
> The Secretary [of Labor] shall have the power, in order to determine whether any person has violated or is about to violate any provision of this title or any regulation or order thereunder...to make an investigation, and in connection therewith to require the submission of reports, books, and records, 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 reviewed 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.

An appointment has been scheduled for the review of the referenced plan to commence at 9:30 a.m. on Wednesday February11th to February 13th at your office. The documentation listed on the enclosed Attachment A is needed for the review of the above reference plan. If any items are not applicable or available, please so indicate and provide an explanation at the commencement of the review.

If you have any questions regarding this matter, please feel free to contact me at ([redacted]. Thank you for your anticipated cooperation. .

Sincerely,



Senior Investigator
Chicago Regional Office
Employee Benefits Security Administration

Enclosure: Customer Service Standards Brochure[1]

[1]Page 6 of the brochure describes DOL's enforcement responsibilities and your rights under the Small Business Regulatory Enforcement Fairness Act of 1996.

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 summaries of material modifications, if any, as well as any insurance booklets or other materials provided to participants and beneficiaries that describe benefits under the Plan.

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

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

5. Documents such as premium schedules which describe the responsibilities of both the employer and employees with respect to the payment of the costs associated with the purchase and maintenance of health and welfare benefits.

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

   a. A copy of the Plan's rules for eligibility (including continued eligibility) to enroll under the terms of the Plan (should this not appear in the plan's SPD).

   b. A sample of the certification provided to those employees who have lost health care coverage 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 in the past 2 years.

   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. Records of claims denied in the past 2 years 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.

h. 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.

i. A copy of the written claims and appeal procedures established by the Plan (should this not appear in the plan's SPD).

7. A copy of the Plan's rules regarding coverage of medical/surgical and mental health benefits, including information as to any aggregate lifetime dollar limits and annual dollar limits (should this not appear in the plan's SPD).

8. The Plan's Newborns' Act notice (should this not appear in the plan's SPD), including lists or logs of notices an administrator may keep of issued notices.

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

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

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

12. Materials describing any wellness programs or disease management programs offered by the plan (e.g., offering a non-smoker discount). If the program offers a reward based on an individual's ability to meet a standard related to a health factor, the plan should also include its wellness program disclosure statement regarding the availability of a reasonable alternative.

13. If the Plan is claiming or has claimed grandfathered health plan status within the meaning of section 1251 of the Affordable Care Act, please provide the following records:

a. A copy of the grandfathered health plan status disclosure statement that was required to be included in plan materials provided to participants and beneficiaries describing the benefits provided under the Plan.

b. Records documenting the terms of the Plan in effect on March 23, 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.

14. Regardless of whether the Plan is claiming grandfathered status, please provide the following records in accordance with section 715 of ERISA as added by the Affordable Care Act:

    a. In the case of a plan that provides dependent coverage, please provide a sample of the written notice describing enrollment opportunities relating to dependent coverage of children to age 26.

    b. If the Plan has rescinded any participant's or beneficiary's coverage in the past 2 years, 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 also 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.

15. If the Plan is **NOT claiming** grandfathered health plan status under section 1251 of the Affordable Care Act, please also provide the following records:

    a. A copy of the choice of provider notice informing participants of the right to designate any participating primary care provider, physician specializing in pediatrics in the case of a child, or health care professional specializing in obstetric or gynecology in the case of women, and a list of participants who received the disclosure notice.

    b. If the Plan provides any benefits with respect to emergency services in an emergency department of a hospital, please provide copies of documents relating to such emergency services for each plan year on or after September 23, 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 External Review Processes.

e. If applicable, any contract or agreement with any independent review organization or third party administrator providing external review.

16. Copies of a notice of adverse benefit determination, notice of final internal adverse determination notice, and, if applicable, notice of final external review decision.

17. Except to the extent previously provided, all documentation regarding Plan policies and procedures.

18. Minutes from any administrative committee meetings relating to the administration of the Plan.

19. New hire and open enrollment documentation with respect to the Plan.

20. Current fiduciary insurance policy, including all endorsements and riders.

21. With respect to Plan finances:

a. Health insurance billing invoices and payroll records of withholdings for benefits for the last 6 months.

b. Proof of payment of the last 6 months of premiums/claims.

c. All records relating to delinquent contributions and any collection activities.

d. Records depicting, or in support of, the allocation of shared expenses between the Plan and any related parties.