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ERISA COMPLIANCE – 18 THINGS YOU NEED TO KNOW

WE MAKE THE COMPLEX SIMPLE

Sterling offers the preparation of ERISA Wrap plan documents for employers with large and small groups to comply with ERISA welfare benefit plan requirements. ERISA is a federal law that regulates group-sponsored benefits, often called welfare benefit plans. Besides requiring the provision of specific plan features and funding information, the law mandates employers to comply with strict requirements for disclosing plan information to all eligible employees.

If an employer is audited by the Department of Labor (DOL), there are 18 documents that may be required as part of the audit process. A number of these documents are provided as part of Sterling's ERISA Wrap and Form 5500 Filing services. Below we provide a detailed list of the 18 documents and which entitiy will typically provide them. Let us help you be prepared.

STERLING ERISA WRAP & FORM 5500 FILING SERVICES PROVIDE:

1. Signed Plan Document, Adoption Agreement, Wrap Document, Trust Agreement and all amendments to these documents as applicable. Sterling's service provides all of these except Trust Agreements.
2. Summary plan description.
3. Signed Annual Reports (Form 5500) for the last 2 years filed, including audited financial statements. Sterling provides the annual reports, if we file the Form 5500 for the employer. We cannot provide the audited financial statements. That would have to be done by the employer.
4. Summary annual reports for the last 2 years. Sterling provides this if we file the Form 5500 for the employer.
5. A copy of the following notices provided to participants and beneficiaries are incorporated into the SPD that Sterling provides. The DOL may also require lists/logs of issued notices and a description of procedures for distribution, but these would need to be provided by the employer.
    a. Special enrollment rights notice
    b. WHCRA enrollment notice and annual notice
    c. Newborn's Act notice relating to hospital stays in connection with childbirth
    d. Medicaid or CHIPRA notice relating to health care premium assistance
    e. Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) notice explaining rights to continuation of coverage

EMPLOYER OR COMPANY MUST PROVIDE:

6. Financial records:
    a. Account statements identifying the receipts and disbursements of Plan assets.
    b. Invoices/records identifying fees paid from Plan assets.
    c. Checkbook register/canceled checks.

7. Latest fidelity bond (including all riders and endorsements) for the Plan(s) covering fraud and dishonesty and including the following ERISA-required information:
    a. The named insured
    b. The length of discovery period
    c. The bond lapse date
    d. That there is no deductible
    e. The amount of the bond
8. Minutes of the Board of Directors or any Plan committee meetings.
9. To ensure HIPAA nondiscrimination rule compliance, which prohibits discrimination in individual plan premiums based on a health factor (including list bills), the following items may be reviewed: health insurance billing invoices, premium schedules, employee and employer contribution schedules, and/or payroll records of withholdings for benefits.
10. Service provider contracts and fee schedules (broker, investment manager, third party administrator, attorney, and accountant). As part of our ERISA services, Sterling can provide copies of our service agreement with the employer.

EMPLOYER'S INSURANCE CARRIER OR EMPLOYER MUST PROVIDE:

11. Health insurance contracts and policies, including all amendments and riders covering the Plan since a specified date provided by the DOL.
12. A sample copy of each employee enrollment application in use since the date specified by the DOL.
13. Plan and issuer compensation agreements with attending providers for hospital stays in connection with childbirth and reconstructive surgery in connection with a mastectomy.
14. All documents relating to the use or collection of genetic information, for any reason, with respect to the Plan.
15. Materials describing any wellness programs or disease management programs offered by the Plan. If the program offers a reward based on an individual's ability to meet a standard related to a health factor, the Plan should also include its wellness program disclosure statement regarding the availability of a reasonable alternative.
16. 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 required to be included in materials provided to participants and beneficiaries describing the benefits provided under the Plan.
    b. Records documenting the terms of the Plan in effect on a specified date and any other documents necessary to verify, explain or clarify status as a grandfathered health plan. This may include documentation related 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 health insurance contracts that were in effect on the specified date.
17. 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. If the Plan provides dependent coverage, 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, 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 a specified date, documentation showing the limits applicable for each Plan year on or after the specified date and a sample of the 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 a specified date, documentation showing the limits applicable for each Plan year on or after the specified date.

18. If the Plan is NOT claiming grandfathered health plan status under section 1251 of the Affordable Care Act, please provide the following records:
    a. A notice informing participants of the right to designate any participating primary care provider, physician specializing in pediatrics in the case of a child, or healthcare 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, documentation related to such emergency services for each Plan year on or after a specified date.
    c. Copies of documents relating to the provision of preventive services for each Plan year on or after a specified date.
    d. Copy of the Plan's Internal Claim and Appeals and External Review Processes.
    e. Copies of a notice of adverse benefit determination, notice of final internal adverse determination notice, and notice of final external review decision.
    f. If applicable, any contract or agreement with any independent review organization or third party administrator providing external review.