

U.S. DEPARTMENT OF LABOR HEALTH INSURANCE PLAN - **2013**
 AUDIT COMPLIANCE CHECKLIST



The following list of documents may be requested by the U.S. Department of Labor for plan audit purposes:

Documents	Have	Need
1. Plan Document;		
2. Summary Plan description, including any changes in Plan Benefits and entitlement to benefits;		
3. Summary Annual Reports for 2010 and 2011;		
4. The name, title, address and phone number for the Plan's contact person for all day to day Plan issues;		
5. List of all service providers to the Plan from January 1, 2010 to the present;		
6. All contracts with insurance companies for the provision of health benefits;		
7. If the Plan is fully insured, please provide a copy of the most recent bill, premium request/invoice from the insurance carrier;		
8. A copy of the cancelled check, wire transfer records or other method payment of premium described in #7;		
9. If self-insured, all contracts for claim processing, administrative services and reinsurance;		
10. Documents which describe the responsibilities of both the employer and employees with respect to the payment of the costs associated with the purchase and maintenance of health and welfare benefits;		



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<p>11. In accordance with the Health Insurance Portability and Accountability Act (“HIPAA”), provide the following:</p> <ul style="list-style-type: none"> a. A copy of the Plan's rules for eligibility to enroll under the terms of the Plan (including continued eligibility); b. A blank enrollment form for the Plan; c. The portion of the Employee Handbook, if any, related to the Plan; d. A sample Certificate of Creditable Coverage provided to those employees who have lost health care coverage since January 1, 2009 or to be provided to those who may lose health care coverage under this plan in the future, which certifies credible coverage earned under this plan; e. A copy of the record or log of all Certificates of Creditable Coverage for individuals who lost coverage under the Plan or requested certificates; f. A copy of the written procedure for individuals to request and receive Certificates of Creditable Coverage; g. 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; h. 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; i. A copy of the necessary criteria for an individual without a Certificate of Credible Coverage to demonstrate creditable coverage by alternative means; j. Records of claims denied due to the imposition of the preexisting condition exclusion (as well as the Plan's determination and reconsideration of creditable coverage, if applicable), or proof that the Plan does not impose a preexisting condition exclusion; k. The Plan's Notice of Special Enrollment rights, including lists or logs the Plan Administrator maintains related to the issuance of the Notice; l. A sample COBRA Notice for the plan; and m. A copy of the written appeal procedures established by the Plan. 		
<p>12. 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;</p>		

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<p>13. The Plan's Newborns' Act Notice, including lists or logs the Plan Administrator maintains related to the issuance of the Notice;</p>		
<p>14. A copy of the Plan's rules regarding pre-authorization for a hospital length of stay in connection with childbirth;</p>		
<p>15. A sample of the written description of benefits mandated by WHCRA required to be provided to participants and beneficiaries upon enrollment;</p>		
<p>16. A sample of the written description of benefits mandated by WHCRA required to be provided to participants and beneficiaries annually;</p>		
<p>17. 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;</p>		
<p>18. 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:</p> <ul style="list-style-type: none"> 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; 		

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<p>19. 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:</p> <p>a. In the case of a plan that provides dependent coverage; provide a sample of the written notice describing enrollment opportunities relating to dependent coverage of children to age 26.</p> <p>b. If the plan has rescinded any participant's or beneficiary's coverage, supply a list of participants or beneficiaries whose coverage has been rescinded, the reason for the rescission, and a copy of the written notice of rescission that was provided 30 days in advance of any rescission of coverage.</p> <p>c. If the Plan imposes a lifetime limit or has imposed a lifetime limit at any point since September 23, 2010, provide documents showing the limits applicable for each plan year on or after September 23, 2010. 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.</p> <p>d. If the Plan imposes an annual limit or has imposed an annual limit at any point since September 23, 2010, provide documents showing the limits applicable for each plan year on or after September 23, 2010.</p>		
<p>20. If the Plan is NOT CLAIMING grandfathered health plan status under section 1251 of the Affordable Care Act, provide the following records:</p> <p>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.</p> <p>b. If the Plan provides any benefits with respect to emergency services in an emergency department of a hospital, provide copies of documents relating to such emergency services for each plan year on or after September 23, 2010.</p> <p>c. Copies of documents relating to the provision of preventive services for each plan year on or after September 23, 2010.</p> <p>d. Copy of the Plan's Internal Claim and Appeals and External Review Processes</p> <p>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.</p>		

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