U.S. Department of Labor Employee Benefits Security Administration

Reply to the Attention of: Case No.

November 2012

Re:

Dear

The Employee Benefits Security Administration of the U.S. Department of Labor is responsible for the administration and enforcement of Title I of the Employee Retirement Income Security Act of 1974 (ERISA). ERISA establishes standards governing the operation of employee benefit plans such as the Welfare Benefits Plan (Plan) and the conduct of fiduciaries with respect to such plans. Section 504 of ERISA vests investigative authority over employee benefit plans in the Secretary of Labor.

The Plan will be examined for the purpose of determining whether it is complying with the laws contained in Part 7 of ERISA, including the Health Insurance Portability and Accountability Act of 1996, the Newborns' and Mothers' Health Protection Act, the Women's Health and Cancer Rights Act (WHCR), the Mental Health Parity and Addiction Equity Act, the Genetic Information Nondiscrimination Act, and the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act (together, the Affordable Care Act). These laws amended Part 7 of ERISA and provide requirements for group health plans.

We have found in the past that submission of relevant documents to our office prior to the inception of an on-site field investigation can lessen the time subsequently spent with, and the administrative burden placed on, plan and corporate officials and may eliminate the need for an on-site visit entirely. To that end, we ask that you submit to this office, ***within ten business days*** of your receipt of this letter, the documentation listed on the enclosed Attachment A. If any items are not applicable, please so indicate and provide an explanation.

Thank you in advance for your cooperation. Should you have any questions, feel free to contact me at

Sincerely,

Senior Investigator

DOCUMENTS TO BE AVAILABLE FOR INSPECTION AND RETENTION
Welfare Benefits Plan

Note: Unless otherwise specified, the documents to be provided should include those covering the period from August 1, 2009 through the present.

1. Plan document, with all amendments.

2. Summary Plan Description (SPD), including any changes in Plan benefits and entitlement to benefits.

3. Documents, including memoranda, correspondence or brochures relating to communications with employees or participants describing the Plan's terms, benefits and administration.

4. Copies of all required annual and one time disclosures provided to participants.

5. Health Plan enrollment package for participants for each medical benefit option.

6. Annual Return/Reports Forms 5500 with all attachments, including accountant's opinion, financial statements, notes to the financial statements and supplemental schedules.

7. Any written policy statements, guidelines or other documents governing the operation or administration of the Plan.

8. Any applications for exemptions under Title I of ERISA.

9. Listing of all individuals responsible, directly or indirectly, for the Plan's operation, administration and the investment of the assets of the Plan during the period under review, specifically:

   a. Plan Trustees, Administrators, and Fiduciaries;

   b. Members of any Plan oversight committee, sub-committee or similar group; and

   c. Accounting, human resources, or other personnel of the Plan sponsor who process claims or enrollment, respond to participant inquiries, or interface with service providers.

   The list should include names, titles, responsibilities, and current contact information.

10. Listing of all service providers to the Plan, including company names as well as names and direct contact information for individual points-of-contact or account representatives.

11. Invoices and fee schedules for all expenses paid by the Plan.

12. Documents sufficient to show all compensation (money and any other thing of value) paid by the Plan or on behalf of the Plan to any person or entity in connection with services rendered to the Plan, including but not limited to commissions and consulting fees, and sales and base commissions where the person's or entity's eligibility for the payment or the amount of the payment is based, in whole or in part, on the value (e.g.,

policy amounts, premiums) of contract or policies (or classes thereof) placed with or retained by the Plan, including persistency and profitability bonuses. The documents should include all direct compensation reported on Schedule A of the Annual Return/Report Form 5500, together with supporting invoices, fee schedules, etc.

13. All written agreements and contracts relating to services rendered to the Plan by all service providers, including but not limited to third party administrators (TPAs), preferred provider organizations (PPOs), preferred provider associations (PPAs), Health Maintenance Organizations (HMOs), actuaries, accountants, insurance carriers, insurance agents, marketing agents, employee or employer representatives, stop-loss insurers or reinsurers, or any other service provider.

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

15. 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.

16. If employee payroll deductions are used to pay health claims, or health insurance provider premiums, records for the prior 3 months showing:

    a. Premium schedules

    b. Employee payroll deductions (per pay period)

    c. Premium payments to health insurance providers to the Plan of the Plan trust, e.g. insurance billing invoices and verification of payment.

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

    a. A copy of the Plan's rules for eligibility to enroll under the terms of the Plan (including continued eligibility).

    b. A sample of the certification provided to those employees who have lost health care coverage since January 1, 2009 or to be provided to those who may lose health care coverage under this plan in the future, which certifies creditable coverage earned under this plan;

    c. A copy of the record or log of all Certificates of Creditable Coverage for individuals who lost coverage under the Plan or requested certificates;

    d. A copy of the written procedure for individuals to request and receive certificates;

    e. A sample general notice of preexisting condition informing individuals of the exclusion period, the terms of the exclusion period, and the right of individuals to demonstrate creditable coverage (and any applicable waiting or affiliation periods) to reduce the preexisting condition exclusion period, or proof that the plan does not impose a preexisting condition exclusion;

f. Copies of individual notices of preexisting condition exclusion issued to certain individuals per the regulations (including any lists or logs an administrator may keep of issued notices), or proof that the Plan does not impose a preexisting condition exclusion;

g. A copy of the necessary criteria for an individual without a certificate of creditable coverage to demonstrate creditable coverage by alternative means;

h. Records of claims denied due to the imposition of the preexisting condition exclusion (as well as the Plan's determination and reconsideration of creditable coverage, if applicable), or proof that the Plan does not impose a preexisting condition exclusion;

i. A copy of the written procedures that provide special enrollment rights to individuals who lose other coverage and to individuals who acquire a new dependent, if they request enrollment within 30 days of the loss of coverage, marriage, birth, adoption, or placement for adoption, including any lists or logs an administrator may keep of issued notices; and

j. A copy of the written appeal procedures established by the Plan.

18. 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.

19. The Plan's Newborns' Act notice (this should appear in the plan's SPD), including lists or logs of notices an administrator may keep of issued notices.

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

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

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

23. 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.

24. 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.

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

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

b. If the Plan has rescinded any participant's or beneficiary's coverage, supply a list of participants or beneficiaries whose coverage has been rescinded, the reason for the rescission, and a copy of the written notice of rescission that was provided 30 days in advance of any rescission of coverage.

c. If the Plan imposes a lifetime limit or has imposed a lifetime limit at any point since September 23, 2010, please provide documents showing the limits applicable for each plan year on or after September 23, 2010.

d. Please provide a sample of any notice sent to participants or beneficiaries stating that the lifetime limit on the dollar value of all benefits no longer applies and that the individual, if covered, is once again eligible for benefits under the plan.

e. 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.

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

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

b. If the Plan provides any benefits with respect to emergency services in an emergency department of a hospital, please provide copies of documents relating to such emergency services for each plan year on or after September 23, 2010.

c. Copies of documents relating to the provision of preventive services for each plan year on or after September 23, 2010.

d. Copy of the Plan's Internal Claim and Appeals and External Review Processes.

e. Copies of a notice of adverse benefit determination, notice of final internal adverse determination notice, and notice of final external review decision.

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

27. Lag reports regarding participant claims, (i.e. for fully insured, all insurance carrier records showing the amount of time from the point that a claim is filed to the point that the claim is paid.

28. All correspondence relating to the Plan's Health benefits, including participant complaints about claim payment or processing, denials and appeal, and including carrier or third party administrator responses.

29. Minutes of Board of Directors, Plan Committee and/or any other committee meetings where Plan health benefits were discussed.

30. If Plan maintains a reserve for the payment of claims, records showing how the reserve amount is determined, and the accounts where reserves are maintained.