COMPLIANCE ASSESSMENT™

Take Control of Your Regulatory Risk

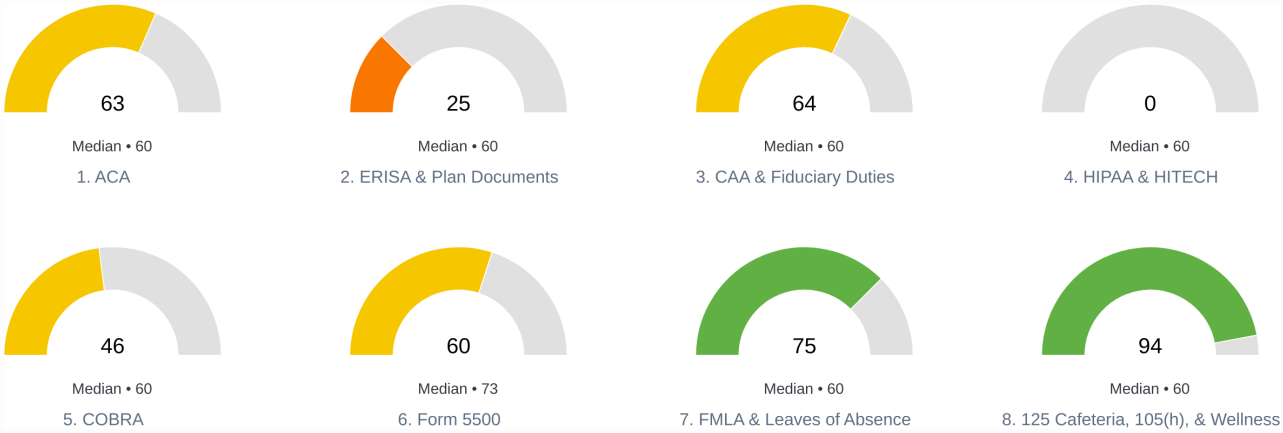
December 15, 2023

Prepared By: Group Planners Insurance Solutions DBA BritePath

Your Overall Score: 49

**Median score is the average of all plans that have completed a Compliance Assessment™.*

Your Score by Compliance Topic



EXECUTIVE SUMMARY

WHAT IS COMPLIANCE ASSESSMENT?

Compliance Assessment is an in-depth review of your plan's compliance with applicable federal regulations related to health benefits. Because these regulations are complex and ever-changing, many employers are unknowingly exposed to potential liability for noncompliance. This report evaluates your practices and compliance risk, highlighting any deficiencies and areas for potential improvement. Compliance Assessment will help you cut though the complexity, educate yourself, and provide direction to help you minimize risk.

WHY IS IT IMPORTANT?

The federal government has recently created new regulatory requirements and increased employee benefit plan oversight, with a particular focus on topics related to transparency and plan sponsor fiduciary duties under ERISA. Noncompliance is costly and can result in hefty fines and penalties, plus regulators more proactively enforce requirements than in the past. Compliance Assessment will help you identify gaps and provide direction to mitigate risk. It can play a key piece of your overall plan improvement strategy. Highlighting potential compliance issues also helps draw attention to other areas for plan improvement, such as member communications, vendor selection, plan design, etc. For example, improving how you communicate compliance notices to plan members can serve as the starting point for a broader assessment of your overall member communication strategy. Another example is that focusing on improving fiduciary duty compliance requires understanding the strengths and weakness of your vendors, which also supports your broader vendor selection process.

HOW TO USE YOUR ASSESSMENT

You and your trusted benefits advisor should evaluate Compliance Assessment results to create a plan for improving areas of weakness or noncompliance. You may find that you need or want to partner with an outside organization to help you meet requirements and potentially outsource some risk. Complete the Assessment at least once per year to track your progress and improvement, while quickly learning about new or changed requirements.

COMPLIANCE ASSESSMENT LIMITATIONS

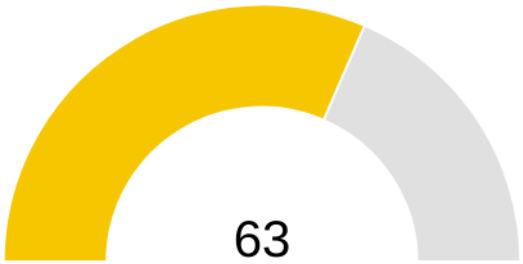
While Compliance Assessment provides a comprehensive view of federal regulations that apply to typical health benefits plans offered by private sector employers, you should understand its limitations, where it applies, and where it only partially applies.

- It relies on the accuracy of data you provide, so it is critical to provide correct information.
- It does not cover any state level requirements that may apply, such as those under state departments of insurance.
- It does not provide guidance on whether a plan qualifies for specific exemptions under ERISA that may apply to churches and governmental entities
- It does not go into detail on certain topics that require additional analysis, such as how to evaluate a group of related companies to determine controlled group analysis. However, it highlights these topics that require deeper assessments to help you define next steps.
- It does not fully cover issues related to unions, VEBA's, PEO's, association plans, MEWA's, or other less common types of plans. These unique circumstances require specialized analysis to determine how various regulations apply.

DISCLOSURE

Please note that Health Rosetta is not a law firm and cannot provider legal advice or certification of regulatory compliance. Nor does Health Rosetta provide tax advice. This document provides an assessment of general compliance risk to your group health plan. We encourage you and the Plan fiduciaries to consult with your legal and/or tax counsel regarding all potential compliance issues identified by Health Rosetta. You agree that this assessment is provided only as a tool and that Health Rosetta has no discretionary authority or control with respect to the management or administration of your employee benefit plan(s).

ACA



Median • 60

If you issue 250 or more W-2s, do you report the total aggregate cost of group health plan coverage on W-2, Box 12, using Code DD?

Under the Affordable Care Act (ACA), employers who issue 250+ Form W-2s, must report the "aggregate cost" of "applicable employer-sponsored coverage" on the employees' Form W-2 for that year.

YOUR RESPONSE: **No**

POINTS SCORE: **0/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are NOT meeting this requirement.

Although not specified, reporting penalties of $137 per affected participant could apply for noncompliance.

How do you file the Form 720 and pay the required PCORI fees by July 31st of each year?

The Affordable Care Act (ACA) created a nonprofit corporation, the Patient-Centered Outcomes Research Institute, to support clinical effectiveness research. This entity is funded in part by fees (sometimes referred to as "PCORI fees") paid by certain health insurers and applicable sponsors of self-insured health plans. The fees are payable for plan years ending after October 1, 2012 and before October 1, 2029. The fee is calculated based on the average number of covered lives and reported and payable using IRS Form 720 and is due by July 31st each year.

YOUR RESPONSE: **N/A. Our group health plan is fully insured and therefore we are not required to file a separate Form 720 and pay the applicable PCORI fees. Our health insurance carrier**

collects and remits these fees on behalf of our plan

POINTS SCORE: **1/1 possible points**

KEY ISSUES

Based on the information you provided, it appears this requirement does not apply to your plans. However, you should always verify with a compliance expert because these determinations can be complex.

If you are an Applicable Large Employer (ALE), do you offer group medical insurance that is Minimum Essential Coverage (MEC) that meets Minimum Value (MV) and is considered affordable to at least 95% of your full-time employees?

The Affordable Care Act (ACA) requires applicable large employers (ALEs) to offer minimum essential health care coverage (MEC) that meets minimum value (MV) and is deemed "affordable" to at least 95% of its full-time employees. A plan meets MV requirements if it covers at least 60% of the total allowed cost of benefits that are expected to be incurred under the plan. Coverage is deemed "affordable" if the cost to the employee for the lowest cost plan does not exceed 9.12% of pay (2023 limits). IRS Safe Harbors: W-2, Rate of Pay, Federal Poverty Level (FPL).

YOUR RESPONSE: **Yes**

POINTS SCORE: **1/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are meeting this requirement.

How do you provide all full-time employees with the required IRS Form 1095-C by March 2nd of each year?

The Affordable Care Act (ACA) requires applicable large employers (ALE) to report to the IRS whether they offer minimum essential coverage (MEC) that meets minimum value (MV) and is deemed affordable. In addition, ALEs must provide all full-time employees with an individual Form 1095-C by March 2nd of each year.

YOUR RESPONSE: **Third Party Vendor/Payroll Vendor**

POINTS SCORE: **3/3 possible points**

KEY ISSUES

Based on the information you provided, it appears you are meeting this requirement.

If you are a NON-ALE and offer self-funded or partially

self-funded medical coverage, how do you provide all covered employees with the required IRS Form 1095-B by March 2nd of each year?

The Affordable Care Act (ACA) requires employers who sponsor a self-funded, or partially self-funded health plan, to report certain coverage information to the IRS annually using Forms 1094/1095-B. Copies of the individual Forms 1095-B must be furnished to covered employees by March 2nd of each year. This includes Health Reimbursement Arrangements (HRA). ALEs who sponsor a self-funded or partially self-funded health plan are required to report this information on Form 1095-C using Part III.

YOUR RESPONSE: **N/A. We are considered an Applicable Large Employer (ALE) and therefore are required to issue 1095-C forms**

POINTS SCORE: **1/1 possible points**

KEY ISSUES

Based on the information you provided, it appears this requirement does not apply to your plans. However, you should always verify with a compliance expert because these determinations can be complex.

If you are an ALE or a NON-ALE who offers self-funded or partially self-funded medical coverage, how do you file IRS Form 1094-B/C along with copies of the 1095-B/Cs with the IRS by February 28th of each year, March 31st if filing electronically?

ALEs and non-ALEs who sponsor a self-funded or partially self-funded group health plan are required to report certain coverage information to the IRS using Forms 1094-B/C and 1095-B/C. The filing deadline for paper copies if February 28th each year. For electronic filing, the deadline is extended to March 31st of each year. ALEs who issue more than 250 1095-Cs are required to file electronically.

YOUR RESPONSE: **N/A. We are not considered an Applicable Large Employer (ALE) and we do not have a self-funded or partially self-funded medical plan and therefore not subject to the ACA reporting requirements**

POINTS SCORE: **1/1 possible points**

KEY ISSUES

Based on the information you provided, it appears this requirement does not apply to your plans. However, you should always verify with a compliance expert because these determinations can be complex.

For group health plan eligibility purposes, do you define

"full-time" as an employee who works on average, 30 hours per week?

ACA defines a "full-time" employee as someone who works an average of at least 30 hours per week.

YOUR RESPONSE: **Yes**

POINTS SCORE: **1/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are meeting this requirement.

For group health plan eligibility purposes, is coverage for all classes of employees effective on or before the 91st day?

The Affordable Care Act (ACA) prohibits group health plans from applying a waiting period for coverage that exceeds 90 days. This requirement applies to all group health plans, including Grandfathered Plans.

YOUR RESPONSE: **Yes**

POINTS SCORE: **1/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are meeting this requirement.

Do all of your health plans cover dependents through age 26?

The ACA requires group health plans to provide coverage for dependent children until age 26.

YOUR RESPONSE: **Yes**

POINTS SCORE: **1/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are meeting this requirement.

How do you obtain signed participant applications and waivers for all eligible employees for each benefit?

While not technically required, it is a best practice to collect and maintain waivers when an employee chooses not to enroll in the employer's group health plan. This is especially important for ALEs who can be penalized if they do not offer coverage to someone who is considered full-time. These waivers serve as documentation of the employer's offer of coverage.

YOUR RESPONSE: **Employees complete and sign applications and waivers using a technology-based system**

POINTS SCORE: **1/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are meeting this requirement.

If you employ variable hourly employees, do you have a defined measurement and stability periods to monitor eligibility for medical coverage?

Under the ACA, an employee is considered "variable hourly" if it cannot be determined, based on the employee's work schedule, whether or not he/she will average at least 30 hours per week. It is necessary for an ALE to establish a look-back measurement period under the regulations in order to track these employees' hours worked and classify as full-time or part-time for ACA purposes.

YOUR RESPONSE: **No**

POINTS SCORE: **0/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are NOT meeting this requirement.

An ALE is liable for penalties under the ACA if they do not offer coverage to enough full-time employees. Determining full-time status for variable hourly employees is difficult. Establishing defined measurement and stability periods is essential in tracking hours for those employees and determining full-time status for ACA purposes.

If you have variable hourly employees, how do you track hours worked and identify as eligible if they average 30 hours/week during measurement period?

Under the "Look-Back Measurement Period" method for variable hourly employees, the ALE must track hours during the measurement period to determine eligibility status for the upcoming stability period.

YOUR RESPONSE: **We do not track variable hourly employees for hours worked and eligibility purposes**

POINTS SCORE: **0/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are NOT meeting this requirement.

An ALE is liable for penalties under the ACA if they do not offer coverage to enough full-time employees. Determining full-time status for variable hourly employees is difficult. Tracking hours during the measurement period is essential in determining eligibility and ensuring coverage is offered timely.

When do you provide the Summary of Benefits & Coverage (SBC) to employees?

The Affordable Care Act (ACA) requires the distribution of the Summary of Benefits & Coverage (SBC) to all applicants, policyholders and enrollees. The SBC must be provided at initial enrollment, during open enrollment each year, at special enrollments that occur mid-year and upon request.

YOUR RESPONSE: **We have not been distributing the SBC.**

POINTS SCORE: **0/3 possible points**

KEY ISSUES

Based on the information you provided, it appears you are NOT meeting this requirement.

Under the ACA, failure to distribute the SBC timely is subject to penalties of up to $1,362 per failure. Each participant or beneficiary who is not provided with the SBC is considered a separate offense.

Do you provide all new hires with the required ACA Marketplace Exchange Notice within 14 days of their date of hire?

The Affordable Care Act (ACA) requires employers to provide all new hires and current employees with a written notice about the health coverage options that are available through the Exchange and consequences if an employee decides to purchase a qualified health plan through the Exchange in lieu of employer-sponsored coverage. The notice must be automatically provided within 14 days of an employee's date of hire.

YOUR RESPONSE: **No**

POINTS SCORE: **0/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are NOT meeting this requirement.

Although there are no specific penalties for failure to provide a timely

Marketplace Exchange Notice to employees, this could be considered a breach of fiduciary duties for ERISA plans.

If you sponsor a fully-insured group health plan and receive MLR rebate from your carrier, did you document how you distributed those funds back to participating employees or otherwise used those funds for the benefit of plan participants?

The ACA requires health insurance carriers to comply with medical loss ratio standards and to provide rebates to policyholders under certain circumstances. There are specific permissible uses of rebates and employees are entitled to share in a portion of the rebate if the employer did not pay 100% of all premiums.

YOUR RESPONSE: **No**

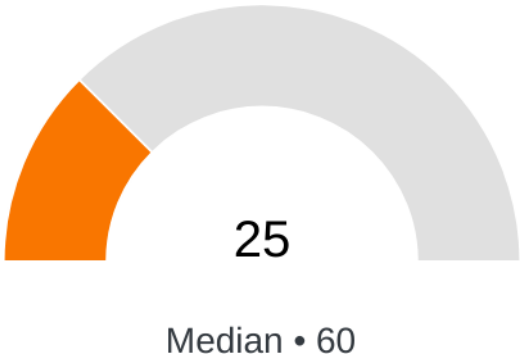
POINTS SCORE: **0/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are NOT meeting this requirement.

ERISA requires plan fiduciaries to act prudently, impartially, solely in the interest of plan participants and treat insurer rebates in accordance with plan terms. It is best practice to have a standard process in place for distributing MLR rebates back to participating employees. This process should take into account ERISA's fiduciary responsibilities as well as the plan asset rules.

ERISA & Plan Documents



Which of the following Notices do you distribute to employees upon initial enrollment and annually during open enrollment?

A number of health and welfare plan notices and disclosure requirements apply to group health plans. Meeting these requirements is the responsibility of the plan sponsor and each have specific timing

requirements.

YOUR RESPONSE: **We're unsure about which notices we distribute**

POINTS SCORE: **0/11 possible points**

KEY ISSUES

Based on the information you provided, it appears you are NOT meeting HIPAA Special Enrollment Rights notice requirement.

HIPAA requires group health plans to notify employees of their special enrollment rights outside of the plan's annual enrollment period. It alerts the employees to specific deadlines to request enrollment or if the deadline is missed, the employee will have to wait until the next open enrollment period to enroll. This notice must be provided when an employee is initially offered coverage. Failure to provide this notice can result in penalties of $137 per participant per day.

Based on the information you provided, it appears you are NOT meeting the Medicare Part D Creditable Coverage Notice requirement.

This notice must be provided annually by October 15th. Failure to do so can result in a breach of your fiduciary duty and can cause employees to incur late enrollment penalties under Medicare Part D if they were not properly notified of their plan's creditable coverage status.

Based on the information you provided, it appears you are NOT meeting Children's Health Insurance Program Reauthorization Act (CHIPRA) notice requirement.

CHIPRA requires employers to notify employees about any premium assistance program available in the state where the employee resides. The notice must be provided annually. Failure to provide this notice can result in penalties of $137 per participant per day.

Based on the information you provided, it appears you are NOT meeting Women's Health and Cancer Rights Act (WHCRA) notice requirement.

WHCRA requires group health plans that provide medical and surgical benefits for mastectomy services to also provide benefits for reconstructive surgery. Group health plans must provide a notice of rights under WHCRA at initial enrollment and on an annual basis during open enrollment. Failure to provide this notice can result in penalties of $137 per participant per day.

Based on the information you provided and assuming your plan(s) does NOT require designating primary care provider, it appears the PPA Patient Protections notice requirement do not apply.

Based on the information you provided and assuming you do not have a grandfathered plan, it appears the Grandfathered Plan Notice requirement does not apply.

Based on the information you provided, it appears you are NOT meeting the Genetic Information Non-Discrimination Act (GINA) notice requirement.

Based on the information you provided, it appears you are NOT meeting the Newborn's and Mother's Health Protection Act (NMHPA) requirement.

Based on the information you provided, it appears you are NOT meeting the HIPAA Notice of Privacy Practices requirement.

Based on the information you provided, it appears you are NOT meeting notice requirements because you are unsure which notices you are distributing. You should confirm which notices are being distributed upon initial enrollment and annually during open enrollment.

How do you distribute the SPD and required notices to participants?

ERISA requires every employee benefit plan to have a Summary Plan Description (SPD) and to provide copies to each covered participant. The SPD must be distributed to a participant within 90 days of their effective date of coverage. In addition, an updated SPD is required to be distributed every five (5) years if there are material changes made and every ten (10) years if no material changes have been made.

YOUR RESPONSE: **SPD and notices are posted on Company intranet**

POINTS SCORE: **2/3 possible points**

KEY ISSUES

If you are providing the SPD and required notices electronically, you must provide employees with an annual notice directing them to the website, explaining the importance of the documents, and that they have the right to request a paper copies without charge.

Do you distribute the SPD(s) to plan participants within 90 days of their effective date of coverage?

ERISA requires every employee benefit plan to have a Summary Plan Description (SPD) and to provide copies to each covered participant. The SPD must be distributed to a participant within 90 days of their effective date of coverage.

YOUR RESPONSE: **Yes**

POINTS SCORE: **1/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are meeting this requirement.

Do you provide plan participants with a new SPD at least every 5 years (or 10 years if the SPD has not changed)?

ERISA requires plan sponsors to update and distribute a new SPD at least every 5 years. The updated SPD must be furnished no later than 210 days following the last day of the 5th plan year after a material change was adopted. The updated SPD must incorporate all amendments that were adopted during the five-year period

YOUR RESPONSE: **No**

POINTS SCORE: **0/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are NOT meeting this requirement.

Failure to update and distribute a new SPD every 5 years (10 years if the SPD has not changed) can result in a breach of fiduciary duty. It can also result in penalties of $110 per day per affected individual if not provided within 30 days of an individual's request.

In addition, the DOL will request copies of the SPD as part of routine audits. If you are unable to respond to the DOL's request, this can result in a penalty of $171 per day (capped at $1,713 per request).

Do you timely provide plan participants with a Summary of Material Modification (SMM) when there are any "material modifications" made to the terms of the plan or any change in information required to be in the SPD?

ERISA requires a plan sponsor to distribute a Summary of Material Modifications (SMM) anytime a "material modification" is made to the plan or any change in the information required to be included in the SPD. As a general rule, the SMM must be provided within 210 days after the end of the plan year in which a modification or change is adopted. Any modification or change that is considered a "material reduction in covered services or benefits" must be disclosed no later than 60 days after the date of adoption of the modification/change.

YOUR RESPONSE: **No**

POINTS SCORE: **0/1 possible points**

KEY ISSUES

You've got work to do! Failure to distribute the required SMM can result in a breach of fiduciary duty and penalties of $110 per day per affected individual if not provided within 30 days of a participant's request. In addition, the DOL will request copies of the SMM as part of their routine audit. If you are unable to respond to the DOL's request, this can result in a penalty of $171 per day (capped at $1,713 per request).

Do you provide plan participants with copies of Certificates of Coverage (COC) and any other participant member materials that reflect eligibility, limitations, etc. under the plan(s) in addition to the SPD?

Even though Certificates of Coverage (COC) and Benefit Booklets provided by the insurance provider do not meet the requirements of an ERISA compliant SPD, it is important to distribute those materials to plan participants because they often supplement with additional information that is not reflected in the SPD alone.

YOUR RESPONSE: **Yes**

POINTS SCORE: **1/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are meeting this requirement.

Do you have a documented process in place that could be provided upon audit to demonstrate how you are meeting your disclosure obligations?

The Department of Labor's (DOL) enforcement division is focused on compliance with federal laws and regulations and as part of their routine audit process will specifically request documentation for review to determine whether a plan is complying with Part 7 of ERISA, including HIPAA, NMHPA, WHCRA, MHPAEA, GINA, PPA and ACA. Maintaining organized records and having the proper processes in place to reflect how a plan is meeting these disclosure requirements will reduce the length of an audit and prevent penalties for noncompliance.

YOUR RESPONSE: **No or Unsure**

POINTS SCORE: **0/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are NOT meeting this requirement.

Without documented processes detailing how you meet your disclosure obligations, it is difficult for an employer to prove compliance in the event

of an audit or participant claim. This can result in fines of up to $137 per day, per person, per violation.

Does your process in place clearly document who was given which notices and on what date?

Keeping track of which notices are provided to employees and the date they are provided is necessary to prove compliance with disclosure requirements under ERISA and other applicable regulations.

YOUR RESPONSE: **No or Unsure**

POINTS SCORE: **0/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are NOT meeting this requirement.

Without documented processes detailing who has been provided the required disclosures and when, it is difficult for an employer to prove compliance in the event of an audit or participant claim. This can result in fines of up to $137 per day, per person, per violation.

Do you have an ERISA compliant plan document in place for all your health and welfare benefit plans?

ERISA requires plan sponsors to have a written plan document for every welfare benefit plan. Some plan sponsors may wish to combine two or more ERISA welfare benefit plans into a single plan for ERISA compliance purposes ("wrap document").

YOUR RESPONSE: **No or Unsure**

POINTS SCORE: **0/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are NOT meeting this requirement.

Although there are no specific penalties for failing to have a written plan document in place, an employer can be sued by participants and beneficiaries to enforce the requirement and seek penalties for failure to prepare a formal document. Criminal penalties may also be imposed on any individual or employer who willfully violates any ERISA disclosure requirement.

If you offer life and/or disability insurance that allows conversion upon employment termination, do you provide a conversion notice and keep record of when that is provided?

A "conversion option" under a group life or disability policy offers the insured an option to convert their group coverage into an individual policy upon termination of employment. The employer is required to give notice of these conversion rights by a designated deadline. If the employer fails to notify the employee and coverage is lost, the employer could be found liable.

YOUR RESPONSE: **No**

POINTS SCORE: **0/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are NOT meeting this requirement.

An employer can be found liable for the loss of coverage, including any benefit amount, if proper conversion notice is not provided.

If you offer life and/or disability coverage, do you maintain beneficiary information on file and have a process in place for employees to update accordingly?

Employers should have plan provisions and administrative practices for employees' beneficiary designations to avoid disputes. It is important to remind employees to change beneficiary designations to reflect life events such as marriage, divorce, etc. and to have processes in place to facilitate these changes. In cases where beneficiary designation disputes occur, plan fiduciaries will have to spend time, as well as financial and other resources to identify the correct beneficiary and fulfill their fiduciary duties.

YOUR RESPONSE: **No**

POINTS SCORE: **0/1 possible points**

KEY ISSUES

There is no legal requirement for the employer to maintain beneficiary information on file for its employees. It is ultimately the responsibility of the employee to designate a beneficiary and update the information accordingly when needed.

However, it is a best practice to have employees complete a beneficiary form and remind them during the open enrollment process to make sure beneficiary information is up to date. Many employees forget to update their beneficiary information to reflect changes such as marriage, divorce or birth of a child.

Do you perform the annual Creditable Coverage Disclosure to CMS?

The Medicare Secondary Payer (MSP) rule requires group health plan sponsors to notify CMS of Medicare Part D creditable coverage status for their group health plan(s). Disclosure is required annually

within 60 days after the beginning of the plan year, within 30 days after termination of a prescription drug plan and within 30 days after any change in creditable coverage status. Submission is made online using the CMS Form.

YOUR RESPONSE: **No or Unsure**

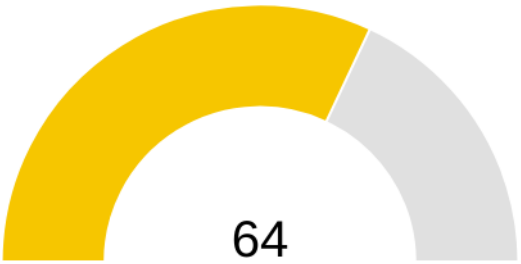
POINTS SCORE: **0/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are NOT meeting this requirement.

There are no specific penalties or sanctions applicable to employers who fail to comply. However, employers that do not comply are likely to encounter creditable coverage status issues with participants who are enrolled or become eligible for Medicare Part D.

CAA & Fiduciary Duties



Median • 60

Does your plan have posted on a public website, the Balance Billing Protection Disclosure (model notice available)?

For plan years beginning on or after January 1, 2022, a group health plan must make publicly available, post on a public website of the plan and include certain information regarding the prohibition on balance billing on each EOB to which the requirements under PHSA 2799A-1 apply.

YOUR RESPONSE: **No or Unsure**

POINTS SCORE: **0/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are NOT meeting this requirement.

Failure to provide the required notice can result in excise taxes.

Do you have a process in place to monitor your service providers and ensure you are receiving the required compensation disclosures?

As part of the Consolidated Appropriations Act of 2021 (CAA), covered service providers are required to disclose compensation to a plan sponsor if they are expected to receive $1,000 or more in direct or indirect compensation for providing their services related to the group health plan. While the new disclosure rules require brokers, consultants and other service providers to provide the information, the consequences of noncompliance falls directly on plan fiduciaries.

YOUR RESPONSE: **No or Unsure**

POINTS SCORE: **0/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are NOT meeting this requirement.

Employers, as plan sponsors, have a fiduciary duty to ensure they receive the proper disclosures from each service provider related to their ERISA group health plans. The responsibility falls on the employer as the plan sponsor and they can be penalized if they do not carry out their fiduciary duty.

Have you collected detailed disclosures from your employee benefit broker/advisor AND any other vendors providing consulting services that reflect all direct and indirect compensation?

Plan fiduciaries have an obligation to timely report a covered service provider's failure to comply with the new disclosure rules to the Department of Labor (DOL).

YOUR RESPONSE: **No or Unsure**

POINTS SCORE: **0/2 possible points**

KEY ISSUES

Based on the information you provided, it appears you are NOT meeting this requirement.

Employers, as plan sponsors, have a fiduciary duty to ensure they receive the proper disclosures from each service provider related to their ERISA group health plans. The responsibility falls on the employer as the plan sponsor and they can be penalized if they do not carry out their fiduciary duty.

Have you requested and received whether fiduciary services are being provided by your service providers (broker/advisor, consultant, TPA, carrier, etc.)?

As part of the new disclosure requirements under the Consolidated Appropriations Act of 2021 (CAA), covered service providers are required to disclose whether they are providing fiduciary services to the plan.

YOUR RESPONSE: **Requested, but not received from at least some service providers**

POINTS SCORE: **1/2 possible points**

KEY ISSUES

You're on your way, but not there yet. Service providers are required to disclose whether or not they provide any fiduciary services on behalf of its ERISA group health plans. Employers, as plan sponsors, have a fiduciary duty to ensure they receive the proper disclosures from each service provider related to their ERISA group health plans. The responsibility falls on the employer as the plan sponsor and they can be penalized if they do not carry out their fiduciary duty.

Has your broker/advisor provided you with a signed, conflict-of-interest disclosure?

Although not technically required, disclosing conflicts of interest is a best practice for brokers/advisors to show they are acting in the best interest of the plan and its participants. It also ensures plan fiduciaries can carry out their duty to monitor service providers and avoid conflicts of interest that could result in a prohibited transaction.

YOUR RESPONSE: **No or Unsure**

POINTS SCORE: **0/1 possible points**

KEY ISSUES

It is highly recommended that employers get a conflict-of-interest disclosure to document compliance with their fiduciary responsibilities under ERISA. In addition, disclosure of any conflicts can help avoid hidden compensation and potential prohibited transactions.

Have you reviewed all plan contracts to ensure all "Gag" clauses have been removed?

The Consolidated Appropriations Act of 2021 (CAA) prohibits group health plans from entering into agreements with a health care provider, network or association of providers, third-party administrator (TPA), or other service providing offering access to a network of providers that would directly or indirectly

restrict a plan from:

1) providing provider-specific cost or quality of care information or data;

2) electronically accessing identified claims and encounter information or data for each covered member; OR

3) sharing information or data with a Business Associate. Plans are required to file an attestation with CMS annually beginning December 31, 2023.

YOUR RESPONSE: **No or Unsure**

POINTS SCORE: **0/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are NOT meeting this requirement.

Group health plans must submit an annual attestation to CMS that they have reviewed all of their plan related contracts to ensure there are no "gag clauses" that violate the CAA. Failure to comply with this requirement can result in penalties under IRC 4980D of $100 per day per affected individual.

Are you prepared to begin filing the Gag Clause Attestation annually using CMS' HIOS system?

Per guidance issued on February 23, 2023, group health plans must begin submitting annual gag clause prohibition attestations on December 31, 2023. The first submission will cover the period beginning December 27, 2020 through the date of the filed attestation. All future attestations are due by December 31st.

YOUR RESPONSE: **Our group health plan is fully-insured and we have verified that our insurance carrier will be responsible for filing the attestation on behalf of our plan.**

POINTS SCORE: **1/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are meeting this requirement.

If you have a self-funded group health plan, have you conducted the required NQTL analysis and have the information on file in case of a DOL audit?

The Consolidated Appropriations Act of 2021 (CAA) requires group health plans that impose a non-quantitative treatment limitation (NQTL) on mental health or substance abuse disorder benefits to

perform and document a comparative analysis of the NQTL's design and application. Beginning February 10, 2021 the comparative analysis must be made available to state and federal agencies upon request. For self-funded plans, the responsibility for the analysis is on the plan sponsor.

YOUR RESPONSE: **N/A. Our group health plan is fully insured and therefore, we rely on the carrier to provide the required analysis**

POINTS SCORE: **1/1 possible points**

KEY ISSUES

Based on the information you provided, it appears this requirement does not apply to your plans. However, you should always verify with a compliance expert because these determinations can be complex.

If you have a fully-insured group health plan, have you requested and received the required NQTL analysis from your carrier?

The Consolidated Appropriations Act of 2021 (CAA) requires group health plans that impose a non-quantitative treatment limitation (NQTL) on mental health or substance abuse disorder benefits to perform and document a comparative analysis of the NQTL's design and application. Beginning February 10, 2021 the comparative analysis must be made available to state and federal agencies upon request. For fully-insured plans, the analysis is typically completed by the insurance carrier.

YOUR RESPONSE: **No**

POINTS SCORE: **0/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are NOT meeting this requirement.

It is important to ensure the fully insured carrier has conducted the required analysis on behalf of your plan. Failing to comply with this requirement can lead to inadvertent violations and participant lawsuits. In addition, employers have only 14 days to respond to an agency's request for a copy of the required analysis. It is important to have the analysis readily available.

How do you meet the RxDC reporting requirements required by the Consolidated Appropriations Act of 2021 (CAA)?

Under the CAA, plans must report certain information related to plan medical costs and prescription drug spending to the Tri-Agencies (DOL, HHS, Treasury). The reporting is based on calendar year plan data and is due each June 1st following the applicable calendar year.

YOUR RESPONSE: **Our group health plan is fully-insured and the insurance**

carrier has confirmed they are reporting the required data on behalf of our plan

POINTS SCORE: **2/2 possible points**

KEY ISSUES

Based on the information you provided, it appears you are meeting this requirement.

How do you meet the Machine Readable File requirements under the Transparency in Coverage Rule?

The Transparency in Coverage Rules require non-grandfathered plans to post certain machine-readable files (MRF) to their public website for plan years beginning on or after July 1, 2022. There are 3 required files: 1) network rates for all covered items/services; 2) out-of-network billed charges and payments; and 3) in-network prescription drug rates and historical prices (this third file requirement has been postponed indefinitely).

YOUR RESPONSE: **Our group health plan is fully-insured and we have received information in writing from our insurance carrier that they have published the required files to their publicly available website**

POINTS SCORE: **1/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are meeting this requirement.

The Transparency in Coverage Rules require non-grandfathered plans to post certain machine-readable files (MRF) to their public website for plan years beginning on or after July 1, 2022. There are 3 required files: 1) network rates for all covered items/services; 2) out-of-network billed charges and payments; and 3) in-network prescription drug rates and historical prices (this third file requirement has been postponed indefinitely).

Does your plan keep an updated provider directory that is available electronically and/or printed for your members?

The Consolidated Appropriations Act of 2021 (CAA) requires group health plans to keep an up-to-date provider directory that is accessible to members.

YOUR RESPONSE: **Our group health plan is fully-insured and the carrier does provide an up-to-date provider directory**

POINTS SCORE: **1/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are meeting this requirement.

Do your member ID cards comply with the Consolidated Appropriations Act of 2021 (CAA) requirements?

Under the Consolidated Appropriations Act of 2021 (CAA), plans are required to include certain information on their member ID cards: 1) in-network deductible and maximum out-of-pocket; 2) out-of-network deductible and maximum out-of-pocket; and 3) a phone number and website address where members can obtain support and provider information.

YOUR RESPONSE: **Our group health plan is fully-insured and our insurance carrier prints the ID cards for our plan**

POINTS SCORE: **1/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are meeting this requirement.

Have your plans been amended to include Independent Dispute Resolution (IDR) requirements under the Consolidated Appropriations Act of 2021 (CAA) requirements?

The Consolidated Appropriations Act of 2021 (CAA) establishes an independent dispute resolution (IDR) process for out-of-network providers and group health plans to resolve disputes over claims subject to the No Surprises Act (NSA). The requirements apply to emergency items and services provided in a hospital's emergency department or in a freestanding emergency department.

YOUR RESPONSE: **Our group health plan is fully-insured and we have verified with our insurance carrier that this provision has been incorporated into our plan**

POINTS SCORE: **1/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are meeting this requirement.

Do your plans allow members to continue benefits for up to

90 days and pay benefits at in-network rates when a provider terminates a contract and is no longer part of the network?

The Consolidated Appropriations Act of 2021 (CAA) requires plans to continue benefits for members up to 90 days at in-network rates when a provider contract terminates and the provider is no longer participating in the plan's network.

YOUR RESPONSE: **Our group health plan is fully-insured and we have verified with our insurance carrier that our plan does allow this provision**

POINTS SCORE: **1/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are meeting this requirement.

Do your plans provide a cost comparison tool by phone and online for members to access real time, cost sharing information?

Effective January 1, 2023, group health plans are required to provide a cost comparison tool online and by phone that includes real-time, cost sharing information that is accurate at the time of the request.

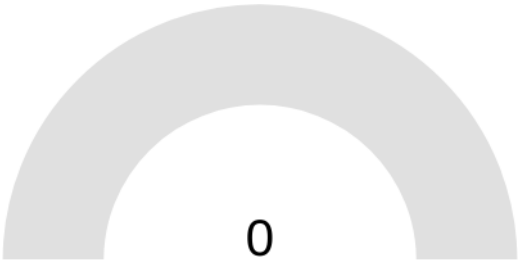
YOUR RESPONSE: **Our group health plan is fully-insured and we have verified with our insurance carrier that this tool is available and compliant with these requirements**

POINTS SCORE: **1/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are meeting this requirement.

HIPAA & HITECH



Median • 60

Do you have written HIPAA Privacy and Security Policies in place to protect Protected Health Information (PHI)?

A group health plan is considered a "Covered Entity" under HIPAA. Self-funded plans and fully-insured plans that have access to PHI are subject to all of HIPAA's privacy and security requirements, including implementing policies that restrict how PHI can be used and disclosed, and adopting administrative, physical, and technical safeguards to protect electronic PHI.

YOUR RESPONSE: **No**

POINTS SCORE: **0/2 possible points**

KEY ISSUES

Based on the information you provided, it appears you are NOT meeting this requirement.

Failing to have HIPAA Privacy and Security policies in place can have significant consequences if PHI is not properly protected. Penalties for failing to comply with HIPAA vary according to the nature of the violation. Penalties of up to $63,973 per violation, with a cap of $1.9 million can apply.

Does your HIPAA Privacy and Security Policies include a breach notification policy?

Under the Health Information Technology for Economic and Clinical Health Act (HITECH Act), detailed breach notification requirements were implemented for covered entities. Upon discovering a breach of PHI, a covered entity must meet strict breach notification requirements that include specific content, method and timing requirements.

YOUR RESPONSE: **No or Unsure**

POINTS SCORE: **0/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are NOT meeting this requirement.

Plans need to be prepared if an unauthorized disclosure of PHI occurs. There are requirements to notify affected employees that their personal information may have been compromised. In addition, notice is required to HHS and prominent media outlets in certain situations. Penalties for failing to comply with HIPAA vary according to the nature of the violation. Penalties of up to $63,973 per violation, with a cap of $1.9 million can apply.

Do you perform an annual risk assessment as required by HIPAA?

Under HIPAA's Security Rule, a risk assessment is required to identify potential risk and vulnerabilities to the confidentiality, integrity and availability of electronic PHI held by a group health plan. The risk assessment should be performed annually to account for changes in business practices and any changes in HIPAA law.

YOUR RESPONSE: **No**

POINTS SCORE: **0/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are NOT meeting this requirement.

A risk assessment helps detect any vulnerabilities that could lead to an unauthorized disclosure of PHI. Penalties under HIPAA vary according to the nature of the violation up to $63,973 per violation, with a cap of $1.9 million.

Do you provide a copy of the HIPAA Privacy and Security Policies to your employees?

Distributing copies of your HIPAA Privacy and Security Policies to employees is necessary to enforce the requirements to protect PHI and the process an employee must follow for reporting a possible breach. It is suggested that employers require employees to attest to receiving copies of the policies.

YOUR RESPONSE: **No**

POINTS SCORE: **0/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are NOT meeting this requirement.

These policies provide guidelines for employees to protect PHI and when and how it may be used and disclosed. Proper education is essential to avoid an unauthorized disclosure of PHI that could lead to penalties. Based on the information you provided, it appears you are NOT meeting this requirement. Penalties under HIPAA vary according to the nature of the violation. Penalties of up to $63,973 per violation, with a cap of $1.9 million can apply.

Do you have a HIPAA Business Associate Agreement (BAA) in place with any outside parties who have access to your employees' PHI?

HIPAA's Security Rule permits a group health plan to disclose PHI to a Business Associate, a person or entity that performs functions, activities or services on behalf of the plan if the Business Associate appropriately safeguards the information. A group health plan is required to have Business Associate Agreements with any entity who creates, maintains, receives or transmits PHI on behalf of the plan.

YOUR RESPONSE: **No or Unsure**

POINTS SCORE: **0/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are NOT meeting this requirement.

Business Associate Agreements are a requirement. Penalties under HIPAA vary according to the nature of the violation. Penalties of up to $63,973 per violation, with a cap of $1.9 million can apply.

Your next step should be to take inventory of any service providers associated with the plan and verify a compliant BAA is in place if they may have access to any PHI.

Do you have an assigned HIPAA privacy officer, security officer and compliance officer in charge of securing PHI and interfacing with outside entities who may access PHI?

HIPAA requires a Covered Entity to assign a person or persons to be responsible for ensuring compliance with the Privacy and Security Rules. The privacy officer is responsible for enforcing policies to protect the integrity of PHI, conducting risk assessments and overseeing the privacy training of employees. The security officer is responsible for enforcing the administrative, physical, and technical safeguards required under the Privacy Rule.

YOUR RESPONSE: **No**

POINTS SCORE: **0/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are NOT meeting this requirement.

Proper designation of an employee or employees responsible for ensuring compliance with HIPAA's Privacy and Security Rules is essential to avoid an unauthorized disclosure of PHI that could lead to penalties. Penalties under HIPAA vary according to the nature of the violation. Penalties of up to $63,973 per violation, with a cap of $1.9 million can apply.

Do you provide initial and annual HIPAA training to your compliance officer and to others who handle or access PHI?

HIPAA requires mandatory, ongoing training for employees of Covered Entities who have access to PHI. HIPAA training is required for "each new member of the workforce within a reasonable period of time after the person joins the Covered Entity's workforce" and also when "functions are affected by a material change in policies or procedures" – within a reasonable period of time. A best practice is to conduct training exercises annually.

YOUR RESPONSE: **No**

POINTS SCORE: **0/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are NOT meeting this requirement.

Ongoing HIPAA training is required and is essential to avoid an unauthorized disclosure of PHI that could lead to penalties. Penalties under HIPAA vary according to the nature of the violation. Penalties of up to $63,973 per violation, with a cap of $1.9 million can apply.

Do you have mechanisms in place to secure all PHI from access by outside parties? Physically and electronically?

Under HIPAA's Security Rule, a Covered Entity is required to implement appropriate, effective security measures to protect PHI and ePHI. This includes physical safeguards to protect the physical security of offices where PHI may be stored or maintained and technical safeguards that include measures to keep ePHI secure.

YOUR RESPONSE: **No**

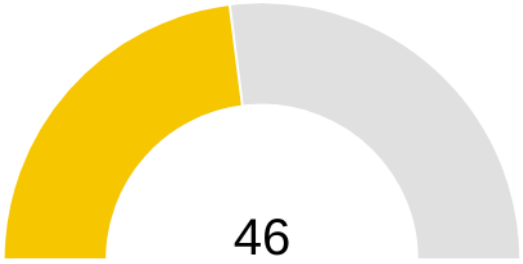
POINTS SCORE: **0/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are NOT meeting this requirement.

Failing to have these mechanisms in place increases the risk of an unauthorized disclosure of PHI. Penalties under HIPAA vary according to the nature of the violation. Penalties of up to $63,973 per violation, with a cap of $1.9 million can apply.

COBRA



Median • 60

How do you handle COBRA administration for your organization?

Employers with 20 or more employees on a typically business day during the previous calendar year must offer COBRA continuation coverage to qualified beneficiaries who lose coverage due to a qualifying event. Employees of related companies are aggregated and if the total is over the 20 employee threshold, all related companies are subject to COBRA regardless.

YOUR RESPONSE: **Third Party Vendor**

POINTS SCORE: **1/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are meeting this requirement.

Do you offer COBRA continuation coverage options for all COBRA eligible benefits to covered employees and beneficiaries who experience a qualifying event?

COBRA applies to all group health plans maintained by an employer. This includes medical, dental, vision, HRAs, health FSAs, and certain EAP and wellness programs.

YOUR RESPONSE: **Yes**

POINTS SCORE: **1/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are meeting this requirement.

Do you provide the Initial General COBRA Notice to newly covered participants and their covered spouse/dependents within 90 days of their effective date of coverage?

A group health plan subject to COBRA must furnish each covered employee (and spouse) with a written notice of COBRA rights within 90 days of the effective date of coverage. The DOL provides a Model Notice that can be used.

YOUR RESPONSE: **No**

POINTS SCORE: **0/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are NOT meeting this requirement.

Statutory penalties of $110 per day apply for the plan's failure to provide required COBRA notices.

Do you provide the Initial General COBRA Notice via first class mail, addressed to the covered employee, spouse and dependents?

Under the COBRA regulations, the Initial General Notice must be furnished in a manner consistent with DOL requirements and is required to be provided to the covered employee AND covered spouse. The DOL disclosure regulations specifically approve first class mailing.

YOUR RESPONSE: **No**

POINTS SCORE: **0/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are NOT meeting this requirement.

COBRA requires the Initial General COBRA Notice to be provided to newly covered participants AND their covered spouse. DOL approved delivery methods are USPS first-class mail or second - or third-class mail with return/forwarding postage and address correction. Statutory penalties of $110 per day apply for the plan's failure to provide required COBRA notices.

Do you have processes in place to document and track when COBRA Notices are sent?

The recommended method for proving that the plan has provided all of the required COBRA notices is to 1) obtain a USPS proof of mailing certificate; 2) maintain copies of the actual notices sent; and 3) be able to provide testimony that the procedure was followed by individuals involved in the process.

YOUR RESPONSE: **No**

POINTS SCORE: **0/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are NOT meeting this requirement.

Plans must adequately document processes and be able to prove that notices were actually provided within the applicable timeframes in the event of an audit or a participant dispute. This information should be maintained for several years. Failure to properly document and track COBRA notice activity can result in IRS excise taxes up to $200 per day for each day the plan fails to prove compliance and statutory penalties of $110 per day for the plan's failure to prove the required COBRA notices were provided timely. In addition, qualified beneficiaries may sue to recover damages including medical expenses due to the plan's failure to offer COBRA coverage and attorney's fees.

During open enrollment each year, do you distribute enrollment materials to COBRA participants and allow them to make changes/enroll?

Under the regulations, a qualified beneficiary who is receiving COBRA continuation coverage may change coverage options during open enrollment. The same open enrollment rights apply to qualified beneficiaries that apply to active employees.

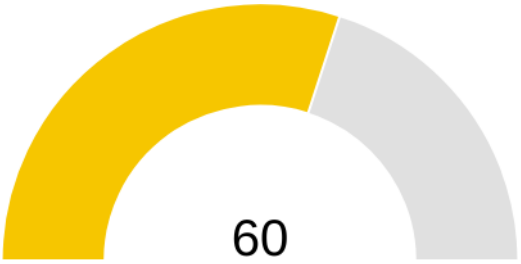
YOUR RESPONSE: **Yes**

POINTS SCORE: **1/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are meeting this requirement.

Form 5500



Median • 73

Do you file a Form 5500 within 7 months after the end of the plan year for each health and welfare benefit plan that covers more than 100 participants at the beginning of the plan year or funded through a trust?

ERISA requires "funded" and "large" welfare benefit plans to file an annual Form 5500 filing with the DOL within seven (7) months after the end of the plan year. Small, fully insured and unfunded plans covering less than 100 participants are exempt from the filing requirement.

YOUR RESPONSE: **Yes**

POINTS SCORE: **1/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are meeting this requirement.

If you file a consolidated Form 5500 annually for your health and welfare benefit plans, do you have an ERISA wrap document/SPD in place?

In general, each welfare benefit is considered a separate ERISA plan and therefore, separate Form 5500 filings are required. However, an employer may choose to combine more than one welfare benefit into a single plan for ERISA purposes, including the Form 5500 filing requirement. If an employer is filing a consolidated Form 5500 for multiple welfare benefits, an ERISA wrap document/SPD is necessary to avoid potential compliance issues.

YOUR RESPONSE: **No or Unsure**

POINTS SCORE: **0/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are NOT meeting this requirement.

In general, each welfare benefit plan is considered a separate ERISA plan and therefore, should be filing separate Form 5500 filings unless the benefits are combined in a single plan for ERISA purposes. The DOL could impose penalties of up to $2,259 per day for failing to comply with the Form 5500 filing requirements.

Do you distribute a Summary Annual Report (SAR) to all participants annually, within 9 months following the end of plan year?

ERISA requires plan sponsors to provide covered participants and certain beneficiaries with an annual statement summarizing the latest annual Form 5500 report for the plan. The Summary Annual Report (SAR) is a narrative statement of the more important information reflected in the plan's Form 5500. The SAR must be distributed within nine (9) months after the end of the plan year. Or if an extension has been filed for the Form 5500 filing, within two (2) months following the due date.

YOUR RESPONSE: **No**

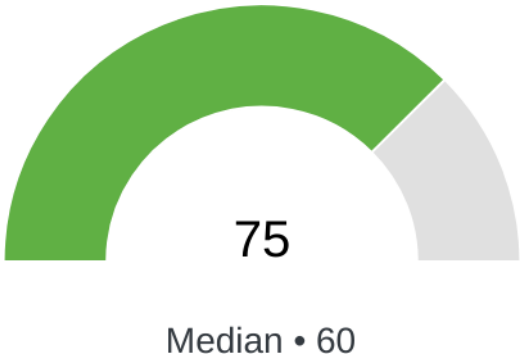
POINTS SCORE: **0/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are NOT meeting this requirement.

Although there are no specific penalties for failing to timely distribute the SAR, an employer can be sued by participants and beneficiaries to enforce the requirement and seek penalties for failure to respond to a request. Criminal penalties may also be imposed on any individual or employer who willfully violates any ERISA disclosure requirement.

FMLA & Leaves of Absence



If you are subject to FMLA, how do you comply with the FMLA notice requirements?

The Family and Medical Leave Act (FMLA) generally requires covered employers to permit eligible

employees to take unpaid, job-protected leave under certain circumstances. FMLA applies to private-sector employers with 50 or more employees for each working day in 20 or more workweeks in the current or preceding calendar year. It also applies to all public agencies and local educational agencies regardless of size.

YOUR RESPONSE: **Third party vendor**

POINTS SCORE: **1/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are meeting this requirement.

Do you have clear administrative procedures in place including how the employee's portion of premiums will be handled while they are out on FMLA or non-FMLA leave of absence?

During FMLA leave, the employer cannot require the employee to pay more for coverage that what the employee was paying while actively at work. During leave, the employer is required to provide the employee with advance written notice of the conditions under which the employee's share of premiums must be made and this should be applied on a non-discriminatory basis.

Having a formal policy for both FMLA and non-FMLA leaves of absence regarding payment of premiums is best practice to ensure nondiscriminatory practices and avoid disputes.

YOUR RESPONSE: **No**

POINTS SCORE: **0/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are NOT meeting this requirement.

The FMLA regulation require the employer to provide the employee with advance written notice of the conditions under which payments must be made. Employers who willfully violate FMLA may be subject to civil penalties by the DOL's Wage and Hour Division of $189 for each offense.

Do you display the poster prepared by the DOL summarizing major provisions of the FMLA in a conspicuous place where employees can see it?

All covered employers are required to display a poster in plain view for all workers and applicants to see, notifying them of the FMLA provisions and providing information on how to file a complaint with the Wage and Hour Division.

YOUR RESPONSE: **Yes**

POINTS SCORE: **1/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are meeting this requirement.

For non-FMLA leaves of absence, do you have a policy in place and a clear process for how coverage will be handled during the leave?

Although not required, many employers permit employees to take non-FMLA leaves of absence. It is important to have a formal policy in place. An established leave policy protects employers by setting out expectations and guidelines for requesting, approving and denying a request for a leave. The policy should address how benefits are handling during leave to avoid ambiguity and setting unintended precedents.

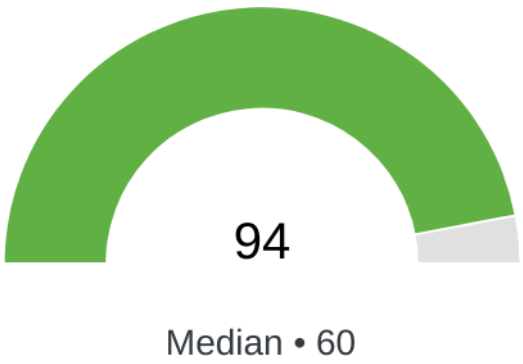
YOUR RESPONSE: **Yes**

POINTS SCORE: **1/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are meeting this requirement.

125 Cafeteria, 105(h), & Wellness



If you allow your employees to pay for any portion of their health insurance premiums on a pre-tax basis, do you have a Section 125 Cafeteria Plan document?

In order for employees to pay for benefits with pre-tax dollars, the IRS requires the employer to have a Section 125 Cafeteria Plan in place. The employer must have a written, up-to-date plan document and

SPD that has been formally adopted by the employer. If these requirements are not met, the employees will be taxed on the cost of their benefits and the employer will be taxed on the missed FICA taxes.

YOUR RESPONSE: **Yes**

POINTS SCORE: **1/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are meeting this requirement.

If your organization is an S Corporation, Partnership, or LLC do you allow owners, partners, or members to pay for benefits on a pre-tax basis?

The IRS prohibits self-employed individuals from participating in a Section 125 Cafeteria Plan. This includes more than 2% shareholders in an S Corporation, a sole proprietor, partners in a partnership and members of an LLC. In addition, the family attribution rules under IRC 318 apply.

YOUR RESPONSE: **N/A, we are not an S Corporation, Partnership or LLC**

POINTS SCORE: **1/1 possible points**

KEY ISSUES

Based on the information you provided, it appears this requirement does not apply to your plans. However, you should always verify with a compliance expert because these determinations can be complex.

Do you limit mid-year election changes to your benefits to only those allowable under HIPAA and IRC Section 125?

Under IRS rules, participants under a Section 125 Cafeteria Plan are not allowed to change their elections mid-year without a qualifying event. Permitted mid-year election changes are set forth in Treas. Reg. 1.125-4.

YOUR RESPONSE: **Yes**

POINTS SCORE: **1/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are meeting this requirement.

Is your Section 125 Cafeteria Plan document newer than 2014?

Certain changes affecting Cafeteria Plans went into effect in 2014 as a result of the Affordable Care Act (ACA). A Cafeteria Plan document that is older than 2014 is likely not in compliance with IRS regulations.

YOUR RESPONSE: **No**

POINTS SCORE: **0/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are NOT meeting this requirement.

Several changes to the Section 125 Cafeteria Plan regulations were effective in 2014 as a result of the Affordable Care Act (ACA). Plan documents and SPDs were required to be updated due to these mandatory legislative changes. If your plan document is older than 2014, it is likely not compliant with current IRS requirements. This could cause disqualification of the plan and cause income tax implications to both the employee and employer.

Do your FSA Accounts limit contributions to the IRS allowable amounts?

Effective with plan years beginning in or after 2013, the IRS imposes a limit on annual salary reduction contributions to health FSAs. The limit is indexed each year for cost-of-living adjustments. In addition, the IRS has always imposed a limit on the Dependent Care FSA.

YOUR RESPONSE: **Yes**

POINTS SCORE: **1/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are meeting this requirement.

Do you conduct the required annual nondiscrimination testing for your POP and/or FSA Accounts?

The IRS requires nondiscrimination testing for Cafeteria Plans because both the employee and employer receive favorable tax treatment. The Code's nondiscrimination rules are generally designed to prevent plans from discriminating in favor of individuals who are either highly compensated or otherwise key to the business. The testing is required to be performed annually. There is a Safe Harbor for Premium Only Cafeteria Plans (POP).

YOUR RESPONSE: **Yes**

POINTS SCORE: **1/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are meeting this requirement.

If you offer HSAs, do you make sure HSA contributions are made equally to all eligible participants?

An employer that makes contributions to its employees' HSA accounts outside of a Cafeteria Plan must meet the comparability rules, meaning contributions must be uniform for all employees with few exceptions. HSA contributions made within a Cafeteria Plan are not subject to the comparability rules. However, those contributions are subject to the nondiscrimination testing requirements under IRC 125.

YOUR RESPONSE: **Yes**

POINTS SCORE: **1/1 possible points**

KEY ISSUES

Based on the information you provided, it appears you are meeting this requirement.

If you have a self-funded group health plan, how do you conduct annual nondiscrimination testing as required under IRC Section 105(h)?

A self-funded group health plan is subject to the nondiscrimination requirements under IRC 105(h). There are two tests that must be performed annually: 1) Eligibility Test; and 2) Benefits Test. Note that 105(h) testing requires deeper analysis than what this assessment covers to address issues, such as how the employee's portion of premium is determined, equitable plan options offered to all employees, and waiting periods. This should be addressed with a compliance expert.

YOUR RESPONSE: **N/A. We do not have a self-funded group health plan**

POINTS SCORE: **1/1 possible points**

KEY ISSUES

Based on the information you provided, it appears this requirement does not apply to your plans. However, you should always verify with a compliance expert because these determinations can be complex.

If offering a Wellness Program with health contingent rewards based on a medical exam for the spouse, do you obtain spousal authorization?

If a wellness program includes a health risk assessment or medical examination/test for spouses, GINA requires a voluntary authorization prior to providing family medical history or genetic information.

YOUR RESPONSE: **N/A. We do not offer a wellness program or we do not require a medical exam for the spouse**

POINTS SCORE: **1/1 possible points**

KEY ISSUES

Based on the information you provided, it appears this requirement does not apply to your plans. However, you should always verify with a compliance expert because these determinations can be complex.

If you are subject to the ADA, do you distribute the ADA Wellness Program Notice prior to collecting health information from your participants?

If a wellness program requires a health risk assessment or medical exam/test, the ADA requires employees to receive a notice describing the information to be collected and how that information will be used, shared and kept confidential.

YOUR RESPONSE: **N/A. We do not offer a wellness program**

POINTS SCORE: **1/1 possible points**

KEY ISSUES

Based on the information you provided, it appears this requirement does not apply to your plans. However, you should always verify with a compliance expert because these determinations can be complex.

If your wellness program offers a reward based on an individual's ability to meet a standard related to a health factor, do you provide an annual HIPAA Wellness Program disclosure statement to plan participants?

Under HIPAA, health-contingent wellness programs must provide a reasonable alternative standard to those individuals for whom it is unreasonably difficult due to a medical condition to satisfy the original standard. The availability of a reasonable alternative standard must be disclosed in all plan materials describing the terms of the program. This includes tobacco cessation programs.

YOUR RESPONSE: **N/A. We do not offer a wellness program**

POINTS SCORE: **1/1 possible points**

KEY ISSUES

Based on the information you provided, it appears this requirement does not apply to your plans. However, you should always verify with a

compliance expert because these determinations can be complex.

Do you provide an annual HIPAA/ACA Wellness Program disclosure statement to plan participants?

If a wellness program provides a health-contingent incentive, a notice is required under HIPAA's nondiscrimination provision.

YOUR RESPONSE: **N/A. We do not offer a wellness program or our wellness program does not include a health-contingent incentive**

POINTS SCORE: **1/1 possible points**

KEY ISSUES

Based on the information you provided, it appears this requirement does not apply to your plans. However, you should always verify with a compliance expert because these determinations can be complex.

Is participation in your wellness program limited based on health, disability, or genetic information?

Wellness programs cannot base participation on health, disability or genetic information. This includes asking questions about family medical history. This includes asking questions about family medical history.

YOUR RESPONSE: **N/A. We do not offer a wellness program**

POINTS SCORE: **1/1 possible points**

KEY ISSUES

Based on the information you provided, it appears this requirement does not apply to your plans. However, you should always verify with a compliance expert because these determinations can be complex.

For those rewards that are considered taxable income, are you providing a value for and taxing the rewards provided to a participant as part of your wellness program?

Wellness programs that reward participants in the form of cash or cash equivalents must include this amount in the employee's taxable income for the year. Certain other rewards can be provided tax-free, such as lower premiums or additional employer contributions.

YOUR RESPONSE: **N/A. We do not offer a wellness program**

POINTS SCORE: **1/1 possible points**

KEY ISSUES

Based on the information you provided, it appears this requirement does not apply to your plans. However, you should always verify with a compliance expert because these determinations can be complex.