PROFESSIONAL GROUP PLANS
Specializing in Employee Benefits

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COMPLIANCE

DOL Audit Checklist

Are your clients prepared in the event of a DOL Audit? The audit of health and welfare plans by the DOL (Department of Labor) can be an extremely stressful experience for any business. The key to surviving an audit successfully is knowing what to expect and being prepared. Below is an example of items typically requested in a DOL Audit letter. With DOL audits on the rise Professional Group Plans is here to help you pro-actively prepare so you can make it through and audit confident and worry-free.

REQUESTED ITEMS
1. Plan document
2. Summary Plan Description (SPD), including any changes in Plan benefits and entitlement benefits
3. All contracts with insurance companies for the provision of health benefits
4. If self-insured, all contracts for claims processing, administrative services, and reinsurance
5. Documents which describe the responsibilities of both the employer and employees with respect to the payment of costs associated with the purchase and maintenance of health and welfare benefits
6: In accordance with the Health Insurance Portability and Accountability Act of 1996, please provide the following records:
a. A copy of the Plan's rules for eligibility 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 converge 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 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 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 of adoption, including any lists or logs and administrator may keep of issued notices; and
j. A copy of the written appeal procedures established by the Plan
7. A copy of the Plan's rules regarding coverage of medical/surgical and mental health benefits, including information as to any aggregate lifetime dollar limits and annual dollar limits
8. The Plan's Newborns' Act notice (this should appear in the plan's SPD), including lists or logs of notices and administrator may keep of issued notices

We are here to help with all of your compliance needs.

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

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

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

12. Materials describing any wellness program 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

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

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

    b. Records documenting the terms of the Plan in effect on March 23, 2010 and any other documents necessary to verify, explain or clarify status as a grandfathered health plan. This may include documentation relating to the terms of cost sharing (fixed and percentage), the contribution rate of the employer or employee organization towards the cost of any tier of coverage, annual and lifetime limits on benefits, and if applicable, any contract with a health insurance issuer, which were in effect on March 23, 2010

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

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

    b. If the Plan has rescinded any participant's or beneficiary's coverage, 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 Sept. 23, 2010, please provide documents showing the limits applicable for each plan year on or after Sept 23, 2010. Please provide a sample of any notice sent to the participants or beneficiaries stating that the lifetime limit on the dollar value of all benefits no longer applies and that the individual, if covered, is once again eligible for benefits under the plan

    d. If the Plan imposes an annual limit or has imposed an annual limit at any point since Sept. 23, 2010, please provide documents showing the limits applicable for each plan year on or after Sept 23, 2010.

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

    a. A copy of the choice of provider notice informing participants of the right to designate any participating primary care provider, physicians 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 Sept. 23, 2010

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

    d. Copy of the Plan's Internal Claim and Appeals and External Review processes; determination notice, and notice of final external review decision

    e. Copies of notice of adverse benefit determination, notice of final internal adverse

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