EMPLOYEE BENEFIT COMPLIANCE CHECKLIST

Plan Administration

Fiduciary
- Ensures participants receive promised benefits and rights are not violated. Carry out duties in a prudent manner, avoiding any conflicts of interest. Manage plans for the exclusive benefit of participants and beneficiaries.
- Report and disclose information on benefit plans to participants and governing agencies as required.
- Maintains fiduciary bond, if duties create fraud risk for benefit funds.
  - Consider if you have physical contact or access to deposits, payments, custody or power to transfer property. Not needed if payments are direct from general assets to providers.

Documentation/Record Keeping
- Maintains a plan document or SPD Wrap that includes a plan document and SPD.
- Determines whether or not Company is an Applicable Large Employer (ALE) and elects to offer coverage or pay fines accordingly (ALE if average 50+ FT or full-time equivalent employees during the prior calendar year).
- Maintains records of insurance billings, premium schedules and payment withholdings.
- Keeps record of anyone where coverage had been rescinded and 30-days advance notice of such rescission of coverage.
- Oversees records of plan’s internal claims, and appeals process.
- Maintains evidence of plan’s compliance with the Affordable Care Act and following all applicable requirements.
- Keeps all materials explaining wellness or disease management programs, if applicable.

Open Enrollment/Communications
- Reviews plan alternatives and coverage options annually looking out for the best interest of participants, beneficiaries and the company.
- Allows participants to enroll or make changes to benefits once a year during open enrollment, unless they experience a qualifying event allowing an additional opportunity to make changes to benefits.
- Follows guidelines allowing participants to make changes mid-year for allowable qualifying events such as loss of coverage, marriage, new baby, divorce, etc.
- Communicates all plan options, rights and rates to eligible participants, including COBRA participants.
- Collects an application or waiver form from all eligible participants.

Administration, Eligibility & Participation - Medical Insurance
Maintains clearly defined benefit eligibility for participation in all benefit plans and allows participation accordingly.

Allows participation in medical insurance for FT employees who average 30 or more work hours per week. If offering part-time employees coverage, is consistent in allowing participation and has this defined in plan documents.

Maintains clearly defined employment categories for full-time (FT), part-time (PT), temporary and seasonal employees.

Allows medical insurance to start no later than 90-days from date of hire for full-time employees (unless using a 30-day orientation period).

Offers benefit coverage to all eligible employees

Collects a completed application or waiver from all eligible participants.

Maintains a measurement period defining the time period to determine eligibility using a monthly method or look back of 90-days to 12 months approach. Anyone averaging 30-hours are more for their defined measurement period is allowed to participate. May define different measurement periods for new hires and ongoing employees.

Defines an administrative period of 30 to 90-days following the measurement period to determine eligibility and get participants on the plan. The combined measurement period and administrative period cannot be more than 13 months for new employees.

Manages a stability period allowing participants to remain on the medical plan, once they meet measurement period requirements for a time period of 6 months or the same time as the measurement period months, whichever is greater.

Does not discriminate in medical insurance and other tax-favored benefits toward highly compensated employees, key employees or owners.

Pays applicable Patient Centered Outcomes Research Institute fees by July 31st (PCORI Fees) of each year.

Provides participants with any applicable refund of Medical Loss Ratio (MLR) insurance rebates, if applicable.

**Benefit Termination / Qualifying Events**

Notifies plan providers of employee termination date and time to remove them from coverage.

Provides HIPAA Certification of Creditable Coverage Notice or confirms this notice is sent by provider.

Sends qualifying event continuation of coverage (COBRA) notice to participant and beneficiaries (or notifies outsourced COBRA provider of the need to send notice).

**Disclosures & Notifications** - If offering medical insurance, provide the following applicable notices to eligible participants and beneficiaries annually, unless noted otherwise:

- Summary of Benefits & Coverage (SBC) - Given to new participants upon application and annually to all participants for renewal.
- Patient protection and provider selection notification (all medical plans, if applicable).
- Grandfathered plan notice (only if you have a grandfathered plan).
- Mental Health Parity and Addiction Equity Notice (50 employees +).
- Employee Notice of Exchange (All employers to all employees) within 14 days of hire.
- Initial COBRA Notice (20+ employees) or State continuation notice (< 20 employees if required by your state).
- HIPAA Notice of Privacy Practices (all plans).
- Special enrollment rights notice (all plans).
- Women’s Health & Cancer Rights Act Notice (all plans).
☐ Newborn’s and Mother’s Health Protect Act Notice.
☐ Children’s Health Insurance Program (CHIP) Reauthorization Act Notice (if applicable to your state).
☐ Wellness Program Disclosure (if offering a health contingent wellness program in order to obtain a reward).
☐ Summary of Material Modifications (SMM) - Given for modifications of the plan that are material within 210 days after the end of the plan year in which a modification or change is adopted. Communicates material plan reductions within 60 days of the change and plan terminations 60 days in advance.
☐ Qualified medical child support order receipt and determination handling – responds to such notices within 20 business days of the date of notice.
☐ Medicare Part D Notice by October 15th (anyone eligible for Medicare).
☐ Registers with the Center for Medicare Services regarding whether or not your prescription drug plan is creditable.
☐ Provides participant’s a list of ERISA rights (all ERISA plans).

**COBRA Administration**

☐ Maintains a COBRA administration policy and procedures or outsources COBRA administration to ensure all rights and responsibilities are met.
☐ Provides initial/general COBRA notice to new participants within 90-days of joining the plan.
☐ Provides qualifying event or election notices within 14-days of a qualifying event such as termination of employment and other loss of coverage events.
☐ Collects COBRA participant’s premium payments and pays on their behalf to insurance providers.
☐ Provides COBRA participants with benefit plan information, changes, rights and costs similar to information given to employee participants.
☐ Allows COBRA rights for past employees and eligible dependents.
☐ Allows participants to stay on for their eligible amount of time.
☐ Provides notice of unavailable continuation of coverage for the following:
  - If someone applies for continuation coverage and is not eligible.
  - If participants are 30-days or later on making COBRA premium payment.
  - When the plan is about to terminate.
    ▪ Provides details about the date the plan terminates, reason for termination and applicable rights, if any.

**HIPAA Privacy Policies and Practices** (if handling Protected Health Information (PHI)).

☐ Designates a HIPAA Privacy Officer who has responsibility for HIPAA program and maintenance.
☐ Maintains a HIPAA policy defining permitted use and disclosure of PHI. Documentation and retention, complaint procedure and documentation and retention.
☐ Maintains privacy safeguards in storing and transmitting data, both physical and electronic information.
☐ Takes steps to minimize or eliminate handling of PHI.
☐ Secures a business associate agreement with any outside party who handles or has access to company PHI.
Summary Plan Descriptions (SPD) or SPD Wrap Documents
☐ Provides a summary plan description for each group benefit plan offered or use an SPD Wrap document.
☐ Distributes the SPD or SPD Wrap to new participants within 90-days of their joining benefit plans.
☐ Distributes an updated SPD or SPD Wrap to ongoing employees at least every 5 years.
☐ Maintains current plan documents and SPDS or SPD Wrap.

125 Premium Only Plans (POP) (If allowing payment of eligible premiums on a pre-tax basis and does not have an FSA)
☐ Maintains an up-to-date 125 Plan document (later than 2014).
☐ Does not allow owners to participate in the 125 POP plan.
☐ Does not discriminate in favor of Highly Compensated Employees (HCE) in the following nondiscrimination tests:
  ☐ Eligibility Test: Does not exclude non-HCEs from participating in favor of HCEs and key employees.
  ☐ Concentration & Benefit (Utilization) Test: Waiting periods, employee contributions and benefit levels are uniform for participants, not favoring HCE.
  ☐ Key Employee Concentration Test: Key employees do not receive more than 25% of the total of nontaxable benefits provided to all employees.

Flexible Spending Accounts (If allowing payment of eligible premiums on a pre-tax basis and/or allowing payment of eligible uncovered medical cost or work related dependent care on a pre-tax basis)
☐ Participants estimate contributions for medical and/or dependent care spending accounts at the beginning of the year with deductions coming out each pay period.
☐ Changes to contribution levels are not allowed, unless participant experiences a mid-year qualifying event. Changes once a year during open enrollment are allowed.
☐ Contribution amounts for medical FSA are limited to not more than $2,550 (see new annual limit each year).
☐ Distributions to FSA medical and dependent care are only allowed for eligible expenses.
☐ Unused contributions are subject to “use-it-or-lose-it”. Employees are not directly refunded estimated deductions, and they do not carry over to the next year except as defined here.
  • If written into your plan, you may allow a grace period of up to 2.5 months after the end of the plan year to allow qualified deductions.
  • Plans may allow up to $500 of unused amounts remaining at the end of the plan year for medical expenses incurred in the following year.
    ▪ The plan may allow either the grace period or a carryover, but not both.

Health Reimbursement Accounts (if applicable)
☐ Solely funded by the employer. No salary deductions are allowed by participants.
☐ Reimburses eligible participants for qualified medical expenses up to the maximum amount for a coverage period on a tax-free basis.
☐ Are not reported on W-2 or shown as wages.
☐ Carries over unused amounts in the HRA for reimbursement in later years.
☐ Does not allow self-employed individuals to participate.
Health Savings Accounts (if applicable)

- Are made available only to participants in a high deductible health plan (HDHP) (See HDHP limit requirements).
- Does not allow contributions in excess of HSA limits allowed on a pre-tax basis:
  - Family - $6,750 (2016)
  - Allows up to an additional $1,000 for participants who are 55 or older at the end of the tax year.
- Reimbursement are allowed only for eligible medical expenses.
- Allows participants to transfer the contributions to another plan or institution (allows portability).
- Submits forms $498-SA and 1099-SA, as needed to report contributions to and distributions from HSAs.

ACA Reporting (If Applicable Large Employer (ALE) 50+ employees or offering a self-funded medical plan).

- Tracks the following data throughout the year:
  - Employee name
  - Employee SS#
  - Employee address
  - Employee telephone number
  - The month coverage was offered to each employee and each month thereafter for which the employee was eligible for coverage
  - Number of employees (full-time and full-time equivalent)
  - Employee’s cost of the lowest cost monthly premium for self-only
  - Name, SS# OR DOB if no SS# is attainable for spouse and dependents for ALL self-funded plans (ALE and small employers)
- Provides form 1095-C to anyone who was FT for one month during the year by January 31st each year.
- Provides form 1094-C to IRS, along with copies of 1095-C by May 31st, if mailing forms or by June 30th, if done electronically. (If 250 + EEs, must file electronically)
- (If self-funded plan and not ALE) Provides form 1095-B to anyone who was FT for one month during the year by January 31st each year. Provides form 1094-B to the IRS, along with copies of form 1095-B by May 31st, if mailing forms or by June 30th, if done electronically.

ACA W-2 Reporting (if 250 or more W-2s in previous year)

- Shows the cost of coverage under employer’s medical insurance plan showing both amounts paid by employer and employee.

5500 Reporting & Summary Annual Reports (SAR) (100+ participants)

- Files form 5500 report for each group plan that has 100 or more participants or files one 5500 for all benefits at once under a Summary Plan Description (SPD) Wrap document.
- Files form 5500 and any applicable schedules (A, B or C) with in seven months following the end of the plan year, which is the contract year, unless a plan document specifics a different plan year end.
- Provides participants with a Summary Annual Report (SAR).
401(k) Plans
☐ Executes copies of latest plan document, adoption agreement, plan amendments and IRS determination letter.
☐ Maintains an investment policy statement.
☐ Distributes a 401(k) Summary Plan Description (SPD) to participants.
☐ Maintains a list of members of the board of directors and plan trustees/fiduciaries.
☐ Keeps proof of ERISA fidelity bond.
☐ Maintains contact information for all service providers and investment advisor.
☐ Completes Form 5500 annually.
☐ Provides IRS with Form 1099-R reporting on pension distributions.
☐ Conducts annual discrimination testing ensuring that highly compensated employees (HCE) do not benefit more than 25% of non-HCE. Makes any needed adjustments in tax-favored contributions of HCE, if needed to pass discrimination test.
☐ Ensures that employer matches employee contributions per their contact and policy.
☐ Communicates participation rights and provides enrollment materials for newly eligible participants.

Family Medical Leave Act (FMLA) (50+ Employees)
☐ Maintains an up-to-date FMLA policy and procedure.
☐ Continues medical, dental, and vision plans (as well as other voluntary benefits) while someone is out on FMLA.
   • Can require participants to make regular payments or may terminate coverage.
   • Has those going on longer term FMLA sign an agreement to make payments for medical, dental, and vision plans should the employee not return from FMLA leave.
☐ Follows process for FMLA eligibility and approval.
☐ Allows up to 12 weeks FMLA leave either all at once or intermittently.
☐ Tracks FMLA leave and notifies participants when FMLA has expired.

GINA – Genetic Information Nondiscrimination Act
☐ Ensures that employment decisions, including anything dealing with employee benefits, are not based on genetic information.
☐ Does not gather genetic information from employees that could be implied as being used in decision making.

USERRA – Uniformed Services Employment & Re-Employment Rights Act
☐ Maintains a USERRA policy ensuring all military employee rights and employer requirements are covered.
☐ Follows reemployment rights, hiring back military employees who meet requirements.
☐ Does not discriminate against military employees or applicants in all terms of employment.
☐ Allows military employees to use vacation, paid time off and sick leave before military service. Does not require employee to use paid leave times during military service. Entitles employees to same rights and benefits that they would have attained if they had remained continuously employed with the company.
☐ Allows employees performing military service the right to remain on the employer’s medical plan under COBRA continuation for the employee and dependents for up to 24 months while in the military.
☐ Allows returning military employees to join benefit plans.