Documents and Information Requested

The items below should be made available for review. Unless otherwise specified, the period covered by this requested is from January 1, 2011 through the present. Please provide photocopies of documents with an asterisk (*). Additional documentation and photocopies may be requested as a result of our review.

1. **Signed** Plan Documents, Adoption Agreements, Trust Agreements, Wrap documents, and Amendments to Date *

2. Summary Plan Description *

3. **Signed** Forms 5500, audited Plan Financial Statements (if applicable), and all supplemental schedules for the last three years filed *

4. Summary Annual Reports for the last three years filed *

5. Minutes of any Plan or Committee meetings *

6. Financial records, including:

    a. Trust Reports,

    b. Bank and Brokerage Account Statements

    c. Account Ledgers/Journals (Receipts and Disbursements of Plan Assets)

    d. Invoices/Records relating to Expenses and/or Fees paid from Plan Assets

    e. Checkbook registry, canceled checks, and deposit slips

7. Service Provider Contracts or Letters of Engagement (Investment Manager Agreements, Third Party Administrator Contracts, Attorneys, and Accountants) *

8. Latest Fidelity Bond Policy, including all Riders and Endorsements, covering fraud and dishonesty *

9. Latest Fiduciary Liability Insurance Policy (if applicable) *

10. Listing of all officers of the Plan Sponsor and their tenure *

11. Listing of all Plan Trustees and/or Fiduciaries and their tenure *

12. All health insurance contracts and policies including all amendments and riders covering the Plan *

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

14. Documents which describe the responsibilities of both the employer and employees with respect to the payment of the costs associated with the purchase and maintenance of health and welfare benefits

15. A copy of an employee enrollment application in use *

16. Plan and issuer compensation agreements with attending providers for hospital stays in connection with childbirth and reconstructive surgery in connection with a mastectomy *

17. A copy of the following required notices, including lists of logs of issued notices and a description of procedures for distribution *:

    a. Notice of special enrollment rights

    b. Enrollment and annual notices required under the Women's Health and Cancer Rights Act

    c. Newborn's Act notice relating to hospital stays in connection with childbirth

    d. Notice regarding premium assistance under Medicaid or CHIP

    e. Michelle's Law notice

18. To ensure compliance with the HIPAA nondiscrimination rules that prohibit discrimination in individual premiums based on a health factor (including list bill), the following items may be reviewed: health insurance billing invoices, premium schedules, employee and employer contribution schedules, and/or payroll records of withholdings for benefits

19. A sample of the Certificate of Creditable Coverage provided to those employees who have lost health care coverage 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 *

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

21. A copy of the written procedure for individuals to request and receive certificates *

22. A sample general notice of preexisting condition informing individuals of the exclusion period; the terms of the exclusion period, and the right of the 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 *

23. A copy of the necessary criteria for an individual without a certificate of creditable coverage to demonstrate creditable coverage by alternate means *

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

25. Materials describing the Plan's procedures regarding notification to participants of the length of preexisting condition exclusion period that remains after offsetting for prior creditable coverage (if not completely offset) *

26. Materials describing any wellness programs or disease management programs offered by the Plan. If the program offers a reward based on an individual's ability to meet a standard related to a health factor, the Plan should also include its wellness program disclosure statement regarding the availability of a reasonable alternative *

27. 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 *

28. 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, a sample of the written notice describing enrollment opportunities relating to dependent coverage of children up to age 26 *

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

c. If the Plan imposes a lifetime limit or has imposed a lifetime limit at any point since September 23, 2010, please provide documents showing the limits applicable for each plan year on or after September 23, 2010 *
Please provide a sample of any notice sent to participants or beneficiaries stating that the lifetime limit on the dollar value of all benefits no longer applies and that the individual, if covered, is once again eligible for benefits under the plan *

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

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

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

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

    c. Copies of documents relating to the provision of preventative services for each plan year on or after September 23, 1010

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

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

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

30. Notices provided to participants and beneficiaries explaining their rights to continuation of coverage as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), including a list or logs of notices issued *

31. All documents relating to the use or collection of genetic information, for any reason, with respect to the Plan

32. For Plan years or open enrollment periods beginning on or after September 23, 2012, a copy of the Summary of Benefits and Coverage and Uniform Glossary provided to participants (if applicable) *

33. All documents relating to the recipient and disposition of any medical loss ratio rebate paid by an insurer *

34. Any other documents which may explain or clarify the above items