SAMPLE AUDIT QUESTIONS

UBA WisdomStream

GENERAL BACKGROUND

1. What is your title?

2. How long have you been in your current position?

3. Have you held any other positions with the company?

4. What are the duties in your current position?

5. What are your duties with respect to the plan?

6. What is the background of the interviewee?

    a. Any ERISA knowledge/experience?

BACKGROUND OF SPONSOR

7. Who is the plan sponsor?

8. What business is the sponsor engaged in?

9. Where is the sponsor headquartered?

    a. Does the sponsor have more than one business location?

    b. Where?

10. How many employees does the sponsor have?

11. Is the sponsor a publicly held company?
    a. If yes, on which exchange is it traded?

    b. Or is the sponsor a closely held company?

        i. If closely held, who are the owners?

        ii. What are their ownership interests?

12. What is the sponsor's year-end for tax purposes?

13. Who are the sponsor's officers?
    Name:
    Title:
    Tenure:

14. Who are on the sponsor's board of directors?
    Name:
    Title:
    Tenure:

BACKGROUND OF PLAN

15. When was the plan established?

16. Is the plan a Multiple Employer Welfare Arrangement (MEWA) or a multiemployer plan?

17. Is the plan fully insured or self-insured?

    a. If self-insured, does the plan have a trust?

    b. If self-insured, does the plan have an outside claims administrator?

18. How many participants does the plan have (approximately)?

19. When are employees eligible to participate in the plan?

    a. Is coverage effective on that date or the beginning of the following month?

    b. Are there any minimum requirements (age, years of service, etc.)?

20. Are there any employees covered by a collective bargaining agreement (union) participating in the plan?

21. Does the employer maintain any other plans (e.g., pension or welfare)?
    a. Additional Plans Maintained by Employer
        Plan name:
        Established:
        Eligibility/coverage:
        Fully insured or self-funded?

PLAN ADMINISTRATION

22. Who is the plan administrator?

23. What are the duties of the plan administrator?

24. Who handles day-to-day administration of the plan?

25. How long has this person/entity served as plan administrator?

26. Is there an administrative committee?

    a. What are its duties?

    b. How often does the committee meet?

    c. How was the committee selected?

    d. Members:
       Name:
       Title:
       Tenure:

27. Who maintains plan records?

28. Who has the authority to sign checks or documents on behalf of the plan?

SERVICE PROVIDERS

29. Does the plan utilize any outside service providers?
    If so, who are they and explain the services each provides:
    Type:
    Provider:
    Address:
    Since:
    Contact:
    Accountant:
    Attorney:
    Actuary:
    Other:

30. Are there service agreements with all providers?

31. Does the sponsor or any of its owners or employees have a business or other relationship with any of the providers?

BONDING & DISCLOSURE

32. Does the plan have a fidelity bond?

    a. Is it current?

    b. What is the amount of the fidelity bond?

33. Does the plan/sponsor have a fiduciary liability policy?

34. Does the plan have a stop-loss insurance policy?

    a. Is it current?

35. Has a copy of the plan's Summary Plan Description (SPD) been provided to all participants?

    a. Date of SPD? (Less than 5 years old?)

    b. When is it distributed? (Before or after enrollment?)

    c. Who distributes it (e.g., sponsor or insurer)?

    d. How (in what method) is the SPD distributed?

36. Does the plan provide a Summary of Benefits and Coverage (SBC)?

    a. Who distributes it (e.g., sponsor or insurer)?

    b. When is it distributed?

    c. Does the plan make available the uniform glossary?

37. Does the plan file annual reports (IRS Form 5500 series)?

    a. When was the last IRS Form 5500 filed?

    b. Have you filed for an extension?

38. Does the plan prepare summary annual reports for participants?

    a. Who distributes this?

    b. When?

    c. How?

39. Are copies of the plan documents, under which the plan is established or operated, available for review for participants?

40. Has the plan applied for or received any PT exemptions under ERISA?

    a. When?

    b. What for?

    c. Outcome?

41. What is the plan's year end?

CONTRIBUTIONS & CLAIMS

42. How often are employee contributions taken out of employees' paychecks?

43. How often does the employer remit contributions to the trust or premiums/payments to the insurer or claims administrator?

44. How are premiums/payments remitted?

    a. Via wire transfer?

    b. Via check?

    c. Via authorized debit from the employer's account?

        i. How is authorization given?

        ii. How is the amount of the debit reviewed by the sponsor?

45. Who is responsible for remitting the contributions?

    a. Is any approval needed from a higher level prior to transfer of funds?

46. Are the plan's contributions/premiums currently up-to-date?

    a. In the past two years, has the plan ever been late with contributions/premiums?

    b. When must contributions/premiums be remitted by to avoid a lapse in coverage?

47. Are all claim payments up to date?

    a. In the past two years, have claims ever been paid late?

    b. In the past two years, has there ever been a lapse in coverage?

PLAN FEES

48. What fees are charged to the plan?

    a. Recordkeeping fees:

    b. Administrative services:

    c. Other:

49. Who paid the fees (e.g., the employer or the plan)?

50. What services were provided for the fees charged?

PART 7 OF ERISA

51. Aside from the SPD, if applicable, what notices are provided to participants at or prior to enrollment?

52. What additional annual notifications, if any, do participants receive?

53. Is the plan being administered to impose a pre-existing condition period?

54. When does the plan provide the general notice of pre-existing condition exclusion?

55. Does the plan provide individual notices of pre-existing condition exclusion?

56. Does the plan provide a Certificate of Credible Coverage (COCC) automatically upon loss of coverage and upon request?

    a. Whose responsibility is this (e.g., plan, insurer)?

57. When does the plan provide the special enrollment notice?

58. Does the plan follow the special enrollment provisions provided in the plan's SPD?

59. Does the plan discriminate with regard to eligibility or benefits based on any health factor?

60. When does the plan provide information to employees regarding eligibility for coverage?

61. Who provides eligibility information?

62. Do participants' premium amounts vary based on any health factor?

63. Does the plan offer a health or disease wellness program (can also be referred to as disease management, smoking cessation, case management, etc., programs)?

64. Does the plan offer mental health benefits?

    a. If yes, what limitations (e.g., dollar limits, treatment limits, separate deductibles), if any, are on the mental health coverage?

    b. Is preauthorization required for obtaining mental health benefits?

        i. If yes, is preauthorization required for obtaining medical/surgical benefits?

    c. What is the copay for receiving mental health outpatient benefits?

        i. Is this a higher specialist copay that is higher than the copay for seeing one's primary care physician?

        ii. If a higher specialist copay, is this copay amount the predominant level that applies to substantially all medical/surgical benefits within the same classification?

65. Does the plan provide benefits for hospital stays in connection with childbirth?

66. When does the plan provide the Women's Health and Cancer Rights Act (WHCRA) notice?

    a. At or before enrollment?

    b. Annually?

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA)

67. Have any changes been made to the plan since March 23, 2010?

    a. If yes, what changes were made to the plan?

    b. Is the plan a grandfathered plan?

68. Did the plan change its insurance company (issuer) after March 23, 2010?

    a. If yes, what was the effective date of the contract with the new issuer?

69. Does the plan include a statement that it believes it is a grandfathered health plan in any plan materials provided to participants and beneficiaries that describe the benefits provided under the plan?

70. Does the plan have documentation available upon request of the terms of the plan in effect on March 23, 2010?

71. Did the plan provide eligible dependents under 26 with the one-time notice and opportunity to enroll?

72. Under what circumstances does the plan rescind a participant's coverage?

73. For any participants who may have been subjected to a lifetime limit, does the plan comply with the requirements regarding one-time notice and opportunity to enroll?

74. Does the plan require or provide for designation of a participating primary care provider by any participant or beneficiary?

75. Does the plan provide coverage for OB/GYN care provided by a participating health care professional who specializes in obstetrics or gynecology for a female participant or beneficiary without requiring authorization or referral by the plan, issuer, or any person (including a primary care provider)?

76. Does the plan provide coverage of emergency services provided out-of-network without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements that apply to emergency services provided in-network?

77. Does the plan provide coverage without imposing any cost-sharing requirements for evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force?

    a. Does the plan receive anything from its insurer/claims administrator identifying what these preventive items are?

78. When recommended preventive services are not billed separately from an office visit and is the primary purpose of the office visit, does the plan provide coverage for the office visit without imposing cost-sharing requirements?

79. Have the plan's internal claims and appeals processes been updated for PPACA?

    a. Does the plan provide internal claims and appeals processes with respect to rescissions of coverage?

    b. Does the plan provide claimants with any new or additional evidence or rationale considered in connection with a claim (i.e., new evidence that was not considered in an initial adverse benefit determination, but was considered in a final internal adverse benefit determination)?

    c. How does the plan ensure that claims and appeals are adjudicated in a manner that maintains independence and impartiality of decision making and not based on the likelihood that benefits will be denied?

    d. Does the plan defer to the attending provider as to whether a claim involves urgent care (i.e., those claims for which a benefit determination must be made as soon as possible, but no later than 72 hours after receipt)?

    e. Have there ever been any situations in which a claimant has requested an external review prior to exhausting the plan's internal claims and appeals procedures?

        i. What were the circumstances?

    f. Are the plan's internal claims and appeals notices provided in a culturally and linguistically appropriate manner?

80. Does the plan follow a state external review process or a private accredited independent review organization (IRO) process?

    a. What is the process?

    b. Other

81. COBRA: Has the plan's administrator provided written notification to employees and their spouses of their rights to continued coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) within 14 days of their being notified that a qualifying event has occurred?