ERISA Wrap Plan Employer Application Completion Guide

Please have a copy of the Sterling ERISA Wrap Plan Employer Application available for reference.

Company Name
The information provided should be the company's full legal name (including DBA) and this will be used on the employer's legal Plan Documents.

Tax ID Number
This is a 9-digit number that is used to identify the business entity, is reflected in the Plan Documents and 5500 filing, and is issued by the IRS for the purpose of tax administration.

State of Organization or Incorporation
The state in which the employer entity was organized or incorporated is reflected in the legal Plan Documents.

Type of Entity
The type of entity of the employer is reflected in the legal Plan Documents.

Affiliated Employers
List any entity that will adopt this Plan as it is designed and be considered, with the Plan Sponsor, as a single employer for purposes of this Plan. For example, ABC Company is a subsidiary of XYZ Company. ABC Company implements a Plan and allows XYZ Company to adopt that same Plan instead of implementing a separate Plan. All employees for both companies are eligible to participate in the Plan after meeting the stated eligibility requirements. The two entities are combined and treated as one for all purposes of the Plan.

Controlled Group
Provide the name of the parent-subsidiary or brother-sister entity of which the employer is a group of Corporations in which 50% or more of each Corporation is owned by the same person(s) or entity.

Primary Contact Name, Title, Phone and Email
This is the main contact we use for all communication – implementation, documents, and 5500 filings.

Additional Contact Name, Title, Phone and Email
Additional contacts can be added to the distribution list for communication – implementation, Plan Documents, and 5500 filings. Multiple names, titles, phone numbers, and email addresses my be typed in the same line separated by a comma or semicolon.

Broker Contact Name, Agency Name, Phone and Email
The broker contact provided will be copied on communications such as implementation discussions, Plan Documents, and 5500 filings. Multiple names, phone numbers, and email addresses may be typed in the same line separated by a comma or semicolon.

Plan Number
It is important that Plan Numbers are between 501 and 599 and are not duplicated even if a prior Plan has been terminated and is no longer in force. This number is included on the 5500 filing and is used by the Department of Labor in conjuction with the employer tax ID number to identify the employer. There is one exception to this rule. IF the employer has a Cafeteria Plan with Health Care Flexible Spending Account and/or a Health Reimbursment Arrangement (HRA) AND they want one or both of these Plans to be encompassed by the ERISA Wrap Plan, then the Plan Numbers should be the same. The FSA and HRA are not required to be included in the ERISA Wrap because their Plan Documents satisfy the ERISA requirements on their own. If the FSA and/or HRA have more than 100 participants and require a 5500 filing then the employer may want to include that Plan in the Wrap in order to avoid an additional 5500 filing. In this instance, the FSA and/or HRA would need the same Plan number as the ERISA Wrap. This may or may not require an amendment to the FSA and/or HRA depending on the situation.

New Wrap Plan vs. Renewal Wrap Plan
If this the the first year with Sterling, "New" will be checked. If this is a subsequent year with Sterling "Renewal" will be checked.

> **Effective Date**
> The effective date is the first date of the coming Plan Year.

Restatement of Previsouly Adopted Plan
If the employer has had an ERISA Wrap Plan in the past with another TPA and is transitioning to Sterling, check here. The new Plan Documents will become a restatement of the original Plan and will reflect the following:

> **Original Effective Date**
> The first date of implementation of the ERISA Wrap Plan.
>
> **Effective Date of Transition to Sterling**
> The date on which the Plan is effective with Sterling.

Plan Year
The Plan Year cannot be longer than 12 months and is typically on the same cycle as the lines of coverage encompassed by the ERISA Wrap Plan. The Plan Year cycle of the ERISA Wrap Plan will dictate when the 5500 is filed. Most employers find it best to synch the Plan Year cycle with the Plans encompassed by the ERISA Wrap, however, if there are lines of coverage that are off-cycle, those Schedule As will be included in the 5500 based on their contract end date and the year in which the ERISA Wrap Plan ends. For instance, an ERISA Wrap Plan is 1/1/12 – 12/31/12 and all lines of coverage are as well with the exception of a Dental Plan which is 7/1/11 – 6/30/12. The 5500 for the Wrap is due on 7/31/13. The Schedule A for the Dental Plan ending 6/30/12 will be submitted with the 5500 application for the 1/1/12 - 12/31/12 Plan Year filing.

Short Plan Year

Short Plan Years are allowed for a specific business purpose. Typically, this is used to synch with other Plan renewals. Sequential Short Plan Years are a red flag for audit. If there happens to be a business purpose back to back to change the Plan Year cycle, it should be well documented in the event of an audit.

Total Number of Employees in the Company

The total number of employees in the company is used to determine the applicablity of COBRA and FMLA. This number should include any individual employed by the employer receiving a W2 – full time and part time regardless of meeting eligiblity requirements. If an employer is on the cusp of 20 (COBRA) or 50 (FMLA) employees, it is recommended that they notify Sterling upon reaching those thresholds and request an amendment to the Plan Document to incorporate the applicable legal language.

Total Number of Benefit Eligible Employees in the Company

The number of benefit eligible employees is used for purposes of estimating service fees.

Over 100 Plan Participants in Any Health and Welfare Plans

If the employer has more than 100 partcipants in any line of coverage, a 5500 will be required for that Plan. If there was not an ERISA Wrap Plan in place on or before the first date of that Plan Year, the 5500 will need to be filed independently. If there are multiple lines of coverage that had more than 100 particpants without an ERISA Wrap Plan, each line of coverage will require a separate 5500 filing. After the ERISA Wrap Plan is in place, the lines of coverage selected will be bundled and require one 5500 filing for each bundle.

Subsidiary Contracts

Subsidiary contracts refers to the carrier lines of coverage that will be encompassed by, or specifically excluded from, the ERISA Wrap Plan. For example, medical, dental, vision, EAP, etc. Select one of the following options.

Option 1 – All Plans Subject to ERISA

Most employers prefer this option as it automatically encompasses all Plans subject to ERISA without the need to specifically list each one. This avoids the need for amendments down the road when Plans or carriers change.

Option 2 – Only Specifically Listed Plans Subject to ERISA

This option is useful when an employer wants to wrap only specific benefits in to the Plan. The ERISA Wrap Plan will list only those benefits as being part of the Wrap.

Option 3 – All Plans Subject to ERISA Except Those Specifically Listed

This option is useful when an employe wants to specifically exclude certain benefit(s) from the Plan. The ERISA Wrap Plan will specify that all Plans subject to ERISA are include except XYZ.

Grandfathered Status

If there are any Plans covered by the ERISA Wrap Plan that are Grandfathered the ERISA Wrap Plan will include specific language reflecting that status.

Self Administered Plans

Employers that have non-Grandfathered Plans that are being self administered need to comply with the ACA required Notice of Adverse Benefits Determination and Notice of Final Adverse Benefits Determination format when denying benefits. Insured Plans and those being administered by a TPA are already performing this function for the employer. In the case of a self-administered Plan, Sterling has access to these forms and can provide them at an additional fee. The forms are completely customizeable in order to pertain to the plan and claim at hand.

Notice of Adverse Benefits Determination

This is notice is meant as the first denial for a claim for health benefits.

Final Adverse Benefits Determination

This is notice is meant as the final internal denial for a claim for health benefits.

Claims Language

Indicate whether you would like general or specific claims language to appear in the Summary Plan Description. There is no right or wrong answer here. This is simply a preference as the employer. The following language will appear in the Summary Plan Description dependent on the answers below:

No: The general claims statement will be inserted into the ERISA Wrap SPD:
The claims procedures of each welfare benefit plan will apply. See the applicable Summary Plan Description or the welfare benefit plan's plan administrator for more information.

Yes: Very specific claims procedures based on various benefit plans and compliant with ERISA regulations will appear. See APPENDIX 1 to this document.

Appendix with Eligibility and/or Employer/Employee Contribution Amounts

Indicate if you would like an appendix to the Summary Plan Description reflecting the eligiblity requirements and/or employer and employee contribution amounts for lines of coverage available. Again, there is no right or wrong answer here and this is also simply an employer preference. Keep in mind that if specifics are inserted into the Plan Document it may require an amendment at a later date if changes are made. The following language will appear in the Summary Plan Description dependent on the answers below:

No: The general eligibility statement will be inserted into the ERISA Wrap SPD:
You should receive separate Summary Plan Descriptions from each of the welfare benefit plans described above. In the separate Summary Plan Descriptions you should find information about eligibility, benefits and employee/employer contributions for each of the separate welfare benefit plans. You are eligible to participate in this Plan if you are eligible to participate in one of the welfare benefit plans described above. In addition, in general, all benefits of this Plan are provided by the welfare benefit plans described above.

Yes: The following chart will be inserted as an appendix into the ERISA Wrap SPD:

WELFARE BENEFIT PLAN CHART APPENDIX

Welfare Benefit Plan Name	Eligibility
Medical	Eligibility: 1st of the month after 30 days; Employer pays 100% for single coverage, Employee pays 100% for dependent coverage
Dental	Eligibility: 1st of the month after 30 days; Employer pays 100% for single and family coverage
Vision	Eligibility: 1st of the month after 30 days; Employer pays 50% for single and family coverage, Employee pays 50% for single and family coverage

Additional Forms and Notices

Typically, the insurance carrier is providing these notices. If, at any time, the employer would like Sterling to provide them, they are included at no additional charge.

ARRA Election Form

Although qualified beneficiaries generally can only elect the same coverage they had in place immediately before the occurrence of the qualifying event, the American Recovery and Reinvestment Act of 2009 (ARRA) permits (but does not require) a plan administrator to let qualified beneficiaries who are assistance eligible individuals (AEIs) change their coverage at the time of their COBRA election—subject to certain restrictions. While technically, outdated, this notice is still available for any employer who may wish to obtain it.

CHIPRA Annual Notice

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) amended provisions of the Code, ERISA, and the PHSA to impose additional notice and disclosure obligations on employers and plan sponsors, the purpose of which is to coordinate coverage under a qualifying employer plan with state Medicaid and CHIP.

Certificate of Creditable Coverage

The notice must be furnished automatically to:

- An individual who is entitled to elect COBRA continuation coverage, at a time no later than when a notice is required to be provided for a qualifying event under COBRA
- An individual who loses coverage under a group health plan and who is not entitled to elect COBRA continuation coverage, within a reasonable time after coverage ceases
- An individual who has elected COBRA continuation coverage, either within a reasonable time after the plan learns that COBRA continuation coverage ceased or, if applicable, within a reasonable time after the individual's grace period for the payment of COBRA premiums ends

Qualified Medical Child Support Order Procedures
Plan administrator must notify the affected Participants and any alternate recipients identified in the order of the receipt of the order and the Plan's procedures for determining whether such an order is a qualified medical child support order (within the meaning of ERISA section 609(a)(2)(A)). Within a reasonable period the Plan Administrator shall determine whether the order is a qualified medical child support order and shall notify the Participant and alternate recipient of such determination.

WHCRA Annual Notice
The Women's Health and Cancer Rights Act of 1998 (WHCRA) requires plans that provide coverage for mastectomy benefits to provide the WHCRA notice upon enrollment and to provide a shortened version of the notice annually. The notice provided by the system is actually a combined version of the enrollment notice and the annual notice. Note that WHCRA requires the notice to also include annual deductibles and coinsurance limitations applicable to the mastectomy benefits.

Invoicing and ACH Setup

Application Agreement/Signature:
The application must be signed by an authorized representative of the employer who affirms the accuracy of the information provided on the application and also agrees to indemnify Sterling Health Services Administration against any and all loss, damages or lawsuits brought against Sterling to recover benefits under the plan.

APPENDIX 1

Claim Procedures - In General

This section applies for any claim for benefits under a welfare benefit plan that is covered by ERISA unless the welfare benefit plan has a claims procedure that is compliant with ERISA section 503. If the welfare benefit plan has a claims procedure that is compliant with ERISA section 503, the claims procedure of the welfare benefit plan will apply. In general, this means that if the claims procedure of the welfare benefit plan has timeframes and procedures that are at least as favorable to you or more favorable than the deadlines provided below, the claims procedure of the welfare benefit plan will apply. In the case of a group health plan, any procedures for obtaining prior approval as a prerequisite for obtaining a benefit, such as preauthorization procedures or utilization review procedures are described in the relevant SPD for that plan and incorporated herein.

You or any other person entitled to benefits from the welfare benefit plan (a "Claimant") may apply for such benefits by completing and filing a claim with the applicable welfare benefit plan provider in accordance with the provider's claim filing guidelines. In general, claims must be filed in writing (except urgent care claims, which may be made orally) with the applicable welfare benefit plan provider. Any claim that does not relate to a specific benefit under the plan (for example, a general eligibility claim or a dispute involving a mid-year election change) must be filed with the welfare benefit plan's plan administrator. Any claim must include all information and evidence that the welfare benefit plan provider or plan administrator (the "Claim Reviewer") deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. If a claim is received, but there is not enough information to process the claim, you will be given an opportunity to provide the missing information.

A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" under these rules, unless it is determined that your inquiry is an attempt to file a claim.

If you want to bring a claim for benefits under the Plan, you may designate an authorized representative to act on your behalf so long as you provide written notice of such designation to the applicable provider identifying such authorized representative. In the case of a claim for medical benefits involving urgent care, a health care professional who has knowledge of your medical condition may act as your authorized representative with or without prior notice.

Timing of Notice of Claim

The Claim Reviewer will notify the Claimant of any benefit determination within a reasonable period of time but not later than the timeframe specified below depending on the type of claim.

Group Health Plan Claims

Group health plan claims may involve urgent care, concurrent care claims, pre-service care claims or post-service claims. Each has different time-frames that may apply and is described below.

Urgent Care. The Claim Reviewer will notify the Claimant of the benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the plan, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable. In the case of such a failure, the Claim Reviewer will notify the Claimant as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Claim Reviewer will notify the Claimant of the determination as soon as possible, but in no case later than 48 hours after the earlier of (A) the plan's receipt of the specified information, or (B) the end of the period afforded the Claimant to provide the specified additional information.

Concurrent care (a group health plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments). The welfare benefit plan will notify a Claimant of any reduction or termination of a course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. Any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care that will be decided as soon as possible, taking into account the medical exigencies, and the Claim Reviewer will notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the plan, provided that any such claim is made to the plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Pre-service claims. The Claim Reviewer will notify the Claimant of the plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the plan. This period may be extended one time by the plan for up to 15 days, provided that the Claim Reviewer both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the Claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Claim Reviewer expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Post-service claims. The Claim Reviewer will notify the Claimant, of an adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the plan for up to 15 days, provided that the Claim Reviewer both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Disability Claims

In the case of a claim for disability benefits, the Claim Reviewer will notify the Claimant, of the plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the plan. This period may be extended by the plan for up to 30 days, provided that the Claim Reviewer both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the Claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If, prior to the end of the first 30-day extension period, the administrator determines that, due to matters beyond the control of the plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Claim Reviewer notifies the Claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the plan expects to render a decision. The notice of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the Claimant will be afforded at least 45 days within which to provide the specified information.

Other Claims

The Claim Reviewer will notify the Claimant of any adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim. This period may be extended one time by the Plan for up to 90 days, provided that the Claim Reviewer both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial review period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Content of Notice of Denied Claim

If a claim is wholly or partially denied, the Claim Reviewer will provide the Claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary, (4) an explanation of the steps that the Claimant must take if he wishes to appeal the denial including a statement that the Claimant may bring a civil action under ERISA.

In addition to the above information, if it is a group health plan or a plan providing disability benefits, the following information must be included with the notice described above:

(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or

(B) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

In addition, in the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims must be included with the notice described above and may be provided to the Claimant orally within the time frame described above, provided that a written or electronic notification is furnished to the Claimant not later than 3 days after the oral notification.

Appeal of Denied Claim

If a Claimant wishes to appeal the denial of a claim, he must file an appeal with the Claim Reviewer on or before the 180th day (or the 60th day in the case of a claim other than a group health plan benefit or a disability benefit) after he receives the Claim Reviewer's notice that the claim has been wholly or partially denied. The appeal will identify both the grounds and specific Plan provisions upon which the appeal is based. The Claimant will be provided, upon request and free of charge, documents and other information relevant to his claim. An appeal may also include any comments, statements or documents that the Claimant may desire to provide. The Claim Reviewer will consider the merits of the Claimant's presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Claim Reviewer may deem relevant. The Claimant will lose the right to appeal if the appeal is not timely made.

In considering the appeal of a group health plan benefit or a disability benefit, the Claim Reviewer will:

(1) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(2) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(3) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(4) Provide that the health care professional engaged for purposes of a consultation under Subsection (2) will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

(5) In addition, in the case of a claim involving urgent care, provide for an expedited review process pursuant to which (A) a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the Claimant; and (B) all necessary information, including the plan's benefit determination on review, will be transmitted between the plan and the Claimant by telephone, facsimile, or other available similarly expeditious method.

Notice of Denied Appeal Review

Except as provided below for group health urgent care, pre-service and post-service claims, the Claim Reviewer will notify the Claimant of the Plan's benefit determination on review within 60 days after receipt by the Plan of the Claimant's request for review of an adverse benefit determination (45 days in the case of a claim involving disability benefits). If the Claim Reviewer determines that an extension of time for processing is required, written notice of the extension will be furnished to the Claimant prior to the termination of the initial 60-day period (45 days in the case of a claim involving disability benefits). In no event will such extension exceed a period of 60 days from the end of the initial period (45 days in the case of a claim involving disability benefits). The extension notice will indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the determination on review.

Urgent care claims. In the case of a claim involving urgent care, the Claim Reviewer will notify the Claimant of the plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request for review of an adverse benefit determination by the plan.

Pre-service claims. In the case of a pre-service claim, the Claim Reviewer will notify the Claimant, of the plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Such notification will be provided not later than 30 days after receipt by the plan of the Claimant's request for review of an adverse benefit determination.

Post-service claims. The Claim Reviewer will notify the Claimant of the plan's benefit determination on review within a reasonable period of time. Such notification will be provided not later than 60 days after receipt by the plan of the Claimant's request for review of an adverse benefit determination.