



# *Employer Health & Welfare Benefit Plan ERISA Compliance*

*... What employers need to know.*

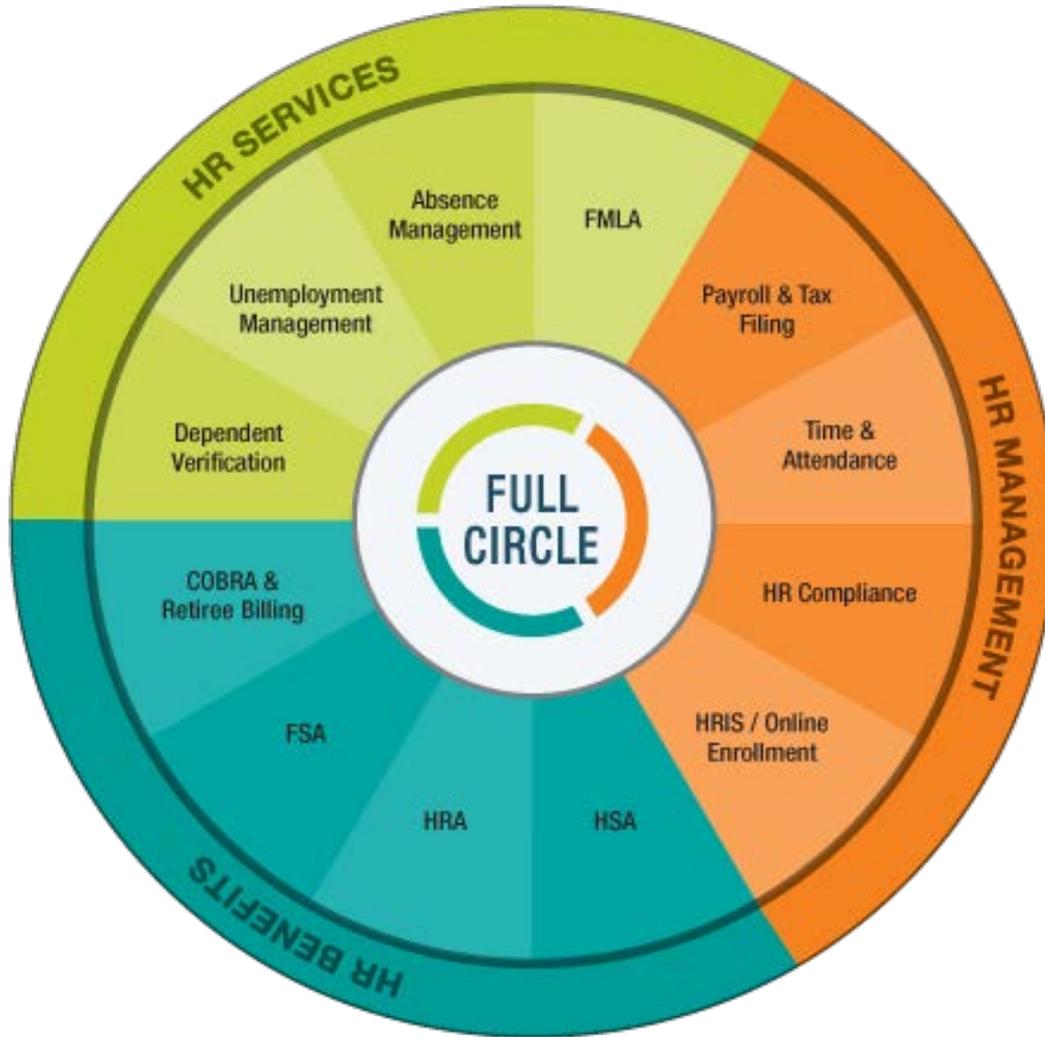


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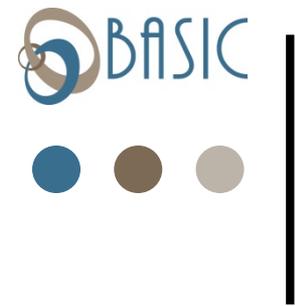


**Joe Aitchison, SPHR, SHRM-SCP, CHRS - BASIC Vice President.**

Joe provides Business & HR client advisory services and HR out-source services nationally. He is a Human Resource professional with over twenty five years business management and HR consulting experience. He has worked with multi plant International Tier I Automotive Manufacturing, retail, food processing, health care, legal administration and professional services.



**Colleen Gole, JD - Regulatory Compliance Advisor** - Colleen joined BASIC as the Compliance Advisor in 2014. At BASIC, Colleen uses her extensive knowledge and skill to offer legal compliance expertise to clients. Prior to joining BASIC, Colleen practiced as an attorney at Ottawa County Circuit Court. Colleen has particular expertise in the Employee Retirement Income Security Act (ERISA), employer health and welfare benefits and federal Health Care Reform law employer compliance. Colleen graduated from University of Michigan with a B.A. in English and History. She completed her law degree at Wayne State University Law School.



## AGENDA

### ... ERISA

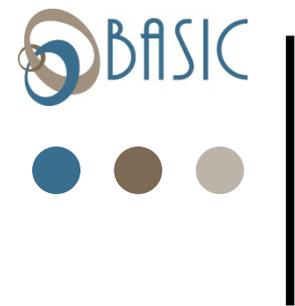
#### *Employer Health & Welfare Benefit Plan Compliance*

- *Employer Health & Welfare Plans Subject to ERISA*
- *What does an Employer need to do to be Compliant*
- *What ERISA Records are required*
- *What's the risk if an employer is not compliant*
- *Best Practice Review*

# What is ERISA and Which Health and Welfare Plans are Subject to ERISA?

## What is ERISA and Which Health and Welfare Plans are Subject to ERISA?

- The Employee Retirement Income Security Act (ERISA) is a federal law that applies to most employee benefit plans
- Sets for uniform minimum standards for plans
- Employee benefit plans sponsored by governmental employers and church employers are exempt from ERISA's requirements



## What is ERISA and Which Health and Welfare Plans are Subject to ERISA?

- ERISA contains two broad categories of employee benefit plans: pension plans and welfare plans
- An “employer welfare benefit plan” is any plan established or maintained by an employer that provides any of the following through purchase of insurance:



## What is ERISA and Which Health and Welfare Plans are Subject to ERISA?

- Medical, prescription drug, dental and/or vision benefits (self-funded and fully-insured)
- Self-funded 105(h) medical reimbursement benefits
- Health reimbursement arrangements (HRAs) - Most often embedded in with the Medical Plan.
- Health savings accounts (HSAs) are generally not considered subject to ERISA but the related high deductible health plan (HDHP) is a medical plan for purposes of ERISA

## What is ERISA and Which Health and Welfare Plans are Subject to ERISA?

- Employee assistance plans (EAPs) providing counseling benefits (referral only EAPs are not subject to ERISA)
- Short-term disability (STD) benefits if provided through an insurance policy or funded through a trust (self-funded STD benefits are generally not subject to ERISA)
- Long-term disability (LTD) benefits
- On-site medical clinics providing more than treatment for minor injuries and illnesses
- Wellness programs providing medical care
- Executive physicals



## What is ERISA and Which Health and Welfare Plans are Subject to ERISA?

- Group term life/accidental death and dismemberment (AD&D) insurance benefits
- Group travel accident insurance benefits
- Medical flexible spending accounts (FSAs), but the pre-tax premium and dependent care FSA portions of a Section 125 cafeteria plan are not subject to ERISA
- Most severance benefits

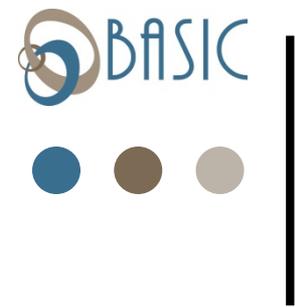
# Which Plans are not Subject to ERISA?

## Which Plans Are Not Subject To ERISA?

- Most HSAs, provided the employer has limited involvement
- Referral only EAPs
- Self-funded STD plans paid through the employer's general assets
- Cafeteria plans (other than the medical FSA portion)

# Which Plans Are Not Subject To ERISA?

- Dependent care assistance plans
- Severance benefits that don't require "ongoing administrative scheme"
- Fringe benefit plans, such as:
  - Adoption assistance plans
  - Tuition reimbursement and other educational assistance plans
  - Qualified transportation plans, including pre-tax parking, transit pass and van pooling plans



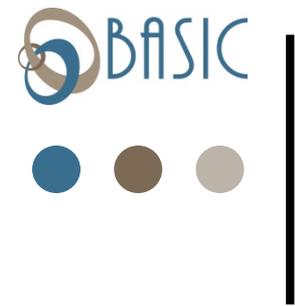
# Which Plans Are Not Subject To ERISA?

- Voluntary plans
  - Under a voluntary plan
    - The employee pays the entire premium—the employer does not contribute
    - Participation by the employees is completely voluntary
    - Employer has minimal involvement in plan operations and does not “endorse” the plan

# Which Plans Are Not Subject To ERISA?

The following employer activities are not considered an “endorsement” of the plan:

- Permitting the insurer to publicize the program
- Collecting premiums by payroll deduction and remitting premiums to the insurer



# Which Plans Are Not Subject To ERISA?

The following activities would be considered an endorsement of the plan:

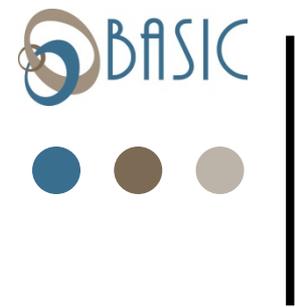
- The employer urges or encourages employee participation in the program
- States in communications that the employer is “enthusiastic” about the program
- States that the plan is part of the employer’s benefit package

# Plan Document Requirements



# Plan Document Requirement

- A written plan document is required for each plan
- But an employer may choose to bundle various benefits into a single plan. Some employers adopt an umbrella or wrap welfare benefit plan to accomplish this



# Plan Document Requirement

- Required plan document provisions
  - Identification of one or more named fiduciaries to control and manage the plan
  - The source of funding (e.g., self-funded through general assets, self-funded through a trust or fully-insured)
  - Amendment procedures
  - HIPAA privacy



# Plan Document Requirement

- Optional Provisions
  - Discretionary language for court review of benefit claims
  - Identification of benefits for Form 5500 filing purposes
- Many health plans have one document that is intended to serve as both the plan and SPD



# SPD Requirement

- The SPD is the required participant communications document summarizing the terms of the plan
- Time limits for SPD distribution
  - An SPD is required to be distributed within 120 days after a plan is established
  - A new participant must be provided an SPD within 90 days after becoming a participant
- A new SPD must be prepared and distributed generally at least once every five years if any material change is made to the plan (every 10 years if no material change)

# Satisfying the SPD Requirement

- Compliance with the SPD requirement can be a problem for a fully-insured health plan because the booklet/certificate from the insurer/HMO often does not contain all the information required to be included in an SPD
- Many employers with fully-insured health plans satisfy the SPD requirement by creating a **“wrap” document** to supplement the booklet/certificate. These two documents together can satisfy the SPD requirement

# SMM Requirement

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# SMM Requirement

- An SMM must be provided to each participant within 210 days after the end of a plan year in which a material change is made to the plan

## SMM - Material Reduction in Benefits

- A special rule applies if an amendment causes a material reduction in covered services or benefits under a health plan
- In that case, the SMM must be provided no later than 60 days after the date the health plan amendment is adopted
- Examples of material reductions for this purpose include the elimination or reduction of a benefit, an increase in deductibles or copays, a reduction in the HMO service area or the addition of a pre-authorization requirement

# Other Rules for SPDs and SMMs

- Must be written in a manner designed to be understood by the average participant
- Must be distributed in a permissible manner
  - First-class mail
  - Second or third-class mail with postage guaranteed and address correction requested
  - Hand delivery
  - Electronically if certain requirements are satisfied
- Maintain records of distribution

# Form 5500

- Form 5500 is the annual report form that must be filed with the federal government with regard to a plan that is subject to ERISA having 100 or more employee (or retiree) participants on the welfare benefit plan at the beginning of the plan year or is funded through a trust regardless of the number of employees/retirees.
- Welfare plans subject to the Form 5500 requirement
  - Fully-insured plans
  - Self-insured plans funded through the employer's general assets
  - Self-insured plans funded through a trust regardless of the number of enrolled employees or retirees
- Plans not subject to ERISA are not required to file a Form 5500

## Form 5500

- A Form 5500 must be filed for each plan. An employer can adopt a wrap or umbrella plan to consolidate all of its various health and welfare benefit plans into a single plan for Form 5500 filing purposes
- The Form 5500 filing for a fully-insured plan must include a Schedule A for each insurer
- The Form 5500 filing for a self-funded health plan must include a Schedule C for each service provider (such as a TPA) if the service provider was paid \$5,000 or more
  - Unfunded self-funded plans where any employee contributions are paid on a pre-tax basis under a 125 plan are exempt from the Schedule C requirement

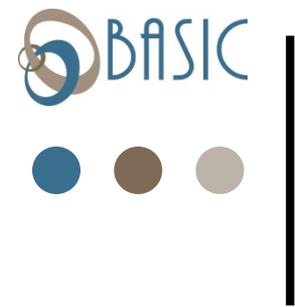
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## Form 5500

- The DOL can assess a penalty of up to \$1,100 per day for a late 5500 filing per plan per plan year
- The DOL has a delinquent filer voluntary compliance program (DFVC program) which caps penalties

# Form 5500

- The penalty for a late filing under the DFVC program is \$10 per day up to a maximum of \$2,000
- There is also a per plan maximum penalty that applies regardless of how many late filings (plan years) for the plan are being filed under the DFVC program. **The maximum penalty is \$4,000**
- The U.S. Department of Labor (DOL) has a model form for SARs
- The SAR must be provided within 9 months after the end of the plan year (or 2 months after the extended due date for Form 5500, if later)

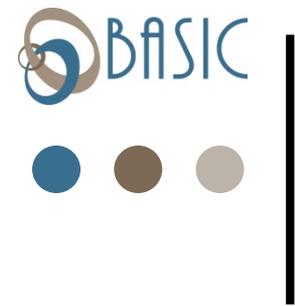


# Form 5500

## CAUTION

If all benefit component plans are wrapped together into one Welfare Benefit Plan, it MAY create a situation where the company would have to file 5500 filing if they had less than 100 participants in their benefit programs.

# Participant Notifications & Disclosures



# Participant Notifications and Disclosures

- Participants entitled to notifications include
  - Active employees
  - Inactive employees receiving some type of extension of coverage (e.g., due to FMLA, COBRA, etc.)
  - Retirees
  - Dependents generally are not required to be provided with separate notices unless the dependent has an independent right to coverage

# Participant Notifications and Disclosures

- Posting or leaving copies in a common meeting area such as a break room is generally impermissible
- Electronic notice is permissible if certain requirements are satisfied
  - Disclosure may be made electronically to a participant who has the ability to access documents at any location where the participant reasonably could be expected to perform employment duties and whose access to the employer's electronic information system is an integral part of his/her employment duties
    - Example – employee with computer terminal at his/her desk
    - Example – employee who is set up with a computer to work from home
- Making a computer kiosk generally available for use by participants does not satisfy this requirement

# Participant Notifications and Disclosures

- Disclosure may be made electronically to a participant who does not fall into the first category but who has access to computer (e.g., a home computer) and who consents to receiving notices electronically
  - Example – worker in a manufacturing facility does not regularly work with a computer at work but has a personal computer at home and consents to receiving notices electronically
- If a participant doesn't fall in one of these two categories, the participant must be provided with a paper copy of the SPD, SMM, etc.

# Model Notices & Other Required Participant Notifications

- Women's Health and Cancer Rights Act (WHCRA) – summarizing the plan's coverage for mastectomies and breast reconstructive services
- Medicare Part D certificate of creditable coverage/non-creditable coverage
- HIPAA notice of privacy practices
- Summary of Benefits and Coverage (SBC)
- ACA Notice of Exchange Availability
- Notice of ACA Grandfathered Status (if applicable)

Note: the notices for COBRA, the WHCRA, Medicare Part D and HIPAA privacy can be included in the SPD. The SPD is only required to be distributed to participating employees and not their dependents. On the other hand, the COBRA notice must be distributed to spouses and should also be distributed to dependent children if living at a separate address

# Required Participant Notifications

- Annual notice requirements
  - WHCRA
  - Medicare Part D certificate of creditable/non-creditable coverage
- SBC
- Grandfathered Status (if applicable)
- CHIP

## Required Participant Notifications

- Once every 3 years notice requirement – the HIPAA notice of privacy practices must be distributed once every 3 years. Alternatively, the plan may notify participants that they may receive a new copy of the notice at least once every 3 years. If notification is provided annually, this requirement will be deemed satisfied

# Required Participant Notifications

- **Notices due by each January 31**
  - W-2 reporting of health benefit costs
  - 1094-C and 1095-C (pursuant to IRC Sections 6055 and 6056)
- **Notices required upon termination of participation**
  - COBRA notice/election form
  - Notice of conversion privilege (fully-insured plans)



# Record Retention

- **Necessary to comply with governmental audits**
  - DOL
  - IRS
  - HHS
  - State insurance bureau
- **What records should be maintained?**
  - Board resolutions pertaining to the plan
  - Plan documents and amendments
  - Insurance policies and insurance booklets/certificates
  - Contracts with any service providers
  - SPDs and SMMs
  - Administrative policies

# Record Retention

- Initial and annual enrollment materials and forms
- COBRA notices, forms and other documents evidencing compliance
- Other administrative forms
- Nondiscrimination testing documents and evidence of compliance
- Form 5500s and back-up documentation
- SARs
- HIPAA documentation to show steps taken to comply with privacy and security rules such as notice to participants, privacy policies, written risk analysis for security rules, training materials and business associate agreements
- Evidence of the procurement of fiduciary bond/liability insurance

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# Record Retention

- How long should records be retained?
  - At a minimum, for each plan year, 6 years after the Form 5500 for the year has been filed (the 5500 is due 7 months after the plan year ends with a potential 2½ month extension)
  - Many employee benefit practitioners view 8 years after the end of the plan year as an advisable time frame to comply with all potential reasons why the information in the records may be needed

# What Prompts DOL ERISA Investigations

Complaints  
Directed Investigation



## EBSA's Mission Statement

The Employee Benefits Security Administration protects the integrity of pensions, health plans, and other employee benefits for more than 150 million people. Our Agency mission is to:

- Assist workers in getting the information they need to exercise their benefit rights
- Assist plan officials to understand the requirements of the relevant statutes in order to meet their legal responsibilities
- Develop policies and regulations that encourage the growth of employment-based benefits
- Deter and correct violations of the relevant statutes through strong administrative, civil and criminal enforcement efforts to ensure workers receive promised benefits

# DOL ERISA / EBSA Investigation

- Reasons for initiating investigations
  - Participant complaints to Office of Participant Education
  - Referrals from other regulators (e.g., SEC, IRS)
  - Enforcement initiatives (National Enforcement Projects)
  - Form 5500 filings / Employers having 100 or more ee's
  
- Procedure for DOL investigation
  - Initial Letter (Document Request or Appointment Letter)
  - Document Production and On-Site Interviews
  - Closing Letter: (1) No DOL action to be taken, (2) "Voluntary Compliance" notice, or (3) Litigation letter



# Potential Penalties for ERISA Violations

- Restitution and “make-whole” remedies for covered employee benefit plans
- Civil monetary penalties
- Injunctive relief (including putting service providers out of business)
- Reversal of prohibited transactions
- Referrals to other agencies, such as the IRS
- Criminal sanctions

# The AUDIT / Examination Process

1. The employer is notified by letter
2. In the letter, the examiner requests plans records and documents
3. The examiner and employer schedule a date for an appointment
4. Preliminary meeting with examiner to discuss audit overview and planning
5. The examiner conducts an on-site audit
6. Resolution of audit findings that require a change
7. A “closing letter” is issued



# Welfare Benefit Plan

## ...The Audit Letter

**U.S. Department of Labor** Employee Benefits Security Administration  
2300 Main Street, Suite 1100

### **DELIVERED VIA MAIL**

Dear REDACTED,

The Department of Labor has responsibility for the administration and enforcement of Title I of the Employee Retirement Income Security Act of 1974 (ERISA). Title I establishes standards governing the operation of employee benefit plans such as the REDACTED Plan).

The Plan is scheduled for investigation by this office. Investigative authority is vested in the Secretary of Labor by Section 504 of ERISA, 29 U.S.C. 1134, which states in part:

The Secretary [of Labor] shall have the power, in order to determine whether any person has violated or is about to violate any provision of this title or any regulation or order thereunder...to .make an investigation, and in connection therewith to require the submission of reports, books, and records, and the filing of data in support of any information required to be filed with the Secretary under this title....



## The Letter *(continued)*

Additionally, the Plan will be examined for the purpose of determining whether it is complying with the laws contained in Part 7 of ERISA, including the Health Insurance Portability and Accountability Act of 1996, the Newborns' and Mothers' Health Protection Act, the Women's Health and Cancer Rights Act (WHCRA), the Mental Health Parity and Addiction Equity Act, the Genetic Information Nondiscrimination Act, and the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act (together, the Affordable Care Act). These laws amended Part 7 of ERISA and provide requirements for group health plans.

We have found in the past that submission of relevant documents to our office prior to the possible inception of an on-site field investigation can lessen the time subsequently spent with, and the administrative burden placed on the plan and corporate officials. To that end, we ask that you submit the documentation listed on the enclosed attachment to this office within 10 working days from your receipt of this letter. After our office receives and reviews the requested documents, you will be contacted about the possibility of setting up the onsite portion of our investigation. Additional records and copies may be requested as needed at a later date. For reference and your information when preparing the documents for our review, **the period to be examined for the Plan is the period from July 1, 2011 through the present.**

An initial background interview will also eventually be conducted with yourself, and/or any other Plan or corporate official as is necessary to complete our review. The interview will be conducted in the later stages of my review and can be conducted over the telephone if necessary. Any other interviews that may be necessary will be conducted as needed.

Thank you in advance for your cooperation. Should you have any questions, please feel free to contact me at REDACTED.

# Requested Documents

**COPIES OF ITEMS IDENTIFIED BELOW SHOULD BE PROVIDED AS INDICATED IN THE COVER LETTER**

## **ATTACHMENT A**

1. Plan document.
2. Summary Plan Description (SPD), including any changes in Plan benefits and entitlement to 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 the costs associated with the purchase and maintenance of health and welfare benefits.

# Requested Documents *(continued)*

6. In accordance with the Health Insurance Portability and Accountability Act of 1996, please provide the following records:
  - A copy of the Plan's rules for eligibility to enroll under the terms of the Plan (including continued eligibility).
  - A sample of the certification provided to those employees who have lost health care coverage since **January 1, 2011** 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;
  - A copy of the record or log of all **Certificates of Creditable Coverage for individuals** who lost coverage under the Plan or requested certificates;
  - A copy of the written procedure for individuals to request and receive certificates;
  - 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;



# Requested Documents *(continued)*

- 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;
- A copy of the necessary criteria for an individual without a certificate of creditable coverage to demonstrate creditable coverage by alternative means;
- 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;
- 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 for adoption, including any lists or logs an administrator may keep of issued notices; and
- A copy of the Written appeal procedures established by the plan

## Requested Documents *(continued)*

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 including lists or logs of notices an administrator may keep of issued notices.
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 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.

## Requested Documents *(continued)*

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 January 1, 2011 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 January 1, 2011.

# Requested Documents *(continued)*

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 January 1, 2011, please provide documents showing the limits applicable for each plan year on or after January 1, 2011.  
 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 January 1, 2011, please provide documents showing the limits applicable for each plan year on or after January 1, 2011.

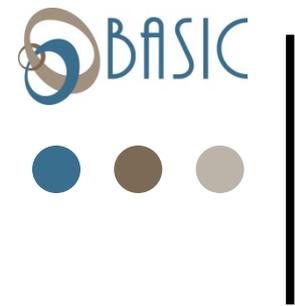
## Requested Documents *(continued)*

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, 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 preventive services for each plan year on or after January 1, 2011.
  - 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.
16. All documents relating to any bankruptcy filings involving the Health Plan
17. Insurance premium billing statements for the examination period and schedules of insurance premium rates for employees and employ

# Best Practices

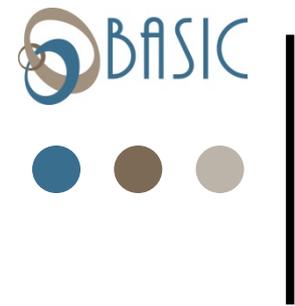
During the audit

- 1) Choose one point person to serve as liaison.
- 2) Ask DOL for permission to bring in ERISA counsel.
- 3) Negotiate scope of document request (e.g., limit to sampling of documents).
- 4) Perform legal review of any requested materials before delivery to DOL.
- 5) If any discrepancies are uncovered, provide explanation and/or proposed remedial action.
- 6) Prepare personnel for on-site interviews.



## Best Practices to Manage the Audit

- Be responsive to requests
  - Obtain extensions when needed
  - Negotiate scope of overly broad requests
- Involve your ERISA counsel and consultants
- Review responses to identify problems before the examining agent discovers them
- Propose appropriate corrective actions to known problems
- Be proactive to negotiate appropriate resolutions of audit findings



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# Contact the Presenter



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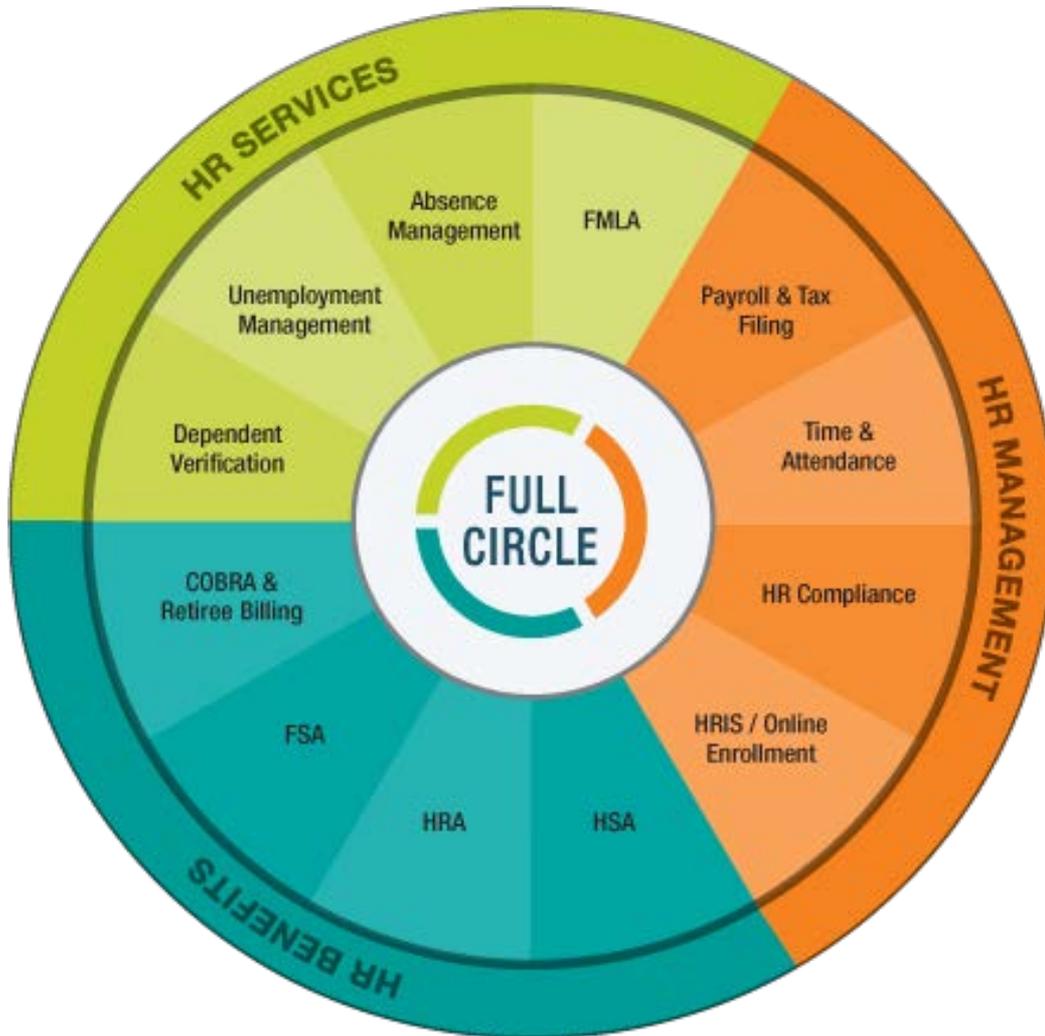
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# Contact Us



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**Keep it BASIC.**



800.444.1922  
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# BASIC's Award Winning Services

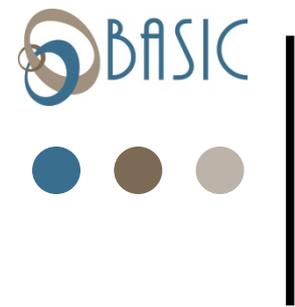


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# Disclaimer



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