chapter 13

Cafeteria Plans, Employee Fringe Benefits And COBRA

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chapter 13

Cafeteria Plans, Employee Fringe Benefits And COBRA

I. IRC §125 CAFETERIA PLANS.

A. Introduction.

A cafeteria plan is an employer fringe benefit plan that permits participating employees to choose from two or more benefits consisting of "cash" and "qualified" benefits. The cafeteria plan must offer both "cash" and at least one "qualified" benefit. A plan which offers only two "qualified" benefits or only two "cash" benefits is not a cafeteria plan. The cash may result from contributions by the employer to the plan, or may be the result of a voluntary salary reduction by the employee.

B. Qualified Benefits.

A benefit is qualified if it does not defer the receipt of compensation and it is excluded from gross income by an express provision of another section of the Internal Revenue Code ("IRC"). Qualified benefits include medical disability insurance, accident/health insurance, group-term life insurance (up to $50,000.00), dependent care assistance, group legal coverage and §401(k) cash or deferred arrangements. Qualified benefits <u>cannot</u> include:

1. Contributions to a medical savings account under IRC §106(b);

2. Scholarship and fellowship grants excludable under IRC §117;

3. Qualified educational assistance excludable under IRC §127;

4. Fringe benefits excludable under IRC §132 (de minimus fringes, no-additional-cost service fringes, employee discounts, working condition fringes);

5. Any product which is advertised, marketed or offered as long-term care insurance. IRC §125(f);

6. Deferred compensation under IRC §125(d)(2); and

7. Meals and lodging under IRC §119. (Prop. Reg. §1.125-2, Q. and A.-4(d)).

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Benefits do not lose qualified status merely because they are included in income solely due to violations of non-discrimination rules affecting the underlying benefits. Prop. Reg. §1.125-2, Q. and A.-4(a)(2)(iii).

As a result of the Patient Protection and Affordable Care Act, effective January 1, 2014, the term "qualified benefit" shall not include any qualified health plan offered through an exchange except in the case of an employee of a qualified employer offering the employee the opportunity to enroll through such an exchange in a qualified health plan in a group market.

C. Cash Benefits.

A benefit is treated as cash if:

1. It does not defer the receipt of compensation; and

2. The employee either purchases the benefit with after-tax contributions or, for Federal income tax purposes, is treated as if the employee had. Prop. Reg. §1.125-2, Q. and A.-4(b).

D. Plan Participants.

Participation in a cafeteria plan must be limited to employees. IRC §125(d)(1)(A). Former employees are treated as employees, but self-employed individuals, as defined in IRC §401(c), are not. Even though former employees are generally treated as employees, a cafeteria plan may not be established predominately for their benefit. Further, although only employees may have the right to elect benefits under the plan, the plan may provide benefits for the spouse and beneficiaries of an employee who is a participant. Prop. Reg. §1.125-1, Q. and A.-4.

Eligibility to participate in a cafeteria plan may require up to a three years of service requirement. Participation commences not later than the first day of the first plan year after eligibility requirements are met. IRC §125(g)(3)(B).

Although a spouse and dependents may benefit from the plan, they are not active participants in the plan. Upon the death of the employee, the spouse may be given a right to elect coverage. However, the surviving spouse is not treated as an active participant merely because the surviving spouse makes an election. Reg. §1.125-1 Q. and A.-4.

E. Plan Contributions.

The cafeteria plan may be financed with employer contributions, as well as after-tax employee contributions. In addition, the employer and employee may enter into a salary-reduction agreement under which the employee's salary is reduced by a given amount and the employer agrees to contribute an equal amount to the cafeteria plan for the employee's benefit. The contribution is treated as the employer's contribution if the employee had not actually or constructively

received the salary payment when the salary-reduction agreement was entered into. Prop. Reg. §1.125-1, Q. and A.-5 and 6. Therefore, the employee is allowed to make a contribution with pre-tax dollars.

F. Taxation of Employee.

In order for a qualified benefit to be received tax-free by an employee under a cafeteria plan, the benefit must meet all of the requirements of the specific Code section that gives the benefit tax-free status. IRC §125 suspends application of the constructive receipt rules for benefits that are otherwise not taxable, but, it does not create new tax-exempt benefits. Prop. Reg. §1.125-1, Q. and A.-16. Benefits treated as cash are fully taxable.

G. Electing Benefits.

An employee must elect non-taxable benefits under an IRC §125 cafeteria plan before the alternative cash benefit becomes currently available to him. Otherwise, the employee will be taxed as if the employee had received the cash benefits. Prop. Reg. §1.125-2, Q. and A.-2. A benefit is currently available to a plan participant ("Participant") if the Participant is free to receive the benefit currently or if the Participant could receive it by making an election or by giving a notice of intent to receive the benefit. However, a benefit is not currently available if there is a substantial limitation or restriction on the Participant's receipt of the benefit. Prop. Reg. §1.125-1, Q. and A.-14.

A Participant who has elected a benefit under the plan and has started to receive the benefit may not generally revoke the election during the period of coverage (i.e. the plan year) even if the revocation only applies to future benefits. Prop. Reg. §1.125-2, Q. and A.-6.

A cafeteria plan may, on a reasonable and consistent basis, automatically adjust all effective participants' elective contributions for health plans if (1) the cost of a health plan provided by an independent third-party provider under a cafeteria plan changes and (2) under the terms of the cafeteria plan, employees are required to make a corresponding change in their premium payments. Alternatively, if the premium increases significantly, a cafeteria plan may permit participants to (1) make a corresponding change in their premium payments or (2) revoke their elections and, in lieu thereof, to receive, on a prospective basis, similar coverage under another health plan. For dependent care assistance, election changes may not be made due to a change in cost if the provider is a relative of the employee. Reg. §1.125-4.

A cafeteria plan will not fail to satisfy §125 if it changes the employee's election to provide coverage for a child if a judgment, decree or order resulting from a divorce, legal separation, annulment, or change in custody requires coverage for a child under the employer's plan. An employee is also permitted to make an election change to cancel coverage for such a child if the order requires the spouse, former spouse, or other individual to provide coverage for the child and that coverage is in fact provided.

If an employee, spouse, or dependent who is enrolled in an accident or health plan of the employer becomes entitled to coverage under Medicare or Medicaid (part a or part b of Title XVII of the Social Security Act, or Title XIX of the Social Security Act), the cafeteria plan may permit the employee to make a prospective election change to cancel or reduce coverage of that employee, spouse, or dependent under the accident of health plan. In addition, if an employee, spouse or dependent who has been entitled to such coverage under Medicare or Medicaid loses all eligibility for such coverage, the cafeteria plan may permit the employee to make a prospective election to commence or increase coverage of that employee, spouse, or dependent under the accident or health plan.

If coverage under a plan is significantly curtailed or ceases during a period of coverage, the cafeteria plan may permit affected employees to revoke their elections under the plan. In that case, each affected employee may make a new election on a prospective basis for coverage under another benefit package option providing similar coverage. Coverage under an accident or health plan is significantly curtailed only if there is an overall reduction in coverage provided to participants under the plan so as to constitute reduced coverage to participants generally. Reg. §1.125-4.

If during a period of coverage a plan adds a new benefit package option or other coverage option (or eliminates an existing benefit package option or other coverage option), the cafeteria plan may permit affected employees to elect the newly-added option (or elect another option if an option has been eliminated) prospectively on a pre-tax basis and to make corresponding election changes with respect to other benefit package options providing similar coverage. Reg. §1.125-4.

A participant may revoke a benefit election and make a new election during a period of coverage if the change is caused by, and consistent with, a change in the participant's family status. Examples of such changes are marriage or divorce, death of a spouse or a dependent, birth or adoption of a child, change in residence of an employee, spouse or dependent, the switching from full-time to part-time status (or vise versa) of the employee or his spouse, taking of an unpaid leave of absence of the employee or his spouse, significant change in the health coverage of the employee or employee's spouse attributable to the spouse's employment and the termination (or commencement) of a spouse's employment. Additionally, an employee who separates from service may terminate benefits. Lastly, the plan may terminate the benefits of an employee during a period of coverage if the employee fails to make the required premium payments. Reg. §1.125-4.

H. FICA and FUTA Tax.

Payments under a cafeteria plan are excluded from the definition of "wages" subject to FICA and FUTA tax if they are otherwise excluded from such wages and it is reasonable to believe that under IRC §125 they would not be treated as constructively received. IRC §3121(a)(5)(G), IRC §3306(b)(5)(G).

I. Deferral of Compensation.

A cafeteria plan may not include any plan that provides for the deferral of compensation. IRC §125(d)(2)(A). Further, it may not allow employees to carry over unused elective contributions for plan benefits from one plan year to the next. Such a carry-forward is treated as a deferral of compensation. Also, a plan may not allow participants to use contributions for one plan year to purchase benefits that will be supplied in a later year. Prop. Reg. §1.125-2, Q. and A.-5(a). However, reasonable premium rebates or policy dividends paid with respect to benefits provided under a cafeteria plan do not defer compensation if they are paid within twelve months of the close of the plan year. Prop. Reg. §1.125-2, Q. and A.-5(b).

1. Two and One-Half Month Grace Period. IRS Notice 2005-42 permits a grace period immediately following the end of each plan year during which unused benefits or contributions remaining at the end of the plan year may be paid or reimbursed to plan participants for qualified benefit expenses incurred during the grace period. Expenses for qualified benefits incurred during the grace period may be paid or reimbursed from benefits or contributions remaining unused at the end of the immediately preceding plan year. The grace period must not extend beyond the fifteenth day of the third calendar month after the end of the immediately preceding plan year to which it relates (i.e., "the 2 and ½ month rule").

J. Vacation Days.

A cafeteria plan may allow employees to receive additional or fewer paid vacation days than the employer otherwise provides. However, an elective vacation provision may not be used to defer compensation. If a plan allows a participant to be paid in cash for unused elective vacation days, the payment must be made before the end of the plan year and before the end of the employee's taxable year to which the elective contributions relate. Allowing employees to exchange vacation days in the current plan year for payments in the next plan year would not be a disqualifying deferral of compensation. Prop. Reg. §1.125-2, Q. and A.-5(c).

Example: Employer A provides all of its employees with one week of paid vacation each calendar year. Employer A establishes a calendar year cafeteria plan under which each participant may choose to forgo cash or other benefits for any calendar year in exchange for one additional week of paid vacation during the year. If the employee elects the optional week of vacation and fails to use it during the calendar year, the value of the unused week may be paid to the employee in cash before the end of the year. However, the week may not be carried over to the next calendar year and its value may not be cashed out or used for any other purpose during the next calendar year.

A participant is deemed to use his non-elective vacation days before his elective vacation days. Prop. Reg. §1.125-2 Q. and A.-5(c)(2).

K. Qualified Cash or Deferral Arrangement.

Although a cafeteria plan cannot include plans providing for deferred compensation, it can include a profit-sharing or stock bonus plan that has a qualified cash or deferral arrangement under IRC §401(k). Amounts contributed under the employee's election are treated as non-taxable benefits for cafeteria plan purposes. IRC §125(d)(2)(B). After-tax employee contributions under a defined contribution plan subject to the non-discrimination rules of IRC §401(m), are also allowed. Furthermore, employer matching contributions may be made with respect to before-tax or after-tax employee contributions. Prop. Reg. §1.125-2, Q. and A.-4(c).

L. Formal Plan Requirements.

The written cafeteria plan document must contain:

1. A description of each benefit available under the plan including the periods of coverage (need not be self-contained; the description may be incorporated by reference [e.g. group legal plans, dependent care plans]);

2. The plan rules governing participation;

3. Procedures by which employees make elections under the plan (specified period during which elections are made and the extent such election is irrevocable and the period in which such election is effective);

4. The manner in which employer contributions are made under the plan;

5. The plan year; and

6. The maximum amount of employer contributions available for any participant.

The plan document must also describe the maximum amount of elective contributions available to any employee. This may be done by stating the maximum dollar amount or the maximum percentage of compensation that may be contributed as the elective contributions by employees or by stating the method for determining the maximum amount or percentage. Prop. Reg. §1.125-1, Q. and A.-3; Prop. Reg. §1.125-2, Q. and A.-3

As a practical point, employers may wish to maintain separate written plans for benefits offered under cafeteria plans. An employer may wish to offer the benefits to employees outside of the plan or the same benefit may be offered in two or more plans. Moreover, cafeteria plans may avoid being subject to ERISA if each substantive benefit in the cafeteria plan is a separate written plan satisfying ERISA. Additionally, certain benefits (e.g. group legal services, uninsured medical expense reimbursements and dependent care service) are required to be set forth in separate written plans.

If the cafeteria plan is subject to ERISA, the plan must name the fiduciaries and comply with ERISA.

M. Flexible Spending Arrangements.

A flexible spending arrangement ("FSA") is an employee benefit program that reimburses employees for certain expenses they incur and under which the maximum amount of reimbursement for a period of coverage is not substantially greater than the total premiums paid. The flexible spending arrangement rules apply if the maximum reimbursement is less than five times the premium. Prop. Reg. §1.125-2, Q. and A.-7(c). As a result of the Patient Protection and Affordable Healthcare Act, reimbursements under a FSA generally will be limited to $2,500, effective January 1, 2013 (with adjustment for inflation beginning January 1, 2014.

Special rules are applied to health plans that are FSAs in order to prevent them from being used as devices for avoiding the restrictions on the deduction of personal medical expenses. This deduction applies for medical expenditures in excess of 7.5% of the individual's adjusted gross income. Health FSAs must be bona fide health plans and not separate, employee-by-employee health expense reimbursement accounts that operate like employee-funded defined contribution plans. A health FSA must qualify as an accident or health plan under IRC §105 and IRC §106. In particular, health FSAs must exhibit the risk-shifting and risk-contribution characteristics of insurance and payments must be made specifically to reimburse participants for medical expenses incurred previously during the period of coverage. Prop. Reg. §1.125-2, Q. and A.-7(a).

The employer's risk can be controlled by limiting the maximum salary reduction and health care spending account reimbursement to a relatively low amount (e.g.: $500.00) or by establishing a year of service requirement for eligibility.

The maximum amount of reimbursement under a health FSA must be available at all times during the period of coverage. It cannot depend on the extent to which the participant has paid the required premiums for the period. Nor may the schedule for premium payments during the period of coverage be based on the rate or amount of claims already incurred during the period. The period of coverage for a health FSA must be 12 months or, in the case of a short plan year, the entire short year. Prop. Reg. §1.125-2, Q. and A.-7(b)(2) and (3).

1. Reimbursements. A health FSA can only reimburse medical expenses as defined in IRC §213. It may not treat participants' premium payments for other health coverage as reimbursable expenses. To obtain reimbursement, the participant must provide the health FSA with a written statement from an independent third party stating the amount of the medical expense incurred. The participant must also provide a written statement that the expense is not reimbursable under any other health plan. The medical expenses must have been incurred during the participant's period of plan

coverage. The time when the medical expense is billed or paid is not relevant. Prop. Reg. §1.125-2, Q. and A.-7(b)(5) and (6).

2. As a result of the Patient Protection and Affordable Care Act of 2010, health FSAs can only reimburse medicines and drugs other than insulin if the medicine or drug is prescribed (determined without regard to whether a prescription is necessary to acquire the drug).

3. Experience Gains. If a health FSA has an experience gain for a year of coverage, the gain may be used to reduce the next year's premiums or may be returned to the premium payers. The experience gain must be allocated on a reasonable uniform basis that is not related to the claims experience of individual participants. Prop. Reg. §1.125-2, Q. and A.-7(b)(7).

4. Dependent Care Assistance FSAs. FSAs providing dependent care assistance are subject to rules similar to those for health FSAs, except that the requirement of uniform coverage throughout the coverage period does not apply. Prop. Reg. §1.125-2, Q. and A.-7(b)(8).

N. Non-Discrimination Rules.

The non-discrimination rules are designed to encourage cafeteria plans to provide adequate benefits to rank and file employees. IRC §125(b). If a cafeteria plan meets the other requirements of IRC §125, but fails to comply with the non-discrimination rules, the benefits received by rank and file employees are protected by cafeteria plan rules. However, benefits received by highly compensated participants or key employees may be included in income. Prop. Reg. §1.125-1, Q. and A.-10.

1. Highly Compensated Participants.

a. The cafeteria plan rules do not apply to any benefit of a highly compensated participant that is attributable to a plan year in which the plan discriminates in favor of highly compensated individuals as to eligibility to participate, or in favor of highly compensated participants as to contributions or benefits. IRC §125(b)(1). "Highly compensated individual or participant" is not the same as a "highly compensated individual" under IRC §414(q). For purposes of IRC §125, "Highly compensated participants" and "highly compensated individuals" mean plan participants and individuals who are:

i. officers;

ii. greater than 5% (voting or valuation) shareholders;

iii. highly compensated; or

iv. spouses or dependents of any persons in (i) - (iii). IRC §125(e).

b. Any benefit taxable because of violation of the non-discrimination rules is treated as received or accrued in the tax year in which the plan year ends. IRC §125(b)(3). If the cafeteria plan is discriminatory in favor of highly compensated employees, a highly compensated employee is taxed on the maximum taxable benefits that such employee could have selected for the plan year. Prop. Reg. §1.125-1, Q. and A.-11.

2. Non-Discrimination Test. A plan is considered to have non-discriminatory coverage if it benefits a class of employees that the IRS determines is not discriminatory in favor of highly compensated employees. Such a plan must not require more than three consecutive years of employment for plan participation, and the employment requirement for each employee must be the same. Further, the plan must permit otherwise eligible employees to begin participation no later than the first day of the plan year beginning after the completion of three consecutive years of employment. IRC §125(g)(3).

Health benefits under a cafeteria plan will not be considered to be discriminatory if:

a. total contributions for each participant include either an amount equal to 100% of the cost of health benefit coverage under the plan of the majority or of similarly situated highly compensated participants, or an amount equal to or greater than 75% of the cost of health benefit coverage of the similarly situated participant who has the highest cost health benefit coverage under the plan; and

b. contributions or benefits exceeding those amounts bear a uniform relationship to compensation. IRC §125g(2)

3. Key Employees. If statutory non-taxable benefits provided to key employees under the plan exceed 25% of the total of such benefits provided to all employees under the plan, tax favored treatment will not apply to any benefit of a key employee. "Statutory non-taxable benefits" in this context does not include group-term life insurance in excess of $50,000.00 or benefits that are normally taxable but permitted by the Regulations. "Key employee" is defined in IRC §416(i)(1). Any benefit taxable because of violation of the discrimination rule is treated as received or accrued in the tax year in which the plan year ends. IRC §125(b)(2) and (3).

4. Other Non-Discrimination Rules. A plan is not discriminatory if it is maintained under an agreement that the IRS finds to be a collective bargaining agreement. IRC §125(g)(1). Also, for purposes of the non-discrimination tests, all employees of a commonly controlled group of

businesses or of an "affiliated service group" are treated as employed by a single employer. IRC §125(g)(4).

O. Regulations.

The IRS has recently released new proposed regulations for cafeteria plans. The guidance replaces the prior proposed regulations by consolidating existing guidance from IRS Notices, Revenue Procedures, and other IRS releases. The existing final regulations relating to FMLA (§1.125-3) and changes in status (§1.125-4) were not modified or replaced.

P. Effect of the Family and Medical Leave Act on the Operation of Cafeteria Plans.

1. Under the Treasury Regulations at §1.125-3, an employee taking FMLA leave may revoke an existing election of group health plan coverage under the cafeteria plan. Additionally, the employee must be permitted to choose to be reinstated (under the same terms) in the group health plan coverage provided under the cafeteria plan upon returning from FMLA leave. Reg. §1.125-3, Q & A-1.

2. While on FMLA leave, an employee is entitled to continue group health plan coverage whether or not provided under the cafeteria plan. Such employee is responsible for continuing to make the premium payments. The cafeteria plan may, on a non-discriminatory basis, offer one or more of the following payment options to an employee who continues group health plan coverage while on unpaid leave:

   a. Pre-pay Option. Under the pre-pay option, the cafeteria plan may permit an employee to pay, prior to commencement of the FMLA leave, the amounts due during the FMLA leave period. These contributions may be made on a pre-tax salary reduction basis.

   b. Pay-as-you-go Option. This option is generally made available on an after-tax basis. These payments are due (by the premium due date) during the FMLA leave period.

   c. Catch-up Option. The employer and employee may agree to allow the premiums to be paid after the FMLA leave period is over. Under this provision, the employer and employee must agree in advance of the FMLA leave period that: (1) the employee will continue health coverage during the FMLA leave period; (2) the employer will assume responsibility for advancing payments of the employee's premiums during the FMLA leave period; and (3) these advanced amounts must be paid by the employee when the employee returns from the FMLA leave. Contributions under this option may be made on a pre-tax salary reduction basis when the employee returns from the FMLA leave. Reg. §1.125-3, Q & A-3.

3. These provisions do not apply if the employee is on paid FMLA leave. Reg. §1.125-3, Q & A-4.

4. FMLA does not require employers to maintain an employee on non-health benefits (e.g., life insurance) during the leave period. Reg. §1.125-3, Q & A-7.

Q. Simple Cafeteria Plans. Code §105(b), as amended by Reconciliation Act Section 1004(d).

One intent of the new health care reform legislation is to encourage small employers to provide health insurance coverage benefits to their employees, particularly on a tax-free basis. To accomplish this goal, for years beginning after December 31, 2010, the law provides eligible small employers with the ability to offer a "simple cafeteria plan" under which a safe harbor from the nondiscrimination requirements generally applicable to cafeteria plans is provided. Additionally, small employers are provided a safe harbor from the nondiscrimination requirements applicable to certain qualified benefits offered under the plan. For purposes of the simple cafeteria plan provisions, a small employer is defined as an employer that employed an average of 100 or fewer employees on business days during either of the two preceding tax years.

Under a traditional cafeteria plan, an employer may offer employees a choice of either certain qualified benefits or cash. If an employee selects any of the qualified benefits offered, the value of such benefits is not includible in his or her income. Despite its advantages, however, a cafeteria plan is subject to strict rules whereby it may not discriminate in favor of highly compensated participants. A failure to satisfy these nondiscrimination rules results in the inclusion of the qualified benefits in the highly compensated participant's income.

Conversely, under the new health care reform, a simple cafeteria plan provides small employers with a safe harbor from these nondiscrimination requirements applicable to cafeteria plans and certain qualified benefits offered under the plan. Under this safe harbor, an eligible employer offering a simple cafeteria plan and certain qualified benefits offered under it will be treated as meeting any applicable nondiscrimination requirements during such year, provided certain requirements are met.

First, under a simple cafeteria plan, an employer must make a contribution to provide qualified benefits under the plan on behalf of each qualified non-highly compensated employee eligible to participate in the plan, regardless of whether such employee makes a salary reduction contribution, in an amount equal to: (i) a uniform percentage of not less than 2% of the employee's compensation for the plan year; or (ii) an amount which is not less than the lesser of 6% of the employee's compensation for the plan year or twice the amount of the salary reduction contributions of each qualified employee.

Second, all employees with at least 1,000 hours of service for the preceding plan year must be eligible to participate in the plan (with certain exceptions) and each

eligible employee must be given the opportunity to elect any qualified benefit offered under the plan subject to the terms and conditions applicable to all participants.

Essentially, like the increasingly popular safe harbor 401(k) plan, the simple cafeteria plan's safe harbor allows a small employer to avoid complex nondiscrimination rules. With relatively minimal required contributions and a broadening of eligibility for the plan, this new health care reform tool may be a great asset to eligible small employers.

II. EMPLOYEE FRINGE BENEFIT QUALIFICATION AND NON-DISCRIMINATION RULES.

A. In General.

Upon the repeal of §89 of the Internal Revenue Code on November 7, 1989, most of the pre-§89 non-discrimination and other qualification requirements for employee fringe benefit plans were restored. In general, the non-discrimination rules for group-term life insurance plans under IRC §79 and for self-insured medical reimbursement plans under IRC §105(h) have been restored.

In addition to repealing IRC §89, some of the pre-§89 non-discrimination rules have been changed or slightly modified. Under the law, church plans offering group-term life insurance to church employees are exempt from discrimination rules found under IRC §79. Further, dependent care assistance plans which fail to meet non-discrimination tests or other qualification rules under IRC §129 can still provide tax-free employee fringe benefits to non-highly compensated employees.

Until plan years beginning some time after final regulations or other definitive guidance has been issued pursuant to the Patient Protection and Affordable Care Act, insured health and accident plans have no non-discrimination requirements.

B. Group-Term Life Insurance.

Under IRC §79, an employer can provide up to $50,000.00 of group-term life insurance to employees tax-free. Coverage exceeding $50,000.00 is included in an employee's income, not at actual cost but at the favorable rates provided in Regulation §l.79-3(d)(2). The $50,000.00 threshold refers to the life insurance coverage amount, not to an employee's earned income; therefore, the fact that an employee earns less than $50,000.00 is irrelevant. Robert Charles Fohrmeister, T.C. Memo 1997-159.

1. Eligibility Requirements. IRC §79(d)(3)(B).

   a. Employees may be excluded from a plan if:

      i. such employees have not completed three years of service;

ii. they are part-time (customary employment of less than 20 hours per week) or seasonal employees (customary employment of not more than five months per year);

iii. they are non-resident aliens who receive no U.S. income from the employer; or

iv. they are covered by a collective bargaining agreement in which benefits provided under the plan were subject to good faith bargaining.

2. Anti-discrimination Rules. IRC §79(d)(3)(A).

a. A plan is not discriminatory as to eligibility to participate if one of the following four tests is satisfied:

i. at least 70% of all employees receive benefits under the plan; or

ii. at least 85% of all employees participating in the plan are not key employees; or

iii. the plan benefits employees under a classification set up by the employer that the IRS determines does not discriminate in favor of key employees; or

iv. the plan is part of a cafeteria plan satisfying IRC §125 requirements.

b. If a group-term life insurance plan discriminates in favor of key employees either with respect to benefits provided or eligibility to participate, then the key employees will report as income the higher of the actual premium paid by the employer or the amount from the table found in the Regulations for all coverage provided by the employer.

c. Key employees [as defined in IRC §416(i)] are: (i) officers whose annual pay is greater than one-half of the current IRC §415(b)(1)(A) limit (for plan years after December 31, 2001, $80,000.00); and (ii) the ten employees whose annual pay exceeds the limit in effect under IRC §415(c)(1)(A) (for plan years after December 31, 2001, $40,000.00) and who own the largest interest in the employer; (iii) 5% owners; and (iv) 1% owners whose income is more than $150,000.00.

d. Plan benefits are discriminatory unless all benefits available to key employees are also available to all other participants; provided, however, that there is no discrimination merely because the

insurance provided each participant bears a uniform relationship to compensation.

e. The non-discrimination rules do not apply to church plans maintained for church employees. The terms "church plan" and "church employee" are defined in IRC §414(e)(1) and (3). A church plan must be established and maintained by a church or association of churches exempt from tax under IRC §501(c)(3); provided, however, that the term "church employee" does not include any employee of an educational entity above the secondary school level (other than a school for religious training) and it does not include an employee of a hospital, a medical school, a medical research institution or other charity with similar exempt purposes.

3. Employers with Less than 10 Employees.

Additional requirements apply with the group-term life insurance provided to less than ten (10) full-time employees throughout the calendar year.

a. The insurance must be provided to all full-time employees of the employer or to all full-time employees who provide evidence of insurability that is satisfactory to the insurer. Reg. §1.79-1(c)(2)(i).

b. The amount of the insurance provided can be uniform for all employees regardless of compensation (e.g. $10,000.00 of life insurance for all employees) or based on compensation. If based on compensation, the insurance must be computed as a uniform percentage of compensation or on a basis of "coverage brackets" established by the insurer. No coverage bracket may be more than 2-1/2 times the next lower bracket and the lowest bracket must be at least ten percent (10%) of the highest bracket. Reg. §1.79-1(c)(2)(ii); Rev. Rul. 80-220.

c. The evidence of insurability concerning eligibility for coverage or the amount is limited to a medical questionnaire completed by the employee that does not require a physical examination. Reg. §1.79-(c)(2)(iii).

In applying these rules, employees may be excluded if they are denied insurance because they are part-time or fail to complete a waiting period not to exceed six months. Reg. §1.79-1(c)(4).

4. Reporting Requirements.

The cost of group-term life insurance that is includable in the gross income of the employee is considered "wages" subject to Social Security Tax. IRC §3121(a)(2). Generally, only the cost of life insurance coverage in excess of $50,000.00 will be subject to Social Security Tax. The

employer is required to report amounts includable in the wages of current employees on the W-2. The employer may treat the wages as though paid on any basis so long as they are treated as paid at least once each year. IRS Notice 88-82. The employer is not subject to the withholding requirements, but must file an information return for each calendar year. Currently, the Form W-2 satisfies this requirement. IRC §6052; Reg. §1.6052-1(a).

5. Miscellaneous.

Group-term life insurance coverage up to $2,000.00 for an employee's spouse or other dependent is excludable from gross income as a de minimus fringe benefit under IRC §132(e). Since benefits excludable under IRC §132 may not be provided under a cafeteria plan, the group-term life insurance coverage of the spouse or dependent may not be offered under a cafeteria plan.

C. Accident and Health Plans.

1. Insured Plans.

Under the reinstated prior law rules of IRC §§105 and 106, there are no discrimination rules which apply to insured health and accident plans.

2. However, as a result of the Patient Protection and Affordable Healthcare Act, effective for plan years beginning on or after September 23, 2010 (with the exception of grandfathered plans for a limited time), the nondiscrimination rules of IRC §105(h)(2), including "rules similar to" those in IRC §105(h) are extended to fully-insured health and accident plans. These rules regarding nondiscrimination eligibility, nondiscriminatory benefit, and controlled groups, prohibit discrimination in favor of highly compensated individuals. The nondiscrimination requirement appears in PHSA §2716, which was added by the health care reform law. Please Note: Although the health care law initially required compliance with the nondiscrimination rules for insured plans for plan years beginning on or after September 23, 2010, the IRS announced in IRS Notice 2011-1 that compliance with the rules will not be required until the agencies have issued regulations or other guidance regarding the rules. Until that time, sanctions for failure to comply with the rules will not apply.

3. Self-Insured Plans. IRC §105(h)

If an employer maintains a self-insured medical plan, the non-discrimination tests in IRC §105(h) apply.

a. Employees may be excluded from a plan if:

i. they have not completed three years of service;

ii. they are under age 25;

iii. they are part-time (less than 35 hours per week) or seasonal employees (less than 9 months per year);

iv. they are covered by a collective bargaining agreement if health and accident benefits were the subject of good faith bargaining; or

v. they are non-resident alien employees who receive no U.S. income from the employer. Reg. §1.105-11(c)(2)(iii).

b. A plan is not discriminatory as to eligibility to participate if one of the following tests is satisfied:

i. 70% or more of all employees receive benefits under the plan; or

ii. 80% or more of all eligible employees receive benefits under the plan if at least 70% of all employees are eligible; or

iii. the plan benefits employees under a classification set up by the employer that is determined by the IRS not to discriminate in favor of highly compensated individuals (e.g. a "fair cross-section"). Reg. §1.105-11(c)(2)(i) and (ii).

c. A discriminatory self-insured plan will require highly compensated individuals to take "excess reimbursements" into income.

i. Highly compensated individuals [as defined in IRC §105(h)(5)] include the five highest paid officers, the more than 10% owners, and the highest paid 25% of all employees (other than excludable employees who are not participants).

d. The amount that is treated as "excess reimbursement" depends on whether the plan is discriminatory as to eligibility to participate or as to benefits offered under the plan.

i. If a plan provides discriminatory benefits (benefits available to highly compensated individuals are not available to all other plan participants), then the entire amount of the benefit is an excess reimbursement. A plan discriminates in favor of highly compensated employees as to benefits unless all benefits provided for highly compensated employees and their dependents are also

provided for all other participants and their dependents. Reg. §1.105-11(c)(3).

ii. If a plan provides discriminatory coverage (benefits are the same for all participants, but the plan discriminates in eligibility to participate), then the excess reimbursement is determined by multiplying a highly compensated individual's reimbursement by a fraction where the numerator is the amount of benefits received by all highly compensated individuals during the plan year and the denominator is the total amount of benefits received by all plan participants during the year.

4. Penalties for Noncompliance With Nondiscrimination Rules.

a. Insured Plans. Subject to civil action to compel nondiscriminatory benefits and excise taxes or civil money penalties.

b. Self-Insured Plans. Loss of tax benefits for highly compensated individuals.

5. Health Reimbursement Arrangements ("HRAs").

a. The IRS sanctioned a new type of plan for reimbursing employee and dependent medical expenses called a "Health Reimbursement Arrangement" in Revenue Ruling 2002-41 and Notice 2002-45.

b. The IRS states that an HRA is an arrangement that:

i. is paid for solely by the employer and not provided pursuant to a salary reduction election or otherwise under a Section 125 cafeteria plan;

ii. reimburses the employee for medical care expenses (as defined in IRC §213(d)) incurred by the employee and the employee's spouse and dependents (as defined in IRC §152); and

iii. provides reimbursements up to a maximum dollar amount for a coverage period and any unused portion of the maximum dollar amount at the end of a coverage period is carried forward to increase the maximum reimbursement amount in subsequent coverage periods.

c. HRAs are subject to the non-discrimination rules of IRC §105(h) and Reg. §1.105-11.

D. Dependent Care Assistance Programs. IRC §129.

1. Under an IRC §129 dependent care assistance program, employees generally receive tax-free dependant care assistance up to $5,000.00 annually. The contributions and benefits under the plan cannot discriminate in favor of highly compensated employees as defined in IRC §414(q) or their dependents. In addition, the dependent care assistance program must benefit a class of employees which the IRS determines does not discriminate in favor of highly compensated employees.

2. Employees may be excluded from a plan if:

   a. such employees have not reached age 21 and completed one year of service; or

   b. such employees are in a unit of employees covered by a collective bargaining agreement if dependent care benefits were the subject of good faith bargaining. IRC §129(d)(9).

3. The "average benefits test" requires that the "average benefit" provided to non-highly compensated employees be at least 55% of the benefits provided to highly compensated employees. If the benefits are provided through a salary reduction plan, this test may disregard any employee whose compensation is less than $25,000.00. Although there is no statutory Code specifically authorizing the 55% test to be limited to a line of business basis, the legislative history states that the 55% average benefit test was to be performed on a separate line of business basis. IRC §129(d)(8).

4. In addition to the "average benefits test", no more than 25% of the dependent care assistance benefits paid during the year may be provided to 5% (or more) owners (or their spouses or dependents). IRC §129(d)(4).

5. Benefits provided under a discriminatory dependent care assistance plan will be taxable income to the highly compensated employees participating in the plan. Non-highly compensated employees will continue to exclude benefits from taxable income.

6. Generally, by January 31 of each year, the employer must give the participating employee a written statement showing the amount of expenses paid or incurred for that employee during the preceding calendar year. IRC §129(d)(7).

7. The expenses must be incurred for either: (1) a dependent under the age of 15 or (2) a spouse or other dependent of the employee who is physically or mentally incapable of caring for himself or herself. Reg. §1.44A-

1(b)(4). An individual is considered to be physically or mentally incapable of caring for himself if, because of the mental or physical defect, the individual is "incapable of caring for his hygienic or nutritional needs or requires full-time attention of another person for his own safety or the safety of others." Reg. §1.44A-1(b)(4). The mere fact that the individual is unable to engage in substantial gainful activity or to perform the normal household functions of a homemaker or care for minor children is not sufficient. A person's status as a qualified dependent is determined on a day-to-day basis. Thus, for example, if a dependent turns 15 on July 1, the expenses incurred after July 1 will not be treated as employment-related expenses.

E. Educational Assistance Programs. IRC §127.

1. An educational assistance plan under IRC §127 enables an employee to receive tax-free $5,250.00 annually for use on qualifying educational expenses.

2. The only employees excludable from a plan are those who are covered under a collective bargaining agreement, provided that educational assistance benefits were bargained for in good faith.

3. The non-discrimination rules of IRC §127 provide that no more than 5% of the educational expenses paid under the plan during a plan year may benefit 5% (or more) owners, their spouses and their dependents.

4. The plan must be written and for the exclusive benefit of employees and the employer may not allow employees to choose between educational assistance and other taxable pay.

5. The Small Business Act of 1996 retroactively extended the exclusion for employer-provided educational assistance for tax years beginning after December 31, 1994 to tax years beginning before May 31, 1997. For tax years beginning in 1997, only expenses paid for courses beginning by July 1, 1997 are excludable. However, under the Small Business Act, expenses for graduate-level courses beginning after June 30, 1996 are not excludable. §1605 of the Small Business Act.

F. Qualified Group Legal Services Plan. IRC §120.

1. A group legal services plan under IRC §120 enables each employee to receive tax-free an annual premium valued up to $70.00 for legal services insurance.

2. The only employees excludable from a plan are those who are covered under a collective bargaining agreement, provided that group legal services were bargained for in good faith.

3. The non-discrimination rules under IRC §120 provide that not more than 25% of the contributions made under the plan during a plan year may benefit the 5% (or more) shareholders or owners (their spouses and dependents). In addition, the plan must be written and for the exclusive benefit of employees, their spouses and dependents.

G. Other Employee Fringe Benefits.

Under IRC §132, no-additional-cost services, qualified employee discounts and employee eating facilities meeting certain requirements are non-taxable fringe benefits. Highly compensated employees may exclude these benefits only if such benefits are provided in a non-discriminatory manner.

III. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPAA").

A. Statutory Provisions.

1. ERISA: §701 — Increased Portability Through Limitation on Pre-Existing Condition Exclusions:

a. There can be a pre-existing condition exclusion only under the following circumstances:

i. The exclusion relates to physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received within six months preceding the Enrollment Date.

ii. The exclusion period cannot be longer than 12 months (18 months for late enrollee).

iii. The exclusion period is reduced by Creditable Coverage.

b. Definitions.

i. Pre-existing condition exclusion--a limitation or exclusion of benefits relating to a condition that was present before the Enrollment Date. Genetic information is not a condition subject to pre-existing condition exclusion unless there was diagnosis of a condition related to such information.

ii. Enrollment date--the earlier of: the date of enrollment in the plan or the first day of the waiting period for such enrollment.

iii. Late enrollee is a person who enrolls in the plan at a time other than the first time eligible or a special enrollment period described in §701(f).

iv. Waiting period is the time that must pass before a person is eligible for the benefit.

c. Rules Relating to Crediting Previous Coverage.

i. Creditable coverage is defined as coverage of a person under a group health plan, health insurance coverage, Medicare, Medicaid, Armed Forces Medical Care, Government Employee Health Insurance, Indian health service, state health benefits risk pool, public health plan, or Peace Corps health plan.

ii. Exception--do not count prior coverage if there is a 63 day or more gap between creditable coverage and enrollment date. Waiting period or affiliation period (related to HMOs) is not treated as a break in coverage.

iii. Methods of crediting coverage:

(a) Standard Method--count period of coverage without considering specific benefits.

(b) Election of alternative method--elect to apply coverage period based on classes of benefits. The election must be uniform and nondiscriminatory. The alternative method must be disclosed to participants.

(c) Periods of coverage established by certificates.

d. Exceptions.

i. Newborns under creditable coverage within 30 days.

ii. Children adopted or placed for adoption under creditable coverage within 30 days.

iii. Pregnancy is not a pre-existing condition.

iv. The 63-day period break applies to these exceptions.

e. Certificates and Disclosure of Coverage.

i. Time periods--certificates provided at time a person loses coverage, at time a person loses COBRA coverage or at

person's request within two years after the loss of original coverage or COBRA coverage. Time period to provide the certificate consistent with COBRA time periods.

ii. Certification - written document stating the period of creditable coverage under the plan and under COBRA. The certification must also disclose the waiting period.

iii. A plan sponsor is deemed to satisfy the certification requirement if the health insurance issuer offering the coverage provides the certification.

iv. Disclosure of information on previous benefits. If the alternative method (described in §701(e)(1)(C)(3)(B)) is chosen, the new plan or issuer can request disclosure on coverage of classes and categories of health benefits. The prior plan or issuer may charge a reasonable fee to provide this information to the new plan or issuer.

f. Special Enrollment Periods.

i. Individuals losing other coverage--plans allow eligible employee (eligible but not enrolled) to enroll if the following conditions are met:

(a) The individual was covered under a plan or insurance at time this plan was previously offered;

(b) The eligible employee stated in writing that the coverage noted above was the reason he declined health care coverage (if such statement required by plan);

(c) COBRA is exhausted or coverage terminated as a result of loss of eligibility or employer contributions terminated; and

(d) The eligible employee requests enrollment within 30 days of lost coverage.

ii. Dependent beneficiaries. If a group health plan is available for dependents of an individual and the individual is a participant and a person becomes a dependent of such individual through marriage, birth, adoption or placed for adoption, then the dependent may enroll during a period of not less than 30 days after the dependent coverage is available, date of marriage, birth, adoption or placement for adoption. If the dependent is enrolled within the first 30 days, then there is <u>no</u> waiting period and coverage is

effective on the date of birth or adoption or placement of adoption or not later than the first day of the month following the receipt of the request for enrollment by the newly married individual.

g. Use of Affiliation Period by HMOs as Alternative to Pre-Existing Condition Exclusion.

i. HMOs may have an affiliation period if:

(a) There is no pre-existing condition exclusion;

(b) The affiliation period is applied uniformly without regard to health status; and

(c) The affiliation period does not exceed two months (three months for late enrollee).

ii. Affiliation period is the time that must expire before coverage becomes effective. The affiliation period begins on the enrollment date and runs concurrent with the waiting period. During this time, no benefits are available and no premiums are due.

iii. Alternative Methods--may use such other methods as approved by the appropriate State Insurance Commissioner (or such other person who enforces Medicare compliance for the state).

2. ERISA: §702 — Prohibiting Discrimination Against Individual Participants and Beneficiaries Based on Health Status.

a. Eligibility. The following items cannot be conditions of enrollment or waiting period for the individual or dependent.

- Health Status
- Medical Condition (mental or physical)
- Claims Experience
- Receipt of Health Care
- Medical History
- Genetic Information
- Evidence of Insurability
- Disability

b. "Eligibility" includes:

- Enrollment
- Effective Date of Coverage
- Waiting (or affiliation) Period

- Late and Special Enrollment
- Eligibility for Benefit Packages
- Benefits
- Continued Coverage
- Terminating Coverage

c. No application to benefits or exclusions. Does not require particular benefits other than as provided by the plan and does not limit the plan from establishing limitations or restrictions on the amount, level, extent or nature of the benefits or coverage for similarly situated individuals enrolled in the plan.

d. Premium contributions cannot be greater than those paid by others similarly situated on the basis of a health status related factor. An employer is not restricted on the amount to charge for health coverage or an issuer is not restricted from offering discounts or rebates relating to health promotion and disease prevention.

3. ERISA: §703 — Guaranteed Renewability in Multi-Employer Plans and Multiple Employer Welfare Arrangements.

Plan cannot deny access to the same or different coverage under the terms of the plan other than for:

- Nonpayment of Contributions
- Fraud or Intentional Misrepresentation of Material Fact by the Employer
- Noncompliance with Material Plan Provisions
- Plan Ceasing to Offer Coverage in a Geographic Area
- No Longer Anyone Enrolled in a Network Plan In the Service Area
- Failure to Meet the Terms of the CBA

4. ERISA: §731 — Preemption; State Flexibility; Construction.

a. State law regarding health insurance issuers still applies except to the extent that it prevents the application of HIPAA.

b. HIPAA does not affect the preemption rule (§514) of health plans.

c. HIPAA supersedes state law on the preexisting condition exclusions.

5. ERISA: §732 — Special Rules Relating to Group Health Plans.

a. If a plan has less than two participants who are current employees, HIPAA does not apply.

b. Plan maintained by partnerships are subject to HIPAA.

c. The term Employer includes a partnership.

d. Participant includes a partner or self-employed individual.

B. Disclosure Requirements. HIPAA - DOL Regulations: 65 Federal Register 70225 (November 21, 2000); 67 Federal Register 17263 (April 9, 2002). §102.

1. <u>DOL Reg. §2520.102-3. Contents of Summary Plan Description</u>.

a. If a health insurance issuer is responsible (in whole or in part) for the financing or administration of a group health plan, the SPD must state the following information:

i. Name and address of the issuer;

ii. Whether and to what extent benefits under the plan are guaranteed under a contract or policy of insurance issued by the issuer; and

iii. The nature of any administrative services (e.g., payment of claims) provided by the issuer.

Disclosure must be made within 60 days after the first day of the plan year beginning after 6/30/97.

b. New address for ERISA required statement "... contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefit Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210."

Disclosure must be made within 60 days after the first day of the plan year beginning after 6/30/97.

c. New Subsection (u) - If a group health plan provides maternity or newborn infant coverage, the SPD must include a statement indicating that group health plans and health insurance issuers offering group insurance coverage generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a caesarian section, or require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

Disclosure must be made within 60 days after the first day of the plan year beginning on or after 1/1/98.

2. DOL Reg. §2520.104b-3. Summary of Material Modifications.

   a. If there is a material reduction in covered services or benefits, a participant must receive notice of such reduction within 60 days after the date of adoption of the change.

   b. A material reduction generally includes:

      i. Eliminating benefits payable under the plan;

      ii. Reducing benefits payable under the plan (i.e., changes in formulas, methodologies or schedules that serve as a basis for making benefit determinations);

      iii. Increasing deductibles, co-payments or other amounts to be paid by a participant or beneficiary;

      iv. Reducing the services covered by an HMO; or

      v. Establishing new conditions or requirements (i.e., pre-authorizations) to obtain services or benefits under the plan.

3. DOL Reg. §2520.104b-1. Disclosure.

   a. Disclosure requirements can be satisfied through electronic media if:

      i. Steps are taken to ensure that participants actually receive the information;

      ii. The document is prepared consistent to the applicable format, style and content requirements;

      iii. Participants receive notice apprising them of the document, its significance (e.g., the document describes changes in benefits provided by your plan) and their right to receive (free of charge) a hard copy; and

      iv. At the participant's request, the administrator furnishes a hard copy (at no charge).

   b. Disclosure is satisfied only with respect to participants who have the ability to effectively access the document at their worksite and have the opportunity to print a hard copy.

C. Sanctions for Failing to Comply with HIPAA. IRC §4980D.

   1. There is an excise tax on health plans failing to comply with HIPAA.

2. Amount of tax: $100 per day, per person during noncompliance period (from the first day of noncompliance until the day of correction).

3. Minimum tax for the noncompliance period is equal to the lesser of $2,500.00 or the actual amount of the tax when the failure is discovered after the IRS sends a notice of examination of income tax liability and such failure occurred during the time period under examination. However, if the failure is more than de minimis, the minimum tax is the lesser of $15,000.00 or the actual amount of the tax. This minimum tax does not apply to church plans.

4. Limits on the tax.

   a. The tax does not apply when the failure is not known or would not have been known by the person liable for the tax if he or she had exercised reasonable diligence (as determined by the Secretary).

   b. The tax does not apply if the failure was due to reasonable cause (not willful neglect) and such failure is corrected within 30 days after the discovery occurred (or the date discovery would have occurred by a person exercising reasonable diligence).

   c. Overall limitation for unintentional failures is equal to the lesser of: (i) ten percent (10%) of the aggregate amount paid or incurred by the employer during the preceding tax year for the health plan or (ii) $500,000.00.

   d. The secretary may waive all or part of the tax in the case of a failure which is due to reasonable cause and not to willful neglect.

5. There is no tax on any small employer (an employer employing at least 2 and no more than 50 employees) who offers a health plan through a health insurance issuer (e.g., an insured plan; not a self-insured plan).

6. Generally, the employer is liable for the tax except in the case of a multiemployer plan or failure under IRC §9803 in which case the plan is liable for the tax.

D. No Discrimination on the Basis of Genetic Information (GINA).

1. The Genetic Information Act of 2008 (GINA) amended the HIPAA portability rules in the Code, ERISA, and the PHSA, adding new provisions regarding genetic information that apply to group health plans and insurance issuers offering group health insurance coverage. GINA, Pub. L. No. 110-233 (May 21, 2008).

2. The genetic information provisions described in Title I of GINA apply for plan years beginning after May 21, 2009. GINA also includes other provisions, including employment nondiscrimination provisions contained

in Title II. of GINA, that apply to employers beginning November 21, 2009. Code §9802(e); ERISA §702(d); PHSA §§2705(e); GINA, Pub. L. No. 110-233 (May 21, 2008).

3. GINA's Prohibitions — In General.

a. Prohibition on Adjusting Group Rates on the basis of genetic information.

b. Prohibition on requesting or requiring genetic testing with the three exceptions — for certain healthcare professionals, for determinations regarding payments, and for research.

c. Prohibition on collection of genetic information, either for underwriting purposes or prior to or in connection with enrollment.

4. GINA's Proposed Modifications to HIPAA's Privacy Regulations.

a. Title I of GINA contains privacy protections for genetic information that address the application of the HIPAA privacy regulations to genetic information. There is a requirement under Title I that HHS revise the HIPAA privacy regulations to clarify that genetic information is health insurance, and to prohibit group health plans and health insurance issuers from using or disclosing genetic information for underwriting purposes.

b. HHS issued proposed regulations in 2009 modifying the HIPAA privacy regulations, that would do the following:

i. explicitly provide that genetic information is health information;

ii. prohibit health plans from using or disclosing PHI that is genetic information for underwriting purposes;

iii. revise the provisions relating to the privacy notice for health plans that perform underwriting;

iv. make a number of conforming modifications to definitions and other provisions; and

v. make technical corrections to update the definition of health plans. 74 Fed. Reg. 51698 (October 7, 2009).

IV. MEDICAL SAVINGS ACCOUNTS IRC §220.

A. A medical savings account, now known as an Archer MSA, ("MSA") is a trust created exclusively for the purpose of paying the qualified medical expenses of

the account holder. The account holder is the individual on whose behalf the MSA is established. IRC §220(d)(3).

MSAs were established under the IRC effective January 1, 1997 and expired on December 31, 2003. MSAs established prior to December 31, 2003 remain in effect. Contributions and withdrawals can continue to be made under these plans. However, no new MSAs may be created after December 31, 2003.

B. A MSA must be created by a written document stating:

1. No contribution will be accepted unless it is in cash or to the extent that such contribution, when added to the previous contributions to the trust for the calendar year, exceeds 75% of the highest annual limit deductible permitted for the calendar year;

2. The trustee is a bank, insurance company or other person who satisfies the Secretary's requirements;

3. No part of the trust assets will be invested in life insurance contracts;

4. The trust assets will not be commingled with other property (with certain limitations); and

5. The interest of an individual in the balance of his account is non-forfeitable. IRC §220(d)(1).

C. Any eligible individual or small employer may establish a MSA with a qualified MSA custodian or trustee beginning on January 1, 1997. No authorization is needed from the IRS. While a MSA is similar to an IRA, a taxpayer cannot use an IRA as a MSA nor can he combine an IRA with a MSA. IRS Notice 96-53.

D. An eligible individual is any individual who is covered under a high deductible health plan and is not covered under any non-high deductible health plan. Further, the high-deductible plan must be established by the employer of either the individual or his spouse and the employer must be a small employer. IRC §220(c)(1)(A). A small employer is defined as an employer who employed an average of 50 or fewer employees on business days during either of the two preceding calendar years. If an employer was not in existence during the first preceding calendar year, the average number of employees that the employer reasonably expects to employ on business days during the current calendar year is used. IRC §220(c)(4). A high-deductible health plan is defined as a health plan, in the case of self-only coverage, which has an annual deductible which is not less than $1,500.00 and not more than $2,250.00 and the annual out-of-pocket expenses required to be paid under the plan for covered benefits do not exceed $3,000.00. In the case of family coverage, a high-deductible health plan is a health plan which has an annual deductible which is not less than $3,000.00 and not more than $4,500.00 and the annual out-of-pocket expenses required to be paid under the plan for covered benefits do not exceed $5,500.00. IRC §220(c)(2)(A). Out-of-pocket expenses include deductibles, co-payments and

other amounts that the participant must pay for covered benefits. Premiums, however, are not considered out-of-pocket expenses. IRS Notice 96-53. After 1998, the annual deductible amounts and out-of-pocket expense amounts will be adjusted for cost of living. Any increases will be made in multiples of $50.00. IRC §220(g).

E. An eligible individual may deduct an amount equal to the aggregate amount paid in cash and to the MSA during the taxable year subject to a limitation of 65% of the annual deductible for individuals with self-only coverage and 75% of the annual deductible for individuals with family coverage. IRC §§220(a) and (b)(2). For individuals married to each other, if either spouse has family coverage, both spouses are treated as having only such family coverage and the deduction limitation is divided equally between them unless they agree on a different division. If two spouses both have family coverage under different plans, both spouses are treated as having only the family coverage with the lowest deductible. IRC §220(b)(3).

F. The deduction allowed to a MSA for contributions cannot exceed such individual's wages which are attributable to such individual's employment by the employer. IRC §220(b)(4).

G. If a MSA receives any excess contributions for a taxable year, distributions from the MSA are not includable in income to the extent that the distributions do not exceed the aggregate excess contribution to all MSA accounts of the individual for the taxable year if the distribution is received by the individual on or before the last day for filing the individual's income tax return for the year (including extensions) and the distribution is accompanied by the amount of net income attributable to the excess contribution. IRC §220(f)(3)(A). Excess contributions to a MSA are subject to a tax equal to 6% of the amount of the excess contribution to the individual's accounts. However, the tax may not exceed 6% of the value of the account determined at the close of the taxable year. IRC §4973(a).

H. A MSA is exempt from income tax unless it ceases to be a MSA. IRC §220(e). Rules similar to those applicable to IRAs regarding the loss of income tax exemption for an account where an employee engages in a prohibited transaction and those regarding the affect of pledging an account as security apply to a MSA. IRC §220(e).

I. A distribution from a MSA that is used exclusively to pay the qualified medical expenses of any account holder is not includable in gross income. IRC §220(f). In contrast, any distribution from a MSA that is not used exclusively to pay the qualified medical expenses of the account holder must be included in the account holder's gross income. Further, any distributions from a MSA that is includable in income because it was not used to pay qualified medical expenses is also subject to a penalty tax equal to 15% of the includable amount. Includable distributions received after a MSA holder becomes disabled, dies or reaches Medicare eligibility age are not subject to the 15% penalty tax. IRC §220(f)(4).

Qualified medical expenses are amounts paid by the account holder for medical care (as defined in IRC §213(d)) for the individual, his spouse and any dependents to the extent that expenses were not compensated by insurance or otherwise. IRC §220(d)(2).

K. The MSA may be transferred without income taxation from one spouse to another if the transfer is made under a divorce or separation decree. IRC §220(f)(7). At the death of an individual with a MSA, if the surviving spouse is designated as the beneficiary, the MSA is treated as if the spouse were the account holder. IRC §220(f)(8)(A). However, if the MSA is acquired by anyone other than the surviving spouse, it ceases to be a MSA as of the date of death. The fair market value of the assets in the MSA must be included in the person's gross income for the year if the person is not the account holder's estate. IRC §220(f)(8)(B)(i).

L. Contributions to MSA are not subject to employment taxes. IRS Notice 96-53.

M. Each year an employer must provide a written statement to each employee showing the amount contributed to the MSA. The report must be received by January 31 of the following year. IRC §6051(a).

COMPARISON OF TAX-QUALIFIED FRINGE BENEFIT PLANS

PLAN ELEMENTS	GROUP TERM LIFE INSURANCE IRC §79	DEPENDENT CARE ASSISTANCE IRC §129	EDUCATIONAL ASSISTANCE IRC §127	HEALTH INSURANCE IRC §§105 & 106	HEALTH BENEFITS SELF-INSURED IRC §105(h)
1. Excludable Employees:					
(a) Service Less Than —	3 Years	1 Year	None	Any	3 Years
(b) Union Coverage	Yes	Yes	Yes	Yes	Yes
(c) Part-Time or Seasonal	Yes (20 hours per week/ five months per year)	No	No	Yes	Yes (25-35 hours per week/ 9 months per year)
(d) Under Age —	None	21 Years	None	Any	25 Years
2. Discrimination Testing:	(i) 70% of all employees; or (ii) 85% of participants are not <u>key employees</u>. plus special rules for employers with less than 10 employees.	Average benefits to non-highly compensated employees are at least 55% of highly compensated employee benefits and no more than 25% of total benefits go to 5% owners, their spouses and dependents.	No more than 5% of the total benefits paid to 5% owners, their spouse and dependents. *See outline for changes as a result of Patient Protection and Affordable Care Act.	N/A *See outline for changes as a result of Patient Protection and Affordable Care Act.	(i) 70% or more of all employees receive benefits; or (ii) 80% of <u>eligible employees receive benefits if 70% of all employees are eligible</u>.
3. Penalty for Discrimination as to:					
(a) Benefits	Key employees receive no exclusion; key employees include in income the higher of actual premium or table amount in regulations.	Highly compensated employee takes entire benefit into income.	Highly compensated employee takes benefits into income. *See outline for changes as a result of Patient Protection and Affordable Care Act.	N/A *See outline for changes as a result of Patient Protection and Affordable Care Act.	Highly compensated employees take into income the excess reimbursements they receive over the non-highly compensated employee's benefits.

PLAN ELEMENTS	GROUP TERM LIFE INSURANCE IRC §79	DEPENDENT CARE ASSISTANCE IRC §129	EDUCATIONAL ASSISTANCE IRC §127	HEALTH INSURANCE IRC §§105 & 106	HEALTH BENEFITS SELF-INSURED IRC §105(h)
(b) Coverage	Key employees receive no exclusion; key employees include in income the higher of actual premium or table amount in regulations.			N/A *See outline for changes as a result of Patient Protection and Affordable Care Act.	Highly compensated employees take into income a portion of their reimbursement multiplied by a ratio in which all highly compensated employee reimbursements bears to total benefits paid under the plan.
4. Maximum Tax Free Benefit if Plan Non-Discriminatory:	$50,000.00 term life insurance policy	$5,000.00	$5,250.00	N/A *See outline for changes as a result of Patient Protection and Affordable Care Act.	N/A

V. HEALTH SAVINGS ACCOUNTS. IRC §223

A. Introduction.

Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, which became law on December 8, 2003 added IRC §223 to permit eligible individuals to establish Health Savings Accounts ("HSAs") for taxable years beginning after December 31, 2003.

Initially, to provide guidance on Health Savings Accounts, the IRS issued Notice 2004-2. The IRS released additional guidance on specific issues involving HSAs on March 30, 2004 (Notice 2004-23), Notice 2004-25, Rev. Rul. 2004-38 and Rev. Proc. 2004-22), May 11, 2004 (Rev. Rul. 2004-45), June 21, 2004 (Notice 2004-43) and July 23, 2004 (Notice 2004-50). Additionally, the IRS issued Notice 2008-59 which addresses additional questions relating to HSAs.

B. What are HSAs and Who Can Have Them?

1. An HSA is a tax-exempt trust or custodial account established exclusively for the purpose of paying qualified medical expenses of the account beneficiary who, for the months for which contributions are made to an HSA, is covered under a high-deductible health plan ("HDHP"). Generally, an HDHP is a health plan that satisfies certain requirements with respect to deductibles and out-of-pocket expenses. Specifically, for self-only coverage, an HDHP has an annual deductible of at least $1,200.00 for 2012 (indexed) and annual out-of-pocket expenses not exceeding $6050.00 in 2012 (indexed). For family coverage, an HDHP has an annual deductible of at least $2,400.00 in 2012 (indexed) and out-of-pocket expenses not exceeding $12,100.00 in 2012 (indexed).

2. An "eligible individual" can establish an HSA. An "eligible individual" means, with respect to any month, an individual who:

    a. is covered under an HDHP on the first day of such month;

    b. is not also covered by any other health plan that is not an HDHP;

    c. is not entitled to benefits under Medicare; and

    d. may not be claimed as a dependent on another person's tax return.

C. How can an HSA be established?

Beginning on January 1, 2004, any eligible individual can establish an HSA with a qualified HSA trustee or custodian, in much the same way that an individual can establish an IRA with qualified IRA trustees or custodians. No permission or authorization from the IRS is necessary to establish an HSA. An eligible

individual who is an employee may establish an HSA with or without the involvement of the employer.

D. HSA Contributions.

1. Any eligible individual may make contributions to an HSA. Contributions to the HSA must be made in cash. Payments for the HDHP and contributions to the HSA may be made by the eligible individual through a cafeteria plan.

2. For an HSA established by an employee, the employee, the employee's employer, or both may contribute to the HSA of the employee. For an HSA established by a self-employed or unemployed individual, the individual may contribute to the HSA. Family members may also make contributions to an HSA on behalf of another family member as long as that other family member is an eligible individual.

3. The maximum annual contribution to an HSA is the sum of the limits determined separated for each month, based on status, eligibility, and health plan coverage as of the first day of the month. For the 2012 calendar year, the maximum contribution for eligible individuals with self-only coverage under an HDHP is $3,100.00. For eligible individuals with family coverage under an HDHP, the maximum contribution is $6,250.00. For individuals (and their spouses covered under the HDHP) between ages 55 and 65, the HSA contribution limit is increased by $1,000.00 in 2012. As with the annual contribution limit, the catch-up contribution is computed on a monthly basis.

E. Distributions from HSAs.

1. An individual is permitted to receive distributions from an HSA at any time. Distributions from an HSA used exclusively to pay for qualified medical expenses to the account beneficiary, his or her spouse, or dependents are excluded from gross income. However, for distributions made on or before December 31, 2010, any amount of the distribution not used exclusively to pay for qualified medical expenses of the account beneficiary, spouse, or dependents is includible in gross income of the account beneficiary and is subject to an additional 10% tax on the amount includible in gross income, except in the case of distributions made after the account beneficiary's death, disability, or attainment of age 65. For distributions made on or after January 1, 2011, the tax is increased to 20%.

2. The term "qualified medical expenses" are expenses paid by the account beneficiary, his or her spouse, or dependents for medical care, but only to the extent the expenses are not covered by insurance or otherwise. The qualified medical expenses must be incurred after the HSA has been established.

3. HSA trustees or custodians are not required to determine whether HSA distributions are used for qualified medical expenses. The same rule also applies to employers who make contributions to an employee's HSA.

4. Upon death, any balance remaining in the account beneficiary's HSA becomes the property of the individual named in the HSA instrument as the beneficiary of the account. If the account beneficiary's surviving spouse is the named beneficiary of the HSA, the HSA becomes the HSA of the surviving spouse. If, by reason of the death of the account beneficiary, the HSA passes to a person other than the account beneficiary's surviving spouse, the HSA ceases to be an HSA as of the date of the account beneficiary's death, and the person is required to include in gross income the fair market value of the HSA assets as of the date of the death.

F. Employer Contributions.

1. If an employer makes HSA contributions, it must satisfy certain discrimination rules.

2. The employer must make available comparative contributions on behalf of all "comparable participating employees" (i.e., eligible employees with comparable coverage) during the same period. Contributions are considered comparable if they are either the same amount or same percentage of the deductible under the HDHP. The comparability rule is applied separately to part-time employees (those customarily employed for fewer than 30 hours per week). The comparability rule does not apply to amounts rolled over from an employee's HSA or Archer MSA, or to contributions made through a cafeteria plan. If employer contributions do not satisfy the comparability rule during the period, the employer is subject to an excise tax equal to 35% of the aggregate amount contributed by the employer to HSAs for that period.

   Effective January 1, 2007, employers may provide lower HSA contributions to highly compensated employees.

3. Employer contributions to HSAs must be reported on the employee's Form W-2.

4. Although employer contributions to HSAs are not subject to the comparability rule if made via a cafeteria plan, the HSA contributions are subject to the general cafeteria plan non-discrimination rules. There are no specific non-discrimination rules for HSA contributions made within a cafeteria plan.

VI. COBRA GROUP HEALTH PLAN CONTINUATION COVERAGE UNDER IRC §4980B.

A. Overview and Affected Plans.

1. Under the 1988 Technical and Miscellaneous Revenue Act, group health plans must give each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event, the right to elect within the election period, continued coverage under the plan. Continued coverage means that the coverage must be identical to the coverage provided to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred. If the coverage is modified for a group of similarly situated beneficiaries, then the same modification must be made for all qualified beneficiaries under the plan.

2. Employers with fewer than twenty (20) employees on a typical business day during the preceding calendar year are exempt from the federal continuation coverage regulations.

3. Qualified Beneficiary. This is defined as the spouse or dependent child (including a newborn, adopted child or child placed for adoption at the time of the qualifying event or at any time during the COBRA coverage) of the covered employee on the date before the qualifying event for that employee. In case of employment termination or reduction in the hours of the covered employee resulting in loss of coverage, the term "qualified beneficiary" includes the covered employee.

B. Qualifying Events.

This means any of the following events which, but for the continuation coverage required under these rules, would result in the loss of coverage of a qualified beneficiary. They are as follows:

1. The death of the covered employee;

2. The employment termination (other than in the case of gross misconduct) or reduction of hours of the covered employee's employment;

3. The divorce or legal separation of the covered employee from the employee's spouse;

4. The covered employee becoming entitled to benefits under the Social Security Act Title XVIII;

5. A dependent child ceasing to be a dependent child under the generally applicable definitions of the Plan; or

6. A bankruptcy proceeding commencing on or after July 1, 1986 with respect to the employer from whose employment the covered employee retired at any time.

C. Period of Coverage.

The period of required coverage begins on the date of the qualifying event and ends on the earliest of the following: (1) 18 months after termination of employment (except in the case of discharge for gross misconduct) or reduction in hours of the covered employee's employment, except in the case of a bankruptcy proceeding with respect to the employer; or (2) if within 18 months after such termination or reduction in hours of covered employment, the covered employee dies, becomes divorced or legally separated, becomes entitled to benefits under Social Security Act Title XVIII, or the covered individual ceases to be a dependent child of the employee, then the covered period is 36 months after such termination or reduction in hours of covered employment.

Additionally, coverage is extended for up to a maximum of 29 months for certain employees who are disabled at the time of a qualifying event or become disabled during the first 60 days of COBRA coverage.

Notwithstanding the above rules, eligibility for coverage will cease on:

1. The date the employer ceases to provide any group health plan to any employee;

2. The date when coverage ceases because of failure by the beneficiary to make a timely premium payment (generally considered timely if payment is made within 30 days after the due date); or

3. The date when the qualified beneficiary becomes covered under any other group health plan (that does not contain any exclusion or limitation with respect to any pre-existing condition or if such plan does contain an exclusion or limitation with respect to pre-existing conditions, when the qualified beneficiary is not subject to the exclusion or limitation due to the application of the Health Insurance Portability and Accountability Act of 1996) or in the case of a qualified beneficiary other than a retiree, the spouse of the covered employee, the dependent child of the employee, or the surviving spouse of the covered employee, the date on which he or she becomes entitled to benefits under Social Security Act Title XVIII.

   (A qualified beneficiary who becomes covered under a new employer's plan will be permitted to continue coverage on the prior plan if the new employer's plan does not cover pre-existing conditions of that qualified beneficiary.)

D. Premium Payments.

The Plan may require the payment of a premium from the beneficiary for the period of continued coverage but in no event can the payment exceed 102% of the regular premium. A payment can be made in monthly installments. If an election is made after the qualifying event, the Plan can permit payment for continuation coverage during the period preceding the election to be made within 45 days of the date of the election.

For a disabled qualified beneficiary extending the 18 month continuation coverage to 29 months, the premium for the additional 11 months continuation beyond the 18 month coverage may not exceed 150% of the regular premium.

E. No Requirement of Insurability.

The coverage may not be conditioned upon, or discriminate because of, a lack of evidence of insurability.

F. Election Period.

This is the period: (i) beginning on the date of the qualifying event, (ii) which is of at least 60 days in duration and (iii) ending on the later of 60 days after the qualifying event or 60 days after the qualified beneficiary receives notice as provided for under the notice requirements.

A qualified beneficiary who, during the election period, voluntarily waives COBRA can revoke the waiver at any time prior to the end of the election period. However, if the waiver is revoked, coverage need not be provided retroactively. Reg. §54.4980B-6, Q. and A.-4.

G. Notice Requirement.

Notice requirements are as follows:

1. Written notice at the time coverage begins of the rights of the covered employee and his or her spouse;

2. The employer must notify the Plan Administrator of:

    a. the death of the covered employee;

    b. the termination (except by reason of gross misconduct) or reduction of hours of the covered employee's employment;

    c. the covered employee becoming entitled to benefits under the Social Security Act Title XVIII; and

d. a bankruptcy proceeding within 30 days of the date of the above event;

3. The covered employee or qualified beneficiary must notify the Plan Administrator of the divorce or legal separation of the covered employee from the spouse and a dependent child ceasing to be a dependent child under the generally applicable definitions of the Plan; or

4. The Plan Administrator shall notify the qualified beneficiary, in the case of the events described in Section 2 above and, in the case of events described in Section 3 above, where the covered employee or qualified beneficiary notifies the Plan Administrator of such beneficiary's rights under this subsection. Notification of a qualified beneficiary's rights must be given within 14 days of the Plan Administrator receiving notice either from the employer or employee, whichever is applicable.

H. Penalties and Non-Compliance.

1. Excise Tax. Under prior law, if a group health plan failed to satisfy the health care continuation rules of former Code §162(k), deductions for expenses paid or incurred for the Plan were disallowed beginning with the year of the failure and for subsequent years, including the year of correction. The new rule under Code §4980B provides that the failure to satisfy the health care continuation rules results in an excise tax equal to $100.00 per day for each qualified beneficiary not receiving an option to continue coverage during the non-compliance period. For purposes of determining the amount of the excise tax, if there is more than one qualified beneficiary in the same family, the maximum amount of the excise tax with respect to such family is $200.00 per day. The non-compliance period starts on the date the failure first occurs and ends on the earlier of: (1) the date the failure is corrected, or (2) six months after the last date on which the employer could have been required to provide such continuation coverage to the qualified beneficiary, determined without regard to whether the qualified beneficiary paid any required premium. The excise tax does not apply if a failure was due to reasonable cause and not to willful neglect, provided the failure is corrected within the first 30 days of the non-compliance.

2. Audit Rule. A special audit rule applies despite the 30-day grace period or reasonable diligence rule. Under the audit rule, where a failure with respect to a qualified beneficiary is not corrected by the date a notice of examination of income tax liability is sent to the employer and the failure took place or continued during the period under examination, the excise tax will not be less than the smaller of (a) $2,500.00 or (b) the amount of the excise tax computed without regard to the reasonable diligence exception and 30-day grace period rule. Further, if the failure is more

than de minimis with respect to the employer (or multi-employer plan) then the dollar amount in (a) is $15,000.00.

3. Maximum Sanction. The maximum penalty for failure to provide coverage due to reasonable cause and not willful neglect is the lesser of: (a) 10% of the total amount paid or incurred by the employer (or predecessor employer) during the preceding tax year for the employer's group health plans, or (b) $500,000.00.

4. Correction of Failures. A failure to comply with continued health coverage rules is considered corrected if (1) the rules are retroactively satisfied to the extent possible and (2) the qualified beneficiary is put in the same position that he/she would have been in but for the failure.

I. Recent Case Law.

1. Tolling of Election Period.

a. The election period for making a valid COBRA election can be extended during the period the beneficiary is incapacitated. *Branch v. G. Bernd Co.*, 955 F.2d 1574 (11th Cir. 1992).

b. The notice must be provided to a person legally capable of acting on it (e.g. if a beneficiary is incapacitated, his or her guardian) and also capable of acting on it intelligently. *Meadows v. Kagle's, Inc.*, 954 F.2d 686 (11th Cir. 1992).

2. Notice of Right to COBRA.

a. COBRA requires separate notice to the covered employee and the qualified beneficiary. *Mlsna v. Unitel Communications, Inc.*, 825 F. Supp. 862 (N.D. Ill. 1993).

b. Where a former employee and qualified beneficiary testify that they did not receive a COBRA notice and the plan administrator cannot produce any documents to substantiate that the COBRA notice was, in fact, mailed, the courts will conclude that the COBRA notice was not sent. *Brown v. Neely Truckline, Inc.*, 1995 U.S. Dist. LEXIS 5185 (Ala. 1995). The Court advised the plan administrator to:

> implement a system which will bear proof of actual provision of COBRA notice. For example, [the plan administrator] could submit notice by certified mail or by procuring a certificate of mailing.

When the court is forced to believe one faction or the other and supporting proof is virtually non-existent, the court has no choice but to conclude that the party bearing the burden may not prevail. See Also: *Stanton v. Larry Fowler Trucking, Inc.* (8th Cir. 1995); *Martin v. Marriott Corp.*, 15 EBC 1217 (D.D.C. 1992). But See: *Truesdale v. Pacific Holding Company/Hay Adams Division*, Civil Action Case No. 91-1261 (D.D.C. 1991). (The employer will be given the benefit of the doubt regarding providing notice of the qualified beneficiary COBRA rights where it uses an automated COBRA notice system. The employer need not show that the notice was actually received. However, the presumption of delivery only applies if the employer can show a procedure for mailing the notice and the notice had the proper address.)

c. A spouse may be liable for failing to assist his ex-spouse to obtain COBRA continuation coverage. *Gaymon v. Leyden*, Ala Ct. Civ. App., No. 2900500, 11-15-91.

3. Termination for Gross Misconduct.

a. Termination for breach of a company confidence does not constitute termination for "gross misconduct". *Paris v. F. Korbel & Brothers, Inc.*, 751 F. Supp. 834 (N.D. Cal. 1990).

b. Termination for "cash handling irregularities, invoice irregularities and the failure to improve the performance of one of the company's stores" constitutes gross misconduct. *Avina v. Texas Pig Stands, Inc.*, 1991 U.S. Dist. LEXIS 13957 (WD Tx. 1991). The Court defined gross misconduct as "the substantial deviation from the high standards and obligations of a managerial implead that would indicate that said employee cannot be entrusted with his management duties without danger to the employer".

c. Where an employer affords an employee the opportunity to resign before the employee is fired for "gross misconduct", COBRA notice must be given. *Conery v. Bath Associates*, 803 F. Supp. 1388 (N.D. Ind. 1992).

4. Core Coverage.

An employer may have the responsibility to provide coverage identical to that which the qualified beneficiary lost although such coverage may not be available in the area where the qualified beneficiary lives. *Coble v. Bonita House, Inc.*, 1992 U.S. Dist. LEXIS 3620 (ND Cal. 1992).

5. Personal Liability of Officers of Employer or Plan Administrator.

In general, officers and shareholders of a corporation are not personally liable for the ERISA violations of the corporation unless a traditional basis exists for piercing the corporate veil. *Khouri v. Gies*, 1993 U.S. Dist. LEXIS 8813. However, individuals could have personal liability if they themselves commit ERISA violations in the course of their duties for the corporation. *Murphy v. Cutter Development Corporation*, 1993 Conn. Super. 1832.

J. Pre-Existing Condition Clauses.

If a qualified beneficiary receives coverage from another employer, his COBRA rights terminate. IRC §4980B(f)(2)(B)(iv). This does not apply if the other group health plan has an exclusion with respect to any pre-existing condition of the beneficiary.

K. Ohio Group Health Plan Continuation Coverage Requirements. Ohio Revised Code §3923.38.

1. Eligible for Coverage. Employees eligible for the continuation coverage are those who have been continuously insured under the group policy for hospital, surgical or major medical insurance for at least three (3) months and who are eligible for unemployment compensation under Chapter 4141 of the Ohio Revised Code at the time of their employment termination. (Entitlement to unemployment compensation is no longer required with regard to insurance policies issued, delivered or renewed on or after April 1, 2009.) Employees eligible for coverage by Medicare or any other insured or uninsured plan are not eligible for this special continuance program. In addition, with regard to insurance policies issued, delivered or renewed on or after April 1, 2009, employees must be involuntarily terminated, other than for gross misconduct.

2. Continued Coverages. Only hospital, surgical or major medical insurance for the employees and any insured dependents are affected. Other coverages, such as life, loss of time and long-term disability insurance are not continued under this program. However, with regard to insurance policies issued, delivered or renewed on or after April 1, 2009, continuation coverage must include prescription drug coverage if it is included in the group coverage.

3. Cost of Continued Coverage. The full cost of the continued coverage is paid monthly by the employee directly to the employer, who then continues to include the employee (and any insured dependents) on the monthly premium statement for hospital, surgical or medical care insurance only.

4. Notification Procedures. Notification to a terminated or laid-off employee of the right to elect to continue medical coverage and details of the required monthly payment (including the amount and manner of payment)

must be given to the employee at the time the employer notifies the employee of the employment termination.

A former employee's request for continuance should be returned to the employer at the earliest of:

a. 31 days after the date coverage would otherwise end;

b. 10 days after the date coverage would otherwise end if the employee has been notified prior to such date; or

c. 10 days after the employee is notified, if notice is given after the date on which coverage would normally cease.

5. Length of Continuation Coverage. Cessation of the continuance of medical care insurance will occur whenever the former employee fails to pay the required monthly payment for the coverage or on the earliest of the following events:

   a. In the case of the employee:

      i. the end of a period (which begins on the day the employee's insurance would have terminated had the employee not elected the continuance) not to exceed 6 months (12 months with regard to insurance policies issued, delivered or renewed on or after April 1, 2009); and

      ii. the first day of the policy month after the employee becomes eligible for medical care coverage under another group or group type plan, or under Medicare; or

   b. In the case of any insured dependent, the day the dependent's insurance terminates on that dependent, as provided in the group policy; or

   c. The day the policy is terminated or the employer terminates participation under the policy, unless the employer replaces the coverage by similar coverage under another group policy or other group health arrangement.

6. Military Reservist. Every group policy shall provide that any military reservist called to order to active duty ("Active Reservist"), a spouse of an Active Reservist, or a dependent child of an Active Reservist may continue insurance coverage for 18 months after the Active Reservist is called to active duty. This coverage extends for 36 months if death, divorce, separation or cessation of dependency occurs during the 18 months. This 36-month period begins when the Active Reservist is called to active duty; the 36-month period is not in addition to the 18-month period. An employer must give notice of the right to continue coverage at the time the Active Reservist is called to active duty. The election period is 31 days after notification. An individual who elects continuation

coverage may pay the employer up to 102% of the group rate. However, the employer may pay a portion or all of the premium. When the Active Reservist returns to employment, every eligible person entitled to coverage receives coverage without satisfying the waiting period.

L. Effect of the Family and Medical Leave Act (FMLA) on COBRA Continuation Coverage.

1. FMLA applies to employers with 50 or more employees. Among its many provisions, FMLA requires covered employees to permit eligible employees unpaid leave up to three (3) months annually. During such leave, however, the employer must continue the employee's group health plan coverage. In other words, the employee on the FMLA leave, although the leave may be an unpaid one, is still an active employee for purposes of the employer's group health insurance plan. Therefore, an employee who takes FMLA leave has not experienced a "qualifying event" under COBRA so as to require the employer to provide a COBRA continuation coverage notice under the Internal Revenue Code.

2. In context of the FMLA leave, IRS Notice 94-103 states that COBRA applies if:

   a. the employee is covered by the employer's health plan on the day before the first day of the FMLA leave, or becomes covered during the leave; and

   b. the employee does not return to employment with the employer at the end of the FMLA leave; and

   c. the employee will lose coverage under the group health insurance plan in the absence of COBRA continuation coverage.

3. If an employee fails to return to work following FMLA leave, the date of the qualifying event is the last day of the FMLA leave, unless the employee informs the employer earlier that he will not return to work from the FMLA leave.

4. Some employees may elect not to maintain group health insurance coverage while on FMLA leave. This is most likely to occur in situations where the employee contributes to or pays the premium on a regular basis and does not want to do so during an unpaid leave. In such a circumstance, the employee's decline of coverage during the FMLA leave is <u>not</u> a qualifying event requiring the employer to issue a COBRA continuation coverage notice. Under FMLA, the employee would be entitled to be reinstated on the group insurance plan upon return to work from FMLA leave. Therefore, an employee who declines coverage or loses coverage by failing to pay required premiums during a FMLA leave may still be able to choose COBRA continuation coverage at the time his or her FMLA leave expires. According to IRS Notice 94-103, the employee's COBRA continuation coverage rights upon expiration of

FMLA leave cannot be retroactively applied to cover the employee's medical expenses during the FMLA leave.

M. Uniformed Services Employment and Reemployment Rights Act. 38 USC §4317.

1. If a person is covered under a health plan and leaves employment due to military service, the person and his dependents may elect continuation coverage.

2. Maximum period of coverage is the lesser of 18 months or the day after the date such person fails to return to employment.

3. Premium amount--no more than 102%; however, if military service is less than 31 days, no more than the amount an active employee pays.

4. When the person returns to employment from military service, there is no exclusion or waiting period; however, this does not apply to illness or injury (determined by the Secretary of Veteran's Affairs) incurred or aggravated during the performance of military service.

COMPARISON OF COBRA AND OHIO HEALTH PLAN CONTINUATION COVERAGE REQUIREMENTS

	COBRA IRC §4980B	ORC §3923.38
WHAT THE LAW DOES	Requires an employer to provide an employee or his covered dependents with the option to extend group coverage under health insurance plans and contracts for any participant who would otherwise lose coverage for virtually any reason.	Requires an employer to provide an employee with the option to extend group coverage for himself and his participating dependents under health insurance plans and contracts after the employee is terminated from employment.
WHEN IS IT EFFECTIVE	Plan years beginning after June 30, 1986. However, for collectively bargained plans, the law is effective for plan years beginning after the later of December 31, 1986 or after the termination date of the longest-running labor contract in effect on April 7, 1986.	Policies issued or renewed after June 28, 1984.
WHICH EMPLOYERS MUST COMPLY	Employers with twenty (20) or more employees in the preceding year; Government and Church plans are exempted.	All public and private employees (i.e., include employers with less than twenty (20) employees).
WHICH INDIVIDUALS HAVE CONTINUATION COVERAGE UNDER THE LAW	Each "Qualified Beneficiary" is covered by the law. Qualified Beneficiaries are those individuals covered by the plan (even for one day) who are: 1) Widowed spouses and dependent children, 2) Employees (and their spouses and dependent children) who have been terminated (voluntarily or involuntarily, except for gross misconduct) or have had their hours reduced, 3) Divorced or separated spouses and their legal dependents, 4) Medicare ineligible spouses and their dependent children, 5) Dependent children no longer meeting the plan's definition of dependent children.	Employees and their dependents are covered by the law if the employee: 1) has been covered by the health plan for three (3) months prior to termination of employment (with regard to insurance policies issued, delivered or renewed on or after April 1, 2009, employees must be involuntarily terminated, other than for gross misconduct); and 2) is entitled to unemployment compensation by reason of termination from employment (entitlement to unemployment compensation is no longer required with regard to insurance policies issued, delivered or renewed on or after April 1, 2009).

	COBRA IRC §4980B	ORC §3923.38
WHAT IS THE DURATION OF CONTINUATION COVERAGE	1) Coverage for eighteen (18) months from termination date for employees or eighteen (18) months from date hours are reduced below plan eligibility. 2) Coverage for 29 months if employee is disabled at time of termination or reduction of hours or during 18 month continuation coverage period. 3) Coverage for thirty-six (36) months for: a) Widowed spouse and dependent children; b) Divorced or legally separated spouse and dependent children; c) Medicare ineligible spouse; and d) Dependent children who no longer meet plan's eligibility. 4) Coverage by another group health plan will terminate COBRA coverage during the continuation coverage period only if the new plan does not contain a preexisting condition exclusion or limitation that applies to the qualified beneficiary.	Coverage for six (6) month period from the date coverage would otherwise terminate. Twelve (12) months with regard to insurance policies issued, delivered or renewed on or after April 1, 2009.
EMPLOYEE CONTRIBUTION TO COST OF COVERAGE	Employer may require the employee or qualified beneficiary to pay up to 102% of the cost to the employer for identical coverage for similar individuals covered by the employer-paid plan. Qualified Beneficiary may elect to pay contribution monthly. For disabled employees, employer may charge 150% of premium for the 19th through 29th months of coverage.	Employee bears cost of coverage in form of monthly premiums, payable in advance, equal to the employer's premium cost.

	COBRA IRC §4980B	ORC §3923.38
EMPLOYER NOTIFICATION REQUIREMENTS	1) Notice must be given to every covered employee <u>and</u> his or her spouse at the time the law takes effect. 2) New employee <u>and</u> his or her spouse must get notice when coverage commences. 3) Notice must be given within fourteen (14) days to every Qualified Beneficiary when they actually become eligible for continuation coverage, and the option to continue coverage must last at least sixty (60) days after the later of the eligibility date or notification date.	1) Notice to employee must be contained in the health insurance contract's Certification of Coverage; and 2) Employer must notify employee of his right to continue coverage at the time the employee is notified of his termination from employment.

EXHIBIT A

Revised August 25, 2010

Model Continuation Coverage Election Notice
For use where coverage is subject to State Continuation Coverage requirements.

[*Enter date of notice*]

Dear: [*Identify the qualified beneficiary(ies), by name or status*]

This notice contains important information about your right to continue your health care coverage in the [*enter name of group health plan*] (the Plan). Please read the information contained in this notice very carefully.

To elect continuation coverage, follow the instructions on the following pages to complete the enclosed Election Form and submit it to us.

If you do not elect continuation coverage, your coverage under the Plan will end on [*enter date*] due to [*check appropriate box)*]:

☐ End of employment	☐ Reduction in hours of employment
☐ Death of employee	☐ Divorce or legal separation
☐ Entitlement to Medicare	☐ Loss of dependent child status

Eligible employees are entitled to elect continuation coverage for themselves and their eligible dependents which will continue group health care coverage under the Plan for up to 12 months. If elected, continuation coverage will begin on [*enter date*] and can last until [*enter date*] [*Add, if appropriate:* You may elect any of the following options for continuation coverage: [*list available coverage options*].

Continuation coverage will cost: [*enter amount each qualified beneficiary will be required to pay for each option per month of coverage and any other permitted coverage periods*]. *[Indicate whether any payment is due with the Election Form].* Important additional information about payment for continuation coverage is included in the pages following the Election Form.

If you have any questions about this notice or your rights to continuation coverage, you should contact [*enter name of party responsible for continuation coverage administration for the issuer, with telephone number and address*].

Continuation Coverage Election Form

Instructions: To elect continuation coverage, complete this Election Form and return it to us. Under Ohio law you have a limited number of days to decide whether you want to elect continuation coverage. Your employer must receive the request:

> **(a) 10 days after the date your coverage would end if your employer has notified you of your continuation right prior to that date; or**
> **(b) 10 days after your employer notifies you of your right to continuation if the notice is given after the date your coverage ends; or**
> **(c) 31 days after your coverage ends if that date is earlier than the date you get notice under (b).**

Send completed Election Form to: [*Enter Name and Address*]

This Election Form must be completed and returned by mail [*or describe other means of submission and due date*]. If mailed, it must be post-marked no later than [*enter date*].

If you do not submit a completed Election Form by the due date shown above, you will lose your right to elect continuation coverage. If you reject continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. However, if you change your mind after first rejecting continuation coverage, your continuation coverage will begin on the date you furnish the completed Election Form.

Read the important information about your rights included in the pages after the Election Form.

I (We) elect continuation coverage in the [*enter name of plan*] (the Plan) as indicated below:

Name Date of Birth Relationship to Employee SSN (or other identifier)

a. ____

[*Add if appropriate:* Coverage option elected: ______________________]

b. ____

[*Add if appropriate:* Coverage option elected: ______________________]

c. ____

[*Add if appropriate:* Coverage option elected: ______________________]

______________________________ ______________________________
Signature Date

______________________________ ______________________________
Print Name Relationship to individual(s) listed above

____

____

______________________________ ______________________________
Print Address Telephone number

Important Information about Your Continuation Coverage Rights

What is continuation coverage?

State law requires group sickness and accident policies and group health insuring corporation contracts to provide continuation coverage to eligible employees, and their eligible dependents. You are an eligible employee if you have been covered under your former employer's health care coverage for the past three months, you were involuntarily terminated for other than gross misconduct and you are not covered by or eligible for coverage under Medicare or any other group health care coverage.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, except that under state law the continuation coverage is not required to include benefits in addition to hospital, surgical or major medical coverage and prescription drug coverage if covered under the group policy or contract.

How long will continuation coverage last?

State continuation coverage lasts for twelve months. Continuation coverage will be terminated before the end of the maximum period if:

- Any required premium is not paid in full on time,
- You become covered by or eligible for Medicare
- You become covered by or eligible for other group coverage
- The employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

How can you elect continuation coverage?

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have a 63-day gap in health coverage, and election of continuation coverage may help prevent such a gap. Second, you will lose the guaranteed right to purchase individual health coverage that does not impose a preexisting condition exclusion if you do not elect continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. *[Insert general information regarding the cost of continuation coverage.]*

[*If employees might be eligible for trade adjustment assistance, the following information must be added*: The Trade Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC). Under the tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.]

When and how must payment for continuation coverage be made?

[Insert information regarding the requirements related to payment for continuation coverage, including any periodic payment provisions or permissible grace periods.]

You may contact [*enter appropriate contact information for the party responsible for continuation coverage administration under the Plan*] to confirm the correct amount of your first payment.

Your first payment and all periodic payment(s) for continuation coverage should be sent to:

[*enter appropriate payment address*]

For more information

This notice does not fully describe continuation coverage or other rights with respect to your coverage. More information is available from [*enter appropriate contact information for the party responsible for continuation coverage administration under the Plan*].

If you have any questions concerning the information in this notice, or your rights to coverage you should contact [*enter name of party responsible for continuation coverage administration for the Plan, with telephone number and address*].

For more information about your rights under state law, contact the Ohio Department of Insurance at 1(800) 686-1526.

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep [*enter name and contact information for the appropriate party responsible for continuation coverage administration under the Plan*] informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to [*enter the name of the party responsible for continuation coverage administration under the Plan*].

EXHIBIT B

Model General Notice Of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)

** Continuation Coverage Rights Under COBRA**

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [*choose and enter appropriate information:* must pay *or* are not required to pay] for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

[*If the Plan provides retiree health coverage, add the following paragraph:*]

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to [*enter name of employer sponsoring the plan*], and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, [*add if Plan provides retiree health coverage:* commencement of a proceeding in bankruptcy with respect to the employer,] or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days [*or enter longer period permitted under the terms of the Plan*] after the qualifying event occurs. You must provide this notice to: [*Enter name of appropriate party*]. [*Add description of any additional Plan procedures for this notice, including a description of any required information or documentation.*]

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered

employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. [*Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice.*]

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

[*Enter name of group health plan and name (or position), address and phone number of party or parties from whom information about the plan and COBRA continuation coverage can be obtained on request.*]

Model COBRA Continuation Coverage Election Notice
(For use by single-employer group health plans)

[*Enter date of notice*]

Dear: [*Identify the qualified beneficiary(ies), by name or status*]

This notice contains important information about your right to continue your health care coverage in the [*enter name of group health plan*] (the Plan). Please read the information contained in this notice very carefully.

To elect COBRA continuation coverage, follow the instructions on the next page to complete the enclosed Election Form and submit it to us.

If you do not elect COBRA continuation coverage, your coverage under the Plan will end on [*enter date*] due to [*check appropriate box*]:

☐ End of employment	☐ Reduction in hours of employment
☐ Death of employee	☐ Divorce or legal separation
☐ Entitlement to Medicare	☐ Loss of dependent child status

Each person ("qualified beneficiary") in the category(ies) checked below is entitled to elect COBRA continuation coverage, which will continue group health care coverage under the Plan for up to ___ months [*enter* 18 *or* 36*, as appropriate and check appropriate box or boxes; names may be added*]:

☐ Employee or former employee
☐ Spouse or former spouse
☐ Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage
☐ Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan

If elected, COBRA continuation coverage will begin on [*enter date*] and can last until [*enter date*]. [*Add, if appropriate:* You may elect any of the following options for COBRA continuation coverage: [*list available coverage options*].

COBRA continuation coverage will cost: [*enter amount each qualified beneficiary will be required to pay for each option per month of coverage and any other permitted coverage periods.*] You do not have to send any payment with the Election Form. Important additional information about payment for COBRA continuation coverage is included in the pages following the Election Form.

If you have any questions about this notice or your rights to COBRA continuation coverage, you should contact [*enter name of party responsible for COBRA administration for the Plan, with telephone number and address*].

COBRA Continuation Coverage Election Form

Instructions: To elect COBRA continuation coverage, complete this Election Form and return it to us. Under federal law, you must have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan.

Send completed Election Form to: [*Enter Name and Address*]

This Election Form must be completed and returned by mail [*or describe other means of submission and due date*]. If mailed, it must be post-marked no later than [*enter date*].

If you do not submit a completed Election Form by the due date shown above, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form.

Read the important information about your rights included in the pages after the Election Form.

I (We) elect COBRA continuation coverage in the [*enter name of plan*] (the Plan) as indicated below:

Name   Date of Birth   Relationship to Employee   SSN (or other identifier)

a. ____

[*Add if appropriate:* Coverage option elected: ___________________________]

b. ____

[*Add if appropriate:* Coverage option elected: ___________________________]

c. ____

[*Add if appropriate:* Coverage option elected: ___________________________]

______________________________   ______________________________

Signature   Date

______________________________   ______________________________

Print Name   Relationship to individual(s) listed above

____

____

______________________________   ______________________________

Print Address   Telephone number

Important Information About Your COBRA Continuation Coverage Rights

What is continuation coverage?

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired employee) covered under the group health plan, the covered employee's spouse, and the dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including [*add if applicable:* open enrollment and] special enrollment rights.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

[*If the maximum period shown on page 1 of this notice is less than 36 months, add the following three paragraphs:*]

How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify [*enter name of party responsible for COBRA administration*] of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. [*Describe Plan provisions for requiring notice of disability determination, including time frames and procedures.*] Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan of that fact within 30 days after SSA's determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

How can you elect COBRA continuation coverage?

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

[*If employees might be eligible for trade adjustment assistance, the following information may be added*: The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.cfm.

When and how must payment for COBRA continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact [*enter appropriate contact information, e.g., the Plan Administrator or other party responsible for COBRA administration under the Plan*] to confirm the correct amount of your first payment.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the [*enter due day for each monthly payment*] for that coverage period. [*If Plan offers other payment schedules, enter with appropriate dates:* You may instead make payments for continuation coverage for the following coverage periods, due on the following dates:]. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan [*select one:* will *or* will not] send periodic notices of payments due for these coverage periods.

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period [*or enter longer period permitted by Plan*] to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. [*If Plan suspends coverage during grace period for nonpayment, enter and modify as necessary:* However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.]

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Your first payment and all periodic payments for continuation coverage should be sent to:

[*enter appropriate payment address*]

For more information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator.

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, you should contact [*enter name of party responsible for COBRA administration for the Plan, with telephone number and address*].

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.