Maintaining Your Plan

Explanation of Qualifying Benefits

Your Section 125 Premium Only Plan (POP) saves money for you and your employees by reducing payroll taxes. It works by making one simple adjustment in your payroll process: employees (via payroll deduction) pay their portion of insurance premiums, or applicable HSA contributions, if any, on a pre-tax basis, rather than on an after-tax basis.

The POP reduces your taxable payroll by reducing your employees' taxable income. So that, for every $1,000 of insurance your employees deduct (pre-tax) off their payroll checks, you, the employer, save about $80 in FICA taxes.

With POP, the IRS allows pre-tax payroll deductions for only certain types of health, disability and group-term life insurance premiums. In addition, employees can make contributions to their Health Savings Account (HSA) via pre-tax payroll deduction with POP.

Health Plans

Your POP plan allows pre-tax payroll deductions for the following types of health insurance and voluntary benefits:

- Low-deductible, or traditional, group health insurance
- Qualified HDHP or HSA-Compatible group health insurance
- High deductible group health insurance
- Spousal Surcharges included in group health insurance
- Mini-Med and Short-term medical
- Hospital indemnity and accident coverage. Benefits paid in excess of unreimbursed medical expenses will be taxable.
- Dental insurance and vision insurance
- Accidental death & dismemberment insurance
- Cancer and critical illness insurance. Benefits paid in excess of unreimbursed medical expenses will be taxable.

Premiums for "cash-value" and "return of premium" types of insurance may NOT be deducted on a pre-tax basis from employee paychecks. Products with a "cash-value" feature include: whole life insurance, universal life insurance and variable life insurance. Products with a "return of premium" feature include certain critical illness and cancer policies.

Premium Only Plan Open Enrollment: Employer's qualified POP benefits may have different plan years that do not coincide with the POP documents. The POP open enrollment period is only for the qualified benefits that are also open for enrollment changes. As other insurance plans and policies come up for their open enrollment periods, changes to POP participant elections may be changed at that time.

For example, if the employer's health insurance and the POP are on the same plan year and the vision and dental policies are on different plan years, employees may change their elections to the health insurance at the POP open enrollment and also change just their vision and dental elections when the vision and dental policies are open for new year enrollments.

Marketplaces/State Exchanges: Employees may elect pre-tax payroll deductions for any employer-sponsored group health insurance which also includes Marketplace/State Exchanges Small Business

Health Options Program (SHOP Exchange) or federally facilitated Small Business Health Options Program (FF SHOP).

Small Business Health Options Program (SHOP Exchange) or federally facilitated Small Business Heath Options Program (FF SHOP) allows small employers to offer their employees group health insurance. Generally, a "small employer" is an employer with 50 or fewer full-time employee equivalents. Some states may consider employers with 100 employees to be small employers.

Employers participating in the SHOP may pay a portion of the group health coverage premium for their employees. Prior to your employees' enrollments in a SHOP, you will select the method of employer contributions at the Exchange.

Consult with your agent or broker for more information about the Exchange option offered in your state.

Tax Treatment of Health Coverage Provided for Domestic Partners: The federal government recognizes legal, same-sex marriages and applies all rights and privileges to spouses in same-sex marriages. Participants may only pay the domestic partner's portion of the premiums on a pre-tax basis through the Premium Only Plan if the domestic partner qualifies as the Participant's IRC Section 152 tax dependent or is legally married.

Under federal law, if a Participant's (non-spouse) domestic partner does not qualify as the Participant's tax dependent, then the portion of the premiums the employer pays for the coverage of the Participant's domestic partner will be included in his/her gross income, subject to federal income tax withholding and employment taxes. This amount will be reported on his/her Form W-2.

Individual Medical Premiums are NOT Eligible for POP: It is important to be aware of guidance* issued by the IRS and Department of Labor that prohibits the use of pre-tax funds for the purchase or reimbursement of Individual Medical (IM) coverage, in turn eliminating the associated tax advantages. In other words, premiums for IM do not qualify for pre-tax payroll deduction. If you plan to send your employees to the Marketplace (Exchange) for IM coverage, you may want to reconsider. While employer-sponsored group health insurance premiums continue to be tax deductible, IM premiums do not qualify for the same favorable treatment. That said, the voluntary benefits mentioned above still qualify for POP because the law does not consider them to be IM.

*The Department of Labor (DOL) released "FAQs about Affordable Care Act Implementation (Part XXII)" on November 6, 2014.

In addition to health insurance, your POP permits employees to make pre-tax payroll deductions for employer-sponsored group-term life insurance, disability insurance and Health Savings Accounts.

Group-term life insurance

Employees may payroll deduct, on a pre-tax basis, up to $50,000 of group term life coverage. The $50,000 limit must include any employer-provided group-term life insurance coverage. For example, if the employer provides $20,000 of employer-sponsored group-term life insurance for every employee, then participants in the POP can only pay premiums on a pre-tax basis for an additional $30,000 worth of coverage.

However, employees may not pay premiums that cover spouses or dependents on a pre-tax basis, even if the amount is de minimis.

Disability insurance

Although short- and long-term disability premiums may be deducted on a pre-tax basis, there may be negative consequences when and if a claim is made. That's because, when disability is payroll deducted on a pre-tax basis, any benefits received in the future will be taxable to the employee. Therefore, under most circumstances, it is recommended that disability premiums NOT be included in the plan.

New Guidelines for Excepted Benefits and Annual and Lifetime Limits
There's more to benefits than just major medical coverage. Other types of insurance are utilized by employers; however, confusion reigns in the murky waters of these "other" types of coverage. See our alerts "New Rules for Excepted Benefits" and "Final Rules for Excepted Benefits." On June 10, 2016, the Departments of Labor (DOL), Health and Human Services (HHS) and the IRS ("The Departments") issued proposed regulations with respect to requirements for short-term limited-duration insurance, similar supplemental health coverage, and prohibition on lifetime and annual limits.

Final rules for these excepted benefits and prohibition on lifetime and annual dollar limits were issued October 28, 2016 and apply to group health plans and health insurance issuers beginning on the first day of the first plan year (or, in the individual market, the first day of the first policy year) beginning on or after January 1, 2017.

Short-Term, Limited-Duration Insurance is designed to fill temporary gaps in coverage when someone is moving from one plan to another or changing jobs, is not an excepted benefit, and is not exempt from the annual or lifetime annual dollar limits. It cannot take the place of regular insurance cover either.

In order for short-term insurance to qualify as an excepted benefit, the coverage must have an initial coverage period of fewer than 12 months. The plan must have an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder with or without the issuer's consent) that cannot be longer than a total of 36 months from the active date of the contract. The plan also must prominently display in the contract or any application materials, in at least 14 points type, "THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFILES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE ADDITIONAL PAYMENT WITH YOUR TAXES."

Similar Supplemental Health Coverage is designed to fill in the gaps in cost sharing of the primary coverage only if the benefits covered by supplemental insurance products are not an essential health benefit (EHB). If any benefit provided by the supplemental policy is either included in the primary coverage or is an EHB in the State where the coverage is issued, the insurance coverage would not be supplemental excepted benefits.

However, supplemental health insurance products that both fill in the gaps of cost sharing in the primary coverage, such as coinsurance and deductibles, **and** cover additional categories of benefits that are not EHB, would be considered supplemental excepted benefits provided all other criteria are met.

Definition of EHB for Purposes of the Prohibition on Lifetime and Annual Limits
For plan years or policy years beginning on or after January 1, 2017, a plan or issuer that is not required to provide EHB must define EHB for purposes of the prohibition on lifetime and annual dollar limits in a manner consistent with any (1) one of the EHB-benchmark plans applicable in a State under 45 CFR 156.110, and includes coverage of any additional required benefits that are considered EHB consistent with 45 CFR 155.170(a)(2); or (2) one of the three Federal Employees Health Benefit Program (FEHBP) plan options as defined by 45 CFR 156.100(a)(3), supplemented as necessary, to meet the standards in 45 CFR 156.110.

The revised definitions apply to policy years beginning on or after January 1, 2017. However, due to policies currently in force, HHS will not take enforcement action against the issuer before April 1, 2017.

The Departments intend to address hospital indemnity or other fixed indemnity insurance and expatriate health plans in further rulemaking, taking into account comments received on these issues.

Health Savings Account (HSA)

There are IRS rules that govern an employer's ability to offer an HSA and who may qualify under any such program. Please contact your insurance agent, broker or benefit plan consultant for more information concerning HSAs and your ability to utilize such programs. Employees may payroll deduct, on a pre-tax basis, elected contributions to a Health Savings Account established on their behalf. Employers may also contribute matching or other employer contribution amounts through this Plan.

Health Savings Account (HSA) -Indexed Figures	2019	2020	2021
Minimum deductible amounts for the qualifying high deductible health plan (HDHP)			
Individual Coverage	$1,350	$1,400	$1,400
Family Coverage	$2,700	$2,800	$2,800
Maximum contribution levels			
Individual Coverage	$3,500	$3,550	$3,600
Family Coverage	$7,000	$7,100	$7,200
Catch-up contribution allowed For those 55 and over	$1,000	$1,000	$1,000
Maximum for HDHP out-of-pocket expenses			
Individual Coverage	$6,750	$6,900	$7,000
Family Coverage	$13,500	$13,800	$14,000

Summary Plan Description (SPD)

The Department of Labor requires a Summary Plan Description (SPD) be distributed to participants covered under a plan within 90 days after a participant first becomes covered under the plan. For new plans, the plan administrator must distribute an SPD to participant within 120 days after the plan has been established.

The SPD is to be written in a manner that can be understood by the average plan participant and may be provided in written, electronic, or other appropriate form to the extent the SPD is reasonably accessible.

Every fifth year, if the SPD is updated, but no "material" modifications are made to the SPD, an updated SPD which integrates all plan amendments must be distributed to employees.

Every tenth year, if the SPD has not been modified, an SPD is required to be distributed to employees.

However, it is common sense to provide this important information to employees before requiring they make an election to the POP for the plan year. That is why the Section 125 Premium Only Plan Checklist advises the employer to photocopy and distribute a copy of the SPD to every employee each plan year.

W-2 Reporting

The Form W-2 instructions and reporting requirements include rules for reporting employer-sponsored health coverage. Each employee's W-2 must include the total cost of employer-provided health insurance. What does this mean to you? Contact your payroll company to ensure they have all the information they need for this new W-2 obligation. They will need the employer-paid portion of the health insurance coverage to complete the W-2 correctly. And don't worry – this reporting will not increase the employee's taxable income.

Code DD has been added to box 12 of the Form W-2 to report the cost of employer-sponsored health coverage. Additional reporting guidance is available in Notice 2010-69 at www.irs.gov/irb/2010-44_IRB/ar13.html.

Change in Status

The "Permitted Election Changes" 1.125-4 Regulations may be lengthy, but are very important to understand. That's why we've included the change in status regulations in Section 7 of the POP-Kit.

There is a two-prong approach to determining whether a participant may change their election during the POP year. First, did the participant incur a change in status event that resulted in a loss or gain of eligibility for the participant, spouse or dependent and secondly, was the change to their election consistent with the reason for the change? Asking these two questions before allowing a change to a participant's election will keep your POP in compliance with current IRS Regulations.

For instance, if a participant in your POP requests to revoke their election during the POP year and make a new election for the remaining portion of the POP year, the change may be permitted if under the facts and circumstances 1) the change in status described in the Regulations has occurred; and 2) the election change satisfies the consistency rule of paragraph (c)(3) of the IRS 1.125-4 Regulations as follows:

> "(c)(3) An election change satisfies the requirements of this paragraph (c)(3) with respect to accident or health coverage or group-term life insurance only if the election change is on account of and corresponds with a change in status that affects eligibility for coverage under an employer's plan. A change in status that affects eligibility under an employer's plan includes a change in status that results in an increase or decrease in the number of an employee's family members or dependents who may benefit from coverage under the plan."

(This is an excerpt from IRS 1.125-4 Regulations)

Addition or Improvement of a Benefit Package Option

Also contained in the "Permitted Election Changes" Regulations is a blanket reason where all employees may change their election in the middle of a POP year.

If a plan adds a new benefit package option or other coverage option, or if coverage under an existing benefit package option or other coverage option is significantly improved during a period of coverage, the cafeteria plan may permit eligible employees (whether or not they have previously made an election under the cafeteria plan or have previously elected the benefit package option) to revoke their election under the cafeteria plan and, in lieu thereof, to make an election on a prospective basis for coverage under the new or improved benefit package option.

Election Change Due to Reduction of Hours

Per IRS Notice 2014-15, employees are now allowed to change their elections under the Premium Only Plan during their period of coverage (the plan year) due to moving from full-time to part-time employment. If the move results in a reduction in hours, they may revoke their election if they are still eligible or ineligible for the group health plan coverage.

Conditions for revocation due to reduction in hours of service:

- An employee who previously was reasonably expected to average at least 30 hours of service per week now is reasonably expected to average less than 30 hours of service per week, even if the reduction in hours does not result in the employee ceasing to be eligible under the group health plan; and
- The revocation of election from the group health plan corresponds to the intended enrollment of employee and spouse and dependents, if applicable, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

Election Change Due to Marketplace Enrollment

Per IRS Notice 2014-15, participants may now revoke elections for employer health coverage during a Marketplace open enrollment period or a Marketplace "Special Enrollment Period." For instance, this allows participants in non-calendar year cafeteria plans to switch from employer to Marketplace coverage with no double coverage or loss in coverage for the transition period. Another example entails employees that may have a change in status event such as marriage or birth. They may not want to add new family members to their existing employer-provided coverage, but seek coverage for the family at the Marketplace.

Conditions for revocation due to enrollment in Marketplace Qualified Health Plan (QHP):

- employee is eligible for a Special Enrollment Period to enroll in a QHP through a Marketplace or employee seeks to enroll in QHP through a Marketplace during the Marketplace's annual open enrollment period; and
- The revocation of election from the group health plan corresponds to the intended enrollment of employee and spouse and dependents, if applicable, in a QHP through the Marketplace for new coverage effective no later than the day immediately following the last day of the original coverage that is revoked.

In either situation, the plan can rely on the reasonable representation of an employee that the employee and spouse and dependents, if applicable, have enrolled or intend to enroll in another plan that meets the above requirements.

Small Group Expansion

The definition of a small employer, for purposes of the market reforms under the Affordable Care Act, has been revised. It still defines a small employer as an employer who employed an average of 1-50 employees on business days during the preceding calendar year, but provides States the option of extending the definition of small employer to include employers up to 100 employees.
Talk with your agent or broker in your State to determine employee counts.

Services Provided to Data Breach Victims

In response to data breaches, organizations often provide credit reporting and monitoring services, identity theft insurance policies, identity restoration services, or other identity protection services. The IRS announced that the value of the identity protection services should not be included in individuals' gross incomes whether the employees were or were not victims of a data breach.
This announcement does not apply to cash in lieu of these services or proceeds received under an identity theft policy.
Employees may **not** pay for identity theft policies through a Code Section 125 Premium Only Plan.

Medicare Supplement Plans

Confused about Medicare, supplement plans and pre-taxing? Here's the scoop.

Medicare supplement plans named "C," "F," "G," and "N" are not offered by social security. The Social Security Administration at www.ssa.gov is where you'll find out about retiring and Medicare, including Medicare Part A, B, and D. But, you won't find any information about Medicare Parts C, F, G, or N.

Medicare Parts C, F, G, and N are insurance carriers' names for Medicare supplement plans and you'll only find out information about these plans from insurance companies selling supplemental plans.

The next question we receive is if the premiums for Medicare plans and these supplemental plans can be paid on a pretax basis through the Premium Only Plan (POP). The answer is – generally, no. Although there is no Internal Revenue Service (IRS) direct guidance regarding pre-taxing Medicare Part B or D premiums or Medicare supplemental policies, the Medicare second Payer (MSP) rules and agency guidance regarding "employer payment plans" will restrict such arrangements.

Disaster Relief for Plans Affected by Natural Disasters

Generally, disaster relief is afforded to individuals as to filing tax returns. Plan participants may encounter an array of problems due to such difficulties meeting certain deadlines for filing benefit claims and COBRA elections. And, a great deal of the disaster relief is for retirement and 401(k) plans. Such as forwarding contributions to the retirement plans.

Unfortunately, “financial hardship” due to natural disasters is not a qualifying event that would allow your Premium Only Plan (POP) participants to discontinue paying their premiums through your plan.

Why Compliance is Important

Each year Congress enacts new laws and/or IRS issues new rulings to protect employees and their benefit plans.

In the event of an IRS audit the IRS agent will ask to see a plan document and amendments. A current plan document and summary plan description are the employer's contract with employees. Next, the IRS looks at election forms to see that all qualified employees are allowed to participate. Finally, the IRS agent looks to see that you perform non-discrimination testing, each year, to confirm that owners or key employees do not receive benefits at the expense of others.

As an employer that sponsors a Section 125 Plan, failure to comply with these rules puts you at risk for substantial tax liabilities and penalties. Without a plan document (or a plan document not amended to comply with recent tax changes), or even if your plan has a plan document but fails the annual discrimination test, you would be forced to repay employer and employee tax savings, plus penalties and interest. You would also incur the expense of issuing corrected W-2 forms to affected employees.

What the IRS Looks for on an Audit

This kit is designed to ensure that your plan is kept in compliance with current IRS requirements. As new requirements develop we will automatically notify you.

Documents the IRS may request include:

- Executed plan document and amendments
- Summary Plan Descriptions (SPD)
- Signed election forms
- List of employees that are both eligible and ineligible for the plan
- Related insurance policies
- The results of non-discrimination tests
- Reconciliation of employee pretax reductions with Form W-2
- Form 5500 (requirement suspended on April 4, 2002 in IRS Notice 2002-24)

Annual POP Compliance Confirmation

Your annual compliance kit will include all the necessary documents required to keep your Section 125 POP plan in compliance with new developments in the regulations. Please complete and sign the **POP Compliance Confirmation Form** and return it to us. You should keep a copy of the completed form in this section of your binder.

Newsletter

Your "*POP Insights*" newsletter will be available several times each year. It is filled with the latest developments and compliance reminders.

Questions?

If you have questions, please call 800-876-7548 or email, pophelp@healthequity.com.

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Premium Only Plan Change in Status Matrix

Event	Health Insurance (medical, dental, vision)	Employee Group Life, AD&D and STD/LTD
I. Change in Status		
Note: In order for election changes to be permitted under this exception, the election change must be on account of and correspond with the change in status.		
A. Change in Employee's Legal Marital Status		
1. Gain of Spouse (marriage). Note: HIPAA special enrollment rights may also apply.	Employee may enroll or increase election for newly eligible spouse and dependent children (under tag-along rule, preexisting dependents also may be enrolled) coverage option (e.g., HMO to PPO) change may be made; employee may revoke or decrease employee's or dependent's coverage only when such coverage becomes effective or is increased under the spouse's plan.	Employee may enroll, increase, decrease, or cease coverage even when eligibility is not affected.
2. Loss of Spouse (divorce, legal separation, annulment, death of spouse). (See loss of dependent eligibility below for discussion of dependent eligibility loss following divorce, separation etc.) Note: HIPAA special enrollment rights may also apply.	Employee may revoke election only for spouse; coverage option (e.g., HMO to PPO) change may be made. Employee may elect coverage for self or dependents who lose eligibility under spouse's plan if such individual loses eligibility as a result of divorce, legal separation, annulment, or death (under tag-along rule, any dependents may be enrolled so long as at least one dependent has lost coverage under spouse's plan).	Employee may enroll, increase, decrease, or cease coverage even when eligibility is not affected.
B. Change in Number of Employee's Dependents		
1. Gain Dependent (birth, adoption). Note: HIPAA special enrollment rights may also apply.	Employee may enroll or increase coverage for newly eligible dependent (under tag-along rule, any other dependents that were not previously covered may also enrolled); coverage option (e.g., HMO to PPO) change may be made. Employee may revoke or decrease employee or dependents coverage if employee or dependent becomes eligible under spouse's plan.	Employee may enroll, increase, decrease, or cease coverage even when eligibility is not affected.
2. Loss of Dependent.	Employee may drop coverage only for the dependent who loses eligibility; coverage option (e.g., HMO to PPO) change may be made.	Employee may enroll, increase, decrease, or cease coverage even when eligibility is not affected.
C. Change in Employment Status of Employee, Spouse or Dependent that Affects Eligibility		
1. Commencement of Employment by Employee, Spouse or Dependent (or other change in employment status) that Triggers Eligibility		

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Event	Health Insurance (medical, dental, vision)	Employee Group Life, AD&D and STD/LTD
a. Commencement of employment by employee or other change in employment status (e.g., PT to FT, hourly to salaried, etc.) triggering eligibility under component plan.	Provided that eligibility was gained for this coverage, employee may add coverage for employee, spouse, or dependents and coverage option (e.g., HMO to PPO) change may be made.	Employee may enroll, increase, decrease, or cease coverage even when eligibility is not affected.
b. Commencement of employment by spouse or dependent or other change in employment status triggering eligibility under spouse's or dependent's plan.	Employee may revoke or decrease election as to employee's, spouse's or dependent's coverage if employee, spouse or dependent is added to spouse's or dependent's plan; coverage option (e.g., HMO to PPO) change may be made.	Employee may enroll, increase, decrease, or cease coverage even when eligibility is not affected.
2. Termination of Employment by Employee, Spouse, or Dependent (or other change in employment status) that Causes Loss of Eligibility		
a. Termination of employee's employment or other change in employment status (e.g., unpaid leave, FT to PT, strike, salaried to hourly, etc.) resulting in a loss of eligibility	Employee may revoke or decrease election for employee, spouse, or dependent who loses eligibility under the plan. Coverage option change may be made.	Employee may enroll, increase, decrease, or cease coverage even when eligibility is not affected.
• Termination and rehire within 30 days	Prior elections at termination are reinstated unless another event has occurred that allows a change (as an alternative, employer may prohibit participation until next plan year).	Same as previous column.
• Termination with rehire after 30 days	Employee may make new elections.	Same as previous column.
b. Termination of spouse or dependent's employment (or other change in employment status resulting in a loss of eligibility under their employer's plan. Note: HIPAA special enrollment rights may also apply.	Employee may enroll or increase election for employee, spouse, or dependents who lose eligibility under spouse's or dependent's employer's plan. Also, coverage option (e.g. HMO to PPO) change may be made. In addition, other previously eligible dependents may also be enrolled under the "tag-along" rule.	Employee may enroll, increase, decrease, or cease coverage even when eligibility is not affected.
D. Event Causing Employee's Dependent to Satisfy or Cease to Satisfy Eligibility Requirements		
1. Event by Which Dependent Satisfies Eligibility Requirements Under Employer's Plan (attaining a specified age, becoming single, becoming a student, etc.).	Employee may enroll or increase election for newly eligible dependent. In addition, other previously eligible dependents may also be enrolled under tag-along rule; coverage option (e.g., HMO to PPO) change may be made.	Employee may enroll, increase, decrease, or cease coverage even when eligibility is not affected.
2. Event by Which Dependent Cease to Satisfy Eligibility Requirements Under Employer's Plan (attaining a specified age, getting married, ceasing to be a student, etc.).	Employee may decrease or revoke election only for affected dependent; coverage option (e.g., HMO to PPO) change may be made.	Employee may enroll, increase, decrease or cease coverage even when eligibility is not affected.

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Event	Health Insurance (medical, dental, vision)	Employee Group Life, AD&D and STD/LTD
E. Change in Place of Residence of Employee, Spouse or Dependent		
1. Move Triggers Eligibility.	Employee may enroll or increase election for newly eligible employee, spouse, or dependent. Also, other previously eligible dependents may be enrolled under tag-along rule; coverage option (e.g., HMO to PPO) change may be made.	Employee may enroll, increase, decrease, or cease coverage even when eligibility is not affected.
2. Move Causes Loss of Eligibility (e.g., employee or dependent moves outside HMO service area). NOTE: Special enrollment rights may also apply.	Employee may revoke election and make a new election if the change in residence affects the employee's, spouse's or dependent's eligibility for coverage option.	Employee may enroll, increase, decrease, or cease coverage even when eligibility is not affected.
II. Automatic Small Cost Changes		
Cost Changes With Automatic Increase/Decrease in Elective Contributions (including employer-motivated changes and changes in employee contribution rates).	Plan may automatically increase or decrease (on a reasonable and uniform basis) affected employees' elective contributions under the plan, so long as the terms of the plan require employees to make such corresponding changes.	Same as Health Insurance column.
III. Significant Cost Changes		
	Increase: Employee may increase election correspondingly or may revoke election and elect coverage under another benefit package option providing similar coverage. If no option providing similar coverage is available, employee may revoke election. Decrease: Employees may decrease election correspondingly or may elect coverage (even if had not participated before) with decreased cost and drop election for similar coverage option. Though unclear, it appears that tag-along concepts may apply.	Same as Health Insurance column.
IV. Significant Curtailment of Coverage (with or without Loss of Coverage)		
	Without Loss of Coverage: Affected participant may revoke election for curtailed coverage and make new prospective election for coverage under another benefit package option that provides similar coverage. With Loss of Coverage: Affected participant may revoke election for curtailed coverage and make new prospective election for coverage under another benefit package option that provides similar coverage, or drop coverage if no similar benefit package option is available. Though unclear, it appears that tag-along concepts may apply.	Same as Health Insurance column.

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Event	Health Insurance (medical, dental, vision)	Employee Group Life, AD&D and STD/LTD
V. Addition or Significant Improvement of Benefit Package Option		
	Eligible employees (whether currently participating or not) may revoke their existing election and elect the newly added (or newly improved) option. Though unclear, it appears that tag-along concepts may apply.	Same as previous column.
VI. Change in Coverage Under Other Employer's Plan		
Note: In order for election changes to be permitted under this exception, the election change must be on account of, and correspond with, the change in coverage under the plan of the spouse's, former spouse's or dependent's employer. In addition, either 1) the plan of the spouse's, former spouse's or dependent's employer must permit elections specified under the Regulations (as specified in this matrix) and an election must actually be made under such plan; or 2) the employee's cafeteria plan must permit elections for a period of coverage different from that under the plan of the spouse's former spouses or dependent's employer (Election-Lock rule).		
1. Other Employer Plan Increases Coverage.	Employee may decrease or revoke election for employee, spouse, or dependents if employee, spouse or dependents have elected or received corresponding increased coverage under other employer's plan.	Same as Health Insurance column.
2. Other Employer Plan Decreases or Ceases Coverage.	Employee may enroll or increase election for employee, spouse, or dependents if employee, spouse, or dependents have elected or received corresponding decreased coverage under other employer plan. Though unclear, it appears that tag-along concepts may apply.	Same as Health Insurance column.
3. Open Enrollment Under Other Employer Plan/Different Plan Year.	Corresponding changes can be made under employer's plan.	Corresponding changes can be made under employer's plan.
VII. FMLA Leave of Absence		
Note: Employees can fund this coverage by 1) pre-paying their contribution obligations on a pre-tax basis provided the leave does not straddle two plan years; 2) making contributions on a month-by-month basis (pre-tax if they are receiving salary continuation payments); or 3) catching up on their contributions upon returning from the leave provided the leave does not straddle two plan years.		

Event	Health Insurance (medical, dental, vision)	Employee Group Life, AD&D and STD/LTD
1. Employee's Commencement of FMLA Leave.	Employee can make same election changes as employee on non-FMLA leave. In addition, an employer must allow an employee on unpaid FMLA leave either to revoke coverage or to continue coverage but allow employee to discontinue payment of this or her share of the contribution during the leave (the employer may recover the employee's share of contributions when the employee returns to work). FMLA also allows an employer to require that employees on paid FMLA leave continue coverage if employees on non-FMLA paid leave are required to continue coverage.	Same as Health Insurance column.
2. Employee's Return From FMLA Leave.	Employee may make a new election if coverage terminated while on FMLA leave. In addition, an employer may require an employee to be reinstated in his or her election upon return from leave if employees who return from a non-FMLA leave are required to be reinstated in their elections.	Same as previous column.
VIII. Changes in 401(k) Contributions		
	No Change.	No Change.
IX. HIPAA Special Enrollment Rights		
1. Special Enrollment for Loss of Other Coverage.	Employee may elect coverage for employee, spouse, or dependent who has lost other coverage. Though unclear, it appears that tag-along concepts may apply.	No Change.
2. Special Enrollment for Acquisition of New Dependent by Birth, Marriage, Adoption, or Placement for Adoption. (If newborn or newly-adopted child is enrolled under HIPAA's special rules, child's coverage may be retroactive to date of birth, adoption or placement for adoption; employee may change salary reduction election within 30 days to pay for cost of child's coverage retroactive to date of birth, adoption or placement for adoption. (For marriage, salary reductions may only be changed prospectively.)	Employee may elect coverage for employee, spouse, or dependent. Under the tag-along rule, election coverage may also extend to previously eligible (but not yet enrolled) dependents.	No Change.
3. Special Enrollment for Loss of Medicaid or SCHIP Coverage. Note: There is a 60-day special enrollment period for this event.	Employee may elect coverage for employee or dependent who has lost Medicaid or SCHIP coverage. Though unclear, it appears that tag-along concepts may apply.	No Change.
4. Special Enrollment Due to Eligibility State Premium Assistance Subsidy from Medicaid or Children's Health Insurance Program (CHIP). Coverage retroactive if elected within 60 days of event.	Employee may elect coverage for employee or dependent who has become eligible for premium assistance subsidy from Medicaid or SCHIP. Though unclear, it appears that tag-along concepts may apply.	No Change.

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Event	Health Insurance (medical, dental, vision)	Employee Group Life, AD&D and STD/LTD
X. COBRA Qualifying Events		
	Employee may increase pre-tax contributions under employer's plan for coverage if COBRA event (or similar state-law continuation coverage event) occurs with respect to the employee, spouse, or dependents (such as a loss of eligibility for regular coverage due to loss of dependent status or a reduction of hours, etc.) and, if applicable, the individual still qualifies as a tax dependent for health coverage purposes.	No Change.
XI. Judgment, Decree or Orders		
1. Order That Requires Coverage for the Child Under Employee's Plan.	Employee may change election to provide coverage for the child. Though unclear, it appears tag-along rule concepts may apply.	No Change.
2. Order That Requires Spouse, Former Spouse or Other Individual to Provide Coverage for the Child.	Employee may change election to cancel coverage for the child provided the child is enrolled in the plan of the spouse, former spouse or other individual required to provide coverage.	No Change.

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Event	Health Insurance (medical, dental, vision)	Employee Group Life, AD&D and STD/LTD
XII. Medicare or Medicaid Entitlement		
1. Employee, Spouse or Dependent Enrolled in Employee's Plan Becomes Entitled to Medicare or Medicaid (other than coverage solely for pediatric vaccines).	Employee may elect to cancel or reduce coverage for employee, spouse or dependent as applicable.	No Change.
2. Employee, Spouse, or Dependent Loses Eligibility for Medicare or Medicaid (other than coverage solely for pediatric vaccines). See IX HIPAA Special Enrollment Rights	Employee may elect to commence or increase coverage for employee, spouse, or dependent as applicable. While unclear, tag-along concepts might apply, allowing the employee to add coverage for family member as well.	No Change.
XIII. Loss of Governmental or Educational Institution Group Health Coverage.		
Loss of Group Health Coverage Sponsored by Governmental or Educational Institution. Note: In the event of a loss of coverage under SCHIP, HIPAA special enrollment rights may apply.	Employee may enroll or increase election for employee, spouse, or dependent if employee, spouse, or dependent loses group health coverage sponsored by governmental or educational institution. Though the issue is unclear, tag-along concepts might apply, allowing the employee who loses individual coverage to add coverage for family members as well.	No Change.
XIV. Health Insurance Marketplace (Marketplace enrolment)		
1. Employee becomes eligible to enroll in qualified health place (QHB) during open enrollment as outlined by the Affordable Care Act.	Employee may elect to cancel coverage for employee, spouse, or dependents as applicable and enroll in a QHP through a Marketplace. The revocation of election from the group health plan corresponds to the intended enrollment for new coverage effective no later than the day immediately following the last day of the original coverage that revoked.	No Change.
2. Employee becomes eligible to enroll in a Qualified Health Plans (QHP) during a special enrollment period, such as a marriage or addition of dependent	Same as above	No Change.
XV. Reduction of Hours		
1. Employee who previously reasonably expected to average at least 30 hours of service per week now is reasonably expected average less than 30 hours of service per week, even if the reduction in hours does not result in the employee ceasing to be eligible under the group health plan.	Employee may elect to cancel coverage for employee, spouse or dependent, as applicable and enroll in a QHP through a Marketplace. The revocation of election from the group health plan corresponds to the intended enrollment of employee and spouse and dependents, if applicable, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.	No Change.

Notes: