

SBU Compliance Guide

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# Plan Administration Best Practices

Administration, Eligibility & Participation - Medical Insurance

* Maintains clearly defined benefit eligibility for participation in all benefit plans and allows participation accordingly.
* Allows participation in medical insurance for FT employees who average 30 or more work hours per week. If offering part-time employees coverage, is consistent in allowing participation and has this defined in plan documents.
* Maintains clearly defined employment categories for full-time (FT), part-time (PT), temporary and seasonal employees.
* Allows medical insurance to start no later than 90-days from date of hire for full-time employees (unless using a 30-day orientation period).
* If group benefits are offered, employer offers to all eligible employees (non-discrimination)
* Maintain annual records of completed VT Form HC-2 for all employees
* **ACA -** counting employees and offer of coverage for **part-time/variable hour** employees
  + Maintains a measurement period defining the time period to determine eligibility using a monthly method or look back of 90-days to 12 months approach. Anyone averaging 30-hours are more for their defined measurement period is allowed to participate. May define different measurement periods for new hires and ongoing employees.
  + Defines an administrative period of 30 to 90 calendar days following the measurement period to determine eligibility and get participants on the plan. The combined measurement period and administrative period cannot be more than 13 months for new employees.
  + Manages a stability period allowing participants to remain on the medical plan, once they meet measurement period requirements for a time period of 6 months or the same time as the measurement period months, whichever is greater.
* Does not discriminate in medical insurance and other tax-favored benefits toward highly compensated individuals, key employees or owners.
* If employer has an HRA, pays applicable Patient Centered Outcomes Research Institute fees by July 31st (PCORI Fees) of each year.
* Periodically and timely review of carrier billing statements.

Benefit Termination / Qualifying Events

* Timely notification to plan providers of employee termination date and time to remove them from coverage.
* Sends qualifying event continuation of coverage (COBRA/Viper) notice to participant and beneficiaries (or notifies outsourced COBRA provider of the need to send notice).

Documentation/Record Keeping

* Documentation should be kept for 6 years following the end of the ERISA plan year (essentially 7 years)
* Maintains an ERISA Wrap Plan Document/Summary Plan Description.
* **ACA -** Maintains a written eligibility policy that defines the measurement, administrative and stability periods for full-time, part-time and variable hour employees.
* Keeps record of all participants, whose coverage has been rescinded and 30-days advance notice of such rescission of coverage.
* Maintains evidence of plan’s compliance with the Affordable Care Act and following all applicable requirements.

Open Enrollment/Communications

* Reviews plan alternatives and coverage options annually looking out for the best interest of participants, beneficiaries and the company.
* Allows participants to enroll or make changes to benefits once a year during open enrollment, unless they experience a qualifying event allowing an additional opportunity to make changes.
* Follows guidelines allowing participants to make changes mid-year for allowable qualifying events such as loss of coverage, marriage, new baby, divorce, etc.
* Communicates all plan options, rights and rates to eligible participants, including COBRA participants and if applicable, Retirees.
* Collects an application or waiver form from all eligible participants.

# Disclosures & Notifications

If offering medical insurance, provide the following applicable notices to eligible participants and beneficiaries annually, unless noted otherwise:

* Summary of Benefits & Coverage (SBC) - Given to new participants upon application and annually to all participants for renewal. *Failure to provide an SBC could be subject to a penalty of $1,105 per employee per failure to provide.*
  + SBC is also required 60 days in advance of a material modification not in conjunction with renewal.
* Employee Notice of Exchange (All employers to all employees) within 14 days of hire.
* ACA required patient protection and provider selection notification (all medical plans, if applicable).
* Initial COBRA Notice (20+ employees) or Viper/NH Continuation notice (< 20 employees).
* HIPAA Notice of Privacy Practices (all plans).
* HIPAA Special enrollment rights notice (all plans).
* Women’s Health & Cancer Rights Act Notice (all plans).
* Newborn’s and Mother’s Health Protect Act Notice.
* Children’s Health Insurance Program (CHIP) Reauthorization Act Notice.
* Medicare Part D Notice each year by October 15th (any participant eligible for Medicare – includes dependents).

# COBRA/Viper/NH Continuation of Coverage Administration

VT/NH Employers with 20 or more employees

* Maintains a COBRA administration policy and procedures or outsources COBRA administration to ensure all rights and responsibilities are met.
  + Provides initial/general COBRA notice to new participants within 90-days of joining the plan.
  + Provides qualifying event or election notices within 14-days of a qualifying event such as termination of employment and other loss of coverage events.
  + Collects COBRA participant’s premium payments and pays on their behalf to insurance providers.
  + Provides COBRA participants with benefit plan information, changes, rights and costs similar to information given to employee participants.
  + Allows COBRA rights for past employees and eligible dependents.
  + Allows participants to stay on for their eligible amount of time.
  + Provides notice of unavailable continuation of coverage for the following:
    - If someone applies for continuation coverage and is not eligible.
    - If participants are 30-days or later on making COBRA premium payment.
  + When the plan is about to terminate.
    - Provides details about the date the plan terminates, reason for termination and applicable rights, if any.

VT Employers with fewer than 20 employees (Viper)

* + Employers must notify former employee of Viper rights within 30 days following qualifying event.
  + Viper participant has 60 days to notify the insurer in writing if they want to continue coverage.
  + Initial premium must be paid to the insurance company within 60 days after receiving Viper rights notice.
  + Collects Viper participant’s premium payments and pays on their behalf to insurance providers.
  + Provides Viper participants with benefit plan information, changes, rights and costs similar to information given to employee participants.
  + Allows Viper rights for past employees and eligible dependents.
  + Allows participants to stay on for their eligible amount of time.

NH Employers with fewer than 20 employees

* + Employers must notify former employee of NH Continuation Law rights within 30 days following qualifying event.
  + Initial premium must be paid to the employer within 45 days after receiving Continuation rights notice.
  + Collects Continuation participant’s premium payments and pays on their behalf to insurance providers.
  + Provides Continuation participants with benefit plan information, changes, rights and costs similar to information given to employee participants.
  + Allows Continuation rights for past employees and eligible dependents.
  + Allows participants to stay on for their eligible amount of time.

# Flexible Spending Accounts (if applicable)

(A written plan document is required if allowing payment of eligible premiums on a pre-tax basis and/or allowing payment of eligible uncovered medical cost or work related dependent care on a pre-tax basis.)

* Participants estimate contributions for medical and/or dependent care spending accounts at the beginning of the year with deductions coming out each pay period.
* Changes to contribution levels are not allowed, unless participant experiences a mid-year qualifying event.
* Participants are allowed to make annual changes during open enrollment.
* Contribution amounts for medical FSA are limited to not more than $2,650 (2018) (New annual limit each year).
* Distributions to FSA medical and dependent care are only allowed for eligible expenses.
* Unused contributions are subject to “use-it-or-lose-it”. Employees are not directly refunded estimated deductions, and they do not carry over to the next year except as define here.
  + If written into your plan, you may allow a grace period of up to 2.5 months after the end of the plan year to allow qualified deductions.
  + Plans may allow up to $500 of unused amounts remaining at the end of the plan year for medical expenses incurred in the following year.
    - The plan may allow either the grace period or a carryover, but not both.
* It is the employer’s responsibility to distribute the Section 125 Health Flexible Spending Account and/or Dependent Care Account summary plan description(s) to plan participants.

# Health Reimbursement Accounts (if applicable)

* Administers plan according to plan provisions (i.e. if HRA funds are allowed to be rolled over to the next year, proper accounting and funding is established; if no rollover provision, participants are notified prior to enrollment).
* Solely funded by the employer. No salary deductions are allowed by participants.
  + Reimburses eligible participants for qualified medical expenses up to the maximum amount for a coverage period on a tax-free basis.
  + Employer is not required to report on W-2 or show as wages.
  + Does not allow self-employed individuals to participate.

# Health Savings Accounts(if applicable)

* Employer understands employer contributions are subject to comparability rules if contributions are made outside of a cafeteria plan.
* HSA is only made available only to participants in a high deductible health plan (HDHP)
  + Participants cannot participate in an HSA and FSA, unless the FSA is a “limited” FSA plan. This includes coverage through a spouse.
  + Reimbursements are allowed only for eligible medical expenses.
* HDHP minimum deductible amounts
  + Single - $1,300 (2017) / $1,350 (2018)
  + Family - $2,600 (2017)/ $2,700 (2018)
* HDHP maximum out-of-pocket amounts
  + Single - $6,550 (2017) / $6,650 (2018)
  + Family - $13,100 (2017) / $13,300 (2018)
* Does not allow contributions in excess of HSA limits allowed on a pre-tax basis:
  + Single - $3,400 (2017) $3,450 (2018)
  + Family - $6,750 (2017) $6,900 (2018)
* Allows up to an additional $1,000 for participants who are 55 or older at the end of the tax year.

# 125 Premium Only Plans (POP) (if applicable)

(If allowing payment of eligible premiums on a pre-tax basis and does not have FSA healthcare/dependent care)

* Maintains a current Section 125 Plan document (post 2014).
* Does not allow owners (except C Corp owners) to participate in the 125 POP plan.
* Does not discriminate in favor of Highly Compensated Individuals (HCI) in the following annual nondiscrimination tests:
  + **Eligibility Test:** Does not exclude non-HCIs from participating in favor of HCIs and key employees.
  + **Concentration & Benefit (Utilization) Test:** Waiting periods, employee contributions and benefit levels are uniform for participants, not favoring HCI.
  + **Key Employee Concentration Test:** Key employees do not receive more than 25% of the total of nontaxable benefits provided to all employees.